

Michigan Story Boards

Michigan's MLC-2 Efforts

As part of its MLC-2 efforts Michigan has selected four local health departments (LHDs) to participate in a collaborative process to design, develop, and implement accreditation-based quality improvement projects. The counties of Berrien, Kent, Genesee, and Ottawa chose organizational capacity targets and are applying the Plan-Do-Check-Act approach using Rapid Cycle Improvement.

Organizational Capacity

Organizational capacity may be defined as the ability of an organization to carry out the essential public health services, and in particular, to provide specific services; for example, disease surveillance, community education, or clinical screening. This ability is made possible by specific program resources and by maintenance of the basic infrastructure of the public health system. The Ottawa County Health Department is addressing leadership, planning, and communication issues spanning their entire organization; Berrien County Health Department is building media capacity; Genesee County Health Department is improving their capacity for surveillance and communication; and Kent County Health Department is building organizational capacity in the areas of outreach and education.

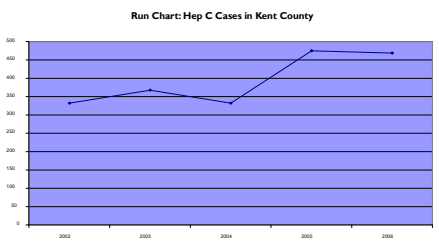
Michigan Story Boards

Each of the LHDs presented their QI efforts by using Quality Improvement Story Boards. The story board is a way of reporting on quality improvement or performance excellence by highlighting key points and breakthroughs within a story of the project. The Michigan story boards depict the progress each LHD has made to date on their projects, and will be updated once the project is completed in February.

Plan

Identify an Opportunity and Plan for Improvement

1. Getting Started
 Hepatitis C cases being reported are increasing (Run chart). The Kent County Health Department (KCHD) seeks to strengthen its provision of hepatitis C education to infected patients through providers offices.



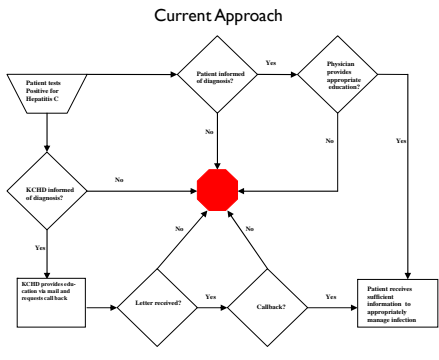
Approval for the project was sought and received by the Administrative Health Officer. The Deputy Administrative Health Officer is a member of the project team. Staff members were from the Health Education and Promotion (HEP) and Communicable Disease and Epidemiology Unit (CD/Epi).

2. Assemble the Team
 Team members were assigned to the project based on their expertise and experience related to the project initiative (hepatitis C and provision of education to health care providers). Prior to 2005, KCHD did not perform any follow-up with patients infected with hepatitis C. When attempts to reach this population were initiated, limited success was obtained. For example, of 1,300 education surveys that went out, only 90 (7%) were returned. Combining the efforts of the two KCHD units (HEP and CD/Epi) with a focus on education to primary care physicians rather than individual patients is an improvement theory the KCHD team will test.

- A timeline for CQI activities was constructed.
- April—Identify high-volume providers via Pareto analysis of surveillance data
 - May/June—Create and distribute provider assessment
 - July/August—Analyze provider assessment, develop training session, and collect baseline data.
 - January (originally scheduled for October) - Deliver training session (delayed due to identification of speaker, scheduling, and issues with application for continuing medical education credits)
 - February and beyond—Evaluation and sustained communication with training participants (via newsletters, reminders, etc.)

AIM Statement
 Ensure the receipt of appropriate education by those infected with hepatitis C to aid in the management of their illness. This will be done by providing education to a group of health care provider offices submitting the highest volume of hepatitis C reports to the health department. KCHD will increase the percentage of patients receiving counseling and resource materials from their provider by 20% by October 2007 and by 25% by February 2008.

3. Examine the Current Approach
 The current approach identified missing or incomplete follow up of patients who tested positive for hepatitis C.



- Baseline data shows multiple causes for this lack of follow up including:
- Fraction of cases are transient
 - 13% of educational mailings are returned
 - Only 20% of cases receive verbal follow-up
 - Some cases are unaware of their status

Key informant interviews identified shortfalls in education provided by physicians to their patients diagnosed with hepatitis C.

Surveillance data identified which providers account for the largest number of hepatitis C case reports. A modified Pareto chart displayed the 14 providers who accounted for 50% of all case reports.

	Clinic	N	%	Cumulative %
1	Heartside Health Center	66	7.4	7.4
2	Grand River Gastroenterology	54	6.1	13.5
3	Cherry Street Health Services	48	5.4	18.9
4	Wege Family Medicine	45	5.1	24.0
5	Westside Health Center	43	4.8	28.8
6	Ferguson Adult Health Center	31	3.5	32.3
7	Breton Health Center	29	3.3	35.5
8	Biolife Plasma Services	22	2.5	38.0
9	Browning Claytor Health Center	21	2.4	40.4
10	Spectrum Health	20	2.2	42.6
11	OCC HEALTH CLINIC - St. Mary's	18	2.0	44.7
12	Metro Health Southwest	18	2.0	46.7
13	McAuley Health Center	16	1.8	48.5
14	Academic Medical Associates	14	1.6	50.1

4. Identify Potential Solutions
 To assist in targeted training, a provider assessment survey was crafted and distributed to 63 providers practicing in the high volume clinics. The survey included questions pertaining to the following:

1. Demographics (physician and patients served)
2. Patient education (who?, how?, barriers)
3. Training needs and logistics
 - Cover letter/survey packets were mailed to 63 physicians
 - Reminder letters were sent to increase the response rate
 - Received 20 of 63 (32%) completed provider assessments
 - 48% of providers preferred a two hour morning training
 - Training should focus on patient treatment decisions and types of treatment.

KCHD scheduled a 2 hour morning workshop for primary care physicians in January 2008. The workshop focused on hepatitis treatment options and how to make referrals for management and treatment so physicians could more effectively counsel their patients on these issues.

5. Develop an Improvement Theory
 KCHD designed an improvement theory for health care providers to deliver more effective education and counseling regarding hepatitis C treatment to their patients armed with greater knowledge and confidence about the topic. The predictions:

- If KCHD provides a two-hour training to a minimum of 40 health care providers from the highest volume provider offices for hepatitis C referrals in Kent County by September 30, 2007 then hepatitis C positive patients will have more appropriate education to aid in the management of their cases as measured by pre and post test assessments conducted at the training sessions and through an enhanced surveillance questionnaire of hepatitis C clients.
- If KCHD develops and delivers the training then physicians and patients will increase use of KCHD as an information and referral resource as measured by the number of referrals/contacts to KCHD for hepatitis C related issues.
- If KCHD provides focused educational messages through trainings along with targeted correspondence to the health care provider then identified barriers to providing patient education issues and barriers will be addressed as measured through a health care provider follow up survey.

Do

Test the Theory for Improvement

6. Test the Theory

- Pre and post test surveys at the workshop were used to assess provider knowledge and effectiveness of the training.
- The enhanced questionnaire will continue to be used to determine the extent to which providers deliver education to their patients.
- Although only the pre and post test data will be available at the end of the first cycle, data to test the theory will continue to be collected by KCHD staff.

- Baseline data collected revealed the main difficulty in testing the theory will be obtaining an adequate sample size. This is because:
- Referrals come from all provider offices in the county
 - Surveys and training were targeted to a select group of 14 providers who submit the highest volumes of referrals
 - Enhanced questionnaires are only performed on those patients who respond to KCHD's request for contact or answer the phone when contacted.
 - Limited data from patients of the providers participating in the training may make it difficult to measure improvement

Study

Use Data to Study Results of the Test

7. Study the Results
 The pre and post test questionnaire for the educational session contained 10 knowledge-based questions and 5 evaluation statements. Pre and post test assessment during the workshop revealed the provider scores increased from 63.3% to 89.3% on the post test.

Evaluation Question	Mean Rating
Dr. Brown was knowledgeable, well prepared, and effective.	4.93
The resource materials will be useful in my work.	4.57
I am more knowledgeable about...	
The importance of early identification and diagnosis of hepatitis C in minimizing disease progression and negative patient health outcomes.	4.57
How to determine individual patient risk for hepatitis C infection.	4.29
The current standard treatment for hepatitis C and the diagnostic tests that can be used to guide treatment decisions.	4.29

- Data from the enhanced surveillance questions were also analyzed. It shows:
- Of 171 patients contacted, 41 interviews were completed (24%)
 - Of 41 interviews, 13 (31.7%) were referred from high volume clinics
 - 29% of patients interviewed did not receive education from the training physician
 - 68.7% were not referred to the LHD for additional information.
- Of note, while 71% of patients received education from their providers, the percentage of patients who were unable to be contacted, and to the high percentage of those who were not referred to the LHD emphasized the importance of patient's receiving education via their health care provider.

Act

8. Standardize the Improvement or Develop New Theory
 At this time the team is still in the study stage.

- If successful, the program can be utilized as a model to institute provider outreach around other disease/surveillance issues
- QI principles and tools will be applied to resolve additional gaps in internal communication

9. Establish Future Plans
 The KCHD will continue to disseminate information about their project to KCHD leadership. One of the team's successes was the increased collaboration between the CD/Epi Unit and the HEP section. A future goal of KCHD will be to continue to improve the collaborative efforts within the health department. Future QI activities and PDSA cycles focused on increasing organizational capacity must include the Personal Health Services Unit on a greater scale in order to improve the collaborative approach to addressing hepatitis C issues in Kent County.

In April, KCHD will publish a special edition of its CD/Epi newsletter (*Epi Focus*) that focuses on hepatitis C issues. This newsletter is distributed quarterly to every physician in Kent County.

Genesee County Health Department (GCHD)

150 employees
Clinics in Flint and Burton
Serving a population of 439,000



Team Members:

Ward Lindsay - Supervisor, Development, Planning, and Grants section of the GCHD
April Swartout - Public Health Program Coordinator
Dorothy Gonzales - Supervisor, Food Service Sanitation Program
Denise Kremick/Ronda McCall - Public Health Nursing Coordinator for the CD and TB Control Program
Fatema Mamou - Epidemiologist
Karen McIntosh - Public Health Information Systems Coordinator
Amy Roberts - Health Information Systems Technician

Quality Improvement Story Board



Digitizing Foodborne Illness Surveillance Data

Plan

Identify an Opportunity and Plan for Improvement

1. Getting Started

The problems/opportunities for improvement included:

- Outdated processes to document FBI information
- Gaps in illness surveillance exist
- Communication gaps between EH, CD, and Epi
- There is a burden of FBI in Genesee County
- Undetected outbreaks result in the perpetuation of ignorance about safe food handling in the community

Department/Division	Staff	Physical Address	Equipment	Other
Administrative Services
Communicable Disease Control
Environmental Health
Food Service Sanitation
Health Information Systems
Infectious Disease Control
Public Health Nursing
Surveillance and Control
Training and Education
Community Health Promotion
Public Health Laboratory
Public Health Support Services
Public Health Administration
Public Health Finance
Public Health Information Systems
Public Health Legal Services
Public Health Planning and Evaluation
Public Health Research and Statistics
Public Health Safety and Security
Public Health Training and Education
Public Health Transportation
Public Health Utility Services
Public Health Volunteer Services
Public Health Workforce Planning

GCHD committed staff time, technical, and financial resources to the QI project. Approval and support was received from the supervisors of staff involved in the project, the Health Department's Management Team, and the Health Officer.

2. Assemble the Team

- The Team was assembled from the stakeholder programs identified in the project logic models. Individuals who could coordinate the project and offer technical assistance in QI were also included in the project.
- The timeline for the FBI Project stretched until December 31, 2007. That has since been extended into 2008.

Original AIM Statement

Design a quality database to log and document EH FBI complaints with 100% of needed data fields and 90% user satisfaction by December 31, 2007.

3. Examine the Current Approach

GCHD created a process map to illustrate the current FBI complaint process.

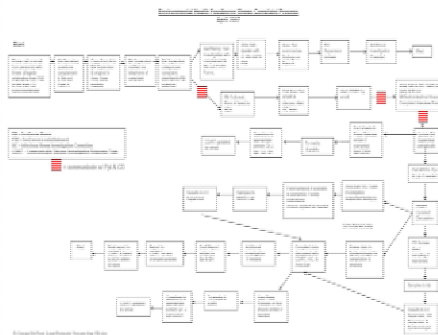
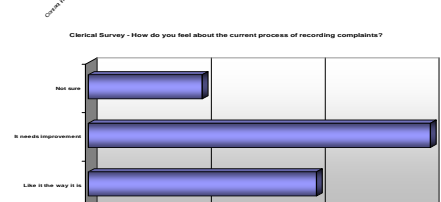
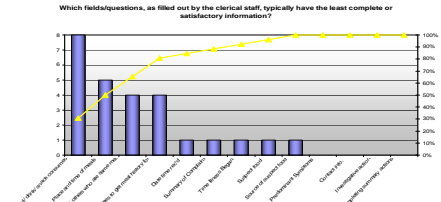
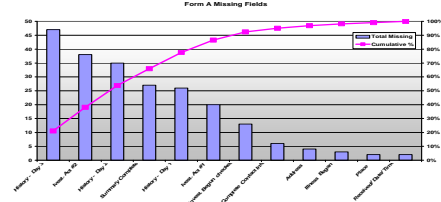
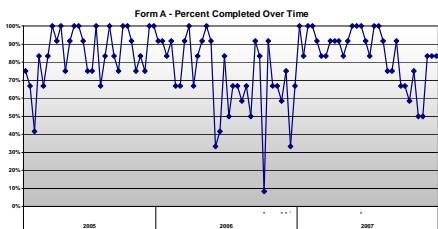


Chart reviews, customer satisfaction surveys (of end users) and time studies were conducted to determine and examine the root cause(s).



After reviewing baseline data and further examining the problems, the AIM statement was revised to include vital communication work. As the project began, GCHD realized that improving FBI surveillance meant more than going from "paper to digital." It had to include consistent communication between program areas at prescribed points.

Revised AIM Statement

Design a quality database to log and document 100% of EH FBI complaints with 100% of needed fields and capability to generate 90% of needed reports electronically and 90% user satisfaction by December 31, 2007--AND - Increase successful and appropriate communication between EH, CD, and Epi as measured by the percentage of timely and complete notifications between EH, CD, and Epi at the communication points shown on the work flow maps.

4. Identify Potential Solutions

Potential solutions to the problem were based on a root cause analysis and included creating:

- A database to log and document FBI complaint investigations.
- Create electronic forms that have required fields to eliminate the problem of missing data.
- Process maps to plot out the investigation procedures in EH and CD and identify points where cross program communication should take place.
- Overlay maps to ensure that necessary communication points are built into normal EH and CD procedures.

Best practices were reviewed to identify potential improvements including:

- Current forms to determine required fields
- Electronic databases used in Ottawa and Jackson counties were reviewed for Genesee County needs.
- MDA staff were consulted about the project aims and specifications
- FBI process maps from Wayne County were compared with those from Genesee County.

Since neither database studied suited GCHD's needs, Ottawa County's electronic database was used as a template to create a system broad enough to correct the issues identified with chart reviews and surveys, but remained easy to access by both EH secretaries and sanitarians.

5. Develop an Improvement Theory

Predictions:

1. If communication between EH and CD were improved and regularized to recognize associations between diagnoses received by CD through the Michigan Disease Surveillance System and complaints received by EH, then small FBI outbreaks would not be overlooked. This theory was developed by using process maps of the different procedures in EH and CD, including points where communication between divisions should occur, by comparing and correcting maps, and by testing maps during an actual FBI outbreak event.

2. If GCHD moved from a paper-based system in EH to an electronic one, enabling CD and Epidemiology staff to have easy access to FBI reports received in EH, then FBI surveillance would be improved along with ensuring that all data fields are filled in by clerical staff and sanitarian employees with no lost records. This theory was developed through piloting a paper based form that mirrors potential electronic form and log, and then employee users were surveyed to evaluate satisfaction with final electronic system.

Do

Test the Theory for Improvement

6. Test the Theory

Several tools were used to test GCHD's theories:

- The theory about cross divisional communication was tested during a suspected foodborne illness outbreak.
- The theory about the ideal EH FBI intake form and log was tested by piloting a paper version of the proposed electronic form.
- The theory about end user satisfaction will be tested by a survey after the new system is implemented.
- Qualitative data was collected from the test of the process map and the tests of the paper form.
- Tests on the database have not yet been conducted. The tests planned include a follow-up chart review, a communications survey, and a customer satisfaction survey.

GCHD experienced some difficulties while testing the theory. During the outbreak investigation it was observed that while the FBI Process Map is linear, the actual process is not. Several actions can and should occur simultaneously. Also, GCHD discovered that some clerical staff are still not writing all required information on the paper form being tested.

Study

Use Data to Study Results of the Test

7. Study the Results

By studying the results of the first paper pilot of the FBI complaint form, GCHD realized they needed to be able to attach additional personal illness histories to the index case under the initial case number assigned to it in the electronic database. As a result, the software is being designed to link all personal histories to the index case. GCHD thinks that they will see a huge improvement in collection of required data because the electronic program is being written to require certain fields be filled out before staff can save the record into the system.

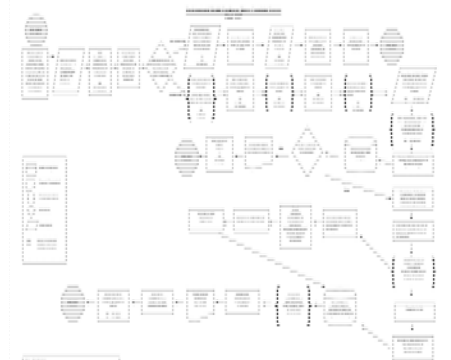
Not all of GCHD's tests have been completed. A follow-up chart review, a communications survey, and an end user customer satisfaction survey are planned. These will help to determine if GCHD's theories are successful.

Act

Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop New Theory

GCHD believes the electronic database will be an improvement over the paper forms because they will be collecting better and more complete data. Epi, CD, and EH staff will have easy access to the computerized complaint log for increased surveillance. The process maps have been incorporated into the Health Department's disease investigation procedures and are being used for staff training.



9. Establish Future Plans

GCHD communicated its accomplishments through a variety of methods. Articles were published monthly in the internal agency newsletter about the quality improvement project. Monthly project updates were provided at management team and Environmental Health food project staff meetings. In the 2007 State of the County Address, the GCHD's quality improvement efforts were highlighted.

Ottawa County Health Department (OCHD)
115 employees
Four offices; main office in Holland
Serving a population of 260,000



Team Members:
Lisa Stefanovsky – Health Officer
Dorovan Thomas – Assistant Health Administrator
Dr. Paul Heidej – Medical Director
Brian Bieber – Epidemiologist
Sandy Boven – Health Promotion Manager
Helen Ash – Clinical Health Manager
Lynne Doyle – Community Health Manager
Adam London – Environmental Health Manager
Gail VanVels – Administrative Assistant

Quality Improvement Story Board

Creating a Culture of Quality

Plan

Identify an Opportunity and Plan for Improvement

1. Getting Started

Ottawa County Health Department (OCHD) was transitioning into a new leadership team and a dramatic change of organizational values and expectations. To help define the OCHD organizational areas of opportunity, a variant of the Baldrige Organizational Assessment Survey was implemented.

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
LEADERSHIP & MANAGEMENT					
1. My organization has a clear vision and mission statement.					
2. My organization has a clear strategic plan.					
3. My organization has a clear organizational chart.					
4. My organization has a clear organizational structure.					
5. My organization has a clear organizational culture.					
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99. My organization has a clear organizational strategy.					
100. My organization has a clear organizational plan.					

OCHD leadership was supportive of the planned improvement and committed the personnel and financial resources to the project.

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
LEADERSHIP & MANAGEMENT					
1. My organization has a clear vision and mission statement.	10%	20%	30%	30%	10%
2. My organization has a clear strategic plan.	15%	25%	35%	25%	10%
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60. My organization has a clear organizational culture.	10%	20%	30%	30%	10%
61. My organization has a clear organizational values.	10%	20%	30%	30%	10%
62. My organization has a clear organizational goals.	10%	20%	30%	30%	10%
63. My organization has a clear organizational objectives.	10%	20%	30%	30%	10%
64. My organization has a clear organizational priorities.	10%	20%	30%	30%	10%
65. My organization has a clear organizational focus.	10%	20%	30%	30%	10%
66. My organization has a clear organizational strategy.	10%	20%	30%	30%	10%
67. My organization has a clear organizational plan.	10%	20%	30%	30%	10%
68. My organization has a clear organizational process.	10%	20%	30%	30%	10%
69. My organization has a clear organizational system.	10%	20%	30%	30%	10%
70. My organization has a clear organizational structure.	10%	20%	30%	30%	10%
71. My organization has a clear organizational culture.	10%	20%	30%	30%	10%
72. My organization has a clear organizational values.	10%	20%	30%	30%	10%
73. My organization has a clear organizational goals.	10%	20%	30%	30%	10%
74. My organization has a clear organizational objectives.	10%	20%	30%	30%	10%
75. My organization has a clear organizational priorities.	10%	20%	30%	30%	10%
76. My organization has a clear organizational focus.	10%	20%	30%	30%	10%
77. My organization has a clear organizational strategy.	10%	20%	30%	30%	10%
78. My organization has a clear organizational plan.	10%	20%	30%	30%	10%
79. My organization has a clear organizational process.	10%	20%	30%	30%	10%
80. My organization has a clear organizational system.	10%	20%	30%	30%	10%
81. My organization has a clear organizational structure.	10%	20%	30%	30%	10%
82. My organization has a clear organizational culture.	10%	20%	30%	30%	10%
83. My organization has a clear organizational values.	10%	20%	30%	30%	10%
84. My organization has a clear organizational goals.	10%	20%	30%	30%	10%
85. My organization has a clear organizational objectives.	10%	20%	30%	30%	10%
86. My organization has a clear organizational priorities.	10%	20%	30%	30%	10%
87. My organization has a clear organizational focus.	10%	20%	30%	30%	10%
88. My organization has a clear organizational strategy.	10%	20%	30%	30%	10%
89. My organization has a clear organizational plan.	10%	20%	30%	30%	10%
90. My organization has a clear organizational process.	10%	20%	30%	30%	10%
91. My organization has a clear organizational system.	10%	20%	30%	30%	10%
92. My organization has a clear organizational structure.	10%	20%	30%	30%	10%
93. My organization has a clear organizational culture.	10%	20%	30%	30%	10%
94. My organization has a clear organizational values.	10%	20%	30%	30%	10%
95. My organization has a clear organizational goals.	10%	20%	30%	30%	10%
96. My organization has a clear organizational objectives.	10%	20%	30%	30%	10%
97. My organization has a clear organizational priorities.	10%	20%	30%	30%	10%
98. My organization has a clear organizational focus.	10%	20%	30%	30%	10%
99. My organization has a clear organizational strategy.	10%	20%	30%	30%	10%
100. My organization has a clear organizational plan.	10%	20%	30%	30%	10%

2. Assemble the Team

The QI team consisted of the OCHD Administrative Team because the nature of the project required a department-wide approach. A workplan and timeline were created and regular meetings were scheduled.

AIM Statement

Improve organizational health by improving the relationship between staff and management by addressing communication issues highlighted in the annual employee survey, and providing leadership development to current and future leaders.

3. Examine the Current Approach

The initial process flow of the health department was "business as usual". Organizational changes were implemented based on anecdotal evidence and informal employee communication. A process was developed and mapped to examine and improve the three key organizational elements.

