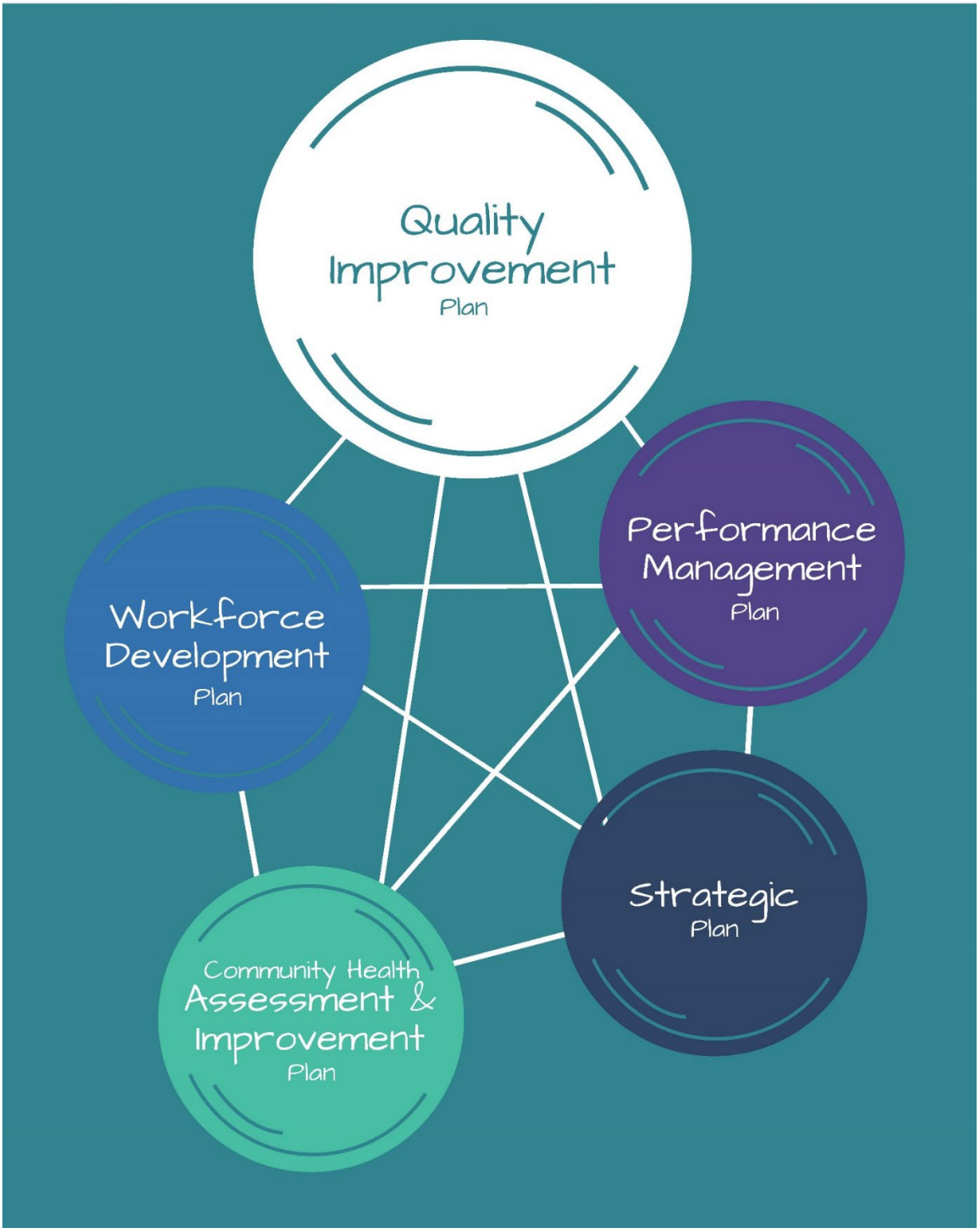
Public Health
Idaho North Central District



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PLAN REVIEWS AND REVISIONS

Date	Section/Pages Affected	Responsible Staff
October 2012	Original document approved	Tara Macke
October 2015	Document revised	Tara Macke
December 2016	Annual Review	Tara Macke
September 2017	Reformatting and annual review	Tara Macke & Kayla Sprenger
September 2018	Annual review APPENDIX B: CQI Project Overview, APPENDIX E: PDSA Single Change Form	Tara Macke
September 2019	Annual Review for 2020-20203 Plan Revisions	Tara Macke
December 2019	2020-2023 Plan approval	Carol Moehrle, Director
2020	COVID-19 Pandemic	
September 2021	Annual Review and Revision	Tara Macke, Kayla Sprenger, & Kaylie Bednarczyk

BACKGROUND

In 2011, PH-INCD received funding from NACCHO to establish a Quality Improvement Program with a written policy, plan and a documentation process for QI activities. In order to build an adequate QI infrastructure, the QI Team, also known as the Administrative Team, was established and trained creating a comprehensive philosophy which then created a QI/PM Team. While applying for Accreditation, a team with the necessary skills and knowledge were chosen to represent the district. These teams were combined in an effort to best utilize resources and are now known as the CREW Team. QI training is ongoing and is provided for all staff. Through this effort we established a framework for how performance standards may be met by engaging in a rigorous Continuous Quality Improvement (CQI) process, and we established an infrastructure to sustain CQI.

PURPOSE

The purpose of the Public Health - Idaho North Central District (PH-INCD) Quality Improvement Plan (QIP) is to provide context and framework for the Quality Improvement (QI) activities at Public Health - Idaho North Central District.

Policy Statement: PH-INCD has an interest in systematically evaluating and improving the quality of programs, processes and services to achieve a high level of efficiency, effectiveness and customer satisfaction. To achieve this culture of continuous improvement, QI efforts should target the department-level ("Big QI") as well as the program- and project- level ("Small QI").

This plan has been approved and adopted by the PH-INCD District Director.

Carol McMackin

District Director

12/09/2021

Date

DEFINITIONS

Strategic Planning and 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 is used to design program improvements and to measure the results of the improvements as implemented.

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.

Quality Improvement (QI): An integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes within an organization.

Quality Improvement Plan (QIP): Identifies specific areas of current operation performance for improvement within the agency. These plans can and should cross-reference one another, so a quality improvement initiative that is in the QIP may also be in the Strategic Plan. See also performance management.

Quality Methods: Builds on an assessment component in which a group of selected indicators 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 by the PDCA cycle.

Quality Improvement Project Teams: Program-level teams, organized by Program Managers and staff, to carry out QI activities, namely PDCA cycles. QI Project Teams are charged with developing, implementing, evaluating and reporting QI projects.

Quality 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. A list of basic QI Tools (along with an information sheet, template and example) can be found on the PH-INCD intranet page. Each CREW member will possess a pocket guide of tools for continuous improvement and effective planning. (The Public Health Memory Jogger II, Public Health Foundation)

Performance Management (PM): PM is the process of ensuring that a set of activities and outputs meets an organization's goals in an effective and efficient manner. PM can focus on the performance of an organization, a department, an employee, or the processes in place to manage particular tasks. PM standards are generally organized and disseminated by senior leadership at an organization and by task owners, it can include specifying tasks and outcomes of a job, providing timely feedback and coaching, comparing employee's actual performance and behaviors with desired performance and behaviors, instituting rewards, etc.

Plan-Do-Check-Act (PDCA): is an iterative four-stage problem-solving model for improving a process or carrying out change. PDCA stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDCA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned. (Embracing Quality in Local Public Health, Michigan's QI Guidebook)

LEADERSHIP AND ORGANIZATION

The CREW Team provides ongoing leadership for continuous quality improvement efforts at PH-INCD. These efforts will include development and revision of a QI Plan, preparing to meet accreditation standards related to QI, and utilizing rapid-cycle QI tests. The CREW Team consists of approximately 10 members, representing staff from all divisions of PH-INCD including the district director, division directors, program managers, and administrative staff. The CREW team remains static to enhance consistency of plans. CREW Team members will be expected to attend regular monthly meetings, QI trainings, and engage in mentoring activities with other staff.

ROLES AND RESPONSIBILITIES

District Director

- Provide leadership for the PH-INCD vision, mission, strategic plan and direction related to QI efforts.
- Assure that all staff have access to resource to carry out QI projects and training.
- Advocate for a culture of QI, including messages and presentations to staff as well as internal and external partners.
- Promote a CQI environment (learning environment) for PH-INCD.
- Apply QI principles and tools to daily work.

Accreditation Coordinator

- Coordinate, support, guide and define overall QI program.
- Develop and manage all aspects of the annual Quality Improvement Plan (QIP) with input from the CREW.
- Integrate QI principles in PH-INCD policies and protocols.
- Assist QI projects at Director, Division and Program level.
- Document all QI related activities.
- Ensure communication of QI project results.
- Identify continuing education resources.
- Facilitate CREW.
- Assist CREW members in addressing problems encountered by QI Project Teams.
- Ensure QIP meets PHAB Accreditation Standards.
- Implement other strategies to develop “culture of QI.”
- Apply QI principles and tools to daily work.

Division Directors

- Facilitate the implementation of QI activities at the Division Level.
- Facilitate the development of QI Project Teams for all programs and offices.
- Participate in QI projects as requested.

- Support Program Manager sin their efforts with QI activities.
- Document QI efforts.
- Communicate regularly with the District Director to share QI successes and lessons learned.
- Provide feedback to shape annual QIP
- Apply QI principles and tools to daily work.

CREW Team

- Provide QI expertise and guidance for QI Project Teams.
- Provide QI training to new and existing staff.
- Assist in development of PH-INCD QI activities.
- Review annual QIP prior to approval.
- Advocate for QI and encourage a culture of learning and QI among staff.
- Apply QI principles and tools to daily work.

Program Managers

- Support program QI Project Teams.
- Serve as QI leads.
- Assure staff participation in QI activities.
- Assure staff QI training.
- Facilitate an environment of CQI for all staff.
- Keep Division Director apprised of QI activities.
- Apply QI principles and tools to daily work.

All Staff

- Develop an understanding of basic QI principles and tools through QI training.
- Participate in the work of at least one QI project.
- With the Program Manager, identify program areas for improvement and suggest improvement actions to address identified projects, paying particular interest to quarterly performance measures.
- Report QI training needs to Program Manager.
- Complete QI activities under the normal supervisory authority and supervisory structure of PH-INCD.
- Apply QI principles and tools to daily work.

BUDGET AND RESOURCE ALLOCATION

PH-INCD allocates resources for PM and QI by allowing staff time for training, projects and activities.

STAFF TRAINING

New Staff

- Presentation at New Employee Orientation.

Current Staff

- Ongoing staff training at least annually
- Program specific QI training as available.
- Hands-on training via work on QI projects.
- QI included in performance evaluations.

CREW

- Will be offered hands on in classroom training to develop their skills to serve PH-INCD QI Project Team.

CONNECTING PERFORMANCE MANAGEMENT AND QI

PERFORMANCE MANAGEMENT SYSTEM

Performance management is a systematic process by which an organization involves its employees in improving the effectiveness of the organization and achieving the organization's mission and strategic goals. PH-INCD's PM system uses the Public Health Performance Management System Framework developed by the Turning Point Performance Management National Excellence Collaborative, which was further updated by the Public Health Foundation.

Performance Standards

The PH-INCD Strategic Plan establishes performance standards in the form of goals and data-driven objectives. These standards were identified by aligning with the PH-INCD's Strategic Plan priorities areas, which were developed through data analysis, community input, Healthy People 2030 targets, and comparisons to state and national performance.

Performance Management

Workgroups comprised of all levels of staff define numerators and denominators for performance indicators that support the Strategic Plan's objectives. Each indicator includes a data collection plan that identifies data sources, reporting frequency, and assigned responsibilities.

Quality Improvement

Strategic goals and objectives drive priorities for PM and the data that is collected during performance measurement is used to identify opportunities to improve policies, programs, processes and outcomes.

Reporting Progress

PH-INCD uses SharePoint and Power BI software to update data, track trends and progress, evaluate performance information and align efforts according to guiding plans and standards. This provides a centralized and uniform tool that simplifies the alignment and evaluation of goals, objectives, indicators, strategies and projects.

DESCRIPTION OF QI PROJECT SELECTION

Below is the current standard methodology for quarterly strategic planning and performance management. The objectives, goals, Key Performance Indicators (KPI) and Key Strategies below should receive priority attention for all QI projects that are addressed by staff.

A. Each program selects an annual objective based on best practice, historical data, other national standards or objectives. Progress toward the annual objective is tracked and reported at quarterly strategic planning meetings.
B. Program goals are developed to help reach the annual objective.
C. Key Performance Indicators (KPI) are then Identified to measure the amount of work being done to address the program goal.
D. Key strategies are set to help the program reach its annual objective; key strategies are also tracked and reported quarterly.
E. Quarterly progress is presented at CREW meetings.

In 2022, staff will apply QI tools and principles to opportunities for improvement in the agency, with emphasis placed on addressing measures related to the PH-INCD Performance Management Plan. In the past, program managers and staff have used a variety of methods to improve measurable outcomes; the use of PDCA and QI Project Teams will provide a strategic and uniform method for planning, implementing, reporting and documenting change.

PH-INCD's performance management system connects to the goals and objectives of the Strategic Plan, staffing requirements from the Workforce Development Plan, and Community Health Assessment identified needs. All these plans help identify programs and activities that should be prioritized for quality improvement projects.

Customer feedback is important for the improvement of PH-INCD programs and activities. The process for regular customer feedback is for the front desk staff to hand out cards to each customer who comes into our offices. These cards ask two questions: Were you satisfied with your experience today? If no, what could we have improved on or done better?

On the bottom of the cards, there is the name, phone number, and email of a staff member if the customer would like to speak to someone about their experience. The completed cares are gathered and compiled with any phone or email feedback to be analyzed. This customer feedback is analyzed quarterly and presented annually during quality improvement project selection.

QI activities at the program level will be led by staff via QI Project Teams and provided resources by the program manager. QI Project Teams are a collaborative which include “frontline” staff, program managers, division directors, (at least one) QI/PM CREW member and other staff as needed. A QI Project Team may be developed to address a single QI project or it may be a more long term team to address a series of QI projects over time.

QI Project Teams should generally be developed after staff and the program manager have identified an issue to address. This may be done through intentional brainstorming or after an issue has "bubbled to the surface". Once a project has been identified, the project manager and applicable staff should identify appropriate team members. The team should then hold an initial meeting to define roles and complete the Rapid Cycle Improvement Project Proposal. A CREW member will be available to assist in facilitating the process. After the project plan is finalized, the team will initiate the steps of the PDCA model for improvement. The team should be intentional about documenting each step of the process, including use of QI tools. Upon completion of the PDCA cycle, the QI Project Team should document the completed process (using a storyboard or a written summary). The report will be shared with the Division Director and CREW. The Accreditation Coordinator will present the finding at CREW meetings. The Division Director or Program Manager will present the findings at the next Admin team meeting. Some projects may also be shared at quarterly All Staff Meetings or other venues. It is up to the QI Project Team to determine if another PDCA cycle will be completed or what steps should be taken next.

CULTURE OF QI

PH-INCD is building and sustaining a culture of quality by instituting PM and QI principles and practices that permeate throughout the department.

2022 AGENCY QI GOALS

QI Project Teams

- Each Program Manager will facilitate the development of a staff-led, "single-project-focused" QI Project Team of three to five staff, including the Project Manager.

QI Projects

- Each program should complete at least one QI project annually. The project may be related to program outcome measures, health outcomes, KPI measures, documentation, policy review or development, staff training, another measurable variable, etc.
- QI projects will be documented and easily accessible in electronic format. Division Directors will ensure that QI Project team leads understand how the PH-INCD Intranet will facilitate this.
- QI Project reports will indicate how program changes will be made based on QI Project results.

Training

- All new and existing staff will receive introductory QI Principles, QI Tools training and QI Plan orientation.
- CREW members will receive ongoing training to better serve as agency QI Champions.

Recognition

- The District Director will recognize high performing staff, programs and divisions for advancing QI at PH-INCD.

Promotion

- The Accreditation Coordinator will work with the District Director and CREW to identify opportunities to present PH-INCD "QI efforts" at conferences, in publications, presentations, etc.

Long-term QI Goals

- Long-term QI Goals will be developed midway through the 2022 QI Plan, with annual revisions.

QUALITY IMPROVEMENT MANAGEMENT PLAN

National Benchmark/Objective: (see PHAB, Guide to Standards and Measures, Standard 9.2)	
Goal 1: Develop a QI Plan based on organizational policies and direction.	
Objective: Annually review and revise agency QI Plan that seeks to improve public health services, health outcomes and address the requirements of PHAB Accreditation.	
Measure 1: Signed and documented annually PH-INCD QI Plan.	
Key Strategies:	Draft of QI Plan drafted by Accreditation Coordinator.
	QI Plan vetted by CREW
	QI Plan vetted and approved by the District Director.
Goal 2: Implement QI Efforts	
Objective: Effectively implement each element of the agency QI Plan within the defined timeline for each.	
Measure 1: Achieve 100% compliance with required Division QI Projects (1/program/year)	
Measure 2: Complete 100% of requested Administrative QI Projects (1/quarter)	
Key Strategies:	Annually, each Division Director will complete a brief summary of QI Projects to monitor programs of QI-related activities.
	Accreditation Coordinator will document 100% of the approved QI Project Proposals.
	Accreditation Coordinator will make the following data available: # of Division and Administrative QI Projects (annually, quarterly, per division, per program, per staff).
	Accreditation Coordinator will document the impact of Division and Administrative Program QI Projects.
Goal 3: Demonstrate staff participation in QI Methods and QI Tools training.	
Objective: Provide adequate QI training to all staff.	
Measure 1: Train 100% of current and new staff on “QI Principles and Tools” and “QI Plan”	
Key Strategies:	Accreditation Coordinator will maintain and an up-to-date log of staff who have attended QI training (“QI Principles and Tools” and “QI Plan”).
	All Staff will complete a Pre and Post training test (QI Maturity Tool) to evaluate effectiveness of training material.
	Accreditation Coordinator will work with HR to develop communication strategy to ensure all new staff are identified and trained.

COMMUNICATION STRATEGIES

It is important to have regular communication with staff on quality improvement initiatives. The following methods will be implemented to ensure regular internal communication regarding the QI Plan:

1. QI Project updates at each All Staff Meeting.
2. Presentations (QI Projects, QI Tools, etc.) at Division and program level meetings.
3. Presentations at each department All Staff Meeting.
4. Visual Storyboards on display.

Furthermore, frequent external communication regarding the implementation of the QI Plan and ongoing QI projects is essential for the Board of Health and other stakeholders to be aware of quality across the district.

SUSTAINABILITY

QI and Employee Performance Evaluation

- Overview: a mandatory, performance review system that has been revised by the Administrative Team to include QI standards. Each employee will be evaluated annually.
- Division Directors and Program Managers will tie QI activities to the employee performance review.
- Staff involvement in QI activities will be evaluated in their annual Performance Evaluation.

Agency QI Policy

- The agency QI Policy, developed in 2011, was created explicitly to create an environment of sustainability for the agency's first comprehensive QI Plan. The QI Policy will be included in the Employee Policy Manual and updated regularly to ensure its effectiveness in guiding agency-wide QI efforts.
-

MONITORING AND REPORTING

The CREW Team will review and provide feedback for the QI Plan, QI activities, and all related process annually to ensure to remain adaptive to change and meet the needs of all who are impacted by QI efforts. Regular feedback regarding improvement activities is critical to assessing the effectiveness of PM and QI efforts. The CREW Team will administer the QI Maturity Tool annually in December and review the progress from the previous year. The 2022 revisions of the QI Plan will be updated to reflect the needs identified from the annual QI Maturity Tool and posted to the PH-INCD website.

The Director will present an annual report of the PM and QI Plans to the Board of Health which summarizes:

- QI projects, including plans for addressing barriers, successes, key learnings and sustainability plans.

- Achievement on the comprehensive QI Maturity Score and data from the specific ten questions that make up the QI Maturity Tool.
- A work plan for the next year.
- Alignment with other plans.
- Any recommended revisions to the QI Plan and CREW.
- Customer satisfaction.

APPENDIX A: RAPID CYCLE IMPROVEMENT PROJECT PROPOSAL

Project title:	***Submitted by:***
Date submitted to QIC:	***Logic model attached:*** ☐Yes ☐No
Briefly identify or describe the program, project or process that should be addressed with an RCI project:	
Priority: ☐ High ☐ Medium ☐ Low	***Please explain why you selected this priority level:***
Departmental Implications ***How does this project support our mission, vision, and/or strategic directions?*** ***Who are the stakeholders (internal and external) and what are their concerns?*** ***What resources and support will be needed to complete the project?*** ***What potential impact could there be on other programs/activities if this RCI project is conducted?***	
What are we trying to accomplish? (A brief goal statement)	
How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project) ***Long term:*** ***Medium term:*** ***Short term:***	
What changes can we make that will result in an improvement? (Initial hypotheses and description of data needed to focus the project and the development of an intervention)	
Who should be on this RCI team?	***Who should lead this RCI team?***

APPENDIX B: CQI PROJECT OVERVIEW

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CQI Project Overview
Program

PROJECT TITLE

OPPORTUNITY STATEMENT

What problem(s) will be addressed by this project?

PROJECT AIM

Write your **Specific, Measurable, Attainable, Relevant, Time-oriented** aim statement. *Example: By December 31, 2018, we will increase visit compliance by 15% for families that are eligible for 24 visits per year.*

CQI TEAM MEMBERS AND ROLES

Who will be on your CQI team and what will their role will be? *Potential roles: project lead, notetaker, data manager, document manager, information liaison, researcher, etc.*

Name	Role/Task
Name	**Role/Task**
Name	**Role/Task**

How often will you meet?

TIMELINE

How long will this project last? How frequently will you collect data? What are your reporting periods?

LENGTH OF PROJECT: MM/DD/YY – MM/DD/YY	
Baseline Data Due: MM/DD/YY	**Final Data Due: MM/DD/YY**
Baseline report date range: MM/DD/YY - MM/DD/YY	**Final report date range: MM/DD/YY - MM/DD/YY**

Based on data collection frequency: add mid-project due dates if necessary.

CORE MEASURES

Outcome measures reflect the impact of the intervention.

Example: Percentage of "high needs" families (active during the entire reporting timeframe) that have completed 75% of their "expected visits" within the reporting timeframe.

OUTCOME MEASURE	
Numerator:	**Denominator:**
Example: Total of "high needs" families active during the entire reporting timeframe who completed 75% of their "expected visits"	*Example: Total of "high needs" families active during the entire reporting timeframe*

Process measures indicate what you must do or change to impact the intervention.

Example: Percentage of pre-visit calls made during the reporting timeframe that resulted in a family making their visit.

PROCESS MEASURE	
Numerator:	**Denominator:**
Example: Total number of calls that resulted in a family making their visit.	*Example: Total number of pre-visit calls made.*

Are changes designed to improve one part of your program causing new problems in other parts of your program?

Example: Is the staff time that is takes to do pre-visit calls taking away from time spent with timely documentation?

BALANCING MEASURE	
Numerator (if measuring quantitative data):	**Denominator (if measuring quantitative data):**

**Balancing measures can be measured by qualitative or quantitative data.*

CONSIDERATIONS

What barriers or additional considerations should your team plan for?

CONTROL FACTORS

WHAT CAN WE CONTROL?

WHAT CAN'T WE CONTROL?

ACTION ITEMS AND EXPECTATIONS

What objectives do you need to complete?

Submit completed Project Overview, at least two PDSA Cycles, Baseline and Final Data, and the End of Project Report to the MIECHV team. (Refer to the CQI Project Process Map for submission timeline.)

APPENDIX C: PROJECT TRACKING SHEET

	Steps of PDCA Approach	Key Elements	Notes
PLAN	**Step 1** Getting Started	☐ Identify area, problem, or opportunity for improvement ☐ Estimate and commit needed resources ☐ Obtain approval (if needed) to conduct QI	
	Step 2 Assemble the Team	☐ Identify and assemble team members (including customers and/or stakeholders) ☐ Discuss problem or opportunity for improvement ☐ Identify team member roles & responsibilities ☐ Establish initial timeline for improvement activity and schedule regular team meetings ☐ Develop Aim Statement *What are we trying to accomplish?* *How will we know that a change is an improvement?* *What change can we make that will result in improvement?*	
	Step 3 Examine the Current Approach	☐ Examine the current approach or process flow ☐ Obtain existing baseline data, or create and execute data collection plan to understand the current approach ☐ Obtain input from customers and/or stakeholders ☐ Analyze and display baseline data ☐ Determine root cause(s) of problem ☐ Revise Aim Statement based on baseline data as needed	
	Step 4 Identify Potential Solutions	☐ Identify all potential solutions to the problem based on the root cause(s) ☐ Review model or best practices to identify potential improvements ☐ Pick the best solution (the one most likely to accomplish your Aim Statement)	
	Step 5 Develop an Improvement Theory	☐ Develop a theory for improvement *What is your prediction?* *Use an "If . . . . Then" approach* ☐ Develop a strategy to test the theory *What will be tested? How? When?* *Who needs to know about the test?*	
DO	**Step 6** Test the Theory	☐ Carry out the test on a small scale ☐ Collect, chart, and display data to determine effectiveness of the test ☐ Document problems, unexpected observations, and unintended side effects	
CHECK	**Step 7** Check the Results	☐ Determine if your test was successful: *Compare results against baseline data and the measures of success stated in the Aim Statement* *Did the results match the theory/prediction?* *Did you have unintended side effects?* *Is there an improvement?* *Do you need to test the improvement under other conditions?* ☐ Describe and report what you learned	
ACT	**Step 8** Standardize the Improvement or Develop a New Theory	☐ If your improvement was successful on a small scale test it on a wider scale *Continue testing until an acceptable level of improvement is achieved* *Make plans to standardize the improvement* ☐ If your change was not an improvement, develop a new theory and test it; often several cycles are needed to produce the desired improvement	
	Step 9 Establish Future Plans	☐ Celebrate your success ☐ Communicate your accomplishments to internal and external customers ☐ Take steps to preserve your gains and sustain your accomplishments ☐ Make long term plans for additional improvements ☐ Conduct iterative PDCA cycles, when needed	

APPENDIX D: QUALITY IMPROVEMENT MATURITY TOOL

QI Maturity Tool (version 5)

Background:
This survey was created by the Multi-State Learning Collaborative evaluation team at the University of Southern Maine's Muskie School. The tool was designed to:

- Identify features of an organization that may be enhancing or impeding QI approaches
- Monitor the impact of efforts to create a more favorable environment for QI to flourish
- Define potential cohorts of public health agencies for evaluation purposes

Contact Information:
For more information on the QI Maturity Tool, including its development, reliability, validity, administration and scoring, please contact Brenda Joly at 207-228-8456 or bjoly@usm.maine.edu

Preferred Citation:
Joly BM, Booth M, Mittal P, Shaler G. (2012). Measuring Quality Improvement in Public Health: The Development and Psychometric Testing of a QI Maturity Tool. *Evaluation & the Health Professions*, 35(2) 119-147.

Or

Joly BM, Booth M, Mittal P, Zhang Y. (2013). Classifying Public Health Agencies Along a Quality Improvement Continuum. *Frontiers in Public Health Services and Systems Research* Vol. 2: No. 3, Article 2. Available at: http://uknowledge.uky.edu/frontiersinphssr/vol2/iss3/2

QI Maturity Tool

Directions: Please complete the following items by checking the most appropriate box.

		Strongly Agree				Strongly Disagree
		5	4	3	2	1
1.	Leaders (e.g. board, senior management team) of my public health agency are receptive to new ideas for improving agency programs, services, and outcomes.	❒	❒	❒	❒	❒
2.	The impetus for improving quality in my public health agency is largely driven by an *internal* desire to make our services and outcomes better.	❒	❒	❒	❒	❒
3.	The board and/or the management team of my public health agency work together for common goals.	❒	❒	❒	❒	❒
4.	Staff consult with, and help, one another to solve problems.	❒	❒	❒	❒	❒
5.	Staff members are routinely asked to contribute to decisions at my public health agency.	❒	❒	❒	❒	❒
6.	The *leaders* of my public health agency are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	❒	❒	❒	❒	❒
7.	*Staff* at my public health agency who provide public health services are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	❒	❒	❒	❒	❒

QI Maturity Tool – Joly et. al. (2013) 1

	Strongly Agree 5	4	3	2	Strongly Disagree 1
8. Many individuals responsible for programs and services in my public health agency have the skills needed to assess the quality of their program and services.	❒	❒	❒	❒	❒
9. My public health agency has objective measures for determining the quality of many programs and services.	❒	❒	❒	❒	❒
10. Many individuals responsible for programs and services at my public health agency routinely use systematic methods (e.g., root cause analysis) to understand the root causes of problems.	❒	❒	❒	❒	❒
11. Many individuals responsible for programs and services at my public health agency routinely use best or promising practices when selecting interventions for improving quality.	❒	❒	❒	❒	❒
12. Programs and services are continuously evaluated to see if they are working as intended and are effective.	❒	❒	❒	❒	❒
13. My public health agency has designated a Quality Improvement Officer.	❒	❒	❒	❒	❒
14. The quality of many programs and services in my agency is routinely monitored.	❒	❒	❒	❒	❒
15. Job descriptions for many individuals responsible for programs and services at my public health agency include specific responsibilities related to measuring and improving quality.	❒	❒	❒	❒	❒
16. Good ideas for measuring and improving quality in one program or service USUALLY are adopted by other programs or services in my public health agency.	❒	❒	❒	❒	❒
17. Staff members at all levels participate in quality improvement efforts.	❒	❒	❒	❒	❒
18. My public health agency has a quality improvement council, committee or team.	❒	❒	❒	❒	❒
19. My public health agency has a quality improvement plan.	❒	❒	❒	❒	❒
20. Customer satisfaction information is routinely used by many individuals responsible for programs and services in my public health agency.	❒	❒	❒	❒	❒
21. Accurate and timely data are available for program managers to evaluate the quality of their services on an ongoing basis.	❒	❒	❒	❒	❒
22. Many individuals responsible for programs and services in my agency have the authority to change practices or influence policy to improve services within their areas of responsibility.	❒	❒	❒	❒	❒

QI Maturity Tool – Joly et. al. (2013) 2

	Strongly Agree 5	4	3	2	Strongly Disagree 1
23. When trying to facilitate change, staff has the authority to work within and across program boundaries.	❒	❒	❒	❒	❒
24. Improving quality is well integrated into the way many individuals responsible for programs and services work in my public health agency.	❒	❒	❒	❒	❒
25. Agency staff is aware of external quality improvement expertise to help measure and improve quality.	❒	❒	❒	❒	❒
26. Spending time and resources on quality improvement is worth the effort.	❒	❒	❒	❒	❒
27. The key decision makers in my agency believe quality improvement is very important.	❒	❒	❒	❒	❒
28. Using QI approaches will impact the health of my community.	❒	❒	❒	❒	❒
29. Public health agency staff and stakeholders will notice changes in programs and services as a result of our QI efforts.	❒	❒	❒	❒	❒

Thank you for participating.

Legend	
	Domain = Culture: values & norms that pervade how agency interacts with staff & stakeholders
	Domain = Capacity & competency: skills, functions & approach used to assess & improve quality
	Domain = Alignment & spread: QI supports & supported by organization & is diffused within agency

Score	
≤99	**Beginning:** Have not yet adopted formal QI projects, applied QI methods in a systematic way, or engaged in efforts to build a culture of QI.
100-106	**Emerging:** Newly adopted QI approaches, with limited capacity. Limited QI culture and few, if any, examples of attempts to incorporate QI as a routine part of practice.
107-120	**Progressing:** Some QI experience and capacity but often lack commitment, have minimal opportunities for QI integration throughout the agency and are less sophisticated in their application and approach.
121-139	**Achieving:** Fairly high levels of QI practice, a commitment to QI, and an eagerness to engage in the type of transformational change described by QI experts.
≥140	**Excelling:** High levels of QI sophistication and a pervasive culture of QI.

Retrieved from NACCHO.org 4/28/2015. Edits to question 2 internal/external forces made, scoring and legend added in order to align with: Joly BM, Booth M, Mittal P, Zhang Y. (2013). Classifying Public Health Agencies Along a Quality Improvement Continuum. *Frontiers in Public Health Services and Systems* Research Vol. 2: No. 3, Article 2. Available at: http://uknowledge.uky.edu/frontiersinphssr/vol2/iss3/2.

APPENDIX E: PDSA SINGLE CHANGE FORM

Use this worksheet to test small changes that will contribute to your overall aim. Each PDSA you do should test a single change, for a short amount of time, using a small sample size. Each PDSA cycle should be as brief as possible for you to gain knowledge that it is working or not. Each cycle should also include only a portion of your program (one or two families or home visitors). Once you find an effective change, the intervention can be expanded to the rest of your program.

As you work through a strategy for implementation, you may want to adjust your plan and test whether the change you made is effective or not. Each time you make an adjustment, you will begin a new cycle. Below is an example of a program using the PDSA Model for Improvement to increase visit compliance for "high needs" families.

Plan Do Study Act Cycle #1

Aim Statement: By December 2018, we will increase visit compliance by 15% for families that are eligible for 24 visits per year.

Change Being Tested: Implementing Pre-Visit Calls	**Time Limit:** 06/01/18 – 06/30/18	**Target Population:** Two "high needs" families per home visitor

What is the problem?	Low visit compliance for families that qualify for two visits per month.
What do we predict will happen during this test?	If we implement a pre-visit call, families will be less likely to miss or cancel their visits.
Write a concise statement of one change your team will make during this cycle that will benefit the overall CQI project.	We will call each family chosen for this study on the Monday before their visit to help ensure attendance.
What tasks/activities need to be completed during this test? Examples: develop process map, amend policies, meet with stakeholders, etc.	1. Identify which "high needs" families will participate in this study. 2. Develop a process map. 3. Track missed visits and cancellations for target population. 4. Meet weekly to discuss the effectiveness of our plan.
PLAN	▪ Who: Each home visitor and two of their "high needs" families ▪ What: Pre-visit phone call ▪ Where: By phone ▪ When: Every Monday before home visit
DO	▪ Is the test being carried out as planned? Yes, pre-visit calls are being completed on the Monday before home visits for the target population. ▪ Do we have to modify the plan? Why? Yes, the families are canceling their visits during the calls. ▪ How have you been communicating with your organization/team about this intervention?

	We have been meeting weekly to discuss the effectiveness of our plan and to review data.
STUDY *Record how well the test worked and if you met your goal.*	▪ Did this test result in our prediction (if we do X, will it result in Y)? No, though visit compliance has improved slightly, we are not meeting our Aim because some families still canceled their visits. ▪ What did you observe that wasn't part of the plan? Many families canceled their visits during the call. The plan increased staff time on the phone.
ACT *If the test did not work, record what you can improve in the next test cycle. If it did work, can the change be expanded to affect the whole program?*	▪ What did we learn from this test? Families missed visits less due to the pre-visit calls; however, families also canceled during the calls. If we reschedule visits immediately during the pre-visit calls, families may be more likely to make their next visit. ▪ Based on our observations, should we adapt, adopt, or abandon this intervention? Check one: ☒ Adapt ☐Adopt ☐Abandon

Plan Do Study Act Cycle #2

Aim Statement: By December 2018, we will increase visit compliance by 15% for families that are eligible for 24 visits per year.

Change Being Tested: Implementing Pre-Visit Calls	**Time Limit:** 07/01/18 – 07/31/18	**Target Population:** Two "high needs" families per home visitor

What is the problem?	Low visit compliance for families that qualify for two visits per month. + Some families are canceling their visits during the pre-visit calls. + We do not have a standardized plan for rescheduling visits during the pre-visit calls.
What do we predict will happen during this test?	If we implement a pre-visit call, families will be less likely to miss or cancel their visits. + If a family cancels during the pre-visit call and we reschedule their appointment immediately, we will improve visit compliance.
Write a concise statement of <u>one</u> change your team will make during this cycle that will benefit the overall CQI project.	We will call each family chosen for this study on the Monday before their visit to help ensure attendance. If a family cancels, the home visitor will reschedule the appointment during the call.
What tasks/activities need to be completed during this test? Examples: develop process map, amend policies, meet with stakeholders, etc.	1. Meet weekly to discuss the effectiveness of our plan. 2. Track missed visits and cancellations for target population. 3. Edit our process map to include rescheduling procedures.

PLAN	▪ Who: Each home visitor and two of their "high needs" families ▪ What: Reschedule canceled visits ▪ Where: By phone ▪ When: During the pre-visit call
DO	▪ Is the test being carried out as planned? Yes, home visitors are conducting pre-visit calls and rescheduling canceled visits. ▪ Do we have to modify the plan? Why? No, the plan is improving visit compliance. ▪ How have you been communicating with your organization/team about this intervention? We have been meeting weekly to discuss the effectiveness of our plan and to review data.
STUDY *Record how well the test worked and if you met your goal.*	▪ Did this test result in our prediction (if we do X, will it result in Y)? Yes, families were more likely to attend home visits after the home visitors conducted pre-visit calls and immediately rescheduled canceled visits. ▪ What did you observe that wasn't part of the plan? Increased staff time due to checking schedule in preparation for the calls. Increased staff time on the phone due to rescheduling visits.
ACT *If the test did not work, record what you can improve in the next test cycle. If it did work, can the change be expanded to affect the whole program?*	▪ What did we learn from this test? Families appreciated the pre-visit calls, which reminded them of their visits. Families who canceled were more likely to make their next visit when being rescheduled immediately during the pre-visit call. ▪ Based on our observations, should we adapt, adopt, or abandon this intervention? Check one: ☐ Adapt ☒Adopt ☐Abandon

Plan Do Study Act Cycle #__

Aim Statement: Copy statement from CQI Project Overview.

Change Being Tested: xxx	Time Limit: DD/MM/YY – DD/MM/YY	Target Population: xxx
What is the problem?		
What do we predict will happen during this test?	If we do X… it will result in Y…	
Write a concise statement of <u>one</u> change your team will make during this cycle that will benefit the overall CQI project.	We will…	
What tasks/activities need to be completed during this test? Examples: develop process map, amend policies, meet with stakeholders, etc.	1.	
PLAN	▪ Who will implement the change? ▪ What ▪ Where ▪ When	
DO	▪ Is the test being carried out as planned? ▪ Do we have to modify the plan? Why? ▪ How have you been communicating with your organization/team about this intervention?	
STUDY *Record how well the test worked and if you met your goal.*	▪ Did this test result in our prediction (if we do X, will it result in Y)? ▪ What did you observe that wasn't part of the plan?	
ACT *If the test did not work, record what you can improve in the next test cycle. If it did work, can the change be expanded to affect the whole program?*	▪ What did we learn from this test? ▪ Based on our observations, should we adapt, adopt, or abandon this intervention? Check one: ☐ Adapt ☐Adopt ☐Abandon	

APPENDIX F: PM AND QI WORK PLAN

Public Health – Idaho North Central District

Performance Management & Quality Improvement Work Plan

Goal #1: Develop PM and QI Plan based on organizational policies and direction.

Objective: Annually review and revise agency PM and QI Plan that seeks to improve public health services, health outcomes and address the requirements of PHAB Accreditation.			
Action Steps	**Timeframe**	**Responsible**	**Expected Outcomes**
Turning Point Performance Management Self-Assessment	Every 3 years 2020	CREW	Complete assessment
Review/Revise PM and QI Plan	September 2021	Accreditation Coordinator	Updated plans that reflect progress.
Review QI Plan	November 2021	CREW	Plans to be presented for approval
Approval of PM and QI Plan	December 2021	Director	Plan with Director approval and signature

Goal #2: Implement and monitor PM and QI Efforts

Objective: Effectively implement each element of the agency PM and QI Plans within the defined timeline.			
Action Steps	**Timeframe**	**Responsible**	**Expected Outcomes**
Division Directors will complete brief summaries of QI Projects to monitor programs QI related activities	Annually	Division Directors	100% compliance with required division projects
Document approved QI Project Proposals	Ongoing	Accreditation Coordinator	100% documented for tracking
Make data available	Ongoing	Accreditation Coordinator	Detailed information available for all staff
Conduct reports of progress against performance targets	Quarterly	CREW	All performance measures on target with identified areas for improvement
Refine and revise performance measures as needed	Ongoing	CREW	Refined and revised performance measures