galion city
HEALTH DEPARTMENT

Quality Improvement Plan

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Record of Changes

DATE	WHAT IS CHANGED	NAME
6/8/2015	**Initial Document**	**T Factor**
10/30/15	Updates to training components	T Factor
12/29/2015	Formatting, completion of Appendices	T Factor

Definitions & Acronyms

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.

Definitions

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) – 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 of the jurisdiction that the health department serves (Public Health Accreditation Board, 2011).

Continuous Quality Improvement (CQI) – An integrative process that links knowledge, structures, processes, and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes (Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012). A systematic, department-wide approach for achieving measurable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of the processes or services provided. Applies use of a formal process (PDSA, PDSA, etc.) to "dissect" a problem, discover a root cause, implement a solution, measure success/failures, and/or sustain gains.

Evidence-based practice (EBP) – Entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected.

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

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).

Performance Management (PM) – The practice of actively using performance data to improve the public's health. This practice involves strategic use of performance measures and standards to establish performance targets and goals. *(Turning Point, 2003)*.

Plan, Do, Check, Act (PDCA) – An iterative, four-stage, problem-solving model for improving a process or carrying out change. PDCA stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDCA 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) *PDCA is often used interchangeably with Plan Do Study Act (PDSA)

Project Team Leader – Active member of a Project Team, provides direction and support; not responsible for all decision making or for the Team's success or failure; responsible to prepare for and conduct meetings, assign activities to Team members, assess progress, represent the Team to management, manage paperwork, and facilitate communication with the Team.

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)*.

Qualitative Data – Data composed of words, providing in-depth, contextualized, and meaning-driven descriptions of anything from an individual's experience to a community's history (Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012).

Quality Assurance – Guaranteeing that the quality of a product/service meets some predetermined standard.

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 Improvement (QI) – Raising the quality of a product/service to a higher standard.

Quality Improvement Plan – A plan that identifies specific areas of current operational performance for improvement within the agency. This plans can and should cross-reference one another, so a quality improvement initiative that is in the QI Plan may also be in the Strategic Plan (PHAB Acronyms and Glossary of Terms, 2009)

Quantitative Data – Data that is measured or identified numerically and can be analyzed using statistical methods.

S.M.A.R.T. – Acronym used to ensure evaluation and research objectives are S=Specific, M=Measurable, A=Attainable, R=Realistic, T=Timely (Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012).

Strategic Plan (SP) – 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). A technique to display the thoughts and ideas of a group in some logical grouping or sequence. It may also be used to communicate the activities in a more visual format.

Acronyms

CHA- Community Health Assessment
CHIP- Community Health Improvement Plan
CQI- Continuous Quality Improvement
EBP- Evidence-based Practice
GCHD- Galion City Health Department
NACCHO- National Association of County & City Health Officials
PDCA- Plan, Do Check, Act
PHAB- Public Health Accreditation Board
PM- Performance Management
SMART (Objectives) - Specific, Measurable, Achievable, Realistic, Timely
SP- Strategic Plan
QIC- Quality Improvement Council
QIP- Quality Improvement Plan
WFD- Workforce Development

Purpose and Introduction

Galion City Health Department is committed to the ongoing improvement of the quality of services it provides. This Quality Improvement Plan serves as the foundation of this commitment.

Executive Summary

The Galion City Health Department (GCHD) has embraced the concept of continuous quality improvement (CQI), and the development of this plan will insure that the principles of CQI will be implemented throughout the organization. GCHD has adopted the Plan, Do, Check, Act (PDCA) CQI methodology, and this methodology will be used throughout the department on an ongoing basis in order to develop a culture of quality. Taking this approach will not only allow GCHD to better serve its customers, but its employees as well. This plan will provide a framework for the selection of quality improvement (QI) projects, the formation of QI teams, and ultimately instilling a culture of CQI throughout the agency. The implementation of this plan will assist GCHD in its efforts to become nationally accredited, as well as to achieve the strategic priorities set forth in its strategic plan.

Purpose

The purpose of the Galion City Health Department (GCHD) Quality Improvement Plan (QIP) is to provide context and framework for quality improvement (QI) activities at the Galion City Health Department.

This QIP aligns with the GCHD Strategic Plan and the Crawford County Health Partners Community Health Improvement Plan. The mission and vision of the GCHD guide the design and implementation of the QI plan. The intent is to improve the level of performance of key processes and health outcomes in a systematic manner, utilizing the input and strengths of staff, leadership and the community. All actions and decisions by the QI Council will be with the purpose of improving GCHD's ability to execute our mission.

Mission and Vision

All actions and decisions by the QI Council will be with the purpose of improving GCHD's ability to execute our mission as guided by our vision:

Mission Statement

To promote and protect the health and well-being of the communities we serve.

Vision Statement

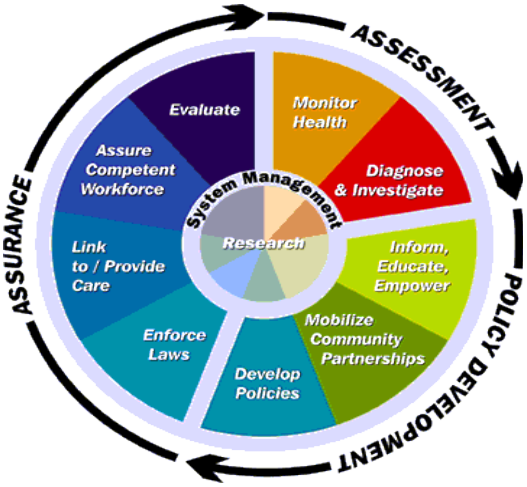
Inspire and engage our citizens and community to be optimally healthy.

Ten Essential Services

CQI activities at GCHD are conducted to strive for the highest quality of services while meeting the needs and expectations of our customers. The goal is to continuously improve the

execution and design processes across the Ten Essential Public Health Services (Center for Disease Control and Prevention, 2010):

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate, and empower** people about health issues.
4. **Mobilize** community partnerships and action to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce laws and regulations** that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. **Assure** competent public and personal health care workforce.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.



Strategic Priorities

Continuous Quality Improvement activities at GCHD strive to systematically assess and improve care and service to meet the priorities set forth in the GCHD Strategic Plan.

The GCHD's strategic priorities do not cover all the work done at the Galion City Health Department (GCHD). GCHD engages in a broad range of activities that help it achieve its overall mission of promoting and protecting the health and well-being of the communities we serve. With all its work, GCHD is committed to addressing all health disparities. The strategic priorities were selected based on information gathered from the CHA, CHIP, SWOT Analysis, and a variety of focus groups and/or staff input. In order to achieve the mission of the Galion City Health Department, the following four strategic priorities and associated goals were identified.

A. **Strengthen Program and Service Impact**
    1. Drive coordination of Public Health efforts to accomplish mission

2. Define measures, coordinate data collection and analysis, evaluate impact (PMS)
3. Inventory personnel resources to align with program and agency needs/ priorities

B. **Expand Community Awareness and Engagement**
   1. Increase visibility of all divisions, programs, and services to Galion City residents
   2. Increase health education in community from all appropriate programs/ divisions
   3. Become Social Media Accessible to constituents

C. **Address Current and Emerging Public Health Issues**
   1. Increase awareness of Public Health preparedness
   2. Increase awareness and/or community education about healthy eating/ active living
   3. Increase awareness and/or community education about injury prevention
   4. Increase awareness and/or community education about tobacco interventions
   5. Increase the abilities to report and/or track trends regarding communicable diseases

D. **Increase Organizational Collaboration through Workforce Development and Continuous Quality Improvement**
   1. Foster a culture of trust and engagement
   2. Update technology and ensure staff is educated and aware of technology available
   3. Develop and foster workforce development for all employees
   4. Achieve PHAB Accreditation
   5. Create a culture of Continuous Quality Improvement

Description of Quality Efforts

In January 2016 an Organizational Culture of Quality Self-Assessment will done at GCHD. Members of all levels of staff will be included in conducting this baseline assessment of organizational maturity within critical aspects of a culture of quality, revealing opportunities for improvement, and transforming a trajectory for next steps to reaching a culture of quality at GCHD.

Results of this assessment will be incorporated into this plan upon completion.

Roles & Responsibilities

(See Culture of Responsibility Pyramid below – Figure 1)

Galion City Health Department (GCHD) is committed to improving quality in all of its services, processes and programs, and is seeking accreditation through the national

Public Health Accreditation Board (PHAB). In order to accomplish both of these things, a formal structure is necessary to lead and guide these efforts.

The key to the success of the Continuous Quality Improvement (CQI) process is leadership. The leaders support QI activities through planned coordination and communication of the results of QI initiatives. Leaders ensure that the Board of Health, staff and various stakeholders have knowledge of and input into ongoing QI initiatives as a means of continually improving performance. See Organizational Chart *Appendix A*.

The following describes the roles of GCHD leadership and staff to provide support to quality improvement activities.

A. The **Board of Health (BOH)** provides leadership, support and resources for Quality Improvement (QI) initiatives as follows:
    1. Establish QI as a Priority
    2. Approve the QI Plan
    3. Recognize Improvements

B. The **Health Commissioner and Division Directors** provide leadership, support and resources for QI initiatives as follows:
    1. Establish QI as Priority
    2. Approve the QI Plan
    3. Support QI Initiatives
    4. Reflect QI in the Strategic Plan
    5. Provide Oversight and Guidance for Operational Performance Management
    6. Provide/ Allocate Resources
    7. Maintain Departmental Quality
    8. Identify Areas Needing Improvement
    9. Recognize Improvements
    10. Participate in QI activities
    11. Report on QI activities to the BOH
    12. Incorporate QI concepts into daily work
    13. Budget for QI activities

C. The **Quality Improvement Council (QIC)** creates, implements, monitors and evaluates the quality improvement efforts at GCHD and to support the

management team in building a culture of continuous quality improvement throughout the Department.

1. The QIC's function is to support leadership and staff by providing training, resources and structures for quality improvement efforts. This includes:
    a. Develop and implement the QI Plan
        1 Monitor plan performance; analyze performance gaps, and make recommendations for closing gaps
        2 Review the QI plan annually, or as needed, and adjust as required to reflect current and emerging priorities
        3 Set the goals and objectives for the QI Plan
    b. Coordinate the selection of QI projects
    c. Support QI Teams by:
        1 Providing guidance and technical assistance to staff engaged in QI projects
        2 Recognizing QI efforts and celebrating successes
        3 Providing staff access to QI training materials and tools
        4 Identifying and seeking resources needed to provide additional QI training
    d. Maintain the QI Activity reporting system
    e. Under the direction/advisement of the Health Commissioner, Division Directors, and/or the Accreditation Coordinator, the Quality Team will assess gaps in meeting PHAB standards and will help facilitate a plan to improve compliance
    f. Provide guidance to Health Commissioner, Division Directors, and Program Managers regarding best practices in operational performance management, monitoring, and accountability
    g. Assist Program Managers with development of meaningful indicators and measures to monitor their operational performance and progress toward goals
    h. Update Health Commissioner, Division Directors, and Board of Health on QI activities
    i. Communicate to all staff about QI efforts
    j. Membership of the QIC rotates based on staff volunteers
        1 Participation in the QIC is solely a volunteer activity

D. **Program Managers** provide leadership, support and resources for QI initiatives as follows:

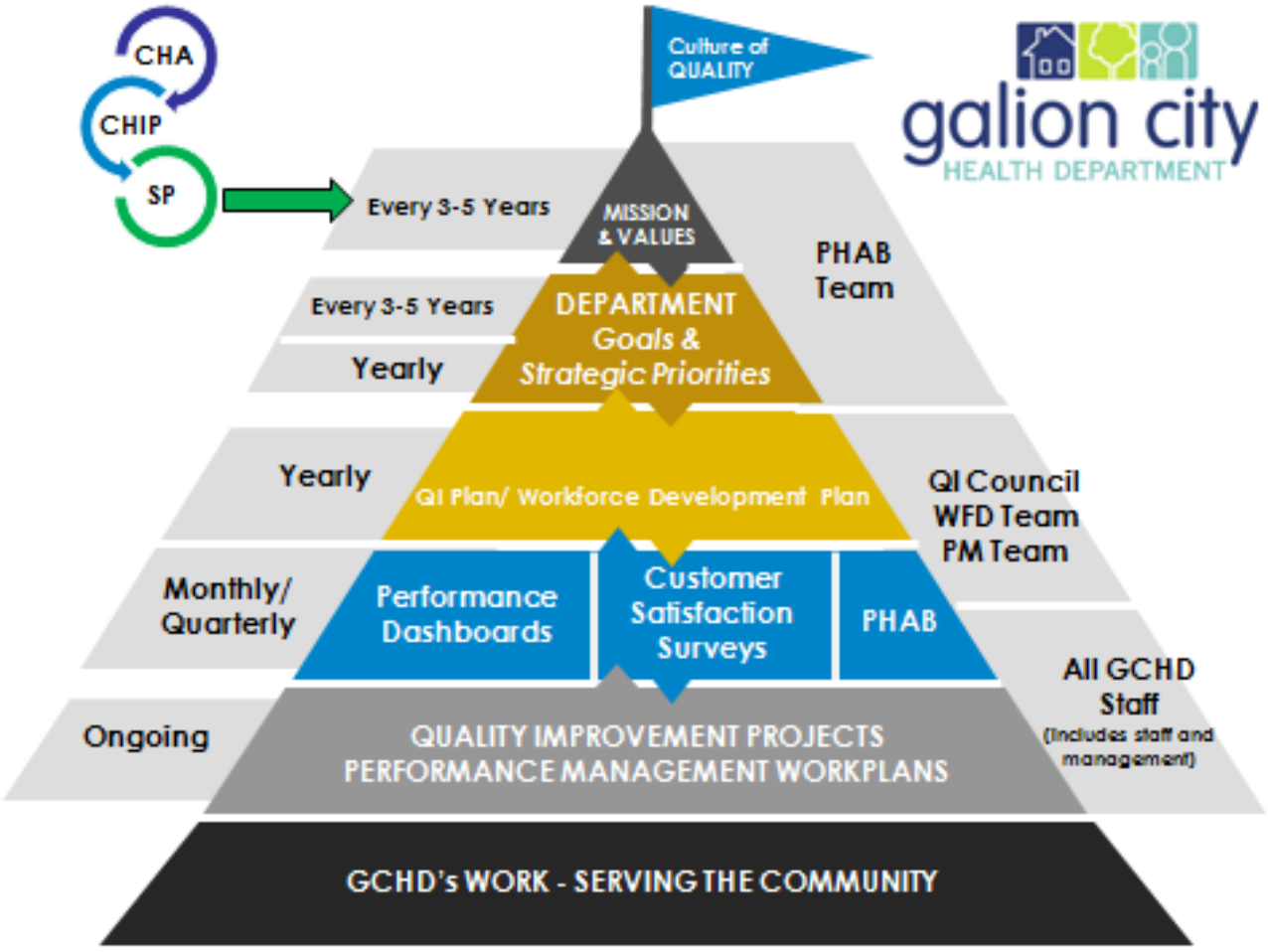
1. Identify and develop meaningful indicators and measures to monitor operational performance of their program/programs
2. Facilitate a plan to implement improvements for program measures that are not meeting their stated goal
3. Facilitate the implementation of QI activities and an environment of CQI at the program level
4. Identify and initiate problem solving processes and/or QI projects.
5. Oversee QI projects in their area
6. Participate in QI projects
7. Schedule staff time for QI projects
8. Update Health Commissioner and Division Directors on all QI activities
9. Report progress of QI projects to the Quality Team
10. Incorporate QI concepts into daily work.

E. **All GCHD Staff** are responsible for working with their supervisors and Quality Improvement Council members to identify areas for improvement and suggest improvement projects to address these areas.

Other responsibilities include:

1. Participating in QI projects, as requested by Division Directors or Program Managers
2. Collecting and reporting data for QI projects
3. Developing an understanding of basic QI principles and tools by participating in QI training
4. Incorporating QI concepts into daily work

Culture of Responsibility Pyramid



A. Membership Includes:
   1. Quality Improvement Council Team Lead
   2. Any and all staff members with an interest in CQI
   3. Health Commissioner, Division Directors, and Program Managers are also invited to participate in all QIC meetings

B. Communication
   1. The QIC meets monthly, or as needed
   2. The QIC Team Lead reports significant issues, findings, and actions to Health Commissioner
      a. Significant issues, findings and actions are reported, as necessary, to appropriate leaders/individuals and/or other committees, particularly those that support aspects of the QI program
      b. At a minimum, quarterly updates are provided to the QIC by the Project Team Leader or his/her designee and this information is reported using the QI Project Tracking Form found in *Appendix E*. The QIC Team Lead /designee is responsible to share the updates with the Health Commissioner and/or Division Directors on a quarterly basis
      c. An evaluation of the QI initiatives is completed annually.
         1) The evaluation summarizes the goals and objectives of the GCHD Quality Improvement Plan, the QI activities conducted during the past year, including the targeted process, systems and outcomes; the performance indicators utilized; the findings of the measurement, data aggregation, assessment and analysis processes; and the QI initiatives taken in response to the findings
         2) The QIC Team Lead is responsible to complete the evaluation with the input and approval of the members of the QIC
         3) Once the evaluation is approved by the QIC, it is submitted to the Health Commissioner for review
   3. Review of Performance Management Measures
      a. At least one QIC meeting each quarter a review of the Performance Management Measures will be completed.
         1) QIC will receive a report from the Performance Management Team regarding any goals not indicated as

completed (green) that they feel they need assistance with

2) Indicated measures will be discussed to determine any possible QI projects to assist
    i. Attention must be paid to the quarterly notes provided in the dashboard and/or PM Report
3) Identified areas of improvement and/or potential QI projects will be shared with the appropriate Division Director, the Health Commissioner, and/or the Performance Management Team
    i. It will be left to management's discretion whether an intervention or QI project will be started

C. Quality Improvement Council Guiding Principles

1. The QIC will operate using the following principles:
    a. All work is grounded in CQI methodology including the use of CQI tools to increase understanding and facilitate the improvement of outcomes. (For an example of tools, see QI Tools *Appendix D*)
    b. Decisions are data-driven and evidence-based in addition to using and respecting peoples' knowledge and experience
    c. The customer perspective (both internal and external) is central to decision-making striving to consistently meet or exceed customer expectations
    d. Processes are transparent, collaborative and inclusive
    e. Engagement and accountability are fostered with all persons involved in CQI efforts
    f. The focus is on learning and improvement over judgment and blame, and values prevention over correction

Quality Improvement within GCHD

A QI philosophy recognizes that there are costs to everything one does or does not do. Until complete satisfaction is reached with public health funding levels and accomplishments, staff should continually seek quality improvements that reduce costs and improve outcomes. QI methods can help document evidence based costs, identify outcomes of activities, and provide ways to make improvements that ultimately improve the health of all and meet the expectations of customers.

Three questions one should focus on when conducting QI activities are:

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?

(Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012)

Meaningful measures and indicators are used to monitor both operational performance and progress on special initiatives such as strategic efforts or quality process improvements. Operational performance management and evaluation have been integral components of measuring program efficiency and effectiveness. GCHD uses a "dashboard" set of measures to tie all operational performance measures into a more cohesive appraisal of department performance and progress. The Performance Management System is a living document/ dashboard.

Quality improvement activities emerge from a systematic and organized framework. This framework, utilized by Galion City Health Department leadership, is understood, accepted and utilized throughout the organization, as a result of education and involvement of staff at all levels.

Quality Improvement involves two primary activities:

- Measuring and assessing performance objectives through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the design of new services and/or improvement of existing services.

Quality Improvement Projects

A. **Project Selection**: The suggestion for a QI project may originate from various sources.
   1. Anyone in the health department can suggest a potential QI project by submitting the Quality Improvement Form found in *Appendix B* to the QIC.
   2. Projects may come from the managers based on data from their program and information from their staff. The decision to undertake an initiative is based upon agency priorities and project limitations.
   3. QIC may look at data from four major sources to identify new projects and evaluate the necessity of organizing a QI project. These sources of information are:
      a. PHAB Accreditation Domains
      b. Customer Satisfaction Surveys

c. Performance (Program) Management/Dashboards
d. GCHD Strategic Plan
    i. This includes projects to aid in aligning with Strategic Priorities and/or Associated Goals

4. Additional sources to identify new projects and evaluate the necessity of organizing a QI project include, but are not limited to:
    a. After- Action Reports
    b. Staff Survey Results/ Suggestions
    c. Program Evaluations
    d. Community Health Assessment or Systems Performance Assessment Findings
    e. Community Health Improvement Plans
    f. Audit or Compliance Issues

B. **Prioritization of Projects**: In order to ensure a comprehensive approach, the QIC examines QI opportunities for implementation based on the information from the following sources:

- Public Health Accreditation Board (PHAB) Standards & Measures
- Customer Satisfaction Surveys
- GCHD Strategic Plan
    - Strategic Priorities and/or Associated Goals
- Performance Measure Dashboards
- Leadership (Health Commissioner and Division Directors)
- GCHD staff
- Audit/ Grant Compliance

1. When selecting from among several identified project ideas, you may consider things such as:

- Alignment with agency's Mission or Strategic Plan
- Number of people affected
- Financial consequence
- Timeliness
- Capacity
- Availability of baseline data or present data collection efforts
- Alignment with PHAB Domains/ Standards/ Measures or prior review feedback

C. **Project Formation**:

1. Once the QIC receives information on the formation of a new QI team, the Project Team Leader will assemble team members and develop the QI project plan of action.
2. The QIC will then enter the information from the Quality Improvement Form found in *Appendix B* into the QI Project Tracking Form found in *Appendix E*.
3. Tracking of prioritized QI opportunities is in the form of a log (see QI Project Tracking Form *Appendix E*).
    a. QI opportunities may be specific and limited measures, entire projects, or program evaluations.
    b. QI opportunities may be identified by the QIC or recommended to the QIC by management/leadership or other staff.
    c. All opportunities listed in the log have SMART objectives and specifically assigned accountabilities.

D. **Project Implementation**: The purpose of a QI project is to improve the performance of an existing process. The model utilized at the Galion City Health Department is called Plan-Do-Check-Act (PDCA) Cycle (Gorenflo, 2010). Not all process improvement is a PDCA QI project.

- **Plan** – The purpose of this phase is to investigate the current situation, fully understand the nature of any problem to be solved, and to develop potential solutions to the problem that will be tested.
- **Do** - This step involves implementing the action plan.
- **Check** - At this stage, data is again collected to compare the results of the new process with those of the previous one.
- **Act** - This stage involves two actions. The first is to decide, based upon the data collected in the Check phase whether to adopt the change theory, make slight changes to the theory, or to abandon the improvement theory and start over. The second action in this phase is to decide future plans. So if the team decided to adopt or adapt the improvement theory, it must indicate how it will monitor the gains going forward. If the improvement theory was abandoned, the team must decide on how it will continue.

At a minimum, quarterly updates are provided to the QIC by the Project Team Leader or his/her designee and this information is reported using the QI Project Tracking Form found in *Appendix E*.

Plan, **D**o, **C**heck, **A**ct Cycle

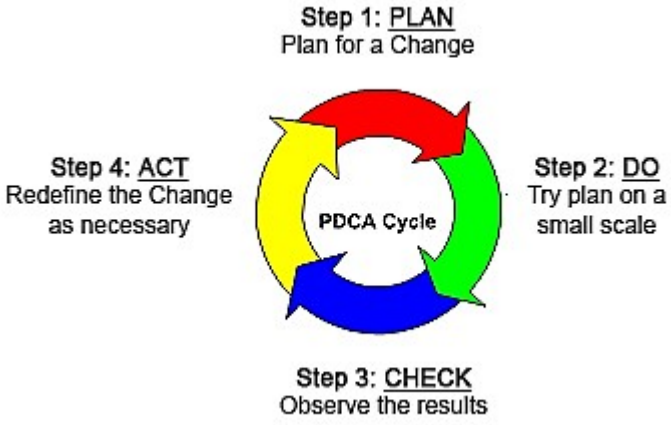


***Figure 2**: Diagram to illustrate the continuous process of quality improvement*
(Davenport, 2013)

E. **Project Summation**: Once the project is complete, each team needs to complete a Storyboard, which is a one page snapshot of the project in each step of the PDCA cycle. *Appendix C* contains a QI Storyboard (template). This Storyboard can be shared with staff, leadership and the Board of Health to demonstrate the projects completed in the health department.

F. **QI Education**: The Quality Improvement Council identifies and defines general goals and specific objectives to be accomplished each year. These goals include training of clinical, environmental and administrative staff regarding both continuous quality improvement principles and specific quality improvement initiative(s). QI training courses are addressed within the Galion City Health Department Workforce Development Plan as well as within this QIP. Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities. Quality Improvement Performance Measures are tracked and monitored

through the Galion City Health Department Performance Management System.

Budget & Resource Allocation

Decisions on budget and resource allocation for QI training and activity needs will be made by the Health Commissioner and Division Directors. Recommendations regarding budget and resource allocation may come from the Quality Improvement Council. The amount of resources available may be a determining factor in selecting QI activities during the QI project review process. The Quality Improvement Council and individual QI Teams will seek to address sustainability beyond the initial project period.

Communication

In order to support quality as a usual-way-of-business, quality-related news is communicated on a regular basis using a variety of methods to staff, Board of Health members, the general public, and others. This section describes how quality initiatives are shared.

A. Quality Sharing- Also identifying who the communication is targeted toward, such as Board of Health, community members, District Advisory Council, staff, etc.

1. Health District Employees

a. A Quality Report during monthly staff meetings will provide regular updates on quality initiatives, including Quality Improvement Council membership, project outcomes, policy changes, training opportunities, etc.

- Trainings can also be found within the Workforce Development Plan.

b. In staff meeting (retreat), at least once each year:

- QI projects completed within the past 12 months can report experiences and results with all staff.
- Team members will be recognized.
- The Quality Improvement Council Lead/ or designee will report plan progress and evaluation results.

c. Project storyboards will be posted in designated areas.

d. All Quality Improvement Council meeting documents (minutes, summaries) and QI Team documents (QI Form, Storyboards, data tools, etc.) will be maintained on the

shared network drive for review by all staff members at any time.

2. Board of Health
    a. BOH members will receive an update of QI projects at least annually.
3. Public
    a. Project descriptions and results may be featured on the agency's website.
4. Other
    a. In addition to these regularly occurring communications, the Quality Improvement Council may seek avenues to share quality initiatives with community partners and other state and national audiences, as appropriate.

Quality Goals, Implementation, & Performance Measurement

The goals and objectives for the GCHD Quality Improvement Plan focus on developing the capacity and culture of Continuous Quality Improvement (CQI).

2016-2017 Quality Improvement Goals

Goal: Establish and maintain organizational capacity and resources to support continuous quality improvement.			
	OBJECTIVES	**TIMEFRAME**	**RESPONSIBILITY**
1.	By January 15, 2016, the 2016-17 Quality Improvement Plan will be vetted through the Quality Improvement Council, the Health Commissioner, and Division Directors for final approval by the Board of Health.	By January 15, 2014	Quality Improvement Council
2.	At least quarterly, or at the conclusion of a project, the QI Project Team Leaders/designee of all active QI teams will present a progress update to the Quality Improvement Council.	Quarterly	QI Project Team Leaders
3.	At least quarterly, the QIC Team Lead/designee will provide QI activity updates to Health Commissioner and/or Division Directors.	Quarterly	Quality Improvement Council Team Lead/Designee
4.	By December 31, 2016, QI Training will be conducted, per the Workforce Development Plan.	By December 31, 2016	Quality Improvement Council Leader/Designee Workforce Development Leader/Designee
5.	By March 31, 2017 the annual evaluation of QI initiatives will be submitted to the Health Commissioner and Division Directors by the QIC Team Lead.	By March 31, 2017	Quality Improvement Council Quality Improvement Council Team Lead
6.	By December 1, 2017, the 2018-19 Quality Improvement Plan will be approved by the Quality Improvement Council and submitted to the Health Commissioner and Division Directors for final approval by the Board of Health.	By December 1, 2017	Quality Improvement Council

Quality Performance Measurement

The selection and measurement of performance measures enables the QI Council to understand: a) if the Public Health System is improving the health of Galion City residents; b) if agency performance goals are improving the health of Galion City residents; and c) if service areas are implementing efficient and effective processes and programs. Continuous quality improvement involves taking action as needed based on the results of the data analyses and the opportunities for performance they identify.

A. Measurement and assessment is for the purpose of:
   1. Assessing the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
   2. Identifying problems and opportunities to improve the performance of processes.
   3. Assessing the outcome of the service and/or care provided.
   4. Assessing whether a new or improved process meets performance expectations.

B. Performance Indicators
   1. As stated earlier, the Quality Improvement Council may determine indicators of quality on a priority bases. Key performance indicators (KPIs), in practical terms and for strategic development, are *objectives* to be targeted that will add the most *value* to the organization and to the community. They are ways to periodically assess the performances of organizations and their departments and employees. Accordingly, KPIs are most commonly defined in a way that is understandable, meaningful, and measurable.

C. Assessment of Performance Indicators
   1. Assessment is accomplished by comparing actual performance on an indicator with:
      a. Self over time.
      b. Pre-established standards, goals or expected levels of performance.
      c. Information concerning evidence based practices.
      d. Other local health departments or similar service providers.
   2. GCHD will use federal, state, and local resource documents as objective sources of measures in determining priorities for performance improvement.

D. Health Indicators

1. Health indicators aid internal Department staff, as well as external key public health stakeholders, in program planning and evaluation by monitoring key outcomes that are affected by public health programs and policy. Many indicators are used as intermediate or long-term outcome measures as part of program evaluation.

Training

Galion City Health Department has incorporated QI training goals and objectives within the agency's Workforce Development Plan (WFD Plan). The WFD Plan includes goals, objectives, target audience (who will receive training), resources/sources of training, and the individual(s) responsible for leading each objective. One goal within the GCHD Workforce Development Plan is "Establish a culture of quality within the agency"; objectives associated with this goal are:

- *All staff and managers will participate in quality improvement training annually.*
- *In 2016, all managers will lead an internal quality improvement team.*
- *Beginning 1/1/2016, all new employees will complete an introductory level QI training within the first 30 days of hire.*
- *All members of the QI Council will complete an advanced level QI training within 1 year of joining.*

Within the GCHD Curricula and Training Schedule Continuous Quality Improvement is addressed on an annual basis. See the table below.

Topic	Description	Target Audience	Competencies Addressed	Schedule
Continuous Quality Improvement	*Quality Improvement in Public Health; see Quality Improvement Plan for detailed courses. Various levels of training will be provided (new employee introduction, introductory level, advanced level, continuation or refresher courses, as well as other position specific training as needed.*	*All Staff*	*Analytical/Assessment, Policy Development/ Program Planning, Communications, Community Dimensions of Practice, Public Health Sciences, Leadership and Systems Thinking*	*Annually-March*

Additional quality improvement training will be made available based on position and/or project specific needs.

Quality Improvement Training Requirements		
Staff	**Training Type**	**Frequency**
New Employees	Orientation/ Introduction to QI QI Quick Guide Tutorial	Once, within 30 days of hire (Beginning 1/1/15)
All Staff	Orientation/ Introduction to QI Continuous Quality Improvement	At least Annually
Quality Improvement Council Members	Advanced QI training i.e. CQI in Public Health: The Fundamentals (Modules 1-8)	At least Annually (as needed), within one year of joining
Designated Positions/ Teams	Implementing and Sustaining CQI in an Organization The PDCA Cycle for Change Leaders and Handling Change Resistors Building a QI Culture QI Team Development	As needed
* Specific courses may vary based on availability. * Courses may be added or removed based on lessons learned and best practices.		

Quality Improvement Plan Monitoring and Assessment

A. The QI Plan will be reviewed annually, or as needed, by the Quality Improvement Council, Health Commissioner, and Division Directors. Revisions will be made by the Quality Improvement Council with the approval of the Health Commissioner and Division Directors.

B. An annual progress report will be prepared by the Quality Improvement Council and will include:

1. A summary of the process and progress towards the QI Plan goals and objectives
2. Outline of revisions made to the QI Plan (including rationale where necessary)
3. Any notable efficiencies and effectiveness obtained
4. Any notable lessons learned or best practices

5. Results of any pertinent customer/ stakeholder satisfaction surveys as they relate to QI activities
6. Goals and objectives for the upcoming year (to be incorporated into the QI Plan revision)
7. Status update on QI projects (utilizing the QI Project Tracking Form *Appendix* E)

C. The data collected for the annual progress report will be utilized when determining the need for QI Plan revisions.

D. Data on approved Program QI projects and activities specifically related to the QI Plan will be collected, compiled, analyzed, and reported through the GCHD's Performance Management System.

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Appendices

Appendix A Organizational Chart

Appendix B Quality Improvement Form

Appendix C QI Storyboard

Appendix D QI Tools

Appendix E QI Project Tracking Form

Plan Review & Responsibility

Review of Plan

The Quality Improvement Plan will be reviewed annually by the Quality Improvement Council; and others with expertise in public health quality improvement, as needed. This is a dynamic plan that will be reviewed and updated as needed. The Quality Improvement Council and GCHD Management Staff will be responsible for maintaining the plan.

Authorship

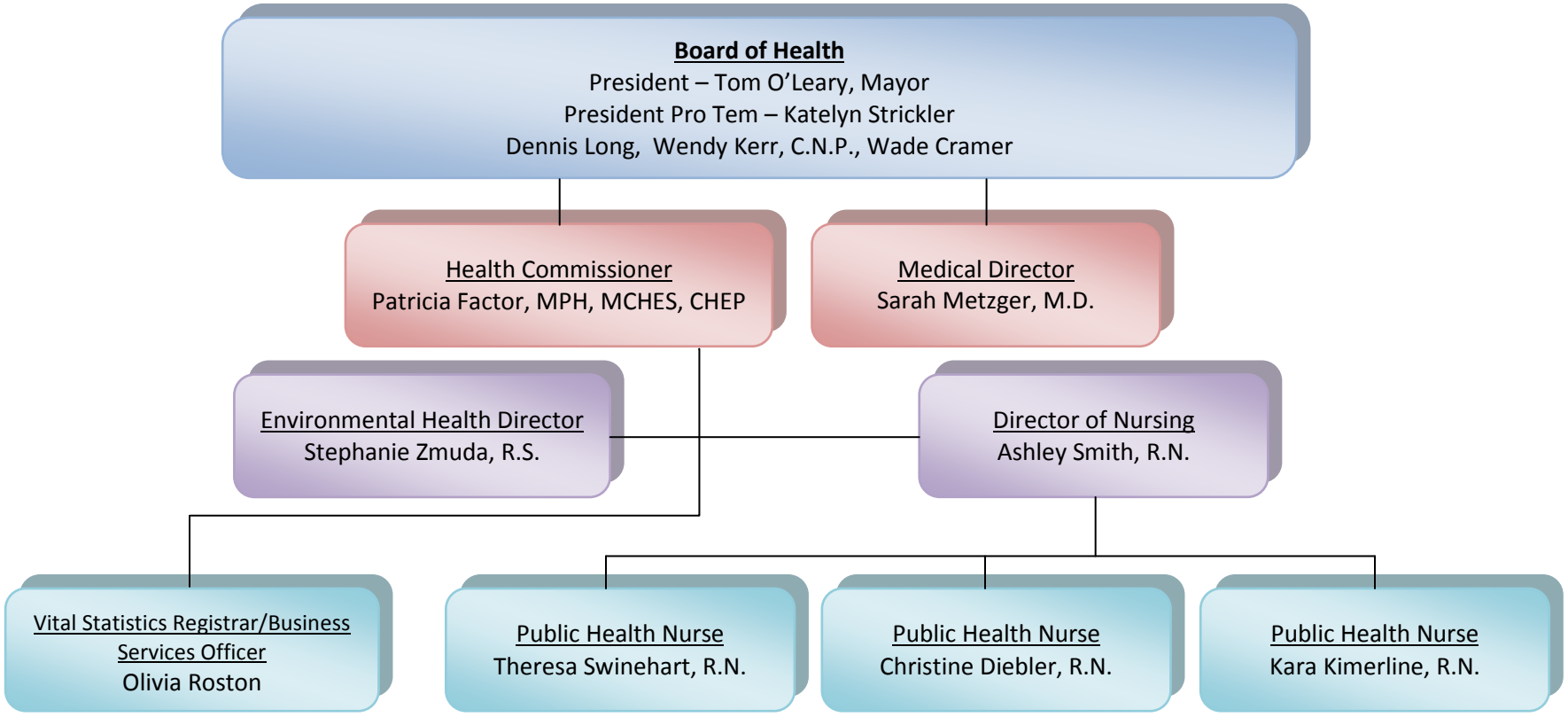
This plan was written by the Quality Improvement Council and GCHD Management Staff, with input from GCHD Staff.

Approval

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

President, Galion City Board of Health	Date
Health Commissioner, Galion City Health Department	Date

Galion City Health Department
Organizational Chart



Rev. 12/15

galion city
HEALTH DEPARTMENT

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QUALITY IMPROVEMENT FORM

Project Title:	
Division/ Program:	**Date:**
Problem/ Opportunity Statement: *(Why the need for the project- what's the problem?)*	
Goal: *(What is the goal of your project?)*	
Objectives: *(What **SMART** objectives do you have to reach your goal? **S**pecific, **M**easurable, **A**ction Oriented, **R**ealistic/ Relevant, **T**imeframe) (At least one)*	
Benchmarks/ Success Metrics: *(How can you measure the success of the improvement effort or project?)*	
Projected Start Date:	**Projected End Date:**
Team Leader:	
Team Members:	

Supervisor Approval: Y / N

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Project Title:

QUALITY IMPROVEMENT STORY BOARD

PLAN *Identify an Opportunity and Plan for Improvement*

1) Getting Started What is the problem that you identified?

2) Assemble the Team Who's on the team?

3) Examine the Current Approach How are things done now?

4) Identify Potential Solutions How do you think you can fix the problem?

5) Develop an Improvement Theory Why do you think this will make things better?

DO *Test the Theory for Improvement*

6) Test the Theory How did you carry out your plan?

STUDY *Use Data to Study Results of the Test*

7) Check the Results What happened?

ACT *Standardize the Improvement and Establish Future Plans*

8) Standardize the Improvement or Develop a New Theory Do we keep the changes?

9) Establish Future Plans What's the next step?

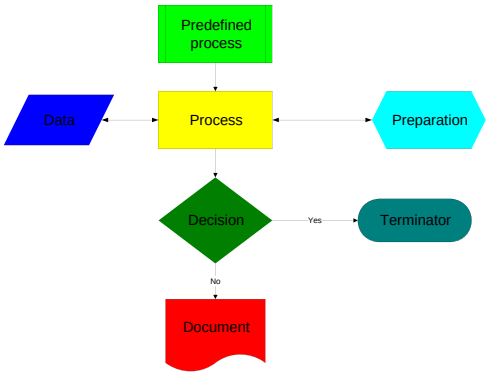
Quality Improvement Tools

Following are some of the tools available to assist in the Quality Improvement process.

1) **Flow Charting:** Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the team understand how the process currently works. The "as-is" flow chart may be compared to how the process is intended to work. At the end of the project, the team may want to then re-plot the modified process to show how the redefined process should occur. The benefits of a flow chart are that it:

   a) Is a pictorial representation that promotes understanding of the process
   b) Is a potential training tool for employees
   c) Clearly shows where problem areas and processes for improvement are

FLOW CHART SYMBOLS



Flow charting allows the team to identify the actual flow-of-event sequence in a process.

2) **Brainstorming:** A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism. Team members generate issues and agree to "defer judgment" on the relative value of each idea. Brainstorming is used when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take. The advantages of brainstorming are that it:

   a) Encourages creativity
   b) Rapidly produces a large number of ideas
   c) Equalizes involvement by all team members
   d) Fosters a sense of ownership in the final decision as all members actively participate
   e) Provides input to other tools: "brain stormed" ideas can be put into an affinity diagram or they can be reduced by multi-voting

3) **Decision-making Tools:** While not all decisions are made by teams, two tools can be helpful when teams need to make decisions.
   a) Multi-voting is a group decision-making technique used to reduce a long list of items to a manageable number by means of a structured series of votes. The result is a short list identifying what is important to the team. Multi-voting is used to reduce a long list of ideas and assign priorities quickly with a high degree of team agreement.
   b) Nominal Group technique-used to identify and rank issues.

4) **Affinity Diagram:** The Affinity Diagram is often used to group ideas generated by brainstorming. It is a tool that gathers large amounts of language data (ideas, issues, opinions) and organizes them into groupings based on their natural relationship. The affinity process is a good way to get people who work on a creative level to address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. This process is useful to:

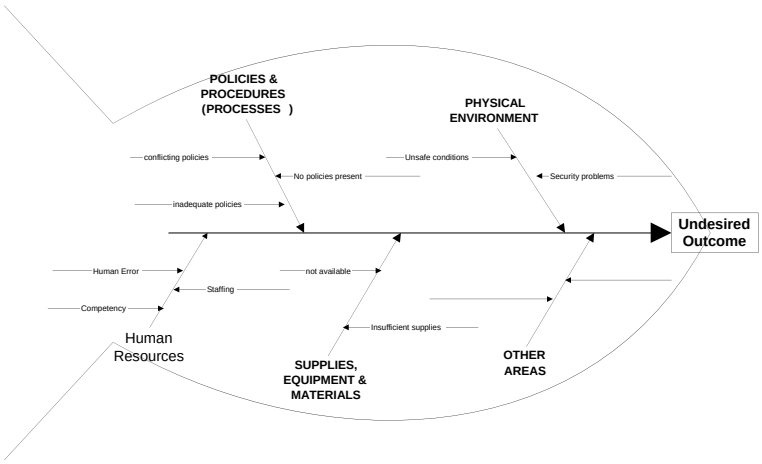
   a) Sift through large volumes of data.
   b) Encourage new patterns of thinking.

   As a rule of thumb, if less than 15 items of information have been identified the affinity process is not needed.

5) **Cause and Effect Diagram (also called a fishbone or Ishakawa diagram):** This is a tool that helps identify, sort, and display. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a problem. The structure of the diagram helps team members think in a very systematic way. The benefits of a cause-andeffect diagram are that it:

   a) Helps the team to determine the root causes of a problem or quality characteristic using a structured approach
   b) Encourages group participation and utilizes group knowledge of the process
   c) Uses an orderly, easy-to-read format to diagram cause-and-effect relationships
   d) Indicates possible causes of variation in a process
   e) Increases knowledge of the process
   f) Identifies areas where data should be collected for additional study.

CAUSE & EFFECT DIAGRAM



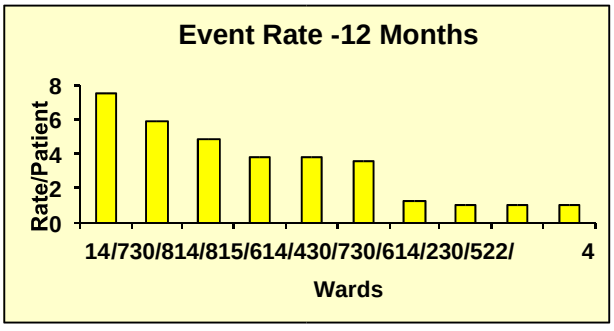
Cause and effect diagrams allow the team to identify and graphically display all possible causes related to a process, procedure or system failure.

6) **Histogram:** This is a vertical bar chart which depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation. The histogram is used in the following situations:

   a) To graphically represent a large data set by adding specification limits one can compare;
   b) To process results and readily determine if a current process was able to produce positive results assist with decision-making.

7) **Pareto Chart:** Named after the Pareto Principle which indicates that 80% of the trouble comes from 20% of the problems. It is a series of bars on a graph, arranged in descending order of frequency. The height of each bar reflects the frequency of an item. Pareto charts are useful throughout the performance improvement process - helping to identify which problems need further study, which causes to address first, and which are the "biggest problems." Benefits and advantages include:

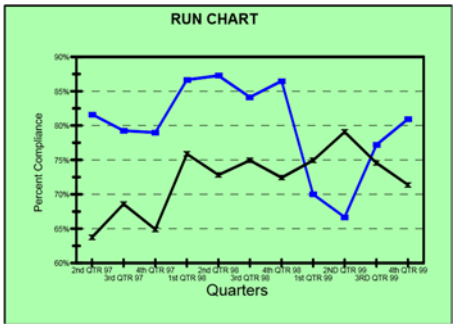
   a) Focus on most important factors and help to build consensus
   b) Allows for allocation of limited resources



The "Pareto Principle" says 20% of the source causes 80% of the problem. Pareto charts allow the team to graphically focus on the areas and issues where the greatest opportunities to improve performance exist.

8) **Run Chart:** Most basic tool to show how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable, consistent and predictable. Simple statistics such as median and range may also be displayed. The run chart is most helpful in:

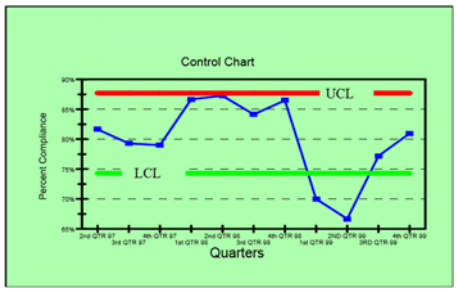
a) Understanding variation in process performance
b) Monitoring process performance over time to detect signals of change
c) Depicting how a process performed over time, including variation



This allows the team to see changes in performance over time. The diagram can include a trend line to identify possible changes in performance.

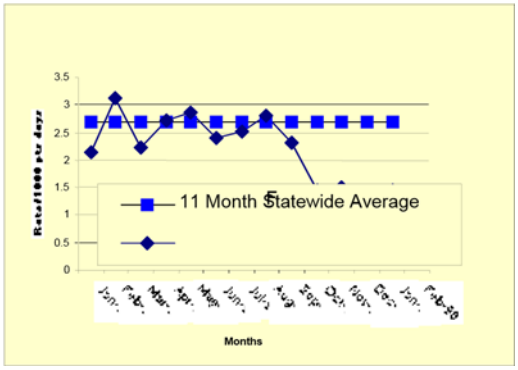
9) **Control Chart:** A control chart is a statistical tool used to distinguish between variation in a process resulting from common causes and variation resulting from special causes. It is noted that there is variation in every process, some the result of causes not normally present in the process (special cause variation). Common cause variation is variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing if data fall within control limits based on plus or minus specific standard deviations from the center line. Control charts are used to:

a) Monitor process variation over time
b) Help to differentiate between special and common cause variation
c) Assess the effectiveness of change on a process
d) Illustrate how a process performed during a specific period



Using upper control limits (UCLs) and lower control limits (LCLs) that are statistically computed, the team can identify statistically significant changes in performance. This information can be used to identify opportunities to improve performance or measure the effectiveness of a change in a process, procedure, or system.

10) **Bench Marking:** A benchmark is a point of reference by which something can be measured, compared, or judged. It can be an industry standard against which a program indicator is monitored and found to be above, below or comparable to the benchmark.



11) **Root Cause Analysis:** A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

Project Demographics					Plan										Do	Study	Act		QI Council Notations						
Project Name	Start Date	End Date	Division	Program	Problem/ Opportunity Statement	Goals	Objectives	Benchmarks/ Success Metrics	Getting Started	Team Leader	Team Members	Examine the Current Approach	Identify Potential Solutions	Develop an Improvement Theory	Test the Theory	Check the Results	Standardize the Improvement or Develop a New Theory	Establish Future Plans	QI Form Received	QI Story Board Received	Project Shared w/ Staff	Project Location Posted	Performance Measure Match	Strategic Plan Match	Project Completion