Sedgwick County... working for you

Sedgwick County Health Department

Project Title: QI Billing Team
SCHD Quality Improvement Training, 2010-2011
Project Manager: Adrienne Byrne-Lutz
Team Members: Deb Riead, Roderick Harris, Lucretia Burch

PLAN
Identify an opportunity and Plan for Improvement

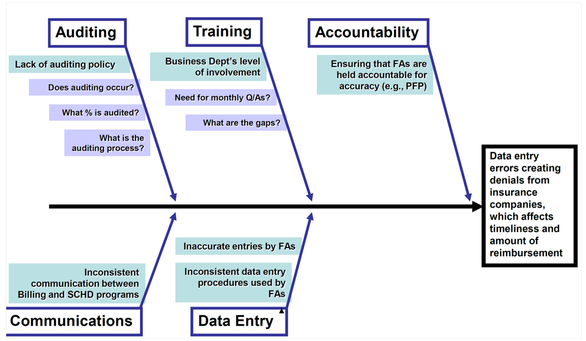
1. Getting Started
Data entry errors and efficiency of billing process was identified as a possible area for improvement.

2. Assemble The Team
The Billing Project Team members were from 3 different Health Department Programs:
- Finance/Billing,
- Health Equity, and
- Children and Family Health.

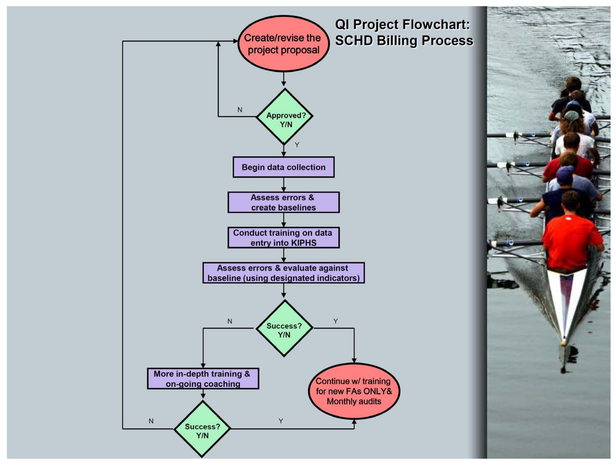
AIM Statement
We seek to improve the efficiency in the billing process by reducing the most common data entry errors of incorrect/incomplete insurance information. Currently the billing department reports encountering an average of 45 insurance errors each month related to incorrect or incomplete information. This results in insurance denials, decreases reimbursement time and inefficient use of billing staff time. Insurance error rate can be reduced either by complete information being entered into the "Notes" section or by scanning the insurance card.

3. Examine the Current Approach
An informational meeting was conducted with the billing staff to determine the top billing errors. Top two errors identified: Incomplete and inaccurate insurance information entered into KIPHS. (see Cause and Effect Diagram)

Cause and Effect Diagram



4. Identify Potential Solutions
Providing training to FA's on required information to be entered into KIIPHS or all insurance types.



5. Develop an Improvement Theory
If Fiscal Associates are provided training on the most common errors related to insurance data entry, related errors should decline. (See SIPOC Diagram)

SIPOC Diagram
Suppliers/Inputs/Processes/Outputs/Customers

SUPPLIERS	INPUTS	PROCESS	OUTPUTS	CUSTOMERS
List the suppliers of any inputs to this process (materials, resources, services or information).	List the inputs to this process (materials, resources, services or information).	Describe the process and/or list the key process steps.	List the outputs of this process (products, services or information).	Identify the customers of these process outputs.
PH Division FAs Data Entry/Billing Policy KIPHS Database SCHD Billing Staff QI Billing Project Team Insurance Companies Patients	Reports of data entries Key informant interviews Data entry training session Database software upgrade	Identify opportunity for improvement → Examine current billing process/policies → Plan & implement intervention (training & IT upgrade) → Analyze data → Present Outcomes → END	Formal FA data entry training curriculum Trend data of FA entry errors QI process for continuous monitoring and training of FAs	PH Division FAs QI Billing Project Team SCHD Billing Team

DO
Test the Theory for Improvement

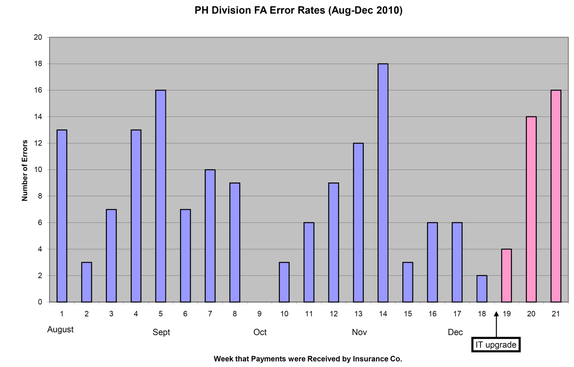
6. Test the Theory
Gantt Chart

Task	Week of 10-18 (1 2 2 4 5)	Week of 10-25 (1 2 3 4 5)	Week of 11-5 (1 2 3 4 5)	Week of 12-13 (1 2 3 4 5)	Week of 12-20 (1 2 3 4 5)	Week of 1-10-11 (1 2 3 4 5)	Responsible
Complete Project Proposal	■						Team
Gather back up ins. Data	■	■					Lucretia/staff
Analyze insurance data pre training		■	■				Lucretia/ABL
Train FA's			■	■			Deb/Crystal
Audit 1 month of ins info post training				■	■		Lucretia/Deb/Crystal
Compile results					■	■	Lucretia/staff/ABL
Present Story board						■	Billing Team

One training session occurred with Preventive Health and Healthy Babies Fiscal Associates in October of 2010 to review types of insurance and information needed for each field in Ph Clinic.
During discussion it was determined that an upgrade was needed to KIPHS to help reduce insurance entry error and PH initiated modification.

Study
Use Data to Study Results of the Test

7. Study the Results



We anticipate the error rates will decrease as of 2011. We will use the above graph as a base-line and will provide updated results graph after the 1st Quarter of 2011 (if applicable).

ACT
Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop a New Theory
Based on the results of the study, the amended theory is as follows:
Standardized training on insurance data entry along with the modifications made to PhClinic will result in a reduction of data entry errors related to missing or inaccurate insurance information . All data entry staff must receive the same training.

9. Establish Future Plans
New theory will be tested during the first quarter of 2011.

Project Title: **Lab Test Reporting Accuracy**

SCHD Quality Improvement Training, 2010-2011

Project Manager: Preston Goering

Team Members: Jeff Anschutz, Joab Barbosa, Rus Hodges

Sedgwick County... working for you

Sedgwick County Health Department

PLAN
Identify an opportunity and Plan for Improvement

1. Getting Started

Lab personnel at the Sedgwick County Health Department had noticed for some time that the totals for Gonorrhea and Chlamydia (G&C) tests in the "Lab Tests Performed" report from KIPHS, the data management system, did not match. Since both tests are to be completed on the same specimen, the totals should be the same in any month or year-end reports. The data must be accurate for monthly reporting, CLIA certification, and reports to Kansas Department of Health and Environment.

2. Assemble The Team

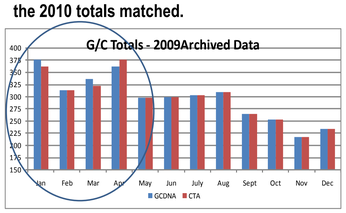
The QI Project team consisted of lab, information technology, and data entry/encounter processing personnel. Each of these were input experts for one of the three possible areas where the cause might be located. These also represented some of the stakeholders. A timeline was established using a GANNT chart and general team member assignments were agreed upon.

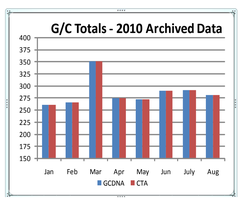
AIM Statement

The totals of Gonorrhea tests performed as seen in the "Lab Tests Performed" report in KIPHS will match the totals for Chlamydia tests in the same report for each month from Jan. 2009 through Aug. 2010, as will the following months through Nov. 2010.

3. Examine the Current Approach

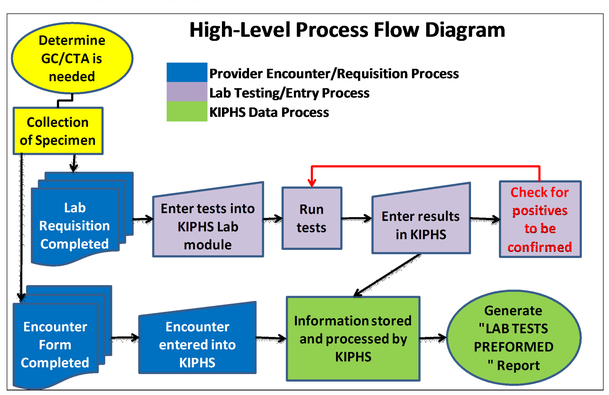
The total number of Gonorrhea tests performed did not match the total Chlamydia tests in 2009 or 2010. It was discovered that the problem was mainly in the early months of 2009. After the tests were run a second time after the end of the month, the 2010 totals matched.





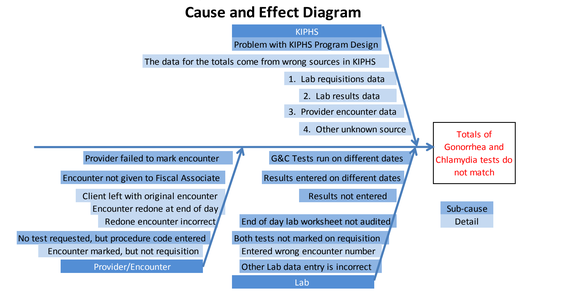
The problem appeared to be rooted in three possible processes:

a. Lab testing and reporting,
b. Numbers generation and reporting in the KIPHS data system itself,
c. Generation of encounter forms and data entry by provider and fiscal associates.

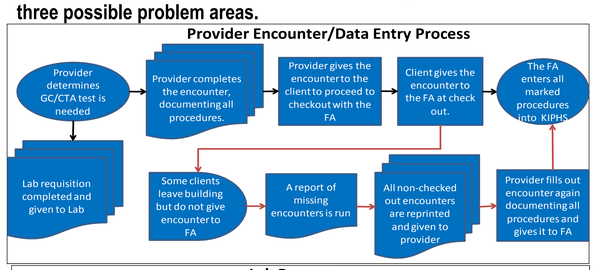


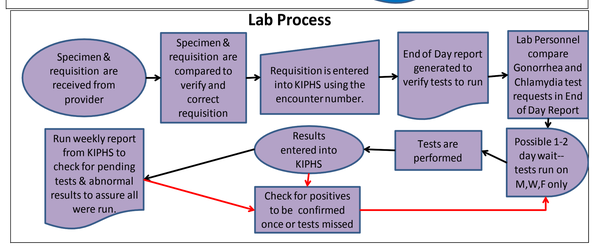
3. Examine the Current Approach (cont'd)

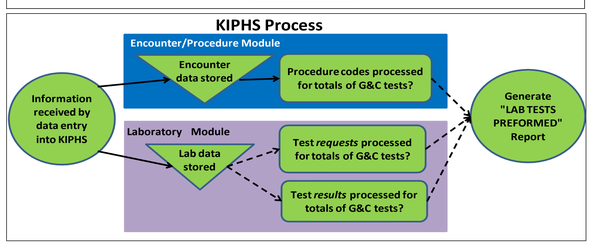
A Cause and Effect diagram was completed to determine possible causes within the three problem areas.



A low-level analysis of Process Flows were completed for each of the three possible problem areas.



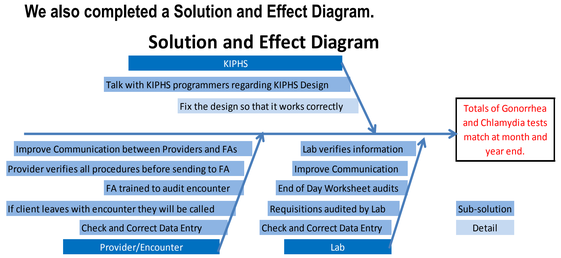




It is important to note that KIPHS includes separate modules for lab data and procedure activity data.

4. Identify Potential Solutions

We also completed a Solution and Effect Diagram.



4. Identify Potential Solutions (cont'd)

The exercises above helped us reach 3 conclusions which gave us direction:

a. The Lab process has the most controls in place so it is not a likely problem area.
b. The Provider/Encounter process is the most complicated and time intensive to research.
c. The simplest course is to address the KIPHS process about program design before going further.

5. Develop an Improvement Theory

Prediction: If the data used to populate the totals for Gonorrhea and Chlamydia tests within the "Lab Tests Performed" report are being pulled from the correct sources within the KIPHS system, then the totals for the two tests will match for particular months and year totals.

DO
Test the Theory for Improvement

6. Test the Theory

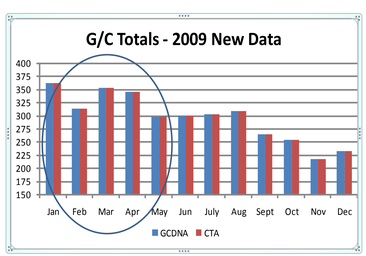
The developers of KIPHS were contacted to learn how the numbers were generated for the G&C totals in the "Lab Tests Performed" report. It was discovered that KIPHS was pulling the data from two different sources – test request date and test completed date - which do not necessarily match. KIPHS redesigned the software in September 2010 to pull the numbers from the correct source – the test request date (which matches the encounter date).

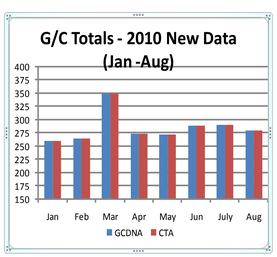
The "Lab Tests Performed" report for G&C tests was run for 2009 through August 2010 after the redesign was complete. It was also checked for matching totals monthly from September through November 2010 to make sure the totals continued to match.

Study
Use Data to Study Results of the Test

7. Study the Results

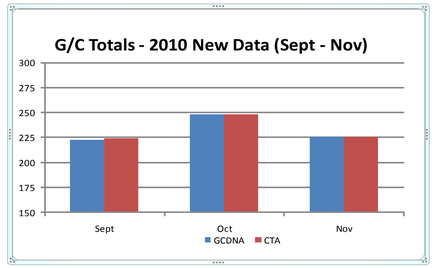
The "Lab Tests Performed" report had been run before the changes were made to the software. Immediately following the changes in September 2010, the report was run again for the same periods (Jan.-Dec. 2009 and Jan-Aug 2010). It was found that the changes made in KIPHS corrected the problem going back to January 2009. The tests results now match in every month during these periods.





7. Study the Results (cont'd)

The September through November reports seem to indicate that the improvement held, except for the presence of one test in September:



ACT
Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop a New Theory

The original improvement theory was proven incorrect since the totals did not match in September after we corrected KIPHS.

However, when the correction was made in the design of KIPHS the totals of G&C tests matched in every month in which they had not previously matched. This indicates that an improvement was made to the system.

This particular improvement was standardized by redesign of KIPHS.

However, the September report showed that G&C totals did not match by one test. The discrepancy in the September test report indicates

--A different problem was at work in September not related to the KIPHS redesign.
--Investigation showed that the lab completed a Chlamydia but no Gonorrhea test on one person's specimen, and that the test had not been requested on the requisition.
--The lab's system of checks and balances may need to be further examined, but one error out of 2,000-3,000 tests a year may not require quality improvement action.

9. Establish Future Plans

A. Establish a method with KIPHS to correct lab data inside the lab module after data has already been entered.
B. Create an option for a more detailed "Lab Tests Performed" report to show which clients did not receive both tests.
C. Develop a system to cross-check between the encounter form and the lab test requisition form.
D. Analyze the provider/encounter/data entry system for quality improvement to make it a viable way to validate the lab totals.

Sedgwick County... working for you

Sedgwick County Health Department

Project Title: Asset Management
SCHD Quality Improvement Training, 2010-2011
Project Manager: Cindy Pollard
Team Members: Mary Davenport, Curtis Kirkpatrick, Susan Wilson

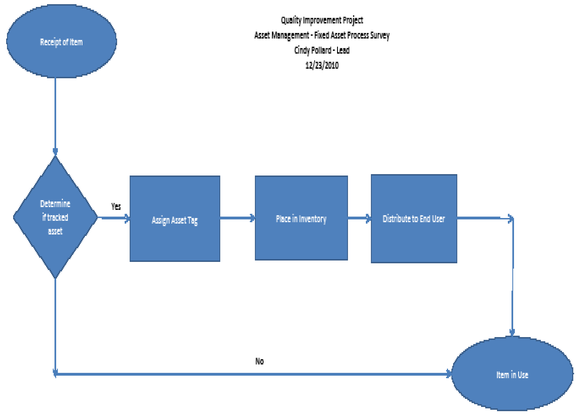
PLAN
Identify an opportunity and Plan for Improvement

1. Getting Started
Sedgwick County departments are required to maintain master data records for all controlled assets in the central controlled asset SAP database within their area. Tracking controlled assets allows departments, and the SC Finance department, to readily track equipment for maintenance or replacement purposes and make budget adjustments accordingly. SCHD has five divisions with staff working at six different worksites. Multiple purchase points have been established to help facilitate various day-to-day operational needs within the divisions. Along with multiple purchase points, the opportunity for variance among purchasing processes tends to increase.

2. Assemble The Team
Team Members were assigned to the project based on their expertise and experience related to the project initiative.

AIM Statement
Provide an updated Asset Management process flow to 100% of HD staff by January 2011.

3. Examine the Current Approach
A review of county policies for the "preferred method" of tracking controlled assets was completed. A fixed asset tag number is assigned to a controlled asset when purchased through the county purchasing system. SCHD Finance is responsible for maintaining the inventory. Upon inspection, many controlled asset items found within the HD are either missing a fixed asset tag or not properly identified in the departmental controlled asset inventory. Multiple purchase points allow controlled assets to be purchased by credit card, which bypasses the process for which a record is created to match the item purchased with a fixed asset tag number.



4. Identify Potential Solutions
- Compare purchasing processes used by divisions to identify differences from "preferred method" and educate.
- Provide "preferred method" training to department.
- Encourage Program Managers to plan purchases in advance so items can be purchased via the SC Purchasing Dept.

5. Develop an Improvement Theory
The Team designed an improvement theory to create efficiencies in the methods in which controlled assets are assigned fixed asset tags and added to the controlled asset inventory.

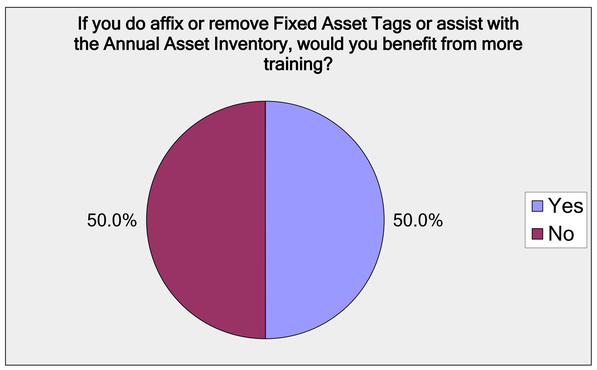
The predictions:
- A pre-test to determine the level of purchasing knowledge will yield similarities and differences of processes used by divisions to make purchases.
- A flowchart of the "preferred method" will guide the buyer through the appropriate steps to follow to assure future controlled asset purchases are assigned a fixed asset tag and identified on the controlled asset inventory systematically .

DO
Test the Theory for Improvement

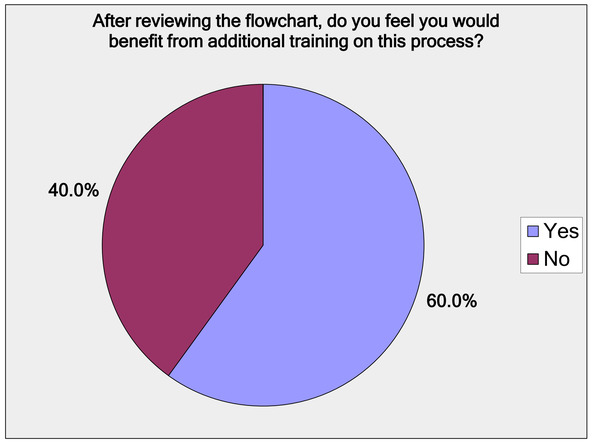
6. Test the Theory
Two surveys were provided to the 14 staff identified as "frequent buyers" across the divisions. The first survey was given with instructions to complete only. The second survey requested a flow-chart of the "preferred method" be reviewed prior to completing the survey. The results of both surveys showed a need for additional training.

Study
Use Data to Study Results of the Test

7.Study the Results
Pretest given to determine understanding of process.



Education provided then knowledge retested to determine if increase in understanding of process.



Review of second survey results show respondents feel they already know process but all feel they need more training.

ACT
Standardize the Improvement and Establish Future Plans

8.Standardize the Improvement or Develop a New Theory
- Develop training for process of determining what qualifies to be a tagged item and listed on inventory.
- Develop system of reminder that there is a process developed for tagging new items that should be placed on SAP inventory list.
- Provide annual training or refresher training for those who purchase and tag controlled assets.

9.Establish Future Plans
- HD Finance & Buyer from SC Purchasing to schedule meetings with divisions to review "preferred method" with a question and answer session.
- Continue to monitor all purchases made and see if inventory is complete in SAP.

Sedgwick County... working for you

Sedgwick County Health Department

Project Title: Purchasing Process
SCHD Quality Improvement Training, 2010-2011
Project Manager: AAron Davis
Team Members: Brad Ashens, Bill Farney, Janice McCoy

PLAN
Identify an opportunity and Plan for Improvement

1. Getting Started

It became apparent that Health Department staff lacked an understanding of the purchasing process. This resulted in staff being frustrated with the process, and a number of Charter 57 violations. These violations were not suspect of ill intentions, so an underlying reason needed to be identified. Many staff supported the need to address this issue, and it was outlined by the QI team as a priority.

2. Assemble The Team

A talented group of staff members were assembled to work on this project. Staff included those who work with the purchasing processes regularly and members of the Quality Improvement team. A work plan and timeline were created and regular meetings were scheduled. A Gantt chart was created and added to as new tasks developed.

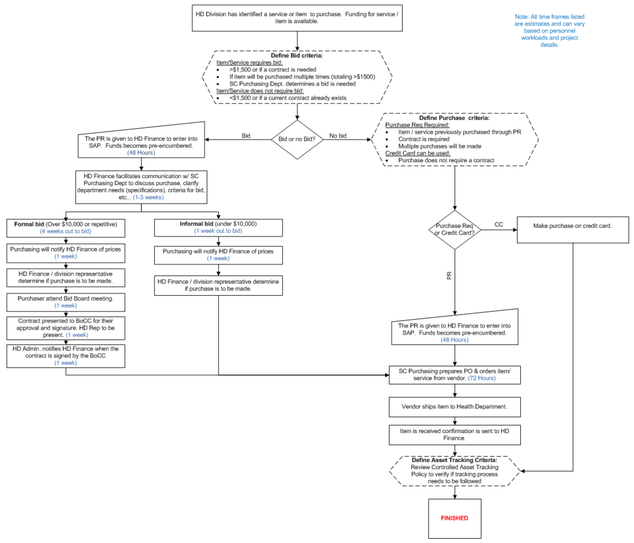
Task	AUG '10				SEP '10				OCT '10					NOV '10				DEC '10				JAN '11		Responsible
	1	2	3	4	1	2	3	4	1	2	3	4	5	1	2	3	4	1	2	3	4	1	2	
Problem identification																								
Initial as-is Flow Chart																								Team
Cause & Effect Diagram																								Team
Aim Statement																								Team
SIPOC+CM Diagram																								Team
Finalize Aim Statement																								Team
Finalize Flow Chart																								Team
Create document repository																								Brad & AAron
QI Project Proposal																								Team
Gantt Chart creation																								Team
High Level Flow Chart																								AAron
Create Survey																								Team
Impliment Survey																								Bill
Identification of PDRs																								Brad
Training of PDRs																								Brad
Communicate actions and DR to staff																								Bill
Imliment Follow-up survey																								Bill
Develop Story board																								AAron/team
Develop recommended action steps																								Team

AIM Statement

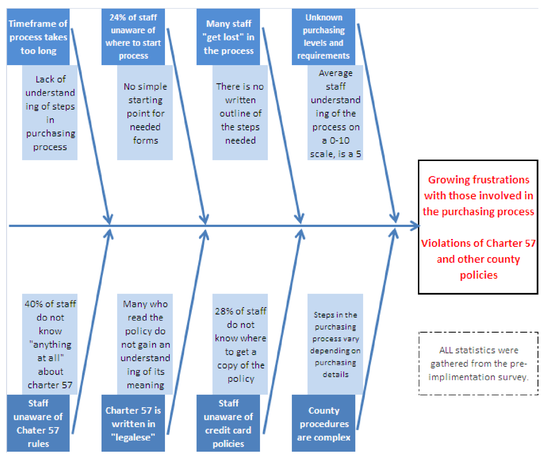
To develop clear instructions and guidance on the major steps of the purchasing process. All clarification/education actions will be implemented by December 2010. Measurements will be made through a simple satisfaction and knowledge survey of various Health Department staff who deal with major purchases. The target audience for these actions will be staff identified by division directors who have a key role in the purchasing process.

3. Examine the Current Approach

A high-level flow chart was created showing the major steps of the purchasing process, as viewed by Health Department staff. While the purchasing process can be long and tedious, and has many variables in it, our teams' approach was to keep the process as simple as possible. We began by identifying the basic steps, from the point of view of the average Health Department staff member, who is looking to begin the purchasing process.



To acquire baseline data, our team developed a pre-implementation survey. This survey was intended to collect information on Health Department staff awareness and understanding of the purchasing process. Analysis of survey results, as well as "water-cooler" conversations, gave us the need to analyze the causes and effects of the problem before us. While a number of tools were used, this cause and effect diagram was seen as the most instrumental.



4.Identify Potential Solutions

Dissatisfaction was a call for education and information sharing. Our potential solutions include 1) creating a document repository, 2) communicate the overall steps taken in the purchasing process, 3) Identify and train members of each division to help guide those in the purchasing process, and 4) educate all staff of available tools.

The team decided to address the first three solutions identified, but instead of educating *all* staff, we focused on specific division representation.

5. Develop an Improvement Theory

We expect survey results (knowledge and satisfaction) to improve as more staff have a chance to utilize the document repository. Our predictions are the following:

1. If we create a Document Repository, then knowledge of where to turn for clarification will increase.
2. If we share a flow chart and discuss new tools with staff, then more staff will better understand the overall purchasing process.
3. If we identify members of divisions to train in researching purchasing information, then satisfaction with the process will increase.

DO
Test the Theory for Improvement

6. Test the Theory

The process for testing the theory included the actual creation of the Document Repository, along with the education and training of various department staff through division meeting presentations.

Once staff were given time to review the information provided and view the high-level flow chart of the purchasing process, time was allowed to elapse, and they were presented a post-implementation survey. This survey was identical to the previous one. Not everyone who took the second survey was able to attend the educational sessions. There was also error in the data in that more people took the survey who did not regularly participate in the purchasing process.

Study
Use Data to Study Results of the Test

7. Study the Results

The new survey data was compared against the previous baseline data. The new data showed very few changes in many of the survey answers. We first will look at survey participation. We must note that numbers and division percentages changed, but we still feel the results are valid.

Survey Participation

Division	Pre-Survey		Post-Survey	
Administrative Services	10	31.3%	5	22.7%
Center for Health Equity	1	3.1%	1	4.5%
Children and Family	4	12.5%	6	27.3%
Health Protection and Promotion	11	34.4%	9	40.9%
Preventative Health	6	18.8%	1	4.5%
Total Responses:	32	100%	22	100%

Average number of purchases made per month	Pre-Survey		Post-Survey	
Zero	14	43.8%	9	40.9%
1 to 5	16	50.0%	11	50.0%
6 to 10	0	0.0%	1	4.5%
10+	2	6.3%	1	4.5%
Total Responses:	32	100.0%	22	100.0%

The biggest change from the pre survey is found in our attempts to educate and change employee expectation with time-lines, when making purchases. You can see the two different questions below that represent two types of purchases (formal bid and informal bid). Highlighted in red are the acceptable answers.

Purchasing Timetable (1)

When you are making $20,000 purchase, how long do you expect the entire process to take from start (filling out a purchase request form) to finish (item has been ordered and is on its way).

Answers	Pre-Survey	Post-Survey	
2 weeks	13.8%	*0%	
1 month	34.5%	33.3%	
2-3 months	31.0%	47.6%	Acceptable answers
4-5 months	13.8%	9.5%	
6-8 months	3.4%	0.0%	
9+ months	3.4%	9.5%	

*note the change in those with unrealistic expectations

Purchasing Timetable (2)

When you are making $2,000 purchase, how long do you expect the entire process to take from start (filling out a purchase request form) to finish (item has been ordered and is on its way).

Answers	Pre-Survey	Post-Survey	
Less than 1 week	17.2%	9.5%	
1 week	10.3%	23.8%	
2-3 weeks	34.5%	33.3%	Acceptable answers
4-6 weeks	27.6%	23.8%	
2-3 months	6.9%	4.8%	
4+ months	3.4%	4.8%	

We make note that the educational portion of our project was sharing the flow-chart with staff and working on educating them on *why* the purchasing process is confusing. The flow chart was the most essential part in curbing expectations of the process and will continue to be used when staff have questions about the process. There is still much work to do. Overall results showed Theory two to be true, and theory one and three to be untrue. Reasons for this are explained in step 8.

ACT
Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop a New Theory

The newly created Document Repository will continue to grow as new information and documents are created. Staff asked for a one-stop location for information and one now exists, however, the information is, at times, still confusing.

The number one lesson learned from the project was our plan to focus on individuals who actively make purchases for both the surveys and the training, was not carried out as we had hoped. If we had been able to narrowly direct the survey to only those who participated in the educational sessions, we believe all theories would have proved true.

9. Establish Future Plans

The survey results still show that more education is needed for staff, as well and more generic outlines for the process. With the frustrations of many staff members still existing, there are a number of recommendations the team has for future projects. The main recommendation will be to walk a number of purchases through the flow chart to document "issues" that arise, and set up projects to address various items. This was one of the original goals of the team but is a long-term project that requires a lot of outside participation and cooperation.

Improve Customer Experience with West Central Entrance

SCHD Quality Improvement Training, 2010-2011

Project Manager: *Seth Konkel*

Team Members: *J'Vonnah Maryman; Sandy Gray; Christy Hillard*

Sedgwick County... working for you

Sedgwick County Health Department

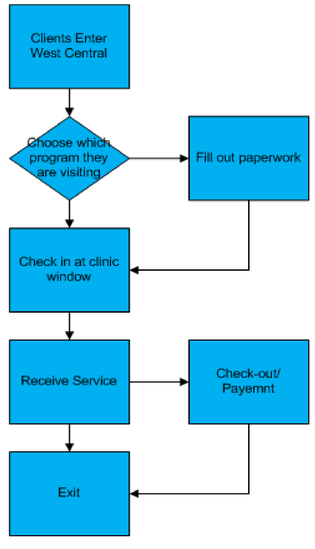
PLAN
Identify an opportunity and Plan for Improvement

1. *Getting Started*
   West Central Customers and Providers made informal comments about the entrance to the clinic being very difficult to navigate and understand what they were supposed to do.

2. *Assemble The Team*
   Team was assembled and met to begin the planning process.

   AIM STATEMENT – By January 2011, increase client's ability to successfully navigate the West Central Clinic, upon entrance by measuring survey results.

3. *Examine the Current Approach*
   Current approach is that signs are posted but very limited and are often covered when customers enter the clinic. At peak times and when staffing allows, a staff member will great customers to help them to the appropriate location.

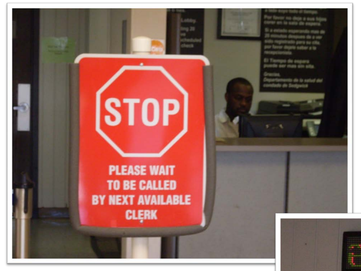


4. *Identify Potential Solutions*
   The following were all identified as possible solutions:
   - Status quo
   - Change/add signage
   - Play video on a loop to give directions
   - Rearrange current check- in counters
   - Remodel entrance area (add additional entrance/exit doors)

5. *Develop an Improvement Theory*
   Changes that were implemented include:
   - Increase and improve the signage in the entrance area
   - Change the location of current signage for better visibility

DO
Test the Theory for Improvement

6. *Test the Theory*
   - Collect current customer data via Pre Survey October 25 – Nov12
   - Identify and finalize changes that will be made – by November 10
   - Implement Changes at W Central – November 15 – 17
   - Collect customer data via post survey – November 18 – December 17
   - Analyze data and produce final report – December 20 – January 10

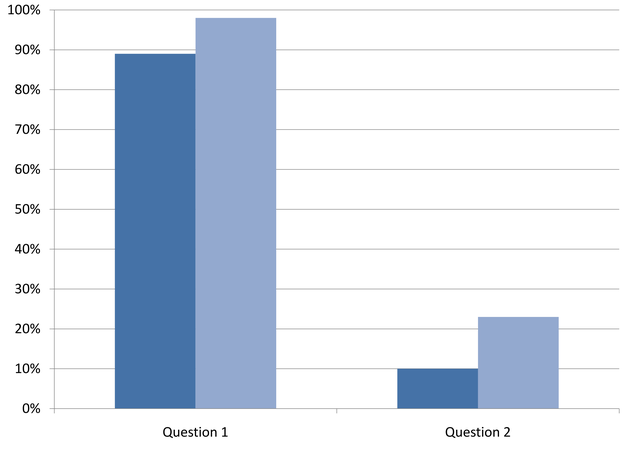


Study
Use Data to Study Results of the Test

7. *Study the Results*
   The results listed on the graph below show a increase in customer satisfaction based on the questions that were asked.

   Question 1 - How easy was it to determine where I needed to go once I entered the clinic lobby?

   Question 2 - Have you been to the west central clinic in the last 30 days?



ACT
Standardize the Improvement and Establish Future Plans

8. *Standardize the Improvement or Develop a New Theory*
   The changes to the signage at West Central have been made permanent and no future plans for a change have been planned at this time.

9. *Establish Future Plans*
   Continue to evaluate the clinic entrance flow to ensure the best possible outcomes.

Sedgwick County... working for you

Sedgwick County Health Department

Project Title: Supervisor New Employee Orientation Checklist (SNEOC)
SCHD Quality Improvement Training, 2010-2011
Project Manager: Becky Tuttle
Team Members: Claudia Blackburn, Jeff Goetzinger, Pamaline King-Burns

PLAN
Identify an opportunity and Plan for Improvement

1. <u>Getting Started:</u>
   Quality Improvement Committee identified 8 items of improvement for the Sedgwick County Health Department:
   1. New Employee Orientation
   2. Consistency of KIPHS data entry methods
   3. Purchasing Process
   4. Vaccination Processes
   5. Billing Process
   6. Customer Satisfaction
   7. Asset Management
   8. WIC Clinic Wait-Time

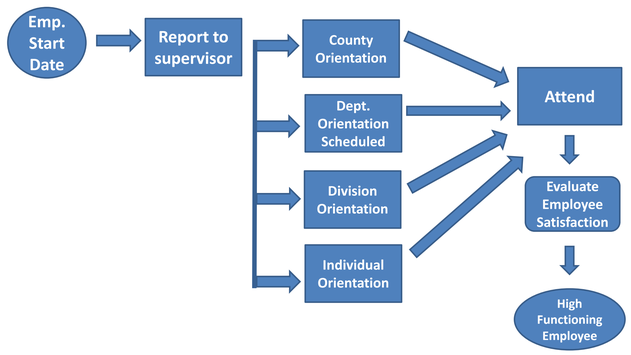
2. <u>Assemble the New Employee Orientation Quality Improvement Team:</u>
   a. Team Leader and Team Expert chosen
   b. Other team members given the opportunity to volunteer for the Quality Improvement projects of their choice.

3. <u>Examine the Current Approach:</u>

   Met to discuss current New Employee Orientation process and narrowed focus down to Departmental Orientation.

4. <u>Identify Potential Solutions:</u>
   a. Cycle I Flow Chart discussed and created
   b. Flow Chart created to guide team's focus

New Employee Orientation Process



5. <u>Develop an Improvement Theory:</u>
   Aim Statement:
   By December 1, 2010, 90% of SCHD supervisors will be given a pre-test/training/post-test and a cover letter will be developed to ensure standardization of a Supervisor's New Employee Orientation Checklist (SNEOC) at the program level.

GANTT CHART

Supervisor's New Employee Orientation Checklist (SNEOC)

Task	Responsible
Review the SNEOC	Becky/Lead with Team Feedback
Develop the Pre/Post/Training	Becky w/ consensus
Send Curtis map for the cal for all	Becky
Implement the Pre/Post/Training Test	Jeff
Analysis of Results Using Survey Monkey and Intern	Becky w/ Intern to Team
Distribution of Analysis to Team	Becky
Team Meeting to come to Consensus on Revis on Recommendations	Becky/Lead coordinate
Revis ons based on Analysis Results	Team
Develop Cover Sheet	Pamaline
Finalize Cover Sheet	Pamaline
Distribute SNEOC and Cover Sheet to Supervisors thru Leadership Group	Claudia

This Chart was las: updated on: October 14, 2010

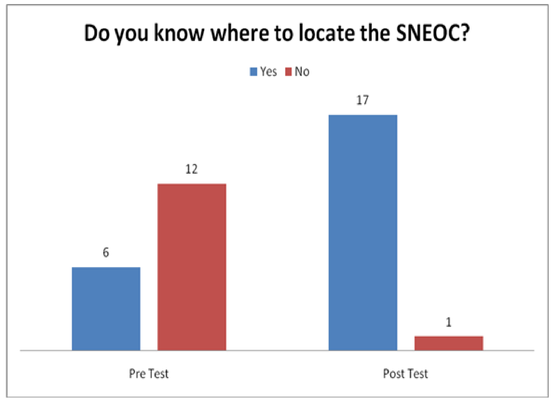
DO
Test the Theory for Improvement

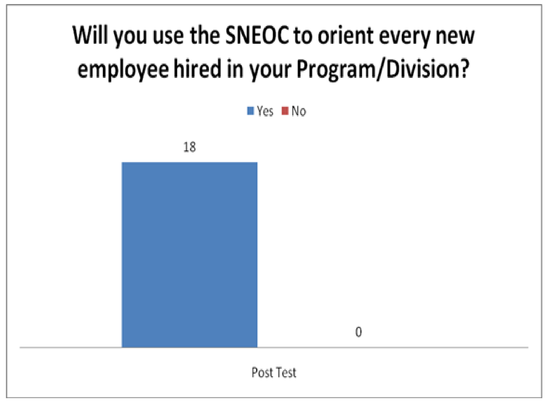
6. <u>Test the Theory:</u>
   a. Pre-Test Surveys administered
   b. Discussion of Supervisors' New Employee Orientation Checklist (SNEOC)
   c. Post-Test Surveys administered

During a SCHD Quarterly Strategic Plan Monitoring meeting, 18 supervisors were administered a Pre-Test Survey regarding their knowledge of the SNEOC. Then a brief orientation of the SNEOC was facilitated by the SCHD HR Assistant. A Post-Test Survey was given immediately following the orientation.

Study
Use Data to Study Results of the Test

7. <u>Study the Results:</u>





ACT
Standardize the Improvement and Establish Future Plans

8. <u>Standardize the Improvement or Develop a New Theory:</u>
   a. Developed a cover letter explaining the purpose and usage of the SNEOC.
   b. Made suggested changes to SNEOC, posted to H drive and notified supervisors of location for future use.

9. <u>Establish Future Plans:</u>
   a. Cycle 2: Within 6 months, send an electronic survey, to assess supervisors' usage of the SNEOC and to solicit suggestions for improvement.
   b. Cycle 3: Revise SNEOC, based on survey findings from Cycle 2. Then, distribute revised SNEOC to supervisors.

Sedgwick County... working for you

Sedgwick County Health Department

Project Title: Customer Satisfaction Quality Improvement Process
SCHD Quality Improvement Training, 2010-2011

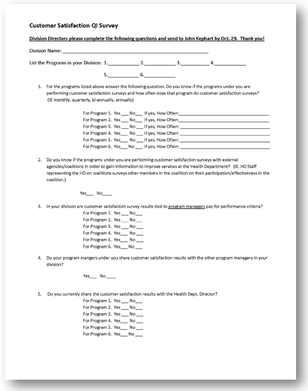
Project Manager: J. Kephart

Team Members: S. Blankenship; P. Martin; M. Nguyen; S. Reichenberger

PLAN
Identify an opportunity and Plan for Improvement

1. Getting Started

As a part of Sedgwick County Health Dept's (SCHD) Mission Statement, the need to continuously assess and improve upon customer satisfaction is a crucial component in assuring that excellent service is provided to Sedgwick County residents, as well as meeting grant requirements and health department accreditation requirements. To understand how this process is carried out, surveys were distributed to all SCHD program managers, division directors, and the Health Director.



Customer Satisfaction QI Survey

Division Directors please complete the following questions and send to John Kephart by Oct. 29. Thank you!

Division Name: _____

List the Programs in your Division: 1._____ 2._____ 3._____ 4._____ 5._____ 6._____

1. For the programs listed above answer the following question. Do you know if the programs under you are performing customer satisfaction surveys and how often does that program do customer satisfaction surveys? (IE monthly, quarterly, bi-annually, annually)

   For Program 1. Yes___ No___ If yes, How Often: _____
   For Program 2. Yes___ No___ If yes, How Often: _____
   For Program 3. Yes___ No___ If yes, How Often: _____
   For Program 4. Yes___ No___ If yes, How Often: _____
   For Program 5. Yes___ No___ If yes, How Often: _____
   For Program 6. Yes___ No___ If yes, How Often: _____

2. Do you know if the programs under you are performing customer satisfaction surveys with external agencies/coalitions in order to gain information to improve services at the Health Department? (IE. HD Staff representing the YD on coalitions surveys other members in the coalition on their participation/effectiveness in the coalition.)

   Yes___ No_____

3. In your division are customer satisfaction survey results tied to program managers pay for performance criteria?

   For Program 1. Yes___ No___
   For Program 2. Yes___ No___
   For Program 3. Yes___ No___
   For Program 4. Yes___ No___
   For Program 5. Yes___ No___
   For Program 6. Yes___ No___

4. Do your program mangers under you share customer satisfaction results with the other program managers in your division?

   Yes___ No_____

5. Do you currently share the customer satisfaction results with the Health Dept. Director?

   For Program 1. Yes___ No___
   For Program 2. Yes___ No___
   For Program 3. Yes___ No___
   For Program 4. Yes___ No___
   For Program 5. Yes___ No___
   For Program 6. Yes___ No___

2. Assemble The Team

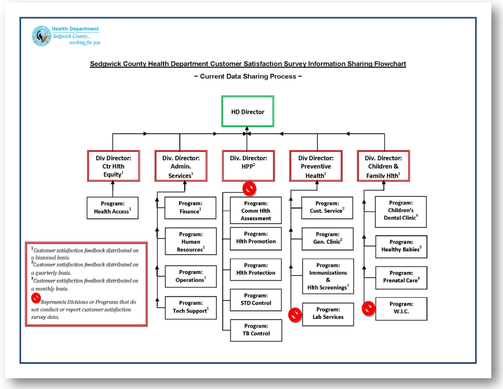
The QI team members were assembled from members of the SCHD Division of Preventive Health, Division of Children & Family Health, and Health Protection & Promotion. Members were selected for their knowledge of customer satisfaction surveys and client interaction.

AIM Statement

By January 13, 2011, a policy will be developed for the systematic review and reporting of customer satisfaction surveys within SCHD programs.

3. Examine the Current Approach

It was found that the current process flow of customer service survey data varied by program; however, process flow was consistent in its reporting of data to the Health Director. To visualize this, we created a flowchart.



Sedgwick County Health Department Customer Satisfaction Survey Information Sharing Flowchart

~ Current Data Sharing Process ~

HD Director

Div Director: Ctr Hlth Equity[1]
- Program: Health Access[1]

Div. Director: Admin. Services[1]
- Program: Finance[1]
- Program: Human Resources[1]
- Program: Operations[1]
- Program: Tech Support[1]

Div. Director: HPP[1]
- Program: Comm Hlth Assessment[1]
- Program: Hlth Promotion[1]
- Program: Hlth Protection[1]
- Program: STD Control[1]
- Program: TB Control[1]

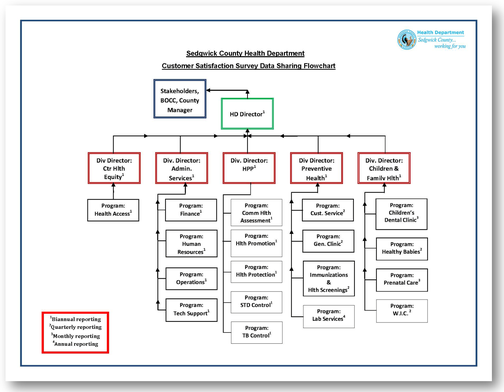
Div Director: Preventive Health[1]
- Program: Cust. Service[1]
- Program: Gen. Clinic[1]
- Program: Immunizations & Hlth Screenings[1]
- Program: Lab Services[1]

Div. Director: Children & Family Hlth[1]
- Program: Children's Dental Clinic[1]
- Program: Healthy Babies[1]
- Program: Prenatal Care[1]
- Program: W.I.C.[1]

[1]Customer satisfaction feedback distributed on a biannual basis.
[2]Customer satisfaction feedback distributed on a quarterly basis.
[3]Customer satisfaction feedback distributed on a monthly basis.
Represents Divisions or Programs that do not conduct or report customer satisfaction survey data.

4. Identify Potential Solutions

Based on survey results, it was…



Sedgwick County Health Department
Customer Satisfaction Survey Data Sharing Flowchart

Stakeholders, BOCC, County Manager

HD Director[2]

Div Director: Ctr Hlth Equity[2]
- Program: Health Access[2]

Div. Director: Admin. Services[2]
- Program: Finance[2]
- Program: Human Resources[2]
- Program: Operations[2]
- Program: Tech Support[2]

Div. Director: HPP[2]
- Program: Comm Hlth Assessment[1]
- Program: Hlth Promotion[1]
- Program: Hlth Protection[1]
- Program: STD Control[1]
- Program: TB Control[1]

Div Director: Preventive Health[2]
- Program: Cust. Service[2]
- Program: Gen. Clinic[2]
- Program: Immunizations & Hlth Screenings[4]
- Program: Lab Services[4]

Div. Director: Children & Family Hlth[2]
- Program: Children's Dental Clinic[2]
- Program: Healthy Babies[2]
- Program: Prenatal Care[2]
- Program: W.I.C.[3]

[1]Biannual reporting
[2]Quarterly reporting
[3]Monthly reporting
[4]Annual reporting

5. Develop an Improvement Theory

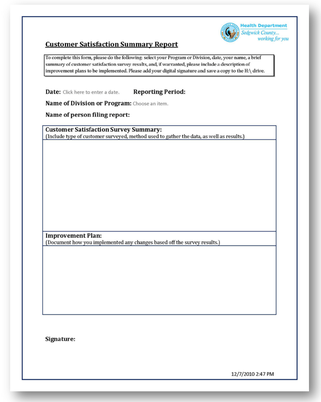
Predictions:

1. If SCHD Programs had a policy for the reporting of customer satisfaction data, quality improvements would be more easily communicated among SCHD personnel, as well as ensuring consistent and high quality customer service will occur at the SCHD.
2. If SCHD Program Managers, Division Director, and the Health Director use the H:\Drive or SCHD SharePoint site to store customer satisfaction summary reports, data will be more accessible for accreditation purposes.

DO
Test the Theory for Improvement

6. Test the Theory

QI project team requested Customer Satisfaction Survey Summary Report form be completed by the Prenatal Care program to determine the efficacy of this new process.



Customer Satisfaction Summary Report

To complete this form, please do the following: select your Program or Division, date, your name, a brief summary of customer satisfaction survey results, and, if warranted, please include a description of improvement plans to be implemented. Please add your digital signature and save a copy to the H:\ drive.

Date: Click here to enter a date. Reporting Period:

Name of Division or Program: Choose an item.

Name of person filing report:

Customer Satisfaction Survey Summary:
(Include type of customer surveyed, method used to gather the data, as well as results.)

Improvement Plan:
(Document how you implemented any changes based off the survey results.)

Signature:

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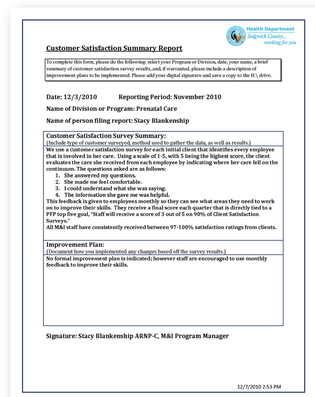
Study
Use Data to Study Results of the Test

7. Study the Results

The Prenatal Care program tested the newly developed Customer Satisfaction Summary Report. Upon completion of the summary report, the Program Manager for the Prenatal Care concluded that this newly developed process was an efficient process.



Customer Satisfaction Summary Report

To complete this form, please do the following: select your Program or Division, date, your name, a brief summary of customer satisfaction survey results, and, if warranted, please include a description of improvement plans to be implemented. Please add your digital signature and save a copy to the H:\ drive.

Date: 12/3/2010 Reporting Period: November 2010

Name of Division or Program: Prenatal Care

Name of person filing report: Stacy Blankenship

Customer Satisfaction Survey Summary:
(Include type of customer surveyed, method used to gather the data, as well as results.)
We use a customer satisfaction survey for each initial client that identifies every employee that is involved in her care. Using a scale of 1-5, with 5 being the highest score, the client evaluates the care she received from each employee by indicating where her care fell on the continuum. The questions we use are as follows:
1. She answered my questions.
2. She made me feel comfortable.
3. I could understand what she was saying.
4. The information she gave me was helpful.
This feedback is given to employees monthly so they can see what areas they need to work on to improve their skills. They receive a final score each quarter that is directly tied to a PFP top five goal, "Staff will receive a score of 3 out of 5 on 90% of Client Satisfaction Surveys."
All M&I staff have consistently received between 97-100% satisfaction ratings from clients.

Improvement Plan:
(Document how you implemented any changes based off the survey results.)
No formal improvement plan is indicated; however staff are encouraged to use monthly feedback to improve their skills.

Signature: Stacy Blankenship ARNP-C, M&I Program Manager

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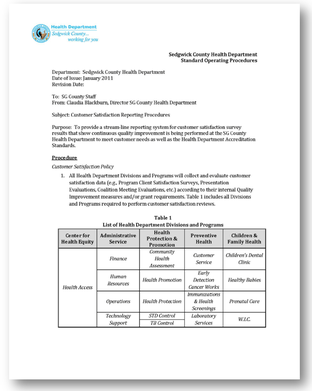
ACT
Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop a New Theory

To ensure the high standard of quality care at SCHD, a policy will be set in place to ensure that all SCHD Programs meet and achieve the high standards of customer satisfaction expected of a local health department.



Sedgwick County Health Department
Standard Operating Procedures

Department: Sedgwick County Health Department
Date of Issue: January 2011
Revision Date:

To: SG County Staff
From: Claudia Blackburn, Director SG County Health Department

Subject: Customer Satisfaction Reporting Procedures

Purpose: To provide a stream-line reporting system for customer satisfaction survey results that show continuous quality improvement is being performed at the SG County Health Department to meet customer needs as well as the Health Department Accreditation Standards.

Procedure

Customer Satisfaction Policy

1. All Health Department Divisions and Programs will collect and evaluate customer satisfaction data (e.g., Program Client Satisfaction Surveys, Presentation Evaluations, Coalition Meeting Evaluations, etc.) according to their internal Quality Improvement measures and/or grant requirements. Table 1 includes all Divisions and Programs required to perform customer satisfaction reviews.

Table 1
List of Health Department Divisions and Programs

Center for Health Equity	Administrative Service	Health Protection & Promotion	Preventive Health	Children & Family Health
Health Access	*Finance*	*Community Health Assessment*	*Customer Service*	*Children's Dental Clinic*
	Human Resources	*Health Promotion*	*Early Detection Cancer Works*	*Healthy Babies*
	Operations	*Health Protection*	*Immunizations & Health Screenings*	*Prenatal Care*
	Technology Support	*STD Control*	*Laboratory Services*	*W.I.C.*
		TB Control		

9. Establish Future Plans

1. Division Directors will receive customer satisfaction updates from Program Managers.
2. Customer Satisfaction summary reports will be made available on the H:\Drive and SCHD SharePoint site for Health Department Accreditation and standardized customer satisfaction reporting.
3. Health Department Director will be able to use data collected to promote the quality of services provided at the Sedgwick County Health Department.

Sedgwick County... working for you

Sedgwick County Health Department

Project Title: WIC Clinic Wait Times

SCHD Quality Improvement Training, 2010-2011

Project Manager: Alyson Taylor

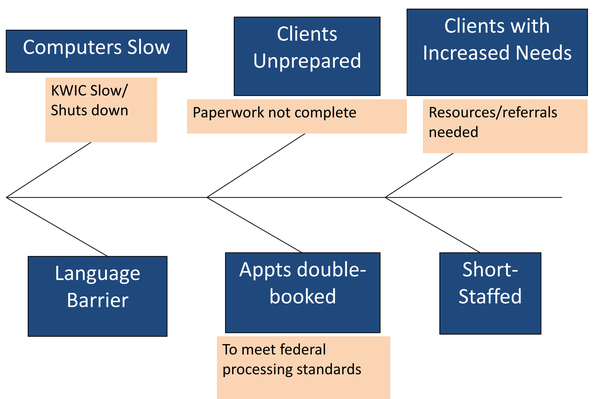
Team Members: Sandy Lewis, Socorro Lozano, Jason Ybarra

PLAN
Identify an opportunity and Plan for Improvement

1. Getting Started
   Team members were tasked with reviewing WIC clinic wait times and identifying areas for improvement.

2. Assemble the Team
   Project team members were from several different programs within the health department: WIC (2), Healthy Babies (1), and Health Protection and Promotion (1).

3. Examine the Current Approach
   The overall flow of the WIC clinic was reviewed and discussed. The project team brainstormed possible causes for increased clinic wait times.



One area that WIC clients have communicated as an area of frustration is the additional wait times that occur if their paperwork is not complete prior to their scheduled appointments. This was also identified as a cause of increased wait times by WIC clinic staff.

AIM Statement
To provide standardized reminder calls to all WIC clients one day before their scheduled appointment to increase client preparedness for appointment.

4. Identify Potential Solutions
   a. Develop a script for WIC clerical staff to use when making reminder calls to clients.

STANDARDIZED REMINDER CALLS

When calling a client to remind them of their appointment, we need to make sure these key points are being said.

State what kind of an appointment it is and who it is for. Example: NC/RC/MC.
Tell them the time of their appointment and what Clinic it is.
Remind them that they need to have the questionnaires fully completed.
**Ask these questions:*
a) Have you received your questionnaires in the mail or handed to you at your previous appointment?
b) Do you have your questionnaires completed?
c) If not, then ask if there is anything you can assist them with at that time.
Remind them that they need to have all the proofs with them.
Remind them that they need to bring in the child(ren).

If the client states that they do not have the questionnaires, please advise them that they need to come in 15-30 minutes before their appointment time to complete them. Or tell them they can come by the office to pick-up the questionnaires so that they can be completed by their appointment time the next day.

   b. Provide training to WIC clerical staff on the reminder calls.

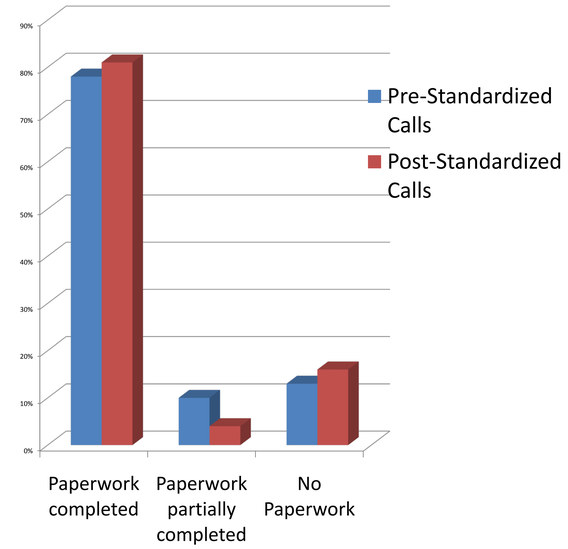
5. Develop an Improvement Theory
   If Clients receive a standardized reminder call informing them of the time of their appointment and necessary documentation to have completed then the clients will arrive on time better prepared for appointment. This will result in decreased wait times.

DO
Test the Theory for Improvement

6. Test the Theory
   WIC staff developed a script for a standardized reminder call to be used for clients. A staff training was conducted with clerical staff and the standardized reminder calls were implemented.
   Client paperwork was tracked pre- and post-reminder call implementation to look for any changes.

Study
Use Data to Study Results of the Test

7. Study the Results
   Client paperwork was tracked for a 3 day period during a time when clients were not receiving standardized reminder calls.
   WIC clerical staff were later trained to use a script that was developed for the standardized reminder calls and began using this script when calling clients.
   Client paperwork was again tracked for a 3 day period during the time that clients were receiving the standardized reminder call.



ACT
Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop a New Theory
   a. Data suggests that providing standardized reminder calls to all WIC clients prior to their scheduled appointments may not be a productive use of time.
   b. Paperwork compliance may require more extensive efforts on WIC staff involving relationship building with client.
   c. Evaluating compliance based on the type of client (eg. new client vs. recertification) may provide more insight to paperwork compliance barriers.

9. Establish Future Plans
   Possible plans for future projects could include:
   a. reviewing the overall flow of the WIC clinic to determine other areas of improvement for decreasing wait times
   b. review processes and wait times at other WIC sites