2018 TUSCARAWAS COUNTY HEALTH DEPARTMENT QUALITY IMPROVEMENT AND PERFORMANCE MANAGEMENT

Board of Health Approved Revision on: April 11, 2018

PLAN

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**Revision Page**

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**Purpose of a Quality Improvement and Performance Management Plan**

The purpose of the Tuscarawas County Health Department (TCHD) Quality Improvement and Performance Management (QI/PM Plan) is to a provide context and framework for Quality Improvement (QI) and Performance Management (PM) activities at the Tuscarawas County Health Department.

**Public Health Accreditation Standard 9.1:** Use performance management system to monitor achievement of organization objectives

Performance management identifies actual results against planned or intended results. Performance management systems ensure that progress is being made towards department goals by systematically collecting and analyzing data to track results to identify opportunities and targets for improvement (Public Health Accreditation Board, 2013).



*Developed in 2013, adapted from the 2003 Turning Point Performance Management System Framework*

**Policy Statement for Performance Measures:** TCHD will implement and maintain a performance management system. This system will function in conjunction with the agency’s Community Health Improvement Plan (CHIP) and Strategic Plan. The performance management system will be reviewed and updated on an annual basis.

**Public Health Accreditation Standard 9.2:** Develop and implement quality improvement processes integrated into organizational practice, programs, processes and interventions

Quality improvement is an element of performance management that uses processes or address specific targets for effectiveness and efficiency (Public Health Accreditation Board, 2013).

**Policy Statement for Quality Improvement:** TCHD will implement a quality improvement system including a plan, interventions and processes as part of the department’s performance management system.

## Key Terms

**Continuous Quality Improvement (CQI):** An ongoing effort to increase an agency’s approach to manage performance, motivate improvement and capture lessons learned in areas that may or may not be used for accreditation. This effort will utilize the Plan-Do- Check-Act (PDCA) cycle.

**Performance Management:** The process of actively using performance data to improve the public’s health.

**Plan-Do-Check-Act (PDCA):** Four stage problem solving model for improving process or carrying out change. A fundamental principle of PDCA is iteration.



**Quality Improvement (QI**): The use of a deliberate and defined improvement process which is focused on activities that are responsive to community needs and improvement of health. It is a continuous and ongoing process to achieve measurable improvements in efficacy, effectiveness, performance, accountability, and outcomes.

**Quality Improvement and Performance Management Plan (QI/ PM Plan):** A plan that identifies specific areas of current operational performance for improvement within the department. This plan is crossed referenced in other plans such as the Strategic Plan.

**Quality Improvement Tools (QI Tools):** Tools designed to assist the team when solving a defined problem.

## TCHD Mission, Vision and Values

Mission

The Tuscarawas County Health Department promotes healthy, safe choices, prevents disease, and protects the environment for everyone.

Vision

Serving our community for a healthier tomorrow.

Values

*These are the guiding principles of the Tuscarawas County Health Department.*

Ethics: Honesty and integrity that create an inclusive environment

Professionalism: Demonstrate knowledge and skill while providing respectful, courteous, treatment to all

Attitude: Supportive and compassionate to all

Leadership: Accountability for your actions by courageously inspiring others to succeed Communication: Sharing ideas and information to promote understanding

The mission, vision and values were determined through the planning process for the Department’s Strategic Plan. Aligning performance objectives and goals with the QI activities in this plan will enable the Department to meet its mission.

## Ten Essential Services of Public Health

The Tuscarawas County Health Department strives to continually assure that the Ten Essential Services of Public Health are provided with quality in our community:

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 a 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 innovated solutions to health problems.

## Quality Overview

The Quality Improvement Committee (QI) underwent structural and leadership changes in September 2014. Prior to this, efforts for quality improvement had been conducted in an isolated manner within divisions and programs within the Health Department. Activities included clinic chart audits, collection of customer satisfaction survey data, and direct observation of staff for annual employee evaluations. The role of the new QI committee sought to align themselves with the requirements for PHAB accreditation. Additionally, creation, implementation and evaluation of this plan is one of their primary responsibilities. The QI/PM plan is meant to be an ongoing plan however, annual reviews and updates will be completed but a complete rewrite of the document will not always be required. Annually, the QI goals, objects and projects will be updated as well as performance measures. By December 2015, all members of the QI Committee were to complete a QI Fundamentals online learning course. Leadership and the QI Coordinator will continue to emphasize committee and staff QI training. The QI Committee is funded through general health funds.

## Organizational Structure

**QI Committee:** The TCHD QI Committee will assure the carrying out of QI efforts and activities which can include but not limited to:

* Development and annual evaluation of QI/PM Plan
* Meeting accreditation standards relative to QI and PM
* Ensuring progress on the Strategic Plan
* Monitoring the medical chart audit process
* Supporting the work of department improvement projects
* Provide QI updates to TCHD employees via the employee newsletter and bulletin board

**TCHD Leadership Team:** The Health Department Leadership Team will support the efforts of the QI Committee by implementing QI activities within their respective divisions. The Leadership Team will also be asked to participate in QI training activities and provide feedback and evaluation of the QI training and projects. The Leadership Team will also be primarily responsible for the PM of their division. TCHD Leadership Team consists of Department Directors and the Health Commissioner.

**Tuscarawas County Board of Health:** The Board of Health will provide oversight of the QI/PM activities and approve this plan and any future revisions.

## Membership and Rotation

TCHD QI Committee members will be representative of the six divisions of the Health Department. Those divisions include Accounting, Alcohol and Addiction, Environmental, Clinic, Medical Records/Vital Statistics, Women, Infant and Children Program (WIC) and Health Education. All Directors of the Health Department divisions will participate in the QI committee as well as at least one representative from each division. The Health Commissioner will also be required to participate.

Division representatives should be considered with the following:

* Expressed interest in the committee
* Opportunity given to all to participate
* Identified as a potential lead in a QI project

While it is not mandatory that the representative expressed interest in the committee it is beneficial to create “buy-in” from the participants. This is better accomplished if the representative has an interested in the topic at hand.

QI Committee representatives will typically serve a term of two years. These terms may be extended or shortened based on divisional needs. The QI Coordinator will always be a member of the committee as well as the Department Directors and Health Commissioner.

## Roles and Responsibilities

### Health Commissioner

* Provide leadership for Department mission, vision and Strategic Plan
* Provide direction related to QI/PM activities
* Promote a learning environment
* Advocate for a QI/PM culture
* Report activities of the QI committee to the Board of Health
* Participate in efforts related to PM
* Report PM results to the Board of Health
* Encourage staff to use QI resources

### Department Directors

* Facilitate implementation of QI/PM activities
* Facilitate discussions about departmental PM
* Participate in QI projects as requested
* Communicate with staff to identify projects and PM
* Communicate regularly with the Health Commissioner to share QI/PM successes or lessons learned
* Report to the QI Committee regarding QI/PM successes or lessons learned, at minimum, quarterly
* Provide feedback to revise QI/PM plan annually
* Identify representatives for the QI committee
* Communicate staff training needs
* Apply QI principles to daily work
* Monitor departmental PM
* Encourage staff to use QI resources

### QI Coordinator

* Coordinate, support and guide QI/PM department wide
* Lead QI/PM plan annual revision and/or update
* Convene and facilitate the agenda and meetings for the QI Committee
* Work with the Leadership Team to define and document QI issues
* Communicate QI updates to Newsletter Editor and Health Commissioner for Board of Health reports
* Assure documentation of all QI activities
* Facilitate the PM review committee
* Apply QI principles and tools to daily work

### QI Committee

* Attend monthly meetings
* Complete assigned tasks
* Complete all required trainings
* Assist in development of QI activities
* Advocate for QI culture
* Apply QI principles and tools to daily work

### All TCHD Staff

* Participate in QI projects, as directed
* Engage in outputs and activities to meet departmental PM
* Identify areas needing improvement and make suggestions
* Develop an understanding of basic QI principles
* Participate in QI trainings, as directed
* Apply QI principles and tools to daily work

### Board of Health

* Provide oversight of QI/PM efforts
* Set policies to facilitate implementation of QI/PM plan
* Participate in QI activities as required

## Administrative Support

Administrative support for QI/PM activities may be provided to the QI Coordinator by the Department Directors, QI Committee members, or TCHD administrative assistant.

## Budget and Resource Allocation

The primary budget allocation for this program is paid out of the general health fund which is primarily made up of local levy money. Personnel time associated with tasks related to QI and PM will be billed back to each division or program that the individual’s salary is paid out of. TCHD Grant Coordinator may work with the QI Coordinator to seek awards for QI related funding. As resources allow, through Board of Health approval, budget line items may be dedicated to QI/PM efforts.

# Training

### New Employee Orientation

As part of the new employee orientation process, all newly hired TCHD employees will be provided an orientation to the QI/PM system by the QI Coordinator and the employee’s Department Director. New employees will be encouraged to become involved with the QI Committee and oriented to past and current QI projects. Completion of an online QI course from The Ohio State College of Public Health titled “CQI for Public Health: The Fundamentals” accessible at <https://cph.osu.edu/practice/free-online-learning> must be completed within 6 months of hire and proof of completion submitted to the Administrative Assistant.

### Advance Training for Lead QI Staff

Members of the QI Committee and TCHD Leadership Team are expected to have higher level QI skills. Thus, a list of online courses required for completion by member and leaders is listed below. All courses can be accessed via The Ohio State College of Public Health website at [https://cph.osu.edu/practice/free-online-learning.](https://cph.osu.edu/practice/free-online-learning)

* CQI for Public Health: Tool Time
* CQI for Public Health: The Fundamentals

CQI members will also be responsible for knowledge of the information presented in NACCHO’s 2012 Roadmap to a Culture of Quality Improvement.

Additional QI and PM resources will be added to the employee portal and QI Committee members should be familiar with their content.

# Quality Improvement Process

QI project selection will be based on the need to improve program processes, objectives, and/or performance measures and are tied to the Strategic Plan and PM system. Projects

may be selected in a number of ways including, but not limited to, identification by Leadership and QI Committee during reviews of PM data.

It is the eventual goal of the Department to have each division of the Health Department select and develop at least one project on an annual basis. However, until all staff can be trained initial decisions for projects will rest with the QI Committee. After selecting the project, the workgroup will be expected to complete a QI proposal and project plan (Appendix A and B) to be submitted to the QI Committee for discussion and feedback. The QI Committee will be available to the workgroups to provide support and assistance in the development of projects and plans.

The Department is committed to the use of the Plan, Do, Check, Act model for quality improvement. All agency staff will receive training on this model and its use. The four stages of the method include *planning* an improvement, *doing* the plan, *checking* which includes measurement and evaluation of data associated with the implementation on the plan and then *acting* to adopt the change and incorporate into the standard operation.



Phases of the PDCA Model as outline by Gorenflo and Moran (2010) are highlighted below:

The phases of the PDSA model below assume that just one underlying, or root, cause will be addressed by testing just one intervention. When undertaking the PDCA process, the team may decide to address more than one root cause, and/or to test more than one intervention to address a root cause. In such instances, it will be important to measure the effect of each intervention on the root cause it is intended to address.

A number of national efforts to support QI in public health have used a storyboard format that was developed by the Michigan department of public health and can be accessed at <http://nnphi.org/CMSuploads/Storyboard-Guidelines-FINAL-05868.pdf>

**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.

1. Identify and prioritize quality improvement opportunities. Usually a team will find that there are several problems, or quality improvement opportunities, that arise when programs or processes are investigated. A prioritization matrix may help in determining which one to select. Once the quality improvement opportunity has been decided, articulate a problem statement. Revisit and, as appropriate, revise the problem statement as you move through the planning process.
2. Develop an AIM statement that answers the following questions:
	1. What are you seeking to accomplish?
	2. Who is the target population?
	3. What is the specific, numeric measure(s) you are seeking to achieve?
	4. The measurable improvement objective is a key component of the entire quality improvement process. It’s critical to quantify the improvement you are seeking to achieve. Moreover, the entire aim statement also will need to be revisited and refined as you move through the planning phase.
3. Describe the current process surrounding the problem in order to understand the process and identify areas for improvements. Flow charts and value stream mapping are two examples of methods to accomplish this.
4. Collect data on the current process. Baseline data that describe the current state are critical to further understanding the process and establishing a foundation for measuring improvements. The data may address, for example, time, people, space, cost, number of steps, adverse events, and customer satisfaction. A host of tools are available to collect and interpret data on the process, such as Pareto charts, histograms, run charts, scatter plots and control charts. The data collected must be aligned with the measures listed in the aim statement.
5. Identify all possible causes of the problem and determine the root cause. While numerous causes will emerge when examining the quality improvement opportunity, it is critical to delve in and carefully identify the underlying, or root, cause of the problem, in order to ensure that an improvement or intervention with the greatest chance of success is selected. Brainstorming is a useful way to identify possible causes and a cause and effect/fishbone diagram and the 5 Whys are useful for determining the actual root cause.
6. Identify potential improvements to address the root cause, and agree on which one to test. Once the improvement has been determined, carefully consider any unintended consequences that may emerge as a result of the implementing improvement. This step provides an opportunity to alter the improvement and/or develop countermeasures as needed to address any potential unintended consequences. Revisiting the aim statement and revising the measurable improvement objectives are important steps at this point.
7. Develop an improvement theory. An improvement theory is a statement that articulates the effect that you expect the improvement to have on the problem. Writing an improvement theory crystallizes what you expect to achieve as a result of your intervention, and documents the connection between the improvement you plan to test and the measurable improvement objective.
8. Develop an action plan indicating what needs to be done, who is responsible, and when it should be completed. The details of this plan should include all aspects of the method to test the improvements – what data will be collected, how frequently data are collected, who collects the data, how they are documented, the timeline, and how results will be analyzed.

**Do:** The purpose of this phase is to implement the action plan.

1. Implement the improvement.
2. Collect and document the data.
3. Document problems, unexpected observations, lessons learned and knowledge gained.

**Check/Study:** This phase involves analyzing the effect of the intervention. Compare the new data to the baseline data to determine whether an improvement was achieved, and whether the measures in the aim statement were met. Pareto charts, histograms, run charts, scatter plots, control charts and radar charts are all tools that can assist with this analysis.

1. Reflect on the analysis, and consider any additional information that emerged as well. Compare the results of your test against the measurable objective.
2. Document lessons learned, knowledge gained, and any surprising results that emerged.

**Act:** This phase marks the culmination of the planning, testing, and analysis regarding whether the desired improvement was achieved as articulated in the aim statement, and the purpose is to act upon what has been learned. Options include:

1. Adopt: Standardize the improvement if the measurable objective in the aim statement has been met. This involves establishing a mechanism for those performing the new process to measure and monitor benchmarks on a regular basis to ensure that improvements are maintained. Run charts or control charts are two examples of tools to monitor performance.
2. Adapt: The team may decide to repeat the test, gather different data, revise the intervention, or otherwise adjust the test methodology. This might occur, for example, if sufficient data weren’t gathered, circumstances have changed (e.g., staffing, resources, policy, environment, etc.), or if the test results fell somewhat short of the measurable improvement goal. In this case, adapt the action plan as needed and repeat the “Do” phase.
3. Abandon: If the changes made to the process did not result in an improvement, consider lessons learned from the initial test, and return to the “Plan” phase. At this point the team might revisit potential solutions that were not initially selected, or delve back into a root cause analysis to see if additional underlying causes can be uncovered, or even reconsider the aim statement to see if it’s realistic. Whatever the starting point, the team will then need to engage in the Plan cycle to develop a new action plan, and move through the remaining phases. PDCA offers a data- based framework based on the scientific method.

This simple yet powerful format drives continuous and ongoing efforts to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.

While it is a requirement that each division work on one project annually, divisions may choose to work on more than one project simultaneously. Documentation of process, tools, outcomes and lessons learned should be completed and submitted to the QI Coordinator.

## Department and Division Level Performance Measures

Annually, TCHD will conduct a process to identify Department and division level Performance Measures (PM). This process will include participation of all employees in each division and selected measures will be documented. Division Directors are responsible for maintaining these measures and providing a copy to TCHD Administrative Assistant who will pass on to the Health Commissioner.

Performance measures will have a direct correlation with the Strategic Plan, Community Health Improvement Plan, Healthy People 2020 or another recognized performance standard.

Documentation of Divisional Performance Measures will be submitted to the Health Commissioner on the approved forms. Additionally, progress towards the Performance Measures will be done by Divisional Directors and turned into Administration on a quarterly basis using the approved data collection form.

Annually Department Directors will review the performance measures and summarize successes and challenges that will be provided to the Health Commissioners. Performance measures should be re-evaluated annually to determine whether measures should be edited or reconstructed altogether. Additional performance measures may be added at any time. Indicator reporting will occur on a quarterly basis and output reporting will occur monthly. These reports will be provided by the department directors to the health commissioner who will then facilitate discussions with the Board of Health.

## QI Project Selection

In 2016, all QI projects will be selected by the QI Committee. Performance measures may be a potential source for QI projects. Priority for these initial projects will consider divisional performance and operational goals for 2016. Sources for potential projects mat also include customer satisfaction data, staff suggestions, program evaluations, audit or compliance findings, or needs related to the accreditation process.

All QI projects selected will be in compliance with PHAB requirements under Measure

9.2.2 (program or administrative type projects).

As the year progresses and staff become more familiar with the QI process any employee will have the ability to make suggestions through the QI division representative.

## 2018 and 2019 QI Goals, Objectives and Projects

2016 and 2017 goals and objectives are based on PHAB Standards and Measures, Version

* 1. These goals were selected as primary goals for this plan due to their connection with accreditation. Annual goals and objectives will always be linked with the most current version of PHAB Standards and Measures.

### Goal 1: Establish and maintain a comprehensive communication plan including protocols and procedures.

**National Benchmark: PHAB standard 3.2 Provide information on public health functions through multiple methods to a variety of audiences.**

**Objective 1.1: Develop and maintain a comprehensive communication plan**

|  |  |  |
| --- | --- | --- |
| Action Step 1:Review existing communication policies and protocols  | Timeline: June 2018 | Responsible Party: CQI CommitteeHealth CommissionerPHEP coordinatorHealth EducatorsDirectors Accreditation Coordinator |
| Action Step 2: Consolidate and/or remove duplicate policies  | Timeline: September 2018 | Responsible Party: CQI CommitteeHealth CommissionerPHEP coordinatorHealth EducatorsDirectors Accreditation Coordinator |
| Action Step 3: Addition of required components of standard 3.2 and other domains, as needed | Timeline: December 2018 | Responsible Party: CQI CommitteeHealth CommissionerPHEP coordinatorHealth Educators Directors Accreditation Coordinator |
| Action Step 4: Review and Approval by Board of Health | Timeline: January 2019 | Responsible Party: Board of Health |
| Action Step 5: Dissemination to TCHD Staff  | Timeline: February 2019 | Responsible Party: Health Commissioner |
| Action Step 6:Annual Review and update | Timeline:ongoing | Responsible Party: CQI CommitteeHealth CommissionerPHEP coordinatorHealth EducatorsDirectors Accreditation Coordinator |
| **Goal 2: Tailor Health Education Programs to align with Community Health Assessment and Community Health Improvement Plan benchmark** |

**National Benchmark: PHAB standard 3.1 Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness**

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| **Objective 2.1: Develop and maintain Health Education Programming that aligns with the Community Health Assessment and Community Health Improvement Plan** |
| Action Step 1: Familiarize Health Educators on PHAB domains that relate to health education | Timeline:June 2018 | Responsible Party: Director, Health Education |
| Action Step 2:Review 2018 Community Health Plan to identify new areas of need | Timeline:November 2018 | Responsible Party: Health CommissionerAccreditation CoordinatorHealth Educators |
| Action Step 3:Modify and/or create Health Education policy and procedures | Timeline:March 2019 | Responsible Party:Director, Health EducationHealth EducatorsAccreditation CoordinatorHealth Commissioner |
| Action Step 4:Review and Approval by Board of Health | Timeline:June 2019 | Responsible Party:Board of Health |
| Action Step 5:Implement Health Education Policy and Procedures  | Timeline: July 2019 | Responsible Party:Director, Health EducationHealth Educators |
| Action Step 6: Annual Review and update | Timeline:On-going | Responsible Party:Director, Health EducationHealth Educators  |

**Goal 3: Demonstrate employee participation in quality improvement**

**National Benchmark: PHAB Standards and Measures, Standard 9.2; Implement QI of public health processes, programs and interventions**

**Objective 3.1: Train 100% of employees on QI process by 2020**

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| Action Step 1: Maintain training log | Timeline: Ongoing | Responsible Party: Administrative Assistant |
| Action Step 2:Train all new employees during their orientation process | Timeline: Ongoing | Responsible Party: Division Director, QI Coordinator |
| Action Step 3:Train all new QI members within 30 days of their representation on the QI committee | Timeline: Ongoing | Responsible Party: QI Coordinator, QI Committee |
| Action Step 4:Provide all division trainings on topics related to QI and PM | Timeline: Ongoing | Responsible Party: Health Commissioner, Division Directors, QI Coordinator |
| **Goal 4: Use performance management system to monitor achievement of Departmental and divisional objectives** |

**National Benchmark: PHAB Standards and Measures, Standard 9.1; Use a performance management system to monitor achievement of organizational objectives**

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| **Objective 4.1: Maintain and augment a fully functioning performance management system at TCHD** |
| Action Step 1:Selection of performance measures for each division | Timeline: Annual | Responsible Party: Division Directors, TCHD Employees |
| Action Step 2:Update progress on PM to employees in respective divisions | Timeline: Quarterly | Responsible Party: Division Directors |
| Action Step 3:Discussion with Board of Health on PM | Timeline: Annually | Responsible Party: Health Commissioner |
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**Collection, Analysis and Monitoring of QI/PM Data**

Data will be collected for each of the TCHD performance measures by the division indicated on the Performance Measure Data Description and Collection Form. QI data will be collected by the QI Coordinator. A summary of data points from each division and the QI Coordinator will be submitted to the Administrative Assistant on a quarterly basis. The data will be submitted on the 15th of the months of April, July, October and January. Output reports for PM will be reported on monthly basis and due by the 10th of each subsequent month. The Health Commissioner will keep record of all data. Data will also be reported quarterly at Board of Health Meetings and annually at District Advisory Meetings.

## Reporting Progress

TCHD Division Directors will report progress on performance measures to the respective staff on a quarterly basis. This update will include data and a summary of progress.

## Promotion and Communication Strategies

Numerous methods will be used to assure regular and consistent communication regarding QI/PM efforts within TCHD (“quality sharing”).

Reporting to the Board of Health

* + - The Board of Health will receive annual updates on QI project
		- The Board of Health will receive quarterly updates on PM progress
		- The QI/PM Plan will be brought to the Board of Health for initial approval and then approval anytime updates or revisions are made

Reporting to the District Advisory Council

* + - A section of the annual report will highlight the updates related to QI and PM from the previous year

Reporting within Department staff:

* + - Posting project storyboards on the bulletin board
		- Quarterly updates in division meetings
		- Employee newsletter updates

Reporting to the community:

* + - Annual report with QI/PM section will be posted on TCHD website

## Approval and Evaluation of QI/PM Plan

Annually, the QI/PM plan will be reviewed and revisions made when necessary. Revisions will be Board of Health approved prior to implementation. In December of each year the QI Committee and Leadership Team will evaluate the activities of the divisions regarding QI. This evaluation will include:

* + - A review of progress towards achieving goals and objectives
		- Lessons learned
		- A summary of QI projects and their results
		- Progress on performance measures

A summary of this evaluation will be forwarded to the Health Commissioner and Board of Health. This annual evaluation will be used in aiding the creation of future QI/PM plans, goals and objectives.

## Resources and Adaptations

The TCHD QI/PM Plan was created utilizing information from the following sources:

Kane County Health Department Quality Improvement and Performance Management Plan, November 2014

Medina County Health Department QI Plan, 2014

National Association of County and City Health Officials (NACCHO), *Quality Improvement Plans,* 2015

Ohio State University, College of Public Health, *CQI: The Fundamentals,* 2015 Sedgwick County Health Department Quality Improvement Plan, February 2011

## Tuscarawas County Health Department Quality Improvement PDCA Project Proposal Form

|  |  |
| --- | --- |
| ***Project title:*** | ***Submitted by:*** |
| ***Date submitted:*** | ***PDCA Matrix Attached:* Yes No** |
| ***Briefly describe the program, project or process that should be addressed with a QI project:*** |
| ***Priority:* High Medium Low** |
| ***Departmental Implications***1. ***Which strategic initiative and or CHIP priority does this project support or how does it support TCHD Mission and/or vision?***
2. ***What resources and support will be needed for the project?***
3. ***What potential impacts could there be on other programs?***
 |
| ***What are we trying to accomplish?*** |
| ***What changes can we make that will result in improvements?*** |
| ***Who should be on the QI team?*** | ***Who should lead the QI team?*** |

### Reviewed by QI Committee on: QI Member Signature:

**Tuscarawas County Health Department Quality Improvement PDCA Project Plan**

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| **Project Name:** |
| **Project Leader:** |
| **Strategic Direction/Goals:** |
| **Measures:** | **Targets: (how much improvement is hoped for)** |
| **Primary recipients of the program or service:** |
| **Processes to be addressed:** | **Which will be focused on first:** |
| **Division or Department Director:** |
| **Potential Constraints: (examples: space, time, finance, policy)** |
| **Team Members:** | **Resources:** |
| **Start Date:** | **Target Completion Date:** |

**Reviewed by QI committee on: QI member signature:**

**Tuscarawas County Health Department Storyboard Template**

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| **PLAN – DO – CHECK – ACT (PDCA)** |
| **PLAN** | **AIM Statement:** | **Identify potential causes of the problem: (attach cause and effect diagram)** | **What changes may cause improvement? How will you collect data?** |
| **Key measures:** |
| **Team:** |
| **DO** | **Carry out the change or test the changes:** | **Collect data and begin analysis:** |
| **CHECK** | **Data and analysis:** | **Summarize what was learned:** |
| **ACT** | **Was desired outcome achieved?**Yes – Adopt & Adapt No – Abandon & Predict New Change |

**Quality Improvement Committee Project Proposal Scoring Form**

# TUSCARAWAS COUNTY GENERAL HEALTH DISTRICT

*This is an internal document to be used by the CQI Committee*

Below are the QI project selection criteria to prioritize project proposals. Mark each item with an appropriate numerical value from 0-5. A 5 indicates that it has a strong connection to the question and 0 indicates no connection. A total score should then be summed. If the proposal receives a score of 80% or 64 points or higher the committee should make a motion to accept the proposal as a QI project. The higher the score indicates that the project will receive higher priority.

\_\_\_\_\_\_\_ Is this a TCHD process?

 What type: \_\_\_\_\_\_\_ Programmatic \_\_\_\_\_\_\_ Administrative

\_\_\_\_\_\_\_ Is the problem that is targeted for improvement clearly defined?

\_\_\_\_\_\_\_ Can it be reliability measured?

\_\_\_\_\_\_\_ Is the scope manageable?

\_\_\_\_\_\_\_ Can it be completed in the proposed timeframe?

\_\_\_\_\_\_\_ Is data currently available?

\_\_\_\_\_\_\_ Will the resources necessary for completion incur costs?

\_\_\_\_\_\_\_ Is it important to several staff?

\_\_\_\_\_\_\_ Is it important to the community?

\_\_\_\_\_\_\_ Does it align with one or more TCHD plans?

\_\_\_\_\_\_\_ Does it align with TCHD mission, vision, values?

\_\_\_\_\_\_\_ Does it have a customer focus?

\_\_\_\_\_\_\_ Are there no other QI projects related to the same strategic objective?

\_\_\_\_\_\_\_ Is it free from pre-conceived solutions?

\_\_\_\_\_\_\_ Is leadership prepared to implement change?

\_\_\_\_\_\_\_ Is there a probability of success?

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