ADMINISTRATIVE PROTOCOL

Kane County Health Department

Level:	DHP Division	**Policy Number:**	DHP-MIECHV 3
Applicability:	MIECHV	**Date of Last Update:**	
Effective Date:	12/13/2013	**Approved**	12/13/2013

Subject: **Maternal Infant Early Childhood Home Visitation Project**
CI and CSD Continuous Quality Improvement

Policy: **CI and CSD implement continuous quality improvement in alignment with KCHD Departmental policy and MIECHV requirements.**

Purpose: Continuously improve the home visit referral system and community development system by using quality improvement tools and processes in alignment with performance measurement

Procedure: CI and CSD, with the support and collaboration of the supervisor, use QI tools and processes to plan, implement, measure outcomes, and plan improvements.

1. CI and CSD complete training on the Department QI model, Plan-Do-check-Act, participate in setting and quarterly measuring the CI/CSD performance management measures, and assists in the Departmental, Division, and program implementation of the agency QI Plan.
2. CI and CSD select QI tools from those they have been trained to use as they implement the MIECHV plans and activities.
3. Prior to MIECHV events, SMART objectives are developed and used in evaluation.
4. CI and CSD participate in monthly QI segments of Community Health Section meetings.
5. CI and CSD carry out quarterly CQI activities according to the MIECHV Quarterly CQI Plan.
6. CI and CSD identify and carry out job duties and activities that contribute to the MIECHV Elgin Referral Action Plan, the Parent Empowerment Plan, and the current state fiscal year program plan.
7. CI and CSD follow the KCHD MIECHV Data Collection, Monitoring, Reporting, and Analysis procedures in collaboration with other MIECHV and/or community partners.

FORMS: KCHD QI Plan, CQI Template

Approved By: (Signature)	Theresa Heaton
Approved By: (Name & Title)	**Theresa Heaton, CI/CSD Manager**
Date of Approval:	**12/13/13**

Kane County
Health Department

KANE COUNTY HEALTH DEPARTMENT

FY2014 QUALITY IMPROVEMENT & PERFORMANCE MANAGEMENT PLAN

KANE COUNTY HEALTH DEPARTMENT
FY2014 QUALITY IMPROVEMENT & PERFORMANCE MANAGEMENT PLAN

Table of Contents

I. Purpose of the Quality Improvement & Performance Management Plan
II. Key Quality Terms
III. Culture of Quality
IV. Governance of Quality Improvement & Performance Management Plan
    a. Organizational Structure
    b. Membership and Rotation
    c. Roles and Responsibilities
    d. Staffing and Administrative Support
    e. Budget and Resource Allocation
V. Training
    a. New Employee Orientation
    b. Introductory QI Course for All Staff
    c. Advanced Training for Lead Staff
    d. On-going Staff Training
    e. Position-Specific QI Training
VI. Identification of Improvement Projects & Alignment with Strategic Plan
    a. Project Selection Criteria
    b. Agency and Division Level Goals and Objectives (Performance Measures)
VII. Goals, Objectives & Performance Measures of QI/PM Plan
VIII. Monitoring of Quality Improvement/Performance Management
IX. Sustainability of Quality Improvement/Performance Management
    a. Communication & Promotion
    b. Recognition
    c. Agency Policies
X. Approval and Evaluation of Quality Improvement & Performance Management Plan

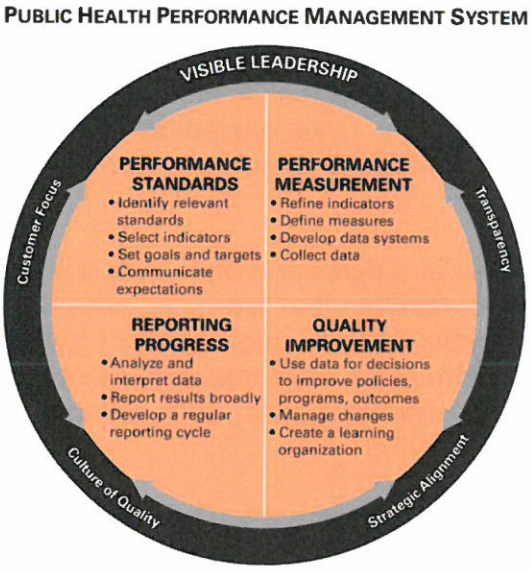
Appendices

Appendix A: QI PDCA Project Proposal
Appendix B: QI PDCA Project Plan
Appendix C: QI PDCA Project Decision Matrix
Appendix D: Performance Measure Data Description and Collection Form
Appendix E: Agency and Division-Level Performance Measures
Appendix F: 2014 QI PDCA Projects

KANE COUNTY HEALTH DEPARTMENT
FY2014 QUALITY IMPROVEMENT & PERFORMANCE MANAGEMENT PLAN

I. Purpose of the Quality Improvement & Performance Management Plan

The purpose of the Kane County Health Department (KCHD) Quality Improvement & Performance Management Plan (QI/PM Plan) is to provide context and framework for quality improvement (QI) and performance management (PM) activities at the Kane County Health Department. KCHD utilizes the Turning Point Performance Management Framework as their performance management system, as described in the image below (Image source: Public Health Foundation).



Policy Statement, Performance Management Policy (9.1): KCHD will implement and maintain a performance management system, as outlined by the performance management system "Turning Point: Collaborating for a New Century in Public Health", published by the Public Health Foundation and the Robert Wood Johnson Foundation. This system will function in conjunction with the agency's annual budgeting process, the Community Health Improvement Plan (CHIP) and Strategic Planning. The performance management system will be reviewed and updated on an annual basis.

Policy Statement, Quality Improvement Policy (9.2): KCHD will implement a quality improvement system, including a plan, for all of its programs, interventions, and processes as a part of the agency's performance management system.

II. Key Quality Terms

So as to provide a common vocabulary and a clear, consistent message, the following key quality terms are defined below.

Continuous Quality Improvement (CQI): An ongoing effort to increase an agency's approach to manage performance, motivate improvement, and captures lessons learned in areas that may or may not be measured as part of accreditation. Also, CQI is an ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, and outcomes. These efforts seek "incremental" improvement over time or "breakthrough" all at once. Among the most widely used tools for continuous improvement is a four-step quality model, the Plan-Do-Check-Act (PDCA) cycle (Public Health Accreditation Board [PHAB] Acronyms and Glossary of Terms, 2009).

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

Performance Measurement: The regular collection and reporting of data to track work produced and results achieved (Turning Point, 2003).

Plan-Do-Check-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 (Embracing Quality in Local Public Health: Michigan's QI Guidebook, 2008).

Quality Improvement (QI): The use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. (Accreditation Coalition Workgroup, 2009).

Quality Improvement/Performance Management (QuIPM) Committee: Agency-wide committee, organized by the Health Data and Quality Coordinator and the KCHD Leadership Team, to carry out QI activities, namely PDCA cycles. The QuIPM Committee objectives include supporting PDCA cycles occurring at the section level, developing and facilitating All Hands meetings as they pertain to QI. This committee is representative of each division of KCHD, and includes representatives at both staff and leadership levels. This committee also supports the work by the KCHD Leadership Team of implementing the agency's Performance Management system.

Quality Improvement & Performance Management Plan (QI Plan): 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 Plan may also be in the Strategic Plan. See also Performance Management (PHAB Acronyms and Glossary of Terms, 2009).

Quality Methods (QI Methods): Builds on an assessment component in which a group of selected indicators (selected by an agency) are regularly tracked and reported. The data should be regularly analyzed through the use of control charts and comparison charts. The indicators show whether or not agency goals and objectives are being achieved and can be used to identify opportunities for improvement. Once selected for improvement, the agency develops and implements interventions,

and re-measures to determine if interventions were effective. These quality methods are frequently summarized at a high level as the Plan-Do-Check-Act (PDCA) or Shewhart Cycle (PHAB Acronyms and Glossary of Terms, 2009).

Quality Planning: A systematic process that translates quality policy into measurable objectives and requirements and lays down a sequence of steps for realizing them within a specified time frame. Quality planning is used in situations where a process does not yet exist, or a process is need of a complete redesign.

Quality Tools (QI Tools): Tools designed to assist a team when solving a defined problem or project. Tools will help the team get a better understanding of a problem or process they are investigating or analyzing (The Public Health QI Handbook, Bialek et al, 2009). Tools used by KCHD are outlined in the Public Health Memory Jogger (Public Health Foundation, 2007), the Public Health QI Handbook, and the Public Health Quality Improvement Encyclopedia (Public Health Foundation, 2012).

Strategic Planning, Program Planning and Evaluation: Generally, Strategic Planning and Quality Improvement occur at the level of the overall organization, while Program Planning and Evaluation are program-specific activities that feed into the Strategic Plan and into Quality Improvement. Program evaluation alone does not equate with Quality Improvement unless program evaluation data are used to design program improvements and to measure the results of the improvements as implemented (PHAB Acronyms and Glossary of Terms, 2009).

III. Culture of Quality

KCHD is committed to fostering a culture of quality within the organization, and the development of this culture is outlined below. In order to assess the integration of a quality culture, KCHD evaluates their progress annually against the Roadmap to a Culture of Quality Improvement, developed by the National Association of County and City Health Officials (NACCHO).

2006 – KCHD participates in the Common Ground project, sponsored by the Robert Wood Johnson Foundation. This project served to use business process analysis and redesign to develop toolkits for public health preparedness.

2007 – KCHD created their first Quality Improvement/Process Improvement (QI/PI) Committee resultant from the development of the agency's first strategic plan.

2008 – KCHD was awarded a grant by NACCHO through the Accreditation Preparation and Quality Improvement Demonstration Sites Project. KCHD completed a self-assessment using the Operational Definition Prototype Metrics Assessment Tool, analyzed the scores, and identified priority areas to address through a Quality Improvement process. The agency leadership team received training on PDCA from a consultant as well. In addition, KCHD completed a QI project to improve the external display of data for the Community Action Plan, the result of which was Vital Signs, an annual report to the community on the status of the Community Action Plan. This project was led by the agency's QI/PI Committee.

2009 - 2010 June - As the self-assessment also indicated that "Evaluate and continuously improve process, programs, and interventions" (Domain 9 of the self-assessment) was an area for

improvement, the QI/PI Committee began work to remedy this gap. This included an inventory of current quality initiatives within programs, training on and initial development of logic models for programs and began work to develop goals, objectives, and performance measures at the program level. In addition, all-staff training on PDCA was completed in March 2010.

2010, July-November - Planning and implementation of a large-scale agency-wide reorganization took priority, and a restructured KCHD began work to move forward on initiatives regarding Quality Improvement. This restructure included the creation of a Health Data and Quality Coordinator (HDQC) position, charged with coordinating all QI efforts within the agency, and assuring the agency is working toward application for accreditation.

2011 - KCHD worked to remedy the gaps identified in Public Health Accreditation Board (PHAB) standards. Staff and leadership were surveyed on their training needs, as well as their level of engagement in QI. All staff participated in monthly QI training, correlated with the completion of six section-level QI projects. PDCA project results were displayed in June in a poster presentation event attended by all staff. KCHD's first QI Committee was formed in March, with the goals of overseeing the implementation of the QI Plan, assisting in implementation of PDCA projects, and developing skills through completion of "Train-the-Trainer" modules on QI tools. Additionally, KCHD received support from the Kane County Health Advisory Committee (HAC) through the development and implementation of the QI and Accreditation framework as well as the QI Plan. The HAC is comprised of representatives from healthcare and academia and serves to provide consultation and support to KCHD as well as be a liaison to the Kane County Board.

2012 – KCHD continued to build a culture of quality with the development of the agency's first performance management (PM) system. Using the Turning Point model, KCHD assessed the department's capabilities, trained staff on the system, and developed the first set of performance measures. These measures were monitored on at least a quarterly basis, with internal reporting occurring on the same schedule. PDCA projects were selected based on opportunities identified in the PM system, and many were directly integrated with the CHIP and Strategic Plan. As a means to communicate progress, the first annual report dedicated to QI was released this year. KCHD was nationally recognized for their QI efforts in 2012, with the receipt of a Model Practice Award from the National Association of County and City Health Officials (NACCHO), and inclusion of two QI projects into the Public Health Quality Improvement Exchange (PHQIX). As KCHD expanded their QI culture into a broader PM system, the QI Committee structure was changed to the Quality Improvement/Performance Management Committee (QuIPM).

2013 – With the selection of new PDCA projects, the membership of the QuIPM Committee was rotated to include new members. These members took the lead role on the PDCA project implementation that was begun in December 2012. A series of web-based training modules on 13 QI tools was released to KCHD, with a requirement of all staff completing a specific set of six. As an additional means of communication, a quarterly QI-focused newsletter was developed and released by the QuIPM Committee beginning in 2013 (4 issues). Finally, with the conclusion of the first year of the PM system, a decision was made to integrate the PM system with the county fiscal year. As a result, the QI Plan and PM system measures were extended for a "fifth quarter" through fall 2013. Also during this period, each section completed a process to identify and develop a new set of performance measures that aligned with key outcomes of each program. The expectations for these measures included representation of all programs, at least one customer-facing measure per section,

and inclusion of measures developed for the agency budget. This QI/PM Plan was also realigned to match the PM system, and all rolled out on December 1, 2013, for county fiscal year 2014.

The future state of quality at KCHD includes the following:

- Continued growth of the QI & PM systems at KCHD, assuring participation in both systems by all employees of the department,
- Demonstrated competence by all staff in a wide range of quality improvement tools,
- Increasing use of quality improvement tools and methodologies in daily work tasks by individuals and by teams at meetings,
- Additional exploration and use of Quality Planning in the QI/PM system,
- Integration of Quality Planning into existing systems of Quality Improvement and Quality Control,
- Sustained or increasing levels of engagement and participation regarding QI/PM as evidenced through annual staff QI surveys,
- Completion of at least one PDCA project for all sections at least annually, and
- QI & PM not only impact daily operations, but serve to improve population level outcomes and indicators, as described in the Community Health Improvement Plan (CHIP) and Strategic Plan.

IV. Governance of Quality Improvement Plan

a. Organizational Structure

QuIPM Committee: The QuIPM Committee will assure the carrying out of QI efforts and activities, which include: development and evaluation of an annual Quality Improvement Plan, meeting PHAB accreditation standards relative to QI, as well as supporting the work of department improvement projects. Committee members will also be asked to plan and participate in QI training activities, and to become skilled in the implementation of QI tools. Committee members will also serve as section-level support to the KCHD Leadership Team in implementing, monitoring and evaluating the performance management system.

KCHD Leadership Team: The KCHD Leadership Team will support the efforts of the QuIPM Committee by implementing QI activities within Divisions and Sections, and contribute to the development and implementation of agency-level QI activities. Leadership Team members will also be asked to participate in QI training activities, become skilled in the implementation of QI tools, and to provide concrete feedback and evaluation of QI training and PDCA projects. Leadership Team members will serve as the primary group responsible for implementation, monitoring and evaluation of the agency's Performance Management system.

Kane County Health Advisory Committee: The Kane County Health Advisory Committee will provide bi-directional support to the QI/PM efforts of the agency, providing consultation and feedback to KCHD staff regarding QI/PM efforts, and both informing the Kane County Board about QI/PM and making recommendations on policy change.

Kane County Board/Board of Health: The Kane County Board, which includes the role as the Kane County Board of Health, will provide high-level oversight of QI/PM efforts by the

agency, as well as approve policies to facilitate implementation of this plan and activities included therein.

b. Membership and Rotation

QuIPM Committee members will be representative of each of the three Divisions/Offices of KCHD, and will assure that each Section within the Division/Office is represented. In addition, each Division/Office will be represented by one member of the Leadership Team and two members of the staff to participate (for a total of nine members, including the HDQC, representing the Office of Community Health Resources).

Committee members should be selected with a set of criteria in mind, in this order: 1) expressed interest in committee participation, 2) assurance that all KCHD employees have an opportunity to participate in the QuIPM Committee, and 3) identified lead for a PDCA project. The major goal for Committee participation is to develop champions of QI and PM, and this can be done best if Committee members have an expressed interest in the Committee. However, it is also important to consider that KCHD desires to have all staff be champions of QI and PM, so a balance must be met between those with a high desire to participate and the need to have all staff take a turn on the Committee. While it is not required that Committee members are project leads for PDCA, this should also be a consideration in selecting members. The HDQC will work with Division Leadership to select QuIPM Committee members.

QuIPM Committee members will typically serve a term of two years. These terms may be shortened or extended based on agency/operational need, so long as each Division/Office has three representatives, one from the Leadership Team, and two from staff, and that both Sections are represented. The Health Data and Quality Coordinator will always be a member of the committee, serving as its facilitator.

Roles and responsibilities of QuIPM Committee members can be found in the next section of this document.

c. Roles and Responsibilities

Executive Director

- Provide leadership for department vision, mission, strategic plan and direction related to QI efforts.
- Allocate resources for QI programs and activities, assuring that staff has access to resources to conduct QI projects and training.
- Promote a continuous quality improvement (CQI) learning environment for KCHD.
- Advocate for a QI culture, both to staff and external customers, through presentation and messaging.
- Report on QI activities to the Board of Health, Public Health Committee and Health Advisory Committee.
- Request the review of specific program evaluation activities or the implementation of QI projects.
- Review and provide final approval on documents such as the QI/PM Plan, QI Policy.
- Apply QI principles and tools to daily work.

- Participate in efforts to implement, monitor and evaluate the Performance Management system.

Division Directors

- Facilitate the implementation of QI activities at the Division level.
- Support Assistant Directors and Supervisors in QI activity work.
- Participate in QI project teams as requested or required.
- Facilitate the development of QI project teams.
- Provide staff with opportunities to share results of QI efforts (findings, improvements, lessons learned).
- Communicate with Assistant Directors and Supervisors to identify projects or processes to improve and assist with development of proposals for QI projects.
- Document QI efforts.
- Communicate regularly with Executive Director and Health Data and Quality Coordinator to share QI successes and lessons learned.
- Communicate regularly with division representatives of the QuIPM Committee to stay updated on Committee work.
- Provide feedback to develop annual QI/PM Plan.
- Identify representatives for QuIPM Committee.
- Communicate staff training needs to HDQC.
- Encourage program staff to incorporate QI concepts into daily work.
- Apply QI principles and tools to daily work.
- Assure implementation, monitoring and evaluation of the agency's Performance Management system.

Assistant Directors and Supervisors

- Facilitate the implementation of QI/PM activities and an environment of CQI at the section/program level.
- Participate in and facilitate the development of QI/PM project teams.
- Assure staff participation in QI/PM activities.
- Orient staff to the QI/PM Plan processes and resources.
- Provide staff with opportunities to share results of QI efforts (findings, improvements, lessons learned), including visual representations of work.
- Document QI efforts.
- Determine messages to communicate selected QI activities and results to staff, the public and other audiences (via Public Information Officer and with the support of the HDQC).
- Keep Division Director apprised of QI/PM activities.
- Communicate regularly with section representatives of the QuIPM Committee to stay updated on Committee work.
- Initiate problem solving processes and/or QI projects.
- Encourage staff to incorporate QI concepts into daily work.
- Apply QI principles and tools to daily work.
- Assure implementation, monitoring and evaluation of the agency's Performance Management system, including communication to staff.

Health Data & Quality Coordinator (HDQC)

- Coordinate, support, and guide QI/PM department-wide.
- Develop the annual QI/PM plan and evaluation with the input of the QuIPM Committee and Leadership Team, assuring that it meets PHAB accreditation requirements.
- Counsel QuIPM Committee members on the implementation of the QI program and serve as Committee Chair.
- Provide training, consultation, and technical assistance to QI project teams, the QuIPM Committee and for other staff.
- Convene and facilitate the agenda and meetings for the QuIPM Committee.
- Work with the Leadership Team to define and document QI issues.
- Support Assistant Directors and Supervisors in development of messages to communicate QI activities to staff, the public and other audiences.
- Provide technical assistance on the development, implementation, monitoring and evaluation of the agency's Performance Management system.
- Assure communication of QI project results, including posting on KCHD website.
- Support dissemination of agency QI/PM efforts, including application to PHQIX and presentation at local, state and national conferences and meetings.
- Assure document all QI-related activities.
- Evaluate staff regarding QI participation and training needs and PM development and integration.
- Integrate QI principles in KCHD policies/protocols.
- Implement other strategies to develop a "culture of QI".
- Apply QI principles and tools to daily work.

All KCHD Staff

- Participate in the work of at least one QI project, as requested by division directors, assistant directors, or supervisors, on an annual basis.
- Collect and report data for PDCA projects and PM system measures.
- Identify areas needing improvement and suggest improvement actions to identified areas (with direct supervisor and supported by the use of data), especially as they pertain to agency goals and mission.
- Develop an understanding of basic QI principles and tools by participating in QI training.
- Report QI training needs to supervisor and/or HDQC.
- Apply QI principles and tools into daily work.
- Contribute to the development, monitoring and evaluation of the Performance Management system.

Quality Improvement Committee

- Attend monthly meetings of QuIPM Committee (typically 1 hour/month) and complete assigned tasks.
- Provide QI expertise and guidance for QI project teams.
- Provide QI training to new and existing staff.
- Serve as liaison between program-level QI project and agency, providing updates at All Hands meetings.
- Assist in development of agency QI activities.

- Participate in the development, implementation, review and evaluation of the QI/PM Plan.
- Advocate for QI and encourage a culture of learning and QI among staff.
- Apply QI principles and tools to daily work.
- Provide support to the KCHD Leadership Team in implementation, monitoring and evaluation of the Performance Management system, providing updates to the QuIPM Committee and making recommendations for improvement projects based on PM results.

Kane County Health Advisory Committee

- Provide consultation and feedback to KCHD staff regarding QI/PM efforts
- Inform the Kane County Board about agency QI/PM efforts
- Make recommendations to Kane County Board on policy change regarding QI/PM
- Participate in orientation regarding QI/PM efforts and assist in development of QI/PM orientation materials for Kane County Board/Board of Health

Kane County Board/Board of Health

- Provide oversight of QI/PM efforts by the agency
- Set policies to facilitate implementation of the QI plan and activities
- Participate in orientation of QI/PM efforts

d. Staffing and Administrative Support

The Health Data and Quality Coordinator position is specifically tasked with the development, implementation, evaluation and coordination of all QI/PM activities within KCHD, comprising 60-75% of the full-time equivalent (FTE) position. As this position is housed within the Office of Community Health Resources, the Support Associate for that Office may be tasked for administrative support as needed. Additional staffing and/or administrative support may be provided by the Assistant Director for Community Health Resources, the members of the QuIPM Committee, or the Executive Director.

e. Budget and Resource Allocation

The primary budget allocation for this program is for the Health Data and Quality Coordinator position, which is paid out of local funds. As resources allow, budget line items may be dedicated to QI/PM efforts, including the purchase of training materials, attendance at conferences, and securing the services of expert consultation in the areas of QI and PM. Future planning in this area will include analysis of cost, return on investment of implementation of quality improvement projects, and a more in-depth understanding of budget allocation specific to QI for staff members, members of the QuIPM Committee, and the Leadership team.

V. Training

a. New Employee Orientation

As a part of the new employee orientation process, all KCHD staff and interns will be provided an orientation to the quality improvement and performance management systems by their direct supervisor, with the support of the HDQC, including assignment to an existing PDCA workgroup. New employees will be provided orientation to the PDCA process, as well as

completed projects. They will be informed on the location of QI and PM materials (network shared drive) and be given time to review those materials as a part of their orientation. Completion of the "QI 101" introductory course will also be a part of the new employee orientation, and within the first six months of employment, new employees should also complete training modules for Aim Statements, Cause & Effect (Fishbone) Diagrams, Data Collection & Analysis, Flowcharts and SWOT Analysis. These web-based training modules will include the completion of a quiz on the material, which will be graded by the HDQC. Failure to reach a score of 80% or higher on the quiz will require the HDQC to complete a one-on-one training session with the individual.

b. Advanced Training for Lead QI Staff

Members of the QuIPM Committee and KCHD Leadership teams are expected to have higher-level QI skills, and as such, will be provided additional training on QI tools and methodologies. A series of "Train-the-Trainer" modules are available for this group, and include:

- Aim Statement
- Affinity Diagrams
- Brainstorming
- Cause & Effect Diagrams
- Data Collection & Analysis (Check Sheet, Bar Chart, Pie Chart, Run Chart)
- Five Whys/Five Hows
- Flowcharts
- Force Field Analysis
- Gantt Chart
- Pareto Diagrams
- PDCA
- Storyboards

These modules are housed on the agency's network shared drive, with the location communicated to the QuIPM Committee and KCHD Leadership team. These modules are available for use as self-study or for hands-on training during QuIPM Committee meetings. QuIPM Committee members are strongly encouraged to practice use of these tools within their sections, reporting back the results and the product created from the training session.

Additional opportunities for advanced training in the areas of QI and PM will be made available to the QuIPM Committee and KCHD Leadership team as applicable and as resources permit. These could include, but are not limited to, webinars, off-site training opportunities, and participation in conferences.

c. On-going Staff Training

Web-based training modules have been developed and are available to use as refresher or for new employees on a number of QI tools. Those indicated in **bold text** are required for completion by all KCHD staff, while completion of the remaining training modules should be strongly encouraged for all staff.

- **Aim Statements**
- Affinity Diagrams
- Brainstorming
- **Cause & Effect Diagrams**
- **Data Collection & Analysis** (Check Sheet, Bar Chart, Pie Chart, Run Chart, Pareto Diagram)
- Five Whys/Five Hows
- **Flowcharts**
- Force Field Analysis
- Gantt Chart
- **QI 101/PDCA**
- Prioritization Matrix
- Storyboards
- **SWOT Analysis**
- Voice of the Customer

Links to each presentation and the corresponding quizzes have been housed on the agency's shared network drive, with the location communicated to staff for access at any time. In addition, a one-page handout on each tool has been made available on the shared drive.

Refreshers on these tools can be provided in a number of venues, including All Hands, Division, Section, and/or Team meetings. Areas of focus for training at these meetings will be based on results of a QI training needs survey, completed annually, or at the request of the KCHD Leadership team. In addition, as a part of the support to begin PDCA projects, the HDQC (or a designee from the QuIPM Committee) will review the tools used as a part of the PDCA process before they are implemented.

Reinforcement of training has also been identified as critical to the use of these tools, and KCHD will utilize a number of strategies for this reinforcement. These strategies include utilizing QuIPM Committee members in a cross-silo format to provide training and technical assistance (as an outside third party), sharing stories of QI tool use in "what's working" sections of meetings, using QI tools with our partners and in the community, and using Line of Sight to help people connect daily QI tool use to bigger picture strategies such as those in the CHIP and Strategic Plan.

Additional opportunities for training in the areas of QI and PM will be made available to staff as applicable and as resources permit. These could include, but are not limited to, participation in webinars, off-site training opportunities and participation in conferences.

d. Position-Specific QI Training

The HDQC, with specific accountability for the implementation of the QI program, will attend trainings and conferences specific to QI as available and as resources allow, assuring that skills are enhanced and that KCHD remains abreast of current topics in QI/PM. In addition, the HDQC will participate as a member of the NACCHO QI Leaders Group, in order to be aware of training opportunities and contribute to national efforts to integrate QI/PM in public health.

New members of the Kane County Board/Board of Health will receive information on the KCHD's QI/PM policies and activities as a part of their new board member orientation.

VI. Identification of Improvement Projects & Alignment with Strategic Plan

a. Project Selection Criteria

Quality improvement project selection will be based on the need to improve program processes, objectives, and/or performance measures and that are tied to the agency Strategic Plan and Performance Management system. Projects may be selected in a number of ways, including, but not limited to, identification by Leadership and QuIPM Committee during quarterly reviews of Performance Management data.

On an annual basis, each of the six sections of KCHD (Community Health Resources, Administration, Public Health Nursing, Communicable Disease, Environmental Health and Community Health) will select and develop at least one PDCA project. After selecting a project, the PDCA workgroup will be expected to complete a QI proposal and project plan (Appendices A, B & C), to be submitted to the QuIPM Committee for discussion and feedback.

The QuIPM Committee can also be called upon to provide support and technical assistance in the development of QI proposals and project plans, and should be regularly updated on the project. While it is ideal that each section's PDCA project involve as many section staff as possible (optimal state: include all section staff), the section may opt to select a project that involves only a small group, so long as the remaining staff remain engaged in other QI activities.

Each KCHD Section will be expected to be working on at least 1 PDCA project each calendar year, but may choose to work on multiple projects simultaneously. It is the expectation that the selected PDCA project for each section will be documented via the storyboard format, and that the finished storyboard be shared with staff. At the discretion of the KCHD Leadership team, the storyboards may also be posted on the agency's website and submitted to the Public Health Quality Improvement Exchange (PHQIX).

In addition, sections or workgroups may choose to develop improvement projects outside of the PDCA model, utilizing appropriate QI tools. While completion of a storyboard is not required for non-PDCA projects, documentation of the process, tools used, outcomes, and lessons learned should be completed, either in the form of progress notes, meeting minutes or through the use of PDCA worksheets (completing applicable sections).

A list of PDCA projects selected by the sections of KCHD can be found in Appendix F of this document.

b. Agency and Division Level Goals and Objectives (Performance Measures)

Annually, KCHD will conduct a process to identify agency and division-level goals and objectives (Performance Measures) as a part of the agency's performance management system. This process will include participation by all staff in each division, and selected measures will be documented using the Performance Measure Data Description and Collection Form (Appendix D). Originals of these documents will be maintained by division Leadership, with copies provided to the HDQC so a central repository of measures is maintained on the agency shared drive.

Performance Measures will have a direct line of sight with the agency's Strategic Plan, the Community Health Improvement Plan or another recognized performance standard, and this information will be captured on the Performance Measure Data Description and Collection Form.

The list of selected Performance Measures is included as Appendix E of this document. Additional information about Performance Management can be found in KCHD policy 9.1 and protocol P35.

VII. Goals, Objectives, and Performance Measures for QI/PM

Goals and objectives are based on the PHAB Standards and Measures, Version 1.0, released in 2011. These goals were selected as priority goals for this plan due to their connection with accreditation. PHAB domain 9 requires evaluation and continuous improvement of health department

processes, programs and interventions. Progress toward these goals is to be evaluated by the QuIPM Committee on a quarterly basis, and the results of this evaluation are included as a measure in the agency Performance Management system.

Goal 1: Establish a quality improvement plan based on organizational policies and direction.

Objective: Develop an annual agency QI/PM Plan that seeks to increase staff knowledge of quality improvement and supports the development of PDCA implementation, while considering the importance of the PHAB accreditation requirements moving forward.

Measure: Approved KCHD QI/PM Plan.

Key Strategies:

1. Creation of draft QI/PM plan by the Health Data and Quality Coordinator and QuIPM Committee.
2. Assessment of draft QI/PM Plan by QuIPM Committee for compliance with PHAB standards.
3. Review and approval of QI/PM plan by Assistant Director for Community Health Resources, QuIPM Committee, Leadership Team and Executive Director.
4. Final KCHD QI Plan approved by KCHD Executive Director.
5. Dissemination of approved plan to KCHD staff, Health Advisory Committee and publishing of document on KCHD website.
6. Year-end evaluation of QI/PM Plan for compliance with goals and initiatives described therein, to be completed by QuIPM Committee and KCHD Leadership Team.

Goal 2: Implement quality improvement efforts

Objective: Based on the framework of the KCHD QI Plan, implement PDCA as a QI strategy at KCHD.

Measure: Achieve 100% compliance with development and completion of PDCA projects.

Key Strategies:

1. HDQC will meet with each PDCA project lead at least monthly to provide training, technical assistance and support of PDCA project.
2. HDQC will maintain an electronic database of PDCA project work for each workgroup and assure that it is available on the KCHD shared computer drive (S Drive) for review by all KCHD staff.
3. HDQC will provide at least monthly updates to the Assistant Director for Community Health Resources on progress of PDCA projects.
4. All PDCA project workgroups will use standard documentation for their projects, including the PDCA Decision Matrix, PDCA Project Proposal, PDCA Project Plan, PDCA Pre-Planning Checklist, progress notes maintained using the PDCA Outlines (Steps 1-9) and the completion of a storyboard at the conclusion of the project.
5. All sections will maintain a record of use of QI tools, both within the context of and independently from PDCA projects. Sections will report QI tool use monthly at QuIPM Committee meetings. Section-level and department-level targets will be included as performance measures.
6. Communication of QI efforts will be completed via posting of materials on the KCHD website and the quarterly completion of the QI Newsletter by the QuIPM Committee (in January, April, July & October).

Goal 3: Demonstrate staff participation in quality improvement methods and tools training

Objective: Provide an adequate level of QI training to all KCHD staff.

Measure: Train 100% of KCHD staff on QI Tools and QI processes as outlined in QI plan.

Key Strategies:

1. HDQC will create and maintain a training log of staff that have participated in QI Training, and will share a summary of that on a quarterly basis with the KCHD Leadership team and QuIPM Committee.
2. All staff will participate in a quiz of the material following training, as well as completing an evaluation of the effectiveness of the training/presentation. Results of both will be used to determine needs for additional training in each area.
3. 100% of staff will have completed the six required QI training modules by the end of the plan year.
4. 50% of staff will have completed all of the available QI training modules by the end of the plan year.
5. An annual survey of staff will be conducted to assess need for training, and specific areas of focus.
6. KCHD Leadership will assure that new employees receive orientation and initial QI training (using web-based modules) within six months of date of hire, as well as on-going training.
7. The QuIPM Committee will demonstrate competence with use of at least 6 QI tools during the year.
8. KCHD Leadership will demonstrate use of at least one QI tool in 75% of their Division/Section meetings. The use of this tool should link directly to work of the meeting agenda.
9. Establish a baseline of KCHD staff that have included among their annual evaluation objectives at least one objective that is directly tied to the demonstrated use of QI tools or methodologies, with a goal of increasing this to 100% over time.

Goal 4: Use a performance management system to monitor achievement of organizational objectives.

Objective: Implement a fully functioning performance management system that is completely integrated into health department daily practice at all levels and includes organizational objectives, indicators of progress, monitoring and reporting of progress, and identifying areas where quality improvement can help achieve objectives.

Measure: Adopt and fully implement a Performance Management system.

Key Strategies:

1. Annual assessment of Leadership using the Turning Point self-assessment.
2. Develop an annual QI/PM Plan that outlines the framework for the Performance Management system, is reviewed by the QuIPM Committee and Leadership Team, and is signed by the KCHD Executive Director
3. Annual selection of performance measures by staff in all KCHD Sections/Divisions, which align with the Strategic Plan, CHIP or other set of standards.
4. Creation and at least quarterly update of a performance management dashboard.
5. Quarterly dissemination of performance management data to all staff and discussion in at least one Division-level meeting quarterly.

5. At least annual training/refresher to all KCHD staff on Performance Management conducted during the year.
6. At least annual discussion of the Performance Management system with the governing entity (Health Advisory Committee and/or Kane County Board).

Goal 5: Implement a systematic process for assessing customer satisfaction with health department services.

Objective: Collect, analyze, draw conclusions and take actions based on customer feedback.

Measure: Quarterly collection of customer data from all KCHD programs.

Key Strategies:
1. Annually review and approve of the Customer Satisfaction policy, which outlines the process to collect customer-facing data.
2. Require the inclusion of a customer-facing measure as a performance measure for each section of KCHD, with results evaluated on at least a quarterly basis.
3. Quarterly, disseminate a standard customer satisfaction tool to all external customers (non-partnerships) receiving services from KCHD.
4. At least annually, disseminate the Wilder Collaboration Factors Inventory to all KCHD-led partnerships. Based on the results, partnerships will select a smaller set of questions from this tool to evaluate at least quarterly.
5. Quarterly analysis of results of all surveys. Results of this analysis provided to individual programs for use in performance measures, in aggregate to the entire department (also included as a performance measure).
6. Actionable improvement steps taken resultant from surveys in at least 50% of KCHD sections on an annual basis.

In addition to these goals, a number of agency performance measures have been developed specific to the areas of QI/PM. These measures can be found in Appendix E of this document (Measures CHR-1 to CHR-7).

VIII. Monitoring of Quality Improvement/Performance Management

a. Collection, Analysis and Monitoring of Data

Data will be collected for each of the KCHD Performance Measures by the program/division indicated on the Performance Measure Data Description and Collection Form. Assistance and support for this process can be provided by staff in the Office of Community Health Resources as necessary. A summary of data points from each division will be submitted to the HDQC on the 15th of the month (for the previous month), for inclusion in the agency's data repository and dashboard. For measures reported on a quarterly basis, the data is to be reported by the 15th of the months of March, June, September and December (unless measure is on an alternate reporting schedule indicated on the Data Description and Collection Form). This data repository and dashboard will be housed and available for all staff on the agency's network shared drive. Once updated, an e-mail will be sent to all staff from the HDQC, notifying them of the available updates.

Quarterly meetings will occur with each Division Leadership team and their QuIPM Committee representatives to review and analyze the results, identifying opportunities for improvement projects. As a part of this meeting, Divisions will also report whether each

performance measure is on-target (identified as green, meaning no QI action is required), slightly/somewhat off-target (identified as yellow, meaning some QI action is required), or far/significantly off-target (identified as red, indicating that significant QI action, such as PDCA, is required).

b. Reporting Progress Toward Achieving Stated Goals

KCHD Divisions and Sections will report progress on performance measures to their respective staff on at least a quarterly basis. This reporting will include a update of the data dashboard, a summary of progress on performance measures, identification of opportunities for quality improvement actions and the plan of action, and a summary of active PDCA projects (including QI tools used, timeline and action steps and data points being used/monitored for the project). Performance Management and Quality Improvement, including progress toward goals and objectives, will be on the agenda of at least one All Hands meeting each year.

c. Actions to Make Improvements Based on Progress Reports

During the quarterly meeting between representatives of OCHR (including the HDQC), Division leadership and Division QuIPM Committee members, the group will review each of the Division performance measures and determine their status (green/yellow/red). For those measures in which QI action is required, an action plan/Gantt Chart will be developed to guide the completion of this work. QuIPM Committee members should take the lead on implementing these QI action plans, with the support of their Division team members and leadership. Technical assistance can be provided by OCHR as needed. The results of these QI efforts are to be reported at the next quarterly meeting.

IX. Sustainability of Quality Improvement

a. Communication & Promotion

A number of methods will be used to assure that regular and consistent communication occurs regarding QI/PM efforts within KCHD. These methods will include, but are not limited to:

- PDCA workgroup updates at All Hands meetings,
- Presentations and training at All Hands, Division, Section and Team meetings regarding QI project updates or QI tools,
- Minutes from meetings of the QuIPM Committee, Health Advisory Committee and Public Health Committee posted on the network shared drive,
- Storyboard presentations at All Hands, Division, Section and/or Team meetings, as well as display of completed Storyboards on KCHD website,
- Creation of a quarterly QI/PM newsletter, created by the QuIPM Committee, updating all staff on QI/PM efforts, both within KCHD and in the public health community. The newsletter will be posted in offices, e-mailed to all staff and posted on the KCHD website,
- Inclusion of QI efforts in Health Matters newsletter at least twice in the calendar year,
- Inclusion in Kane County Board flash reports at least once annually,
- Inclusion of QI efforts on social media sources (Facebook and Twitter) at least once per quarter, and
- Presentation of the approved QI/PM Plan via either e-mail or at a staff meeting, including the expectations of the contributions of all KCHD staff; a link to the plan on the

KCHD shared computer drive (S Drive) will also be provided, and KCHD staff will be encouraged to review and provide comment on the document.

b. Recognition

As KCHD seeks to develop a culture of quality that encourages all staff to develop their own skills relative to quality improvement and performance management, strategies for recognition are also designed to acknowledge the efforts of all use of QI and PM. Strategies designed to recognize QI/PM efforts include, but are not limited to:

- Providing regular updates and recognition of PDCA project teams and work completed at All Hands meetings,
- Sharing stories and "bright spots" of QI tool use at Division, Section and Team meetings, as well as at QuIPM Committee meetings,
- Providing bulletin board space in KCHD offices to highlight a team's QI work, and
- The use of incentives and rewards as resources allow and are recommended by the Leadership team and QuIPM Committee.

c. Agency Policies

KCHD initially developed policies regarding QI and Performance Management in 2010, which were approved by the Executive Director in August 2011. These policies are to be reviewed annually by the QuIPM Committee and modified as necessary to reflect changes in QI/PM efforts. After annual review and approval by the QuIPM Committee, the final policy will be forwarded to the KCHD Executive Director for approval. The approved QI and PM policies will be maintained in the KCHD policy book, and an electronic copy will be maintained on the agency's shared network drive for access by staff.

X. Approval and Evaluation of Quality Improvement Plan

Annually, a draft QI/PM Plan for the fiscal year will be developed by the QuIPM Committee based on progress toward goals and evaluation of the previous year's plan. Once a draft is complete, it will be vetted through the Assistant Director for Community Health Resources, the KCHD Leadership Team, and the Executive Director, in that order. The Executive Director will provide final approval and signature.

In the fourth quarter of each fiscal year, the QI/PM Plan and activities will be evaluated by the QuIPM Committee and the KCHD Leadership team. This evaluation will include:

- A review of the process and progress toward achieving goals and objectives,
- Efficiencies and effectiveness obtained and lessons learned,
- Customer/stakeholder satisfaction results (to be implemented in January 2014),
- A summary of QI projects and results of those projects, including but not limited to PDCA efforts,
- Progress on performance measures related to QI/PM,
- Effectiveness of the agency's PM system, including the results of the annual survey completed by Leadership (Turning Point Performance Management Self-Assessment),
- Effectiveness of the agency's QI training program, including the results of the annual QI Training Needs survey, and
- A summary of how the results impacted the development of the QI/PM Plan for the next year.

The results of this evaluation will be compiled by the QuIPM Committee and forwarded to the Executive Director for review and approval.

Based on the recommendations of the QuIPM Committee and the Executive Director, the plan will be revised annually to reflect program enhancements and revisions. Activities planned for the next year will be based on recommendations from the annual plan evaluation, and supported by the results of the annual staff QI Survey.

Approved this 3rd day of December, 2013 for the period of December 1, 2013 – November 30, 2014.

Barbara Jeffers, Executive Director

Appendix A
Kane County Health Department
Quality Improvement PDCA Project Proposal

Adapted from Tacoma-Pierce County Health Department

Project title:	***Submitted by:***
Date submitted to QuIPM Committee:	***PDCA Matrix Completed & Attached:*** Yes ☐ No ☐
Briefly identify or describe the program, project or process that should be addressed with an QI project:	
Priority: ☐ High ☐ Medium ☐ Low	***Please explain why you selected this priority level:***

Departmental Implications

a. ***Which strategic initiative and/or CHIP priority does this project support, or how does this project support our mission and/or vision?***

b. ***Who are the stakeholders (internal and external) and what are their concerns?***

c. ***What resources and support will be needed to complete the project?***

d. ***What potential impact could there be on other programs/activities if this QI project is conducted?***

What are we trying to accomplish? (A brief goal statement)

How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project)

Long term:

Medium term:

Short term:

What changes can we make that will result in an improvement? (Initial hypotheses and description of data needed to focus the project and the development of an intervention)

Who should be on this QI team?	***Who should lead this QI team?***

Reviewed by QuIPM Committee on _____/_____/20_____

QuIPM Committee Member Signature: _____

Appendix B
Kane County Health Department
Quality Improvement PDCA Project Plan

Adapted from Tacoma-Pierce County Health Department

Project Name:	**Project Leader:** *Who is leading this effort?*
Strategic Directions/Goals : *What does your Division Director/Admin Manager expecting this project to contribute to the Department's strategic plan?*	
Measure(s): *The PRIMARY quantitative indicator(s) which would demonstrate performance had improved & what your baseline data shows.*	**Target(s):** *How much improvement is expected or hoped for?*
Customer(s): *Who is/are the PRIMARY recipient(s) of the program's "product" or service?*	
Process(es) to be addressed: *What are the core work/service processes within the program?*	**Which of these will you focus on first?** *Which process(es) are most directly related to the PRIMARY measures and strategic directions? Where will you have the biggest impact?*
Division Director: *Who is the project leader accountable to? Who is responsible for guiding and resourcing the program's improvement efforts?*	
Constraints: *What time, space, financial, system, policy, organizational or other constraints should the program leader should be aware of?*	
Team Members: *Who will be active participants in your improvement efforts? All staff may be involved in some way, at some point, but who are your PRIMARY participants?*	
Support Resources: *Who are the internal or external analysts, facilitators, consultants that have been assigned to support your improvement efforts?*	
Target Start Date:	
Target date for completion of first improvement cycle:	

Reviewed by QuIPM Committee on _____/_____/20_____

QuIPM Committee Member Signature: _____

Appendix C
Kane County Health Department
Quality Improvement PDCA Project Decision Matrix

Place an X in boxes where the criteria matches the potential project. Add up each column and place the total in the box at the bottom of each column.

	NAME OF POTENTIAL PROJECT	NAME OF POTENTIAL PROJECT	NAME OF POTENTIAL PROJECT
Has an existing process (if not, explore quality planning)			
Has existing data to indicate a problem exists (or data can be easily collected)			
Is connected to CHIP, Strategic Plan or program/grant requirements			
Has potential for rapid turnover (at least monthly)			
Project is on a manageable scale ("bite" vs. "elephant")			
Resources are available to support project's implementation			
We have ownership/control over the outcome of the issue			
Have discussed level of reach and potential need to include others			
Staff has demonstrated interest and engagement in the project			
TOTAL			

Appendix D
Kane County Health Department
Performance Measure Data Description & Collection Form

Year _____ Program _____

___ Division Level Measure ___ Agency Level Measure

Performance standard:	
Performance measure:	
Baseline measurement data and date(s) collected:	
Target or benchmark?	
What is the target/benchmark?	
Rationale for selection of this performance measure:	
Target population:	
Numerator:	
Denominator:	
Source of data:	
Who will collect the information?	
How often will the data be analyzed and reported?	
Definitions and other comments:	

Quarterly Reporting				
1st Qtr	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Year Total**

Appendix D
Kane County Health Department
Performance Measure Data Description & Collection Form

Definitions/Clarifications

Performance standard: National standards, state-specific standards, benchmarks from other jurisdictions, or agency-specific targets to define performance expectations.

Target population: A description of the group of people that your measure covers. For example, will the measure report data for all Kane County residents or only clients that participate in your program? In many cases, this may be the same as the denominator.

Numerator: In a percentage or rate, this is the top number. For example, the numerator for the percent of Kane County adults who smoke cigarettes is the number of adults who currently smoke cigarettes.

Denominator: In a percentage or rate, this is the bottom number. For example, the denominator for the percent of Kane County adults who smoke cigarettes is the number of Kane County adults.

Target: This is the "goal" for the performance measure. What number are you trying to reach? Examples are a percent improvement from previous years or higher than the average rating for comparable local health departments.

Benchmark: This is a "gold standard" goal for a measure, usually set by an external organization. Examples of a benchmark are Healthy People 2010 objectives where the target setting method is listed as "better than the best".

Baseline data: The rate/percent/number that you will be comparing current data with to determine whether there has been a change.

Baseline date(s): When was your baseline data collected? For example, it could be from the previous year or an average from the previous three years.

Definitions: Do any of the words or phrases in your performance measure need further explanation or definition? Here's where you would put that information.

Rationale for selection: Performance measures should have a direct connection to a national performance standard, a CHIP priority, a strategic plan initiative, or the requirements of a program or grant. Measures should also be selected based on the evidence base. This connection should be expressed in this section.

Appendix E
Kane County Health Department
Performance Measures – FY2014 (12/1/2013 – 11/30/2014)

Division	Program - Number	Measure	Baseline	2014 Target	Assigned Staff	Reporting Schedule
OCHR	Administration (ADMIN1)	% of staff that have completed required trainings in Workforce Development Plan	0%	90%	Kathy Fosser	Quarterly
OCHR	Finance (ADMIN2)	% of budget line items within budget with a variance +/- 5%	1.5%	10%	Kinnell Snowden	Quarterly
OCHR	Finance (ADMIN3)	% of months where KCHD maintains 3 months cash on hand	100%	100%	Kinnell Snowden	Quarterly
OCHR	Administration (ADMIN4)	% of employees satisfied with services from KCHD Admin section	TBD – Q1	90%	Kathy Fosser	Bi-annually, January & October
OCHR	Administration (ADMIN5)	% of KCHD job classifications with training schedules with goals & objectives	0%	100%	Kathy Fosser	Quarterly
OCHR	Administration (ADMIN6)	% of evaluations completed on time	71%	90%	Kathy Fosser	Quarterly
OCHR	Administration (ADMIN7)	% of employee files audited on time	100%	90%	Kathy Fosser	Quarterly
Disease Prevention	Communicable Disease (CD1)	% of 24-hour reportable diseases received on time	62.4%	70%	Sara Boline	Quarterly
Disease Prevention	Communicable Disease (CD2)	% of 7-day reportable diseases received on time	90%	95%	Sara Boline	Quarterly
Disease Prevention	Communicable Disease (CD3)	% of closed Gonorrhea cases receiving counseling before closure	15.9%	25%	Sara Boline	Quarterly
Disease Prevention	Communicable Disease (CD4)	% of CD cases completed in INEDSS within 14 days	68.7%	75%	Sara Boline	Quarterly
Disease Prevention	Communicable Disease (CD5)	# of clients served by CD interventions	4260	4000	Kate Marishta	Quarterly, cumulative
Health Promotion	Community Health (CH1)	% of active case capacity in Elgin MIECHV caseload	69%	85%	Theresa Heaton	Monthly
Health Promotion	Community Health-AOK (CH2)	Wilder Survey score	TBD	TBD	Terry Roman	Monthly
Health Promotion	Community Health (CH3)	Aggregated meeting effectiveness scores	TBD	4.3	Terry Roman	Monthly
Health Promotion	Community Health-FFK (CH4)	# of organizations endorsing Fit Kids 2020 Plan	0	24	Janie Maxwell	Monthly
Health Promotion	Community Health-HAV (CH5)	Meeting effectiveness surveys	TBD	4.2	Terry Roman	Monthly

Health Promotion	Community Health (CH6)	% of meeting minutes distributed within 10 business days	75%	100%	Terry Roman	Monthly
Health Promotion	Community Health (CH7)	# of callers and total calls to the Illinois Tobacco Quitline	TBD	TBD	Muneeza Azher	Monthly
Health Promotion	Environmental Health-W&S (EH1)	% of well & septic complaints investigated within 10 business days	95.24%	95%	Julie Wiegel	Quarterly
Health Promotion	Environmental Health-NCW (EH2)	% of required non-community well surveys completed	96.2%	95%	Julie Wiegel	Quarterly in Jan/Apr/Jul /Oct
Health Promotion	Environmental Health-Food (EH3)	% of food workers that have received basic food safety training	84.1%	85%	Julie Wiegel	Quarterly
Health Promotion	Environmental Health-Food (EH4)	% of isolated FBI complaints investigated within 72 hours	96.5%	95%	Julie Wiegel	Quarterly
Health Promotion	Environmental Health (EH5)	# of inspections completed	6689	6689	Julie Wiegel	Quarterly, cumulative
Health Promotion	Environmental Health-WNV (EH6)	% of West Nile Virus visit sites that receive educational information	0%	75%	Julie Wiegel	Monthly: May-October
Health Promotion	Environmental Health –Food (EH7)	% of routine food inspection reports filled out completely	TBD – Q1	80%	Julie Wiegel	Quarterly
Health Promotion	Environmental Health-W&S (EH8)	% of septic inspections with stamped plans on site	75%	90%	Dan Eder	Quarterly
Health Promotion	Environmental Health-Prop Maint (EH9)	% of property maintenance complaints responded to within 10 business days	88.9%	90%	Dan Eder	Quarterly
OCHR	CHR-QI (OCHR1)	% of staff that have completed all QI training modules	3.28%	50%	Julie Sharp	Monthly
OCHR	CHR-QI (OCHR2)	% of staff that have completed 6 required QI training modules	59.02%	95%	Julie Sharp	Monthly
OCHR	CHR-QI (OCHR3)	% of customers satisfied with KCHD services	TBD – Q1	90%	Julie Sharp	Quarterly
OCHR	CHR-QI (OCHR4)	% of KCHD PDCA project objectives met according to deadlines	TBD – Q1	75%	Julie Sharp	Quarterly
OCHR	CHR-QI (OCHR5)	% of key strategies met or exceeded in QI/PM Plan	88.9%	100%	Julie Sharp	Quarterly
OCHR	CHR-QI (OCHR6)	# of QI tools used by KCHD	50	60	Julie Sharp	Monthly
OCHR	CHR-QI (OCHR7)	# of QI tools used by OCHR section	15	15	Julie Sharp	Monthly
OCHR	CHR-Epi (OCHR8)	% of recipients that open ILI newsletter	22.8%	30%	Uche Onwuta	Monthly, Oct to Apr

OCHR	CHR-Epi (OCHR9)	% of TB exchange data sent on time	TBD – Q1	80%	Uche Onwuta	Monthly
OCHR	CHR-Epi (OCHR10)	% of ILI surveillance newsletters sent on time	50%	90%	Uche Onwuta	Monthly, Oct to Apr
OCHR	CHR-Planning (OCHR11)	# of meetings conducted with Kane County planners	0	8	Jackie Forbes	Quarterly, cumulative
OCHR	CHR-Planning (OCHR12)	% of completed CHIP objectives from strategy workplans	TBD – Q1	100%	Jackie Forbes	Quarterly
OCHR	CHR-Planning (OCHR13)	% of CHIP strategy goals that have improved since last CHIP	42%	85%	Jackie Forbes	Quarterly
OCHR	CHR-Epi (OCHR14)	% of Category 1 data requests responded to within 2 working days	85.7%	90%	Uche Onwuta	Quarterly
OCHR	CHR (OCHR15)	New grant dollars secured in fiscal year	$65,973	$157,240	Kinnell Snowden	Monthly, cumulative
OCHR	CHR-PHERP (OCHR16)	% of incidents with hotwash and AAR completed within 2 weeks of incident	TBD	100%	Jenny Fearday	Quarterly
OCHR	CHR-PHERP (OCHR17)	% of action items on improvement plans completed within 60 days of plan implementation	TBD	100%	Jenny Fearday	Quarterly
OCHR	CHR-PHERP (OCHR18)	% of exercises & trainings completed from MYTEP	TBD	100%	Jenny Fearday	Quarterly
OCHR	CHR-PHERP (OCHR19)	% of POD sites with site visit and plan update completed	15%	90%	Jenny Fearday	Quarterly
OCHR	CHR-Communications (OCHR20)	% of Health Matters newsletters opened	23%	29%	Tom Schlueter	Monthly
OCHR	CHR-Communications (OCHR21)	% of communications campaigns planned at least 1 week in advance & using planning tool	TBD	TBD	Tom Schlueter	Quarterly
OCHR	CHR-Communications (OCHR22)	# of unique visitors to kanehealth.com	2591	3109	Tom Schlueter	Monthly
OCHR	CHR-Communications (OCHR23)	# of people who saw Facebook posts ("reach")	128	170	Tom Schlueter	Monthly
Disease Prevention	PHN-Kane Kares (PHN1)	% of unsuccessful scheduled home visits	22.1%	15%	Diane Ferriss	Quarterly
Disease Prevention	PHN-Kane Kares (PHN2)	**MEASURE REMOVED - 11/15/2013**				
Disease Prevention	PHN-Kane Kares (PHN3)	# of eligible referrals received by Kane Kares	62	80	Diane Ferriss	Quarterly
Disease Prevention	PHN-Kane Kares (PHN4)	% of clinical supervision sessions completed	62.7%	100%	Diane Ferriss	Quarterly

Disease Prevention	PHN-Kane Kares (PHN5)	% of participants satisfied with Kane Kares services	TBD – Q1	90%	Diane Ferriss	Quarterly
Disease Prevention	PHN-HRIF (PHN6)	% of HRIF infants with 3 EPSDT visits documented by age one year	63.4%	80%	Arlene Ryndak	Quarterly
Disease Prevention	PHN-HRIF (PHN7)	% of HRIF infants & children up-to-date on immunizations	76.8%	90%	Arlene Ryndak	Quarterly
Disease Prevention	PHN-HRIF (PHN8)	% of referrals documented appropriately in Cornerstone	23%	100%	Arlene Ryndak	Quarterly
Disease Prevention	PHN-Lead (PHN9)	% of EH letters mailed within 30 days of inspection report	0%	50%	Olga DelToro	Quarterly
Disease Prevention	PHN-Immunizations (PHN10)	% of clients satisfied with immunization program services	100%	90%	Arlene Ryndak	Quarterly
Disease Prevention	PHN-Immunizations (PHN11)	% of VFC providers receiving required audits	100%	100%	Kathy Swedberg & Jeannie Walsh	Quarterly
Disease Prevention	PHN-TB (PHN12)	% of individuals removed from TB "Hot List"	22.2%	35%	Sara Boline	Quarterly
Disease Prevention	PHN-TB (PHN13)	% of medication refills accurately documented in Prevention Log	60%	100%	Sara Boline	Monthly
Disease Prevention	PHN-TB (PHN14)	% of expected DOT completed	91%	98%	Sara Boline	Quarterly
Disease Prevention	PHN-TB (PHN15)	# of LTBI clients (not on tx) that begin treatment or sign declination	11	13	Judy Zwart & Cheryl Kane	Quarterly
Disease Prevention	PHN-TB (PHN16)	% of clients completing 3HP treatment within 16 weeks of initiation	100%	100%	Judy Zwart & Cheryl Kane	Quarterly
Disease Prevention	PHN (PHN17)	% of Kane Kares data entered into ETO/Access within 24 hours of receipt	TBD – Q1	100%	Silvia Tijerina	Quarterly
Disease Prevention	PHN-Immunizations (PHN18)	# of immunizations provided by program	800	1500	Kate Marishta	Quarterly, cumulative
Disease Prevention	PHN-Immunizations (PHN19)	# of influenza vaccines provided by program	1000	1068	Kate Marishta	Quarterly, cumulative
Disease Prevention	PHN-Kane Kares (PHN20)	# of families served by Kane Kares program	126	115	Diane Ferriss	Quarterly, cumulative
Disease Prevention	PHN-Kane Kares (PHN21)	# of home visits completed by Kane Kares program	1389	935	Diane Ferriss	Quarterly, cumulative
Disease Prevention	PHN-Kane Kares (PHN22)	# of screenings completed by Kane Kares program	206	160	Diane Ferriss	Quarterly, cumulative
Disease Prevention	PHN-TB (PHN23)	# of TB tests administered by program	1810	1560	Kate Marishta	Quarterly, cumulative

Appendix F

Kane County Health Department

2014 Quality Improvement PDCA Projects

(Appendix F to be updated by March 2014)

Division of Disease Prevention

Communicable Disease Section

Public Health Nursing Section

Division of Health Promotion

Community Health Section

Environmental Health Section

Office of Community Health Resources

Administration Section

Community Health Resources Section

Agency level CQI plan

Agency name:

Is CQI already present on site, either formally or informally? Describe current CQI state (what already exists?) and desired future CQI state (what will be improved/added and how?).

CQI team and members roles and responsibilities:

CQI meetings and training: How Frequently? Who will be present? How many members? How long will they last?

1. Introduction
    a. Agency name:
    b. Is CQI already present on site in a formal or informal manner?
        i. Describe the current state and desired future state of the quality in the organization. Be honest and open about the current state since it is the base upon which you are building. The more accurate that you are in describing the current state, the better able you will be to determine the gap that exists to the future state. Closing the gap may take a few years, but it is where we want to be.
    c. Why does the agency need CQI?
2. Culture of quality
    a. What already exists?
        i. A culture of quality exists in the organization whereby data are valued and striving for process improvement and optimal outcomes is a shared vision of all members, including both staff and management
        ii. Data collection is sufficient to document benchmarks and facilitate CQI
        iii. Reports are produced in a regular basis and reflect important aspects of service processes and outcomes
        iv. Reports are used by key stakeholders to track performance and outcomes
    b. What will be improved or added and how?
3. CQI team and members roles and responsibilities:
    a. CQI responsibilities are not designated to one department, rather they should be imbedded through the entire agency. Principles of CQI should be used by staff throughout each agency.
    b. CQI involves everyone in decision making to improve services to better meet the needs of families. Each team studies a critical process in detail, collects information from stakeholders, and gathers data for the purpose of improving the quality of the critical process.
    c. Teams are the basis of empowerment and problem solving.
    d. They meet on a regular basis to study how to improve the process.
    e. Recommended that the CQI team be made up of at least three people
        i. CQI Lead/Rep/Specialist/Chair/Facilitator
            1. Manage the local (possibly community) CQI process
            2. Prepare and manage the analysis evaluation and synthesis of data
            3. Coordinate, facilitate and ensure proper recording of local (and possibly community) CQI meetings
            4. Collaborate with staff members through the CQI process to analyze policies, procedures and practices that influence the achievement of desired outcomes for stakeholders (families)
            5. Train staff on related CQI processes and procedures
            6. Work closely with State CQI Specialist (Deborah)
        ii. Scribe

1. Take detailed meeting minutes
2. Schedule meeting room

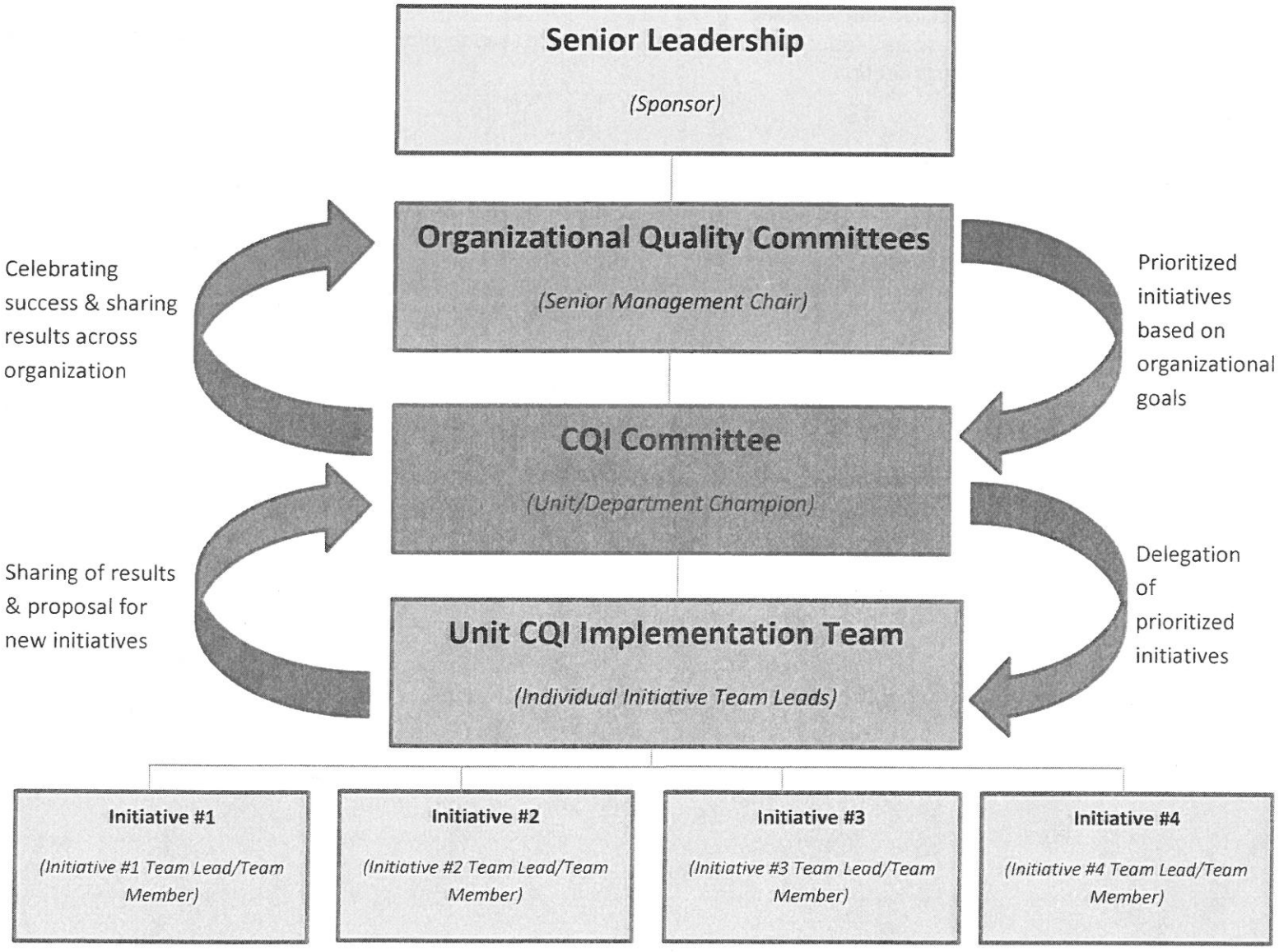
iii. Member

1. Participate in review of issues referred to the CQI team
2. Provide feedback to peers, stakeholders and families
3. Responsible for action steps and assuring that they are completed

iv. Sponsor

1. Highest level manager of the agency
2. Does not serve on the team, but approves the results of each process step taken by the team

4. CQI process map



5. CQI meetings and training
    a. Agency level meeting and trainings
        i. How Frequently? Weekly?
        ii. Who will be present? How many members?
        iii. How long will they last? One to two hours?
        iv. Who is a Chair/Facilitator?
            1. Facilitator can be separate from Chair to manage the team meeting process
    b. State level meetings and trainings
        i. State trains Team Leader/Facilitator who subsequently will provide training for team members
6. CQI data collection and reporting
    a. Reports are produced on a regular basis and are used to inform decision at all levels of the organization

Formulate Goals and Strategies At-A-Glance

A Step-by-Step Overview of the Formulate Goal and Strategies Phase:

1. Develop goals related to the CQI Team Mission Statement, Vision and the identified issues
    a. **Mission statement –** A goal that measures/challenges us in work related to the purpose of the organization and its primary goals
        i. Key questions:
            1. What are we doing?
            2. Why are we doing it?
            3. Why does it matter?
            4. How can we do it better?
            5. How will we know if we are improving?
    b. **Goals –** broad, long-term aims that define the desired result associated with identified strategic issues
        i. **SMART –** Specific, Measureable, Attainable, Relevant and Time Specific
            1. Ex: The HV team will increase the percentage of HV who follow-up on referrals given to families from 42% (current baseline percent) to 52% (reasonably attainable) over the next 6 months (time bound)
    c. **Strategies –** patterns of action, decision, and policies that guide an organization toward a vision or goal
        i. Strategies are broad statements that set a direction
2. Generate a range of strategy alternatives to address the goals and help the community achieve its vision
    a. Take current strategies and activities into consideration, as well as developing new and innovative approaches
        i. Best done using quantitative and qualitative data or information sources
            1. **Quantitative data –** information that is collected, organized and summarized using specific measurement tools and units of analysis
                a. Use Visit Tracker
            2. **Qualitative data –** information gathered by observations, senses or examinations
            3. **Document review –** examining notes, case records, meeting minutes
        ii. Identify all the apparent major causes and contributing factors
            1. Ex: Why referrals are not followed-up
        iii. Identify the major contributing factors
        iv. Identify strategies/activities that will address the major factors that are controllable
            1. Ex: **Strategic issue:** How can our organization ensure access to personal health care services?
                a. **Strategy Alternative:** Establish a community program for city and private services
                b. **Strategy Alternative:** Strength coordination among local health systems partners to eliminate gaps in service and improve referral mechanisms among providers
                c. **Strategy Alternative:** Increase awareness of available services through development of a directory of area public health and health care organizations

d. **Strategy Alternative:** Develop the capacity to provide culturally and linguistically appropriate services
e. **Strategy Alternative:** Increase education and outreach efforts so that all resident are aware of the population-based and personal health services available in the community

3. Consider barriers to implementation
    a. Ex: insufficient resources, lack of community support, legal or policy impediments, technological difficulties
4. Explore implementation details and develop the implementation plan to carry out the action strategies that will ensure attainment of the SMART goal by considering:
    a. Concrete actions that need to occur
    b. Which organization and individuals need to be involved
    c. What resources are required
    d. What the timeline should be
5. Select strategies by choosing among the alternatives
    a. Is it evidence based?
        i. Best practice?
    b. Once selected, adopt the strategies through formal or informal processes
        i. Impact – what is the potential impact of this strategic goal?
        ii. Cost – what is the cost of this strategy in terms of dollars, people, and time?
        iii. Probability of success – how likely is it that the strategy can be successfully implemented?
6. Identify process and outcome indicators
    a. Process example: Count the number of referral factors that home visitors have control over
    b. Process example: Are follow-ups to referrals more common among different geographic areas (rural, bus services), family medical history, family arrangement, employment status, number of children, etc.
    c. Process example: Number of strategies used by the HV to follow-up on referral s(phone calls, texting, incentives, etc.)
    d. Outcome example: See overall SMART goal
7. Draft, adopt and submit the planning report for review, feedback and approval by the MIECHV team
    a. **It serves as a reference** about what has been agreed upon and the direction that has been decided
    b. **It tests the consensus** about the agreements reached
    c. **It communicates the vision, goals and strategies** to partners and the broader community

EXAMPLE OF CQI PROJECT

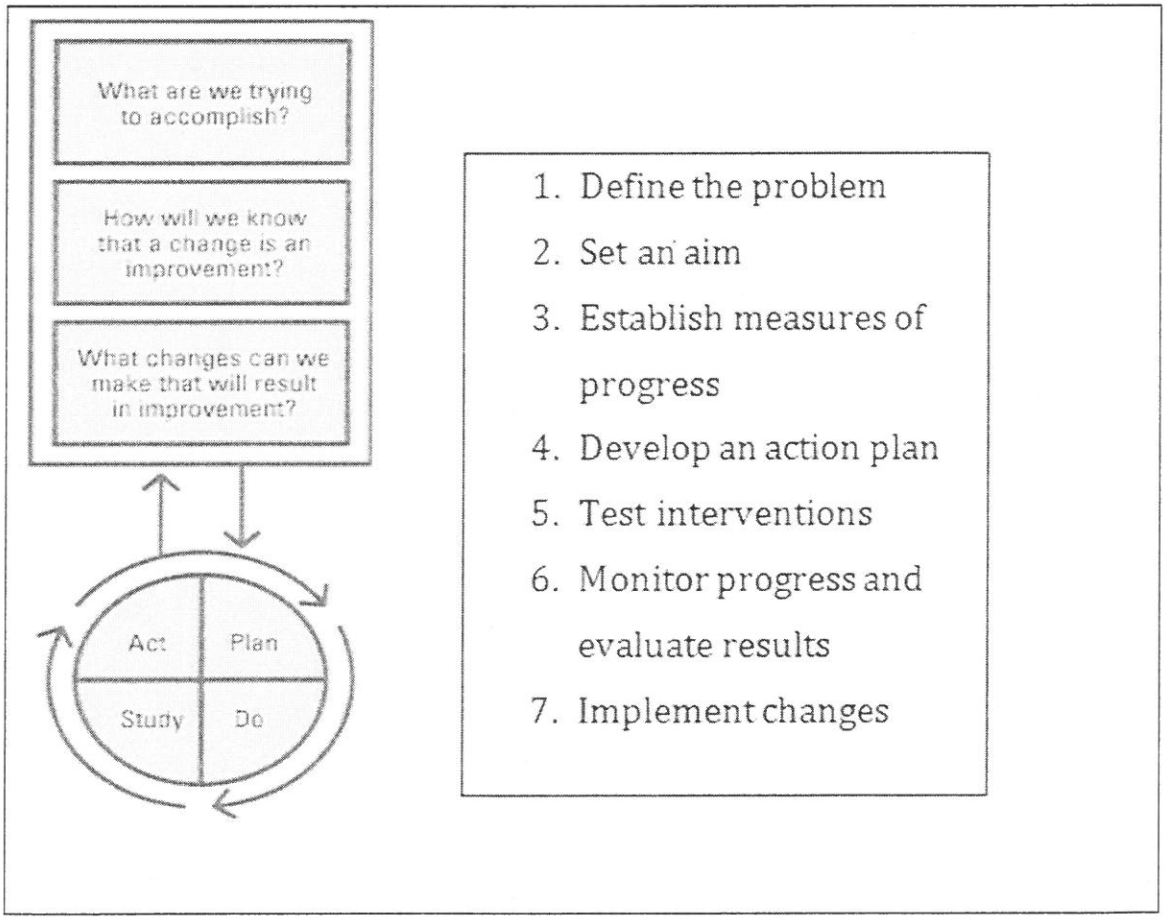
PROBLEM: Referral process not being used at capacity

Plan: Increase follow-up for referrals

Do: Visit offices to explain program and referral process
Create and distribute easy to use referral form
Send program brochure to offices
Attending staff meetings every 3 months to increase awareness of program

Study: Monitor referrals on a monthly basis
Analyze effect of each strategy by # of referrals received

Act: Continue to practice those strategies with the greatest effect/create new ones



CQI ACTION PLAN-CHANGE CONCEPT: Follow-ups for referrals

FACILITY:	TEAM MEMBERS:
CONTACT:	
GOAL: 1.	
PROBLEM STATEMENT: 1.	
ROOT CAUSE(S): 1.	

INPUTS & RESOURCES	ACTION PLAN	RESPONSIBLE TEAM MEMBER	START DATE	ESTIMATED COMPLETION DATE	ACTUAL COMPLETION DATE	IMPACTS & OUTCOMES

SMART GOALS – TEMPLATE

A SMART goal is:

Specific (and strategic): Linked to position summary, departmental goals/mission, and/or overall goals and strategic plans.

Measurable: The success toward meeting the goal can be measured.

Attainable: Goals are realistic and can be achieved in a specific amount of time and are reasonable.

Relevant (results oriented): The goals are aligned with current tasks and projects and focus in one defined area; include the expected result.

Time framed: Goals have a clearly defined time-frame including a target or deadline date.

Specific – WHO? WHAT?

Measurement/Assessment – HOW?

Attainable/Achieve – REASONABLE?

Relevant – EXPECTED RESULT?

Timed – WHEN?