# Florida Department of Health in Seminole County
# Quality Improvement Plan
# Version 1.0
# Fiscal Year 2017-2020

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# TABLE OF CONTENTS

# SECTION 1

## INTRODUCTION

### I. Purpose

The Quality Improvement (QI) Plan serves as a key component of the performance management system that describes the integration of quality improvement processes into (1) leadership structure, (2) staff training, (3) planning and review processes, (4) administrative and programmatic services, (5) sharing of practices, and (6) evaluation of measurable impacts on departmental priorities and public health objectives at the Florida Department of Health in Seminole County (DOH-Seminole).

The DOH-Seminole QI Plan presents a summary of the Department's QI Program and describes the department-wide approach to improvement, in alignment with the Florida Department of Health (Department) Agency Strategic Plan, Agency QI Plan, DOH-Seminole Strategic Plan, and the Seminole Community Health Improvement Plan (CHIP). The goal of the DOH-Seminole QI Plan is to ensure the ongoing improvement of the Department and to implement the appropriate processes to attain/sustain a culture of quality following the key indicators identified in the National Association of County and City Health Officials (NACCHO) Roadmap.

### II. Outcomes

Based on implementation of the QI program described in this plan, the health of Seminole county's citizens will be improved, operations of DOH-Seminole will become more effective and efficient, employees will attain and maintain the competencies required to actively engage in quality improvement activities, and the Department will utilize a common set of tools, skills, and terminology to assess, monitor, and evaluate their culture of quality and performance. Leadership will ensure implementation of practices that will create a workforce culture of action, continuous improvement, and performance excellence.

### III. Quality Terms

Please see Appendix 1, Quality Plan Key Terms, for a summary of common terminology and definitions used throughout this document.

# SECTION 2

## CULTURE OF QUALITY

### I. Mission, Vision, and Values

The Department's focus on quality begins with its mission "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts." Its mission is underpinned by a shared vision "To be the healthiest state in the nation."

The Department's values exemplify a learning organization: Innovation: We search for creative solutions and manage resources wisely. Collaboration: We use teamwork to achieve common goals & solve problems. Accountability: We perform with integrity & respect. Responsiveness: We achieve our mission by serving our customers and engaging our partners. Excellence: We promote quality outcomes through learning and continuous performance improvement. The Department's organizational activities align with the single mission, vision, and shared values.

### II. Current and Future State of Quality

The NACCHO Roadmap to a Culture of Quality Improvement defines organizational culture as:

*"The culture of an organization is the embodiment of the core values, guiding principles, behaviors, and attitudes that collectively contribute to its daily operations. Organizational culture is the very essence of how work is accomplished, it matures over several years, during which norms are passed on from one "generation" of staff to the next. Because culture is ingrained in an organization, transforming culture to embrace QI when minimal knowledge or experience with QI exists requires strong commitment and deliberate management of change over time."*

In May of 2017, the DOH-Seminole Performance Management (PM) Council engaged in the conduction of a formal department-wide culture of quality self-assessment utilizing the NACCHO Roadmap Self-Assessment Tool. Council members agreed on statement scores to achieve the overall self-assessment outcome. Results of the self-assessment reflected the current QI culture as a **3.38 Phase 3: Informal or Ad Hoc QI Culture**. These results were shared with the State Health Office and used to develop the Agency QI Plan.

Council members then prioritized statement scores to identify and select greatest opportunities for improvement. Action plans were developed for selected improvement opportunities and goals associated with the action plans were incorporated into the current QI Plan. To support continued process improvement and development, a formal department-wide culture of quality self-assessment will be conducted every three years. Current action plans will be monitored and evaluated routinely during the established PM Council meetings. If/When the Council determines that action plan goals have been met and the desired improvement obtained, additional opportunities may be incorporated into the QI Plan.

Selected opportunities for improvement are:

**Priority 1** (current 2017) –: 6.7 Process Management Results & Continual Improvement: Feedback from customers, suppliers, and interfacing work processes are gathered and used to drive improvements.

**Priority 2** (anticipated 2018): 4.2 Satisfying the Customer Thru Value Streaming: The employees of the organization, and suppliers, understand the "big picture" of how customer value is created by the organizations processes.

**Priority 3** (anticipated 2018): 6.7 Process Management Results & Continual Improvement: Work process measures are documented (defined measures, data collection, calculations/analysis, and targeted/stretch goals).

**Priority 4** (anticipated 2019): 4.2 Satisfying the Customer Thru Value Streaming: The value streams are defined to include inputs, outputs, individual processes and customer perspective measures of satisfaction.

# SECTION 3

## QUALITY IMPROVEMENT STRUCTURE

### I. Structure

The DOH-Seminole infrastructure for supporting a culture of quality and implementation of improvement initiatives throughout the Department include:

A. DOH-Seminole executive leadership team is accountable for building and sustaining a culture of quality in the department through the following roles:

1) Remove barriers associated with completing strategic goals as outlined in either the Strategic Plan, QI Plan, or Community Health Improvement Plan (within this document all three plans are referred to as Plans) and continuous performance improvement.
2) Engage various stakeholder groups to promote involvement and obtain support for department strategic goals.

B. The Quality Improvement Liaison is appointed by leadership and possesses the core competencies identified by the State Health Office. The liaison is responsible for the following:

1) Serve as the point of contact between the Performance Management Council and Bureau of Performance Assessment and Improvement (BPAI).
2) Lead the development of the annual QI plan and triannual self-assessment.
3) Coordinate training identified in QI Plan.
4) Serve as the point of contact for reporting progress and sharing results of improvement initiatives, lessons learned, and practices that result in improved performance.

C. The Performance Management (PM) Council is chaired by the health officer and comprised of the DOH-Seminole leadership team, QI Liaison, and Plan owners. It will operate in accordance with the team charter and is responsible for the following:

1) Select priority strategies for QI projects.
2) Assess progress towards a sustainable culture of quality within the County Health Department (CHD) using the NACCHO Organizational Culture of Quality Self-Assessment Tool.
3) Develop and implement a three-year Quality Improvement Plan.
4) Develop, approve, monitor, and evaluate Plans, and QI projects.
5) Conduct at least quarterly reviews of progress toward completion of Plans as well as QI projects.

D. DOH-Seminole staff is comprised of all Department staff and is responsible for the following:

1) Participate in QI projects as appropriate.
2) Develop understanding of basic QI processes and tools. Apply QI into daily work.

# SECTION 4

## QUALITY IMPROVEMENT TRAINING

### I. Training Plan

Training in QI methodology and tools is critical for creating a sustainable QI program. QI training opportunities will be available and conducted through providers which may include Department personnel, TRAIN Florida, Public Health Learning Network, and the American Society for Quality (ASQ) and other subject matter experts as needed. The following are minimum DOH-Seminole training requirements, which will be verified with printed certificates of completion maintained by the Office of Performance and Quality Improvement and include:

A. DOH-Seminole Performance Management Council, one representative will complete TOP facilitation training by September 31, 2017.

B. DOH-Seminole QI Liaison will complete TOP facilitation training by September 31, 2017.

C. DOH-Seminole QI project team members will complete the Department's problem solving methodology training series in TRAIN Florida within 30 days post project kick-off meeting and complete the DOH Seminole QI 101 face to face modules prior to starting a next step within the PDCA cycle. Team members will ensure all competencies identified on the X-Matrix resource list are obtained prior to beginning a project.

D. 90% of DOH-Seminole MAC members will complete "Flow Charting Training" by May 30, 2018.

E. 100% of Strategic Plan Objective owners will be trained on the VSMG Dashboard by December 31, 2017.

F. 100% of new hire DOH-Seminole staff will complete "An Introduction to QI Training" within 60 days of hire date.

## II. Budget and Resource Allocation

Funding and additional resource allocation will be supported by the DOH- Seminole leadership team to promote QI training and the development of a culture of quality. DOH-Seminole promotes utilization of internal resources and telecommunications to support financial responsibility and appropriate usage of limited funding.

| Training | Staff | Time | Average Cost per Participant |
|---|---|---|---|
| TOP Facilitation | 1 PMC<br>1 QI Liaison | 40 hours per staff | $600 |
| Flow Charting | 18 Managers | 2 hours per staff | $30 |
| VSMG Training | 18 Managers | 2 hours per staff | $30 |
| QI 101 Modules & Problem Solving Methodology Class | 20 Staff | 10 hours per staff | $150 |

# SECTION 5

## QUALITY IMPROVEMENT PROJECTS

## I. Project Identification, Alignment, and Initiation Processes

DOH-Seminole identifies opportunities for improvement utilizing key performance indicator data. Opportunities for improvement are prioritized based on alignment that supports objectives identified within either the Strategic Plan, CHIP, or other local emerging/priority areas. Project teams are established by the PM Council and team charters developed to determine the QI tools and methodology that will be utilized to structure the project. Action plans are developed by project teams to establish accountability for project monitoring and evaluation expectations. Please see appendix 3 for QI Project Selection Process.

Selected 2017-2018 projects:

**Administrative Project 1** – : By December 31, 2017 DOH-Seminole will reduce the daily average no show rate for clinical services from 35% to 15%.

**Administrative Project 2** – : By June 30, 2018 DOH-Seminole will reduce the average turn-around time for key support services from 16 to 4 working hours.

**Program Project 1** – : By June 30, 2018 DOH-Seminole will increase the percentage of outreach events that directly support a key strategic objective (CHIP or Strategic Plan) from 60% to 90% annually.

*2018-2019 QI projects will be selected during the annual stragic planning meeting set for June 2018.*

Appendix 2 contains a table displaying the alignment between the QI Plan projects and the CHD Strategic Plan, the CHIP, Agency Strategic Plan, and the Agency QI Plan.

# SECTION 6

## QUALITY IMPROVEMENT GOALS

| QI PLAN AREA OF FOCUS | GOAL | MEASUREABLE OBJECTIVE | TIMEFRAME | OWNER |
|---|---|---|---|---|
| Structure | Establish a three-year QI Plan based on organizational strategic priorities and QI cultural opportunities for improvement. | Approved and Implemented 2017-2020 DOH-Seminole QI Plan by July 1, 2017. | May 1, 2017 to July 1, 2017 | Quality Improvement Coordinator |
| Training | Provide introduction to Quality Improvement training to new hire staff. | 100% of new hire staff will receive "Introduction to Quality Improvement" training within 30 days of hire date for those hired between July 1, 2017 and April 30, 2020. | July 1, 2017 to June 30, 2020 | Training Specialist |
| Training | PMC Member and QI Coordinator to complete TOP facilitation training. | PMC/QI TOP facilitation to be completed by September 31, 2017. | July 1, 2017 to September 30, 2017 | Quality Improvement Director |
| Training | Complete VSMG dashboard training. | 100% of objective owners trained on dashboard by December 31, 2017. | July 1, 2017-December 31, 2017 | Accreditation Liaison |
| Training | Complete flow charting training. | 90% MAC members trained with certification of completion obtained by May 31, 2018. | July 1 2017-May 31, 2018 | Training Specialist |
| Training | All QI project members to complete Methodology and 101 trainings prior to executing next phase in PDCA cycle. | 100% of all QI project members have completed required trainings prior to starting the next phase of a PDCA cycle for 2017-2018, 2018-2019 and 2019-2020 projects. | July 1, 2017-June 30, 2020 | Quality Improvement Coordinator |
| Project | Completion of two administrative QI projects and three programmatic projects. | Completion of two administrative QI projects and three programmatic projects that are aligned with the Agency Strategic and/or QI Plan. Required deliverables posted to BPAI SharePoint site within 30 days of project completion. | July 1, 2017 to June 30, 2020 | Quality Improvement Coordinator |
| Monitoring | Measure, monitor, and report progress on the goals and objectives of QI, Strategic, and CHIP Plans, and QI Projects. | 11 monthly PMC meetings will be held between July and December annually. Meeting minutes and scorecard will be submitted to BPAI SharePoint site within 10 business days of the meeting 100% of the time. | July 1, 2017 to June 30, 2020 | Quality Improvement Coordinator |
| Culture | Gather and incorporate feedback from customers, suppliers, and interfacing work processes into improvement activities. | Complete Customer Engagement QI Project to increase the number of feedback forms received monthly by December 31, 2017. | July 1, 2017 to December 31, 2017 | Quality Improvement Coordinator |

| | | | | |
|---|---|---|---|---|
| Culture | Conduct Annual Lessons Learned, QI Plan Evaluation to identify process strengths and OFIs. | Complete QI Plan Evaluation Report (PMC) by August 31 of each year. | -July 1, 2017 to August 31, 2018.<br>-July 1, 2018 to August 31, 2019.<br>-July 1, 2018 to August 31, 2020 | Quality Improvement Director |

# SECTION 7

## QUALITY IMPROVEMENT MONITORING

### I. Monitor Implementation of Plans and QI Projects

Measuring, monitoring, and reporting of progress on the goals and objectives of plans and QI projects are the responsibility of the PM Council. To ensure routine monitoring, the DOH-Seminole Performance Management Council will meet at least quarterly. Data to support evidence of progress will be gathered by the QI Liaison and included in the meeting minutes. The meeting minutes and information below will be submitted to BPAI within ten business days after meeting minutes are approved. The CHD and statewide reports will include the following information:

A. Is DOH-Seminole Performance Management Council meeting at least quarterly? Yes/No

B. Are implementation plans for QI projects on track? Yes/No

C. Short description summarizing progress of QI projects. (no more than a paragraph)

# SECTION 8

## QUALITY IMPROVEMENT COMMUNICATION

### I. Communication

Success of the Department's QI program and progress towards a learning organization is ensured by systematic sharing of information, networking, and reusing knowledge gained. The PM Council, chaired by the Health Officer, will meet at least quarterly. Meetings will be documented using an agenda, sign-in, and meeting minutes. A quorum of two-thirds of members is required for the meeting. The following indicators will be reviewed during the meeting and indicator progress will be communicated to CHD staff, the Board of County Commissioners, other governing entities, and community partners as appropriate. The BPAI will receive documentation of the CHD PM Council meeting within ten business days after meeting completion. This will include:

1) Progress towards Strategic Plan, CHIP and QI Objectives.

2) Status of QI projects.

3) Practices that result in improved performance.
4) Quality of community engagement.
5) Activities undertaken to communicate QI activities with staff.

QI project sponsors will be responsible for sharing project results on a regular basis to keep staff apprised of QI project progress. It is the project sponsor's responsibility to ensure that QI projects are aligned with the CHD's strategic vision and mission. The PM Council will leverage the advantage of Florida's centralized and integrated local public health system by sharing resources and information with peers. The QI Liaison will serve as the point of contact for sharing results of improvement initiatives, lessons learned, and practices that result in improved performance using the following avenues:

1) Monthly/Quarterly PM Council meetings (standing item on each meeting agenda).
2) Sharing/submitting information with BPAI, County Health Systems, and other appropriate state office programs.
3) Statewide/Community meetings or events.
4) Appropriate internal and external award nominations.
5) SharePoint.

# SECTION 9

## QUALITY IMPROVEMENT EVALUATION

### I. Review and Update the QI Plan

DOH-Seminole will maintain a three-year QI Plan. Quarterly the Performance Management Council will meet to monitor the process and progress towards achieving key quality measures identified. Measures that are determined by the Performance Management Council to be trending poorly will be addressed through the action planning process and monitored on a more frequent basis. Meeting outcomes will be communicated to BPAI within ten business days to ensure awareness and alignment of activities.

Annually the Performance Management Council will review the DOH-Seminole QI Plan to identify strengths, opportunities for improvement and lessons learned. This information will be reported through the QI Annual Assessment report and provided to the BPAI by June 30th of each year. This evaluation process will inform planning for each subsequent year and will support a culture of continuous improvement and excellence.

# APPENDIX 1

## QUALITY IMPROVEMENT KEY PLAN TERMS

| TERM | DEFINITION |
|---|---|
| **Accountability** | Establishing a systematic method to assure stakeholders (policy-makers and the public) that the organizational entities are producing desired results. Accountability includes establishing common elements that are applied to all participants. These should include clear goals, progress indicators, measures, analysis of data, reporting procedures, help for participants not meeting goals, and consequences and sanctions.<br>(Source: American Society for Quality) |
| **Analyze** | To study or determine the nature and relationship of the parts of by analysis.<br>(Source: Merriam-Webster Online Dictionary) |
| **Barriers** | Existing or potential challenges that hinder the achievement of one or more objectives.<br>(Source: *The Executive Guide to Facilitating Strategy: Featuring the Drivers Model*. Michael Wilkinson. 1st Ed.) |
| **Benchmarking** | Benchmarks are points of reference or a standard against which measurements can be compared. In the context of indicators and public health, a benchmark is an accurate data point, which is used as a reference for future comparisons (similar to a baseline). Also referred to as "best practices" in a particular field. Communities compare themselves against these standards. Many groups use benchmark as a synonym for indicator or target.<br>(Source: Norris T, Atkinson A, et al. *The Community Indicators Handbook: Measuring Progress toward Healthy and Sustainable Communities*. San Francisco, CA: Redefining Progress; 1997) |
| **Best Practice(s)** | The best clinical or administrative practice or approach at the moment, given the situation, the consumer or community needs and desires, the evidence about what works for a particular situation and the resources available. Organizations often also use the term promising practices which may be defined as clinical or administrative practices for which there is considerable practice-based evidence or expert consensus which indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence.<br>(Source: *National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms*, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf) |
| **Cause and Effect Diagram (Fishbone Diagram)** | The fishbone diagram identifies many possible causes for an effect or problem. It can be used to structure a brainstorming session. It immediately sorts ideas into useful categories.<br>(Source: Excerpted from Nancy R. Tague's *The Quality Toolbox*, Second Edition, ASQ Quality Press, 2004) |
| **Continuous Improvement** | Includes the actions taken throughout an organization to increase the effectiveness and efficiency of activities and processes in order to provide added benefits to the customer and organization.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Core Competencies** | Core competencies are fundamental knowledge, abilities, or expertise associated in a specific subject area or skill set.<br>(Source: Nash, Reifsnyder, Fabius, and Pracilio. *Population Health: Creating a Culture of Wellness*. Jones and Bartlett. MA, 2011) |
| **County Health Department's Leadership Team** | DOH-Seminole leadership is comprised of two defined teams. The Management Advisory Council consists of all managers, supervisors and key support staff. The Performance Management Council consists of the Health Officer and Director level staff. |

| TERM | DEFINITION |
|---|---|
| **Culture of Quality Improvement** | Culture of quality improvement exists when QI is fully embedded into 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 seek out the root cause of problems. Staff do not assume that an intervention will be effective, but rather they establish and quantify progress toward measureable objectives. (*Roadmap to a Culture of Quality Improvement*, Phase 6, NACCHO) |
| **Data** | Quantitative or qualitative facts presented in descriptive, numeric or graphic form.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Department's PDCA Problem Solving Methodology** | Plan-Do-Check-Act problem solving methodology is used when there is a need to identify and eliminate the cause of the problem. This is a simplified version with fewer steps than the *ABCs of PDCA* by Grace Gorenflo and John Moran. |
| **Evaluate** | To systematically investigate the merit, worth or significance of an object, hence assigning "value" to a program's efforts means addressing those three inter-related domains: Merit (or quality); Worth (or value, i.e., cost-effectiveness); and Significance (or importance).<br>(Source: CDC – *A Framework for Program Evaluation*) |
| **Evidence-based Practice** | Evidenced-based practice involves making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision making, conducting sound evaluation, and disseminating what is learned.<br>(Source: Brownson, Fielding and Maylahn. *Evidence-based Public Health: A Fundamental Concept for Public Health Practice*. Annual Review of Public Health) |
| **Goal** | A statement of general intent, aim, or desire; it is the point toward which management directs its efforts and resources in fulfillment of the mission; goals are usually nonquantitative.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Implement** | To put into action; to give practical effect to and ensure of actual fulfillment by concrete measures<br>(Source: Adapted from Merriam-Webster.com) |
| **Indicators** | Predetermined measures used to measure how well an organization is meeting its customers' needs and its operational and financial performance objectives. Such indicators can be either leading or lagging indicators.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Key Functions** | Critical responsibilities which are performed routinely to carry out the mission of the department.<br>(Source: Adapted from BusinessDictionary.com) |
| **Key Processes** | Processes that focus on what the organization does as a business and how it goes about doing it. A business has functional processes (generating output within a single department) and cross-functional processes (generating output across several functions or departments.)<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |
| **Key Customer** | Any individual or group that receives and must be satisfied with the service, work product, or output of a process.<br>(Source: *Certified Manager of Quality/Organizational Excellence Handbook*. Russell T Westcott, editor. 3rd Ed.) |

| TERM | DEFINITION |
|---|---|
| **Key Customer Requirements** | Performance standards associated with specific and measurable customer needs; the "it" in "do it right the first time."<br>(Source: *The Quality Improvement Handbook*, John Bauer, Grace Duffy, and Russell Westcott, editors) |
| **Objective** | Specific, quantifiable, realistic targets that measure the accomplishment of a goal over a specified period of time. (Source: The *Executive Guide to Facilitating Strategy: Featuring the Drivers Model*. Michael Wilkinson. 1st Ed.)<br><br>Objectives need to be **S**pecific, **M**easureable, **A**chievable, **R**elevant and include a **T**imeframe (SMART). |
| **Operational (Action) Plan** | An action plan with specific steps to implement and achieve the objectives. Plans usually include the following: key activities for the corresponding objective; lead person for each activity; timeframes for completing activities; resources required; and evaluation indicators to determine quality and effectiveness of the activities in reaching the strategy.<br>(Source: Adapted from *The Executive Guide to Facilitating Strategy: Featuring the Drivers Model*. Michael Wilkinson. 1st Ed.) |
| **Opportunity for Improvement** | Agents, factors, or forces in an organization's external and internal environments that can directly or indirectly affect is chances of success or failure.<br>(Source: Adapted from BusinessDictionary.com) |
| **Outcomes** | Long-term end goals that are influenced by the project, but that usually have other influences affecting them as well. Outcomes reflect the actual results achieved, as well as the impact or benefit of a program. |
| **Performance Excellence** | An integrated approach to organizational performance management that results in 1) delivery of ever-improving value to customers and stakeholders, contributing to organizational sustainability; 2) improvement of overall organization effectiveness and capabilities; and 3) organizational and personal learning.<br>(Source: *2013 Sterling Criteria for Organizational Performance Excellence*) |
| **Performance Gap** | The gap between an organization's existing state and its desired state (as expressed by its long-term plans). |
| **Performance Improvement** | An ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, outcomes. |
| **Performance Indicators** | Measurement that relates to performance but is not a direct measure of such performance (e.g. the # of complaints is an indicator of dissatisfaction but not a direct measure of it) and when the measurement is a predictor (leading indicator) of some more significant performance (e.g. increased customer satisfaction might be a leading indicator of market share gain.) (Source: 2013 Sterling Criteria for Performance Excellence) |
| **Performance Management Council (PMC)** | The PMC Team is made up of the Health Officer, the executive management team, the Accreditation Liaison, and the staff responsible for implementation of the Community Health Improvement Plan (CHIP), the Strategic Plan and the Quality Improvement (QI) Plan. The PMC Team conducts monthly meetings featuring standing agenda items with reports from: CHIP, Strategic Plan, and Quality Improvement Plan. These reports are comprised of progress updates and meeting minutes documenting the input and collaboration with community partners. |
| **Performance Management System** | A fully functioning performance management system that is completely integrated into health department daily practice at all levels includes: 1) setting organizational objectives across all levels of the department, 2) identifying indicators to measure progress toward achieving objectives on a regular basis, 3) identifying responsibility for monitoring progress and reporting, and 4) identifying areas where achieving objectives requires focused quality improvement processes.<br>(Source: Public Health Accreditation Board. *Standards and Measures* Version 1.0. Alexandria, VA, May 2011) |

| TERM | DEFINITION |
|---|---|
| **Performance Measures or Metrics** | Tools or information used to measure results and ensure accountability; specific quantitative representation of capacity, process, or outcome deemed relevant to the assessment of performance.<br>(Source: Lichiello, P. *Turning Point Guidebook for Performance Measurement*, Turning Point National Program Office, December 1999) |
| **Performance Report** | Documentation and reporting of progress in meeting standards and targets and sharing of such information through feedback. The report should provide information in four categories: facts, meaning, assessments, and recommendations.<br>(Source: *Turning Point Performance Management*, National Excellence Collaborative, 2004) |
| **Plan-Do-Check-Act (PDCA)** | Also called: PDCA, Plan–Do–Study–Act (PDSA) cycle, Deming Cycle, Shewhart Cycle. The Plan–Do–Check–Act cycle is a four–step model for carrying out change. Just as a circle has no end, the PDCA cycle should be repeated again and again for continuous improvement.<br>(Source: ASQ.org) |
| **Plan Owners** | Person designated by Health Officer to bear responsibility for managing the CHIP, strategic plan, or QI plan. |
| **Policy** | Policy is a definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions or a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental entity.<br>(Source: *Acronyms and Glossary of Terms*, Public Health Accreditation Board, version 1.0, September 2011) |
| **Population-based Health** | Population-based health are interventions aimed at disease prevention and health promotion that effect an entire population and extend beyond medical treatment by targeting underlying risks, such as tobacco; drug and alcohol use; diet and sedentary lifestyles; and environmental factors.<br>(Source: Turnock BJH. *Public Health: What It Is and How It Works*. Gaithersburg, MD: Aspen Publishers, Inc.; 1997) |
| **Priorities** | Strategically selected areas on which the department focuses resources (human, financial, other). In some instances, priorities are further identified as those responsibilities expressly assigned statutorily to the department. |
| **Public Health** | The science of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; control of community infections; education of individuals; organization of medical and nursing service for the early diagnosis and treatment of disease; and development of the social systems to ensure every individual has a standard of living adequate for the maintenance of health. The mission of public health is to fulfill society's desire to create conditions so that people can be healthy.<br>(Sources: Winslow CEA. Man and Epidemics. Princeton, N.J.: Princeton University Press, 1952; and (2) Institute of Medicine. *The Future of Public Health*. Washington, DC: The National Academy Pres, 1988) |
| **Quality Improvement** | Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to 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.<br>(Source: Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. "Defining Quality Improvement in Public Health". *Journal of Public Health Management and Practice.* January/February 2010) |

| TERM | DEFINITION |
|---|---|
| **Quality Improvement (QI) Plan** | A QI plan describes what an agency is planning to accomplish and reflects what is currently happening with QI processes and systems in that agency. It is a guidance document that informs everyone in the organization as to the direction, timeline, activities, and importance of quality and quality improvement in the organization. The QI plan is also a living document and should be revised and updated regularly as progress is made and priorities change. The QI plan provides written credibility to the entire QI process and is a visible sign of management support and commitment to quality throughout the health department. (Source: Davis MV, Mahanna E, Joly B, Zelek M, Riley W, Verma P, Solomon Fisher J. "Creating Quality Improvement Culture in Public Health Agencies." *American Journal of Public Health*. 2014. 104(1):e98-104)<br><br>The Public Health Accreditation Board requires a QI plan as documentation for measure 9.2.1 A of the Standards and Measures Version 1.5. |
| **Quality Improvement (QI) Program** | A quality improvement program consists of the enduring infrastructure and processes put in place to support the implementation of quality improvement plans and projects. |
| **Quality Tools** | Seven Basic Tools: Seven Basic Tools - Quality Management Tools \| ASQ<br><br>Seven New Planning & Management Tools: Seven Management & Planning - New Management Tools \| ASQ |
| **Rapid Process Improvement (RPI)** | Typically, a five day event intended to take waste out of work processes by reducing defects, rework, and non-value added steps in the process structure. It is intended to provide a productive forum to address high-volume, low-complexity process problems. |
| **Reporting (performance)** | A process which provides timely performance data for selected performance measures/indicators which can then be transformed into information and knowledge. |
| **Resources** | Personnel, equipment, facilities, and funds available to address organizational needs and to accomplish a goal. |
| **Sustainability** | Sustainability gauges the likelihood that improvements can be maintained over time. It involves how well processes are defined and documented with the goal of being repeated, how outputs and outcomes of the process are measured and monitored, whether ongoing training of those process and standards for implementation is provided, and whether the standards for the process are reviewed periodically as a part of continuous quality improvement. |
| **System** | A network of connecting processes and people that together perform a common mission. (Source: *The Quality Improvement Handbook*, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.) |
| **Targets** | Desired or promised levels of performance based on performance indicators. They may specify a minimum level of performance or define aspirations for improvement over a specified time frame. |
| **Trend Analysis** | Trend analysis is a study design which focuses on overall patterns of change in an indicator over time, comparing one time period with another time period for that indicator. Trend analysis is not used to determine causation; rather associations can be drawn. (Source: Nash, Reifsnyder, Fabius, and Pracilio. *Population Health: Creating a Culture of Wellness*. Jones and Bartlett. MA, 2011) |
| **Validate** | To confirm by examination of objective evidence that specific requirements and/or a specified intended use are met. (Source: Florida Sterling *The Quality Improvement Handbook*, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.) |

# APPENDIX 2

## QI PLAN AND PROJECT ALIGNMENT TO CHIP, CHD STRATEGIC PLAN, AND AGENCY STRATEGIC PLAN

<table>
<tr><th>CHD QI Plan Goals</th><th>Community Health Improvement Plan</th><th>CHD Strategic Plan</th><th>Agency QI Plan</th><th>Agency Strategic Plan</th></tr>
<tr><td>Establish a three-year QI Plan based on organizational strategic priorities and QI cultural OFIs.</td><td></td><td rowspan="11">2017-2020<br><br>G4:<br>Financial and Business Excellence<br><br>Objectives:<br>4.3, 4.4, 4.5</td><td>2015-2016<br><br>G1:<br>Infrastructure</td><td rowspan="11">2016-2018<br><br>G4:<br>Establish a systainable infrastructure, which includes a competent workfore, sustainable processes and effective use of technology, which supports all of the department’s core business functions.</td></tr>
<tr><td>Provide introduction to QI training to new hire staff.</td><td></td><td rowspan="5">2015-2016<br><br>G3:<br>Training</td></tr>
<tr><td>PMC Member and QI Coordinator to complete TOP facilitation training.</td><td></td></tr>
<tr><td>Complete VSMG dashboard training.</td><td></td></tr>
<tr><td>Complete flow charting training.</td><td rowspan="4">2017-2020<br><br>G3:<br><br>Decrease black infant mortality rates in Seminole County</td></tr>
<tr><td>QI project members to complete 101 trainings prior to executing next phase in PDCA cycle.</td></tr>
<tr><td>Complete two administrative & three programmatic QI projects.</td><td>2015-2016<br><br>G4:<br>Projects</td></tr>
<tr><td>Measure, monitor, and report progress on the goals and objectives of QI, Strategic, and CHIP Plans, and QI Projects.</td><td rowspan="3">2015-2016<br>G2:<br>Culture</td></tr>
<tr><td>Gather/incorporate feedback from customers, suppliers, and interfacing work processes into improvement activities.</td><td></td></tr>
<tr><td>Conduct Annual Lessons Learned, QI Plan Evaluation to identify process strengths and OFIs.</td><td></td></tr>
</table>

# APPENDIX 3

## 2017-2018 QI Project Selection Process

| **2016-2017 QI Plan Lessons Learned** (conducted 6/5/17) | |
|---|---|
| **Barrier** | **Aid** |
| 3 out of 6 projects completed (time, staff participation) | Ensure conduction of a resource assessment prior to confirming project selection. (X-Matrix) Define required amount of participation time prior to confirming project selection. 20 hours per participant / 30 hours for project lead. |
| All staff trained on QI process but no ROI (no requirement after training and/or project). | Instal tell-show-do-repeat training approach for flowchart training (each program will develop flowchart for key services after priary training). |
| Loss of project team members (turn over) | Increase teams from 3 to 4, assign primary QI support from OPQI department. |

**Improvement Selection Matrix**

(conducted 6/5/17)

| Data Source | Project | Do-Ability | Strategy | Impact/Need | Measurable | Score |
|---|---|---|---|---|---|---|
| HMS | Reduce the number of clinical no show | 5 | 5 | 3 | 5 | 18 |
| Outreach Log | Increase the number of outreach events that focus is on populations addressed in either the Strategic Plan or CHIP | 3 | 5 | 5 | 5 | 18 |
| Help Desk Ticket System | Reduce turn-around time for key support services (i.e. IT, Facilities, HR) | 5 | 3 | 5 | 5 | 18 |
| Customer Surveys | Increase customer satisfaction | 3 | 3 | 3 | 3 | 12 |
| FIRS | Reduce the end of year encumbrance error rate | 3 | 3 | 3 | 3 | 12 |
| Outreach Log | Increase access to care for the homeless | 1 | 5 | 1 | 3 | 10 |
| County Phone Log | Reduced missed opportunities with phone system | 1 | 3 | 3 | 3 | 10 |
| County Snapshot | Reduce the number of FP Clients with missing income | 5 | 1 | 1 | 3 | 10 |
| Referral Log | Increase the number of referrals Seminole provides to key community partner organizations | 3 | 3 | 3 | 1 | 10 |
| County Snapshot | Increase the percentage of STD cases treated within 14 days | 3 | 3 | 1 | 3 | 10 |

## X-MATRIX (QI CAPACITY AND COMPENTENCY CHECK)

(Conducted 7/31/17)

| IMPACT | | | | QI PROJECTS | TEAM MEMBERS | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | SW | PM | ET | VL | SW2 | LM | MW | CP | BC | CD | ES | SF | SF2 | AM | AS | |
| Primary | 3.0 SP | | | Reduce the number of no show clinical clients | Q | | | L | T | T | T | | | | | | | | | Lead |
| Contributor | | 2.0 SP | | Increase outreach events that focus on SP/CHIP objectives | | Q | | | | | | T | L | T | T | | | | | Team |
| Enabler | | 4.0 SP | | Reduce key support service turn around time | | | Q | | | | | | | | | L | T | T | T | QI |

**STRATEGIC OBJECTIVE**

Sarah Wright/ Meedna Joseph

Ana Sciuteri

John Meyers

DOH-Seminole
2017-2018 QI Projects
Donna Walsh, Health Officer

**SR. LEADERS**

| CHECK COMPETENCIES | SW | PM | ET | VL | SW2 | LM | MW | CP | BC | CD | ES | SF | SF2 | AM | AS | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| QI Methodology Online | H | H | H | H | H | H | H | N | N | H | H | N | N | H | H | H HAS |
| QI Facilitation | H | N | N | N | NA | NA | NA | NA | N | NA | NA | N | NA | NA | NA | |
| Strategic Plan/CHIP Overview | H | H | H | N | H | N | N | N | N | N | N | H | N | N | H | N NEEDS |
| Jdrive Overview | H | H | H | N | N | N | N | N | N | N | N | N | N | N | N | |
| QI 101 PLAN | | N | N | N | N | N | N | N | N | N | N | N | N | N | N | NA-not req. |
| QI 101 DO | | N | N | N | N | N | N | N | N | N | N | N | N | N | N | |
| QI 101 CHECK/ACT | | N | N | N | N | N | N | N | N | N | N | N | N | N | N | |