User & Resource Guide
Quality Improvement Plan Template

Introduction & Table of Contents

In February 2013, the Center for Public Health Practice (CPHP) convened a team of representatives from state and local health jurisdictions in Ohio to create a template for a quality improvement (QI) plan that served to address the documentation requirement associated with Public Health Accreditation Board (PHAB) Standard 9.2.1 and to support Standard 9.2.2 (Version 1.0). In November 2014, the template was revised to respond to Version 1.5 of the PHAB standards and simplify the document overall. The process used to create and revise the original template was modeled after a similar approach applied with significant success to address workforce development plan requirements. In addition to supporting the accreditation documentation requirements, this QI Plan template has been designed as a guide for agency quality improvement efforts and to be adaptable to meet agency-specific needs.

This document serves as a user guide and resource manual for using the template.

Important Note: *This template is based on Version 1.5 of the PHAB Standards and Measures. Use of this template does not guarantee compliance with PHAB Accreditation Standard 9.2.1 or 9.2.2.*

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Template Development

Development team and acknowledgments

Many people contributed guidance, feedback, and content for Versions 1.0 and 1.5 of this template and user guide. With much appreciation they are listed here.

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Development process

In February 2013, the Center for Public Health Practice convened a development team for the purpose of establishing an outline for an agency-based quality improvement plan. The process was modeled after a similar one that took place in 2011 to develop a workforce development plan template. It began with reviews of existing quality improvement plans and development guidance. Key elements of an effective plan, as well as PHAB documentation requirements, were identified. The development team then translated these key elements into a plan outline that included notations about preferences such as balancing thoroughness with flexibility and a desire for brevity.

Using the outline as a guide, CPHP drafted a template and user guide, which were then reviewed by members of the development team and subsequently revised. The template was then vetted to a wider group of practitioners with QI experience.

Version 1.5 of the PHAB Standards and Measures was released in early 2014, taking effect on July 1, 2014. Shortly thereafter, revisions of the QI Plan template were initiated and vetted to the same group that had provided input to the original

continued

Development process, *continued*	template. Revisions were intended to provide thorough, yet simplified, guidance to users. Resources were updated and expanded; some associated documents that may be helpful, but not necessarily required, were removed from the template itself and are instead included in this guide as appendices.
Sponsor	This template and subsequent workshops for writing QI Plans were created by CPHP, located in the College of Public Health at The Ohio State University. The original work was made possible, in part, by the Ohio Public Health Training Center, grant number UB6HP20203, from the Health Resources and Services Administration, DHHS, Public Health Training Center Program. Contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA. Note that there are two other templates created for the purpose of assisting agencies to address accreditation requirements: a Workforce Development Plan Template and Competency-based Job Description Template. Templates are available at http://cph.osu.edu/practice/workforce-development-plan-template.
Questions	The template *User & Resource Guide* may be updated as new resources are identified. For questions about the guide or the template, and/or to share suggestions for additional resources and sample materials, contact: Joanne Pearsol, MA, MCHES, in the Center for Public Health Practice, Ohio State University College of Public Health; pearsol.3@osu.edu or 614-292-1085.

How to Use the Template

Introduction

The quality improvement plan template contains the following sections. These should be edited to meet your agency's specific needs:

- Purpose & Introduction
- Definitions & Acronyms
- Description of Quality in Agency
- Quality Goals, Objectives & Implementation
- Projects
- Training
- Communication
- Monitoring and Evaluation
- References & Resources
- List of Appendices

Editing the template

The template is a Word document formatted as a series of text and tables that can be edited. Section breaks were used between pages. It is helpful to turn on the '*View Gridlines*' feature for tables in Word when editing. The document text is in two colors:

- **Black:** standard language that does not need modified, but could be.
- **Red:** Provides instructions / examples for completing each section. All red text should be edited or deleted to meet your agency's specific needs. If the red text is edited, it should be changed to black before considering the document final. This language is suggestive only; it is not all inclusive.

Sections and appendices also should be added to further customize the document.

Disclaimer

This template has been designed to address the documentation requirement for (version 1.5) Public Health Accreditation Board Measure 9.2.1: *Established quality improvement program based on organizational policies and direction,* and to support Measure 9.2.2: *Implemented quality improvement activities*. Users of this template should thoroughly familiarize themselves with current standards, associated measures, and required documentation. Use of this template does not imply or guarantee acceptance of the final product as meeting PHAB requirements.

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QI plan and template considerations

Before beginning use of this template, it is recommended that users first read the *User & Resource Guide* thoroughly and become familiar with the template itself. This will be useful as the writers will understand the needed contents and anticipate what discussions will need to occur to populate the plan. Other considerations before beginning to write follow:

- The template was created with several purposes in mind. The purpose of supporting agencies in their quest for accreditation has already been stated. Additionally, this plan template was designed to assist agencies in educating their employees, Boards, and especially new QI committee or council members about their organization-wide efforts. It may be particularly useful in orienting new council members to their roles, expectations, and to the agency's aspirations relative to quality improvement. Because of this, agencies may find it to be more descriptive than they desire. If this is the case, simply edit the document accordingly. An agency's plan should be unique to that agency and meet its specific needs. If it is intended that the plan will be submitted for accreditation purposes, refer to the Standards and Measures to be sure that that all requirements have been adequately addressed.

- Examples appear throughout the template and are offered to illustrate a range of types of activities that might apply to organizations of different sizes and/or in different phases of QI implementation. As agencies' QI efforts increase in sophistication, so should the goals, objectives and other efforts outlined within their plans. In all cases, users should consider what is logical, practical, and applicable to their organization when developing their plan.

- If your organization has a particular format or nomenclature for plans, policies or official documents, adapt the template to be consistent with your practices.

- Some organizations that have prepared or are preparing for accreditation have combined their QI plan with an overall performance improvement plan. This is not a requirement of PHAB, and it is neither encouraged nor discouraged. This decision should be made by each individual agency. This template was not intended to serve both purposes but could be modified to do so.

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QI plan and template considerations, *continued*	• Lastly, as the template is applied, consider: o The support of leadership cannot be overestimated - be sure to keep him/her/the team abreast of plan development, communicate regularly, and help them to communicate about the plan. In addition, keep your Board up-to-date on your efforts regarding the development of the plan. If there your leadership does not fully support this work, consider how this might be addressed early in the process. o A quality improvement plan should align with the agency's strategic plan, workforce development plan, and performance improvement plan/system. Make sure these documents are in sync with and support one another; use cross references among plans as applicable. o The quality of a QI plan is not necessarily associated with its length. Template users should be descriptive, yet succinct. o Consider placing documents that will be updated frequently in the plan's appendices rather than within the body of the plan itself. This will make regular updates easier. o Once your plan has been established, be sure to document your efforts related to revising and/or updating the document. This can be done through a revision table of another method used by your agency.

Quality Improvement Resources

Web and Organizational Resources

There are a growing number of resources to support quality improvement in public health. The following table lists some of those resources, both state and national. The list is in no way exhaustive. Resources are listed in alphabetical order. In addition to those listed here, you may also consider local and regional resources, such as community colleges, hospitals (who have a history of implementing quality improvement initiatives), and academic institutions near your jurisdiction. The table is followed by other resources that you may find useful in developing your plan - to include within your plan itself, or for reference purposes.

Resource	Location & Description
American Society for Quality	http://asq.org A membership organization whose mission is: *to increase the use and impact of quality in response to the diverse needs of the world.* Training, resources, certifications, and learning communities.
Association of State and Territorial Health Officials	http://www.astho.org Membership organization for state health officials. Resources, links to QI and performance management tools. http://www.astho.org/Accreditation-and-Performance/Quality-Improvement/QI-Plan-Toolkit/Home/?terms=quality+toolkit QI Plan toolkit.
Center for Public Health Practice, The Ohio State University College of Public Health	http://cph.osu.edu/practice Live and online competency-based training and other organizational development resources, including QI Plan, Workforce Development Plan, and Competency-based Job Description templates. https://www.cphplearn.org/ Learning content management system; searchable catalog of training opportunities, including online CQI modules.
Center for Public Health Quality	http://www.centerforpublichealthquality.org/ A national resource with training, toolkits, consultation, and technical assistance.
Centers for Disease Control and Prevention	http://www.cdc.gov/stltpublichealth/performance/ Concepts, resources, and links about quality improvement and performance management.

continued

Resource	Location & Description
Journal of Public Health Management and Practice	Volume 18 (1) January/February 2012 - pg. 1-101,E1-E16 Volume 16 (1) January/February 2010 - pg. 1-85,E1-E17 Journals dedicated to quality improvement.
Michigan Public Health Institute	https://www.mphiaccredandqi.org/qi-guidebook/ Practitioners Quality Improvement Guidebook.
National Association of County and City Health Officials (NACCHO)	http://www.naccho.org/topics/infrastructure/accreditation/quality.cfm QI resources, training, templates. http://www.naccho.org/topics/infrastructure/accreditation/qi-culture.cfm Roadmap to a Culture of Quality Improvement and Organizational Culture of Quality Self-Assessment Tool.
National Network of Public Health Institutes (NNPHI)	www.nnphi.org/api Accreditation and performance improvement resources. www.nnphi.org/phpit Public health performance improvement toolkit.
Public Health Quality Improvement Exchange (PHQIX)	https://www.phqix.org/ Online community for learning and sharing about quality in public health. Searchable; forum for online dialogue and sharing (uploading) example documents (including example QI Plans).
Public Health Accreditation Board (PHAB)	http://www.phaboard.org/ Non-profit organization that oversees public health agency accreditation. Accreditation standards, measures, and requirements; training, resources, accreditation.
Public Health Foundation (PHF)	http://www.phf.org/focusareas/pmqi/pages/default.aspx Performance management and quality improvement website, including Turning Point framework.
TRAIN/Ohio TRAIN	www.train.org; www.ohiotrain.org Searchable public health-related continuing education opportunities offered by affiliates from across the country, including Ohio.
University of Minnesota	https://webapps-prd.oit.umn.edu/pcas/viewCatalogProgram.do?programID=7580&strm=1153&campus=UMNTC Public Health Certificate in Performance Improvement.

Quality Improvement Plan Checklist

The following checklist includes requirements for PHAB Measure 9.2.1A (v 1.5), addressing quality improvement plan documentation. Related measure 9.2.2A is also included. Please note that use of this checklist does not guarantee PHAB compliance and agencies are strongly encouraged to review the PHAB Standards and Measures independently.

✓	Measure	Documentation Requirement
	9.2.1.1A	The health department must provide a quality improvement plan. (1 plan; dated within 5 years) The plan **must** address:
		• Key quality terms to create a common vocabulary and a clear, consistent message.
		• Culture of quality and the desired future state of quality in the organization.
		• Key elements of the quality improvement effort's structure, for example: ○ Organizational structure ○ Membership and rotation ○ Roles and responsibilities ○ Staffing and administrative support ○ Budget and resource allocation
		• Types of quality improvement training available and conducted within the organization, for example: ○ New employee orientation presentation materials ○ Introduction online course for all staff ○ Advanced training for lead QI staff ○ Continuing staff training on QI ○ Other training as needed- position-specific QI training (MCH, Epidemiology, infection control, etc.)
		• Project identification, alignment with strategic plan and initiation process: ○ Describe and demonstrate how improvement areas are identified and how they are prioritized for project activity ○ Describe and demonstrate how the improvement projects align with the health department's strategic vision/mission
		• Quality improvement goals, objectives, and measures with time-framed targets: ○ Define the performance measures to be achieved ○ For each objective in the plan, list the person(s) responsible fan individual or team) and time frames associated with targets ○ Identify the activities or projects associated with each objective

✓	Measure	Documentation Requirement
		• The health department's approach to how the quality improvement plan is monitored: data are collected and analyzed, progress reported toward achieving stated goals and objectives, and actions taken to make improvements based on progress reports and ongoing data monitoring and analysis.
		• Regular communication of quality improvement activities conducted in the health department through such mechanisms as: ○ Quality electronic newsletter ○ Story board displayed publicly ○ Board of Health meeting minutes ○ Quality Council meeting minutes ○ Staff meeting updates
		• Process to assess the effectiveness of the quality improvement plan and activities, which may include: ○ Review of the process and the progress toward achieving goals and objectives ○ Efficiencies and effectiveness obtained and lessons learned ○ Customer/stakeholder satisfaction with services and programs ○ Description of how reports on progress were used to revise and update quality improvement plan.
	9.2.2.1A	The health department must document implementation of quality improvement activities and the health department's application of its process improvement model. (2 examples: one program and one administrative; dated within 5 years) Examples **must** demonstrate:
		• How staff problem-solved and planned the improvement,
		• How staff selected the problem/process to address and described the improvement opportunity,
		• How they described the current process surrounding the identified improvement opportunity,
		• How they determined all possible causes of the problem and agreed on contributing factors and root cause(s),
		• How they developed a solution and action plan, including time-framed targets for improvement,
		• What the staff did to implement the solution or process change, and
		• How staff reviewed and evaluated the result of the change, and how they reflected and acted on what they learned.

EXAMPLE: Quality Improvement Tools

Quality Improvement (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 chance 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 scare resources on critical tasks.	Page 3
Affinity Diagram	Used to: Gather and group ideas • Encourages team member creativity by breaking down communication barriers. • Encourages ownership of results and helps overcome "team paralysis" due to an array of options and a lack of consensus.	Page 12
Brainstorming	Used to: Create bigger and better ideas • Encourages open thinking and gets all team members involved and enthusiastic. • Allows team members to build on each other's creativity while staying focused on the task at hand.	Page 19
Cause and Effect/Fishbone Diagram	Used to: Find and cure causes, 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.	Page 23
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.	Page 31
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.	Page 36
Data Points	Used to: Turn data into information • Determines what type of data you have • Determines what type of data is needed	Page 52
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 aid. • Shows unexpected complexity and problem areas. Also shows where simplification and standardization may be possible. • Helps the team compare and contrast the actual versus the ideal flow of a process to help identify improvement opportunities.	Page 56
Force Field Analysis	Used to: Identify positives and negatives of change • Presents the "positives" and "negatives" of a situation so they are easily compared. • Forces people to think together about all aspects of making the desired change as a permanent one.	Page 63
Histogram	Used to: Identify process centering, spread, and shape • Displays large amounts of data by showing the frequency of occurrences. • Provides useful information for predicting future performance. • Helps indicate there has been a change in the process. • Illustrates quickly the underlying distribution of the data.	Page 66

Developed from *The Public Health Memory Jogger II (2007)*

EXAMPLE: Quality Improvement Tools, *continued*

Quality Improvement (QI) Toolbox

Tool	Used to	Page
Interrelationship Digraph	Used to: Look for drivers and outcomes • Encourages team members to think in multiple directions rather than linearly. • Explores the cause and effect relationships among all the issues. • Allows a team to identify root cause(s) even when credible data doesn't exist.	Page 76
Matrix Diagram	Used to: Find relationships • Makes patterns of responsibilities visible and clear so that there is even distribution of tasks. • Helps a team come to consensus on small decisions, enhancing the quality and support for the final decision.	Page 85
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 more dominant members.	Page 91
Pareto Chart	Used to: Focus on key problems • Helps teams focus on those causes that will have the greatest impact if solved. (Based on the Pareto principle ~ 20 % of the sources cause 80% of any problem.) • Progress is measured in a highly visible format that provides incentive to push on for more improvement.	Page 95
Prioritization Matrices	Used to: Weigh your options • Forces a team to focus on the best thing(s) to do and not everything they could do. • Increases the chance of follow-through because consensus is sought at each step in the process (from criteria to conclusions)	Page 105
Process Capability	Used to: Measure conformance to customer requirements • Helps a team answer the question "Is the process capable?" • Helps to determine if there has been a change in the process.	Page 116
Radar Chart	Used to: Rate organization 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 organization performance.	Page 121
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.	Page 125
Scatter Diagram	Used to: Measure relationships 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.	Page 129
Tree Diagram	Used to: Map the tasks for implementation • Allows all participants (and reviewers outside the team) to check all of the logical links and completeness at 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.	Page 140

Matrix Diagram example (Page 85):

	A	B	C
1			
2			
3			

Nominal Group Technique example (Page 91):

	Jo	Bob	Hal	Total
A	3	4	4	11
B	2	1	2	5
C	4	3	3	10
D	1	2	1	4

Prioritization Matrices example (Page 105):

Cost	A	B	C	Total
A		1/5	1/10	0.3
B	5		1	6
C	10	1		11

Developed from *The Public Health Memory Jogger II (2007)*

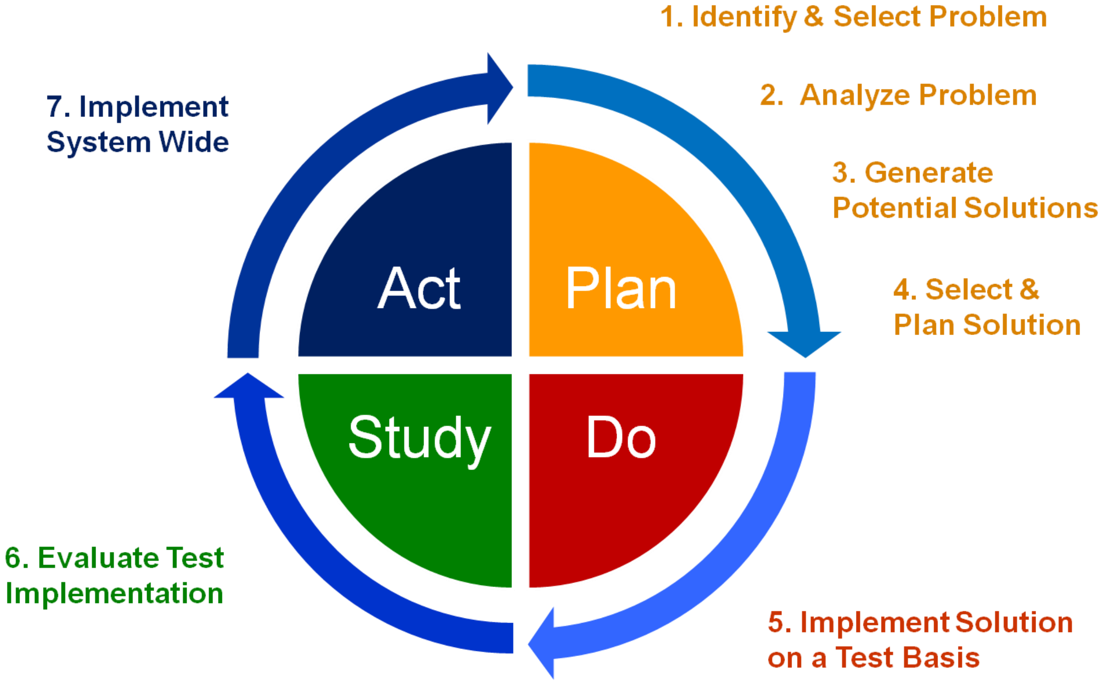
EXAMPLE: Plan-Do-Study-Act Model for Quality Improvement

Plan. The purpose of this phase is to investigate the current situation, fully understand the nature of any problem to be solved, and to develop potential solutions to the problem that will be tested. A solution is selected and implementation on a test basis is planned.

Do. This step involves implementing the action plan on a test basis.

Study (also called Check). - At this stage, data is again used to compare the results of the new process with those of the previous one.

Act - This stage involves two actions. The first is to decide, based upon the data, whether to adopt the change theory, make slight changes to the theory, or to abandon the improvement theory and start over. The second action in this phase is to decide future plans. If the team decided to adopt or adapt the improvement theory, it must indicate how it will monitor the gains going forward. If the improvement theory was abandoned, the team must decide on how it will continue.



EXAMPLE: Summary of QI Projects

Projects Completed in YEAR

Project Name (focus)	Project Mission	Outcome
The Executioners (contract processing)	Improve contract process by increasing accuracy and decreasing time for full execution.	80% of new contracts executed between April and October, YEAR were accurately and fully executed in under seven business days. Continual monitoring occurring.
Talent Magnets (employee hiring)	Improve new hiring process by reducing number of approvals and reducing posting, interview and negotiating time.	New employees hired between January and June YEAR started work an average of 24 days after agency learned of pending vacancy/position opportunity.
Etc.		
Etc.		

Currently Active Projects

Project Name (focus)	Project Mission	Status/Outcome
Mail Birds (outgoing mail processing)	Improve outgoing mail processes by reducing steps to posting and decreasing time from posting to delivery.	As of xx/xx/xxxx: Team members selected & 2 meetings held; Initial data about outgoing items being collected through tracking system; alternate carrier information and shared service opportunities being gathered
Etc.		
Etc.		
Etc.		

EXAMPLE: Agency Project "Nomination" Form

1. Area or process requiring improvement (please provide details):

2. Who it affects or who is involved:

3. What do you think can be done to improve this process?

4. Why are you are suggesting this process as a QI project?

5. Has this concern been discussed with the immediate supervisor responsible for the area or process?

Signature: ____

Printed name:____

Program/division: ____

Date: _________________________

Questions: see NAME at PHONE or E-MAIL
Return form to NAME, LOCATION

EXAMPLE: QI Team Charter Template

Team Name:	
Project Mission:	
Team sponsor(s):	individual(s) who own the existing process and have authority to approve changes
Background:	strategic importance, what has been happening, importance to customer
Boundaries:	limits on scope of process change allowable as defined by team sponsor, legal restrictions, budget, etc.
What team has authority to do:	authority to pilot improvement/make recommendations/other
Estimated date for completion:	
Meeting frequency & duration:	
Team Leader:	
Team members:	(see table below)
Facilitator:	
Timekeeper:	
Notetaker/Scribe:	
Other notes about team/work:	

Team members:

name	**e-mail**	**phone**

EXAMPLE: QI Project Storyboard Template

EXAMPLE: QI Training Plan

Goal	Objectives	Target Audience	Resources	Responsible
EXAMPLE: Establish a culture of quality within the agency	By xx/xx/xxxx, all senior managers will participate in quality improvement training By xx/xx/xxxx, all senior managers will lead an internal quality improvement team By xx/xx/xxxx, all new employees will complete online training within 2 months of hire	Division directors	NACCHO OSU-CPHP CQI online modules	Agency director Supervisors of new hires
Etc.				
Etc.				
Etc.				

EXAMPLE: QI Activity Timeline

This timeline captures the schedule of meetings, monitoring and evaluation and communication activities.

Activity	Timeline/frequency	Person responsible
EXAMPLE: Quality Council meetings	At least every-other-month: January, March, May, July, September, November	Agency director, Quality Council
Evaluate, QI plan & activities	Annually in January (initiate November)	QI Coordinator & Quality Council
Review, evaluate, revise, approve QI plan	Annually in January	QI Coordinator & Quality Council
Select new QI Council representatives	Annually in December; no more than half of members/year	Quality Council
Select QI projects and teams	Ongoing	Quality Council
QI Project reports to Quality Council	Quarterly: March, June, September, December	QI Team leaders
Storyboards to Quality Council	Within one month of project conclusion	QI Team leaders
Evaluation to QI Team members	Within one month of project conclusion	QI Coordinator
Report to Board of Health • Projects, Plan updates, Evaluation	Twice a year: April and October	Agency director
Quality Report feature in the electronic newsletter *Quality Report* feature of QI team *Q-Blog*	Every-other-month: January, March, May, July, September, November Twice a year: as related to progress At least every-other-month	Communication director
Reports in all-staff meeting: • Projects, Team recognition, Quality Council (plan updates, evaluations)	Annually in May	Quality Council members; Quality Team leaders
Reports to public: • Feature on website, Annual report	Ongoing: updated at least annually in March; Annually in February	Communication director & Webmaster Communication director
Storyboards in small conference room	Ongoing	Quality Council
Maintenance of Quality Council and team records on shared drive	Ongoing	Quality Council scribe; team leaders; team scribes