Quality Improvement Plan

Public Health - Dayton & Montgomery County

Original Approval Date by Executive Team: October 8, 2015

Review Frequency: Every 2 years

Review/Revision Dates: December 29, 2016

Public Health
Prevent. Promote. Protect.
Dayton & Montgomery County

Human Services
MONTGOMERY COUNTY

Quality Improvement Plan

Public Health – Dayton & Montgomery County

Signature Page

This Plan has been approved and adopted by the Health Department:

Health Commissioner

27 June 17
Date

Public Health
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Human Services
MONTGOMERY COUNTY

Quality Improvement Plan
Public Health - Dayton & Montgomery County

Record of Change

Modifications made to this plan since the last review period are as follow:

Date of Change	Section	Description of Change	Individual Making Change

Quality Improvement Plan
Public Health - Dayton & Montgomery County

Table of Contents

Public Health - Dayton & Montgomery County (PHDMC) is committed to the ongoing improvement of the quality of services it provides. This Quality Improvement Plan serves as the foundation of this commitment.

Table of contents

This plan includes the following topics:

Purpose and Introduction

Executive summary

PHDMC is committed to developing and implementing a performance management system based on the Public Health Performance Management System Framework (Public Health Foundation, June 2013). This will allow us to measure/ monitor, report, and improve the quality of our programs and services leading to improved health of Montgomery County residents.

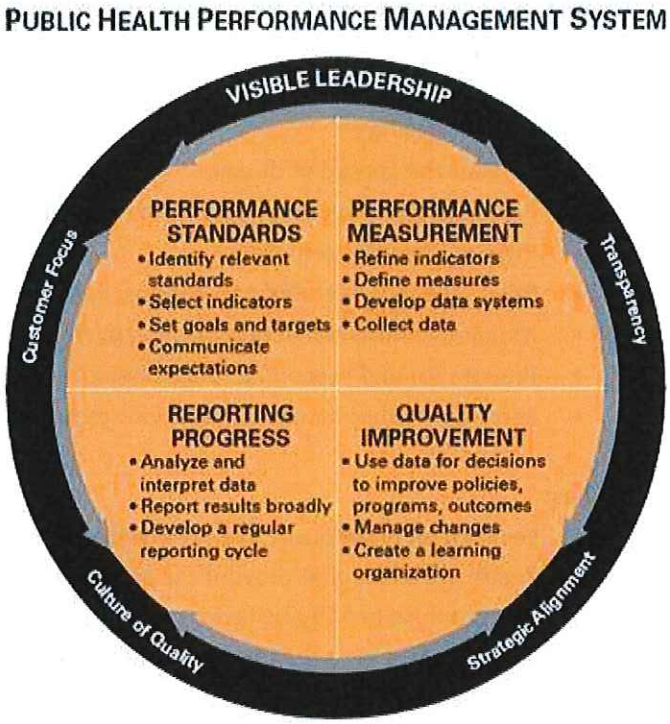

Figure 1: Public Health Performance Management System Framework; Public Health Foundation; Accessed November 22, 2016 at http://www.phf.org/focusareas/performancemanagement/toolkit.aspx

Our Quality Improvement (QI) Plan was written by a diverse team of PHDMC employees with assistance from consultants from the Ohio State University Center for Public Health Practice as well as feedback from our Executive Team and staff. The plan outlines how we, collectively, will establish a culture of continuous quality improvement (CQI) through systematic, department-wide training and project involvement. The plan is available to all our employees and key stakeholders and serves to strengthen our ability to achieve the goals and objectives outlined in our Community Health Improvement Plan (CHIP), Strategic Plan, and Workforce Development Plan. Our QI Plan also serves to address the documentation requirement for the Public Health Accreditation Board (PHAB), Version 1.5, Standard 9.2.1: Quality Improvement Plan.

Mission, vision and values*

*PHDMC Strategic Plan 2013 - 2017, V 2.0

Mission: Our mission is to lead and innovate by working with our community to achieve the goals of public health: prevention, promotion, and protection.

Vision: Our vision is to be an innovative leader in achieving the highest possible health and well-being for Dayton and Montgomery County residents and visitors. To that end, we provide vital, cost effective and culturally competent health services that protect and promote people's health and support and create healthy environments and communities.

Through our services we:

- Prevent the spread of disease
- Protect against health threats in air, food, and water
- Promote healthy behaviors
- Reach out to vulnerable populations, linking or providing direct services
- Mobilize community action through partnerships
- Prepare for and respond to public health emergencies
- Serve as a public health information resource

Values:

- **Focused on Prevention**: We believe that the best investments in the public's health are those that prevent the spread of disease, foster optimal wellness and promote healthy behaviors.
- **Accountable:** We are open and honest in our relationships and good stewards of available resources.
- **Centered on the Community:** We build and sustain our public health system through partnerships that improve health outcomes.
- **Evidence-based:** We implement strategies that are based on science and best practices.
- **Health Equity:** We work to eliminate health disparities and advocate for the needs of the underserved.
- **Respect:** We treat everyone with dignity, sensitivity and compassion.

Strategic Directions

- **Strategic Direction 1** - Promote a culture of health and wellness that results in measurable population health improvement.
- **Strategic Direction 2 -** Improve access to affordable, quality health care for all Montgomery County residents.
- **Strategic Direction 3 -** Enhance our internal foundational capabilities.
  Note: Focus areas relating to this strategic direction include incorporating performance management into all operations and establishing a culture of continuous quality improvement.
- **Strategic Direction 4 -** Promote health equity to eliminate disparities in health outcomes.
- **Strategic Direction 5 -** Continue to strengthen our local public health system by convening and facilitating partnerships.

Definitions and Acronyms

Introduction

A common vocabulary is used agency-wide when communicating about performance management and quality improvement. Key terms and frequently used acronyms are listed alphabetically in this section.

Definitions

Competency: The personal attributes and special qualifications required to perform a job and generally demonstrated through qualifying service, education or training. A competency is defined as:

- Knowledge – an organized body of information, usually factual or procedural in nature, applied directly to the performance of a function.
- Skill – the proficient manual, verbal, or mental manipulation of data or things required for the performance of a job.
- Ability – the power or capacity to perform an activity or task that results in an observable product.

Specific competencies are needed in performing certain jobs. Individual competencies are demonstrated through qualifying experience, education or training.

Individual Professional Development: The ongoing process of acquiring and refining knowledge, skills, and abilities that relate to your profession, job responsibilities and work environment.

Performance Management: The process of actively using data to improve the public's health. It includes the use of performance measures, performance standards, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results (Turning Point, 2003).

Plan, Do, Study, Act (PDSA, also known as the PDSA cycle): A four-stage, problem-solving model for improving a process and learning or carrying out change. PDSA stems from the scientific method (hypothesize, experiment, evaluate) and uses action-oriented learning. A fundamental principle of PDSA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned and create the foundation for continuous quality improvement (Embracing Quality in Local Public Health: Michigan's QI Guidebook, 2008, p. 9).

Quality Assurance (QA): A systematic process of checking to see whether a product or service is meeting predetermined specified requirements.

Quality Council (QC): The group that oversees the implementation of the QI plan,

including the selection of projects, monitoring the progress of projects, and implementing quality improvement throughout the organization based on the findings of completed projects.

Quality Culture: Quality improvement is fully embedded into the everyday activities that are the way the agency does business across all levels, departments and programs. Leadership and staff are fully committed to quality, and results of QI efforts are communicated internally and externally. Even if leadership changes, the basics of QI are so ingrained in staff that they continue to seek out the root cause of problems. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives (Roadmap to a Culture of Quality Improvement, NACCHO, 2012).

Quality Improvement (QI): A continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.

Big QI: A systems approach to quality improvement that is across the entire agency and/or cross-program. It is the practice of incorporating quality improvement into every aspect of PHDMC. Big QI projects are those that are linked directly to the health department's strategic plan, and are responsive to community needs. Examples of processes across the entire agency include employee onboarding, requisitioning supplies, and approving contracts, etc.

Little qi: Quality improvement efforts that are focused at the program level which are tied to a specific program need for improvement which may be identified as a result of a program audit, customer satisfaction survey, grant requirements, etc. Examples include the process of issuing permits, improving forms used by customers, etc.

Continuous Quality Improvement (CQI): A systematic, department-wide approach for achieving measurable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of the processes or services provided. Applies use of a formal process (PDSA, etc.) to "dissect" a problem, discover a root cause, implement a solution, measure success/failures, and/or sustain gains.

Quality Improvement Plan (QI Plan): A plan that identifies specific areas of current operational performance for improvement within the agency. Agency plans can and should cross-reference one another, so a quality improvement initiative that is in the QI Plan may also be in the Strategic Plan.

Quality Liaison: A PHDMC employee who has undergone more extensive QI training and will serve as a consultant to QI project teams, guiding the team through a formal QI process (i.e. PDSA, DMAIC, etc.) and the utilization of quality tools. They will provide technical support by helping a project team determine what to measure, assist in the selection of simple, effective measurement tools, and provide guidance on collection, interpretation, and display of data to determine next steps.

Quality Tools: Charts, graphs, diagrams and techniques used to prioritize Qi projects, clarify a complex issue, solve a QI problem, or improve a problem process. Common tools used by PHDMC are described in the *Memory Jogger 2, 2010*.

Storyboard: Organized, graphic representation documenting and showcasing the quality improvement process conducted by the QI team.

Acronyms

BOH: Board of Health

CHA: Community Health Assessment

CHIP: Community Health Improvement Plan

CMH: Children with Medical Handicaps

DMAIC: QI Methodology; Define, Measure, Analyze, Improve, Control

ET: PHDMC Executive Team

ITS: PHDMC Information Technology Services group

NACCHO: National Association of County and City Health Officials

ODH: Ohio Department of Health

PHAB: Public Health Accreditation Board

PHDMC: Public Health - Dayton & Montgomery County

SMART: An acronym to describe the criteria for setting a goal or objective. The goal/objective should be: **S**pecific, **M**easurable, **A**chievable, **R**esults-focused, and **T**ime-bound.

WIC: Women, Infants and Children program

Description of Quality in Agency

Introduction

This section provides a description of quality efforts within PHDMC, including structure, staffing, culture, processes, and linkages of quality efforts to other agency documents. PHDMC's organizational structure is divided into five Offices.

Description quality efforts

PHDMC is in the earliest stages of initiating quality improvement. Few staff has received performance management or QI training, and even fewer have been involved in a formal QI project using PDSA methodology. Most staff lacks the knowledge, skills, and abilities to perform QI as part of their daily work; however, the data collected from our 2014 Training Needs Assessment shows that staff do have an interest in developing these competencies.

Within PHDMC, there are some programs where the QI culture is more established. To date, there have been Little qi projects initiated and completed, largely within areas where clinical services are offered. There are two Big QI projects currently being completed at PHDMC.

As a first step in drafting our QI Plan, baseline assessments of "where we are now" were performed in January 2015 using qualitative and quantitative measures. This included:

- The QI Plan Writing Team members, along with representatives from PHDMC's CMH, Addiction Services, WIC, and Community Nursing programs, each completed the Organizational QI Maturity Survey. Participants met to compare answers and achieve consensus on a score for each question. The score represents the status of the agency as a whole, not individual or unit perspectives.
- To provide a better understanding of the status of the agency as a whole, a survey was developed, based on questions from the Organizational QI Maturity Survey, and administered to staff via an on-line survey instrument. Approximately 65% of staff participated.
- Our Executive Team completed the Public Health Performance Management Self-Assessment Tool.
- The QI Plan Writing Team completed a plotting exercise using the different human and process characteristics associated with each phase of NACCHO's Roadmap to a Culture of Quality Improvement.

After reviewing the results, it is apparent that, as an agency we are between phase 2 and 3 on NACCHO's Roadmap to Quality Improvement. We intend to show steady, measurable improvement towards achieving a culture of quality. The goals and objectives we have identified in order to advance are found on pages 15-16.

Links to other agency plans

This QI Plan is directly aligned with PHDMC's Strategic Plan, specifically, to "establish a culture of continuous quality improvement". Tiered expectations for QI training are outlined later in this plan. Operational components for training are described in the Workforce Development Plan and tracked monthly by the Workforce Development Coordinator.

We will look to our CHIP, our Diversity and Inclusion plan, our Strategic Plan, as well as other sources as we select quality improvement projects (see "Projects" section of this plan). While we continue to develop a fully functional, multiple-layer performance management system based on the Public Health Performance Management System Framework, we anticipate utilizing the QI Plan in tandem with that system to identify future quality goals and objectives, set measures, and select areas for improvement. Each of these plans is created with improvement and one another in mind.

Quality improvement management, roles & responsibilities

Quality Council

The Quality Council (QC) oversees the implementation of the QI Plan, including the selection of projects, monitoring the progress of projects, and implementing quality improvement throughout PHDMC based on the findings of completed projects. The QC will convene every month through January 2018 and a minimum of every other month thereafter.

The QC consists of a member of the Executive Team, the Quality Improvement Coordinator, Workforce Development Coordinator, program supervisors and managers, and front line staff. A minimum of two members will be from each health department Office and at least two front line staff shall have direct daily interaction with the general public. The QC charter can be viewed in Appendix A. The QC will report activities to the BOH via the Health Commissioner.

QC members are volunteers or are nominated by management staff. Appointments are approved by the director of the Office in which the potential member works. Assignments to the QC are for a minimum three year period. No more than half the council may rotate off in any given year. Half of the members of the initial council will be appointed to a two year term, at which time new members will rotate in to assure

a one year overlap for the next appointed members. Some of the initial members of the QC will be members of the QI Plan Writing Team.

In addition to the core members, ad-hoc members may be part of the QC as needed. Examples of ad-hoc members include ITS, epidemiologists, facilities, etc. An office support person will be assigned to the QC to provide administrative assistance.

Quality Council membership criteria includes:

- Commitment to develop and promote continuous QI throughout PHDMC
- Have an interest in, actively participate in, and have an aptitude for performance improvement planning, QI, and project and program evaluation
- Have a flexible and collaborative nature
- Be available to attend meetings and complete any required work between these meetings

Quality Council membership responsibilities includes:

- Review QI Plan at least annually and adjust as needed
- Implement, monitor, and track completion of QI Plan goals and objectives
- Select and monitor QI projects and teams
- Serve as Quality Liaisons
- Communicate QI efforts throughout the agency to the staff

Quality Improvement Coordinator responsibilities includes:

- Act as QC chairperson
- Monitor and track QI efforts throughout agency
- Act as a representative between the QC and teams performing QI projects
- Report QI activities to the Executive Team
  (Note: See class specification for additional responsibilities).

The Quality Improvement Coordinator is a full time PHDMC staff member. The Quality Improvement Coordinator is positioned in the Office of Administration and reports to the PHAB Accreditation Supervisor.

Quality Liaison responsibilities includes:

- Provide technical assistance to develop project proposal
- Provide or source needed technical assistance for QI project teams
- Utilize QI tools to allow the QI project team to analyze and display data, reach consensus and decision making, and create planning actions
- Keep QI project teams focused on the process
- Assure that QI projects follow a formal QI process model , that data is used to measure improvement or failure, and that QI project worksheets are

completed for assigned projects

- Communicate status of assigned projects at monthly QC meetings.

Quality improvement process

PHDMC currently follows the Institute for Healthcare Improvement recommendation to utilize the PDSA approach to allow swift but thorough cyclical improvements that are monitored and reviewed using data to verify or disapprove the desired outcome. In 2017, PHDMC QI leaders and staff will receive training in the Lean Six Sigma DMAIC methodology and will use this process to facilitate multiple QI projects. All project work is grounded in QI methodology including the use of common QI tools such as Gantt Charts, Fishbone Diagrams, Flowchart Diagrams, Matrix Charts, Run Charts, Scatter Diagrams, as well as other instruments. See Appendix D: Commonly Used QI Tools and The Memory Jogger 2, 2010.

Quality Council Goals and Implementation 2017

Introduction During the development of the QI Plan, the QI plan writing team conducted an Organizational QI Maturity Survey with PHDMC staff. They used the results of the survey, along with an exercise to assess PHDMC's progress within the phases of the Roadmap to a Culture of Quality Improvement (NACCHO 2012), to establish short-term goals for QI Plan implementation. At the end of 2016, the Quality Council reviewed the progress in meeting these short-term goals and identified transition strategies unmet within the Roadmap in order to establish the following new short-term goals.

Goals & Objectives	Responsible Party	Completion Date
Goal #1: PHDMC will demonstrate measurable progress toward achieving a culture of Quality Improvement		
A: Conduct the QI Employee Survey with all staff. (Originally conducted 03/24/2015).	QI Coordinator	September 30, 2017
B: QC to evaluate the effectiveness of QI Plan in advancing QI culture	Quality Council	November 30, 2017
C: QC to review , and if necessary, revise QI plan based on outcomes of Survey and evaluation	Quality Council	December 31, 2017
Goal #2: PHDMC staff has the knowledge and skills necessary to perform QI		
A: 90 employees will receive Lean Six Sigma Yellow Belt training in 2017.	QI Coordinator	December 31, 2017
B1: Continue to update staff on QI topics by producing and sharing the *QTIPS* video quarterly.	Quality Council	March 31, 2017 June 30, 2017 September 30, 2017 December 31, 2017
B2: Increase number of views of the QTIPS video within one month of posting the video by	Quality Council	December 31, 2017

50% of baseline (2016 baseline = 75 views)		
C: Schedule quarterly Q&A opportunities for staff to engage with peers that have completed formal QI projects	Quality Council	May 31, 2017
Goal #3: PHDMC will implement QI activities throughout the agency using a formal process improvement model.		
A: Liaisons from the QC will work with project teams to facilitate 5 formal QI projects in 2017.	Quality Council	December 31, 2017
B: A method for documenting and tracking informal improvements being implemented at the program level will be approved by the Executive Team by June 30, 2017..	Quality Council	June 30, 2017
C: Collaborate with the Executive Team/PMSC each quarter to identify areas in need of focused process improvement.	QI Coordinator	Quarterly

Projects

Introduction

This section describes the process for QI project identification, selection, prioritization, and selection of project team members. Additional information about current and past projects may be obtained from the project leader, liaisons, Quality Improvement Coordinator, or PHDMC's portal.

Project selection

QI projects will be selected by the QC based on need and the importance to PHDMC strategic goals and performance management. All staff members have the ability to nominate projects via the project proposal form on PHDMC's portal (see Appendix B for an example form). All new submissions will be evaluated by the QC monthly. The Quality Council is available to assist staff with identifying and evaluating potential projects. Potential projects may be identified through:

- Internal or external program audits
- Customer satisfaction surveys
- Program evaluations or dashboard reports
- Accreditation requirements
- Incident report findings
- Staff surveys
- CHIP
- Public Health Quality Indicators for local health departments in Ohio

Potential QI projects will be evaluated by the QC using the Project Criteria Worksheet included in Appendix C. Once a QI project has been prioritized, a Quality Liaison will be assigned. The QI Coordinator, Quality Liaison, and/or other QC member will meet with the ET sponsor and process owner to begin to create the project charter.

QI projects that are program specific (Little qi) may be referred back to the Office director and/or program manager/supervisor/coordinator to determine project viability and select a project team. A Quality Liaison will assist the team if needed.

Current projects

Two formal Big QI projects were implement in 2016; Sending Healthcare Provider Alerts and Staff Awareness of Personnel Policies. Three Little qi projects are currently underway; CMH common file clean-up, General Services food safety course scheduling, RAPCA compliance report tracking.

Training

Introduction

PHDMC has incorporated our QI training goals and objectives within the agency Workforce Development Plan. The Workforce Development Plan will include goals, objectives, target audience, resources/sources of training, training documentation and accreditation record keeping, and the individual(s) responsible for leading each objective.

Training and support

PHDMC began introductory training related to QI with staff including the QI Plan Writing Team, the Workforce Development Coordinator, as well as Executive Team members. All staff take basic level training in QI. Additional training is available for all staff that requests it, are a member of a QI project team, are a Quality Liaison, are required because of position needs, act in a leadership role in the QI plan, or are a member of the Quality Council.

QI training steps will include:

- Orientation of new hires to the agency Performance Management Framework and QI Plan, QI project proposal process, QI training, and opportunities to participate on project teams and/or Quality Council.
- Level One online QI training module **CQI for Public Health: The Fundamentals** was completed by all staff in 2015. All new hires will complete this training during orientation and no later than 3 months after date of hire.
- Level Two online QI training module **CQI for Public Health: Tool Time** was completed by members of the Quality Council, Quality Liaisons, and other designated staff by February 28, 2016. New members of the Quality Council will be required to complete this training as they join the team.
- Additional QI training will be made available to staff. By December of 2017, 30% of staff will have received Lean Six Sigma DMAIC training.
- Quality Liaisons will conduct QI refreshers with project teams at the start of each project and just-in-time tools training throughout the project.
- Quality Improvement Coordinator will reinforce QI initiatives, policies, and procedures to all staff through various media as needed.

Evaluation and Monitoring

Introduction

This section describes the evaluation and monitoring of the QI Plan and projects by the QC. A plan and timeline/frequency for these activities is included in Appendix G.

QI plan

This QI Plan will be reviewed and evaluated by the QC annually beginning in September of 2017 and each year thereafter. The evaluation process will begin in September simultaneously with the budgeting process. The QC members will evaluate the effectiveness of the plan in meeting the established goals and objectives. The NACCHO QI Roadmap will be reviewed to assist in evaluating our progress toward achieving a culture of quality and in selecting strategies to implement. Goals will be revised and corrective actions and revisions will be made after this annual review. A written report will be submitted by January 15 each year.

The Quality Council will document the QI plan goals and objectives on the QC performance measure dashboard. Progress on the objectives will be reviewed at monthly QC meetings. Areas for improvement will be identified and action items assigned. The dashboard will be submitted to the Executive Team for review quarterly.

QI project teams

QI Project Teams will provide project progress reports to the Quality Council monthly, as determined by the Project Team Leader, or by special requirement determined by the QC (every other month, quarterly, etc.). A mid-project report will be given to the ET sponsor. The ET sponsor will be notified anytime roadblocks are encountered in progress. All teams will develop and submit project storyboards within 30 days of the conclusion of the project. Within 30 days of a project's finalization, all team members will complete the QI project team evaluation to:

- Identify factors that contributed to the team's success.
- Identify factors that hindered the team's success.
- Identify additional areas in PHDMC where the process solution can be implemented.
- Identify any follow up work that may be required.
- Determine how the results of the project will be communicated

Communication

Introduction

In order to support a culture of quality, quality-related news will be communicated on a regular basis using various methods to the Executive Team, staff, Board of Health, clients, and the public. The QC will communicate such items as project ideas turned in by staff for review, upcoming projects (and start date if known), current project highlights and status, and completed project outcomes. Policy and procedural changes associated with project results will be communicated as well. A plan and timeline for these activities is included in Appendix G.

Quality sharing

Executive Team:

- Presentation as part of the scheduled Executive Team meeting agenda as projects are completed; additional project updates will be provided as requested by the Executive Team.
- The Quality Council Performance Measure Dashboard will be submitted quarterly.

PHDMC Staff:

- QI news video, *QTIPS*, will be produced and shared with all staff quarterly via the PHDMC employee portal. The video will contain tips on using common QI tools, QI project updates, improvements implemented and other QI related information.
- Reported on at Administrative Staff meetings on an as-needed basis. Administrative staff will communicate information shared at these meetings with staff under their direction.
- Project storyboards will be displayed in common areas of the project department and/or at the Reibold Building.
- QI project descriptions, tools, and select documents will be shared in a designated section of the PHDMC employee portal.
- All QC meeting documents (agendas, summaries) and QI Project team documents (agendas, summaries, data tools, storyboards, etc.) will be maintained electronically in a shared folder by the Quality Improvement Coordinator for review by all staff members.

Board of Health:

- BOH members will receive updates in the Health Commissioner/Medical Director Report and QI Project Team Leaders will report on activities in selected monthly meetings. Board members will receive an annual update, focused on the evaluation report of the QC.

Public:

- Project descriptions and results will be featured on the agency's website and included as a narrative in the annual report to the public.

Other:

- In addition to these regularly occurring communications, the QC will seek avenues to share quality initiatives with other community partners and other state and national audiences as appropriate.

References and Resources

- CDC, Performance Management and Quality Improvement: http://www.cdc.gov/stltpublichealth/performance/index.html
- City of Columbus Community Health Improvement Plan 2011-2015 http://www.naccho.org/topics/infrastructure/accreditation/upload/07-9-1-2-2_Signed_QI_Plan_2013.pdf
- NAACHO, Roadmap to a Culture of Quality Improvement http://qiroadmap.org/
- Ohio State University College of Public Health, Center for Public Health Practice, CQI for Public Health: The Fundamentals http://cph.osu.edu/practice/cqi-public-health-fundamentals
- Ohio State University College of Public Health, Center for Public Health Practice, CQI for Public Health: Tool Time https://cph.osu.edu/practice/free-online-learning
- Public Health Accreditation Board, Standard and Measures Version 1.5: http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/
- Public Health Foundation, Turning Point Performance Management Framework: http://www.phf.org/focusareas/performancemanagement/toolkit.aspx
- QI Maturity Tool http://www.health.state.mn.us/divs/opi/pm/lphap/qiplan/docs/qimaturitytool_subset.pdf
- Spokane Regional Health District 2013 Quality Improvement Plan https://www.phqix.org/sites/default/files/Spokane_QI_Plan.pdf
- *The Public Health Memory Jogger 2: Tools for Continuous Improvement and Effective Planning*. (2010). Salem, NH: Goal/QPC.
- Washington County Department of Public Health and Environment (PHE). 2014 Quality Improvement Plan http://www.health.state.mn.us./divs/opi/pm/lphap/qiplan/docs/plans/washington2014.pdf

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Public Health - Dayton & Montgomery County gratefully acknowledges the guidance provided by the Ohio State University College of Public Health, Center for Public Health Practice in the preparation of this Quality Improvement Plan.

List of Appendices

The following documents are included as appendices to this plan:

Appendix A: Quality Council Charter
Appendix B: Quality Council Project Proposal Form (Sample)
Appendix C: Quality Council Project Criteria Worksheet
Appendix D: Commonly Used QI Tools
Appendix E: QI Project Team Charter Template
Appendix F: QI Project Storyboard Template (Sample)
Appendix G: Quality Council Activity Timeline

Appendix A: Quality Council Charter

Public Health - Dayton & Montgomery County

Charter # 7023

Committee Charter

Quality Council

Purpose:
The purpose of the Quality Council (QC) is to oversee the implementation of the agency Quality Improvement (QI) plan.

Scope / Objectives:
The QC is responsible for review and revision of the agency QI plan, selection of PHDMC quality improvement projects, monitoring the progress of projects, implementing improvements throughout PHDMC based on the findings of completed projects, and communicating QI efforts with staff.

Committee Membership:
The Quality Council will consist of the following:

1. A member of the Executive Team
2. Quality Improvement Coordinator
3. Workforce Development Coordinator
4. A minimum of two representatives from each health department Office
    a. Members should represent a diverse range of job classifications including supervisors, coordinators, and front line staff
    b. At least two members should have direct daily interaction with the general public

*Meetings are recorded by an Administrative Assistant.

Responsibilities:

1. Members commit to develop and promote continuous QI throughout PHDMC.
2. Members have an interest in, actively participate in, and have an aptitude for performance improvement planning, QI, and project and program evaluation.
3. Members have a flexible and collaborative nature.
4. Members will be available to attend meetings and complete any required work between meetings.

Meetings:

1. Quality Council Meetings will be held monthly on the 4th Tuesday of each month.
2. Records of Quality Council meeting agendas, minutes, sign-in sheets and materials distributed will be stored by the Quality Improvement Coordinator.

Appendix B: Quality Improvement Project Proposal Form (Sample)

Date (mm/dd/yyyy):	
What is the process that needs improvement?	
Who does the process impact?	
Are you aware of any previous solutions that may have been tried to fix the process?	
What do you think could be done to improve the process?	
What resources and support might be required for this project?	
Is data available that supports/indicates the problem?	
Why is this process important? (i.e. supports PHDMC's mission, strategic priority, stakeholder interest, etc.)	
Who is the immediate supervisor responsible for the process?	
Please list any further comments or suggestions	
Name:	
Phone:	
Email:	
Would you be interested in participating on the project team? Yes No	

Appendix C: Quality Council Project Criteria Worksheet

Date:	Project Title:	Evaluator Initials:

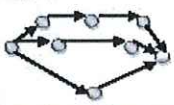
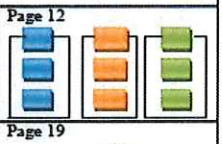
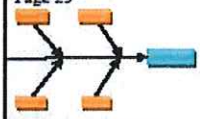
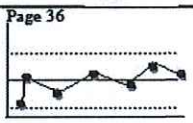
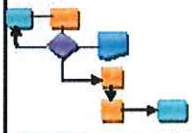
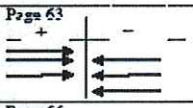
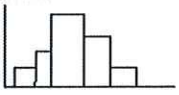
Answer the questions for the project by circling the strength of response:

Strategic		Notes
1. Is it important? To whom?	1 2 3 4 5	
2. Does it support PHDMC strategic plan?	1 2 3 4 5	
3. Does it have a customer focus?	1 2 3 4 5	
4. Does the problem span across the agency?	1 2 3 4 5	
5. Is the project politically feasible? Consider internal and external factors	1 2 3 4 5	
Technical		
6. Is it a process?	1 2 3 4 5	
7. Is the problem measurable?	1 2 3 4 5	
8. Is data available?	1 2 3 4 5	
9. Is the target problem clearly defined?	1 2 3 4 5	
10. Can the project be completed in a reasonable timeframe?	1 2 3 4 5	
Empowerment		
11. Is it within the organization's control?	1 2 3 4 5	
12. Is it free from pre-conceived solutions?	1 2 3 4 5	
13. Is leadership prepared to implement change?	1 2 3 4 5	
14. Is there a high probability of success?	1 2 3 4 5	
Other		
15. Is there a sense of urgency?	1 2 3 4 5	
16. Is it a safety issue?	1 2 3 4 5	
17. Is it a mandated fix?	1 2 3 4 5	
18. Can it be a good success story?	1 2 3 4 5	
19. What is the cost of the project?	1 2 3 4 5	
20. Will there be a cost savings to PHDMC?	1 2 3 4 5	
Total		

Scale Description		
1	Poor	Limitations or barriers do not allow undertaking of criteria (i.e., building infrastructure, etc.)
2	Fair	Limitations or barriers restrict criteria (i.e., policy, legislature, geographical location, etc.)
3	Good	Limitations or barriers present, but workable and non-restrictable (i.e., workflow processes, SOPs, etc.)
4	Very Good	Little to no limitation or barriers
5	Excellent	No limitations or barriers

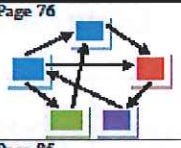
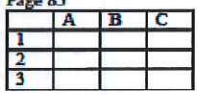
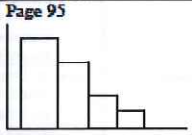
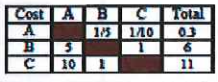
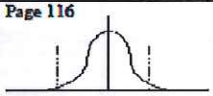
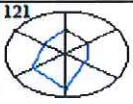
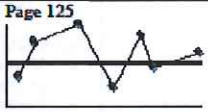
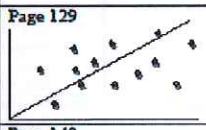
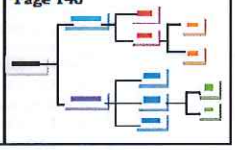
Appendix D: Commonly Used QI Tools

Quality Improvement (QI) Toolbox

QI Tool	*What the Tool Does*	*Public Health Memory Jogger II*
Activity Network Diagram/ Gantt Chart	Used to: Schedule sequential and simultaneous tasks • Gives team members the chance to show what their piece of the plan requires and helps team members see why they are critical to the success of the project. • Helps teams focus its attention and scare resources on critical tasks.	Page 3 
Affinity Diagram	Used to: Gather and group ideas • Encourages team member creativity by breaking down communication barriers. • Encourages ownership of results and helps overcome "team paralysis" due to an array of options and a lack of consensus.	Page 12 
Brainstorming	Used to: Create bigger and better ideas • Encourages open thinking and gets all team members involved and enthusiastic. • Allows team members to build on each other's creativity while staying focused on the task at hand.	Page 19 
Cause and Effect/Fishbone Diagram	Used to: Find and cure causes, not symptoms • Enables a team to focus on the content of the problem, not the problem's history or differing personal issues of team members. • Creates a snapshot of the collective knowledge and consensus of a team around a problem. • Focuses the team on causes, not symptoms.	Page 23 
Check Sheet	Used to: Count and accumulate data • Creates easy-to-understand data ~ makes patterns in the data become more obvious. • Builds a clearer picture of "the facts", as opposed to opinions of each team member, through observation.	Page 31 
Control Charts	Used to: Recognize sources of variation • Serves as a tool for detecting and monitoring process variation. Provides a common language for discussing process performance. • Helps improve a process to perform with higher quality, lower cost, and higher effective capacity.	Page 36 
Data Points	Used to: Turn data into information • Determines what type of data you have • Determines what type of data is needed	Page 52 
Flowchart	Used to: Illustrate a picture of the process • Allows the team to come to agreement on the steps of the process. Can serve as a training aid. • Shows unexpected complexity and problem areas. Also shows where simplification and standardization may be possible. • Helps the team compare and contrast the actual versus the ideal flow of a process to help identify improvement opportunities.	Page 56 
Force Field Analysis	Used to: Identify positives and negatives of change • Presents the "positives" and "negatives" of a situation so they are easily compared. • Forces people to think together about all aspects of making the desired change as a permanent one.	Page 63 
Histogram	Used to: Identify process centering, spread, and shape • Displays large amounts of data by showing the frequency of occurrences. • Provides useful information for predicting future performance. • Helps indicate there has been a change in the process. • Illustrates quickly the underlying distribution of the data.	Page 66 

Developed from *The Public Health Memory Jogger II (2007)*

Quality Improvement (QI) Toolbox

Interrelationship Digraph	Used to: Look for drivers and outcomes • Encourages team members to think in multiple directions rather than linearly. • Explores the cause and effect relationships among all the issues. • Allows a team to identify root cause(s) even when credible data doesn't exist.	Page 76 
Matrix Diagram	Used to: Find relationships • Makes patterns of responsibilities visible and clear so that there is even distribution of tasks. • Helps a team come to consensus on small decisions, enhancing the quality and support for the final decision.	Page 85 
Nominal Group Technique	Used to: Rank for consensus • Allows every team member to rank issues without being pressured by others. • Makes a team's consensus visible. • Puts quiet team members on an equal footing with more dominant members.	Page 91 
Pareto Chart	Used to: Focus on key problems • Helps teams focus on those causes that will have the greatest impact if solved. (Based on the Pareto principle ~ 20 % of the sources cause 80% of any problem.) • Progress is measured in a highly visible format that provides incentive to push on for more improvement.	Page 95 
Prioritization Matrices	Used to: Weigh your options • Forces a team to focus on the best thing(s) to do and not everything they could do. • Increases the chance of follow-through because consensus is sought at each step in the process (from criteria to conclusions)	Page 105 
Process Capability	Used to: Measure conformance to customer requirements • Helps a team answer the question "Is the process capable?' • Helps to determine if there has been a change in the process.	Page 116 
Radar Chart	Used to: Rate organization performance • Makes concentrations of strengths and weaknesses visible. • Clearly defines full performance in each category. • Captures the different perceptions of all the team members about organization performance.	Page 121 
Run Chart	Used to: Track trends • Monitors the performance of one or more processes over time to detect trends, shifts, or cycles. • Allows a team to compare a performance measure before and after implementation of a solution to measure its impact.	Page 125 
Scatter Diagram	Used to: Measure relationships between variables • Supplies the data to confirm a hypothesis that two variables are related. • Provides a follow-up to a Cause & Effect Diagram to find out if there is more than just a consensus connection between causes and the effect.	Page 129 
Tree Diagram	Used to: Map the tasks for implementation • Allows all participants (and reviewers outside the team) to check all of the logical links and completeness at every level of plan detail. • Reveals the real level of complexity involved in the achievement of any goal, making potentially overwhelming projects manageable, as well as uncovering unknown complexity.	Page 140 

	Jo	Bob	Hal	Total
A	3	4	4	11
B	2	1	2	5
C	4	3	3	10
D	1	2	1	4

Cost	A	B	C	Total
A		1/5	1/10	0.3
B	5		1	6
C	10	1		11

Developed from *The Public Health Memory Jogger II (2007)*

Appendix E: QI Project Team Charter Template

QI Project Charter / PDSA Tool

QI TEAM INFORMATION

Team Name		ET Sponsor	
QI Liaison(s)			
Subject			

Team Members	Area of Expertise	Project Role
1.		Team Leader
2.		Timekeeper
3.		Notes Taker
4.		
5.		
6.		
7.		
8.		

Meeting Frequency & Duration					
Planning Start Date		Est. Implementation Date		ACT Date	

PLAN: IDENTIFY AN OPPORTUNITY AND PLAN FOR IMPROVEMENT

1. AIM Statement (What? When? How much? For whom?)

2. Current "As Is" process surrounding the problem. (Tools to be used? e.g. flow charts, process mapping. Attach when completed.)

Customers/Stakeholders	Customer Needs Addressed

3. Collect data on the current process. (List data to be collected. Attach chart/graph as collected.)

4. Problem/Opportunity Statement. (Revisit and revise as needed during the planning phase.)

5. Identify all possible causes. (Tools to be used? e.g. brainstorming, fishbone diagram, or 5 Whys. Attach when completed.)

6. Identify potential improvements: S.M.A.R.T. objectives. (Specific, Measureable, Achievable, Realistic, Time Frame)

- ✓
- ✓
- ✓
- ✓

QI Project Charter / PDSA Tool

✓	
Success Measures	
Available Resources	
Additional Resources Required	

7. Develop an improvement theory. (e.g. *"If we have a centralized call center for WIC, then our WIC caseload will increase."*)

IF		THEN	
IF		THEN	

8. Develop an action plan. (Key milestones, tasks to implement, attach any Gantt charts, etc.)

DO: TEST THE THEORY FOR IMPROVEMENT

1. Implement the improvement. (Implementation date? What is being done?)

2. Collect and document the data. (Attach chart/ graph as collected.)

3. Document problems and unexpected observations. (Assumptions/Constraints/Obstacles.)

STUDY: USE DATA TO STUDY RESULTS OF THE TEST

1. Analyze the effect of the intervention.

2. Document lessons learned, knowledge gained, and any surprising results that emerged.

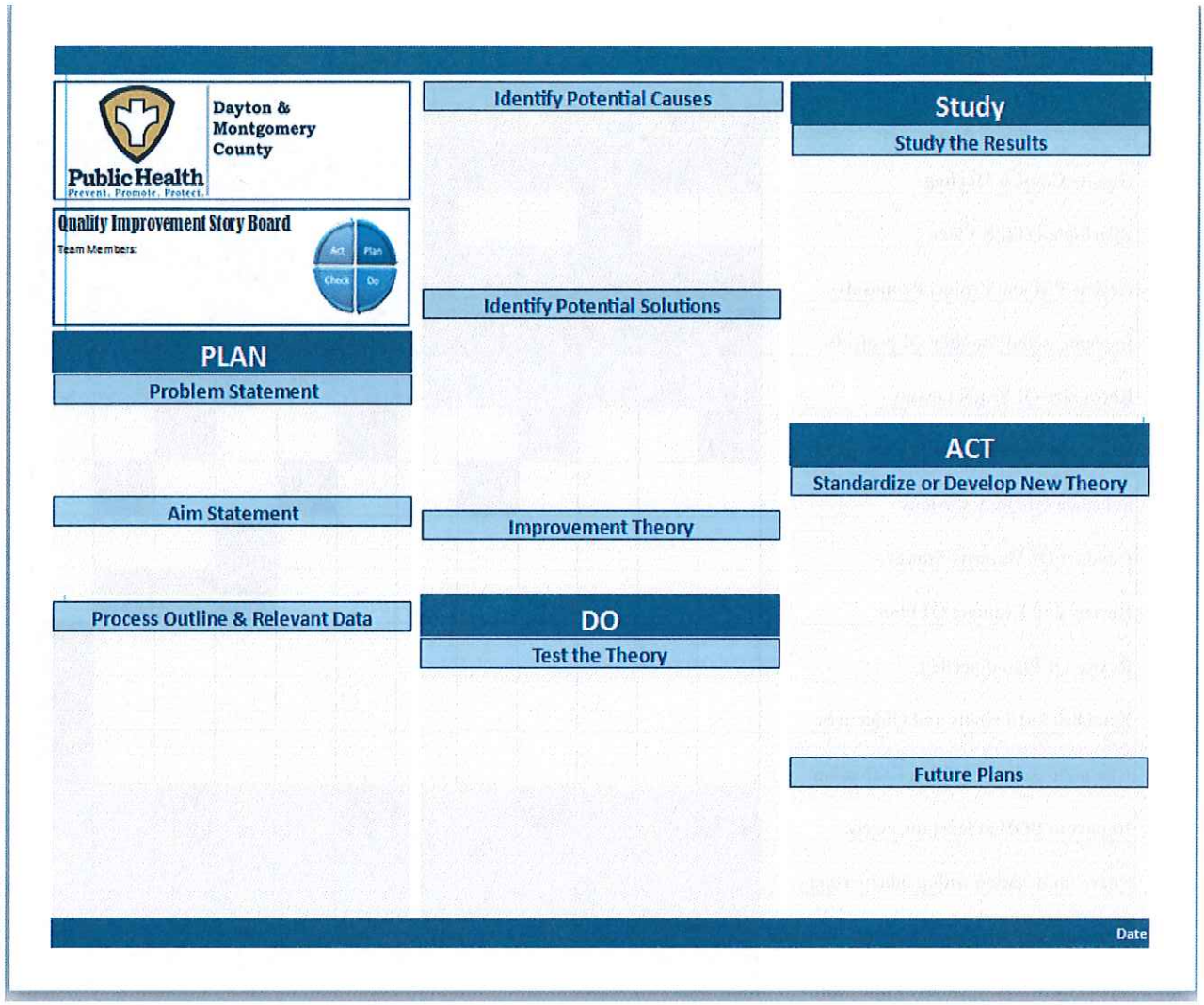
ACT: ESTABLISH FUTURE PLANS

1. Circle one	ADOPT	ADAPT	ABANDON
Explain why and how			

2. Communication Plan (Who, How, and When)

2. Storyboard (Attach/due within 30 days of project completion)

Appendix F: QI Project Storyboard Template (sample)



Appendix G: QC Activity Timeline

Activity 2017	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Quality Council Meetings												
Distribute QTIPS Video												
Review PM and Project Proposals												
Implement and Monitor QI projects												
Recognize QI Project teams	*upon project completion											
Review and Submit PM Dashboard												
Schedule QI Q&A sessions												
Conduct QI Maturity Survey												
Review and Evaluate QI Plan												
Revise QI Plan if needed												
Establish 2018 Goals and Objectives												
Complete written QI Plan Evaluation												
Report to BOH at least quarterly												
Share information with public/partners												
Generate and Display project storyboards												
Maintain all QC records in shared drive												

Month to complete

As needed or ongoing