![Kane County Health Department logo — Your Health Our Commitment]

PDCA STORYBOARD

DIVISION/OFFICE:	Office of Community Health Resources
SECTION:	Community Health Resources
MEMBERS:	Jennifer Fearday, Jackie Forbes, Kristin Preihs, Tom Schlueter, Uche Onwuta, Dan Eder, Michael Isaacson, Sol Figueroa, Nora Arch, Daisy Viyuoh, Sara Boline, Vic Mead, and Mari Pina
PROJECT TITLE:	Assessing and Improving Agency-wide QI Training
DATES OF PROJECT:	5/7/2014 – 9/19/2014

PLAN
Identify an opportunity and Plan for Improvement

1. Getting Started

Using the program SlideRocket, the Kane County Health Department has created QI training modules on 13 different QI tools. Going through the QI training modules can help build staff members scope and ability to use QI tools in finding methods to improve upon the work they do. Section V of the KCHD FY2014 Quality Improvement & Performance Management Plan indicates that all staff members are required to complete 6 QI training modules: Aim Statements, Cause and Effect Diagrams, Data Collection and Analysis, Flowcharts, QI101/PDCA, and SWOT Analysis.

Currently the data shows that only 61.7% (37/60 staff members) of the workforce at KCHD has completed all the 6 required modules. Also, from January to March of 2014 the percentage of those who have completed the trainings has not improved and has remained at 61.7%.

The data tells us that unless an intervention occurs, there is the potential that 100% compliance may not be achieved in a timely manner or may never occur.

2. Assemble the Team

The community Health Resources (CHR) section, who oversees Quality Improvement, were all involved in the process. The 9 members of the Quality Improvement and Performance Management (QuIPM) Committee represent the various sections within the organization, so they also were involved in the process.

By analyzing the baseline and creating the team, the group determined an Aim Statement: By September 19, 2014, the percentage of staff that have completed all 6 of the required quality improvement training modules will increase from 61.7% to 85%.
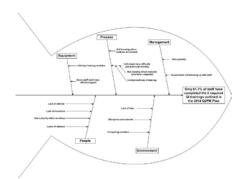
3. Examine the Current Approach

The Community Health Resources section tracks the trainings or training modules that staff have completed in a database, but because it has personal names and completion tracking it cannot be shared on the organization's shared drive. Training modules are available on the shared drive that staff can access at their convenience. There is also no process flow for how staff are notified by managers in regards to completions of trainings within identified timelines.

On 5/20/14 the KCHD staff were surveyed on whether they knew how many training modules they have completed, if they knew where to find the modules, whether there was accountability of completion, and various staff barriers in completing the modules.
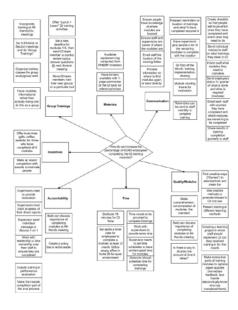
4. Identify Potential Solutions

Using the 5/20 survey as a guide, the QuIPM Committee conducted a Cause and Effect Diagram on 6/4 to analyze potential root causes to completing the modules. The CHR Group then added to the Cause and Effect Diagram during their PDCA meeting on 6/18.

The common causes for not completing the modules were time, not knowing which modules have to be completed, and not knowing where modules are located.

From the analysis of the surveys and Cause and Effect Diagram, the QuIPM Committee then brainstormed potential solutions and created an Affinity Diagram on 7/16/14. The diagram was then analyzed by the CHR section for additional comments.

From those potential solutions, the QuIPM Committee and CHR were surveyed on 7/23 to vote on the best possible solution, with their vote representing their respective section.

5. Develop an Improvement Theory

From the Cause and Effect Diagram and survey results, the strategy was determine to build a notification process using the Health Data and Quality Coordinator (HDQC) at the health department.

This solution involved personalized emails that listed why they should go through the training, what module(s) they had to complete, and direct links to access the training. This solution to help deal with the numerous root causes from the survey and fishbone diagram indicating the confusion about where the modules were and which ones that needed to be completed. The notification was sent out of 08/09 with the deadline to complete the modules by 09/19 (6 weeks).

DO
Test the Theory for Improvement

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6. Test the Theory

A personalized email reminder was sent to each staff member that had not completed the six required trainings, which indicated which trainings that needed to be complete and a hyperlink to the location of the trainings. The already created database was the identified mechanism to track completion rates among staff.

CHECK
Use Data to Study Results of the Test

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7. Check the Results

Just by sending the notification we saw a large fluctuation of handouts that came in within days of notice. One outcome was that time was a frequently listed barrier, yet compliance increased 10% in the first day or two after notification.

By 9/19/14, the total percentage of staff that had completed the required 6 training modules rose from 61.7% to 77.64%, and a few weeks after the testing period the percentage again rose to 83.05%. Some staff had completed modules outside of the required 6 that they still needed to completed, which is an added success that wasn't the direct goal of the project.

ACT
Standardize the Improvement and Establish Future Plans

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8. Standardize the Improvement or Develop New Theory

Even though the desired goal of 85% was not reached, the project was deemed a success by the team. Even after the 9/19 date, staff have continued to submit training modules and some staff have completed all 13 modules.

The tracking of the 6 required modules and the 13 total modules are both performance measures in the agency's performance management system. The process of regularly notifying staff of what modules they have to complete and hyperlinks to the modules is now standard practice performance monthly by the HDQC.

9. Establish Future Plans

There are numerous future plans that arose from the PDCA process. A QI Resource Library was formed during the process that contains other training methods, due to comments around the training modules. The library gives different options to learn about QI, such as a YouTube video on a particular tool.

The QI group had discussed during a meeting on 09/03/14 that QI members should completed ALL 13 training modules, aside from only the 6 required in the QI plan. Members of currently working on achieving that desired goal.

Discussions took place regarding how QI tool usage is tracked within the health department. Currently tools are tallied each month by Section and tracked in a database and as a performance measure. What came from the project is a better and unified method to track QI tool usage throughout the month and what benefit or change the tool led to.

In an effort to make QI more fun, an agency wide QI game using paper airplanes and the PDCA cycle occurred on 9/15/14.

From the barrier of time, the HDQC is working to build the skillset of the QuIPM Committee members so they can train their respective sections. By having the created training tracking database, the HDQC can analyze which trainings have been completed least and compare it to the amount of QI tools conducted at that particular tool during the year. This will help focus a training plan that can be built into existing schedules and meetings, thus training staff while addressing the time barrier.

Finally, QuIPM Committee members agreed to a 5 minute report out on QI during their section and division meetings. This change will hopefully keep QI in the forefront and reinforce the importance of QI, especially to those staff that still have yet to complete the 6 modules.