Quality Improvement Plan

Scott County Health Department

Adopted: May 2017

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Acronyms and Definitions

CQI	Continuous Quality Improvement
NACCHO	National Association of County & City Health Officials
PDCA	Plan-Do-Check-Act Model
PHAB	Public Health Accreditation Board
PHQIX	Public Health Quality Improvement Exchange
QI	Quality Improvement
SAT	Self-Assessment Tool
SCHD	Scott County Health Department

Administrative Team	Scott County Health Department's management team: director, deputy director, administrative office assistant, clinical services coordinator, clinical services specialist, community health coordinator, correctional health coordinator, environmental health coordinator, and public health services coordinator
Continuous Quality Improvement	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 formal process (PDCA, etc.) to "dissect" a problem, discover a root cause, implement a solution, measure successes/failures, and/or sustain gains.
Evidence-Based Practice	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.
Plan-Do-Check-Act	Also known as Plan-Do-Study-Act. 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.
Project Charter	Used to document a team's purpose and clearly define individual roles, responsibilities, and operating rules.
Quality Culture	Quality improvement is fully embedded into the way the agency does business, across all levels, programs, and service areas. Leadership and staff are fully committed to quality, and results of quality improvement are communicated internally and externally. Even if leadership changes, the basics of quality improvement are so ingrained in staff that they seek out the root cause of problems. They do not assume that an intervention will be

	effective, but rather they establish and quantify progress toward measurable objectives.
Quality Improvement Workplan	A plan that identifies specific areas of current operational performance for improvement within the agency. These plans can and should cross-reference one another, so a quality improvement initiative that is in the QI workplan may also be in the strategic plan.
Service Areas	Organizational units of Scott County Health Department: Clinical; Community Relations, Information, and Planning; Correctional; Environmental; Public Safety
Storyboard	Graphic representation of a QI team's quality improvement journey.

I. Purpose & Introduction

A. Purpose

The purpose of the Quality Improvement (QI) Plan is to provide the framework and a guide for the department toward achieving a culture of quality. The QI Plan reflects the mission, vision, guiding principles, goals and strategic priorities of the department and employs evidence-based practices.

The QI Plan focuses on the central theme of advancing a culture of quality through leadership, teamwork and collaboration, employee empowerment, continuous process improvement, customer focus, and QI infrastructure. The plan works in synergy with other department plans to accomplish department goals.

B. Mission, Vision, Guiding Principles, Priorities, and Goals

1. Mission
   "*The Scott County Health Department promotes, protects, and preserves health through leadership, service, education and partnerships*."

2. Vision
   "Scott County - A safe and healthy community."

3. Guiding Principles that drive the culture of Scott County are rooted in **PRIDE**:
   a. **P**rofessionalism
   b. **R**esponsiveness
   c. **I**nvolvement
   d. **D**edication
   e. **E**xcellence

4. Priority areas identified to strategically improve the department are:
   a. Technology
   b. Health Education, Health Promotion, and Marketing
   c. Quality Improvement
   d. Workforce Development
   e. Organizational Culture and Workplace Environment

5. Scott County Health Department has the goal of a fully implemented, department wide culture of quality.

6. Strategic Priorities:
   QI activities at Scott County Health Department (SCHD) are designed to improve care and service needs to support the 2016-2021 community health improvement priorities approved by the Scott County Board of Health in February 2016:
   a. Increase Access to Mental Health Care for Youth, Adults, and Veterans.

b. Promote Healthy Living.
c. Address Obesity in Youth and Adults.
d. Improve Access to Medical Providers for Under-Insured, Uninsured, or with Medical Health Insurance.

7. 10 Essential Public Health Services
QI activities at SCHD are designed to promote the highest quality of service while meeting the needs and expectations of customers. The goal is to continuously improve the execution and design of processes across the 10 Essential Public Health Services (Centers for Disease Control and Prevention, 2010):
a. Monitor health status to identify and solve community health problems.
b. Diagnose and investigate health problems and health hazards in the community.
c. Inform, educate and empower people about health issues.
d. Mobilize community partnerships and action to identify and solve health problems.
e. Develop policies and plans that support individual and community health efforts.
f. Enforce laws and regulations that protect health and ensure safety.
g. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
h. Assure competent public and personal health care workforce.
i. Evaluate effectiveness, accessibility and quality of personal and population-based health services.
j. Research for new insights and innovative solutions to health problems.

II. Description of Quality in Agency

A. Quality Improvement Philosophy

1. Quality Improvement Defined
QI "in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve quality and improve the health of the community" (National Association of County and City Health Officials Roadmap to a Culture of Quality, 2012).

2. Characteristics of a Culture of Quality
Health departments with a culture of quality will embody these characteristics (Gorenflo, 2010):
a. The customer is front and center.
b. Management expects staff to solve problems.
c. Problems themselves are not only freely aired but also embraced as opportunities for improvement.
d. QI is integrated with the strategic plan.

e. Improvement is continuous.

The culture of an organization reflects its core values, guiding principles, behaviors and attitudes. Attaining a culture of quality is not an overnight phenomenon. The National Association of County and City Health Officials (NACCHO) Roadmap defines the culture of quality as a work environment that utilizes data to examine processes to enhance all aspects of operations. A mature culture of quality is exhibited by an agency when QI is fully embedded into the way business and operations are conducted across all levels, departments and programs. Leadership and staff are fully committed to quality and the results of QI efforts are communicated internally and externally. Even if leadership changes, the basics of QI are so ingrained in staff that root causes of problems are always identified and staff feel empowered to be able to work towards solutions (Roadmap to an Organizational Culture of Quality Improvement, 2012).

3. Transforming Culture
   Transforming culture to embrace QI requires strong commitment, deliberate management of change over time, and includes the following foundational elements (Roadmap to an Organizational Culture of Quality Improvement, 2012):
   a. Leadership Commitment: Leadership's primary goal is change management for both the process and human sides of change.
   b. QI Infrastructure: QI efforts are aligned with the strategic direction of the department and linked to organizational performance (Attachment 1).
      1) Performance Management System
      2) Performance Management/Quality Council
      3) QI Plan
   c. Employee Empowerment and Commitment: Employees continuously consider how processes can be improved, innovation is seen as the norm and QI is seen as a frame of mind, rather than an additional task.
   d. Customer Focus: Internal and external customer needs drive improvement efforts in order to meet or exceed expectations and prevent dissatisfaction.
   e. Teamwork and Collaboration: Teams regularly work together to solve problems and share lessons learned. Collaboration across all units of an agency exists to standardize processes and break down silos.
   f. Continuous Process Improvement: Continuous process improvement is a never-ending quest to improve processes by identifying root causes. It abandons the notion of perfection and encourages gradual improvement in everyday processes.

B. Description of Current State of Quality

1. Organization Structure
   SCHD is organized into five program service areas. These service areas include Clinical; Community Relations, Information and Planning; Correctional Health; Environmental Health; and Public Safety. All staff positions within the department fall within the five services areas except for the director, deputy director, and administrative office assistant. These three positions are involved in the work of all five service areas. Staff

from the various service areas, as well as the deputy director, are actively involved in the efforts to advance quality improvement throughout the department. There are no designated QI positions within the department.

2. Quality Improvement Team
   SCHD's 2013-2018 Strategic Plan identified the need to develop a culture of quality. As discussed in the Strategic Plan, QI, as a discipline, has proven to reduce costs; increase staff buy-in and participation; offer employees a greater sense of autonomy; increase morale; and ultimately result in better service outcomes. With these goals in mind, a workgroup with representatives from across all levels of the department was formed to move this strategic priority area forward.

   Initial responsibilities of this workgroup included both QI planning in addition to assessment of the department's ability to meet PHAB standards. Recognizing the scope of work for this group was too large, in 2016 the group divided into an Accreditation Team and a QI Team.

3. Quality Improvement Self-Assessment
   The QI Team selected NACCHO's Roadmap to an Organizational Culture of Quality Improvement (Roadmap) to guide its QI efforts. The NACCHO Organizational Culture of Quality Self-Assessment Tool (SAT) for Local Health Departments was utilized as the tool to measure progress towards achieving a department-wide quality culture.

   In December 2016, the QI Team, plus an additional five staff members to assure representation from all service areas and levels of the department, completed the SAT independently, then convened to review the individual scoring and come to consensus on the final score for each foundational sub-element. The baseline score for the department was 2.2, placing SCHD at Phase 2, Not Involved with QI Activities on the Roadmap.

   Phase 2 is generally characterized as when QI is beginning to be understood in an organization, yet there is still little expectation for its implementation. QI is viewed as a trend, there are few trainings available, and the organization is not customer-focused.

   SCHD is working to attain a culture of quality by focusing on the foundational elements of a QI culture. The NACCHO Self-Assessment will be completed at least annually to measure the department's progress. SCHD will implement suggested NACCHO transition strategies to move to the next stops along the NACCHO Roadmap.

C. Description of Future State of Quality

SCHD's envisions a future state of quality for the department where a true QI Culture exists. This QI culture would equate with Phase 6 of the NACCHO Roadmap and would mean that at SCHD, QI efforts are not influenced by changes in leadership; QI is reflected in how business is conducted across all programs and services areas; our leadership and staff are

fully committed to QI; and results of QI efforts are communicated throughout the department as well as externally. In addition, data not only guides decisions regarding what projects to undertake, but measurable objectives are established and tracked to determine the success and effectiveness of projects. Overall, QI is no longer seen as an additional task; it is second nature and engrained in every day work. In this state of a QI Culture, the QI Council will continue to use the SAT to assure that there is no regression and that a mature culture of quality is maintained.

D. Links to Other Department Plans

1. Strategic Plan
   The Strategic Plan outlines the five-year goals of SCHD and includes the vision, mission, values, goals and strategic priorities for the department. QI is a goal identified in the plan.

2. Health Equity Plan
   The Health Equity Plan is designed to guide SCHD in developing, implementing and improving existing policies, processes and programs to be socially, culturally, and linguistically appropriate for Scott County populations with higher health risks and poorer health outcomes.

3. Workforce Development Plan
   The Workforce Development Plan outlines training vital to quality improvement for new and existing employees in order to build and maintain a culture of quality.

4. Health Improvement Plan
   Portions of the Health Improvement Plan are embedded in all of these plans so that community needs are addressed.

5. Performance Management Plan
   The utilization of operational performance measures is incorporated into the QI plan in order to measure how SCHD is functioning and progressing along the Roadmap. Performance measures will be monitored in order to identify potential QI projects.

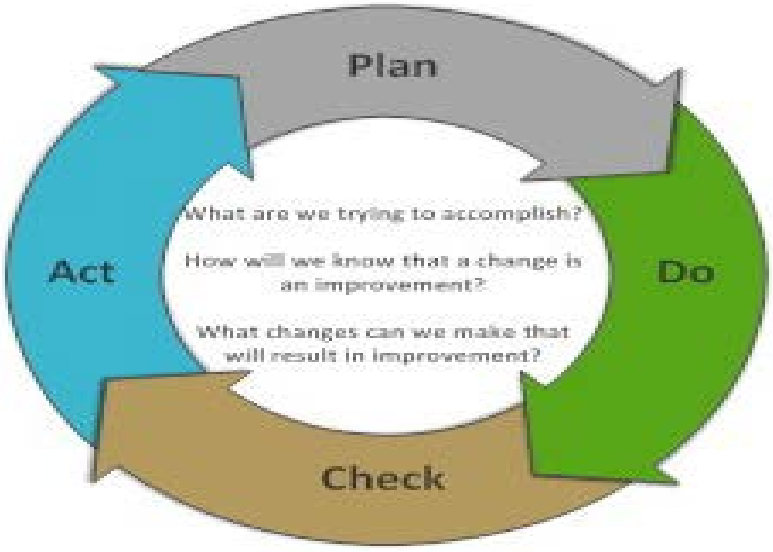
E. QI Process

An organization with a QI culture supports continuous improvements at all levels. The foundation of quality improvement is that it is continuous, not a one-time pursuit. As such, SCHD had adopted the Plan-Do-Check-Act model (PDCA, also known as Plan, Do, Study, Act) as its QI process. The PDCA model can be used in every process and program, providing a systematic way of accomplishing change. PDCA is based on three key questions and four guiding principles (Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook).

1. Key Questions
   a. What are we trying to accomplish?
   b. How will we know that a change is an improvement?

c. What changes can we make that will result in improvement?

2. Guiding Principles
   a. Develop a strong customer focus.
   b. Continually improve all processes.
   c. Involve employees.
   d. Mobilize both data and team knowledge to improve decision-making.



III. Quality Improvement Structure

A. Leadership Roles and Responsibilities

Leadership commitment is vital for the success and sustainability of a QI culture. Leadership roles and responsibilities within the department are defined to assure that there is a structure to support continuous quality improvement throughout the department.

Role	Responsibility
Board of Health	• Provide leadership, support and resources for QI initiatives • Approve the annual QI Workplan (Attachment 2) • Recognize improvements made as a result of QI
Administrative Team	• Identify appropriate staff for QI Project Teams and QI Council • Oversee QI efforts within service area • Assure QI-related performance and/or professional development goals for all service area staff • Encourage staff to incorporate QI efforts into daily work • Facilitate QI Project Teams as needed
QI Council	• Develop, implement and evaluate QI Plan and QI Workplan (Attachment 2) • Reassessment of QI culture annually

	• Monitor movement along QI Roadmap • Guide QI communication and training efforts • Support work of QI Project Teams • Assure use of and compliance with evidence-based practices • Serve as QI mentors • Help scope projects and determine the best approach for achieving desired project goals • Champion QI efforts throughout agency

B. Staff Roles and Responsibilities

A culture of quality cannot be achieved without QI being infused into the way that all staff, leadership to frontline, manage their daily business.

Role	Responsibility
QI Project Teams	• Implement PDCA model • Submit and present reports to the QI Council • Collect and report data for QI projects and performance management system
All Staff	• Identify areas for improvement • Suggest improvement projects • Participate in QI projects • Support the work of QI Project Teams by supplying relevant data upon request • Develop an understanding of basic QI principles and tools by participating in QI training • Incorporate QI concepts into daily work • Actively participate in QI Council when appointed

C. Quality Improvement Council Operations

Membership composition (Attachment 3)	• Consists of six rotating members; deputy director standing member • Selected by solicitation of volunteers, nomination by staff or QI Council, or appointment by coordinator • Representative of all levels of staff • Representative of at least three service areas
Membership rotation	• Serve two year staggered terms based on fiscal year • Successive terms will not be limited, but staff may be rotated as other duties dictate
Council leadership	Deputy director
Meeting frequency	Monthly
Meeting support (agenda and	• Deputy director has the responsibility for developing and distributing QI Council agendas prior to the monthly meeting

minutes)	• Meeting minutes will be recorded by members of the QI Council on a rotating basis
Guiding principles	• All work is grounded in continuous quality improvement (CQI) methodology, including the use of CQI tools to increase understanding and facilitate the improvement of outcomes (Attachment 4) • Decisions are data-driven and evidence-based in addition to using and respecting people's knowledge and experience • The customer perspective is central to decision-making, striving to consistently meet or exceed customer expectations • Processes are transparent, collaborative and inclusive • Engagement and accountability are fostered in those involved in CQI • The focus is on learning and improvement over judgment and blame, and values prevention over correction
Decision making process	• Strives for consensus on all decisions and agrees to abide by vote in absence of consensus. • Distribution of meeting agendas, summaries, and arrangements for meeting needs is supported by council members. • QI Project Teams are accountable to the QI Council. • The Project Feasibility Decision Tree assists in deciding if a project is warranted and provides a graphic of the types of processes that can be utilized to complete the project (Attachment 5)
Tools and Resources (accessible by all staff)	• SmartDraw Computer software • Public Health Quality Improvement Encyclopedia • The Public Health Memory Jogger™ II • SCHD QI Toolbox • Public Health Quality Improvement Exchange

IV. Quality Improvement Projects

A. Introduction

The QI Council will solicit ideas for quality improvement project ideas, prioritize projects according to the quality improvement goals, and assist with implementation. Staff and administration is encouraged to work together in creating new quality improvement projects.

B. Project Idea Collection

The QI Council will solicit project ideas through an electronic SurveyMonkey survey (Attachment 6) to staff during the fourth quarter (April-June) of each fiscal year. In addition, project ideas may be identified by reviewing data reported in the department's performance management system, after-action reports, customer satisfaction surveys, grant and program audits and staff surveys. In nominating a project, staff will be asked to include information regarding the area or process for improvement. The QI Council may

request that staff meet with the council to answer questions and provide additional information during the project review process.

The QI Council will emphasize that projects submitted should truly meet the outcomes and intent of formal quality improvement, rather than program evaluation. While their outcomes are complementary, they are different processes. The following table from the *Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook* (2012) highlights the key differences.

Key Differences Between Evaluation and Quality Improvement		
	Evaluation	***Quality Improvement***
Purpose	Determines whether your program is doing what you intended for it to do	Determines whether adjustments you are making to your program are improving the program
Philosophy	Determines whether the effect of the program on participants is worth the resources needed to implement the program	Uses staff expertise to improve the processes by which the program is implemented
Timeframe	Starting at program outset, continuing through the life of the program	At specific points in time when an improvement opportunity is needed
Responsible Party	Outside, objective observer	Program stakeholders
Outcome	Identify gaps between program activities and goals	Address identified gaps

C. Project Selection

The QI Council will review each project nominated, using the department's Project Feasibility Decision Tree (Attachment 5). The decision tree is designed to help select projects that align with SCHD's mission or strategic plan; are customer-focused; are manageable in scope based on department resources and capacity; are data driven; and are timely both completion and relevance to operations.

The QI Council will prioritize the projects that meet the initial criteria for selection using the prioritization matrix (Attachment 7). The QI Council will use the results to select four to eight projects for the QI Workplan. The QI Council will consider the scope of the selected projects and other departmental factors when determining the final number of projects.

The QI Council will present the proposed projects, including the results of the QI decision tree and prioritization matrix, to the Administrative Team. The Administrative team will review and approve the final QI Workplan.

After approval of the plan by the Administrative team, the QI Council will provide feedback to all submitters regarding the status of their project. The approved QI Workplan will be presented to the Board of Health and at an All Staff meeting.

D. Project Initiation/Implementation

Two members of the QI Council, submitter(s), and appropriate coordinator(s) will meet to complete the QI Team Charter (Attachment 8). The QI Council members will serve as the facilitators for the QI process. Facilitators will not be active participants in the discussion and therefore should not be directly involved in the program or process. The facilitators will: Complete the QI project planning guide to outline the steps in the QI project (Attachment 9).

E. Project Finalization

At the completion of each QI project, each QI Project Team will create a storyboard to celebrate lessons learned (Attachment 10) as well as the summary report (Attachment 11). After the QI Council reviews the final documents, a QI Council member will submit the QI project to PHQIX.

V. Monitoring and Evaluation

A. Introduction

This section describes the monitoring and evaluation for the QI Plan and associated goals.

B. Quality Improvement Council

In July of each year, the QI Council will conduct an evaluation of the QI workplan and activities. This will be conducted through a survey of QI Council members, and a subsequent facilitated discussion. Evaluation will address:

- Progress toward and/achievement of goals and objectives as outlined in the QI Workplan
- Effectiveness of QI Council meetings and meeting schedule
- Effectiveness of QI Project Team meetings
- Effectiveness of the QI Workplan and QI Council in overseeing quality projects and integration with the agency
- Clarity of the QI Plan and Workplan and its associated documents
- Satisfaction surveys
- Lessons learned
- Review of QI Project Team evaluations

A report of this evaluation and subsequent actions will be used to update the QI Plan and associated documents and develop subsequent annual QI Workplans.

C. Quality Improvement Project Teams

QI Project Teams will provide project progress reports to the QI Council once per quarter. All teams will develop and submit project storyboards at the conclusion of the project. Within one month of the a project's completion, all team members will be surveyed to determine QI process learning, perceived contribution to the project, value of the project

experience and ultimate outcome, lessons learned, and to seek suggestions for overall agency QI efforts.

VI. Communication

A. Introduction

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, Scott County Board of Health, and the general public. This section describes how quality and quality initiatives are shared.

B. All Staff

1. **All Staff Meeting Agenda** will include quarterly updates from the QI Council regarding activities/projects underway or upcoming. QI Project Teams will present their storyboard when projects are completed.
2. **Visual Board** will be posted on a centralized wall to provide all staff with valuable information regarding current improvement activities. The QI Council will determine the frequency, duration, and type of information posted on the visual board.
3. **QI Council Meeting Documents** (agendas and minutes) will be maintained in the Quality Improvement folder in 1111 (shared file) for review by all staff.
4. **QI Project Team Documents** (applications, project planning guide, storyboards, and summary documents) will be maintained in the Quality Improvement folder in 1111 (shared file) for review by all staff.

C. Board of Health

1. Board of Health members will receive at least two updates on quality initiatives annually, one of which will be approval of the annual workplan.

D. Public

1. Project descriptions and results will be included in the department's annual report to the public which is posted on the Health Department's website.
2. When appropriate, results of quality improvement initiatives will be communicated to the public through press releases, departmental newsletter, department website feature, or social media post.

E. Public Health Community of Practice

The QI Council will review QI projects to determine their applicability in other public health departments. For those projects that would be relevant to other health departments, the project will be submitted to the Public Health Quality Improvement Exchange (PHQIX). SCHD has benefitted from the knowledge, experiences, and resources of others and has the desire to contribute to the larger public health community of practice.

VII. Training

Scott County Health Department has incorporated QI training goals and objectives within our Workforce Development Plan. The Workforce Development Plan includes training topics and descriptions, competencies, target audience (who will receive training) and resources/sources of training.

VIII.Sustainability

A. Leadership Commitment

Scott County Health Department Leadership (Administrative Team and Board of Health) is committed to developing a Quality Culture and advancing the department along the Roadmap to a Culture of Quality.

B. Staff Resources

Administrative team members will assure that all staff members have time dedicated to participation on QI Project Teams and to complete QI continuing education. QI goals will be incorporated into annual development plans for staff to ensure a continued focus and commitment to quality throughout the department.

C. Budget and Financial Resources

Needs of the QI Council and QI Project Teams will be identified during the annual evaluation of the QI Workplan. Identified needs will be discussed during annual budget preparation in order to assure financial resources are maintained to support training, software, supply, and resource materials related to quality improvement.

IX. References and Resources

Center for Disease Control and Prevention. (2010, December 9). *National Public Health Performance Standards Program (NHPSP).* Retrieved from http://www.cdc.gov/nphpsp/essentialservices.html

Gorenflo, G. a. (2010, April). *The ABCs of PDCA.* Retrieved from Public Health Foundation: http://www.phf.org/resourcestools/Documents/ABCs_of_PDCA.pdf

Oye, D., Dietsch, L., et. al. (2016, November). *2017 Columbus Public Health Quality Improvement Plan.*

Public Health Accreditation Board. (2013). *PHAB Standards and Measures Version 1.5.*

Quality Improvement Plan Toolkit, May 2014. Association of State and Territorial Health Officers

Roadmap to an Organizational Culture of Quality Improvement, Fall 2012. National Association of County and City Health Officials.

Scamarcia-Tews, D., Heany, J., Jones, J., VanDerMoere, R., & Madamala, K. (2012, January). *Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook.*

The Ohio State University, College of Public Health, Center for Public Health Practice. (2015, May). *User & Resource Guide Quality Improvement Plan Template.*

Scott County Health Department
Culture of Quality Diagram

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- SCHD Mission, Vision & Values
- Continuous Process Improvement
- QI Plan and QI Workplan
- QI Council
- Customer Satisfaction Surveys
- Performance Management System

April 2017

Quality Improvement Workplan (May 2017-June 2018)

Goal: Establish a culture of quality within the Scott County Health Department

Objective 1: By June 30, 2018, a reassessment of SCHD's phase of the Roadmap to a Culture of Quality Improvement will increase from a quality improvement infrastructure foundational element score of three to four.

Objective 2: By June 30, 2018, a reassessment of SCHD's phase of the Roadmap to a Culture of Quality Improvement will increase from an employee empowerment foundational element score of two to three.

Objective 3: By June 30, 2018, a reassessment of SCHD's phase of the Roadmap to a Culture of Quality Improvement will increase from a leadership foundational element score of two to three.

Strategic Priority: Quality Improvement

Foundational Element: Quality Improvement Infrastructure

Action Steps	Foundational Sub-Element	Timeline	Responsible Party	Narrative description of progress
Complete reassessment of SCHD's phase of the Roadmap to a Culture of Quality Improvement using NACCHO's Organizational Culture of Quality Self-Assessment Tool		June 2018	QI Council	
QI Resource Toolbox is finalized giving all staff access to resources and tools to support QI work (forms, links to training, templates, instruction guides, etc).	5.4	December 2017	QI Council	

QI Plan and Workplan is presented to Scott County Board of Health	5.3	May 2017	QI Council	
QI Plan and Workplan is presented to SCHD staff.	5.3	May 2017	QI Council	
Implement QI Plan (QI Council, QI Projects, Communication)	5.3	June 2017	QI Council	
Develop QI measures to be added to performance management system.	5.2	September 2017	QI Council	
Review department's performance management system and identify measures appropriate for QI tracking and analysis.	5.2	March 2018	QI Council	

Strategic Priority: Organizational Culture and Work Environment				
Foundational Element: Employee Empowerment and Commitment				
Action Steps	**Foundational Sub-Element**	**Timeline**	**Responsible Party**	**Narrative description of progress**
Solicit QI project ideas from all staff.	1.1	June 2017	QI Council	
Solicit QI project ideas from all staff.	1.1	June 2018	QI Council	
Incorporate quality improvement training as part of the new employee orientation procedure: roles of staff, PDCA method, SCHD key QI principles and tools.	1.2	February 2018	SCHD Administrative Team and Organizational Culture and Workplace Environment Team	
Provide quarterly training to all staff on SCHD key QI principles and tools.	1.2	June 2017 September 2017 December 2017 March 2018 June 2018	QI Council	

Strategic Priority: Workforce Development				
Foundational Element: Leadership				
Action Steps	**Foundational Sub-Element**	**Timeline**	**Responsible Party**	**Narrative description of progress**
Selected individuals receive additional training regarding QI leadership and change management.	3.1 and 3.2	August 2017	QI Council	
Include quality improvement goal in employee annual performance plans.	3.1	January 2018	Administrative Team	

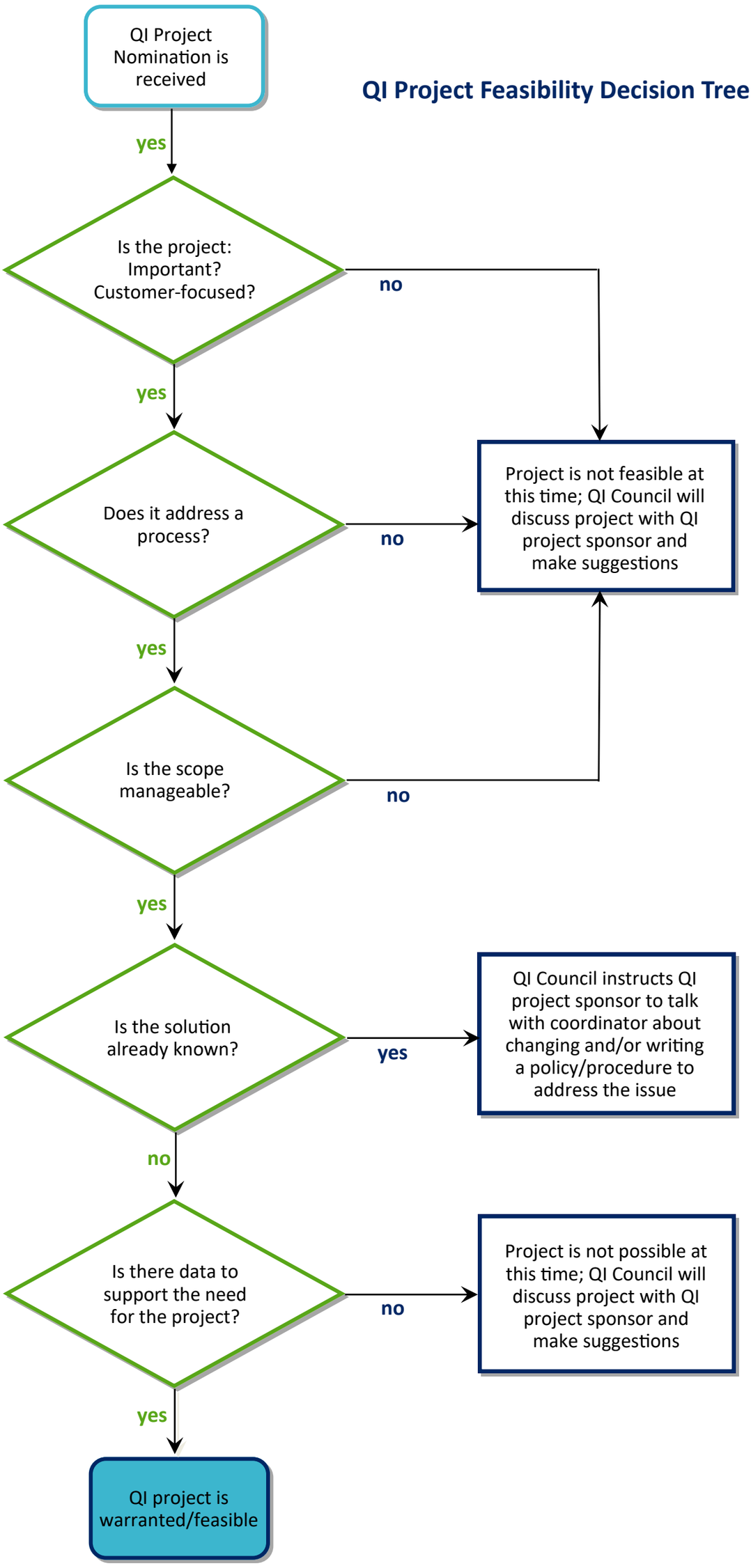
Scott County Health Department
Quality Improvement
Council Members
May 2017-June 2018

Member Name	Position	Service Area	Term Expiration
Brooke Barnes	Community Health Consultant	CRIPS	June 2018
Eric Bradley	Environmental Health Coordinator	Environmental	June 2018
Tara Marriott	Environmental Health Specialist	Environmental	June 2019
Christina McDonough	Community Transformation Consultant	CRIPS	June 2018
Lashon Moore	Clinical Services Specialist	Clinical	June 2019
Amy Thoreson	Deputy Director		Standing Member
Tiffany Tjepkes	Community Health Coordinator	CRIPS	June 2019

Scott County Health Department
Foundational Quality Improvement Tools

Tool	Description	Public Health Memory Jogger II Reference (2007)	Public Health Quality Improvement Encyclopedia Reference (2012)
Affinity Diagram	A tool used to group a large number of ideas, issues, items, and observations into natural groupings for further analysis.	Pages 12-18	Pages 1-2
AIM Statement	A tool used to restrict the problem statement to a discrete issue on which the improvement team will focus.	NA	Pages 3-4
Brainstorming	A technique to generate a large number of ideas in a short period without criticism and judgment.	Pages 19-22	Pages 9-10
Cause and Effect Diagram/Fishbone Diagram	A tool that graphically displays multiple possible causes for a problem with increasing detail in an effort to discover root causes.	Pages 23-30	Pages 11-12
Five Whys	A tool to help explore the cause and effect relationships underlying in a problem by repeatedly asking “why” until the ultimate cause is discovered.	NA	Pages 35-36
Flowcharting	A tool to allow for the identification of the actual flow of steps in a process.	Pages 56-62	Pages 37-38
Force Field Analysis	A tool to identify the forces that support or work against reaching the solution goals/solutions of an issue or problem to build up the positive forces and minimize the negative forces.	Pages 63-65	Pages 41-42
Process Decision Program Chart	A tool used to identify what could go wrong during an improvement plan to develop contingency plans.	Pages 144-145	Pages 97-98

QI Project Feasibility Decision Tree



QI Project Nomination Form

1. Please describe the underlying issue or the process you would like to improve:

2. Do you have information/evidence/data available to support the need to work on this topic?

- ◯ Yes
- ◯ No

If yes, please explain how the data shows a need for improvement:

3. How was this process issue/problem identified?

- ☐ Performance management system
- ☐ Program audit
- ☐ Grant audit
- ☐ Process improvement
- ☐ Other (please specify)

4. What kind of improvement will result? (Check all that apply)

- [ ] Increased efficiency
- [ ] Improved safety
- [ ] Improved quality of service
- [ ] Improved use of resources
- [ ] Improved teamwork and communications
- [ ] Improved working conditions and employee morale
- [ ] Enhanced employee performance
- [ ] Reduced waste
- [ ] Satisfied customers and/or stakeholders
- [ ] Reduced cost
- [ ] Other (please specify)

5. Describe what change you expect to see in the program/process? (Example: fewer errors in data entry; reduced wait time)

6. Who will benefit? (Check all that apply)

- [ ] Program
- [ ] Service Area
- [ ] Department (SCHD)
- [ ] External stakeholders
- [ ] Public
- [ ] Other (please specify)

7. Optional: Do you have a project plan in mind?

- ◯ Yes
- ◯ No

If yes, please describe. Please consider project scope, measures of success, resources (time and money), limitations and barriers, timeline, etc.

8. Have you previously discussed this with your coordinator?

9. Name:

10. Title:

11. Date:

Today's Date: MM / DD / YYYY

Scott County Health Department Project Selection Matrix

Project Title	Strategic connection to SCHD mission/strategic plan	Customer-focused	Data demonstrate that a gap exists	Small scale-it will show results in 2-3 months	"Low hanging fruit"-it will produce a quick win and gain buy-in	Wow! factor-desperately needs improvement	Strong support from staff	Strong support from coordinators/administration	Is within SCHD's scope to change	Total Score
Assign value to each criteria based on a 1-5 scale (1=poor and 5=excellent)										
										0
										0
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Modified from Center for Public Health Quality Project Selection Matrix

QI Project Charter

Enter Project Title

Date: Click here to enter a date.

Opportunity Statement: Describe what it looks like when the QI project is implemented.

Background/Problem: Strategic importance, what has been happening, importance to customer.

How was this process issue/problem identified?

- ☐ Performance management system
- ☐ Program audit
- ☐ Grant audit
- ☐ Process improvement
- ☐ After Action Report (AAR)
- ☐ Other: Please specify:

Project Scope Includes:

Project Scope Excludes:

Estimated date for completion:

Meeting frequency and duration:

Project Time Table:

Project Phase	Start Date	End Date
Initiation: Project charter developed and approved		
Planning: Specific tasks and processes to achieve goals defined		
Implementation: Project carried out		
Monitoring: Project progress observed and results documented		
Closing: Project brought to close and summary report written		

Team Members:

Name and Title	Area of Expertise

Facilitator(s): Name, Title

Note taker: Name, Title

Customers:

Primary and other	Customer Needs Addressed

Resources Required for the Project:

Project Planning and Completion Barriers:

What could get in the way of success?	What can be done about this?

QI Project Planning Guide

A Guide for QI Facilitators

As a member of the QI Council, you will be asked to facilitate quality improvement projects within the Department. Your job as a facilitator is to make the process easier for the participants. The main task will be to help the team increase its effectiveness by improving the process. Creating an environment where groups can be productive and effective in achieving their goals is the primary role of the facilitator. This guide was developed to assist with that process.

Facilitator Responsibilities:

- Schedule and lead QI project team meetings and discussions
- Guide QI project team through the Plan, Do, Check, Act cycle
- Intervene if discussion starts to fragment
- Prevent dominance and include everyone
- Summarize discussions and conversations
- Bring closure to the meeting with an end result or action

For each QI project, the facilitator will helping address three basic 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 an improvement?

1. Select a Project	Tools
☐ Identify QI Project Team	
☐ Complete the QI project charter	QI Charter
☐ Conduct stakeholder analysis (what is going on?)	

2. Schedule Meeting(s)	Tools
☐ Schedule meeting(s)	
☐ Prepare agenda for the first meeting	

3. Set a Goal	Tools
☐ QI Refresher o Team rules, expectations o Change management	
☐ Write an initial AIM Statement/SMART goal (Specific, Measurable, Attainable, Relevant, and Time Bound) o **What** are we trying to accomplish? o **Why** is it important? o **Who** is the specific project's target population? o **When** will this be accomplished?	
☐ Examine the current process	Flow Chart
☐ Determine root causes of problem	Cause & Effect/Fishbone; Affinity Diagram; Root Cause Analysis Rating Form

4. Identify Measures	Tools
Answers the question: how will we know our changes are an improvement?	
☐ Establish measures that will tell team if there is an improvement o Ex: Overall wait time for an STI examination; time to receive final septic tank permits; overall time to process a food permit	
☐ Determine data needs	
☐ Identify a baseline (what is our current situation?)	
☐ Refine SMART goal, if needed	

5. Develop Ideas for Improvement	Tools
☐ Research best practices, solutions that have worked for others	
☐ Brainstorm ideas	Affinity Diagram
☐ Prioritize ideas	Prioritization Matrix
Other suggested tools:	
What could go wrong with suggested improvements?	Process Decision Program Chart (PDPC)
Identify factors possibly standing in the way of implementing change	Force Field Diagram

6. Action Plan & Timeline	Tools
☐ Develop a timeline for implementation of improvement(s) into the work process	
☐ Establish responsibilities/roles of each team member	GANTT Chart
☐ Establish way to track progress on activities being implemented	

7. Test Ideas/Improvements	Tools
☐ Test the improvements on a small scale (pilot project) o Identify the period of time for piloting the change o Identify the tools for collecting the data to measure the improvement	
☐ Document problems, unexpected observations, lessons learned, and knowledge gained	

8. Check	Tools
☐ Meet with the QI Project sponsor/team o Evaluate the degree of improvement of the pilot project o Assess the measureable data based on the AIM statement of the project o Recommend the project to be adopted, adapted, or abandoned	
☐ Share results with stakeholders	Summary Report; Storyboard

9. Opportunities	*Tools*
☐ Discuss lessons learned and next steps	Summary Report; Storyboard
☐ Determine plan to sustain the improvement/maintain the gains	

QI forms and tool examples are available in the QI Toolbox ..\QI Toolbox.

Title of QI Project

Scott County Health Department ♦ Davenport, Iowa ♦ Month, Year

PLAN

Identify an opportunity and plan for improvement

1. Problem/Situation

Describe the scope of the issue that the QI initiative addressed.

2. Aim Statement

Insert the AIM statement here.

3. QI Tools

- List the QI methods and tools used during QI process.

4. Methods of Evaluation

- Insert process and outcome measures here; include data sources used to capture the measures.

5. Measurable QI Outcomes

- List all measures that will be used to show the outcome of the initiative.

DO

Test the theory for improvement

6. Analysis

Describe what actually happened when you implemented the project.

CHECK

Use data to study results of the test

7. Results/Outcomes

What worked and what didn't, changes that were made along the way, things that might be done differently next time. Indicate whether or not the AIM and measures were achieved. Describe results.

ACT

Standardize the improvement and establish future plans

7. Future plans

Describe if the project will be adopted, adapted, or abandoned?

8. Lessons Learned

Describe 2-3 key lessons learned through this QI process.

QI Project Summary Report

Title of QI Project

Date Summary Report was completed: Click here to enter a date.

Summary of QI Project: Brief description of the project undertaken.

Information on the Area for Improvement: Describe the scope of the public health issue in your jurisdiction, or introduce the problem that the QI Initiative addressed.

Use data (include references) to frame the issue, including health burden and/or economic costs, and specify the affected population(s)

Need for the QI Project: How was the need for the QI Initiative determined?

Describe the process of how the improvement was chosen.

Aim Statement/Improvement Goal: Please provide your preliminary aim statement that articulates the goal of the initiative in terms of the measureable improvement sought.

Project Dates: Provide the timeline for the QI Initiative, including the initiation, planning, implementation, and monitoring.

Final Project Timeframe from Start to Completion:

- ☐ Less than 6 months
- ☐ Between 6-12 months
- ☐ Between 12-18 months
- ☐ Between 18-24 months
- ☐ Greater than 24 months

QI Tools: Select one or more of the following QI tools that were used for this project:

- ☐ Affinity Diagram

- ☐ AIM Statement
- ☐ Brainstorming
- ☐ Cause and Effect/Fishbone Diagram
- ☐ Five Whys
- ☐ Flowcharting
- ☐ Force Field Analysis
- ☐ Process Decision Program Chart
- ☐ Other (please explain):

Root Cause: List the root cause identified in planning the QI Project.

Implementation of QI Project: Describe how the specific QI methods and tools were used. Describe the initiative; why it was chosen; and what was to be done initially, and by whom. Describe how the initiative was implemented and how it addressed the problem. Describe who is impacted by this initiative. These people could be clients, employees, or community members.

Methods of Evaluation: Describe both the outcome and process measures used to evaluate the impact of the QI Initiative. Provide information about the data sources used for capturing each measure (e.g., billing data, direct observation, 13 EHR, survey). Provide information about the type of evaluation design used (e.g., pretest posttest, pretest posttest with comparison group, interrupted time series).

Measurable QI Outcomes: Include all measures available to illustrate the outcomes or results of the Initiative. Include any specific numbers that illustrate the scope of the impact.

Other QI Outcomes: Identify any non-measurable, short-term, or intermediate outcomes as a result of the QI Initiative that demonstrate how the improvement addressed the problem (e.g., change in policy, change in local-level practices, establishment of additional funding).

Standardize the Initiative and Establish Future Plans: Describe plans to standardize the Initiative and future plans established to ensure continued improvement. Describe plans to replicate the Initiative in other units, service lines, or organizations. Describe plans to maintain

the gains, provide any insights on the likelihood that observed gains may weaken over time, and include plans for monitoring and maintaining improvement.

Size of QI Initiative Team

Total number of staff on QI team:
Total number of full-time equivalents (FTEs) on QI team:

Characteristics of QI Initiative Team: Please provide information on the main health department staff who were involved with this QI Initiative. Please provide their role in the Initiative (e.g., Lead, Project Manager), their role in the organization (e.g., job title), and FTE (your best estimate of the staff member's time commitment to the Initiative, ranging from 0 to 1, with .2 = 20% time by a full-time employee).

Role in Initiative	Role in Organization	FTE

Lessons Learned, Observations, and Insights: Describe other factors relevant to the conduct and interpretation of the QI findings. Examples of this information might include the following:

- Any insights regarding the findings of your QI Initiative, including a summary of key successes and difficulties in implementing the improvement
- Efforts to minimize and adjust for study limitations
- Reasons for differences between observed and expected outcomes
- Ethical aspects of implementing and studying the improvement and how ethical concerns were addressed
- Any caution that should be applied when learning about the Initiative (limitations, confounding)
- How the Initiative addressed health equity or disparity