Crook County Health Department
2018-2019
Quality Improvement/Performance Management Plan

Implemented September 1, 2012
Reviewed by QI Team and Revised: Updated 2013, 5/14, 1/17, 2/18
Updated by Muriel DeLaVergne-Brown, RN, MPH/QI Team

Crook County Health Department: FY 2018-2019
Quality Improvement Plan/Performance Management

Table of Contents

Appendices

I. Purpose of the Quality Improvement/Performance Management Plan

The purpose of the Crook County Health Department (CCHD) Quality Improvement Plan (QI) and Organizational Performance Management Plan (OPM) is to align with the Department's Strategic Plan, the Regional Health Improvement Plan, and the National Public Health Accreditation Board's Standards and Measures to provide context and a framework for quality improvement (QI) and Organizational Performance Management within Crook County's Department of Health and Human Services.

Crook County Health Department is committed to developing, implementing and sustaining a model of quality improvement across the department. The QI/PM Plans are aligned with the commitment as contained in Goal #7 of the 2016-2020 Strategic Plan:

"Enhance System Performance and Quality Improvement in CCHD."

The CCHD QI/PM Plans are aligned with Standard 9.1 and 9.2 of the National Public Health Organizational Objectives.

Standard 9.1 Use a Performance Management System to monitor achievement of organizational objectives.

Standard 9.2 Develop and implement Quality Improvement Processes integrated into organizational practice, programs, processes, and interventions.

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

Vision: The Quality Improvement Team (QI Team) will aid in creating, implementing, maintaining, and evaluating the quality improvement efforts at Crook County Health Department (CCHD) with the goal to improve the performance level of key processes and outcomes.

II. Key Working Definitions

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

Collective Impact
A commitment of a group of collaborators from different sectors to create a common methodology for solving complex social problems.

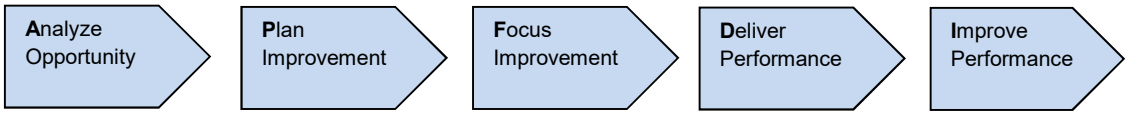
Continuous Quality Improvement (CQI)
An ongoing effort to increase an agency's approach to manage performance, motivate improvement, and capture lessons learned in areas that may or may not be measured as part of accreditation. Also, CQI is an ongoing effort to improve the efficiency, effectiveness, and quality of programs; 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)

Kaizen Event
Type of process improvement – accelerated team approach in three to five days.
Uses the ***Plan, Do, Check, Act*** approach. Also known as Rapid Process Improvement (RPI)

Leadership Team
The department's leadership team is composed of the Director and Supervisors.

LEAN
Establishes a systematic approach to **eliminating waste and creating improved flow throughout the whole organization**. A planned, systematic implementation of LEAN leads to improved quality, more resources, increased reputation and demand, greater productivity, and through-put, and improved morale. The diagram below illustrates steps for implementing a LEAN system.



Organizational Performance Management
A system that is completed integrated into the department's daily practice at all levels, including the following: setting organizational objectives all levels of the department, identifying indicators that measure progress toward achieving objectives on a regular basis, identifying responsibility for monitoring progress and reporting, and identifying areas where achieving objectives requires focused quality improvement processes. (PHAB Acronyms and Glossary of Term, 2013).

Performance Measurement (PM)
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, 2009).

Performance Management Dashboard (Dashboard)
A visual representation of the performance data being collected. The Dashboard is organized according to the QI Team with program input.

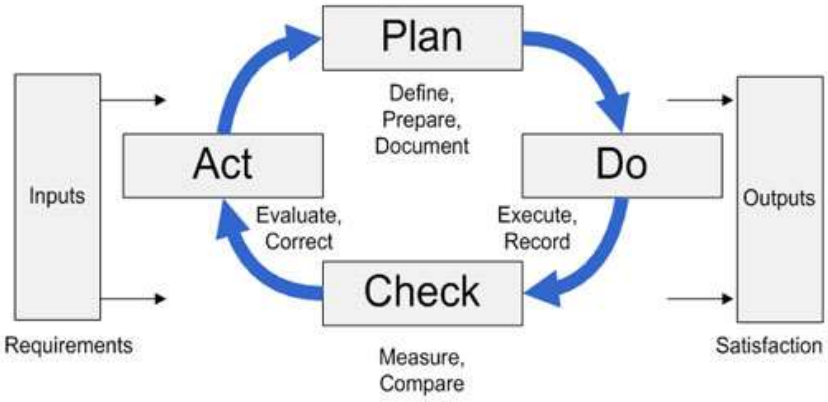
Performance Management Plan
A plan that identifies specific area of currently operational performance for improvement within the agency. This plan should be cross-referenced with the Quality Improvement Plan and Strategic Plan

Performance Measurement
The regular collection and reporting of data to track work produced and results achieved (Turning Point, 2009).

Performance Standard (PS)
A generally accepted, objective standard of measurement such as a rule or guideline which an organization's level of performance can be compared.

Plan, Do, Check, Act (PDCA)
A four-step quality improvement method where the steps are (1) plan an improvement, (2) implement the plan, (3) measure and evaluate how well the outcomes met the goals of the plan, and (4) craft changes to the plan needed to ensure it meet its goal. The "PDCA cycle" can be repeated until the outcome is optimal. This is used to improve a process or carry out change. (Figure 1)

Figure 1: Plan-Do-Study-Act Model of Quality Improvement



Program Evaluation (PE)
This is a formalized approach to studying the goals, processes, and impacts of projects, policies, and programs.

Public Health Quality Improvement Exchange (PHQIX)
The Public Health Quality Improvement Exchange (PHQIX) is an online community designed to be a communication hub for public health professionals interested in learning and sharing information about quality improvement (QI) in public health (Public Health Quality Improvement Exchange, 2012).

Quality Assurance (QA)
This is a set of planned and systematic actions necessary to provide appropriate confidence that a product or service will meet regulatory and quality expectations.

Quality Improvement (QI)
The use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measureable improvements in the efficiency, effectiveness, performance, accountability outcomes, and other indicators of quality in services or processes which achieve quality and improve the health of the community. Strategic and QI plans can and should cross-reference one another, so a quality improvement initiative that is in a QI plan may also be in a strategic plan.

Quality Improvement/Performance Management Committee

Agency-wide committee organized by the QI Coordinator and the CCHD Leadership Team to carry out QI activities, namely PDCA cycles. The QI committee objectives include supporting PDCA cycles occurring in each program area with the supervisor as the lead. This committee is representative of each program area and includes representatives at staff and leaderships levels.

Quality Improvement Plan

The QI Plan identifies specific areas of currently operational performance for improvement within the agency. This plan should be cross-referenced with the Performance Management Plan and Strategic Plan.

Quality Methods (QI Methods)

Builds on an assessment component in which a group of selected indicators (selected by the 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 the high live as the Plan-Do-Check-Act (PDCA) or Deming's Shewhart Cycle (PHAB Acronyms and Glossary of Terms, 2009).

Quality Planning

Quality planning is a systematic process that translates quality policy into measurable objectives and requirements, and determines the 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 in need of a complete redesign.

Quality Improvement Tools (QI Tools)

QI Tools are 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 CCHD 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).

Regional Health Assessment (RHA) (2016)

The regional health assessment was created in collaboration with the hospital system, Central Oregon Health Council, and Crook, Jefferson, and Deschutes County.

Regional Health Improvement Plan (RHIP)

A health improvement plan is a long term, systematic effort to address and improve health problems in the region on the basis of the Regional Health Assessment and the Regional Health Improvement Plan process. The regional health improvement plan was created in collaboration with the hospital system, Central Oregon Health Council partners, Crook, Jefferson, and Deschutes County. This report included input from stakeholders in the region.

Social Determinants of Health
The economic and social factors – and their distribution among the population – that influence individual and group differences in health status.

Strategic Management
In contrast to strategic planning, strategic management is the larger process that is responsible for the development of strategic plans, implementation of strategic initiatives, and ongoing evaluation of their collective effectiveness. A strategically managed public organization is one in which budgeting, performance measurement, human resource development, program management and all other management processes are guided by a strategic agenda that has been developed with buy-in from key actors and communicated among external constituencies as well as internally.

Strategic Planning
The process an organization uses to clarify its mission and vision, define its major goals and objectives, develop its long-term strategies for moving an organization into the future in a purposeful way, and ensure a high level of performance.

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 improvement as implemented (PHAB Acronyms and Glossary of Terms, 2009).

III. Culture of Quality

Building the Foundation
CCHD 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, CCHD evaluated their progress annually against the Roadmap to a Culture of Quality Improvement, developed by the National Association of County and City Health Officials (NACCHO).

CCHD has a long history working with the community to improve its health and well-being. The department has been working with regional partners as well increasing that focus in 2011 in part due to health system transformation in Oregon.

Timeline
2011 - The department was a pilot for a project initiated by the State of Oregon aimed at incorporating LEAN quality improvement principles into health care systems. This project focused on Family Planning processes. The training and Rapid Process Improvement took three days.

2012 - In August of 2012, Crook County Health Department formed the QI Team, developed its first Quality Improvement Plan, and trained all staff. CCHD QI efforts were then guided by the 2012 Regional Health Improvement Plan and the newly created CCHD 2012 Strategic Plan, which both emphasized the need to approach changes in the in the department in a coordinated and collective

manner. This strategy recognizes that all health care and social service interests must work collaboratively in order to create healthier communities.

2013 – Provided a yearly QI training to staff member and created a shared drive for the storage of all training materials and QI materials. The QI Team continued to meet and assessed projects as they were submitted. Projects included improving staff training and orientation, completion of new job descriptions.

2014 – Prepared for the site visit for PHAB accreditation through the QI process. Site visit completed in February of 2014. The department did not receive full accreditation and was directed to complete an action plan of which one area was Quality Improvement. We completed a new document to track our performance and were accredited in September of 2014.

July 2014 – The QI Team used a process for restructuring the department with additional supervisors. The team used the QI process to create a new structure based on programs and workload requirements. This led to a proposal for the Board of Health for approval.

2014 – Continued QI meetings throughout the year with over 10 projects completed.

2015 – The QI Team focused on planning for the triennial review from the State of Oregon which took place in July and August of 2015. Each coordinator was responsible for going through their materials, preparing, and reporting out at the QI meetings. The review ended up being the best one the department had ever received with only four small areas to correct.

September – December 2015 – The QI team was expanded for specific meetings to include all staff for training projects. We chose a QI tool (swim lane) to evaluate the process for the Oregon Health Plan Assister Work flow. This took two full staff meetings to complete the process improvement project.

December, 2015 – The staff met to begin the development of an updated Strategic Plan. The process took a year due to the incorporation of the updated Regional Health Assessment, Regional Health Improvement Plan, and Public Health Modernization in Oregon. During this same timeframe, department staff assisted with the updating of the Regional Health Assessment and Regional Health Improvement Plan. Eight regional workgroups were developed to monitor health in the region along with the Operation committee for the Central Oregon Health Council.

2016 – CCHD was tasked to complete the Public Health Modernization Gap Analysis in January, February, and March of 2016. This analysis of public health involved all staff members at general staff meetings to complete the work in the Spring of 2016.

May - September, 2016 – Planning and implementation of a large-scale agency-wide reorganization took priority, and CCHD added the Human Services Department and Corrections Health. The restructuring included the creation of a new supervisor position and new programming in drug and alcohol prevention. This planning and reorganization continued through the Fall of 2016 with much of the work taking place at general staff meetings.

November 11, 2016 – The newly organized QI team met and set up the structure with a new QI form and planned for the completion of the New Strategic Plan on December 13, 2016. The following was agreed upon:

- Approval of the new QI Team
- Monthly meetings on the 3rd Tuesday from 8 – 9.
- Development of new QI Request Form.
- Plan to update staff and provide QI and PM training on January 3rd, 2017 with and updated training program.

December 13, 2016 – A full day of training (all staff) on Health Equity, Public Health Modernization, and the 2016 – 2020 Strategic Plan completion.

December 2016 – January 2017 – Development of the updated Quality Improvement/Performance Management Plan to be approved for the 2017-2018 year.

CCHD continues to train and build a QI culture. This is ongoing with the addition of new staff members with the restructure of the department. The future of QI/PM in the department includes the following:

- Continued training and growth of the program while assuring participation in both systems by all employees of the department.
- Demonstrated competence by all staff in a wide range of quality improvement tools.
- Sustained or increasing levels of engagement and participation regarding QI/PM as evidenced through annual staff QI surveys.
- Increased use of quality improvement tools and methodologies in daily work tasks by individuals and by teams at meetings.
- Completion of one PDCA project for each program area per year.
- QI and PM not only impact daily operations, but serve to improve population level outcomes and indicators, as described in the Regional Health Improvement Plan and Strategic Plan.

IV. Governance of Quality Improvement/Performance Management Plan – Roles and Responsibilities

Organizational Structure

QI Committee:

The QI Committee will assure the carrying out of QI efforts and activities, which include: development and devaluation of the annual Quality Improvement Plan, meeting PHAB accreditation standards relative to QI, providing QI updates to appropriate program areas, as well as supporting the work of department improvement projects. Team members will also be asked to participate in QI training activities, become skilled in the implementation of QI tools, and to provide feedback and evaluation of QI projects.

CCHD Leadership Team:

The Leadership Team will support the efforts of the QI Committee by implementing QI activities within programs, 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 feedback and evaluation of QI projects.

Crook County Count/Board of Health:
The Crook County Board, which includes the role as the Crook County Board of Health, will provide high-level oversight of the QI/PM efforts by the agency, as well as approve policies to facilitate implementation of this plan and activities through the Strategic Plan.

Membership
The membership of the team is a combination of Leadership Team (Director and Supervisors), program coordinators, and interested staff. (See Appendix B)

Roles and Responsibilities
Everyone has a role in CCHD's quality improvement efforts.

Director:

- Provide leadership the vision, mission, strategic plan, and direction related to QI efforts.
- Allocate resources to 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 CCHD.
- Advocate for a QI culture, both to staff and external customers, through presentation and messaging.
- Participating on the QI Team as lead and supervising QI efforts.
- Review and provide final approval on documents such as the QI/PM Plan and QI
- Report on QI activities to the Board of Health.
- Request the review of specific program evaluation activities or the implementation of QI projects.
- Apply QI principles and tools to daily work.
- Participate in efforts to implement, monitor and evaluate PM Plan.
- Encourage staff to use online QI resources (PHQIX, NACCHO Toolbox).

Program Supervisors, Program Coordinators, Accreditation Coordinator:

- Facilitate the implementation of QI/PM activities and an environment of CQI at the program area.
- Provide feedback to updated QI/PM plans.
- Apply QI principles and tools to daily work.
- Participate in and facilitate the development of QI/PM project teams.
- Assure all staff participation in QI/PM activities.
- Orient staff to the QI processes.
- Document QI efforts.
- Encourage staff to incorporate QI concepts into daily work.
- Assure implementation, monitoring, and evaluation of the agencies PM system.
- Developing a work plan for each program with guidance from the state.
- Reviewing the data from work plans on an annual basis with staff.
- Identifying areas in need of QI processes and initiating problem-solving.
- Implement QI processes and projects.
- Identifying staff QI training needs, providing access to training, and tracking attendance.

- Reporting to the CCHD Director their findings from the reviews, QI projects, state standard gaps, and additional QI trainings needed.
- Revising program work plans based on findings from annual review and QI projects.
- Completing a program logic model or other framework to evaluate activities.
- Compiling program data for measures required by program plans, the RHIP, and the Strategic Plan.

All CCHD Staff:

- Participate in the work of at least one QI project within their program area.
- 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 support 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.
- Apply QI principles and tools into daily work.
- Contribute to the development, monitoring, and evaluation of the PM system.

Quality Improvement Team:

- Attend monthly meetings of QI Committee (typically 1 hour/monthly) and complete assigned tasks.
- Provide QI expertise and guidance for PDCA projects.
- Provide QI training and support to new and existing staff.
- Complete QI training – modules.
- Serve as liaison between QI Team and program area staff.
- Assist in development of agency QI activities.
- Participate in the development, implementation, review and evaluation of the QI/PM Plans.
- Advocate for QI and encourage a culture of learning and QI among staff.
- Apply QI principles and tools to daily work.
- Encourage staff to use online QI resources.

Board of Health (BOH):

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

Staffing and Administrative Support

The Health Department Data Analysist position is the Quality Coordinator is specifically tasked with the development, implementation, evaluation, and coordination of the QI/PM activities within CCHD. Support for the meetings will be provided by the department's administrative assistant.

V. Training

New Employee Training

Advanced Training for Lead QI staff – Accreditation Workgroup, Specific Conferences (Coordinator)

Introductory QI Course for All Staff
There will be a yearly update and training for all staff on Quality Improvement and Performance Management.

Advanced Training for Lead Staff
As noted in the Workforce Development Plan, the QI Team and Supervisors may advance their training in QI through additional training.

On-going Staff Training
Trainings materials are located in the shared drive (QI Materials – Training – Power-points, and handouts)

- Aim Statements, Cause & Effects (Fishbone Diagrams), Data Collection and Analysis, Flowcharts, and SWOT Analysis
- Affinity Diagrams, Brainstorming
- Data Collection – Check Sheet, Bar Chart, Pie Chart, Run Chart
- Five Why's/Five Hows
- Flowcharts
- Force Field Analysis
- Gantt Chart
- Pareto Diagrams
- PDCA
- Storyboards
- Customer Service

Refreshers on these tools can be provided in a number of venues, including all staff and team meetings. Areas of focus for training will be based on results of a QI training needs assessment completed annually.

VI. Identification of Improvement Projects & Alignment with Strategic Plan

Project Section Criteria
QI project selection will be based on the need to improve program processes, objectives and/or performance measures and are tied to the agency Strategic Plan and PM system. Projects may be selected in a number of ways, including, but not limited to, identification by Leadership and QI Committee based on program recommendations or during quarterly reviews of PM data. QI Committee participants are expected to be sponsors for QI project in their area of expertise.

Each CCHD section will be expected to be working on at least one PDCA project each fiscal 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 a storyboard format, and that the finished storyboard be shared with all staff. Leadership may submit these projects on the agency's website and submit to the Public Health Quality Improvement Exchange (PHQIX).

In addition, workgroups may choose to develop improvement projects outside of the PDCA model, utilizing appropriate QI tools. While completion of the storyboard is not required for non-PDCA projects, documentation of the process, tools used, outcomes, and lessons learned should be completed through the use of the PDCA worksheets and meeting minutes.

Agency Level Goals and Objectives (See Performance Management Plan)
Annually, CCHD will update the Performance Management Plan based on program specific measures. Performance Measures will have a direct line of sight with the agency's Strategic Plan, the Central Oregon Regional Health Improvement Plan, and the State of Oregon Health Improvement Plan.

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

Goals and objectives are based on the PHAB standards and Measures, Version 1.5, released in 2014. These goals were selected as priority goals for this plan due to their connection with accreditation. Annual goals and objectives will always be based on the current version of PHAB and will be updated according if changes occur throughout the year. PHAB Domain nine requires evaluation and continuous improvement of health department processes, programs, and interventions. Progress toward these goals is to be evaluated by the QI Committee on a quarterly basis, and the results of this evaluation are included as a measure in the agency PM system.

Goal 1: Establish and maintain a quality improvement plan based on organizational policies and direction.
Objective:
Develop annual agency QI/PM Plans that seek to increase staff knowledge of quality improvement and supports the development of the PDCA implementation, while considering the importance of the PHAB accreditation requirements moving forward.
Measure:
Approved CCHD QI/PM Plans
Key Strategies:
1. Creation of draft QI/PM plans by the Accreditation Coordinator and QI Committee.
2. Assessment of plans for compliance with PHAB standards.
3. Review and approve plan by Director.
4. Dissemination of approved plan to all staff.
5. Year-end evaluation of plans for compliance with goals and initiatives completed by QI Team.

Goal 2: Implement quality improvement efforts.
Objective:
Based on the framework of the CCHD QI Plan, implement PDCA as a QI strategy at CCHD.
Measure:
Achieve 100% compliance with development and completion of PDCA projects.
Key Strategies:
1. The supervisor as a member of the QI Team will guide PDCA projects.
2. All PDCA Project work will be kept on the shared drive.
3. All PDCA Projects will use the proper documentation (Attachment C and D).
4. Reports of PDCA projects will take place at general staff meetings.
5. Storyboards will be published on the shared drive.

Goal 3: Demonstrate staff participation in quality improvement methods and tools training.
Objective:
Provide an adequate level of QI training to all CCHD staff.
Measure:

Train 100% of CCHD staff on QI Tools and QI Processes as outlined in the QI Plan.

Key Strategies:

1. CCHD will create and maintain a training log of staff that have participated in QI Training.
2. 95% of staff will have completed the required QI training modules by the end of the year.
3. An annual survey of staff will be conducted to assess need for training, and specific area of focus.
4. The leadership team supervisors will assure that new employees receive orientation initial QI training within six months of date of hire, as well as on-going training.

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

Objective:

Implement a fully functioning performance management system that is completed 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 annual QI/PM Plans that outline the framework for the Performance Management System.
3. Development of measures based on program requirements, RHIP, and the Strategic Plan.
4. Provide quarterly update of the performance management dashboard in each program area.
5. Quarterly dissemination of PM data to all staff and discussion at general staff meeting.
6. Annual discussion of the Performance Management system the Crook County Board of Health.

Goal 5: Implement a systematic process for assessment 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 CCHD programs.

Key Strategies:

1. Review and approve the Customer Satisfaction Policy and previous efforts surrounding customer satisfaction.
2. Review the Customer Satisfaction Survey and approve.
3. Review and approve plan by Director.
4. Identify and create a process for implementing the Customer Satisfaction Survey.
5. Disseminate a standard customer satisfaction tool to all external customers at least twice per year and create actionable improvement steps as needed.

VII. Monitoring of Quality Improvement/Performance Management

Collection, Analysis, and Monitoring of Data

Date will be collected for each of the CCHD Performance Measures by the program indicated on the Performance Measure Data Description and Collection Form (Appendix D). The data will be

submitted to the Directors office by the 15th of each month to complete the quarterly dashboard. Quarterly QI meetings will review and analyze the results, identifying opportunities for improvement projects. The team will evaluate is the measure is on-target or far/significantly off-target.

Reporting Progress Toward Achieving Stated Goals

CCHD program areas will report progress on performance measures to their respective staff on at least a quarterly basis. This reporting will include an update of the data dashboard, a summary of progress on performance measures, and identification of opportunities for quality improvement actions. QI/PM, including progress toward goals and objectives, will be on the agenda of at least one general staff meeting year.

Actions to Make Improvements Based on Progress Reports

For those measures in which QI action is required, an action plan/Gantt Chart will be developed to guide the completion of this work. QI committee members shall take the lead on implementing these QI action plans. The results of these QI efforts are to be reported at the next quarterly meeting.

IX. Sustainability of Quality Improvement

Communication and Promotion

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

- QI Workgroup updates at general staff meetings.
- Presentations and training at all program meetings.
- Minutes from meetings of the QI committee will be posted on the network shared drive.
- Storyboard presentations will be posted.
- Communication of QI efforts will be completed through the newsletter and other methods.
- Dissemination of the approved QI/PM Plan via e-mail and at staff meetings.

Recognition

As CCHD 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.
- Sharing stories of QI tool use are meetings.

Agency Policies

CCHD initially develop policies regarding QI and Performance Management in 2012, which were approved by the Public Health Director. These policies are to be reviewed annually by the QI Committee and modified as necessary to reflect changes in QI/PM efforts. After the annual review and approval by the QI Committee, the final policy will be provided to the Director for signature. The approved QI and PM Plans/Policies will be maintained in the CCHD shared drive for access by all staff.

X. Approval and Evaluation of Quality Improvement Plan

Annually, draft QI/PM Plans for the fiscal year will be developed by the QI 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 Director, approved, and signed.

In the fourth quarter of each fiscal year, the QI/PM Plans and activities will be evaluated by the QI Committee and 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,
- 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 the Leadership Team (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 QI Committee and forwarded to the Director for review and approval.

Based on the recommendations of the QI Committee and the 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 the _____day of January 2017, for the period of March 1, 2017 – June 30, 2018.

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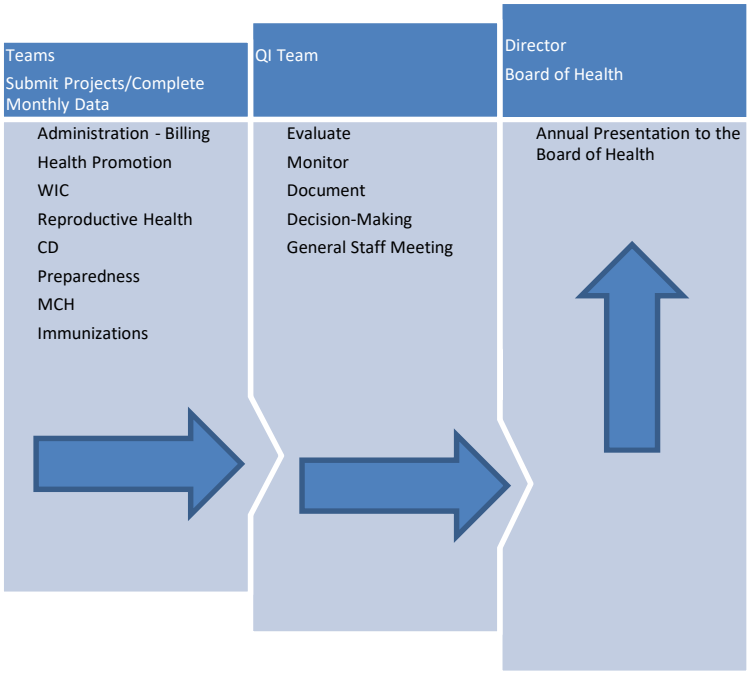
Muriel DeLaVergne-Brown, RN, MPH
Health and Human Services Director

Appendix A
Crook County Health/Human Services
Communication Flow Chart



Appendix B
Crook County Health/Human Services
Quality Improvement Team

Quality Improvement Team Membership

Muriel DeLaVergne-Brown
Public Health Director

Health Educator II

Jo McCabe
Clinical Nursing Supervisor

Emma Reynolds
WIC/Front Desk Supervisor

Katie Plumb
Health Promotion/Prevention Supervisor

Vicky Ryan
Public Health Preparedness Coordinator

Wendy McCoy
Lead Support/Billing/EMR Site Specialist

Kris Williams
Tobacco Prevention/Education

Vickie Rhoden
Administrative Assistant

Appendix C (Use Form ADM143)

Crook County Health/Human Services Department
Quality Improvement Project Proposal
(Complete with input from Supervisor/Director)

Project title:	**Submitted by:**
Date Submitted to QI Team: **Date QI Discussion:**	
Briefly identify or describe the program, project or process that should be addressed with a quality improvement project:	
Priority: ☐ **High** ☐ **Medium** ☐ **Low**	**Notes:**
Departmental Implications **a. How does this project support our mission, vision, and/or strategic directions?** **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? How will we know that a change is an improvement?	
Additional Notes/Comments?	
Solution: **Communication:**	

Crook County Health/Human Services
Quality Improvement Action Plan
(To be completed by QI team upon review of Project Proposal)

Project title:	Submitted by:
Date Submitted to QI Team: Date Initial QI Review:	
Designated QI Lead:	

✓	Action	Person Responsible	Target Date

Target Project Completion Date:

Notes and Outcome:

Appendix D (Form ADM143B)
Crook County Health/Human Services
Quality Improvement PDCA Project Plan

Project title:	**Project Leader:** Who is leading this effort?
Strategic Directions/Goals: What does your supervisor expecting this project to contribute to the 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?
Supervisor Sponsor: **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 eh program sponsor 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: (as needed)	
Target Start Date?	
Target Date for Completion of First Improvement Cycle:	
Reviewed by QI Committee on _____/_____/_____. **QI Member Signature:_____.**	

Appendix E
Crook County Health/Human Services
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 Project**	**Name of Project**
Has an existing process (if not, explore quality planning)		
Has existing data to indicate a problem exist (or data can be easily collected)		
Is connected to RHIP, Strategic Plan, or program/grant requirement		
Has potential for rapid turnover (at least monthly)		
Project is on a manageable scale ("bit" 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 have demonstrated interest and engagement in the project		
Decision Point (TOTAL)		

Appendix F

Crook County Health/Human Services

Performance Measure Data Description & Collection Form

Year: _____Program: _____

CIRCLE: Program Level Measure RHIP Strategic Plan

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:	
Dominator:	
Source of data:	
Who will collect the information?	
How often will the data be analyzed and reported?	
Definitions and other comments:	
Rationale for Selection:	

QUARTERLY REPORTING				
1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.	Year Total

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 Crook 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 Crook 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 Crook County adults who smoke cigarettes is the number of Crook County adults.

Target: This is the "goal" for the performance measure. What number are you trying to reach? Examples are the percent improvement from the 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 2020 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 RHIP 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 G
Crook County Health/Human Services
Quality Improvement Training Work Plan

Type of Training	Level	Delivery Method	Audience	Purpose or Goal
New Employee Orientation	Basic	Internal: Face to Face, written materials by Supervisor	New Employees	Orient new employees to CCHD's QI/PM Program, provide context of Strategic Plan, and work-plans for specific programs. (Provide location of Plans in shared drive – QI Improvement Team)
Introduction to Quality Improvement	Basic	Power-point module training and internal staff	All employees	Provide a general overview to QI principles, methods, and tools. Provide context of Strategic Plan, RHIP, and Program Requirements (Copy of Strategic Plan, RHIP Priorities in orientation manual.
Introduction to Organization Performance Management	Basic	Power-point module training and internal staff	All employees	Provide a general overview to PM principles, methods, and tools.
Applied QI Training	Intermediate	Internal and external; can be web based	QI Team Members	In-depth training about QI with a project-based, applied focus.
Organizational Performance Management Training	Intermediate Advanced	Internal and external	QI Team Members	Turning Pont Performance Management Toolkit.
Just in Time Training	Intermediate Advanced	Internal and external	QI Team Members	Provide QI Training when it is needed for employees.
Change Management and Quality Leadership	Basic Intermediate Advanced	Internal and external	Supervisor and Director	Orient leaders to their role in facilitating a quality culture using Public Health Foundation Change Management for QI: A Primer
Train-the-Trainer	Advanced	Internal or external	Employees with previous QI experience	Develop organizational capacity for internal QI Training
Academic Training	Advanced	External	Supervisors or motivated staff	Lead and implement OPM initiatives.

Quality Improvement Resources for Training

Adapted from Center for Public Health Quality

American Society for Quality (ASQ) is a leading quality improvement organization that offers technologies, concepts, tools, and training to create better workplaces and communities worldwide.

Association of State and Territorial Health Officers (ASTHO) is the national nonprofit organization representing state public health agencies in the United States.

Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. IHI offers information, tools, and resources to health care professionals who want to improve care.

National Association of County and City Health Officials (NACCHO) is the national organization representing local health department. NACCHO offers reports, tools, and resources to support local health department quality and performance improvement efforts.

Public Health Foundation (PHF) is dedicated to achieving healthy communities through research, training, and technical assistance. PHF provides a variety of tools and resources to help state and local public health agencies with performance management and quality improvement.

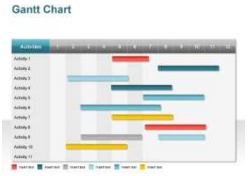
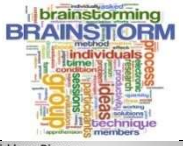
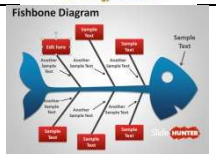
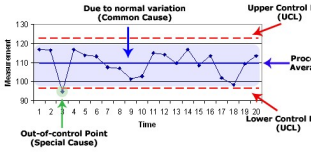
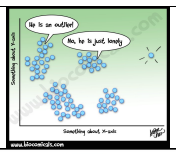
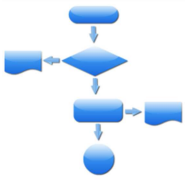
Public Health Quality Improvement Exchange (PHQIX) is a centralized communication hub dedicated to supporting quality improvement efforts in public health practices through

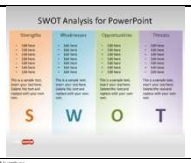
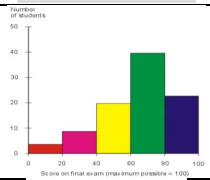
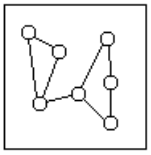
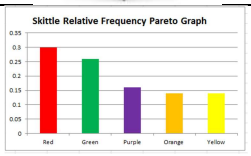
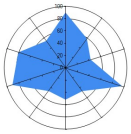
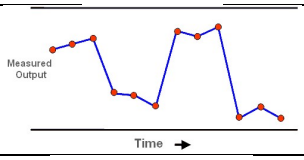
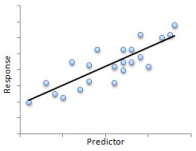
The Community Guide is a free resource that summarizes the effectiveness, economic efficiency, and feasibility of interventions in order to help communities choose programs and policies to improve health and prevent disease.

The Public Health Accreditation Board (PHAB) is dedicated to raising the standard for public health by working with leading public health experts from the field to develop a voluntary national accreditation program that will help public health departments assess their current capacity and guide them to become even better providers of quality service, thus promoting a healthier public.

Appendix H
Crook County Health/Human Services

QI Toolbox

QI Tool	What the Tool Does	Public Health Memory Jogger II
Activity Network Diagram/Gantt Chart	Used to: Schedule sequential and simultaneous tasks • Gives team members the change to show what their piece of the plan requires and helps team members see why they are critical to the success of the project. • Helps teams focus its attention and scarce resources on critical tasks.	
Affinity Diagram	Used to: Gather and Group Ideas • Encourage team member creativity by breaking down communication barriers • Encourage ownership of results and helps overcome "team paralysis" due to an array of options and a lack of consensus.	
Brainstorming	Used to: Gather bigger and better ideas • Encourage open thinking and gets all team members involved and enthusiastic. • Allow team members to build on each other's creativity while staying focused on the task at hand.	
Cause and Effect/Fishbone	Used to: Find and cause, not symptoms • Enables a team to focus on the content of the problem, not the problem's history or differing personal issues of team members. • Creates a snapshot of the collective knowledge and consensus of a team around a problem. • Focuses the team on causes, not symptoms.	
Check Sheet	Used to: Count and accumulate data • Creates easy-to-understand data – makes patterns in the data become more obvious. • Builds a clearer picture of "the facts", as opposed to opinions of each team member, through observation.	
Control Charts	Used to: Recognize sources of variation • Serves as a tool for detecting and monitoring process variation. Provides a common language for discussing process performance. • Helps improve a process to perform with higher quality, lower cost, and higher effective capacity.	
Data Points	Used to: Turn data into information • Determines what type of data you have. • Determines what type of data is needed.	
Flowchart	Used to: Illustrate a picture of the process • Allows the team to come to agreement on the steps of the process. Can serve as a training tool. • Shows unexpected complexity and problem areas. Also shows where simplification and standardization may be possible. • Helps the team compare and contrast the action versus the ideal flow of a process to help identify improvement opportunities.	

Force Field Analysis	Used to: Identify positives and negatives of change • Presents the "positives" and "negatives" of a situation as they are easily compared. • Forces people to think together about all aspects of making the desired change as a permanent one.	
Histogram	Used to: Identify process centering, spread, and shape • Displays large amounts of data by showing the frequency of occurrences. • Provide useful information for predicting future performance. • Helps indicate there has been a change in the process. • Illustrate quickly the underlying distribution of the data.	
Interrelationship Diagraph	Used to: Looks for drivers and outcomes • Encourages team members to think in multiple directions rather than linear. • Explores the cause and effect relationships among all issues. • Allows a team to identify root cause(s) even when credible data doesn't exist.	
Nominal Group Technique	Used to: Rank for consensus • Allows every team member to rank issues without being pressured by others. • Makes a team's consensus visible. • Puts quiet team members on an equal footing with others.	
Pareto Chart	Used to: Focus on key problems • Helps team focus on those causes that will have the greatest impact if solved. (Based on premise that 20% of the sources cause 80% of the problems) • Progress is measured in a high visible format that provides incentive to push on for more improvement.	
Radar Capability	Used to: Rate organizational performance • Makes concentrations of strengths and weaknesses visible. • Clearly defines full performance in each category. • Captures the different perceptions of all the team members about organizational performance.	
Run Chart	Used to: Track trends • Monitors the performance of one or more processes over time to detect trends, shifts, or cycles. • Allows a team to compare a performance measure before and after implementation of a solution to measure its impact.	
Scatter Diagram	Used to: Measure relationship between variables • Supplies the data to confirm a hypothesis that two variables are related. • Provides a follow-up to a Cause & Effect Diagram to find out if there is more than just a consensus connection between causes and the effect.	
Tree Diagram	Used to: Map the tasks for implementation • Allows all participants to check all of the logical links and completeness of every level of plan detail. • Reveals the real level of complexity involved in the achievement of any goal, making potentially overwhelming projects manageable, as well as uncovering unknown complexity.	

Appendix I

Crook County Health/Human Services

2016 – 2018 Quality Improvement PDCA Projects (To be completed)

Appendix J

Crook County Health/Human Services Department
Department Level Performance Measures

The department-level performance measures align with the CCHD Strategic Plan, the Central Oregon Health Improvement Plan based on the Central Oregon Community Health Assessment, Oregon's Health Improvement Plan, Oregon Health Authority Metrics for Health Care Reform, and Healthy People 2020.

See Performance Management Monitoring System Plan