

2014

# Carson City Health and Human Services (CCHHS)

## Quality Improvement Plan (QIP)

CCHHS Performance Management System  
Description and Quality Improvement Plan  
(QIP)



(This page intentionally left blank)

## Table of Contents

---

I.	Mission.....	p. 4
II.	CCHHS Culture of Continuous Quality Improvement: Current Status and Vision for the Future.....	p.4
III.	Key Quality Improvement Terms.....	p. 5
	a. Quality Improvement.....	p. 5
	b. SMART Objectives.....	p. 6
	c. AIM Statement.....	p. 7
	d. Performance Management Team.....	p. 7
	e. Quality Improvement Project Lead.....	p.8
	f. Quality Improvement Plan.....	p. 8
	g. Performance Management System.....	p. 9
	h. Plan-Do-Check-Act.....	p. 10
IV.	Key Elements of the QIP’s Governance Structure.....	p. 12
V.	QI Training.....	p. 16
VI.	QI Project Identification Process and Alignment with Strategic Plan.....	p. 19
VII.	Goals, Objectives, and Measures with Timeframes for 2014.....	p. 21
VIII.	QI Project Monitoring.....	p. 23
IX.	QIP and Performance Management System Review.....	p. 24
X.	Regular Communication of QI Activities.....	p. 28
XI.	Conclusion.....	p. 28
	Appendix A: Activities and Timelines from the CCHHS Strategic Plan – Strategic Priority 4: “Promote a Culture of Public Health Excellence” (CCHHS Strategic Plan 2013-2017, p. 4).....	p. 29
	Appendix B: CCHHS QI Project Process and Development Form.....	p. 30
	Appendix C: PHAB Standards and Measures v. 1.0, Domain 9.....	p. 36
	Appendix D: QI Calendar and Activity Tracking in SmartSheet.....	p. 40

## **I. Mission**

### **A. The CCHHS Organizational Mission**

To protect and improve the quality of life for our Community through disease prevention, education and support services.

### **B. The CCHHS Quality Improvement Mission**

To continuously improve the quality of our programs processes, and services so that we may provide high-performing services that best fulfill the needs of our clients and improve the quality of life in our community.

## **II. CCHHS Culture of Continuous Quality Improvement: Current Status and Vision for the Future**

CCCHHS has a history of conducting small-scale, unofficial quality improvement efforts to adjust to the ever-changing needs of the organization and its community. Most of these efforts were reactive to process glitches or to unmet customer needs. Others were based on meeting the needs of grant deliverables.

CCHHS first developed a Performance Management Team (PMT) in 2011 to further develop an organization-wide performance management system. Several key staff members have been involved in this team throughout the development of the current system, including external specialists, program level and administrative staff. The PMT also conducted a performance management system self-assessment in May 2013 (using the updated Turning Point Performance Management Self-Assessment Tool), that allowed the team to further explore the strengths and weaknesses of the CCHHS performance management system.

PMT has developed this Quality Improvement Plan (QIP) in order to ensure that further QI efforts are documented, measured, evaluated, and implemented in such a way that the performance management system is working to proactively improve the functions of the organization, rather than continuing the reactive efforts of the past. It is also hoped that from QI

education and training, a greater understanding of QI processes will allow both management and staff to develop and alter programs and processes that allow for increases in customer satisfaction, efficiency, efficacy, and improved employee satisfaction.

### III. Key Quality Improvement Terms

#### A. Quality Improvement

“Quality improvement (QI) in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health.

“It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.”

This definition was developed by the Accreditation Coalition Workgroup (Les Beitsch, Ron Bialek, Abby Cofsky, Liza Corso, Jack Moran, William Riley, and Pamela Russo) and approved by the Accreditation Coalition on June 2009.

#### 1. Quality Improvement vs. Quality Assurance

**a. Quality Improvement (QI):** a continuous cycle of improvement in a process, service, or program. (See also “continuous quality improvement”.)

Example of QI: Continuous evaluations of participant wait times at the annual Point of Distribution (POD) exercise, resulting in new strategies to reduce wait time, then further evaluation of those strategies for efficacy.

**b. Quality Assurance (QA):** a singular act to ensure that a program, service, or product is meeting a set standard.

Example of QA: Performing inspections of a clinic immunization storage unit at pre-set intervals to ensure that contents are kept at the correct temperature.

**c. 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 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 can 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. (PHAB Acronyms and Glossary of Terms, 2009)

## 2. SMART Objectives

A SMART objective is one that is Specific, Measureable, Achievable, Realistic, and Time-bound. The components of a SMART objective can be defined and developed as follows:

- **Specific:** Concrete, detailed, and well defined so that you know where you are going and what to expect when you arrive
- **Measureable:** Numbers and quantities provide means of measurement and comparison
- **Achievable:** feasible and easy to put into action
- **Realistic:** Considers constraints such as resources, personnel, cost, and time frame
- **Time-Bound:** A time frame helps to set boundaries around the objective

Developing SMART objectives ensures that there are parameters put in place that will guide all measurements and processes with which they are associated. These are a vital part of the QI process, and will be further discussed in the context of the AIM Statement.

The above definition of SMART Objectives was sourced from the Centers for Disease Control and Prevention. For more information about SMART Objectives, visit: [http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart\\_objectives.html](http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html)

### **3. AIM Statement**

An AIM Statement defines the purpose of the QI project at hand. It specifies the problems and the project goals. AIM Statements include a “SMART” (Specific, Measureable, Achievable, Realistic, and Time-bound) objective and defines what program or group is going to be affected by the QI project. It will also include a description of what numerical measures will be used to determine project success. It is best to begin any QI project with the development of an AIM Statement so that it is clear what the project team is setting out to change with the project.

### **4. Performance Management Team**

The purpose of the CCHHS Performance Management Team (PMT) is to work cohesively with all of the CCHHS Divisions and the Division Managers (DMs) to cultivate a culture of continuous quality improvement within CCHHS, and to guide and provide resources for staff QI projects. A Quality Improvement Plan (QIP) will be developed by the PMT to document this purpose, and guide new and existing staff in obtaining relevant QI training and proper implementation of QI projects.

The PMT is also charged with overseeing the progress towards the QI objectives that are laid out in the CCHHS Strategic Plan (SP) 2013-2017 (see Appendix A). These objectives will be monitored quarterly by the PMT in conjunction with the staff assigned to fulfill them, and progress towards all objectives of the SP will be included in the Annual Report.

## 5. Quality Improvement Project Lead

The Quality Improvement Project Lead (QI Lead) is a CCHHS staff member who has been identified to lead a quality improvement project. The QI Lead does not have to be a member of the PMT, and all CCHHS staff members are encouraged to take the roll of a QI Lead in a QI project that is applicable to his or her scope of work. The QI Lead is responsible for coordinating a team of staff for a QI project, bringing the project through all stages of PDCA, and making reports to designated staff at appropriate intervals.

## 6. Quality Improvement Plan

The Quality Improvement Plan (QIP) is an overarching guide to CCHHS department-wide QI goals and efforts. It will lay out specific objectives to be achieved by the PMT, and will ensure that QIP objectives align with objectives and activities laid out in the CCHHS Strategic Plan.

It is not the purpose of the PMT to identify and conduct QI projects at the program level. However, the PMT may be involved in efforts to identify and direct specific projects within the department, and to provide education, guidance, and support to those staff that are developing and pursuing QI projects.

## 7. Performance Management System

- **Turning Point Performance Management System:** The Turning Point Performance Management System is a framework developed specifically for performance management within public health organizations. It was developed by the Turning Point Performance Management Collaborative (<http://www.turningpointprogram.org/Pages/perfmgt.html>), and is currently housed by the Public Health Foundation (phf.org). CCHHS has adopted this system as the model for their performance management system.

## PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM



From the Public Health Foundation - Turning Point Performance Management System  
[http://www.phf.org/resourcestools/pages/turning\\_point\\_project\\_publications.aspx](http://www.phf.org/resourcestools/pages/turning_point_project_publications.aspx)  
Screen clipping taken: 11/7/2013 1:17 PM

- **Performance Management at CCHHS:** CCHHS will require all Divisions within the department to designate performance measures for the purpose of performance management. These measures should be directly in line with (or may be) measures required by grantors, regulatory bodies, or strategic plan objectives.

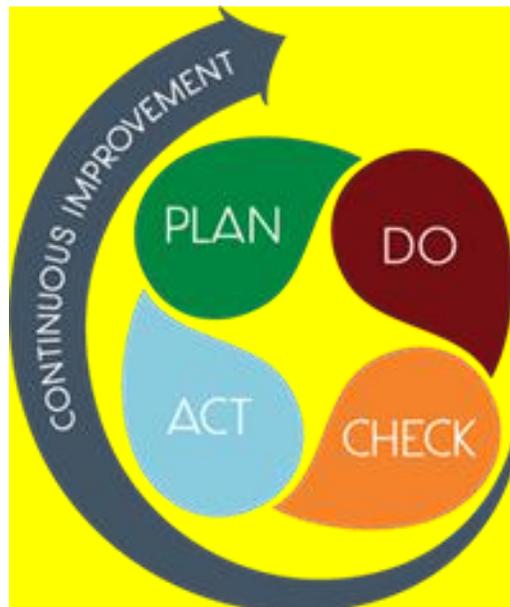
Updates on the designated performance measures will be reported to the Carson City Board of Health (BOH) on a quarterly basis to allow for further direction from the governing entity, as well as to provide transparency to the community at large. An example of these measures could be a review of after-action reports from outbreak investigations and emergency preparedness events and exercises conducted. A comprehensive presentation of the performance

management system and the QIP will be given to the BOH by the CCHHS Director, PMT Lead, or other designated staff on an annual basis.

The data collected from the performance measures will be the basis for large-scale QI projects to improve the overall performance of divisions, administration, or processes thereof. At least one project will be done per year driven by performance measurement data collected, and results will be reported to the BOH at a pre-determined meeting (to be determined in the QI Project Form for the specific project).

## 8. Plan-Do-Check-Act (PDCA)

The PDCA cycle is a nationally accepted approach to QI projects that gives projects direction through CQI. CCHHS has adopted PDCA as the appropriate method to plan, implement, evaluate, and act on new QI projects.



### a. Plan

The "Plan" stage of PDCA includes:

- Identifying all opportunities for improvement
- Prioritizing opportunities
- Developing an AIM statement
- Describing current process

- Collect data on current process
- Identify all possible causes
- Identify potential improvements to be made
- Develop a theory of improvement
- Develop an action plan

**b. Do**

The “Do” stage of PDCA includes:

- Implementing the proposed improvement
- Collecting data after the improvement is implemented
- Document observations of any problems, successes, or lessons learned.

**c. Check**

The “Check” stage of PDCA includes:

- Analyzing new data and contrasting it against data collected before the new improvement measures were implanted
- Documenting any further problems or lessons learned exposed by data analysis.

**d. Act**

“Act” is the final stage of PDCA. In this stage, one of three outcomes may be selected:

- The new improvement is **adopted** into the system,
- The improvement is **adapted** due to any problems that may have been observed either directly through implementation or through data analysis. The improvement then re-enters the PDCA cycle, or
- The improvement is **abandoned** and a new possible improvement enters the PDCA cycle in its place.

Adapted from a presentation of “The ABC’s of PDCA and Basic QI Tools” Jack Moran, Ph.D.; Les Beitsch, M.D., J.D  
NNPHI Public Health Improvement Training, April 22, 2013 Atlanta, GA  
Source: ABCs of the PDCA Cycle, G. Gorenflo and J. Moran, <http://www.phf.org/pmqi/resources.htm>

## **IV. Key Elements of the QIP's Governance Structure**

### **A. Structure of the PMT**

The QIP will be governed primarily by the PMT. The roles and responsibilities of the PMT can be found on the CCHHS shared drive (HDrive > PHAB > Subcommittees > PMT History and Summary)

The PMT will meet on a monthly basis, with additional meetings being held as necessary, and will maintain records and minutes of all meeting which will be available to all CCHHS staff on the shared drive (HD Dept > QI\_Performance Management > Meeting Minutes). At least annually the PMT will provide a report of the QI program to the Board of Health. During quarterly monitoring of objectives (in March, June, September and December), the team may need to meet more regularly.

### **B. Specific Quality Improvement Activities of the PMT**

- Education of Division Managers (DMs) on QI principles and practices
- Education of all staff members on QI principles and practices
- Include QI education in new hire orientation
- Include brief reports of Best Practices guidelines, QI projects, and use of Community Guides at all-staff meetings
- Provide support and guidance to ensure that each CCHHS Division engages in at least one QI project per year
- Include continuing education on QI principles in yearly skills assessment day for all employees
- Include evaluation of performance of QI principles in employee evaluations
- Develop a public recognition program for employees engaging in superior QI efforts, and ensure that these efforts are mentioned in the Annual Report
- Perform annual CCHHS Performance Management System self-assessments

### **C. PMT Membership and Rotation**

The PMT will be an informal committee composed of interested staff members of various backgrounds. Participation of at least one staff member from each CCHHS Division is encouraged to ensure that perspectives of each division are taken into consideration in charting the course and work of the PMT.

DMs will be kept up-to-date as to the activities and progress of QI projects within their division, and although their participation as members of the PMT is encouraged, it is not mandatory. The PMT Lead will provide updates on the activities of the PMT and QI projects to the CCHHS Director, who will provide these updates within DMs' meetings.

PMT members are encouraged to stay involved as long as they are able. Due to staff turnover, and the ability for new members to join from the same division, there will be no limitations as to the length of time a member may be allowed to participate in the PMT.

### **D. Roles and Responsibilities**

- Carson City Board of Health (BOH):
  - Identify area for improvement of performance measures
  - Provide vision and direction for the performance management system
  - Support the activities of the PMT
  
- CCHHS Director:
  - Oversee the development of the QI plan and QI program annual evaluations
  - Request review of specific evaluation activities or the implementation of QI projects
  - Identify appropriate CCHHS staff to participate in QI projects
  - Provide updates on PMT activities and QI projects to DMs
  - Promote a CQI environment for the department

- Apply QI principles and tools to daily work
- CCHHS Division Managers (DMs):
  - Support and participate in QI trainings and projects
  - Assure projects are consistent with Department mission, vision, and division goals and strategic plans
  - Assign QI Project Leads
  - Assure staff participation in QI trainings and activities
  - Assure that staff are oriented to QIP process and resources
  - Evaluate staff regarding QI activity participation
  - Keep Director apprised of QI activities
  - Allocate time and other resources to ensure that a culture of CQI is fostered throughout CCHHS
  - Apply QI principles and tools to daily work
- CCHHS Performance Management Team (PMT):
  - Conduct annual assessments of the CCHHS Performance Management System
  - Monitor QI related Strategic Plan objectives on a quarterly basis
  - Report annually on progress to the BOH
  - Conduct the objectives and activities assigned to the PMT in section VII.
  - Work in conjunction with the Director to develop employee training and recognition programs, with input from staff and DMs
- PMT Lead
  - Develop the QI Project development form to be used by staff members for proposed QI Projects
  - Provide updates on PMT activities and QI projects to Director
  - Provide general oversight for QI projects assigned as a lead
  - Monitor progress for assigned projects
  - Request resources as needed from DM, PMT and other staff

- PMT Members
  - Participate in QI projects as determined appropriate
  - Implement changes as determined appropriate
  - Participate in QI training
  
- CCHHS Staff
  - Participate in the work of at least one QI project annually
  - Act as a QI Lead, as appropriate
  - Develop an understanding of basic QI principles and tools through participation in QI trainings
  - Apply QI principles and tools to daily work

#### **E. Staffing and Administrative Support**

CCHHS does not currently have the capacity to support designated staff specifically for Performance Management and QI. PMT members will be responsible for conducting and/or monitoring all QI activities and elements within the Performance Management System. However, PMT members may call upon other staff to assist in projects as needed, so long as that those tasks are applicable to that person's skills, experience, and/or scope of work and do not require an unreasonable amount of time. It is strongly encouraged that the PMT communicate the needs of any tasks asked of staff outside the PMT with that staff member's DM, and ensure that what is being asked of them is not unreasonable.

#### **F. Budget and Resource Allocation**

CCHHS currently does not have funding specifically allocated to Performance Management or QI efforts. However, the PMT will work with the CCHHS Director, DMs, and other resources to identify means to add funding for Performance Management efforts, including QI.

## V. QI Training

### A. Formats Utilized

The PMT will utilize various types of training tools to train new members of the PMT, offer continued education for current PMT members, educate new and current CCHHS staff members to QI principals and processes, and increase education and understanding of QI within CCHHS as a whole. The formats of training tools utilized may include:

- In-person group training and presentations
- Webinars
- Reading of manuals or other training documents
- Online courses
- Other formats as appropriate tools become available

### B. Training Plan

In order for all staff members to engage in quality improvement projects, they must be appropriately trained in QI principals, as well as processes designated to complete successful QI projects.

Future training modules that may be added to the training curriculum may include (but are not limited to): logic models, program evaluation, advanced data analysis, and other topics related to QI methods for Public Health. These additions will change the QI training plan itself, and so DMS will be updated as to any changes made so that their staff can attain the necessary trainings. It is the intention of the PMT that the CCHHS Training Plan will evolve over time, given that specifics such as training content, mode of delivery, and length are all subject to changes from QI Projects surrounding them. It is the hope of the PMT that this broad and comprehensive knowledge base will aid in the use of evidence-based decision making throughout the organization.

As specified in the CCHHS Strategic Plan 2013-2017 (see Appendix A), there will be various stages of QI training:

**Initial Stage:**

- Training of all staff, including DMs, at Division staff meetings on new training modules

**Second Stage:**

- Annual competency assessment for all staff, including DMs
- Depending upon competency assessment, staff may be provided additional QI training at the discretion of that staff member's DM

**C. Training Composition**

QI Trainings will include the following modules:

- Module 1: Performance Management Systems and QI Principals: "Performance Management and Quality Improvement 101"
  - Basic introduction to QI principals and definition of terms
- Module 2: CCHHS Quality Improvement Project Processes: "I have an idea! How do I make this happen?"
  - CCHHS QI definitions of terms
  - Present QI Project form and process
- Module 3: Measuring Outcomes of QI Projects: "How do you know it worked?"
  - Identifying data resources – What is data?
  - Education on data collection and evaluation
  - Case examples given from other successful projects within CCHHS
- Module 4: Intro to Prioritization Tools
  - Fishbone Diagrams
  - Process Mapping
  - Others as appropriate

Additional training modules may be added to the training plan as needed.

#### **D. Training Record**

It is important to keep an up-to-date record of which training modules, and which version of those modules, staff has completed to ensure that:

- All staff members receive QI training
- As QI training modules evolve and are updated to newer versions, staff can be updated with future trainings

A training record will be kept in a shared location as specified by the PMT, so that it may be updated on a regular basis regardless of PMT membership.

(Training Record Location on CCHHS Shared Drive: PHAB > Subcommittees > PMT > QI Trainings > CCHHS Staff QI Training Record)

The training record will be reviewed annually in conjunction with the QIP review and revision.

#### **E. Training Plan Review**

- The training plan is to be reviewed and revised a minimum of annually, as best practices, new resources, and program needs are further defined and available.
- The training plan may be reviewed and updated more often, based on the direction given from the Director, based on input from DMs, staff, and members of the PMT.
- The results of the review and any revisions will be included in the overall QIP review given to the BOH annually.

## **VI. QI Project Identification Process and alignment with Strategic Plan**

### **A. Description and Demonstration of How QI Projects Align with the CCHHS Strategic Vision and Mission**

The CCHHS organizational Vision Statement (from the CCHHS Strategic Plan 2013-2017) reads as follows: “Carson City Health and Human Services leads the region in providing services that support healthy communities.”

The CCHHS organizational Mission Statement (from the CCHHS Strategic Plan 2013-2017) reads as follows: “To protect and improve the quality of life for our Community through disease prevention, education and support services.”

QI activities directly correlate with the CCHHS Vision and Mission statements through the shared desire to provide the best possible services to the community within the CCHHS organizational capacity and scope of work. In order to achieve the vision of being a leading public health services provider in the region, CCHHS must continuously improve programs, supportive services, marketing, and staff development. The Mission statement also provides specific direction to improve community quality of life, in the pursuit of which an organizational culture of CQI is essential.

There are many projects assigned to the PMT that are in fact measures taken directly from the Strategic Plan (including the development of the QIP, QI Training Plan, etc.). Although there are many other QI-related projects conducted by staff and reviewed by the QI Plan that are not listed in the Strategic Plan, these objectives align and move towards other goals and objectives common to the entire organization set forth in the Strategic Plan (Appendix A). Additionally, all objectives and measures within the strategic plan align with the CCHHS Vision and Mission Statements.

## **B. Description and Demonstration of How Areas for Improvement are Identified**

- Staff members are encouraged to seek out and identify opportunities for improvement through CCHHS's Active Strategy system, results of customer satisfaction surveys, agency-specific health program gaps identified in the Community Health Assessment (CHA), and general staff observations. Each Division will complete at least one QI project annually.
- When the need for a QI project is identified, the staff member's DM will identify or approve a staff member as the QI Lead.
- All QI Leads developing and overseeing QI projects will use the **CCHHS QI Project Development Form** (see Appendix B) as the tool to plan and develop their new QI project. In completing this form, the Project Lead will create an AIM statement and identify:
  - Staff members and resources involved in the project,
  - SMART (Simple, Measurable, Attainable, Realistic, and Timely) project objectives,
  - What data is to be collected,
  - How data is to be analyzed and reported, and
  - Timeframes for project evaluation.
- A PMT staff member will review all and sign all completed QI Project Development Forms. The purpose of this step is to ensure:
  - That project leaders have developed measurable objectives,
  - The project team has appropriate resources to complete project and to offer technical support if necessary,
  - There is an evaluation plan that is relevant to the project and meets CCHHS criteria, and
  - That the project is logged on the QI management monitoring / tracking tool.

- Once a PMT member has signed off on the QI Project Development Form, this becomes the roadmap of the process for the staff involved in that specific project.
- The QI Lead will report progress and results of the project to designated parties (their DM and/or the PMT) at designated intervals specified in the QI Project Development Form.
- Completed QI projects and all relevant data will be stored a minimum of five calendar years, so that they may be accessed for use in the CCHHS Annual Report and any appropriate Carson City Board of Health updates.

**VII. Goals, Objectives, and Measures with Timeframes for 2014**

<b>Objective</b>	<b>Activities</b>	<b>Timeline</b>	<b>Responsible</b>
<b>1</b>	Conduct QI education sessions at division manager meetings for at least six months initially.	a. Complete by December 31, 2013.  b. Develop a system of ongoing QI training for division managers and implement by January 31, 2014	PMT under direction of the Department Director.
<b>2</b>	Conduct QI education sessions for employees.	To be completed by January 31, 2014.	Curriculum recommended by PMT, approved by Division Managers (DMs) and Director. DMs monitor compliance.
<b>3</b>	Include education on QI principles in orientation of new employees; build into the Workforce Development plan.	Included in new employee orientation by December 31, 2014.	As in #2.

<p><b>4</b></p>	<p>Include brief reports of Best Practices guidelines, QI projects and use of Community Guides at all-staff meetings.</p>	<p>Reports at all-staff quarterly meetings, starting by June 30, 2014.</p>	<p>CCHHS Director</p>
<p><b>5</b></p>	<p>Each division engages in at least one QI project per year.</p> <p>a. Divisions develop initial project ideas in year one.</p> <p>b. Divisions submit project ideas each calendar year.</p>	<p>a. First QI project ideas due June 30, 2014; projects completed by December 31, 2014, or in accordance with objectives and timeframes identified in project document.</p> <p>b. Subsequent annual QI project ideas due by end of fiscal year and completed in accordance with project plan.</p>	<p>DMs and PMT</p>
<p><b>6</b></p>	<p>Include continuing education on QI principles in yearly skills assessment day for all employees.</p>	<p>Begin by December 31, 2014.</p>	<p>DMs and Director; PMT serves as a resource.</p>
<p><b>7</b></p>	<p>Explore opportunities to address principles in employee evaluations.</p> <p>a. Examine feasibility through appropriate channels</p>	<p>Begin by December 31, 2014.</p> <p>a. Decision on next steps (either proceed or abandon project) by December 31, 2015.</p>	<p>PMT works with Director and HR.</p>

	<p>b. Develop a plan of action to incorporate QI principals into staff evaluations, if deemed appropriate and necessary.</p> <p>c. Develop an evaluation tool</p>		
8	Develop public recognition program for employees engaging in superior QI efforts (to be included in the Annual Report in the future).	By December 31, 2014	PMT and Director, with input from staff

### VIII. QI Project Monitoring

The CCHHS QI Project Development Form (see Appendix B) will be used by QI Leads to plan each component of the QI project. Once the form has been completed, the QI Lead must have the Form approved by the PMT. The use of the Form enables the PMT to monitor the following factors:

#### A. Ensure data are collected and analyzed

Specific data to be measured within the QI Project will be outlined within the QI Project Development Form. Components of data collection and analysis to be addressed include:

- Data sources
- Data collection methods
- Timelines for data collection (pre-test, post-test, re-test)
- Methods used for data analysis
- Means by which data are reported, including pre-determined timelines

## **B. Progress is reported on stated goals and objectives**

Progress reports will be developed by the QI Lead and his or her team. The QI Project Development Form will include the following information about progress reports:

- What information is to be included in the progress reports
- Who is to receive progress reports
- At what intervals progress reports are to be given over the duration of the project

If reports from a QI project have not been received, a member of the PMT may contact the QI Lead for further information.

## **C. Actions taken to make improvements are based on progress reports, data monitoring and analysis**

Also included in the QI Project Development Plan will be a process of actions taken based on the information discovered by working a QI project. The Form will allow the QI Lead to outline how specific changes (if applicable) will be implemented and how those changes will become normalized into processes. This may involve inclusion of these changes in employee orientations, manuals, policies, skills days, trainings, or any other applicable format for information sharing.

# **IX. QIP and Performance Management System Review**

## **A. Process to Assess the Effectiveness of the QIP and Activities**

The QIP, as well as QI processes and forms may be subject to QI activities themselves. It is the intention that the QI processes, training, and QIP will evolve over time as new resources and information become available. A process to review all activities surrounding the CCHHS QI system will include the following steps:

## 1. Review of Efficiency and Effectiveness:

- Effectiveness:

- Goals:

- All staff have an understanding of basic QI principles and CCHHS practices
- All staff have had access to CCHHS QI training
- All staff are able to participate in and complete QI projects as necessary
- Each Division completes at least one QI project per year

- Evaluation:

- Data resources:

- Results of training evaluations
- Results of QI projects related to QI processes, documents, or trainings
- Results of customer satisfaction surveys
- Documentation of “Lessons Learned”
- Results of CCHHS self-assessments
- Other sources as available

- Efficiency:

- Goals:

- QI projects can be completed in a timely manner (based on the nature of the project), within the timeframes outlined in the QI Project Form, QI Calendar, or other timeframes as pertain to that particular

- Evaluation:

- Data resources:

- QI Calendar
- Feedback from internal/external stakeholders
- Results of customer satisfaction surveys
- Results of QI projects surrounding QI processes

## 2. Customer and Stakeholder Satisfaction with Services and Programs

### a. Customer Satisfaction Surveys

Customer satisfaction surveys are an integral part of overall quality measurement and identifying areas for improvement in the processes and programs at CCHHS. Therefore, customer satisfaction surveys will be administered on an annual basis (or more frequently, as given direction from DMs or the CCHHS Director). Methods for survey administration may include the following:

- Online survey, through:
  - CCHHS Website
  - CCHHS Facebook page
  - Other online sources as appropriate (emailing external partners, etc.)
- Paper surveys, to be administered in-house
- Other methods, to be determined

All of the abovementioned data resources and components will be included when performing the annual revision of the CCHHS QIP (see section IX. c., below). Data will be collected and compiled by the PMT and will be evaluated as deemed most applicable given the mixture of data available.

### b. Self-Assessments

Performance management system self-assessments will be done annually, and will be performed using the Turning Point Self-Assessment Tool (or another designated tool if determined to better suit CCHHS).

Results from the self-assessments will be used to develop improvement projects directly connected to the performance measures used in the self-assessment. One such project will be done per year.

### c. Revision of the QIP

The QIP will be revised and updated annually by the PMT, within one year from the date printed on the cover page (May 2014). During this review process, the PMT will evaluate the effectiveness of previous activities and identify areas for improvement within the QIP and PMT activities. This information will be used to develop an updated QIP and align it to the CCHHS Strategic Plan. Similarly, as the CCHHS Strategic Plan is reviewed and updated, new objectives, activities, and timelines will align with those of the QIP.

During the revision process of the QIP, the PMT will also review and make changes to the purpose, scope, or structure of the PMT and the QIP document itself. Additionally, QI training and resources utilized will be reviewed for relevance and feasibility for use by CCHHS staff and revised as necessary. Results of the plan review will be shared with the Department leadership and incorporated into the annual report to the BOH.

Points to be revised may include (but are not limited to):

- Performance Management System self-assessment
- Progress towards designated performance measures
- Progress on calendared QI Projects
- Training Plan
- Training content
- QI Project Form
- QI Project Process
- Roles and responsibilities
- Budget and staffing
- Linkages with CCHHS Strategic Plan
- Annual Reporting
- Recognition activities, as applicable

## **X. Regular Communication of QI Activities**

### **A. External Communication**

Updates on QI Projects, trainings, and other performance management system activities will be reported to the BOH on a quarterly basis. A more comprehensive presentation on the status of the performance management system will be given annually at BOH meeting.

### **B. Internal Communication**

Various methods of reporting the progress of QI activities to internal staff will be utilized based on CCHHS resources. Communication modalities utilized may include:

- Recognition in the CCHHS Staff Newsletter
- Reporting of project progress in All-Staff meetings
- Reporting of project progress in weekly DM meetings
- Other modalities as available

## **XI. Conclusion**

As CCHHS' first organization-wide QIP, it is acknowledged that most aspects of this plan will evolve with time, based on staff and community input and needs. However, the overarching goal of this plan is to lay a framework that will allow for the continual betterment of processes and procedures, so that CCHHS may strive to always offer services to the community that are rooted in up-to-date evidence-based practices, clarity, and customer service.

**Appendix A**

*Activities and Timelines from the CCHHS Strategic Plan*

*Strategic Priority 4: Promote a Culture of Public Health Excellence (p.4)*

Objective	Activities	Timeline
<p>C. Foster a culture of constant Quality Improvement.</p>	<ol style="list-style-type: none"> <li>1. Conduct QI education sessions at division manager meetings for at least six months initially.</li> <li>2. Conduct QI education sessions for employees.</li> <li>3. Include education on QI principles in orientation of new employees; build into the Workforce Development plan.</li> <li>4. Include brief reports of Best Practices guidelines, QI projects and use of Community Guides at all-staff meetings.</li> <li>5. Each division engages in at least one QI project per year.               <ol style="list-style-type: none"> <li>a. Divisions develop initial project ideas in year one.</li> <li>b. Divisions submit project ideas each calendar year.</li> </ol> </li> <li>6. Include continuing education on QI principles in yearly skills assessment day for all employees.</li> <li>7. Include evaluation of performance of QI principles in employee evaluations.               <ol style="list-style-type: none"> <li>a. Develop an evaluation tool.</li> </ol> </li> <li>8. Develop public recognition program for employees engaging in superior QI efforts (to be included in the Annual Report in the future).</li> </ol>	<ol style="list-style-type: none"> <li>1. a. Begin by June 30, 2013 and end by December 31, 2013.                b. Develop a system of ongoing QI training for division managers and implement by January 31, 2014</li> <li>2. Staggered one month. Begin by July 31, 2013; end by January 31, 2014.</li> <li>3. Included in new employee orientation by December 31, 2014.</li> <li>4. Reports at all-staff quarterly meetings by June 30, 2013.</li> <li>5. a. First QI project ideas due June 30, 2013; project completed by December 31, 2013.                b. Subsequent annual QI project ideas due by end of fiscal year and completed by end of calendar year.</li> <li>6. Begin by December 31, 2014.</li> <li>7. Begin by December 31, 2014.               <ol style="list-style-type: none"> <li>a. Evaluation tool developed by December 31, 2014.</li> </ol> </li> <li>8. Developed by December 31, 2014.</li> </ol>

## Appendix B

### CCHHS QI Project Process and Development Form

---

#### CCHHS Quality Improvement (QI) Project Process

Staff members are encouraged to seek out and identify opportunities for improvement through CCHHS's Active Strategy system, results of customer satisfaction surveys, agency-specific health program gaps identified in the Community Health Assessment (CHA), and general staff observations.

- A QI project is identified.
- A staff member will be identified as the QI Lead by the staff member's Division Manager.
- The QI Lead fills out the "CCHHS QI Project Development Form" as a tool to plan and develop their new QI project.

In completing this form, the Project Lead will identify other staff members involved in the project, SMART (Simple, Measureable, Attainable, Realistic, and Timely) project objectives, what data is to be collected, how data is to be analyzed and reported, and timeframes for project evaluation. This form follows the PDSA (Plan, Do, Study, Act) cycle and will ensure that the project results in measureable outcomes to report to DMs and other appropriate staff.

The QI Lead can seek out a member of the Performance Management Team (PMT) for assistance.

- Completed QI Project Development Forms will be turned into a PMT staff member for review and sign-off.

The purpose of this step is to ensure that project leaders have developed measurable objectives and an evaluation plan that is relevant to the project and meets CCHHS criteria. This shall be done in as timely a manner as possible.

Once the QI Project Development Form has been signed off by a PMT member, it will act as a living team tool that will be a roadmap of the process for the staff involved in that specific project. The form will be kept on the H Drive in the following location:

H Drive → HD Dept → QI\_Performance Management → Open Projects →(Specific project folder)

- The Project Lead will report progress and results of the project to designated parties (their DM and/or the PMT) at designated intervals specified in the QI Project Development Form.

## *CCHHS Quality Improvement Plan (QIP)*

- Completed QI projects and all relevant data will be stored on the H Drive in their own folder within the appropriate Completed Projects folder, so that they may be accessed for use in the CCHHS Annual Report and any appropriate Carson City Board of Health (BOH) updates.

Folder location:

H Drive → HD Dept → QI\_Performance Management → Completed Projects → (Specific project folder)

**CCHHS QI Project Development Form**

<b>PLAN</b>		
<b>Project title:</b>		<b>Submitted by/QI Lead:</b>
<b>Program addressed:</b>	<b>Process addressed:</b>	<b>What is the problem?</b>
<b>Project Identification:</b>  <i>a. How did you determine that this was an issue for your health department?</i>  <i>b. Did you use a method to prioritize this issue? Yes ___ No ___ If yes, please describe the method used.</i>  <i>c. What resources and support will be needed to complete the project?</i>		
<b>What are we trying to accomplish? (A brief AIM statement)</b>		
<b>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)</b>		
<b>DO</b>		
<b>How will your change be implemented?</b>		

## CHECK

***How will we know that a change is an improvement? (These must be SMART objectives: Specific, Measurable, Achievable, Realistic, and Time bound)***

***Long term:***

***Short term:***

***What specific data are we collecting?***

***Where are we going to get this data?***

***What methods are we going to use to collect this data?***

***Who do we need to contact/work with to collect this data?***

***How are data collected going to be evaluated? Be specific as to tools we plan to use.***

***Data Collection Projected Dates (ex: 7/23/13)***

***Baseline/historical data:***

***Pre-test (collected just previous to project implementation):***

***Post-test (to compare to Baseline and Pre-test Data):***

***Second Post-test (for longevity - was there a lasting effect?):***

**ACT**

*After data evaluation, when are we going to decide whether or not to ADOPT, ADAPT, or ABANDON the changes you made to the process? (Specific timeframe. Ex: within two weeks of data evaluation)*

*Is the information you uncovered in this project applicable to any other processes, or programs?*

## TEAM INFORMATION

*Who will be receiving updates and outcomes of this project?*

*At what intervals? Please include specific projected dates.*

*In what format?*

*Who will be responsible for this?*

<b>Other Members of the QI team and their responsibilities:</b>	<b><u>PMT Staff Comments:</u></b>
<b>Name:</b>	
<b>Responsibilities:</b>	
<b>Name:</b>	
<b>Responsibilities:</b>	
<b>Name:</b>	<b><u>PMT Staff Member Signature:</u></b>
<b>Responsibilities:</b>	

**Appendix C**

PHAB Standards and Measures

Domain 9

<b>Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.</b>	
<b>Measure 9.1.1 A</b>	Engage staff at all organizational levels in establishing or updating a performance management system
<b>Required Documentation</b>	<b>Guidance</b>
1. Documentation of engaging the health department leadership and management in establishing or updating a performance management system	1. The health department must document leadership’s engagement in setting a policy for and/or establishing a performance management system for the department. This can be shown through strategic and operational plans; training agendas, training programs, meeting agendas, packets, materials and minutes; draft policies or items discussed with the governing entity, and/or presentations to the governing entity. Documentation may include: minutes of team meetings, quality council monthly reports, and final reports from teams showing results achieved.
2. Documentation of engaging the health department staff at all other levels in establishing or updating a performance management system	2. The health department must document engagement of staff at all levels in determining the nature of a performance management system for the department. This can be shown through meeting agendas, packets, materials, and minutes; orientation presentations/programs for new personnel; health department meeting materials and operational plans.
<b>Measure 9.1.2 A</b>	Implement a performance management system
<b>Required Documentation</b>	<b>Guidance</b>
1. A completed performance management self-assessment	1. The health department must provide a completed performance management self-assessment that reflects the extent to which performance management practices are being used. The health department may develop its own performance management assessment or use existing models, such as The Performance Management Self-Assessment Tool from the Turning Point Performance Management National Excellence Collaborative ( <a href="http://www.phf.org/resourcestools/Documents/PM_Self_Assess_Tool.pdf">http://www.phf.org/resourcestools/Documents/PM_Self_Assess_Tool.pdf</a> ). Self-assessment tools are also available through the Baldrige Performance Excellence Program ( <a href="http://www.nist.gov/baldrige/enter/self.cfm">http://www.nist.gov/baldrige/enter/self.cfm</a> ).
2. A current, functioning performance management committee or team	2. The health department must provide documentation of a department committee, team, council, executive team, or some other entity that is responsible for implementing the performance management system. Documentation could be a charter, agendas, minutes, reports, or protocols of the subsidiary body responsible.
<b>Measure 9.1.3 A</b>	Use a process to determine and report on achievement of goals, objectives, and measures set by the performance management system
<b>Required Documentation</b>	<b>Guidance</b>
1. Written goals and objectives which include time frames for measurement	1. The health department must provide two examples that demonstrate implementation of the performance management system in monitoring and evaluating achievement of goals and objectives with the identified time frames. One example must be from a programmatic area and the other from an administrative area. These examples could be provided in narrative, table, or graphic form, depending on the chosen reporting method.
2. Demonstration of a process for monitoring of performance	2. The health department must demonstrate that actual performance towards the two objectives cited in 1) above was monitored. Evidence can come from

CCHHS Quality Improvement Plan (QIP)

of goals and objectives	run charts, dashboards, control charts, flowcharts, histograms, data reports, monitoring logs, or other statistical tracking forms demonstrating analysis or progress in achieving measures. Also useful: statistical summaries and graphical presentations of performance on the measures, such as run charts, control charts, and meeting minutes from a quality team.
3. Demonstration of analysis of progress toward achieving goals and objectives, and identify areas in need of focused improvement processes	3. The health department must provide evidence that actual performance of the two objectives identified in 1) above was analyzed according to the time frames. Evidence for determining opportunities for improvement can be shown through the use of tools and techniques, such as root cause analysis, cause and effect/Fishbone, force; or interrelationship digraphs or other analytical tools.
4. Documentation of results and next steps	4. The health department must provide evidence that actual performance results, opportunities for improvement, and next steps for the identified goals and corresponding objectives were documented and reported
<b>9.1.4 A</b>	Implement a systematic process for assessing customer satisfaction with health department services
Required Documentation	Guidance
1. Description of the process used to collect and analyze feedback from two different customer groups	1. Using a broad, customer/stakeholder identification list developed as part of a strategic planning or health improvement planning process, the health department must provide two examples of how customer/stakeholder feedback was collected and analyzed from two different types of customers (e.g., vital statistics customers; food establishment operators; individuals receiving immunizations, screenings, or other services; partners and contractors; elected officials, etc.). Examples of documentation to collect customer/stakeholder satisfaction could include: forms, surveys, or other methods. Results and conclusions could be in a report, memo, or other written document.
<b>9.1.5 A</b>	Provide staff development opportunities regarding performance management
1. Documentation of staff development in performance management	1. The health department must document its staff development in the area of performance management. Documentation can be training attendance rosters, training curriculum and objectives, presentations and other training materials, or specific work with consultants or technical assistants in performance. At a minimum, targeted staff should include those who will be directly working on performance measure monitoring and analysis, and/or serving on a quality team that assesses the department's implementation of performance management practices and/or system.

<b>STANDARD 9.2: DEVELOP AND IMPLEMENT QUALITY IMPROVEMENT PROCESSES INTEGRATED INTO ORGANIZATIONAL PRACTICE, PROGRAMS, PROCESSES, AND INTERVENTIONS.</b>	
<b>9.2.1 A</b>	Establish a quality improvement program based on organizational policies and direction
<b>Required Documentation</b>	<b>Guidance</b>
1. A written quality improvement plan	<p>1. The health department must provide a quality improvement plan. An example of an acceptable plan is one that describes:</p> <ul style="list-style-type: none"> <li>a. Key quality terms to create a common vocabulary and a clear, consistent message.</li> <li>b. Culture of quality and the desired future state of quality in the organization.</li> <li>c. Key elements of the quality improvement plan’s governance structure, such as: <ul style="list-style-type: none"> <li>• Organization structure</li> <li>• Membership and rotation</li> <li>• Roles and responsibilities</li> <li>• Staffing and administrative support</li> <li>• Budget and resource allocation</li> </ul> </li> <li>d. Types of quality improvement training available and conducted within the organization, such as: <ul style="list-style-type: none"> <li>• New employee orientation presentation materials</li> <li>• Introductory online course for all staff</li> <li>• Advanced training for lead QI staff</li> <li>• Continuing staff training on QI</li> <li>• Other training as needed – position-specific QI training (MCH, Epidemiology, etc.)</li> </ul> </li> <li>e. Project identification, alignment with strategic plan and initiation process: <ul style="list-style-type: none"> <li>• Describe and demonstrate how improvement areas are identified</li> <li>• Describe and demonstrate how the improvement projects align with the health department’s strategic vision/mission</li> </ul> </li> <li>f. Goals, objectives, and measures with time-framed targets: <ul style="list-style-type: none"> <li>• Define the performance measures to be achieved.</li> <li>• For each objective in the plan, list the person(s) responsible (an individual or team) and time frames associated with targets</li> <li>• Identify the activities or projects associated with each objective and describe the prioritization process used</li> </ul> </li> <li>h. The health department’s approach to how the quality improvement plan is monitored: data are collected and analyzed, progress reported toward achieving stated goals and objectives, and actions taken to make improvements based on progress reports and ongoing data monitoring and analysis.</li> <li>i. Regular communication of quality improvement activities conducted in the health department through such mechanisms as: <ul style="list-style-type: none"> <li>• Quality electronic newsletter</li> <li>• Story board displayed publicly</li> <li>• Board of Health meeting minutes</li> <li>• Quality Council meeting minutes</li> <li>• Staff meeting updates</li> </ul> </li> </ul>

	<p>j. Process to assess the effectiveness of the quality improvement plan and activities, which may include:</p> <ul style="list-style-type: none"> <li>• Review of the process and the progress toward achieving goals and objectives</li> <li>• Efficiencies and effectiveness obtained and lessons learned</li> <li>• Customer/stakeholder satisfaction with services and programs</li> <li>• Description of how reports on progress were used to revise and update The quality improvement plan.</li> </ul>
<p><b>9.2.2 A</b></p>	<p>Implement quality improvement activities</p>
<p><b>Required Documentation</b></p>	<p>Guidance</p>
<p>1. Documentation of quality improvement activities based on the QI plan</p>	<p>1. The health department must provide two examples that demonstrate implementation of quality improvement activities. One example must be from a program area and the other from an administrative area. The examples should illustrate the health department’s application of its process improvement model. The examples should demonstrate:</p> <ul style="list-style-type: none"> <li>• how staff problem-solved and planned the improvement,</li> <li>• how staff selected the problem/process to address and described the improvement opportunity,</li> <li>• how they described the current process surrounding the identified improvement opportunity,</li> <li>• how they determined all possible causes of the problem and agreed on Root cause(s), and</li> <li>• how they developed a solution and action plan, including time-framed targets for improvement.</li> </ul> <p>The example should also demonstrate what the staff did to implement the solution or process change. It should also show how they reviewed and evaluated the result of the change, and how they reflected and acted on what they learned.</p> <p>Examples of acceptable documentation include quality improvement project work plans or storyboards that identify achievement of objectives and include evidence of action and follow-up.</p> <p>The health department’s documentation should demonstrate ongoing use of an improvement model, including showing the tools and techniques used during application of the process improvement model. Documentation should also describe: actions taken, improvement practices and interventions, data collection tools and analysis, progress reports, evaluation methods, and other activities and products that resulted from implementation of the plan.</p>
<p>2. Demonstrate staff participation in quality improvement activities based on the QI plan</p>	<p>2. The health department must demonstrate how staff were involved in the implementation of the plan, worked on improvement interventions or projects, or served on a quality team that oversees the health department’s improvement efforts. Examples of documentation may include minutes, memos, reports, or committee or project responsibilities listings.</p>

**Appendix D**

*QI Calendar and Activity Tracking in SmartSheet*

---

CCHHS has implemented the use of a “cloud-based” project management software to track the progress of various projects throughout the department. It has been decided to use this software to also track the progress various quality improvement and performance management projects. The sample SmartSheet page below illustrates how quality improvement projects will be tracked per division. Also, the performance measures of the PMT itself (review of the QIP, review of the training plan, etc.) will also be added into SmartSheet for assignment and tracking.

				<b>Task Name</b>	<b>Start</b>	<b>Finish</b>	<b>Prec</b>	<b>Assigned To</b>	<b>% Complete</b>	<b>Status</b>	<b>Comments</b>
1				<b>QI Projects</b>							
2				Administration							
3				Animal Services							
4				CDPHP							
5				Clinic							
6				EH/Epi							
7				Human Services							
8				PHP							
9				Subcommittees							

(This Page Intentionally Left Blank)