Cass County Health, Human and Veterans Services  
Public Health Division  

QUALITY IMPROVEMENT PLAN

ISSUE: Cass County Public Health in efforts to become accredited in Public Health must comply with Standard 9.2 for Quality Improvement Plan requirements for policies and demonstration of Quality Improvement within division.

PURPOSE: To implement Quality Improvement Committee and Quality Improvement efforts within Cass County Public Health division.

POLICY:

Standard 9.2

A. Glossary of Terms

Community Health Improvement Plan (CHIP): A long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental, education and human service agencies, in collaboration with community partners, to set priorities and coordinate the target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way.

Continuous Quality Improvement (CQI): An intentional, ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities and outcomes. ¹

Plan, Do, Check, Act (PDCA): A four step quality improvement method in which step one is to plan an improvement, step two is to implement the plan, step three is to measure and evaluate how well the outcomes meet the goals of the plan, and step four is to craft changes to the plan needed to ensure it meets its goal. The “PDCA cycle” is repeated, theoretically, until the outcome is optimal.

Quality Improvement Committee (QIC): Team charged with primary responsibility of quality improvement in public health division for direction of quality improvement efforts and projects.

Quality Improvement (QI) Plan: Identifies specific area of current operational performance for improvement. Strategic and QI plans can and should cross-reference one another, so a
quality improvement initiative that is in the QI plan may also be in the Strategic plan. ¹

**SMART:** Process of identification of S-specific, M-measurable, A-attainable, R-results oriented, T-timebound objectives in quality improvement projects.

**Strategic Management:** In contrast to strategic planning, is the larger process that is responsible for the development of strategic plans, implementation of strategic initiatives, and ongoing evaluation of its 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. ³

**Strategic Planning:** The process an organization uses of clarifying its mission and vision, defining its major goals and objectives, developing its long-term strategies for moving an organization into the future in a purposeful way, and ensuring a high level of performance in the long run. ³

**Standard 9.2.1 A**

**B. Culture of QI**

1. **Quality Improvement** is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization.²

2. **Vision:** The Quality Improvement Committee (QIC) will aid in creating, implementing, maintaining, and evaluating the quality improvement (QI) efforts at Cass County HHVS Public Health (CCPH) with the intent to improve the level of performance of key processes and outcomes.

3. **Goals:** The Quality Improvement Committee goals in supporting this effort are:
   I. Identify, review, monitor and make recommendations on QI processes/efforts
   II. Review QI Plan at least annually and adjust as required
   III. Identify and meet QI training needs
   IV. Provide guidance, support, and resources for QI efforts
   V. Recognize and acknowledge QI efforts

   *(See Appendix A: QIC Goals and Activities Work Plan)*

**C. Governance Structure**

Everyone has a role in CCPH’s quality improvement efforts.

1. **Administrative Roles and Responsibilities**
   Organizational efficiencies dealing with finance, human resources, public information,
information systems and general administration will be evaluated considering confidentiality of information, time and labor cost, methodology utilized, audit results, recruitment and retention, employee status, legal compliance and safety. Identification of issues and/or processes that limit effectiveness will be reported to the QIC by Administrative staff. (Standards 8.1, 8.2, 11.1, 11.2) Administrative support will be available through one of the members on the QIC. Budget allocation for QIC will utilize the Local Public Health Grant unless other funds are available for efforts in quality improvement. The resources allocated will be at a minimum of four nurses on the QIC.

2. Quality Improvement Committee (QIC)

The Cass County Health, Human and Veteran Services (CCHHVS) Director has charged the QIC with carrying out the purpose and scope of quality improvement efforts at Cass County Public Health. The QIC consists of cross-sectional representatives from Director of Public Health Nursing, Public Health Supervisor, program coordinators, and line staff. Ad hoc members will be added to the QIC as necessary. Chair(s) will be selected by the QIC committee for a two year term with a staggered rotation. The QIC meets on a regular basis and maintains records and minutes of all meetings. Team norms will be followed by QIC. QI efforts will be centralized for documentation and access by others. The QIC reports to The CCHHBS Director and CCHHVS Advisory Board.

The QIC will assure ongoing membership renewal and replacement by reviewing annually. The current list of QIC members can be found page 10.

QIC Roles and Responsibilities:
I. Orienting all staff to Quality Improvement Committee process, plan, and resources
II. Developing an initial logic model and/or work plan for each program
III. Reviewing the data from logic models and/or work plans on an annual basis with staff
IV. Initiating problem solving processes and/or QI improvement projects
V. Identifying staff QI training needs, providing access to training, and tracking attendance
VI. Reporting to their directors their findings from their logic model review, QI projects, state standard gaps, and identified QI trainings with no resources available
VII. Revising program logic models and/or work plans based on findings from annual review and QI projects

3. Cass County Health, Human Veteran Services Advisory Board (CCHHVSAB)

The CCHHVAB receives a report annually on health data with recommended actions for health policy decisions, progress toward program goals (Standard 12.2); recommendations based on after-action reviews and other QI efforts. Board members may be asked to attend and participate in meetings as applicable (Standard 12.3). The CCPH Strategic Plan includes objectives around assessment activities, use of health data to make program and policy decisions, After Action Review issues, and prevention
priorities. The Strategic Plan goals, objectives, and performance measures will be reviewed periodically by the Executive Team with recommendations for QI activities reported to the QIC. From the Strategic Planning review of local health data (including the State’s core Public Health Indicators, and other data) and the Plan’s goals, objectives, and performance measures, recommendations for quality improvement efforts will be reported to the QIC.

4. Staff

Staff is responsible for:

I. Completing a prioritization matrix or other framework to evaluate activities
II. Compiling program data for measures
III. Participating in logic model reviews
IV. Working with managers to identify areas for improvement and suggesting improvement projects to address these areas, including meeting the state standards
V. Conducting quality improvement projects in conjunction with managers and other appropriate staff.
VI. Reporting QI training needs to QIC.

D. Training Plan

Periodically, trainings will be held on data analysis, logic models, program evaluation, quality improvement methods (RCI, BPA, survey development, etc.), and the Public Health Standards for staff. The PH Standards describe the measures around program evaluation, quality improvement, and data-driven decision-making that result in program and policy changes. Identified training needs around quality improvement and program evaluation will be solicited from management and staff by the QIC. Training will be developed to meet those needs. The QIC will have advanced training for the QI team such as conferences, Strengths Finder, continuing education, or on-line resources.

CCHHVS Director will receive an annual update on changes made to the plan. Management will be responsible for orienting all of their staff to the Quality Improvement Committee roles and process, QI plan, and available resources. The management orientation checklist for new staff includes providing an overview of the Quality Improvement Committees, QI Plan, resources, and program specific evaluation efforts in each manager’s area and division. (Standard 12.2)

E. QI Project Identification

2012 Selected Quality Improvement Objectives & Performance Measures
The identification of potential QI projects will occur from reports to or other information
obtained by the QIC. QI project ideas may be solicited or suggested by staff at any time for consideration. QI project suggestions may be submitted via the QI proposal form, appendix D. QI projects may also be submitted to the QIC for technical assistance. Projects could use many QI methodologies, such as Rapid Cycle Improvement (RCI), Business Process Analysis (BPA), focus groups, surveys, and more. The QI projects must align with our strategic plan mission, vision, and values for Public Health to be considered for a QI project which is considered by the QIC. A follow-up progress report to the QIC after project completion will be required.

F. Goals, Objectives, Measures & Time Framed Targets and

G. Monitoring of QI Plan

The QIC will monitor one (1) - two (2) indicators at any one time. From each of the QI effort reports to the QIC, up to two prioritized quality improvement areas will be selected for monitoring and assessment of improvement within an established timeframe. The Objectives and Performance Measures Tracking form will be used for reporting to the QIC, with improvement objectives selected prior to the meeting. The Objective and Performance Measures Tracking form includes key area of goals, objectives, measures and time frames for targets for the quality improvement projects as well as definition for performance measure, responsible person for measuring, activities/ projects associated with each objective, and prioritization for activities/projects. The QIC will utilize SMART for determination of objectives. Data for the QI plan will be collected specific to the QI project utilizing PHDoc computer reports, client surveys, MIIC reports, as appropriate for QI project selected and analyzed by the QIC. Progress towards achieving goals and objectives will be monitored on a regular basis by the QIC as available at meetings. If areas are selected by the QIC, program coordinators or other appropriate staff will be asked to fill out the form and return it to the QIC. A Selected Quality Improvement Objectives Log will be kept by the QIC. The QIC will use both forms to monitor work and schedule reports.

Staff and the QIC should select quality improvement activities to monitor that are high-risk, high –volume, or problem-prone and can be tracked and reported as aggregate statistics.

(See Appendix C: Quality Improvement Project Work Plan and Appendix D: Quality Improvement Proposal Form and Appendix E: Quality Improvement Final Project Report)

H. Communicating Quality Improvement Activities

On a periodic basis, articles about QI efforts will be disseminated to the Communications Committee for publication. Periodic updates or presentations about the QIC activities will be given to Executive Team, the Board of Health, and Program Managers. Presentation methods may be thru newsletters, story boards, or meeting updates. Managers will be responsible for ongoing communication to staff about the QI Plan and process established within our agency.
Resources (materials, templates, data collection tools, and trainings) available to staff are posted on the CCPH M-drive under Quality Improvement. As new resources become available, they will be posted to the M-drive and announced to staff.

I. Assessment of Effective Quality Improvement Plan Activities:

Approval of QI Plan and Annual Evaluation
The QIC will annually review and make suggested revisions to this QI Plan. When reviewing, the QIC will work to maintain alignment with Accreditation Standards. A report summarizing the review process, findings, and suggested modifications will be submitted to the CCHHVS Director for approval no later than January 15th of each year. Subsequent to approval, the revised Plan will be provided to the CCHHVSAB in January for their information.

QI efforts include review and improvement of all programs and processes that have a direct or indirect influence on the quality of public health services provided by CCPH. The following QI efforts will be reported to the QIC:

Program Evaluation
Program evaluation is defined as the systematic application of social (or scientific) research procedures for assessing the conceptualization, design, implementation, and utility of CCPH programs. It will consist of creating a logic model or other framework for each program in the agency, creating effective data collection tools to measure each of the program’s impacts, reviewing data with staff on an annual basis, updating the logic models or other framework, and reporting on the outcomes to the division director. Staff and program managers are responsible for conducting program evaluation. A division director or designee will report key findings to the QIC. Findings will be used to inform program planning and QI efforts. (Standards 9.1, 9.2)

After-Action Reviews
After-Action Reviews of emergency preparedness/response exercises, epidemiologic outbreaks, or other public health event will analyze the following areas: monitoring and tracking processes, disease-specific protocols, investigation/compliance procedures, laws and regulations, staff roles, communication efforts, access to essential public health services, emergency preparedness and response plans, and other CCPH plans, such as facility/operations plans. Primary findings and proposed improvements will be reported to the QIC by the Public Health Emergency Preparedness and Response (PHEPR) program staff or other appropriate program staff. (Standard 2.1, 2.2, 2.3, 2.4, 5.4)
(See Appendix B: Quality Improvement Reporting Calendar)

Strategic Plan Review
The CCPH Strategic Plan includes objectives around assessment activities, use of health data to make program and policy decisions, After Action Review issues, and prevention priorities. The Strategic Plan goals, objectives, and performance measures will be reviewed periodically by the Executive Team with recommendations for QI activities reported to the QIC. From the Strategic Planning review of local health data (including the State’s core
Public Health Indicators, and other data) and the Plan's goals, objectives, and performance measures, recommendations for quality improvement efforts will be reported to the QIC.

**Customer Service**
All employees with job functions that require interactions with the general public, stakeholders, and partners will receive appropriate customer service training. Training needs will be identified by the program evaluator and program managers and reported to their director. Customer service training for appropriate staff will be periodically offered by Human Resources or other applicable resources. Training attendance should be documented electronically to verify staff participation and to produce aggregate reports. If training is provided by Human Resources, documentation of attendance will be kept by HR staff.

Customer service satisfaction will be evaluated at program and service levels, and periodically rolled up at the agency level, to assure customer service standards are met. Division reports will include results from program and/or service satisfaction surveys. A core set of questions will be used by all customer service surveys. Community Health Assessment staff will assist program staff in developing and implementing surveys.

**HIPAA Compliance**
Issues surrounding HIPAA policies, confidentiality, data sharing, security, and records retention will be evaluated and reported to the QIC by the HIPAA/Quality Assurance Coordinator.

I. **References**
   d. Public Health Accreditation Board Standards

II. **Visuals** Venn Diagram and Plan, Do, Check, Act (PDCA) page 8

III. **Appendices**
   Appendix A: Quality Improvement Goals & Activities Work Plan page 9
   Appendix B: Quality Improvement Reporting Calendar page 10
   Appendix C: Selected Quality Improvement Objectives Log page 11
   Appendix D: Quality Improvement Proposal Form page 12
   Appendix E: Quality Improvement Final Project Report page 13

Prepared by the Quality Improvement Committee: November 2011

Approved by the Administration and HHVS Advisory Board: 11/28/11

**QI Visuals**
Plan, Do, Check, Act (PDCA)

**ACT**
- Evaluate
- Apply lessons learned
- Modify as necessary
- Start PDCA again

**PLAN**
- Establish a baseline
- Identify priorities
- Set improvement goals and standards.

**CHECK**
- Monitor and measure
- Find and fix
- Document results

**DO**
- Implement actions
- Plan to achieve goals
## Quality Improvement Goals & Activities Work Plan

<table>
<thead>
<tr>
<th>Objective #1: To identify, review, monitor, and make recommendations on Quality Improvement (QI) projects</th>
<th>LEAD</th>
<th>BY WHEN</th>
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</thead>
<tbody>
<tr>
<td>a. Maintain a reporting system [from divisions, administrative services, and other groups] on QI activities</td>
<td>Jeri</td>
<td>Monthly</td>
</tr>
<tr>
<td>b. Review data reports to identify potential QI areas</td>
<td>QIC Team</td>
<td>Monthly</td>
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<tr>
<td>c. Request and review additional information in identified areas for appropriate action</td>
<td>QIC Team</td>
<td>Monthly</td>
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<tr>
<td>d. Track and monitor data reports and outcome variances, and inquire about lessons learned</td>
<td>QIC Team</td>
<td>Monthly</td>
</tr>
<tr>
<td>e. Assist divisions in identifying projects in areas that are high risk, high volume, or problem prone. Request directors to report on logic model data reviews and selected outcome measures.</td>
<td>QIC Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>f. Compile [and make available] information on all QI efforts/ documentation</td>
<td>Jeri</td>
<td>Ongoing</td>
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</table>

**Objective #2: To review the QI Plan at least annually and adjust as required to ensure ongoing quality improvement activities**

<table>
<thead>
<tr>
<th>LEAD</th>
<th>BY WHEN</th>
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<tbody>
<tr>
<td>a. Obtain approval through Management and engagement of Board of Health</td>
<td>Jamie</td>
</tr>
<tr>
<td>b. Review plan annually and update as necessary</td>
<td>QIC Team</td>
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</tbody>
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**Objective #3: To identify and meet QI training needs**

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<thead>
<tr>
<th>LEAD</th>
<th>BY WHEN</th>
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<tbody>
<tr>
<td>a. Solicit information from staff on needed QI training</td>
<td>Merilee</td>
</tr>
<tr>
<td>b. Identify new management and provide orientation to QIC and QI Plan. Assist management with working with staff beginning with small, achievable projects and then moving to more in-depth QI.</td>
<td>Merilee</td>
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<tr>
<td>c. Facilitate provision of technical assistance workshops with follow-up session throughout the year for managers and staff. Provide other identified training, as needed.</td>
<td>Merilee</td>
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<tr>
<td>d. Determine ways to create a universal staff understanding of the importance of QI in our agency.</td>
<td>Merilee</td>
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**Objective #4: To provide guidance, support, and resources to QI efforts**

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<th>LEAD</th>
<th>BY WHEN</th>
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<tbody>
<tr>
<td>a. Maintain resources on Intranet for staff to use to support their QI efforts. Periodically, assess use and effectiveness of materials.</td>
<td>Renee</td>
</tr>
<tr>
<td>b. Continue assigning QC members as project assistants. Expand assistance role in reminding project staff of reporting dates and how to report to the QC.</td>
<td>QIC Team</td>
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<tr>
<td>c. Incorporate QI responsibilities into all position descriptions.</td>
<td>Renee</td>
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<tr>
<td>d. Encourage staff to identify and incorporate science-based methods into QI projects to test and then apply, if effective.</td>
<td>Renee</td>
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**Objective #5: To recognize and acknowledge QI efforts**

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<th>LEAD</th>
<th>BY WHEN</th>
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<tbody>
<tr>
<td>a. Publicize QI minutes on M-Drive for access. Post story boards. Present projects to the BOH.</td>
<td>QI Team members</td>
</tr>
<tr>
<td>b. Submit applications for broader acknowledgements of QI efforts. Work with communication committee on submitting recognition of agency when awarded to the local newspapers and posting on website.</td>
<td>QI Team</td>
</tr>
</tbody>
</table>
# Quality Improvement Reporting Calendar

<table>
<thead>
<tr>
<th>DATA COMPILED Date Due:</th>
<th>DATA REVIEW BY QI Date Scheduled:</th>
<th>REPORT TO</th>
</tr>
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<tbody>
<tr>
<td><strong>2011 Standards Review and National Accreditation Evaluation</strong></td>
<td>Ongoing</td>
<td>November 1, 2011</td>
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<tr>
<td><strong>Administrative Responsibilities</strong></td>
<td>Ongoing</td>
<td>Annual March</td>
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<tr>
<td><strong>After Action Reviews</strong></td>
<td>Per occurrence</td>
<td>Per occurrence</td>
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<tr>
<td><strong>Customer Service (Training &amp; Evaluation)</strong></td>
<td>Deyta (Home Care)</td>
<td>Deyta/HHCAHPS As Available</td>
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<tr>
<td><strong>Public Health Annual Report</strong></td>
<td>Annual January</td>
<td>Annual February</td>
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<tr>
<td><strong>Quality Improvement Projects</strong></td>
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<tr>
<td><strong>Rapid Cycle Improvement Projects</strong></td>
<td>See log</td>
<td>See log</td>
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<tr>
<td><strong>Other Identified Projects</strong></td>
<td>See log</td>
<td>See log</td>
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<tr>
<td><strong>Strategic Plan Review (Incorporate to Annual Report)</strong></td>
<td>Annually End of December</td>
<td>Annual January</td>
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<tr>
<td><strong>QI Evaluation (Incorporate to Annual Report)</strong></td>
<td>Annual January</td>
<td>Annual February</td>
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<tr>
<td><strong>QI Plan Review</strong></td>
<td>Ongoing</td>
<td>Annual January and as needed</td>
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</table>
# Quality Improvement Project Work Plan

**QI Project Name:**

**Goal:** Improve <_________>.

**Objective(s):**
- By <date>, <increase or decrease> <focus area>

**Evaluation Indicators:** *(How will you determine that the goal has been reached? What are your measures?)*
- <X%> of <_____> <increase or decrease>
- Less than <X%> <statement>
- More than <X%> <statement>

<table>
<thead>
<tr>
<th>Key Strategies and Activities</th>
<th>Lead Role</th>
<th>Target Date for Completion</th>
<th>Status of Progress</th>
<th>Actual Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>What will be done?</td>
<td>Who is responsible for ensuring activity is completed on time?</td>
<td>When will activity be complete?</td>
<td>What is the status of the activity? Any challenges or barriers with completing timely?</td>
<td>What date was activity actually completed?</td>
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<tr>
<td>Strategy 1:</td>
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<td>Activity 1A:</td>
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<td>Activity 1B:</td>
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<td>Strategy 2:</td>
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<td>Activity 2A:</td>
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<td>Activity 2B:</td>
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Quality Improvement Proposal Form
(One project/form)

Title of QI Project:      Lead staff:
Start date:       Complete date:
Initial report to QI date:     Final report to QI date:

1. What is the identified issue that you would like to work on?

   How did you determine that this was an issue (background)?

2. What is your specific objective and timeframe for improving the identified area, such as “Increase x by 10% by November 30th?” This should be your one overall objective for the project.

3. What activities are you considering for improvement?
Quality Improvement Final Project Report

Title of Project: Lead staff:
Start date: Complete date:

Initial report to QI date: Final report to QI date:

1. What was/were the performance measure(s) at the start and completion of your improvement activities? Give actual percentage, rate, or other measure.

2. Did you reach your target or goal of your objective? Provide data.

3. What variables were involved in reaching or not reaching your goal?

   a. What is your plan to address the variables that prevented you from reaching your target or goal?