Performance and Quality Improvement Plan 2017-2020

TOLEDO-LUCAS COUNTY
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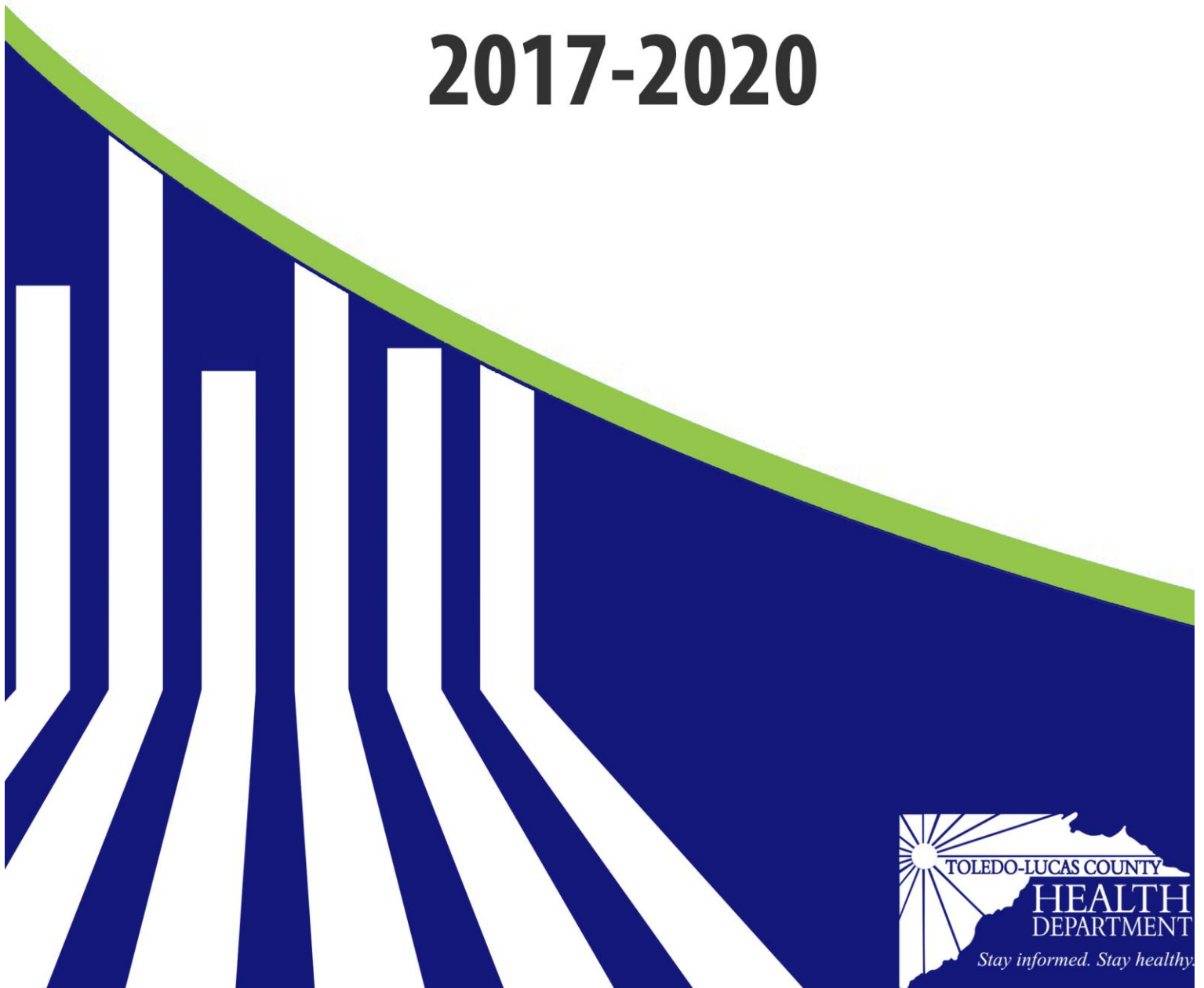
TLCHD Performance & Quality Improvement Plan

Signature Page

This plan has been approved and adopted by the following Administrative Staff and Coordinators:

_____   08-11-17
Health Commissioner   Date

Vacant
_____   _____
Director of Administrative Services   Date

_____   8/11/2017
Director of Environmental Health & Community Services   Date

_____   8/11/17
Director of Health Promotion & Policy Integration   Date

Kelly Burkhalder-Allen
_____   8-11-17
Director of Health Services   Date

_____   8-11-17
Director of Human Resources   Date

_____   8/11/17
Quality Assurance Coordinator   Date

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Overview of Performance Management and Quality Improvement

Introduction

The Toledo-Lucas County Health Department is committed to ongoing performance and quality improvement efforts. The purpose of the Performance & Quality Improvement Plan (PQIP) is to facilitate systematic and department-wide activities that result in an organizational culture of continuous quality and performance improvement. This plan provides the framework by which the development, monitoring, and evaluation of improvement initiatives will be conducted, and is directly aligned with TLCHD's Strategic Plan and Workforce Development Plan. The PQIP focuses on the central themes of advancing a culture of quality, establishing a robust performance management system, improving customer satisfaction, assuring leadership support, and recognition of staff efforts at all levels. As a result of the goals outlined in this plan, TLCHD will continually improve upon its delivery of public health programs and services, working towards *A Healthier Lucas County for Everyone*.

This plan serves to address the Public Health Accreditation Board's Standards and Measures established in Domain 9: *Evaluate and Continuously Improve Processes, Programs, and Interventions. Domain 9 focuses on the use and integration of performance management and quality improvement practices and processes for the continuous improvement of the public health department's practices, programs, and interventions.*

Performance Management

Performance Management is the process of actively using performance data to improve the public's health. It includes the strategic use of performance standards, performance measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results. PM relies on data to determine if our programs and services are having an impact on the health of the people we serve. Data collected from our performance management activities lead us to opportunities to improve the quality of the programs and services we provide to our community. Both performance management and quality improvement assist with creating a culture of quality that leads to improved decision-making and program development.

Quality Improvement

Quality is the systematic evaluation or improvement of policies, processes, programs, and interventions. The purpose of the QI process is to improve the health of Lucas County residents by understanding and improving the efficiency, effectiveness, and reliability of public health processes and practices. This occurs through use of a deliberate and defined improvement process such as Plan-Do-Study-Act and other quality improvement tools.

Culture of Quality and Performance

All health department staff share a role in the establishment and promotion of a culture of quality and performance through the direct participation in QI activities, support for ongoing improvement efforts, working towards performance goals, and celebrating QI and PM successes.

Mission, Vision, & Values

TLCHD's focus on performance and quality begins with our mission, vision, and core values. Reviewed and revised during the 2016-2017 Strategic Planning Process, our *Vision* communicates our agency's highest goal and desired future state; our *Mission* defines the agency's purpose and demonstrates our efforts to be the best leaders in public health for Lucas County; and our *Values* serve as guiding principles to drive the work we do through a common purpose and call to action.

Vision

A Healthier Lucas County for Everyone

Mission

The Toledo-Lucas County Health Department is committed to being the leader in public health by promoting and protecting the health of all people where they live, learn, work, and play.

Core Values

Health Promotion: We actively promote the knowledge, attitudes, and behaviors that enable our community to reach its healthiest state.

People Focused: Our primary focus is to provide the best public health for those who rely on our leadership and guidance to live happier, healthier lives.

Collaboration: We foster partnerships with key community stakeholders to enhance the delivery and effectiveness of public health information and practices.

Communication: We encourage open and clear communication within our agency and to the community in a timely, culturally appropriate, and respectful manner.

Empowerment: We empower our citizens to make healthier choices through education and a shared responsibility for the health of the public.

Disease Prevention: We actively screen, evaluate, and educate our clients through evidence-based prevention strategies to minimize the threat of disease in our community.

Leadership Support

The keys to success for any continuous quality improvement (CQI) or performance management initiative lie within the direct support from administrative leadership. This includes the Health Commissioner, Division Directors, and Supervisors within each division. TLCHD Leaders support PM and QI activities by ensuring the Board of Health, staff, and various stakeholders have knowledge of, and input into, ongoing initiatives as a means of continually improving performance. Leadership support and planning to allow staff participation in PM and QI initiatives is vital to the success of those efforts and the continual improvement of TLCHD's programs and services.

Assessment of Culture

In February 2014, a Quality Improvement Plan Team convened and completed the National Association of County & City Health Official's (NACCHO) Self-Assessment Tool (S.A.T.) to assess the current culture of quality improvement within the agency. The results of that assessment placed TLCHD between *Phase 2: Not Involved with Quality Improvement Activities* and *Phase 3: Informal or Ad Hoc Quality Improvement Activities* on NACCHO's Roadmap to a Culture of Quality Improvement (http://qiroadmap.org/).

In June 2017, QI Council (QIC) members were asked to assess the barriers and other related factors that may have impeded the establishment of a sustained QI Culture in the previous planning cycle. The Council launched a QI project to revamp the plan, council structure, and establish the processes that would guide success during the next QI implementation cycle. As part of this project, Council members were asked to appraise TLCHD's current culture based on QI efforts over the past 3 years, and a review of progress made from the previous "current state to desired state" exercise completed in 2014. The result of this effort placed TLCHD between *Phase 3: Informal or Ad Hoc Quality Improvement Activities*, and *Phase 4: Formal Quality Improvement Activities Implemented in Specific Areas* on NACCHO's roadmap. The QI Council also revised the "Current vs Desired" state of QI and PM efforts to guide the current QI Planning Cycle.

Performance Management Self-Assessment

A performance management self-assessment was conducted by TLCHD supervisors and directors in November 2015. The assessment, based on Multnomah County Health Department's assessment tool and adapted from the *Turning Point Performance Management National Excellence Collaborative, 2004* reflects the extent to which performance management practices are in place, understood, and known.

(See Appendix B for both QI and Performance assessment results)

Current vs Desired State

Current State	Desired State
Lack of communication regarding QI between departments	- Affected Stakeholders receive regular updates as projects progress - Final Results communicated department-wide - Results communicated based on evidence rather than opinion of progress
Supervisors tend to focus on the end results without always understanding the daily staff process to achieve those results, or communicate the big picture	- Want staff to be trusted with the process and understand the big picture of each goal or result - Job responsibilities are accounted for both through the process of their completion and the final result. Employees have more freedom to improve the processes involved in their daily work.
Adequate time is not actively allocated for QI projects. Employees are unable to actively work QI initiatives into their daily responsibilities	- Leadership will encourage discussion about QI projects and processes and communicate opportunities for participation in QI initiatives - Staff understand that time spent on improving processes may free up time for other work in the long run
Limited means to initiate/ start a QI project	- Defined process to submit a QI project idea known by all staff
Lack of recognition of the value of QI	- Widely available trainings in QI and other related areas. - Increase in employee knowledge base regarding QI. - Robust training system for all employees and new hires. - Relatable/ lively/ engaging trainings - All employees see QI as part of their job
Lack of simple processes/tools	- Simplified or understandable tools are available for use/in place
QIC members not comfortable facilitating projects yet	- QIC members are confident in means of achieving goals - Are trained in methods/means to lead projects
Leadership and staff have not been trained in the foundational concepts of performance management	- Staff at all levels understand performance management and receive regular, appropriate training
No cohesive performance management system in place/being used	- Performance Management System that meets the needs of the organization to drive data-based decision making efforts

Agency Roles and Responsibilities

All Staff	Staff members identify and suggest quality improvement projects, and participate in and implement quality improvement activities.
	✓ Identify and suggest areas of improvement or opportunities for program development
	✓ Develop and participate in quality improvement projects and activities
	✓ Participate in quality improvement trainings
	✓ Incorporate quality improvement concepts and principles into daily work
	✓ Demonstrate familiarity with the QI Plan
	✓ Collect and manage quality and performance improvement data
	✓ Document and report on the progress of quality improvement projects and activities
	✓ Communicate success stories and challenges of quality improvement projects and activities
Supervisors	Supervisors oversee the day-to-day implementation or quality improvement projects and activities, as well as support their staff and provide access to training opportunities.
	✓ Carry out responsibilities of TLCHD as described above
	✓ Identify staff QI training needs and provide access to training opportunities
	✓ Orient staff to QI process and QI Plan annually
	✓ Present proposals for QI projects and activities to division director
	✓ Ensure quality improvement projects and activities align with department strategic plan
	✓ Complete quality improvement worksheets and written reports of project results
	✓ Initiate, implement, and ensure oversight of QI projects and activities
	✓ Support staff in quality improvement and data collection efforts
	✓ Recognize and reward staff for participation in quality improvement efforts
Senior Leadership	Senior leadership is comprised of the Health Commissioner and Division Directors. This group provides an overall vision and direction for QI efforts in the department. Senior leadership provides guidance and support of QI efforts.
	✓ Carry out the responsibilities of supervisors as described above
	✓ Foster a culture of quality within the department
	✓ Allocate and request necessary resources and funding to sustain and implement QI efforts
	✓ Ensure QI efforts align with the strategic plan or fulfill critical division/program needs
	✓ Approve quality improvement projects and activities
	✓ Prioritize department-wide and division/program QI projects and activities
	✓ Coordinate oversight of quality improvement projects and activities with the QI Council
	✓ Communicate quality improvement efforts and successes to staff and Board of Health
Board of Health	The Board of Health/Board of Directors provides guidance and advice to senior leadership regarding quality improvement efforts. They receive periodic updates on the progress of quality improvement efforts and findings.
	✓ Support a culture of quality within the department
	✓ Provide guidance and advice to senior leadership regarding quality improvement efforts
	✓ Review progress and findings of quality improvement efforts
	✓ Communicate constituents' concerns and comments to senior leadership
	✓ Communicate quality improvement success stories to constituents
	✓ Fund quality improvement efforts through department budget

Quality Improvement Council

The Health Commissioner has empowered the Quality Improvement Council to provide operational leadership of quality improvement efforts within the department. The QI Council also monitors performance management efforts and is responsible for implementing an agency-wide performance management system.

Council Membership & Rotation

The QI Council maintains a database of all staff who have expressed interest in joining the QI Council or have been nominated by others. Annually, the QI Council will complete a multi-voter ranking assessment to re-order potential members for invitation to the Council considering the following factors: stated interest, schedule availability for participation, overall membership diversity, and program/division representation.

➢ When a vacancy arises, the next appropriate individual will be formally invited to join the QI Council. Interested staff must gain supervisory approval before acceptance to the council to ensure they are able to devote adequate time to Council initiatives and improvement processes.

➢ Acceptance of a QI Council Invitation requires a 1-year commitment to the Council. At the end of that year, Council members may elect to remain on the Council or may vacate their seat. To remain in good standing, a QI Council member must actively participate in QI Council meetings, projects, or other quality and performance efforts to promote a culture of quality at the Health Department.

➢ The QI Council will make all reasonable attempts to incorporate staff from different disciplines, backgrounds, programs, and divisions to ensure a diverse cross-section staff are represented. The Council recognizes that it may not always be possible to have representation from every area based on staff availability, interest, or other extenuating circumstances.

Council Responsibilities

➢ Provide support, guidance, and objectivity for department quality improvement initiatives
➢ Promote, implement, and monitor performance management efforts across the organization
➢ Guide selection of QI projects, monitor progress, and oversee implementation of goals and strategies
➢ Ensure QI project results are communicated to appropriate internal staff and external stakeholders
➢ Provide project updates and reports to the Board of Health on a quarterly basis
➢ Sponsor or participate on QI Project Teams and assist in the identification of the best project team lead
➢ Annually review, monitor, and report on progress towards plan goals & objectives

Council Responsibilities *(cont.)*

➢ Review and contribute to PQI Plan amendments and revisions
➢ On an as-needed basis, elect a chair to aid in QI Council meeting facilitation

QI Council Members may only sponsor or participate on one QI Project Team at a time.

QA Coordinator Responsibilities

The Quality Assurance Coordinator leads TLCHD's Public Health Accreditation efforts and works to ensure appropriate agency plans cross-link to support and strengthen a culture of quality and performance. The QA Coordinator serves as the only permanent member of the QI Council to facilitate sustained knowledge and guidance and to provide consistent coordination of improvement activities across the department. Specific duties related to performance management and quality improvement include:

➢ Serve as subject matter expert for quality improvement and performance management
➢ Develop agenda, meeting materials (including minutes), and facilitate QI Council Meetings
➢ Maintain electronic database of QI Project records and documentation
➢ Engage and involve QI Council members in all PQI Plan updates and revisions. Changes to the plan must be agreed upon by the Council.
➢ Maintain communication protocols for staff to suggest quality improvement initiatives (e.g., anonymous suggestion boxes, "*Coffee with the Commish*", etc.)
➢ Coordinate with Public Information Officer for internal and external customer communication as necessary.
➢ Maintain database of QI training records and staff training certificates.

QI Project Team Responsibilities

QI Project teams are composed of staff who actually investigate proposed quality improvement initiatives to plan and test potential solutions. Their responsibilities include:

➢ Complete all appropriate documentation for each QI project
➢ Report progress to the QI Council at appropriate intervals
➢ Meet every 2 weeks (increasing or decreasing frequency as necessary)
➢ Promote progress and project results at staff and Board meetings as appropriate

*QI Project Team Members may only serve on one QI Project Team at a time.*

Key QI Project Team Roles

Team Role	Description
Administrative Sponsor	Serves as a link to senior management and the strategic aims of the organization; ensures resources and overcomes barriers on behalf of the team; provides accountability for team members; not a day-to-day participant in team meetings or testing, but should review the team's progress on a consistent basis.
QI Council Sponsor	Serves as QI "expert;" aids in the selection of QI processes, tools and methods, and provides guidance to the project Team-Lead.
Team-Lead	Facilitates the QI project; often, but not always, the individual who presented the project idea to the QI Council. Sets agenda, meeting schedule, and works with team to complete documentation of progress.
Local Experts	The "front-line" staff whose daily work is directly affected by the process being investigated; these staff typically have a thorough understanding of the processes and procedures and can offer ideas for process improvement; will benefit from changes and are able to understand the effects of the proposed changes.
Outside Perspective	A team member who is not directly involved with the process being investigated and can provide a "fresh perspective;" this individual serves to promote a broader examination of the process. Typically asks "why is it done that way?"
Recorder	Assigned individual that aids the Team-Lead by keeping meeting minutes, and facilitating document creation and maintenance as requested.

Performance Management System

Performance management is the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results.[1] A Performance management system is a defined process for the establishment of organizational objectives across all levels of the department, identifying indicators to measure progress toward objectives on a regular basis, identifying responsibility for monitoring progress and reporting, and identifying areas where achieving objectives requires focused quality improvement processes.

The core elements of a performance management system are illustrated below:
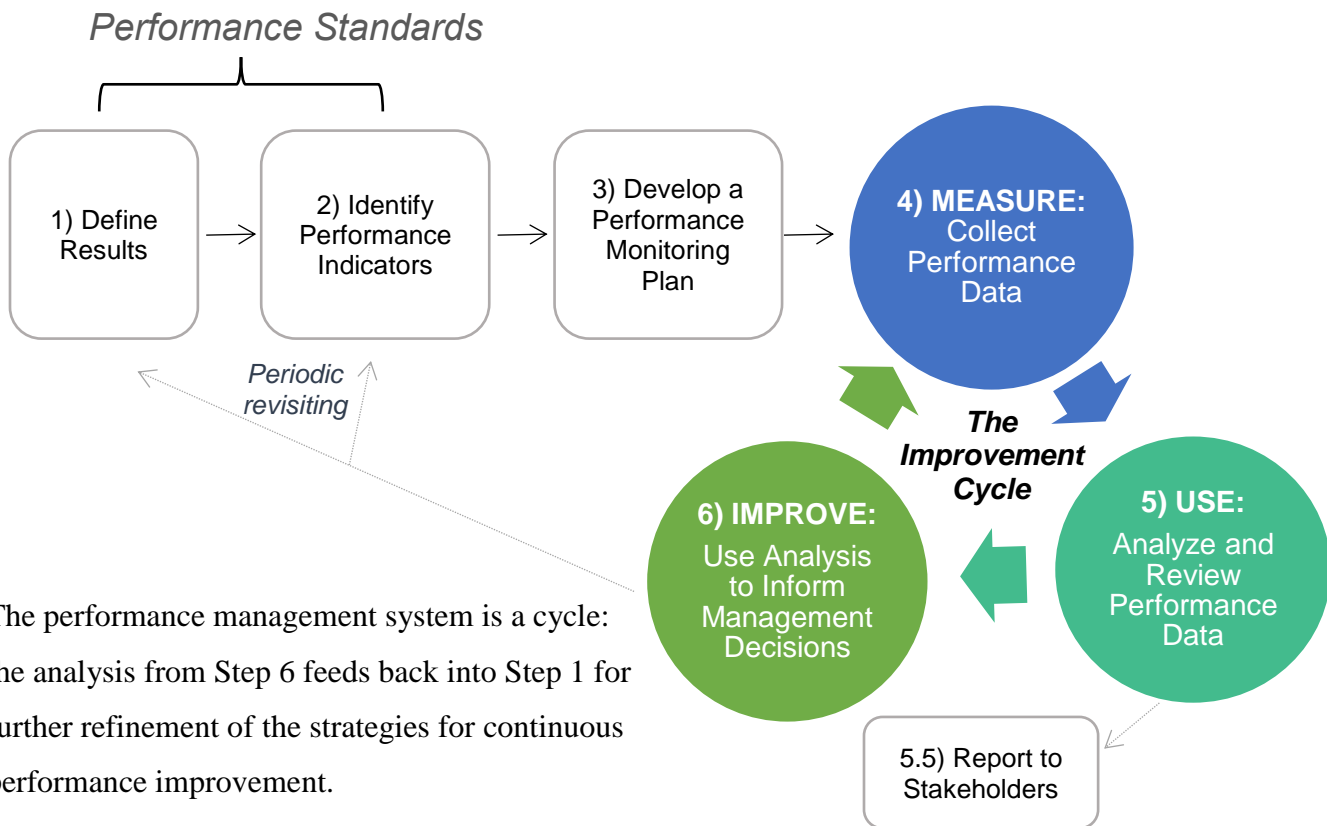
The performance management system is a cycle: the analysis from Step 6 feeds back into Step 1 for further refinement of the strategies for continuous performance improvement.
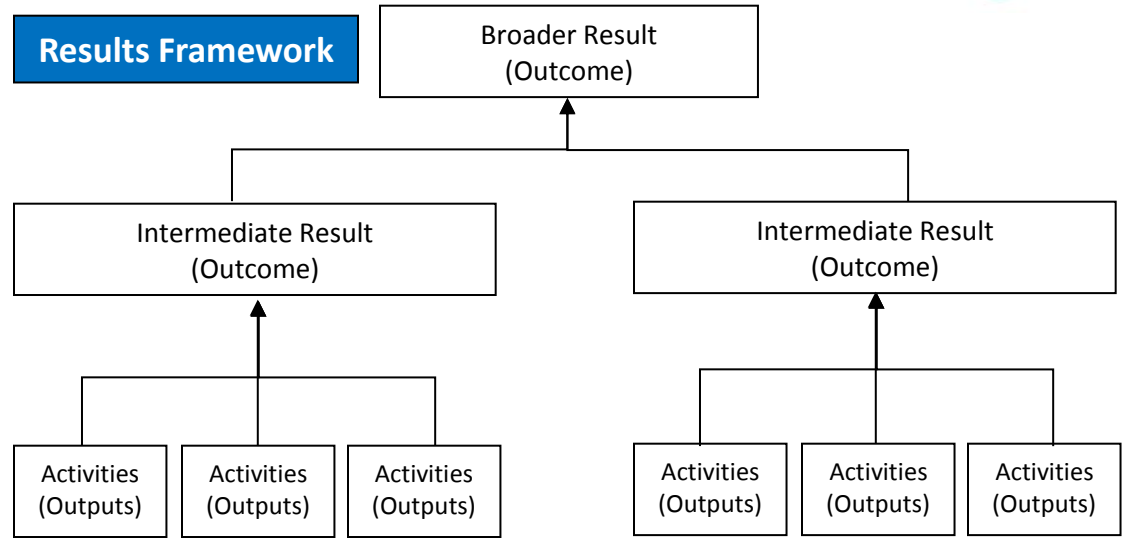
TLCHD's performance management system begins with the Strategic Plan and encompasses all programs and services throughout the department. Based on a results framework (illustrated on the following page), performance measures and data tracking are based on a tiered system starting with activities within the Health Department's control. TLCHD may also track measures outside of its direct influence. The results of each tier are linked in a causal "if / then" relationship within the results framework. TLCHD's Vision for *A Healthier Lucas County for Everyone* is the ultimate outcome the department models its performance management efforts on.

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[1] Performance Management National Excellence Collaborative, Turning Point: From Silos to Systems, Using Performance Management to Improve the Public's Health, 2003

PM Responsibilities

Leadership is responsible for engaging staff at all levels of the organization in the development and maintenance of the performance management system.

Agency-level performance measures are established

Results Framework	Broader Result (Outcome)

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under the Strategic Plan's priorities and objectives. Division and programmatic performance management is the responsibility of Directors, Supervisors, coordinators, and front-line staff:

➢ Division Directors will oversee and guide the development of a performance monitoring plan (PMP) for their division. This includes the development of division level measures, indicators, data collection plans, and reporting.

➢ Supervisors will collaborate with staff to develop appropriate performance measures to monitor the performance of program goals.

➢ Staff will develop performance measures, participate in regular data collection, and establish program goals and measures that support the agency's mission, vision, and core values.

Project Identification and Plan Alignment

Quality Improvement processes will be selected based on an identified need to improve program processes, objectives, and/or performance measures that align with the department's plans, goals, stakeholder feedback, or performance management system.

Projects may be identified in a number of ways, including, but not limited to:

➢ Staff suggestion for improvement idea submitted to leadership, Quality Improvement Council member, suggestion box, surveys, and other avenues.

➢ Identification from agency plan implementation, exercises, and reports (e.g., Strategic Plan, Workforce Development Plan, Emergency Response Plans, Community Health Improvement Plan, etc.)

➢ Identification of possible process improvement through quarterly reviews of the performance measure data.

➢ Stakeholder feedback and external performance assessments.

Quality Improvement Council members will review all project proposals and decide to accept the proposal, request additional information or data, or reject the proposal if it does not meet the selection criteria below. A *QI Project Proposal Form* shall be completed and submitted to the QI Council.

Selection Criteria

The QI Council will complete its review of the project proposal by examining appropriate criteria from the list below:

➢ Is it a process?
➢ Is the problem that is targeted for improvement clearly defined?
➢ Is the scope manageable?
➢ Can it be reliably measured?
➢ Can it be completed within the proposed timeframe?
➢ Is data available? Will data be available to measure improvement?
➢ Is it important? To whom?
➢ Does it align with one or more of the department plans?
➢ Does the project support the department mission, vision and values?
➢ Does it have a customer focus?
➢ Does the project have potential to be replicated across programs or have an impact on other programs/activities?
➢ Is it within the team's control?
➢ Is leadership prepared to implement change?
➢ Is there probability of success?

Plan Alignment

The 2017-2020 Strategic Plan (SP) serves as the cornerstone of TLCHD's performance management system. The SP states the agency's mission, vision, and strategic goals and serves as a roadmap to where the agency wishes to be in the next 3 years. Ensuring that the strategic priorities and objectives are met requires the use of continuous data monitoring and collection as accomplished through TLCHD's Performance Management System. A PM System provides stakeholders the ability to track the progress of action steps outlined in the strategic plan over time. If performance metrics necessary for the success of strategic objectives are not met, then agency quality improvement process can be utilized to discover root causes and possible solutions.

The 2017-2020 Workforce Development Plan highlights training goals and capacity for agency staff and supports development in Quality Improvement, Performance Management, and other topics that promote a culture of quality and performance.

The 2015-2018 Community Health Improvement Plan is a collaborative effort to address the health and social challenges facing Lucas County residents. Although the Health Department is not responsible for ensuring progress is made for every identified priority issue, appropriate data will be monitored by TLCHD to aid community partners in determining the efficacy and impact of planned interventions.

Data Collection, Monitoring, and Reporting

Division Directors are responsible for ensuring performance data collection processes are in place to track, regularly update, and monitor performance standards and measures. Performance measures are tracked using a Performance Management Dashboard template stored on the shared network drive and accessible by all staff.

The Quality Improvement Council will facilitate an annual identification and assessment of agency and division-level goals and performance measures. An annual performance report will be developed by the QA Coordinator and QI Council. The QI Council will also monitor the PM Dashboard on a quarterly basis to assess potential quality improvement initiatives.

All QI Project Teams will complete appropriate documentation, including a storyboard, to be shared with staff and stakeholders. Documentation includes a description of the process, tools used, outcomes, and lessons learned. Project storyboards will be publicly displayed and QI Project Teams will provide updates at staff and stakeholder meetings as appropriate.

Regular Communication

Clear and consistent communication of quality improvement and performance management efforts is critical to building and sustaining a culture of quality and performance improvement throughout the agency. In accordance with the goals and objectives in *Goals, Objectives, and Implementation* section, the Quality Improvement Council will ensure:

➢ Staff QI efforts are acknowledged through monthly staff newsletters, postings on the health department's website, divisional staff meetings, and other communication mediums.

➢ Storyboards for Completed Projects are posted publicly for staff and stakeholders to observe.

➢ Completed projects are shared to the Public Health Quality Improvement Exchange (PHQIX)

➢ Completed project documentation is archived and available on the department's shared network.

➢ Quarterly updates to the Board of Health are provided by QI Project Team members, or QI Council members.

Evaluation and Review

The Performance and Quality Improvement Plan will be evaluated on an annual basis by the QI Council during the first quarter of each year. The evaluation will determine if the aspects of the plan are being followed, and if any improvements or revisions are necessary. The evaluation will include a summary of the progress toward goals and objectives of the agency's QI Plan, as well as the QI activities conducted during the past year. The outcomes accomplished by each QI team will be reviewed including the process that was targeted, the performance indicators utilized, measurement outcomes and data aggregation, the assessment and analysis process, and the improvement initiatives implemented in response to the results of the QI project.

The QI Plan will be fully evaluated and revised every three years following the revision of the Strategic Plan to ensure this plan aligns with TLCHD's strategic mission and vision.

Goals, Objectives, and Implementation

This section provides information regarding TLCHD's performance and quality improvement goals and objectives, including training requirements and available resources.

Goals and Objectives

Goal 1:	All TLCHD Employees will have QI and PM Training corresponding to the level of their involvement with QI activities.		
Objectives	Performance Metrics	Timeline	Responsible Parties
All new hires will complete *CQI for Public Health: The Fundamentals* (modules 1-3)	Certificate of Completion	Within 90 Days of Hire	QA Coordinator, Human Resources
QI Council members will complete *CQI for Public Health: Tool Time* (modules 4-8)	Certificate of Completion	Within 3 weeks of joining Council	QA Coordinator, QI Council
Project Team Leads will complete *CQI for Public Health: Tool Time* (modules 4-8)	Certificate of Completion	Within 2 weeks of project approval	QI Council
Develop and/or seek performance management training curriculums for staff	Available training opportunities	By March, 2018	QA Coordinator, QI Council
Leadership and Staff trained in fundamentals of performance management and data-based decision making	Certificate of Completion/Record of Attendance	By December 2018	QA Coordinator, QI Council, Human Resources
Goal 2:	Employees will have access to internal and external quality improvement training opportunities and resources.		
Objectives	Performance Metrics	Timeline	Responsible Parties
Internal and External training opportunities are communicated to staff	Newsletter entries, postings in copy rooms	Monthly, Ongoing	QA Coordinator, QI Council, PIO
Plan and develop workshop for training QI Council members and staff with hands-on activities	Workshop curriculum, appropriate handouts & templates	By end of August 2018	QI Council
Establish resource library for quick access to QI principles and tools	"QI Corner" on employee login page, easy to use tool templates, room for QI materials	By end of August 2018	QA Coordinator, QI Council
Staff are engaged with QI principles, tools, and methods in their day-to-day work.	"QI on the Fly" defined process and template	By end of June 2018	QI Council
Goal 3:	Regular communication between administrative and frontline staff regarding quality improvement activities and progress		
Objectives	Performance Metrics	Timeline	Responsible Parties
QI & PM activity updates provided to staff regularly	Newsletter entries, staff meeting agenda/minutes	Monthly, Ongoing	Agency Leadership, QI Council
Board of Health receives quarterly updates on QI and PM progress	Reports/presentations to the BOH; BOH meeting minutes	By December 2017	QI Council, QI Project Team Members

Goal 4: Recognition for quality improvement through public sharing of QI project results and efforts			
Objectives	Performance Metrics	Timeline	Responsible Parties
Publicly Shared QI Project Storyboards	Storyboards posted on walls	By the end of September 2017, Ongoing	Agency Leadership, QI Council, QI Project Team
Recognition at All-Staff Retreats for staff participation on QI Projects and Council	Presentation	By end of January 2018	Agency Leadership, QI Council
Certificate of Appreciation provided for completed QI Projects to team members	Certificate of Appreciation, Signed by Commissioner, Mention in Monthly Staff Newsletter	By end of October 2017, Ongoing	Agency Leadership, QI Council
Establish Plaque for TLCHD staff who have participated on / achieved completed QI projects or efforts	Plaque with team name and roster	By end of December 2018	Agency Leadership, QI Council
Goal 5: Assess Culture, Review and Revise Plan, Establish Standards for Reporting			
Objectives	Performance Metrics	Timeline	Responsible Parties
Annual review of progress on quality and performance measure goals and objectives	Annual Report of Progress	By end of January 2018	QI Council
Design and implement regular assessments of quality and performance culture	Assessment Template	By end of January 2018	QI Council
Standardize progress reporting process for reports given to the QI Council, the BOH, and agency Leadership	Standard reporting forms/templates	By end of January 2018	QI Council

Record of Change and Plan Review

Date	Reviewer	Changes Made/Notes	Page Number(s)
12/7/17	BP	Removed "Is it free from pre-conceived solutions?" as a project selection criteria per QI Council Decision	12

Appendix A: Glossary of Key Terms

- **Activities/Action Steps:** Sets of actions through which inputs such as commodities, technical assistance, training, are mobilized to produce specific outputs. (i.e. provide training, revise procedure manual, hold immunization clinic) *(MSI, 2016)*

- **AIM Statement:** A brief set of statements that clarify the goal or purpose of a quality improvement project. The statements answer the questions what are you seeking to accomplish; who is the target population; what is the specific, numeric measure(s) you are seeking to achieve?

- **Baseline:** The condition or level of performance before the implementation of activities.

- **Benchmark:** 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. *(Source Norris T., Atkinson A., et al. The Community Indicators Handbook Measuring Progress toward Healthy and Sustainable Communities. San Francisco, CA Redefining Progress; 1997)*

- **Chain of Results:** Logic of a program or project that follows a "cause and effect" or "if-then" hypothesis. *(MSI, 2016)*

- **Community Health Assessment (CHA):** The CHA is a collaborative process conducted in partnership with other organizations and describes the health status of the population, identifies areas for health improvement, determines factors that contribute to health issues, and identifies assets and resources that can be mobilized to address population health improvement *(Public Health Accreditation Board, 2011).*

- **Community Health Improvement Plan (CHIP):** A community health improvement plan (CHIP) is a long-term, systematic effort to address public health problems identified through the results of the community health assessment The purpose of the CHIP is to describe how a health department and the community it serves will work together to improve the health of the population within department's jurisdiction *(Public Health Accreditation Board, 2011).*

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

- **Cultural Competence:** Cultural competence is a set of skills that result in an individual understanding and appreciating cultural differences and similarities within, among, and between groups and individuals. *(National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf).*

- **Customer/ Partner/ Stakeholder:** "Customer" refers to actual and potential users or beneficiaries of the products or services of the organization. Customers also include stakeholders and partners; "partner" refers to key organizations or individuals who work in concert with you to accomplish a common goal; "stakeholders" are individuals or organizations that might be affected by improvement processes and include employees, customers, partners or policy makers.

- **Customer Satisfaction:** Customer satisfaction is a measure of how products and services supplied by an organization meet or surpass customer expectations. Customer satisfaction is the number of customers, or percentage of total customers, whose reported experience with an entity, its products, or its services (ratings) exceeds specified satisfaction goals. *Farris, Paul W.; Neil T. Bendle; Phillip E. Pfeiffer; David J. Reibstein (2010).*

- **Data:** Quantitative or qualitative facts presented in descriptive, numeric, or graphic form. *(Source Certified Manager of Quality/Organizational Excellence Handbook. Russell T. Westcott, editor. 3rd Ed., 2006)*

- **Effectiveness:** indicates program outcomes that demonstrate how well a program or service is fulfilling its objectives. Effectiveness can represent three qualities:
  - **Program quality:** measuring program performance against known standards, such as Healthy People 2020.
  - **Customer satisfaction:** analyzing customer feedback against performance goals for qualities such as timeliness, accuracy, friendliness, convenience, and flexibility.
  - **Cycle time:** length of time taken to deliver a product or service. Examples are number of days between a report and a corresponding inspection, or length of wait time at a service counter.

- **Efficiency:** indicates how well staff time, funds, equipment, and supplies are utilized, and can be expressed as a unit/cost ratio.

- **Goal:** A statement of a desired future state, condition, or purpose. *(Agency for Healthcare Research & Quality,1999)*

- **Indicator:** Unit of measurement which allows you to monitor performance. (i.e. # of employees trained, % of employees receiving 80% or higher on post-test, # of immunizations provided, % of kindergarteners starting school fully vaccinated.) Indicators should be **DOAP**:
  - **Direct:** The indicator should measure the exact end result.
  - **Objective:** Indicators should be precise, which reduces ambiguity and allows for comparison over time.
  - **Adequate:** The indicator(s) of a result should capture all of its elements. Rule of thumb is 1-3 indicators per result statement.
  - **Practical:** The data should be feasible to collect, be available when needed, be cost-effective to gather, and be reliable to give a consistent measure over time. *(MSI, 2016)*

- **Lean:** Lean refers to a collection of principles and methods that focus on the identification and elimination of non-value added activity (waste) involved in producing a product or delivering a service to customers.

- **Measurable:** Refers to results being collected and quantified to reflect input, output, performance and outcomes. These results are used to inform next steps in planning.

- **Objective:** A measurable condition or level of achievement at each stage of progression toward a goal; objectives carry with them a relevant time frame within which the objectives should be met *(Agency for Healthcare Research & Quality, 1999).*

- **Outcome:** Results that occur due to a program's activities and outputs. Can be short, intermediate, or long term (i.e. new skills utilized, procedures followed, vaccine preventable illnesses decreased) *(MSI, 2016).*

- **Output:** Tangible, immediate, and intended products or consequences of project activities (i.e. people trained, manuals revised, immunizations given). *(MSI, 2016)*

- **Performance:** "Performance" refers to the outcomes resulting from processes, services, or work relative to the stated objective or goal. Performance is quantifiable and stated in measurable terms. "Performance excellence" often refers to a culture within the workplace that routinely looks for opportunities for individual and organizational improvement.

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

- **Performance Management System:** Establishment of organizational objectives across all levels of the department, identifying indicators to measure progress toward objectives on a regular basis, identifying responsibility for monitoring progress and reporting, and identifying areas where achieving objectives requires focused quality improvement processes. *(MSI, 2016)*

- **Performance Measurement:** The process of defining, monitoring, and using objective program indicators on a regular basis. *(MSI, 2016)*

- **Performance Monitoring Plan:** Detailed document that describes your indicators, measures, and approach to data collection, acquisition, analysis, use, and reporting. *(MSI, 2016)*

- **PHAB (Public Health Accreditation Board):** A nonprofit organization dedicated to improving and protecting the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments *(Public Health Accreditation Board, 2012).*

- **Plan, Do, Study, Act (PDSA):** An iterative, four-stage problem-solving model for improving a process or carrying out change. PDSA stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDSA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned. *Embracing Quality in Local Public Health: Michigan's QI Guidebook, 2008.*

- **Process:** A "process" is a set of linked activities with the purpose of producing a product, service, or outcome. Processes may involve people, machines, tools, techniques and materials in a sequence of defined steps. Process may also include a general understanding of reaching a desired end.

- **Proxy Indicators:** Indirect measure used when direct measure is not practical (i.e. The City of New Orleans measured number of tourists during Mardi Gras by measuring the number of gallons of water processed through the sewage treatment plant compared to other times of the year.) *(MSI, 2016)*

- **Public Health:** the science and art of preventing disease, prolonging life and promoting human health through organized efforts and informed choices of society, organizations, public and private, communities and individuals." *(Winslow, Charles-Edward Amory (1920). "The Untilled Field of Public Health". Modern Medicine. 2: 183–191)*

- **Public Health Accreditation:** Public Health Accreditation is a voluntary national program developed to measure health department performance against an established set of nationally recognized, practice-focused, and evidenced-based standards. Overseen by the Public Health Accreditation Board (PHAB) and jointly supported by the Centers for Disease Control and Prevention (CDC) and the Robert Wood Johnson Foundation, PHAB modeled its accreditation requirements on the Ten Essential Public Health Services to ensure all applicants meet or exceed an established baseline of quality and service.

- **QI Tools (Listed in Appendix C):** A variety of tools used to identify how processes, programs and services can be improved. Tools include prioritization matrices, root cause analysis, flow charts, cause-and-effect or fishbone diagrams, Pareto charts, scatter diagrams, control/run charts, brainstorming, logic models, SWOT analysis and numerous others.

- **Quality Assurance (QA):** Guaranteeing that the quality of a product/service meets some predetermined standard.

- **Quality Culture:** Exists when quality improvement is fully embedded into the way the department does business, across all levels, divisions, and programs. Leadership and staff are fully committed to quality and results of improvement efforts are communicated internally and externally. Even if leadership changes, the basics of quality improvement are so ingrained in staff that they seek out the root causes of problems. Staff do not assume that an intervention will be effective, but rather they establish and quantify progress toward measureable objectives. *(Source Roadmap to a Culture of Quality Improvement, Phase 6, NACCHO, retrieved 2014)*

- **Quality Improvement (QI):** 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. (*Riley, W., Moran, J., Corso, L., Beitsch, L., Bialek, R., and Cofsky, A. Defining Quality Improvement in Public Health. J Public Health Management Practice) 2010; 16(1)5-7.*

- **Quality Improvement Council:** The Quality Improvement Council exists to oversee continuous quality improvement efforts related to QI projects, staff QI training, customer satisfaction and related communications. It is a multidisciplinary committee with representation from all divisions.

- **Quality Improvement Process:** By setting performance standards and measuring performance, we are able to use the data collected for decision-making and implementing quality improvement projects. This leads to changes in our policies, programs, and department's culture of quality.

- **Reporting of Progress:** A process which provides timely performance data for selected performance measures and indicators, which can then be transformed into information and knowledge.

- **Results:** Changes that happen because of what a project or program does. Includes outcomes and outputs. *(MSI, 2016)*

- **S.M.A.R.T.:** Acronym used to ensure objectives are (S)pecific, (M)easurable, (A)ttainable, (R)ealistic, and timely (T)imely *(Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012).*

- **Strategic Plan:** A plan that sets forth what an organization plans to achieve, how well it will achieve it, and how it will know if it has achieved it. The SP provides a guide for making decisions on allocating resources and on taking action to pursue strategies and priorities *(Public Health Accreditation Board, 2011).*

- **Storyboard:** Graphic representation of a QI team's quality improvement journey *(Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012).*

- **Target:** Specific, planned level of achievement of the result to be achieved within a given timeframe. *(MSI, 2016)*

Appendix B: Culture Assessment Results

Quality Improvement Council Culture Assessment (n=6)
Qualitative Result Highlights:

Two-thirds (66.67%) of QIC members answered "fairly well" regarding their confidence in their knowledge or understanding of the following: *CQI*, *Performance Management*, and *the difference between the QI Council and a QI project team*.

Half of respondents answered "somewhat" and half answered "fairly well" in their understanding of the *PDSA Cycle*, *What a Quality Culture is/looks like*, and *how CQI & PM relate to one another*.

One-third (33.33%) of respondents answered "slightly" and 50% answered "some-what" in their understanding of their role on the QI Council.

The majority of respondents (83.33%) rated "fairly well" in their understanding of how QI Project ideas can be submitted, but all respondents rated that they only "somewhat" understand the criteria a project idea should meet before becoming an active project.

Two-thirds (66.67%) of respondents indicated they knew where to access QI Plan and project materials.

Two-thirds (66.67%) of respondents also indicated involvement on a QI project either as a regular team member (2) or as a sponsor (2). Only one (1) of these respondents indicated their project reached a successful completion and implementation.

When asked about the ideal composition of the QI Council, respondents answered that the structure/ composition as established in the first QI plan was generally good, but that some areas such as vital statistics would not be able to afford more than a single representative, and other areas including the health services division should have more representation.

Respondents split their answers (50/50) regarding how long a QIC members should serve on the council between *2 years* and *for the life of each QI Planning Cycle* (approx. 3 years). QIC members discussed that this answer will depend on how productive the QIC is, and should center on avoiding stagnation. One member proposed an initial commitment of 1 year, reviewed as appropriate.

Respondents were asked what additional staff they felt might be excellent candidates to approach for QI Council Membership. An initial list was compiled and later ranked via multi-voter tool.

Two-thirds (66.67%) of respondents felt that communication between departments on the progress of QI was only partially achieved, the remaining one-third indicating no, or little progress.

Respondents were split between little to no implementation and partial implementation regarding *a process to share QI projects and results*, and a*dministrative leadership embraces and creates time for QI within daily responsibilities*.

A majority of respondents (83.33%) answered "partially implemented" to the desired state that employees have more freedom to improve their daily work processes.

Two-thirds (66.67%) of respondents answered that there was little to no known progress on the implementation of a robust training system for all employees and new hires.

Finally, Two-thirds (66.67%) of respondents answered that there was partial progress/implementation that all staff see QI as part of their job.

Performance Management Self-Assessment (n=25)

Response choices included "No, Somewhat, Yes, and Not Sure." For reporting purposes, "No and Not Sure" and "Yes and Somewhat" are grouped. The survey group consistent of all leadership (directors, supervisors, commissioner) the grants coordinator, and the Quality Assurance Coordinators. This assessment was completed in November 2015.

Qualitative Result Highlights:

Twenty-one (84.00%) respondents agreed that there was a state commitment from directors to use and develop a performance management system.

Fifteen (60.00%) respondents agreed there was an acceptable level of transparency between leadership and staff communicating the value of a PM system and how it may be used to improve efficiency of programs.

Twenty-two (88.00%) respondents agreed that performance is being managed for at least some priority areas critical to the department's mission and strategic plan.

Eighteen (72.00%) respondents agreed that performance was actively being managed regarding customer satisfaction.

Thirteen (52.00%) respondents indicated there was no known team responsible for integrating performance management efforts across various areas of the organization.

Respondents were split (12/13) on whether supervisors are currently trained to manage performance.

Fourteen (56.00%) respondents agreed that supervisors are held accountable for developing, maintaining, and improving the performance management system.

Nineteen (79.17%) respondents indicated there are no known incentives for performance improvement. (n=24)

Seventeen (68.00%) respondents indicated there is no known process or policy to carry out all the components of a PM system from beginning to end.

Nineteen (76.00%) respondents agreed that directors and supervisors nurture an organizational culture focused on performance improvement.

Fourteen (58.33%) respondents indicated there is no known defined process or method for choosing performance standards, indicators, or targets. (n=24)

Twenty (80.00%) respondents agreed that they currently track performance standards, indicators, or targets for their programs.

Sixteen (64.00%) respondents indicated there was no known relation of performance standards to recognized health goals and frameworks (e.g., Essential Public Health Services).

Sixteen (64.00%) respondents indicated there was no known communication of performance standards, indicators, or targets to stakeholders or partners.

Twenty (80.00%) respondents indicated there is no known coordination between programs or divisions to use the same performance standards and targets.

Sixteen (64.00%) respondents indicated there was no known training or resources available to help staff use performance standards or to understand performance management.

Twenty-one (84.00%) respondents indicated there are no known assessments to coordinate Health Department divisions in an effort to avoid duplication of efforts regarding data collection.

Eighteen (72.00%) respondents indicated there is no known training to help staff set performance standards, or a process to measures 'ourselves' against those standards.

Seventeen (68.00%) respondents agreed that supervisors and directors regularly receive information on progress related to performance standards and targets. Fourteen (56.00%) respondents indicated these types of updates are not regularly communicated to the Board of Health, sixteen (64.00%) indicated no regular communication with stakeholders or partners, and finally, Seventeen (70.83%; n=24) respondents felt no regular communication on the progress related to performance standards and targets occurs between the department and the public (including media).

Thirteen (59.09%) respondents indicated there is no known accountability regarding reporting performance from supervisors and program coordinators at all levels (n=22).
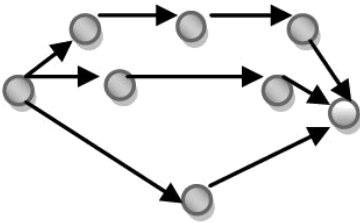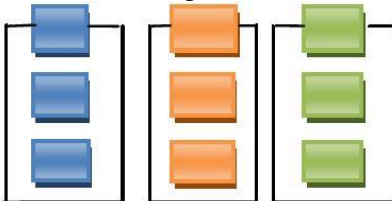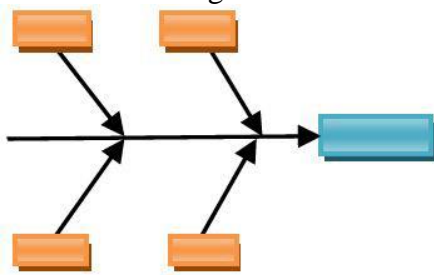
Sixteen (64.00%) respondents indicated that reporting of progress is not part of the strategic planning process (circa 11/2015), nor is there a clear plan for the release of performance reports.

Eighteen (72.00%) respondents indicated no known training is available to help staff analyze and report on performance data.

Seventeen (73.91%) respondents agreed that the agency has a process to improve quality or performance.

Sixteen (64.00%) of respondents indicated there is no know process or mechanism at the Health Department to coordinate efforts among programs or divisions that share the same or similar performance targets.

Appendix C: Quality Improvement Tools

Tool	Summary	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 team focus its attention and scare resources on critical tasks.	Page 3
Affinity Diagram	Used to: Gather and group 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 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 difference 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

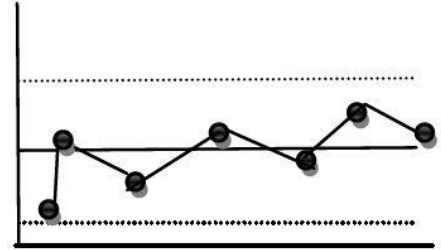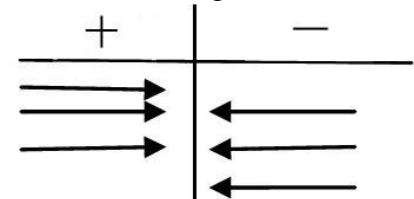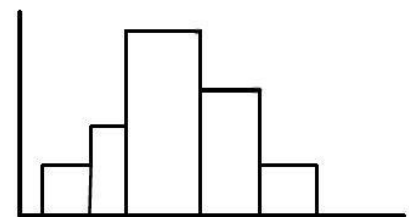| Tool	Summary	Public Health Memory Jogger II
Control Charts	Used to: Recognize sources of variation • Serves as a tool for detecting and monitoring process variation. Provides a common language for discussing process performance. • Helps improve a process to perform with higher quality, lower cost, 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
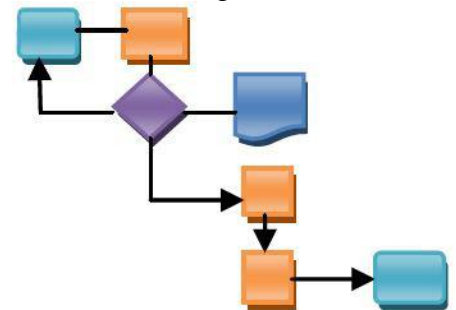
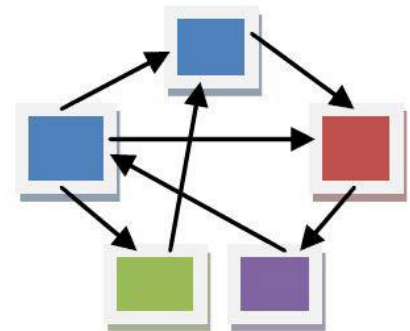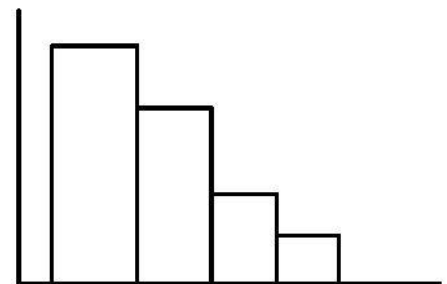| Tool	Summary	Public Health Memory Jogger II
Interrelationship Diagram	Used to: Look for drivers and outcomes • Encourages team members to think in multiple directions rather than linearly. • Explores the cause and effect relationships among all the issues. • Allows a team to identify root cause(s) 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

Matrix Diagram (Page 85):

	A	B	C
1			
2			
3			

Nominal Group Technique (Page 91):

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

Prioritization Matrices (Page 105):

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

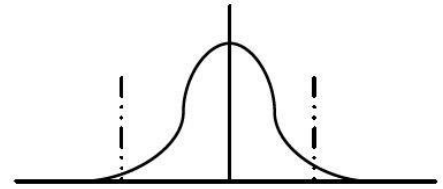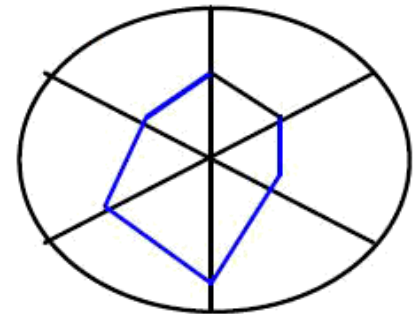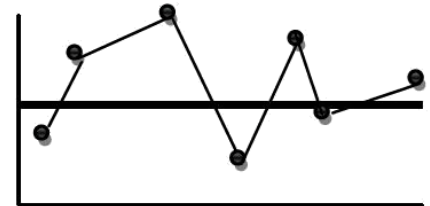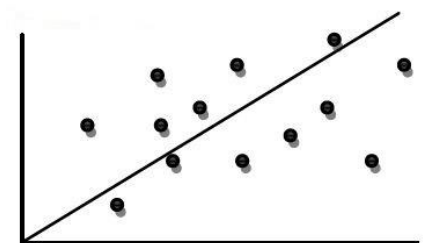| Tool	Summary	Public Health Memory Jogger II
Process Capability	Used to: Measure conformance to customer requirements. • Helps a team answer the question "Is the process capable?" • Helps to determine if there has been a change in the process.	Page 106
Radar Chart	Used to: Rate organization performance • 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