

LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT

QUALITY IMPROVEMENT PLAN - 2015



ALIGNMENT WITH OTHER PLANS



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**Quality Improvement Plan
Lincoln-Lancaster County Health Department
Signature Page**

This plan has been approved and adopted by the following individuals:



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7-6-15



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07.06.15



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Introduction

The Lincoln-Lancaster County Health Department (LLCHD) is committed to practicing Public Health at the highest level of quality, and continually seeks to improve its services to better align with the needs of those it serves. Dr. Kaye Bender, President and CEO of the Public Health Accreditation Board, states that “QI is the cornerstone upon which accreditation is based,” and LLCHD will apply Quality Improvement to achieve the standards set by accreditation. Quality Improvement at LLCHD will be guided by the following principles:

1. **Develop a strong customer focus**
2. **Continually improve all processes**
3. **Involve employees**
4. **Mobilize both data and team knowledge to improve decision making**

Mission, vision, & culture

Mission: The Quality Council (QC) will aid in creating, implementing, maintaining, and evaluating the Quality Improvement (QI) efforts at LLCHD with the intent to improve the level of performance of key processes and outcomes.

Vision: A culture of quality at LLCHD exists to protect and promote the public’s health.

Culture: Quality Improvement is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization. A culture of quality will exist within LLCHD so that anyone, anywhere within the department, at any time will be able to initiate and engage Quality Improvements to the work of the Department.

Policy statement

To achieve a culture of Quality Improvement, LLCHD is dedicated to systematically evaluating the quality of programs, processes, and services to achieve a high level of efficiency, effectiveness, and customer satisfaction.

Purpose & scope

It is imperative that a comprehensive approach to QI exists at LLCHD, ensuring institutionalization of Quality Improvement as the way the Department operates and does business. This approach has the potential to transform organizational culture to one where concepts and principles of QI are ingrained in the shared attitudes, values, goals, and practices of all LLCHD staff.

The purpose of the 2015 LLCHD Quality Improvement Plan (QI Plan) is to provide context, framework, and oversight for Quality Improvements within the Department. The intent is to improve the performance of key processes and health indicators in a systematic manner, utilizing the input and strengths of staff, leaders and community stakeholders.

Three Key Questions

At LLCHD any Quality Improvement submitted for consideration must be able to answer the following clarifying questions:

1. What are we trying to accomplish?
 2. How will we know that a change is an improvement?
 3. What changes can we make that will result in improvement?
-

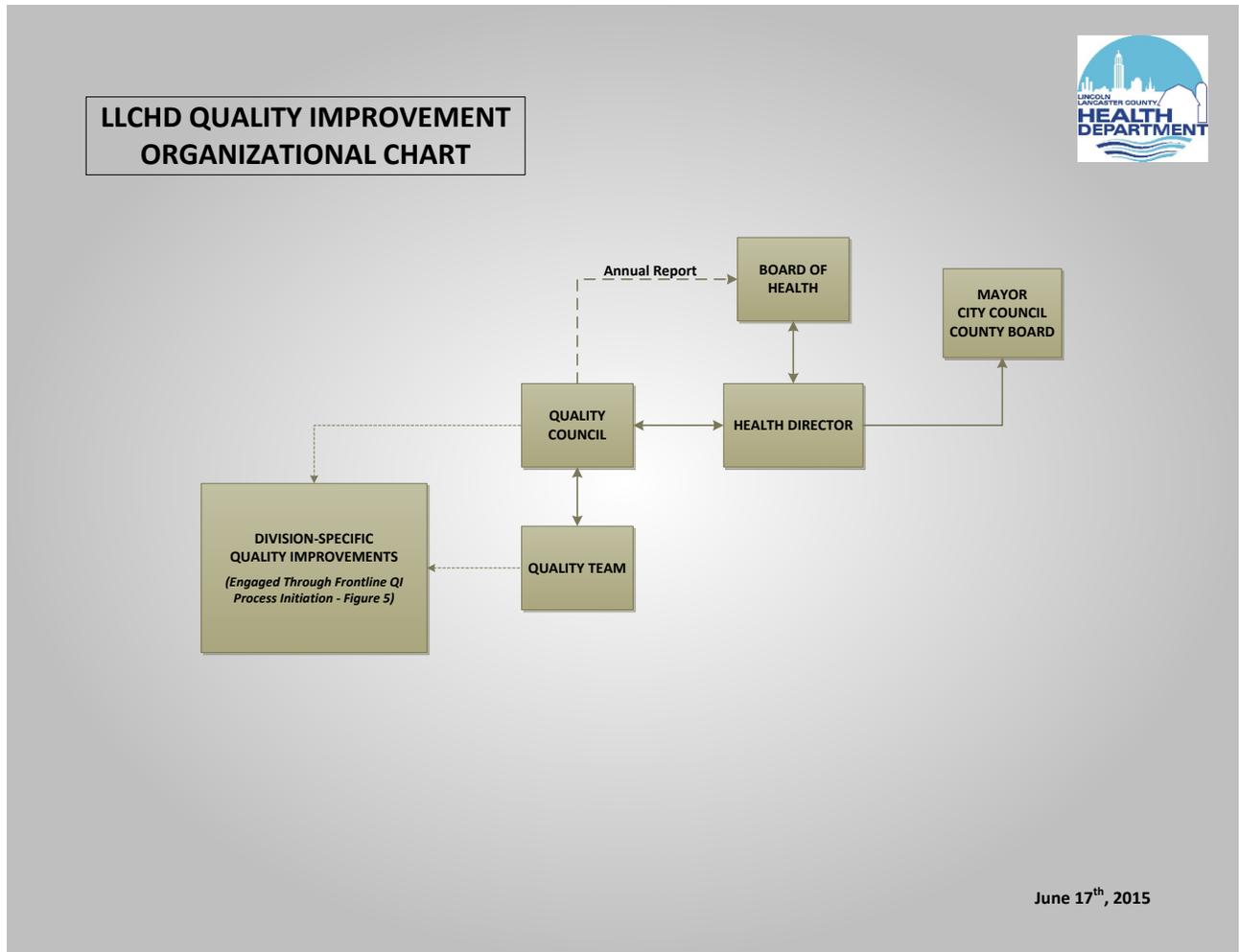


Figure 1

Council structure & membership

The Quality Council consists of the Health Director, Division Managers, members of the management team, and the Quality Improvement Coordinator. The Department’s Accreditation Coordinator serves as Council chair; members serve a minimum two year term, with no more than half of the team rotating off each year.



Responsibilities are described below:

Council Member	Responsibility
Health Director	<ul style="list-style-type: none"> • Provides vision & direction for LLCHD QI • Allocates resources for improvements • Reports to governing and Board of Health twice a year
Division Managers	<ul style="list-style-type: none"> • Identifies appropriate staff for Quality teams • Supports and encourage improvements within division • Assures all staff have QI-related performance and/or professional development goals • Expects staff to incorporate QI into daily work • Facilitates Quality teams as needed • Designates and provide office assistant support as needed
Supervisory Members	<ul style="list-style-type: none"> • Identifies appropriate staff for Quality teams • Supports and encourage improvements within division • Expects staff to incorporate QI into daily work • Facilitates Quality teams as needed
QI Coordinator	<ul style="list-style-type: none"> • Assists the Council Chair in the coordination of all Quality Council efforts • Receives and reviews all potential Quality Improvements for the Department • Coordinates Quality Team Initiatives approved by the Council and reports status of Quality Team progress

It is the role of the Quality Council to:

- Understand Quality Improvement processes and tools
- Assist with development of agency's QI plan
- Identify, review, and prioritize Quality Improvements
- Provide guidance and technical assistance to staff engaged in Quality Improvements
- Evaluate at least annually the QI plan and activities and revise as necessary
- Assist with planning for QI training needs of staff and ensure resources are available
- Communicate with staff, leadership and governing bodies about QI efforts
- Review the Performance Management System

The Council will convene every other month at a minimum.

Procedural Requirements include signing in, keeping minutes, formal motions on Action Items, striving for consensus, but accepting two-thirds majority decisions.

The Quality Team is accountable to the Council.

Scope, responsibilities, roles, & management



All staff at Lincoln-Lancaster Health Department will:

- Participate in QI training
- Participate in Quality Improvements as requested
- Initiate Quality Improvements
- Incorporate QI concepts into daily work.

LCHD QI	Responsibility
Quality Team Members	<ul style="list-style-type: none"> • Representative of the Department Divisions • Conduct Quality Improvements approved by the Council • Promotes QI within their Division • Serves as an ambassador for QI to their Division • Closes the communication loop between the Quality Team, Division Managers, and staff.
Department Staff (Division-Specific)	<ul style="list-style-type: none"> • Promote QI efforts and methods with coworkers • Make recommendations for Quality Improvements • Assist with facilitation of Quality Improvements as needed

Improvement identification

There are three pathways of origination for department-wide Quality Improvement initiatives at LLCHD. Two of the three require Quality Council approval. All three may result in the engagement of the Quality Team.

Health Director QI Initiatives: The LLCHD Health Director may task the Quality Council with an initiative based upon the current needs of the department, and important changes in the Public Health climate for the City of Lincoln and Lancaster County (displayed in Figure 2).

Department-Wide Initiatives: Based on LLCHD’s Performance Management System, in addition to ongoing Public Health analysis, the Quality Council may submit an initiative for approval (displayed in Figure 2).

Frontline QI Process Initiatives: The process for QI initiative identification is described fully in the “Improvements within Divisions” Section of the QI Plan. Initiatives may be submitted to the Quality Council for evaluation through this process by Division Managers or the QI Coordinator (displayed in Figures 2 and 5).

Improvement approval

While Health Director QI initiatives do not need Council approval, the Council will define the role of the Quality Team, and approve recommendations and resources for the Quality Team. All other initiatives must be approved by the Quality Council by consensus. The Council strives for consensus on all decisions and agrees to abide by vote in absence of consensus. In the absence of consensus, a vote by two-thirds of Council members will constitute approval.

Quality improvement process

All Quality Improvements at LLCHD will use the **Plan-Do-Study-Act (PDSA)** process. Although the tools will vary significantly between initiatives, all steps in the PDSA process will be accounted for in each QI proposal and documented upon completion. A list of commonly used tools is in Appendix B.

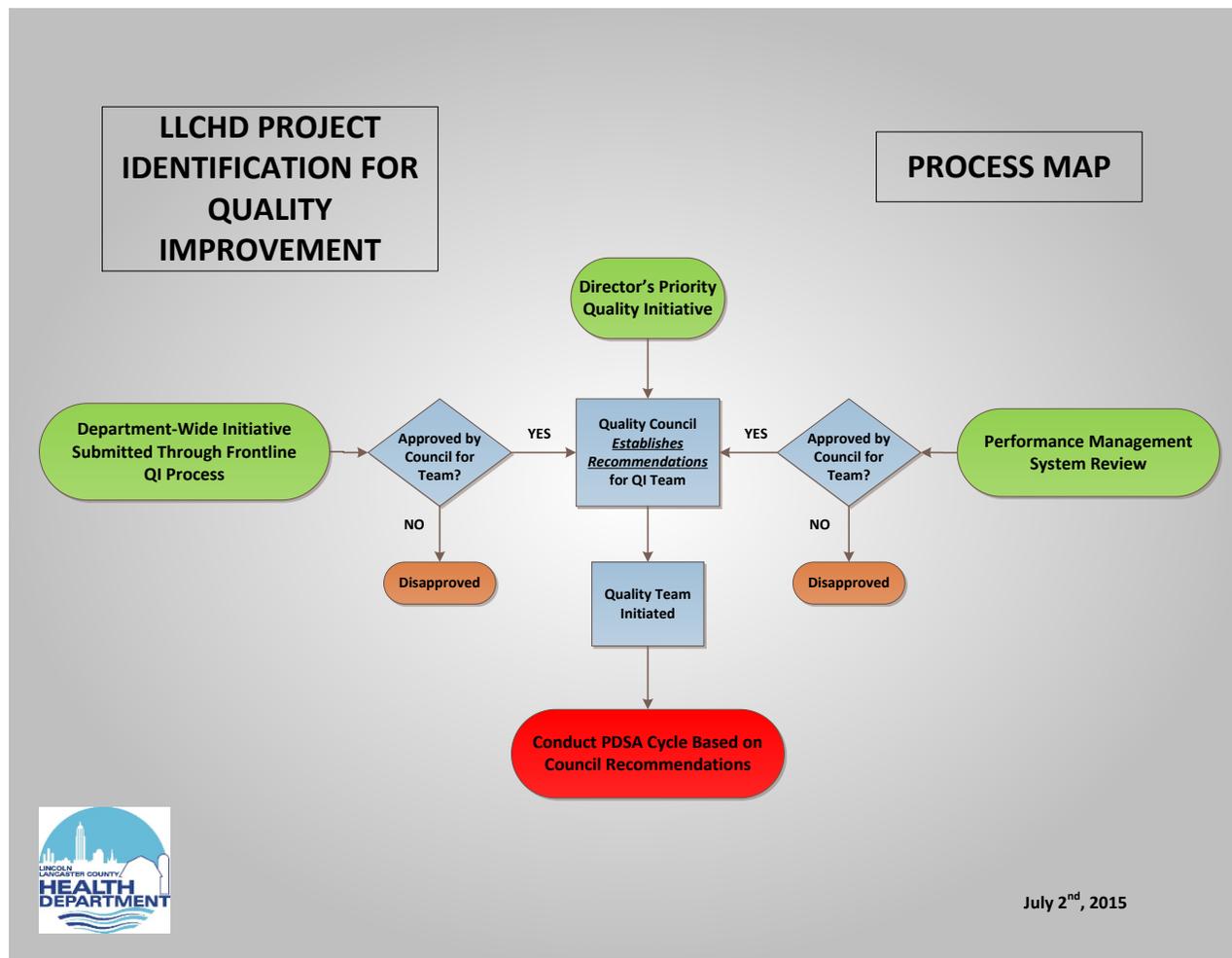


Figure 2

ALIGNMENT WITH OTHER PLANS



Introduction

This section provides a description of quality efforts at Lincoln-Lancaster County Health Department, including structure, staffing, culture, processes, and linkages of quality efforts to other agency documents.

The council will assure the QI Plan clearly connects with the department Community Health Improvement Plan, Strategic Plan, Performance Management Plan, Communication Plan and Workforce Development Plan.

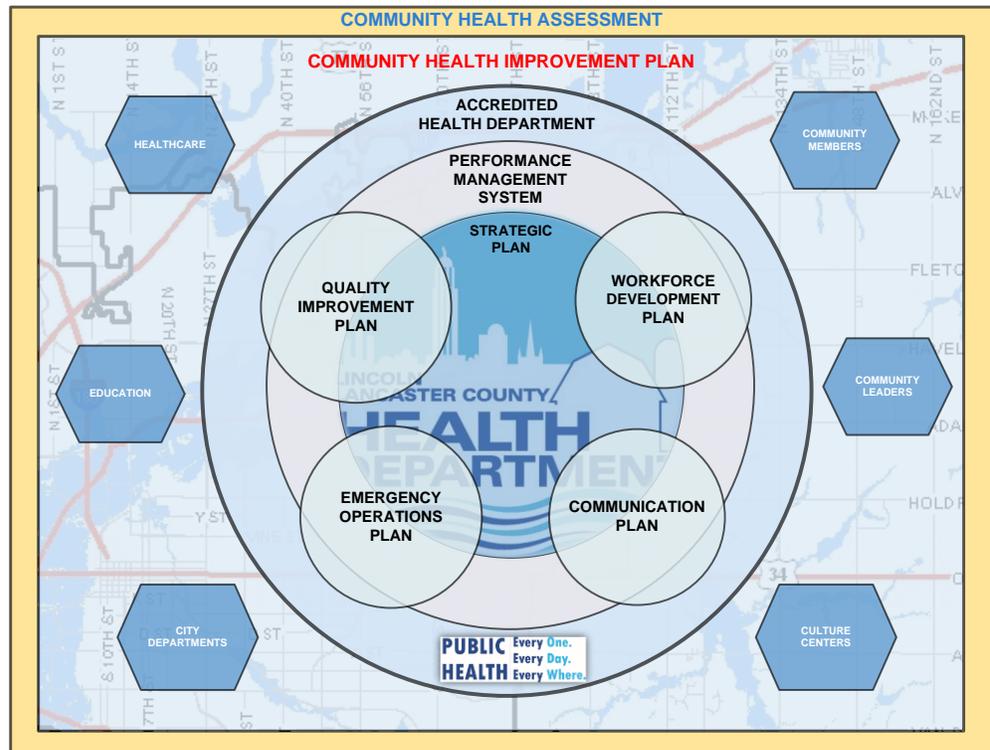


Figure 3

Performance management system

The Department Performance Management system that is integrated into daily practice identifies areas where achieving objectives requires focused Quality Improvement processes.

Community health improvement plan

The Council will monitor the progress made in meeting the performance measures of the Community Health Improvement Plan for opportunities that require Quality Improvement processes.

ALIGNMENT WITH OTHER PLANS



Strategic plan	Links to the Health Department's Quality Improvement Plan. The Strategic Plan need not link to all elements of the Health Department Quality Improvement Plan, but it must show where linkages are appropriate for effective planning and implementation.
Workforce development plan	Implemented strategies in the Workforce Development Plan are monitored for areas that may require the implementation of Quality Improvement processes.
Communication plan	The biannual Quality Report will provide relevant Quality Improvement updates to governing and Board of Health, and is included as an element of the Communication Plan.

Introduction This section presents LLCHD’s overall goals and implementation plan for Quality Improvement. NACCHO’s “Roadmap to a Culture of Quality” was selected for identifying a baseline for Quality Improvement at LLCHD, and improvement strategies for the Department.

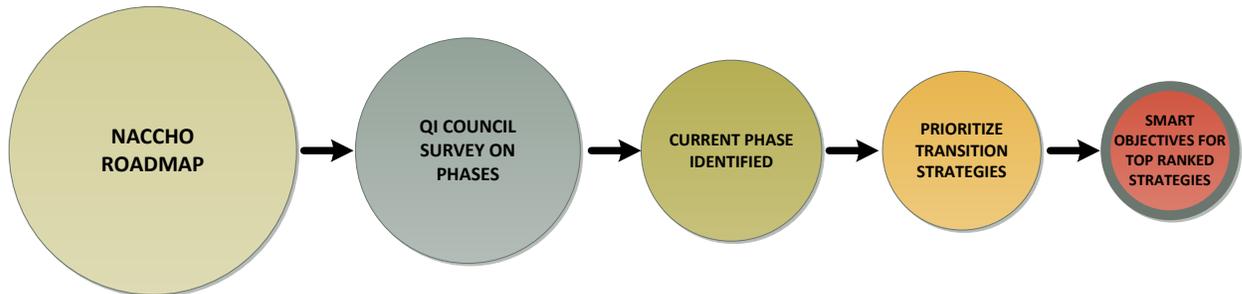


Figure 4

Work Plan The Quality Council will be surveyed annually using the phases of the Roadmap, and results weighted to identify the phase most accurately describing LLCHD’s current “Culture of Quality.” A phase will be identified for all six elements of the Roadmap.

Transition strategies will also be surveyed for each phase to determine which transition strategies result in the greatest “value” for advancement. Through a nominal grouping process, three transition strategies for each element will be selected for implementation. Among the prioritized strategies, the four highest ranking will be identified and SMART Objectives developed for the Annual Quality Plan. The remaining priority transition strategies will be addressed as the initial transition strategies are accomplished. Strategies will be re-assessed during the Annual Quality Plan review in May of each year, and attached as an addendum to the Quality Plan (Addendum 1).

Evaluation and monitoring of QI plan Annual Quality Plan objectives pertinent to the Performance Management System will be monitored along with other department indicators.

The QI Plan will be evaluated annually by the Quality Council in May of each year. Evaluation will occur through a survey of Quality Council members in March of each year. The evaluation will address:

- Progress toward and/achievement of goals as outlined in the Goals Objectives and Implementation section
 - Effectiveness of the QI Plan in overseeing Quality Improvements and integration within the agency
 - Clarity of the QI Plan and its associated documents
 - Review of Quality Team evaluations (see below).
 - Lessons learned
 - Effectiveness of meetings
-

ANNUAL QUALITY WORK PLAN



The aggregated survey results will be reported to the Council prior to the annual review of the QI Plan. Goals will be revised and corrective actions and revisions will be made after this annual review. The QI Coordinator will assume responsibility for the annual survey and analysis of results, with support from Health Data and Evaluation.

Evaluation and monitoring of quality team

The Quality Team will provide improvement progress reports to the Quality Council monthly. All teams will develop and submit improvement storyboards at the conclusion of a Quality Improvement (see Appendix D). Within one month of an improvement's finalization, all team members will be surveyed to determine QI process learning, perceived contribution to the improvement, value of the improvement experience and ultimate outcome, lessons learned, and to seek suggestions for overall agency QI efforts.

IMPROVEMENT WITHIN DIVISIONS



Introduction This section describes the process for QI initiative identification, selection, prioritization, and team member selection within divisions. Additional information about current and past improvements may be obtained by contacting the Quality Improvement Coordinator.

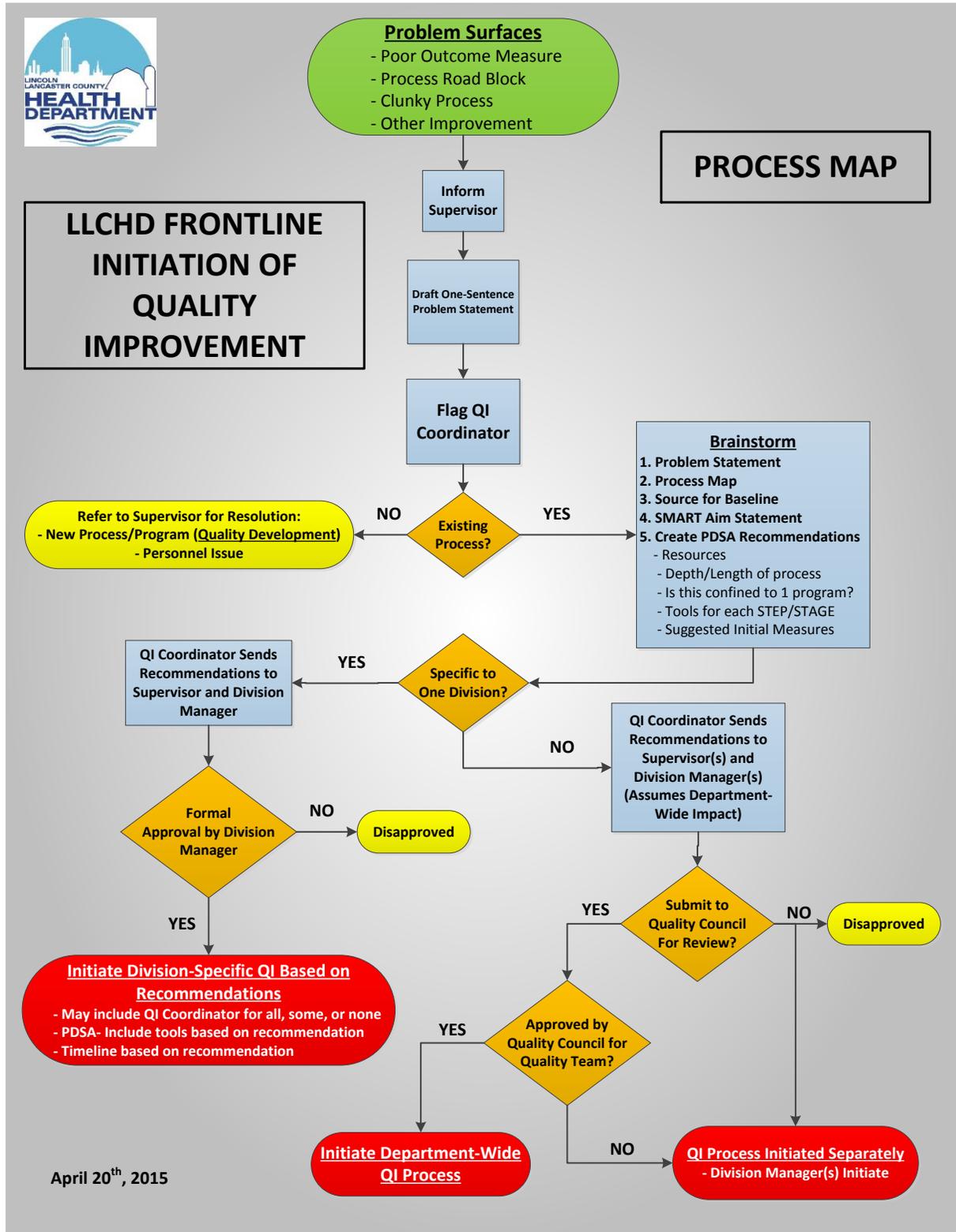
Improvement selection process Each division within LLCHD is committed to supporting the Community Health Improvement Plan, the LLCHD Strategic Plan, and achieving division-specific programmatic indicators. Quality Improvement within divisions will seek to support, strengthen, and improve each division’s fulfillment of these objectives. Quality Improvement initiatives will align with programmatic, divisional, departmental, and community goals.

In order to achieve a culture of Quality Improvement within LLCHD, all staff require exposure, access, and training in the tools of Quality Improvement. A QI process (Figure 5) was created with frontline staff in mind, providing a curb-level entry point for QI initiatives. Each initiative must be approved by a supervisor prior to engaging the QI Coordinator, must be an improvement to a current process, and not driven by interpersonal conflict. Once identified, the QI Coordinator will schedule a one-hour consultation with initiating staff to craft the first attempt at a clear problem statement, a process map, a potential measure, and the outlines of a SMART Aim Statement (**S**pecific-**M**easurable-**A**chievable-**R**elevant-**T**ime-**B**ound). The purpose of this consultation is to establish a foundation for the QI initiative while coaching frontline staff in QI tools necessary to the **Plan** phase of **PDSA**.

Upon completing the consultation, the QI Coordinator will send a formal QI proposal including tools for each of the nine steps in PDSA, and time lines for each, to the initiating staff member, the approving supervisor, and the Division Manager for consideration and approval. Depending on the level of the initiative’s complexity (and the stage of training and familiarity of the initiating staff in Quality Improvement and PDSA) the QI Coordinator will be involved with all, some, or none of the QI process – though always available for consultation and coaching. Each initiative will be conducted by a team of identified staff with involvement or expertise in the process being improved. Additional staff may be asked to support with establishing, monitoring, and evaluating data. There may also be IT needs identified by the process.

If a Division Manager or the QI Coordinator suspect the process for improvement is not isolated to one division, the Quality Council may be approached to consider the initiative for the departmental Quality Team. However, even if the Council declines to promote the initiative, Divisional Managers may choose to initiate an improvement within one or more divisions.

Documentation will be provided through an initiative charter (see Appendix C), meeting minutes (including a list of all attendees), tool completion, and a story board presentation to the Quality Council upon achievement. A survey will be administered to involved staff and stakeholders within a month following implementation of the initiative.



April 20th, 2015

Figure 5

Introduction

LLCHD will provide all staff with introductory, intermediate, and advance Quality Improvement training, resulting in a measurable understanding of QI concepts and tools, their implementation, and application of QI to their work.



Figure 6

LLCHD staff training

All staff at LLCHD will receive an introductory orientation to the Department’s Culture of Quality and the Quality Improvement Plan. The QI orientation will then become a component of the orientation process for all new staff.

A QI 101 course will be required for all staff, creating a baseline understanding of Plan-Do-Study-Act, basic QI tools, and their application to Public Health. Once completed, a refresher version of this training will be required for all staff annually. All-Staff Meetings will provide opportunities to briefly review and update LLCHD staff on Quality Improvement concepts. The resources and tools that will be utilized are further outlined in the Workforce Development Plan.

Division quality improvement teams

As a Quality Improvement is identified and a team selected, the QI 101 Refresher course will be completed by all team members. Follow-up just-in-time training will be conducted in person by the QI Coordinator based on the tools staff will use for the initiative. The resources and tools that will be utilized are further outlined in the Workforce Development Plan.

Department quality team

Ongoing Advanced Training will be provided to the Department Quality Team, and overseen by the Quality Improvement Coordinator. As Divisional representatives for the Department, Team members will facilitate QI as champions. The resources and tools that will be utilized are further outlined in the Workforce Development Plan.



Introduction This section contains a summary of communication activities, such as updating agency intranets, or web sites; communications with agency staff, leadership or city and county government leadership/Board of Health (if not otherwise described in Reporting), celebrations or publicizing of QI activities, etc. What is being communicated or updated should be described as well.

Quality reporting

All Lincoln-Lancaster County Health Department Employees

- *Quality Report* feature within the electronic newsletter (every other month) will provide regular updates on quality initiatives, including Quality Council membership, improvement outcomes, policy changes, and training opportunities
- *Quality Report* will feature a Quality team twice a year
- In All-Staff meeting in the spring of each year:
 - Experiences and results of all improvements done within the past 12 months will be reported.
 - Team members will be recognized
 - A Quality Council representative will report plan progress and evaluation results
- QI storyboards will be posted in the conference rooms.
- All Quality Council meeting documents (agendas, summaries) and Quality Team documents (agendas, summaries, data tools, storyboards, etc.) will be maintained on the shared electronic drive for review by all staff members at any time.

Board of Health

Board of Health members, which include a City Council and County Board member, will receive at least two updates on quality initiatives annually, one of which will summarize the evaluation report.

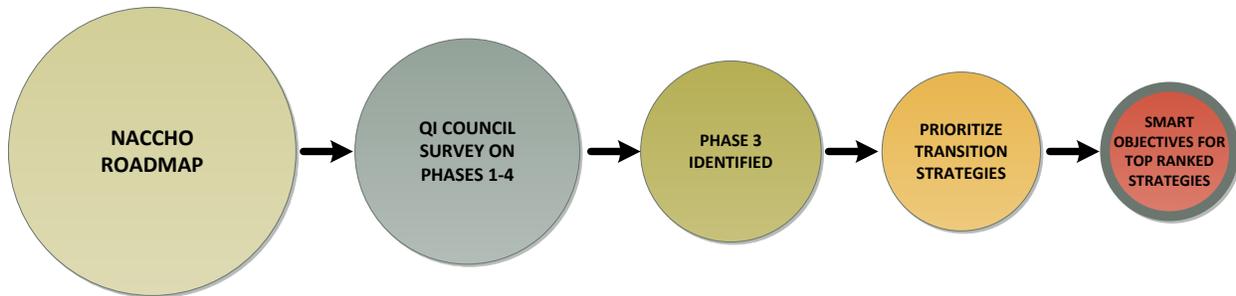
Public

Improvement descriptions and results will be featured on the agency's website.

Other

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

Introduction This section presents LLCHD’s overall goals and implementation plan for Quality Improvement. NACCHO’s “Roadmap to a Culture of Quality” was selected for identifying a baseline for Quality Improvement at LLCHD, and improvement strategies for the Department.



Work Plan The Quality Council was surveyed ([Survey Link](#)) using Phases 1 through 4 of the Roadmap, and weighted to identify the phase most accurately describing LLCHD’s current “Culture of Quality” in 2015. Phase 3 was identified for all six elements of the Roadmap, although some elements were approaching Phase 4.

Transition strategies were also surveyed from Phases 1 through 4, with Phase 3 transition strategies resulting in the greatest “value” for advancement. Through a nominal grouping process, three transition strategies for each element were selected for implementation. Among the prioritized strategies, the four highest ranking were identified and SMART Objectives developed for the 2015 Annual Quality Plan. The remaining priority transition strategies will be addressed as initial transition strategies are accomplished. Strategies will be re-assessed during the annual Quality Plan review in May of 2016.

Moving from Phase 3 to Phase 4 of the QI Roadmap – Transition Strategies

Goal 1: QI Infrastructure - Develop performance standards and measures at the organization, division, and program level, measuring both processes and outcomes. Align performance standards and measures with the agency strategic plan.

SMART Objective 1: *By September 20th, 2015, LLCHD will establish a Performance Management System to track progress on measures and indicators and review at least annually.*



Goal 2: Continuous Process Improvement - Build knowledge on basic QI methods and tools.

*SMART Objective 2: By **December 31st 2015**, 95% of all LLCHD FTE's will receive the initial training modules required for all staff.*

Goal 3: Customer Focus - Develop customer satisfaction performance measures throughout the agency. Include measures related to accessibility, courtesy, value, quality, timeliness, and helpfulness.

*SMART Objective 3: By **December 31st 2015**, every division will identify key internal and external customers and prioritize customers for feedback; and by **July 1st 2016** tools will be identified to measure performance satisfaction for all priority customers.*

Goal 4: Leadership - Leaders continuously communicate updates on QI progress and future plans, maintaining an inclusive and transparent process.

*SMART Objective 4: By **December 31st 2015**, Department Leadership will provide Quality Improvement updates and progress reports at least quarterly as part of All-Staff meetings, Division meetings, and program meetings.*

2015 TRANSITION STRATEGIES

WEIGHTING = YELLOW*3, BLUE*2, RRED*1

QI INFRASTRUCTURE

	OPTION 1	OPTION 2	OPTION 3	OPTION 4
*3	2 (6)	0 (0)	9 (27)	0 (0)
*2	7 (14)	0 (0)	1 (2)	1 (2)
*1	0 (0)	8 (8)	0 (0)	0 (0)
	20	8	29	2

29

- Develop performance standards and measures at the organization, division, and program level, measuring both processes and outcomes. Align performance standards and measures with the agency strategic plan.
- Implement a formal process for choosing performance standards and targets and for developing respective performance measures to manage performance around core functions (e.g., human resources, finance) and public health programs and services.
- All staff identify performance data needs and sources.

TEAMWORK & COLLABORATION

	OPTION 1	OPTION 2	OPTION 3	OPTION 4
	1 (3)	1 (3)	3 (9)	5 (15)
	3 (6)	3 (6)	3 (6)	1 (2)
	3 (3)	4 (4)	2 (2)	1 (1)
	12	13	17	18

- Hold teams accountable to performance goals.
- All staff increase use of collaborative QI techniques for problem-solving including group brainstorming sessions and discussions.
- Leaders provide staff the opportunity to share results achieved through various mechanisms (e.g., staff meetings, storyboards on display).

CUSTOMER FOCUS

	OPTION 1	OPTION 2	OPTION 3	OPTION 4
	4 (12)	0 (0)	1 (3)	4 (12)
	5 (10)	3 (6)	0 (0)	1 (3)
	0 (0)	1 (1)	8 (8)	1 (1)
	22	7	11	16

22

- Develop customer satisfaction performance measures throughout the agency. Include measures related to accessibility, courtesy, value, quality, timeliness, and helpfulness.
- Identify existing customer satisfaction data and data needs.
- Develop a process for monitoring and reporting on customer satisfaction data, and incorporate into the performance management process.

EMPLOYEE EMPOWERMENT

	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5
	2 (6)	2 (6)	3 (3)	0 (0)	3 (9)
	5 (10)	2 (4)	3 (6)	0 (0)	2 (4)
	1 (1)	4 (4)	4 (4)	2 (2)	2 (2)
	17	14	13	2	15

- Encourage staff to engage in QI projects and create opportunities to apply QI knowledge, skills, and abilities (KSAs).
- All staff attend training on an organization-wide performance-management process including how to develop performance measures, input and access data, identify performance gaps, and report methods and frequency.
- Mentor employees and provide advanced QI training to those that need it, including advanced tools of quality, statistical and data analysis, and more complex models for QI, as appropriate.

LEADERSHIP COMMITMENT

	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5	OPTION 6	OPTION 7
	2 (6)	0 (0)	5 (15)	0 (0)	1 (3)	1 (3)	3 (9)
	4 (8)	0 (0)	2 (4)	2 (4)	1 (2)	0 (0)	0 (0)
	3 (3)	6 (6)	1 (1)	1 (1)	0 (0)	0 (0)	0 (0)
	17	6	20	5	5	3	9

20

- Leaders continuously communicate updates on QI progress and future plans, maintaining an inclusive and transparent process.
- Leaders continue to communicate to employees key messages including: (1) QI is not about placing blame or punishment; (2) QI is a way to make daily work easier and more efficient; (3) QI is within reach of all staff and will get easier with practice.
- Executive leaders expect managers and supervisors to hold their employees accountable to QI.

CONTINUOUS PROCESS IMPROVEMENT

	OPTION 1	OPTION 2	OPTION 3	OPTION 4
	2 (6)	0 (0)	6 (18)	0 (0)
	4 (8)	1 (2)	2 (4)	4 (8)
	2 (2)	7 (7)	1 (1)	0 (0)
	16	9	23	8

23

- Build knowledge on basic QI methods and tools.
- The QI Council identifies and sponsors "winnable" QI projects using agency performance data. QI efforts are linked to strategic priorities and identified from performance data to the extent possible.
- All staff practice using the seven basic tools of quality in daily work to identify root causes of problems, assess efficiency of processes, interpret findings, and correct problems.



2015 Transition Strategies

29	<ul style="list-style-type: none"> Develop performance standards and measures at the organization, division, and program level, measuring both processes and outcomes. Align performance standards and measures with the agency strategic plan. 	QI INFRASTRUCTURE
23	<ul style="list-style-type: none"> Build knowledge on basic QI methods and tools. 	CONTINUOUS PROCESS IMPROVEMENT
22	<ul style="list-style-type: none"> Develop customer satisfaction performance measures throughout the agency. Include measures related to accessibility, courtesy, value, quality, timeliness, and helpfulness. 	CUSTOMER FOCUS
20	<ul style="list-style-type: none"> Leaders continuously communicate updates on QI progress and future plans, maintaining an inclusive and transparent process. 	LEADERSHIP COMMITMENT
20	<ul style="list-style-type: none"> Implement a formal process for choosing performance standards and targets and for developing respective performance measures to manage performance around core functions (e.g., human resources, finance) and public health programs and services. 	QI INFRASTRUCTURE
18	<ul style="list-style-type: none"> Hold teams accountable to performance goals. 	TEAMWORK & COLLABORATION
17	<ul style="list-style-type: none"> Encourage staff to engage in QI projects and create opportunities to apply QI knowledge, skills, and abilities (KSAs). 	EMPLOYEE EMPOWERMENT
17	<ul style="list-style-type: none"> All staff increase use of collaborative QI techniques for problem-solving including group brainstorming sessions and discussions. 	TEAMWORK & COLLABORATION
17	<ul style="list-style-type: none"> Leaders continue to communicate to employees key messages including: (1) QI is not about placing blame or punishment; (2) QI is a way to make daily work easier and more efficient; (3) QI is within reach of all staff and will get easier with practice. 	LEADERSHIP COMMITMENT
16	<ul style="list-style-type: none"> Identify existing customer satisfaction data and data needs. 	CUSTOMER FOCUS
16	<ul style="list-style-type: none"> The QI Council identifies and sponsors “winnable” QI projects using agency performance data. QI efforts are linked to strategic priorities and identified from performance data to the extent possible. 	CONTINUOUS PROCESS IMPROVEMENT
15	<ul style="list-style-type: none"> All staff attend training on an organization-wide performance-management process including how to develop performance measures, input and access data, identify performance gaps, and report methods and frequency. 	EMPLOYEE EMPOWERMENT
14	<ul style="list-style-type: none"> Mentor employees and provide advanced QI training to those that need it, including advanced tools of quality, statistical and data analysis, and more complex models for QI, as appropriate. 	EMPLOYEE EMPOWERMENT
13	<ul style="list-style-type: none"> Leaders provide staff the opportunity to share results achieved through various mechanisms (e.g., staff meetings, storyboards on display). 	TEAMWORK & COLLABORATION
11	<ul style="list-style-type: none"> Develop a process for monitoring and reporting on customer satisfaction data, and incorporate into the performance management process. 	CUSTOMER FOCUS
9	<ul style="list-style-type: none"> Executive leaders expect managers and supervisors to hold their employees accountable to QI. 	LEADERSHIP COMMITMENT
9	<ul style="list-style-type: none"> All staff practice using the seven basic tools of quality in daily work to identify root causes of problems, assess efficiency of processes, interpret findings, and correct problems. 	CONTINUOUS PROCESS IMPROVEMENT
8	<ul style="list-style-type: none"> All staff identify performance data needs and sources. 	QI INFRASTRUCTURE

APPENDIX A: DEFINITIONS



Introduction

A common vocabulary is used agency-wide when communicating about quality and Quality Improvement. Key terms and frequently used acronyms are listed alphabetically in this section. There are many terms from which to choose, some common ones are included here as examples only. Refer to the [PHAB glossary](#) of terms for additional terms and definitions.

Definitions

Accreditation – Accreditation for public health departments is defined as: 1) The development and acceptance of a set of national public health department accreditation standards; 2) The development and acceptance of a standardized process to measure health department performance against those standards; 3) The periodic issuance of recognition for health departments that meet a specified set of national accreditation standards; and 4) The periodic review, refining, and updating of the national public health department accreditation standards and the process for measuring and awarding accreditation recognition.

Aim Statement: A concise, specific written statement that defines what the team hopes to accomplish with its QI efforts. It includes a numerical measure for the future target, it is time specific and measurable, and it defines the specific population that will be affected. For more information, see the *Institute for Healthcare Improvement* website: <http://www.ihl.org>.

Baseline Measurement: The beginning point, based on an evaluation of output over a period of time, used to determine the process parameters prior to any improvement effort; the basis against which change is measured.

Best Practice: A superior method or innovative practice that contributes to the improved performance of an organization, usually recognized as best by other peer organizations.

Community Health Assessment (CHA): Community Health Assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation. (Turnock, B. *Public Health: What It Is and How It Works*. Jones and Bartlett, 2009).

Community Health Improvement Plan (CHIP): A Community Health Improvement Plan (CHIP) is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. A plan is typically updated every three to five years. (<http://www.cdc.gov/stltpublichealth/cha/plan.html>)



Community Health Improvement Plan (cont.): This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A Community Health Improvement Plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community (Adapted from: United States Department of Health and Human Services, Healthy People 2010. Washington, DC)

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. (Brownson, Fielding and Maylahn. Evidence-based Public Health: A Fundamental Concept for Public Health Practice. Annual Review of Public Health).

External Customer – Those people that receive the service or offering and whose success you are trying to immediately enable.

Internal Customer – Stakeholders within the organization or between organizations that have requirements to satisfy in order to deliver the service to the external customer. Ex: Handoffs from one person to another in a work process that provides the service to the Customer.

Measure: The criteria, metric, or means to which a comparison is made with output.

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. (Public Health Accreditation Board. Standards and Measures Version 1.0. Alexandria, VA, May 2011)

Performance Measures: Quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator. They are used to assess achievement of standards.

Plan-Do-Study-Act (PDSA): PDSA is an iterative, four-stage, nine-step, 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 has been learned. (*Plan-Do-Check-Act is used similarly and based on the same principles as PDSA. LLCHD will index PDSA terminology for use within the Department.*)

Process Mapping – An improvement method in which a process is depicted graphically with relevant data, which enables understanding and analysis for improvement. Includes methods such as Value Stream Mapping and Sub-Process/Swim Lane Mapping.

Quality Assurance (QA): Quality assurance is a systematic process of checking the delivery of a service to ensure action(s) taken meet established standards and are in compliance with public health practice and applicable state and federal regulatory requirements. QA may help identify opportunity and areas of focus for QI.

Quality Culture: 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. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives. (Roadmap to a Culture of Quality Improvement, NACCHO, 2012)

Quality Development (Planning): One of the three legs of the quality trilogy. Developing the products and processes required to meet customer needs. Establishes measures for quality control from the start. Quality Improvement is initiated when measures move out of the range of control.

Quality Improvement (QI): Quality Improvement in public health is the use of a deliberate and defined improvement process, (Plan-Do-Study-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, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in Public Health. Journal of Public Health Management and Practice. January/February 2010)

Quality Improvement Champion: QI Champions are those individuals who advocate for and support QI efforts across the department. These persons may be former Quality Team members or staff with vested interest in learning about and applying QI processes and tools to their daily role within the department.

Quality Improvement Council (Quality Council): The Quality Council is an LLCHD QI leadership body, tasked with: reviewing and consulting on QI initiatives; oversight of the Quality Team; reviewing the QI Plan at least annually; identifying and addressing QI training needs; providing guidance, support, and resources for LLCHD QI efforts; and recognizing, celebrating, and communicating QI successes. This team is comprised of managers representing each of the LLCHD Divisions



Quality Improvement Coach – A QI expert who is capable of coaching the QI Leadership Team, the QI Leader, and Quality Teams through strategic and QI planning, the improvement process, and QI methods.

Quality Improvement Plan (QI Plan): The QI Plan describes the QI program infrastructure for the LLCHD, and outlines methods by which areas of current operational or program performance will be selected for improvement. The QI Plan and the LLCHD Strategic Plan cross-reference one another. Implementing the QI Plan and accomplishing the goals and objectives set forth by this plan is an objective of the LLCHD Strategic Plan, and is also a performance measure monitored by the LLCHD Performance Management System.

Quality Improvement Team (Quality Team): The Quality Team is a LLCHD team organized by the Quality Improvement Coordinator. The Quality Team objectives include: conducting department-wide QI initiatives and other activities. This team is comprised of representation from each LLCHD Division and includes members from both management and non-management roles.

Quality Improvement Tools: Quality Improvement tools are designed to assist a team when solving a defined problem. Tools will help the team get a better understanding of a problem or process they are investigating or analyzing. Examples of tools include brainstorming, cause-and-effect, root cause analysis, fishbone diagrams, Pareto charts, and process mapping, among others.

Quality Methods: Quality methods are practices that build on an assessment component in which a group of selected indicators [selected by an agency] are regularly tracked and reported. The data should be regularly analyzed through the use of control charts and comparison charts. The indicators show whether or not agency goals and objectives are being achieved and can be used to identify opportunities for improvement. Once selected for improvement, the agency develops and implements interventions, and re-measures to determine if interventions were effective. ⁴ Examples of methods include Plan-Do-Study-Act. *These quality methods are frequently summarized at a high level as the Plan-Do-Study-Act Cycle.*

Rapid Cycle Improvement (RCI): Rapid Cycle Improvement an improvement process based on the Plan-Do-Study-Act (PDSA) model. The Rapid Cycle Improvement model entails four steps: set the aim (goal), define the measures (expected outcome), make changes (action plan), and test changes (solution). The concept behind RCI is to first try a change idea on a small scale to see how it works; then modify it and try it again until it works well for staff and customers and becomes a permanent improvement.

S.M.A.R.T. Format of Evaluation: SMART is an acronym used to ensure evaluation and research objectives are specific, measurable, achievable, realistic, and time limited.



Storyboard: A storyboard is a display created and maintained by a project or process improvement team that tells the story of a project or initiative. The storyboard should be permanently displayed from the inception to the completion of the project in a location where it's likely to be seen by a large number of associates and stakeholders impacted by the project. Storyboards can be printed or presented online.

Strategic Plan: A strategic plan results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. (Swayne, Duncan, and Ginter. Strategic Management of Health Care Organizations. Jossey Bass. New Jersey. 2008)

Subject Matter Experts (SMEs): SMEs are those individuals who can contribute significant knowledge about a program, process, or operation that has been identified and undertaken as a Quality Improvement. The role of SMEs is to provide background information and data related to a given Quality Improvement's focus, and to actively work with management to implement any improvements identified as effective solutions through PDSA.

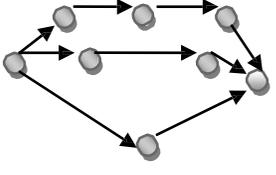
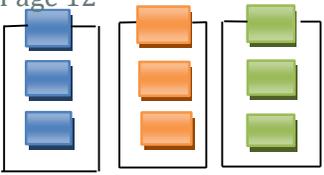
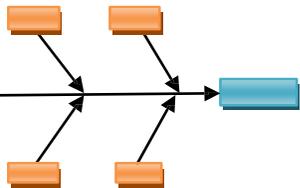
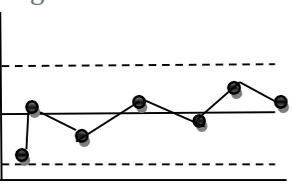
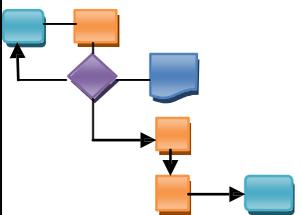
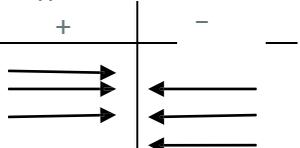
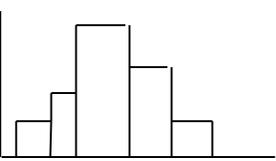
SWOT Analysis – A strategic planning method used to evaluate the Strengths, Weaknesses, Opportunities, and Threats to determine strategic objectives. Strengths are characteristics of organization that give it an advantage over others; Weaknesses are characteristics that place the organization at a disadvantage relative to others; Opportunities are elements that the organization could exploit to its advantage; Threats are elements in the environment that could cause trouble for the organization. The analysis associates the internal and external data to develop strategies.

Workforce Development Plan: A public health workforce development plan sets forth objectives and strategies that are aimed at training or educational programs to bring public health employees up to the date on the skills necessary to do their jobs better or to train the next generation of public health workers and leaders (Rowitz, L. Public Health Leadership, 3rd Ed. Jones and Bartlett, 2014)

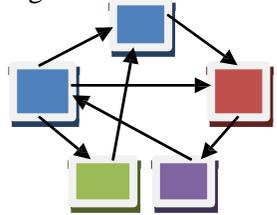
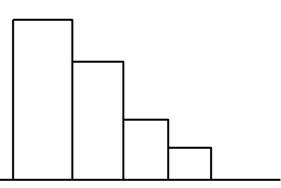
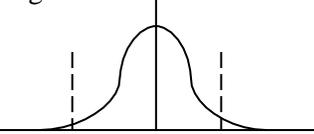
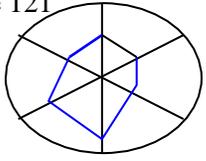
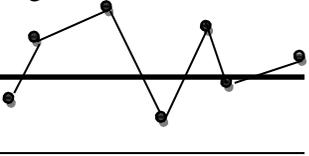
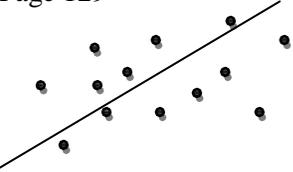
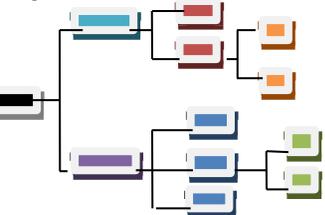


QUALITY IMPROVEMENT TOOLBOX



QI Tool	What the Tool Does	Public Health Memory Jigger II
Activity Network Diagram/ Gantt Chart	Used to: Schedule sequential and simultaneous tasks <ul style="list-style-type: none"> • Gives team members the chance to show what their piece of the plan requires and helps team members see why they are critical to the success of the project. • Helps teams focus its attention and scarce resources on critical tasks. 	Page 3 
Affinity Diagram	Used to: Gather and group ideas <ul style="list-style-type: none"> • Encourages team member creativity by breaking down communication barriers. • Encourages ownership of results and helps overcome “team paralysis” due to an array of options and a lack 	Page 12 
Brainstorming	Used to: Create bigger and better ideas <ul style="list-style-type: none"> • 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 	Page 19 
Cause and Effect/Fishbone Diagram	Used to: Find and cure causes, not symptoms <ul style="list-style-type: none"> • Enables a team to focus on the content of the problem, not the problem’s history or differing personal issues of team members. • Creates a snapshot of the collective knowledge and consensus of a team around a problem. • Focuses the team on causes, not symptoms. 	Page 23 
Check Sheet	Used to: Count and accumulate data <ul style="list-style-type: none"> • 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 	Page 31 
Control Charts	Used to: Recognize sources of variation <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Determines what type of data you have • Determines what type of data is needed 	Page 52 
Flowchart (Process Map)	Used to: Illustrate a picture of the process <ul style="list-style-type: none"> • 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 	Page 56 
Force Field Analysis	Used to: Identify positives and negatives of change <ul style="list-style-type: none"> • 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 	Page 63 
Histogram	Used to: Identify process centering, spread, and shape <ul style="list-style-type: none"> • 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 



<p>Interrelationship Digraph</p>	<p>Used to: Look for drivers and outcomes</p> <ul style="list-style-type: none"> 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. 	<p>Page 76</p> 																									
<p>Matrix Diagram</p>	<p>Used to: Find relationships</p> <ul style="list-style-type: none"> 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. 	<p>Page 85</p> <table border="1" data-bbox="1230 545 1523 688"> <tr> <td></td> <td>A</td> <td>B</td> <td>C</td> </tr> <tr> <td>1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> </tr> </table>		A	B	C	1				2				3												
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<p>Nominal Group Technique</p>	<p>Used to: Rank for consensus</p> <ul style="list-style-type: none"> 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. 	<p>Page 91</p> <table border="1" data-bbox="1230 790 1544 962"> <tr> <td></td> <td>Jo</td> <td>Bob</td> <td>Hal</td> <td>Total</td> </tr> <tr> <td>A</td> <td>3</td> <td>4</td> <td>4</td> <td>11</td> </tr> <tr> <td>B</td> <td>2</td> <td>1</td> <td>2</td> <td>5</td> </tr> <tr> <td>C</td> <td>4</td> <td>3</td> <td>3</td> <td>10</td> </tr> <tr> <td>D</td> <td>1</td> <td>2</td> <td>1</td> <td>4</td> </tr> </table>		Jo	Bob	Hal	Total	A	3	4	4	11	B	2	1	2	5	C	4	3	3	10	D	1	2	1	4
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<p>Pareto Chart</p>	<p>Used to: Focus on key problems</p> <ul style="list-style-type: none"> 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. 	<p>Page 95</p> 																									
<p>Prioritization Matrices</p>	<p>Used to: Weigh your options</p> <ul style="list-style-type: none"> 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) 	<p>Page 105</p> <table border="1" data-bbox="1230 1276 1555 1392"> <tr> <td>Cost</td> <td>A</td> <td>B</td> <td>C</td> <td>Total</td> </tr> <tr> <td>A</td> <td style="background-color: #800000;"></td> <td>1/5</td> <td>1/10</td> <td>0.3</td> </tr> <tr> <td>B</td> <td>5</td> <td style="background-color: #800000;"></td> <td>1</td> <td>6</td> </tr> <tr> <td>C</td> <td>10</td> <td>1</td> <td style="background-color: #800000;"></td> <td>11</td> </tr> </table>	Cost	A	B	C	Total	A		1/5	1/10	0.3	B	5		1	6	C	10	1		11					
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<p>Process Capability</p>	<p>Used to: Measure conformance to customer requirements</p> <ul style="list-style-type: none"> Helps a team answer the question "Is the process capable?" Helps to determine if there has been a change in the process. 	<p>Page 116</p> 																									
<p>Radar Chart</p>	<p>Used to: Rate organization performance</p> <ul style="list-style-type: none"> 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. 	<p>Page 121</p> 																									
<p>Run Chart</p>	<p>Used to: Track trends</p> <ul style="list-style-type: none"> 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. 	<p>Page 125</p> 																									
<p>Scatter Diagram</p>	<p>Used to: Measure relationships between variables</p> <ul style="list-style-type: none"> 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. 	<p>Page 129</p> 																									
<p>Tree Diagram</p>	<p>Used to: Map the tasks for implementation</p> <ul style="list-style-type: none"> 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. 	<p>Page 140</p> 																									



<h1>QUALITY TEAM CHARTER</h1>		
1. Team Name:	2. Version:	3. Subject (Target Area):
4. Problem / Opportunity Statement:		
5. Team Sponsor (Health Official):		6. Team Leader & Scribe:
7. Team Members:		Role:
8. Process Improvement Area:		
9. Initial Aim Statement:		
10. Revised Aim Statement (s):		
11. Scope (Boundaries)/Team Authority:		
12. Customers (Internal and External):		13. Customer Needs Addressed:

APPENDIX C: QUALITY TEAM CHARTER TEMPLATE



14. Success Measures (What does success look like?):	
15. Considerations (Assumptions / Constraints / Obstacles):	
16. PDSA Timeline:	Date:
Plan	
Do	
Study	
Act	
17. Meeting Frequency:	
18. Communication Plan (Who, How, and When):	
19. Stakeholders (Internal and External):	
20. Improvement Theories (If...Then):	
If	Then
If	Then

