Quality Improvement Program

Implementation Plan 2011-2012

Washington State Department of Health
Revised February 2011

The Department of Health (DOH) Quality Improvement Program

Overview

DOH is committed to a quality improvement (QI) program as a proven way to enhance our organization's performance and achieve desired results. A high-performing, quality improvement organization actively changes the way business is done by:

- focusing on the needs of the customer;
- using data to analyze problems and performance concerns;
- involving employees who know and are impacted by the improvement opportunity;
- developing solutions and improvements based on analysis;
- engaging customers and stakeholders;
- implementing improvements based on data;
- monitoring and evaluating performance; and,
- continually making improvements over time.

Quality Improvement is a continuing cycle of measurement, analysis, and improvement.

This current plan builds on past efforts at the DOH. This update is an opportunity to assess the progress the agency has made, reinforce what's working well, and improve in those areas of implementation which are lacking.

Multi-focus program

The DOH Quality Improvement Program is a disciplined approach to performance management that includes organizational strategic planning, performance management and accountability, operational/business planning and performance, and focused quality improvement efforts. This approach is consistent with the Baldrige National Quality Award and Washington State Quality Award (WSQA) frameworks for pursuing and achieving organizational excellence in seven criteria categories: Leadership; Strategic Planning; Customer and Market Focus; Measurement, Analysis and Knowledge; Workforce Focus; Process Management; and Organizational Results.

Leadership and Strategic Planning – DOH senior leadership sets direction for the organization through strategic planning. This plan provides a vision of the organization as it sees itself in the future; a clearly stated mission that expresses the reason(s) the organization exists and for whom; and, goals, objectives, strategies, and performance measures which will move the organization toward its vision in incremental, achievable steps.

Customer and Market Focus – Knowing the needs of our customers and stakeholders is key to focusing agency resources for the greatest impact in addressing changing demands and meeting our mission. Management is charged with implementation of agency strategies, operational plans, and meeting day to day business demands.

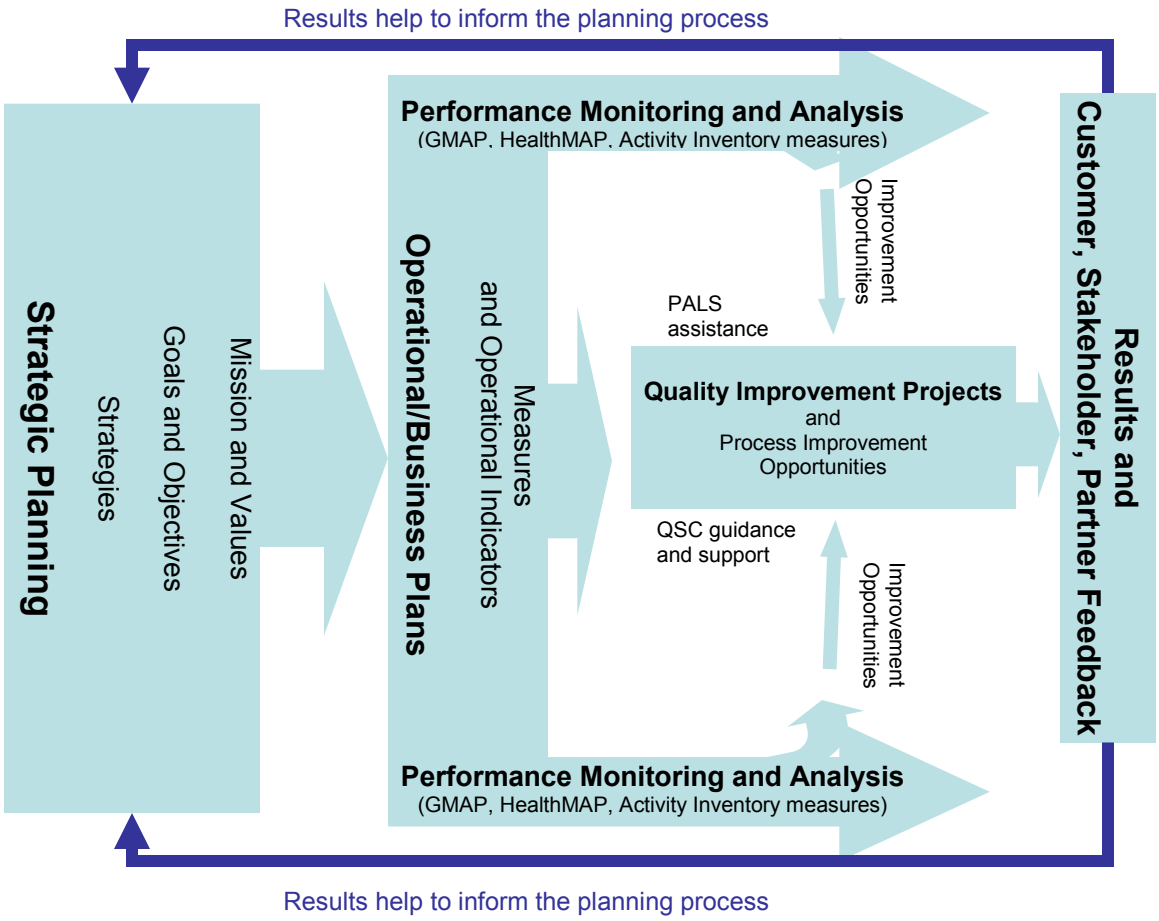
Measurement, Analysis, and Knowledge – Regular reviews of selected performance measures and indicators through the Governor's Government Management Accountability and Performance (GMAP), the agency's internal Health Management Accountability and

Performance (HealthMAP), and agency budget activity inventory measures provide opportunities for assessing progress toward goals and for identifying potential improvements.

Workforce Focus and Process Management – A healthy work environment staffed with a well managed, informed, accountable, and appreciated workforce are key ingredients to a successful quality improvement program. Informed employees who are involved in analysis, identifying root causes for improvement opportunities, and in developing solutions will contribute their knowledge and best practices in the best interests of the agency.

Organizational Results – Monitoring performance and evaluating results of strategic and operational plans provides data and information to inform future planning and decision making.

These various components work together in a continuous cycle, moving the agency towards its vision:



Strategic and Operational Planning

Strategic planning helps focus resources on those vital few objectives the organization has chosen as top priorities that will move the agency toward its vision. Strategic objectives require special effort to accomplish. They cannot be done through a "business as usual" approach. If the agency is fortunate, additional resources may be available through special funding or other means to accomplish major efforts. If not, the agency must choose to either put additional time/effort in, over and above the normal capacity, or it must find ways to carve out resources from other priorities.

It is a significant challenge to balance ongoing operational workloads with the special or extra effort required for strategic initiatives and other quality improvements. The agency may need to reduce or give up doing some of the things it has been doing, in order to find resources for planned improvements.

The DOH strategic planning process is outlined in Appendix A.

Performance Monitoring

By using meaningful measures and indicators to monitor both operational performance and progress on special initiatives such as strategic efforts or quality process improvements we can assure that we are on track with the intended results and help identify additional operational and process improvement opportunities.

The DOH performance management system includes:

- periodic progress and status reviews through the GMAP process,
- internal HealthMAP reviews,
- quarterly progress reports on budget activity inventory measures and strategic plan performance measures
- operational plan reviews and ongoing monitoring of performance data and information
- assessment conducted every three years on the Public Health Standards.
- assessment conducted every three years through the Washington State Quality Award (WSQA).

DOH uses a "dashboard" set of measures to tie all performance measures into a more cohesive appraisal of agency performance and progress.

Annual agency self assessments and periodic employee surveys also provide important information for the agency's planning processes. Continuing analysis of organizational performance and results of internal and external assessments are sources of data and information important to decision making about the agency's future.

The DOH performance management system is outlined further in Appendix B.

Quality Improvement Activities

DOH identifies opportunities to improve and enhance services and performance through active planning and performance monitoring. Quality improvement tools and techniques applied in a variety of group and team situations enable the important data collection, problem analysis, and employee involvement which are keys to improving performance.

This disciplined approach to problem solving and process improvement work very well when quality tools are applied to define and analyze problems and develop process improvements. The well known "Plan – Do – Study – Act" (PDSA) cycle applied at the organizational level, relates to the strategic planning and implementation process. Planning takes place, objectives and strategies are implemented, performance and results are monitored and analyzed, and the organization takes action to reinforce positive outcomes, or explore new opportunities identified through data analysis.

When applied to a specific problem or process, the PDSA cycle is applied in a more focused manner, using specific tools and techniques to help work groups and teams to identify, analyze, and implement measurable improvements.

Quality Improvement Roles and Responsibilities

The ***Quality Steering Committee (QSC)*** at the executive level provides agency oversight and guidance for performance management activities (quality improvement projects, WSQA, Public Health Standards assessment, etc.) and quality improvement in DOH. Primary committee responsibilities include review and approval of the agency Quality Improvement Plan, encouraging and fostering a supportive quality improvement environment; championing quality improvement activities, tools and techniques; and selecting and supporting agency quality improvement projects. The committee is chaired by the Deputy Secretary and guided by its charter.

The ***Performance and Accountability Liaisons (PALS)*** group at the operational level is composed of representatives from across the agency who provide input, advice, and assistance in those activities that strengthen quality improvement and performance management in the agency. Activities these representatives engage in include strategic planning, GMAP and HealthMAP monitoring, analysis, and reviews; activity inventory measures management; Public Health Standards assessment and monitoring; and, quality improvement project support. PALS is chaired by the Director of the Office of Performance and Accountability and guided by its charter.

The ***Office of Performance and Accountability (OPA)*** is responsible for coordinating, liaison, and ensuring consistency in the DOH performance management system. The Director of the Office of Performance and Accountability leads the strategic planning process and develops and coordinates GMAP, HealthMAP, Public Health Standards, and activity inventory performance management processes. The Office provides guidance to senior management regarding best practices in performance management, monitoring, and accountability.

OPA provides a comprehensive performance management system to the employees of DOH to hold ourselves accountable, provide continuous quality process improvement, and maximize resources.

Additional details about the DOH Quality improvement approach are described in Appendix C.

Selecting Quality Improvement Projects

Quality improvement projects may be longer term, larger scale strategic efforts or they may be shorter term, smaller scale efforts such as process improvements. Regardless of the scale, these projects should be approached with some similarity. There should be planning, data collection and analysis, testing and measuring of performance to ensure that changes will in fact be improvements, then continuous review and improvement over time.

In general, quality improvement efforts should follow "project management" principles to provide structure to the activity. This helps to ensure clear purpose and scope, commitment of necessary resources, specified timeframes, expected level of effort, management sponsorship and support, clear decision/implementation authority, and anticipated outcomes.

Agency level QI projects – Agency level projects should be approved only after review and consideration by the agency QSC. The QSC may be given final authority for implementation of project recommendations, or approval may be required from the Senior Management Team (SMT). Agency QI projects cross divisional lines, involve multiple offices and programs and address high priority agency initiatives or key services. These projects may be identified through performance indicator reviews or through strategic and operational planning that identifies a need for improvements or new initiatives. The Performance Accountability Liaison (PALS) group should be a prime source of quality improvement opportunities.

These improvement opportunities will be addressed at the agency level and be afforded the support and resources that a high priority activity deserves. This includes agency level resource support such as facilitation and/or coaching from OPA staff.

Other agency QI projects – Divisions and programs/units are encouraged to initiate their own quality improvements projects. These projects should also follow project management principles and apply common quality improvement tools and techniques to help teams achieve their desired results. Programs/units and sponsors desiring to pursue quality improvement efforts are encouraged to coordinate with OPA for advice and assistance.

See "Quality Improvement: Project Screening Criteria" in Appendix E.

The 2011-12 Quality Improvement work plan for DOH is in Appendix F.

Appendix A – DOH Strategic Planning Process

The DOH strategic plan identifies key goals the agency will pursue during the next four to six year period and the objectives, strategies and measures that will be undertaken to help achieve the agency's vision. The plan undergoes a detailed review every two years in preparation for each new biennial budget and is adjusted as needed to respond to changing conditions and new information that impacts the organization. The plan is formally reviewed annually, in alternate years, for minor adjustments as need. Elements of the plan are monitored quarterly during the DOH HealthMAP sessions.

Divisions should develop and implement their strategic plans during alternate years from the agency's major reviews. This allows the divisions time to receive and develop supportive responses to the agency plan.

Key milestones in the agency strategic planning process:

- Assess and analyze agency performance compared to the current strategic plan, the Governor's and other key stakeholder priorities, selected performance indicators and measures, and emerging issues and trends.
- SMT reaffirms or refreshes the agency vision, mission, and values.
- SMT develops and communicates initial goals and areas of focus to the PALS Strategic Planning team.
- The PALS Strategic Planning team develops objectives, strategies, and measures to achieve goals and develops supporting narrative for the plan.
- SMT modifies and approves final plan.
- The strategic plan is deployed and communicated to agency staff.
- Periodic performance reviews monitor progress through GMAP, HealthMAP, activity inventory updates, and other management reviews.
- Results of performance reviews help inform future planning.

Appendix B – DOH Performance Management

DOH performance management includes the following activities in a systems approach to monitoring and managing agency performance:

GMAP Reviews – The Governor's periodic review forums for analyzing performance for key indicators and focusing resources where needed to achieve desired results.

HealthMAP – The agency's monthly review forums for monitoring performance against key indicators and measures, to focus resources to improve performance, and achieve desired results.

Activity Inventory Updates – Quarterly updates to key measures to track performance at the activity level.

Public Health Standards Assessment – An assessment conducted every three years to measure agency performance against established public health standards.

Washington State Quality Award Assessment – An assessment conducted every three years to assess agency performance in six key areas:
Leadership
Strategic Planning
Customer and Market Focus
Measurement, Analysis, and Knowledge
Workforce Focus and Process Management
Organizational Results

Governor's Agency Self Assessment – Each year since 1998, the Governor's Office has asked agencies to do a self-assessment based loosely on the Baldrige Criteria. It is a way to see if strategies we put in place last year or the year before are working. It shows where we are getting better and where we may want to focus some process improvement activities for the coming year, or elements we may want to address in our strategic plan or business plan.

Employee Satisfaction Survey – Every two years the state's Department of Personnel provides agencies with a set of core questions that are used to assess employee satisfaction. Agencies have the option to include additional questions to address areas of concern. The results of the survey are used to discover areas of concern from the employee's perspective and implement process improvement opportunities.

Operations/Business Plan Reviews – Divisions, offices, and programs identify meaningful indicators and measures to monitor their operational performance and progress toward unit goals. Performance is monitored quarterly at a minimum and may be measured more often, depending on the frequency of the measure and level of activity. These results help tell our story and answer the question, "How are we doing?"

Appendix C – Quality Improvement Approach, Tools, and Techniques

Key Principles

This approach reflects a strong commitment to sustainability and success by emphasizing:

- **Simplicity in design.** The approach uses a disciplined process improvement methodology that can be applied in larger scale projects as well as in smaller scope process improvements through the Rapid Cycle Improvement (RCI) technique. The RCI provides quick results with minimum administrative burden.
- **Just-in-time training.** Training is designed to coincide with actual use, which reinforces the learning process.
- **Clear goals.** This disciplined approach is used to establish project and process improvement goals, strategies, and performance measures.
- **Commitment to oversight.** This includes monitoring and evaluating results to design and implement program improvements. It is important to understand the current situation, or the current level of performance, to allow comparison after improvements are implemented.
- **A focus on the front line.** Staff must see it done at the division and office level to buy into a quality improvement program.
- **Concentration on meaningful business issues.** The ongoing work plan will focus on strategic improvements and significant business practices with measurable gains for internal and external customers.

The program work plan includes the full Plan-Do-Study-Act cycle. The work plan is updated annually in January. An application and chartering method is used to add new projects and quality improvements. Appendix G includes a draft application for the project selection process.

The Rapid Cycle Methodology (Used for smaller in scope process improvements)

The RCI approach uses standard quality improvement tools to answer three basic questions: What are we trying to do? How will we know that a change is an improvement? What change can we make that will result in improvement?

These three questions provide the analytic framework. Based on the success of other organizations, the cycle, from the launch of the team to identifying improvement steps, takes 90 to 100 days. On some sharply defined improvements with strong management support, methods such as the *Breakthrough Approach* can provide actual results within that timeframe.

This is much shorter than some methods. The incremental and time-limited aspects speed completion of the improvement cycle.

The rapid cycle approach does take advantage of many familiar methods and tools. Data is analyzed statistically and visually to reveal where problems exist and improvement makes sense. Root cause analysis determines what is causing bottlenecks, inefficiency, variation outside the norm, and other problems. Problem solving by those who know and understand the process is used to construct solutions and monitoring ensures progress is made, setting the stage for further gains.

Larger Scope Quality Improvements

Basic principles of project management apply in both the RCI approach and for larger scope projects as well. The discipline is in taking time at the beginning to analyze the current situation, to understand current performance, and to establish some means of measuring performance for comparison after improvements are implemented.

Larger projects benefit from time spent to collect and explore data and other current information about the improvement opportunity and to document baseline measures. It is also essential to develop team cohesiveness and to be clear on purpose, scope, time, and resource commitments. By applying proven quality improvement tools and methods along with other team dynamics and meeting management techniques the team stays focused and continues to progress toward team goals.

Including a facilitator in the project to assist with the team process and coach on these various techniques keeps the team moving forward and enables team leaders to focus on goals and results.

Just-in-Time Training

Too often, training is provided before people are ready for it or to individuals who may not need it. Presenting the team process and discussing the project purpose and scope at the beginning helps create a successful team environment. Coaching on appropriate tools and techniques, applied to specific situations when needed increases learning and ensures training time is focused on knowledge and skills that are immediately applied.

Quality Improvement Program Goals

Senior and mid-level managers help answer the question "what are we trying to accomplish?" This input is used to develop the following four program goals:

1. Institutionalize the use of QI principles and skills for better, customer-focused results.
2. Set clear expectations for gains in public health, program quality, and agency efficiency.
3. Communicate program performance targets and achievements to staff and customers.
4. Assure the effective use of public resources.

It is the responsibility of leaders to develop strategies and measures for each of these goals. The program must be a model for applying QI principles. This includes documenting gains through the use of DOH HealthMAP and other tracking systems and regular survey or assessment instruments.

Quality Improvement Tools and Techniques

OPA provides suggested quality improvement tools, techniques, references, and resources through its Intranet page. OPA staff also suggest effective methods or ideas for solving team

issues around making progress and/or staying focused on team purpose and goals. They are also available to facilitate the team through the quality improvement process.

Much of the structure for organizational improvement is already in place. For that reason, this plan emphasizes the quality process improvement side. The overall goal is to institutionalize quality improvement, create clear expectations, communicate performance, and ensure accountability.

Appendix D – Governance

Oversight

The Quality Steering Committee provides guidance and oversight of agency quality improvement activities, including:

- Conduct a quarterly performance review.
- Identify and review implementation issues.
- Resolve staff, management, and resource conflicts.
- Recommend program changes.

The Steering Committee promotes the program. It supports recognition of both individual and team successes. Its members help create a culture in which employees use QI principles and tools in their day-to-day work and have support and guidance from leaders.

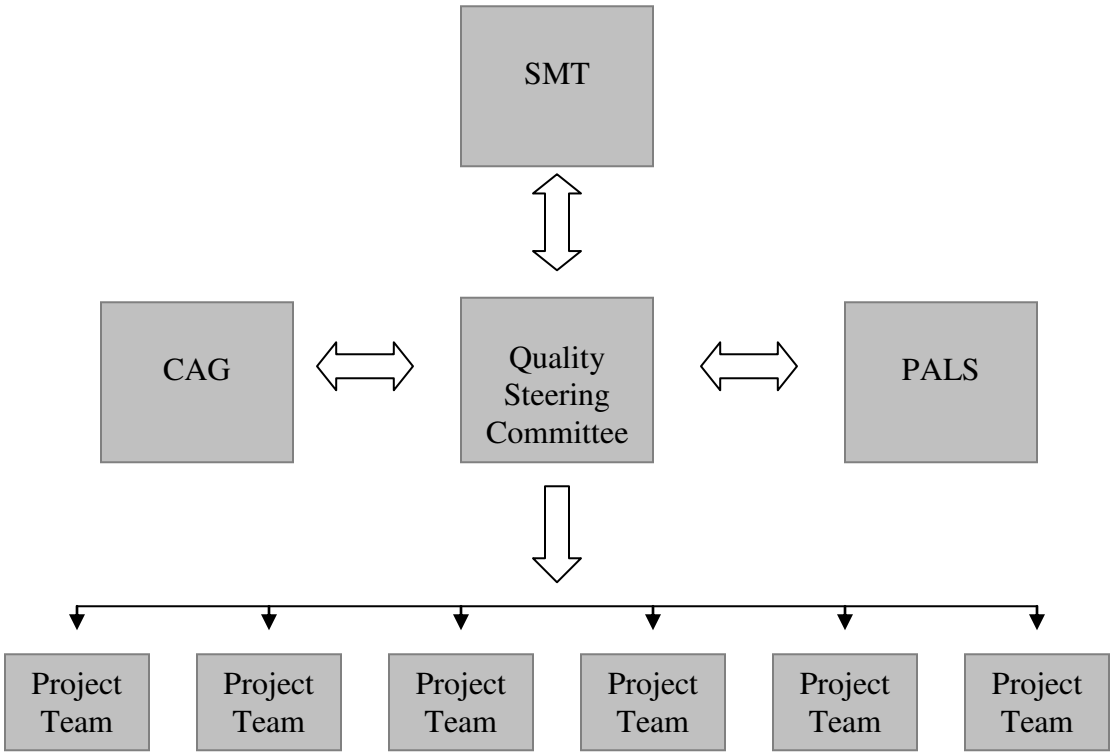
The steering committee reports regularly to the Secretary, SMT, and other management and staff work teams. The executive sponsors play a critical role in maintaining leadership support.

The program focuses on a limited number of agency wide initiatives yearly. As each is completed, learning from the effort is shared and a new project is added to take its place. The approach is exported to divisions and offices for broader use.

The ability to continually make incremental and breakthrough improvements is the ultimate measure of success.

Quality Steering Committee Charter

The Quality Steering Committee Charter defines DOH Quality Improvement Program governance. It serves as the contract between the QI Steering Committee and the Senior Management Team, outlines governance expectations, timelines, and roles and responsibilities. The charter is posted on the agency intranet site and is reviewed and updated annually.



Quality Steering Committee

Lead staff: Performance and Accountability Office Director

Meets: **Once a quarter**. Special sessions may be called by the chairperson. Committee members are expected to be personally engaged by attending meetings.

Reports to: SMT, Secretary, Deputy Secretary

Roles and Responsibilities, <u>ALL</u> Steering Committee Members:

- Establish overall quality improvement (QI) program policies, goals, and selected performance indicators.
- Establish a QI project selection and review process. (Including regular review of customer needs, agency performance data -- ensure that decisions are data-driven, not based on hunches or opinions -- develop criteria for deciding when a QI effort/project might be indicated)
- Provide guidance and oversight of the agency's QI efforts:
  1) Review quality performance indicators quarterly to assure progress toward specific, achievable QI goals and objectives.
  2) Identify potential QI program implementation issues and develop secondary data analysis to determine if further review is warranted.
  3) Resolve conflicts related to funding, priorities, external commitments, cross-organizational boundaries, management, and employees.
  4) Recommend changes in program, process, and policy.
- Prepare an annual report to the SMT.

- Promote QI program and project support with key internal stakeholders: the full SMT, agency mid-management, and employees. Encourage the involvement of teams of highly capable individuals from all DOH levels, disciplines, and divisions.
- Encourage and support timely recognition of individual and team performance accomplishments.
- Communicate clear messages about desired QI outcomes and priorities to internal and external audiences; clearly connect DOH's strategic plan to performance improvement.
- Gather and share best practices.

Roles and Responsibilities, SMT QI Executive Sponsors/Committee Chair:

- **Serve as a catalyst for results and change;** create a clear strategic business plan.
- Lead organizational direction and agency culture for quality improvement.
- Establish QI policy direction for DOH within financial, cultural, operational parameters.
- Monitor and report back to the SMT on progress made to achieve:
  1) Performance-orientated QI priorities, and
  2) Agency cultural changes directly associated with achieving desired outcomes/goals.
- Identify and communicate the consequences of failing to achieve desired QI outcomes, goals.
- Drive out fear of a QI culture and overcome standard resistance ("We've tried that before.").
- Guide and coach peers and middle managers on strategies to achieve operational change (know and use quality principles).
- Obtain and provide regular updates to Senior Management Team members.
- Ensure the strategic significance of the QI program and its projects by endorsing and defending them as a valued investment of resources that serves agency strategic objectives.
- Guide the QI program and project selection process for SMT approval, funding, and staffing. Ensure resources are dedicated; barriers to success removed.

Roles and Responsibilities, CAG Steering Committee Members:

- **Serve as a change agent;** translate the strategic business plan into a strategic operations plan.
- Establish QI policy direction for DOH within financial, cultural, operational parameters.
- Monitor and report back to CAG and division staff progress made to achieve:
  1) Performance-orientated QI priorities, and
  2) Agency cultural changes directly associated with achieving desired outcomes/goals.
- Guide and coach CAG peers and program staff on strategies to achieve operational change.
- Drive out fear of a QI culture and overcome standard resistance ("We've tried that before.").
- Guide the QI program and project selection process through CAG input.

Roles and Responsibilities, PALS Steering Committee Members:

- **Serve as a customer activist:** identify and meet customer expectations.
- Establish QI policy direction for DOH with financial, cultural, operational parameters.

- Monitor and report back to PALS and division staff progress made to achieve:
  1) Performance-orientated QI priorities, and
  2) Agency cultural changes directly associated with achieving desired outcomes/goals.
- Guide and coach PALS peers and program staff on strategies to achieve operational change.
- Guide the QI program and project selection process considering PALS input.
- Help to shape and participate in agency performance management activities

Roles and Responsibilities, QI Steering Committee Lead Staff (OPA):

- Design tools to monitor QI performance compliance.
- Design tools for QI program evaluation and reporting.
- Review and analyze performance reports. Provide secondary data gathering and analysis as needed.
- Prepare quarterly and annual QI reports. Analyze for patterns and indicators of QI program change.
- Provide QI program technical assistance to DOH leadership, management, employees.

Affected Stakeholders/Personnel: Key customer and constituent groups, agency leadership (SMT and CAG), the Program Management Team (PMT). **Key customer and constituent groups include:**

- Public (at-large and individuals)
- State Board of Health
- Elected officials – local, state, and federal
- Other Washington state agencies, non-DOH boards and commissions
- Local Washington governments (not LHJs)
- Other states' agencies
- Federal agencies
- Local Health Jurisdictions
- Regulated entities (DOH boards and commissions, licensees, certificated, permitees, registrants, etc.)
- Service providers and suppliers
- DOH employees (and associated advisory committees)
- DOH programs
- Advocacy groups/individuals
- Media
- Tribes
- Potential, affected businesses (tobacco industry, hospitals, insurance companies, etc.)
- Data providers
- Data users
- Private sector research community
- Academia
- Community-based organizations
- Trade associations

Appendix E – Selecting Quality Improvement Projects

Organizational improvement initiatives come from reviews of organizational performance, and might include:

- Areas where the agency or individual programs partially met or did not meet a public health standard.
- An analysis of activity inventory performance measures where efforts are falling short.
- Strategic Plan measures dealing with human resources, customer service, and organizational improvement.
- Results of evaluations of programs or administrative systems and functions. This could include external and internal audit conclusions.
- Regular surveying of employees about their views on systems that need improvement.
- Regular assessment of internal and external customer service data from across the department.

Management is responsible for implementation, which can be tracked through the regular SMT quarterly review process, GMAP, HealthMAP, and other performance management reviews.

The following screening form will help guide the selection of quality improvement projects.

Quality Improvement: Project Screening Criteria

Program or Activity:*_____

Step 1: What Are We Trying to Accomplish? (A brief statement of the aim)

Step 2: 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

Step 3: What Changes Can We Make That Will Result in an Improvement?
How did you identify this opportunity, with what data, from what source(s)? Brief description of the problem with any data currently available

Initial hypotheses and description of data needed to focus the project and the development of an intervention. Are you aware of benchmark data or best practices?

Impact/overlay with other programs and activities

Who are the stakeholders (internal and external) and what are their concerns

Departmental Implications

1. *Is this program/activity essential to implementation of:* _____
    1. *Agency Strategic Plan*
    2. *PHIP Standards*
    3. *A Governor's Directive*

Explain the significance of this program/activity to the above:

2. *Does this program/activity rank high in terms of risk-reward?*** _____

*A. Risk Impact**** _____ *B. Probability of Failure* _____ *Risk Factor (A*B)* _____

Comments:

3. *Does this program/activity satisfy the SMART criteria?**** Is it:* _____

- *Specific (Can it be defined as a discrete enterprise?)*
- *Measurable (Can its performance be measured?)*
- *Achievable (Can we do it?)*
- *Relevant (Does it make a difference? Do we care?)*
- *Time-Bound (Is it achievable with a reasonable amount of time?)*

Comments:

4. *Are there any significant reasons why it should be included even though one or more of the above criteria is not met?*

5. *What is the proposed makeup of the QI Project Team?*

6. *What resources and supports will be needed to complete the project?*

Notes:
*****These have been identified by divisions and offices.
******Risk Factor is a product of the importance of the activity and the likelihood of it failing (A*B). For example, if the activity rates a ten on the importance scale (i.e. very important) and it has a 60 percent (0.6) chance of failure, then its risk factor is 6. Once all items have been assigned a risk factor, one can either compare them directly or set criteria, such as *all submissions with a risk factor greater than X will be considered.*
*******Impact factor is based on a 1-10 scale, with 10 signifying greatest impact. It is a function of the following criteria: public perception, compliance with laws and regulations, public health impacts, use of public resources, capacity to respond (preparedness) and customer service.
********All five SMART criteria must be met.

Appendix F – DOH Quality Improvement Work Plan

The DOH Quality Improvement Work Plan for 2011 – 2012

Activity	Start Date	Project Leads	Date Completed	Comments
1. Web redesign	2/2008	Laura Blaske	Progress continues	The new web Home Page template is completed and approved. Working on workflow and process for new system.
2. Implementation of training work team recommendations	1/4/2011	Gregg Grunenfelder	Progress continues	By April 12, 2011, leadership competencies will be agreed to and in place
3. Customer satisfaction processes	8/2009	CAG/Susan Ramsey	Progress continues	One year pilot launched with 62 programs in April 2010
4. Public Disclosure	12/2010	Kathy Stout	Progress beginning	QI team established, Aim statement, Charter in draft form.
5. Contract Performance Monitoring	7/2010	Jenifer McNamara/Diane Offord	Progress continues	Baseline done, developing action plan
6. On-line transactions	4/2010	Sam Marshall/Frank Westrum	Progress continues	Online modules will be used, phased approach, anticipated go live date is 6/1/11
7. Policy Review	2011	Kathy Deuel	Progress continues	Policies need to be up-to-date
8. Accreditation preparation	2010	Susan Ramsey	Progress continues	SPIT team is preparing for 2011 accreditation

Projects Completed in 2010

Activity	Start Date	Project Leads	Date Completed	Comments
Verification of Staff Qualifications	6/2010	Susan Ramsey	December 5, 2010	Final report completed
Training Work team – leadership, systems, and leadership	11/2008	Kathy Deuel	October, 2010	Team activity completed, Recommendations accepted.
Public Health Standards Process – Beta Test Site Team	10/2008	Susan Ramsey, Kris Kernan	June 4, 2010	Beta test completed. Preparing agency for applying for national accreditation

Projects On Hold

Activity	Start Date	Project Leads	Date Completed	Comments
Translation	7/2009	Tbd	On hold due to budget constraints	Project team work completed
Optimizing the Contracts Process (Phase II)	2010	Jay Field/Diane Offord	On hold until fully staffed	Financial Services began a new strategy

Appendix G – Project Charter Application

DOH Quality Improvement Project
Charter Application

Program or Activity:*_____

1. Tell us about your proposed project. Please provide a brief description:

2. What are the benefits of this project as a potential focus of quality improvement?

3. How urgent is this issue? What would happen if we did nothing?

4. What are the obstacles? How easy will this project be to implement?

5. How does this issue impact our agency mission?

   - Public perception
   - Compliance with laws, regulations or standards
   - Public health
   - Use of public resources
   - Capacity to respond – preparedness
   - Customer Service

6. Departmental Implications

   Is this program/activity essential to implementation of:

   - Agency Strategic Plan
   - PHIP Standards
   - A Governor's Directive or priority
   - Secretary Priority

7. What changes can we make that will result in an improvement?

8. Please provide a brief description of the data currently available to address the issue identified. How did you identify this opportunity? What data did you use, and what is its source?

9. What are the relationships of this data to the project and the development of an intervention? Are you aware of benchmark data or best practices?

10. Who are the stakeholders (internal and external) and what are their concerns?

11. How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project)

12. Long term(longer than 24 months)

- Medium term (6 to 24 months)

- Short term (less than 6 months)

13. Does this objective meet all of the SMART criteria?

- Specific (Can it be defined as a discrete enterprise?)
- Measurable (Can its performance be measured?)
- Achievable (Can we do it?)
- Relevant (Does it make a difference? Do we care?)
- Time-Bound (Is it achievable with a reasonable amount of time?)

14. Are there other significant reasons why this issue should be considered for the quality improvement plan?

15. Given these factors how does this issue rank in terms of its importance to your program on a scale one to ten, with ten representing the highest ranking?

16. What resources and supports will be needed to complete the project? Do you have any information that might help us estimate the cost of this project?

17. What is the proposed makeup of the QI Project Team?