Kane County
Health Department

KANE COUNTY HEALTH DEPARTMENT

2012 QUALITY IMPROVEMENT PLAN

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I. Purpose of the Quality Improvement Plan

The purpose of the 2012 Kane County Health Department (KCHD) Quality Improvement Plan (QI Plan) is to provide context and framework for quality improvement (QI) and performance management (PM) activities at the Kane County Health Department.

Policy Statement: KCHD will utilize quality improvement in its programs, interventions, and processes as a part of the agency's performance improvement system. The QI Plan will assure public health excellence in promoting and protecting the health of the population living in or visiting Kane County.

II. Key Quality Terms

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

Continuous Quality Improvement (CQI): An ongoing effort to increase an agency's approach to manage performance, motivate improvement, and captures 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 seek "incremental" improvement over time or "breakthrough" all at once. Among the most widely used tools for continuous improvement is a four-step quality model, the Plan-Do-Check-Act (PDCA) cycle (Public Health Accreditation Board [PHAB] Acronyms and Glossary of Terms, 2009).

Performance Management: The process of actively using performance data to improve the public's health. It includes the strategic use of performance standards, performance measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results (Turning Point, 2003).

Performance Measurement: The regular collection and reporting of data to track work produced and results achieved (Turning Point, 2003).

Plan-Do-Check-Act: 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, 2008).

Quality Improvement (QI): The use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality

in services or processes which achieve equity and improve the health of the community. (Accreditation Coalition Workgroup, 2009).

Quality Improvement/Performance Management (QuIPM) Committee: Agency-wide committee, organized by the Health Data and Quality Coordinator and the KCHD Leadership Team, to carry out QI activities, namely PDCA cycles. The QuIPM Committee objectives include supporting PDCA cycles occurring at the section level, developing and facilitating All Hands meetings as they pertain to QI. This committee is representative of each division of KCHD, and includes representatives at both staff and leadership levels. This committee also supports the work by the KCHD Leadership Team of implementing the agency's Performance Management system.

Quality Improvement Plan (QI Plan): A plan that identifies specific areas of current operational performance for improvement within the agency. These plans can and should cross-reference one another, so a quality improvement initiative that is in the QI Plan may also be in the Strategic Plan. See also Performance Management (PHAB Acronyms and Glossary of Terms, 2009).

Quality Methods: Builds on an assessment component in which a group of selected indicators (selected by an agency) are regularly tracked and reported. The data should be regularly analyzed through the use of control charts and comparison charts. The indicators show whether or not agency goals and objectives are being achieved and can be used to identify opportunities for improvement. Once selected for improvement, the agency develops and implements interventions, and re-measures to determine if interventions were effective. These quality methods are frequently summarized at a high level as the Plan-Do-Check-Act (PDCA) or Shewhart Cycle (PHAB Acronyms and Glossary of Terms, 2009).

Quality Tools: Tools designed to assist a team when solving a defined problem or project. Tools will help the team get a better understanding of a problem or process they are investigating or analyzing (The Public Health QI Handbook, Bialek et al, 2009). Tools used by KCHD are outlined in the Public Health Memory Jogger (Public Health Foundation, 2007) and the Public Health QI Handbook.

Strategic Planning, Program Planning and Evaluation: Generally, Strategic Planning and Quality Improvement occur at the level of the overall organization, while Program Planning and Evaluation are program-specific activities that feed into the Strategic Plan and into Quality Improvement. Program evaluation alone does not equate with Quality Improvement unless program evaluation data are used to design program improvements and to measure the results of the improvements as implemented (PHAB Acronyms and Glossary of Terms, 2009).

III. Culture of Quality

KCHD is committed to fostering a culture of quality within the organization, and the development of this culture is outlined below.

2006 – KCHD participates in the Common Ground project, sponsored by the Robert Wood Johnson Foundation. This project served to use business process analysis and redesign to develop toolkits for public health preparedness.

2007 – KCHD created their first Quality Improvement/Process Improvement (QI/PI) Committee resultant from the development of the agency's first strategic plan.

2008 – KCHD was awarded a grant by the National Association of City and County Health Officials (NACCHO) through the Accreditation Preparation and Quality Improvement Demonstration Sites Project. KCHD completed a self-assessment using the Operational Definition Prototype Metrics Assessment Tool, analyzed the scores, and identified priority areas to address through a Quality Improvement process. The agency leadership team received training on PDCA from a consultant as well. In addition, KCHD completed a QI project to improve the external display of data for the Community Action Plan, the result of which was Vital Signs, an annual report to the community on the status of the Community Action Plan. This project was led by the agency's QI/PI Committee.

2009 - 2010 June - As the self-assessment also indicated that Domain 9 of the standards (Evaluate and continuously improve process, programs, and interventions) was an area for improvement, the QI/PI Committee began work to remedy this gap. This included an inventory of current quality initiatives within programs, training on and initial development of logic models for programs and began work to develop goals, objectives, and performance measures at the program level. In addition, all-staff training on PDCA was completed in March 2010.

2010, July-November - Planning and implementation of a large-scale agency-wide reorganization took priority, and a restructured KCHD began work to move forward on initiatives regarding Quality Improvement. This restructure included the creation of a Health Data and Quality Coordinator (HDQC) position, charged with coordinating all QI efforts within the agency, and assuring the agency is working toward application for accreditation.

2011 - KCHD has been working to remedy the gaps identified in Domain 9 of the Public Health Accreditation Board (PHAB) standards by training staff on QI techniques and tools, in order to allow staff to actively participate in section-level QI projects. Staff were surveyed on their training needs, as well as their level of engagement in QI. In addition, Leadership team members provided data in a separate survey on the needs for their team.

In the first half of 2011, training occurred monthly at all-staff "All Hands" meetings and at separate section meetings in between. Trainings were scheduled to correlate with the development of section-level QI projects, and project updates were provided at monthly All Hands meetings. Staff received training on a QI overview, PDCA, aim statements, flowcharts, brainstorming and affinity diagrams, cause and effect diagrams, force field analysis, data collection and analysis, and storyboards. The culmination of this training was displayed in June 2011, when the members of the QI Committee presented their PDCA project storyboards in a poster presentation format attended by all staff.

In addition to the staff training, a QI Committee was formed in March 2011, with the goals of overseeing the implementation of the QI Plan, assisting in the facilitation and implementation of PDCA projects, as well as developing their own skills through completion of "Train-the-Trainer" modules developed by the HDQC.

Additionally, KCHD solicited the support of the Kane County Health Advisory Committee (HAC) through the development and implementation of the QI and Accreditation framework and this plan. The HAC is comprised of representatives from healthcare and academia and serves to provide consultation and support to KCHD as well as be a liaison to the Kane County Board.

The future state of quality at KCHD includes the following:

- Integration of quality as a piece of the larger Performance Management system strategy, "Turning Point: Collaborating for New Century in Public Health", and evolution of existing QI Committee into QuIPM Committee (June 2012).
- Demonstrated competence at the division and program level in quality improvement tools, including but not limited to PDCA.
- Demonstrated use of quality improvement tools and methodologies in daily work tasks.
- Improvements in levels of engagement and participation regarding QI as evidenced through annual staff QI surveys.
- PDCA project completion for all staff at the section level at least annually.
- Quality improvement not only impacts daily operations, but serves to improve population level outcomes and indicators, as described in the Community Health Improvement Plan (CHIP) and Strategic Plan.

IV. Governance of Quality Improvement Plan

a. Organizational Structure

QuIPM Committee: The QuIPM Committee will assure the carrying out of QI efforts and activities, which include: development and evaluation of an annual Quality Improvement Plan, meeting PHAB accreditation standards relative to QI, as well as developing and evaluating PDCA projects. Committee members will also be asked to plan and participate in QI training activities, and to become skilled in the implementation of QI tools. Committee members will also serve as section-level support to the KCHD Leadership Team in implementing, monitoring and evaluating the performance management system.

KCHD Leadership Team: The KCHD Leadership Team will support the efforts of the QuIPM Committee by implementing QI activities within Divisions and Sections, and contribute to the development and implementation of agency-level QI activities. Leadership Team members will also be asked to participate in QI training activities, become skilled in the implementation of QI tools, and to provide concrete feedback and evaluation of QI training and PDCA projects. Leadership Team members will serve as the primary group responsible for implementation, monitoring and evaluation of the agency's Performance Management system.

Kane County Health Advisory Committee: The Kane County Health Advisory Committee will provide bi-directional support to the QI efforts of the agency, providing consultation and feedback to KCHD staff regarding QI efforts, and both informing the Kane County Board about QI and making recommendations on policy change.

Kane County Board/Board of Health: The Kane County Board, which includes the role as the Kane County Board of Health, will provide oversight of QI efforts by the agency, as well as set policies to facilitate implementation of this plan and activities included therein.

b. Membership and Rotation

QuIPM Committee members will be representative of each of the three Divisions/Offices of KCHD, and will assure that each Section within the Division/Office is represented. In addition, each Division/Office will be represented by one member of the Leadership Team

and two members of the staff to participate (for a total of nine members, including the HDQC, representing the Office of Community Health Resources).

In 2011, Committee members were selected based on their expressed interest in committee participation and their level of involvement with the selected PDCA for their section. In this initial iteration, Committee members will serve so long as their PDCA project is on-going. If necessary, Division Directors may select to replace the committee member with another member of the staff, so long as each Division/Office has three representatives, one from the Leadership Team, and two from staff, and that both Sections are represented. The Health Data and Quality Coordinator will always be a member of the committee, serving as its facilitator.

QuIPM Committee members will serve a term no longer than two years. Committee members will be expected to attend regular monthly meetings (1-2 hours per month), assist in development of QI trainings, provide presentation on PDCA projects at All Hands meetings, work with section leadership to support facilitation of PDCA and QI work, and become proficient in the implementation of QI tools.

c. Roles and Responsibilities

Executive Director

- Provides leadership for department vision, mission, strategic plan and direction related to QI efforts.
- Allocates resources for QI programs and activities, assuring that staff has access to resources to conduct QI projects and training.
- Promotes a continuous quality improvement (CQI) learning environment for KCHD.
- Advocates for a QI culture, both to staff and external customers, through presentation and messaging.
- Reports on QI activities to the Board of Health, Public Health Committee and Health Advisory Committee.
- Requests the review of specific program evaluation activities or the implementation of QI projects.
- Reviews and provide final approval on documents such as the QI Plan, QI Policy.
- Applies QI principles and tools to daily work.

Division Directors

- Facilitate the implementation of QI activities at the Division level.
- Support Assistant Directors and Supervisors in QI activity work.
- Participate in QI project teams as requested or required.
- Facilitate the development of QI project teams.
- Provide staff with opportunities to share results of QI efforts (findings, improvements, lessons learned).
- Communicate with Assistant Directors and Supervisors to identify projects or processes to improve and assist with development of proposals for QI projects.
- Document QI efforts.
- Communicate regularly with Executive Director and Health Data and Quality Coordinator to share QI successes and lessons learned.
- Provide feedback to develop annual QI Plan.

- Identify staff for QuIPM Committee and staff training needs (communicated to HDQC).
- Encourage program staff to incorporate QI concepts into daily work.
- Apply QI principles and tools to daily work.
- Assure implementation, monitoring and evaluation of the agency's Performance Management system.

Assistant Directors and Supervisors

- Facilitate the implementation of QI activities and an environment of CQI at the program level.
- Participate in and facilitate the development of QI project teams.
- Assure staff participation in QI activities.
- Orient staff to the QI Plan processes and resources.
- Provide staff with opportunities to share results of QI efforts (findings, improvements, lessons learned).
- Document QI efforts.
- Determine messages to communicate selected QI activities and results to staff, the public and other audiences (via Public Information Officer and with the support of the HDQC).
- Keep Division Director apprised of QI activities.
- Initiate problem solving processes and/or QI projects.
- Encourage staff to incorporate QI concepts into daily work.
- Apply QI principles and tools to daily work.
- Assure implementation, monitoring and evaluation of the agency's Performance Management system.

Health Data & Quality Coordinator (HDQC)

- Coordinates, supports, guides and defines QI/PM department-wide.
- Develops the annual QI plan and evaluation with the input of the QuIPM Committee and Leadership Team, assuring that it meets PHAB accreditation requirements.
- Counsels QuIPM Committee members on the implementation of the QI program.
- Provides training, consultation, and technical assistance to QI project teams, the QuIPM Committee and for other staff.
- Convenes and facilitates the agenda and meetings for the QuIPM Committee.
- Works with the Leadership Team to define and document QI issues.
- Supports Assistant Directors and Supervisors in development of messages to communicate QI activities to staff, the public and other audiences.
- Assures communication of QI project results.
- Documents all QI-related activities.
- Evaluates staff regarding QI participation and training needs.
- Integrates QI principles in KCHD policies/protocols.
- Implements other strategies to develop a "culture of QI".
- Applies QI principles and tools to daily work.

All KCHD Staff

- Participate in the work of at least one QI project, as requested by division directors, assistant directors, or supervisors.

- Collect and report data for PDCA projects.
- Identify areas needing improvement and suggest improvement actions to identified areas (with direct supervisor and supported by the use of data), especially as they pertain to agency goals and mission.
- Develop an understanding of basic QI principles and tools by participating in QI training.
- Report QI training needs to supervisor and/or HDQC.
- Apply QI principles and tools into daily work.
- Contribute to the development, monitoring and evaluation of the Performance Management system.

Quality Improvement Committee

- Provides QI expertise and guidance for QI project teams.
- Provides QI training to new and existing staff.
- Serves as liaison between program-level QI project and agency, providing updates at All Hands meetings.
- Assists in development of agency QI activities.
- Reviews annual QIP prior to approval.
- Advocates for QI and encourage a culture of learning and QI among staff.
- Applies QI principles and tools to daily work.
- Provides support to the KCHD Leadership Team in implementation, monitoring and evaluation of the Performance Management system, providing updates to the QuIPM Committee and making recommendations for improvement projects based on PM results.

Kane County Health Advisory Committee

- Provides consultation and feedback to KCHD staff regarding QI/PM efforts
- Informs the Kane County Board about agency QI/PM efforts
- Makes recommendations to Kane County Board on policy change regarding QI/PM
- Participates in orientation regarding QI/PM efforts and assist in development of QI/PM orientation materials for Kane County Board/Board of Health

Kane County Board/Board of Health

- Provides oversight of QI/PM efforts by the agency
- Sets policies to facilitate implementation of the QI plan and activities
- Participates in orientation of QI/PM efforts

d. Staffing and Administrative Support

The Health Data and Quality Coordinator position is specifically tasked with the development, implementation, evaluation and coordination of all QI activities within KCHD, comprising about 50% of the full-time equivalent (FTE) position. As this position is housed within the Office of Community Health Resources, the Support Associate for that Office may be tasked for administrative support as needed. Additional staffing and/or administrative support may be provided by the Assistant Director for Community Health Resources, the members of the QuIPM Committee, or the Executive Director.

e. Budget and Resource Allocation

The primary budget allocation for this program is for the Health Data and Quality Coordinator position, which is paid out of local funds. In 2011-2012, KCHD received grant funding through the University of Illinois at Chicago to engage in QI efforts; this small grant allowed purchase of some QI and performance management training materials, as well as one-day training on performance management facilitated by a national expert in the field. Future planning in this area will include analysis of cost, return on investment of implementation of quality improvement projects, and a more in-depth understanding of budget allocation specific to QI for staff members, members of the QuIPM Committee, and the Leadership team.

V. Training

a. New Employee Orientation

As a part of the new employee orientation process, all KCHD staff and interns will be provided an orientation to quality improvement by the HDQC and/or their direct supervisor, including addition to an existing PDCA workgroup. New employees will be provided orientation to the PDCA process, as well as completed projects. They will be informed on the location of QI materials (network shared drive) and be given time to review those materials as a part of their orientation. Completion of the "QI 101" introductory course will also be a part of the new employee orientation. As a new employee progresses through orientation, they will be given opportunity to learn specific QI tools as they pertain to their work.

b. Introductory QI Course for All Staff

Within the new employee's first six months of employment or an intern's first 30 days working with KCHD, they will complete the web-based "QI 101" training module, as initially developed by NACCHO and modified by the HDQC to reflect KCHD practices. A link to this module will be sent to new staff by the HDQC. In addition to viewing the web-based training module, staff will be expected to complete a quiz on the material, which will be graded by the HDQC. Failure to reach a score of 80% or better on the quiz will require the HDQC to complete a one-on-one training session on QI with the individual.

Future plans in this area include development of a shorter version of the "QI 101" training module for undergraduate nursing students completing their public health rotation.

c. Advanced Training for Lead QI Staff

Members of the QuIPM Committee and KCHD Leadership teams are expected to have higher-level QI skills, and as such, will be provided additional training on QI tools and methodologies. A series of "Train-the-Trainer" modules were developed by the HDQC, including:

- Aim Statement
- Affinity Diagrams
- Brainstorming
- Cause & Effect Diagrams
- Data Collection & Analysis (Check Sheet, Bar Chart, Pie Chart, Run Chart)
- Five Whys/Five Hows
- Flowcharts
- Force Field Analysis
- Gantt Chart
- Pareto Diagrams
- PDCA
- Storyboards

These modules will be housed on the agency's network shared drive, with the location communicated to the QuIPM Committee and KCHD Leadership team. The HDQC will

complete these modules with the QuIPM Committee during monthly meetings, and the QuIPM Committee members will practice with their sections, reporting back the results and the product created from the training session.

In addition, the HDQC will share opportunities for additional advanced QI learning for the QuIPM Committee and KCHD Leadership team as applicable and resources permit.

d. On-going Staff Training

PowerPoint training presentations have been developed and are available to use as refresher or for new employees on the following QI tools:

- Aim Statements
- Affinity Diagrams
- Brainstorming
- Cause & Effect Diagrams
- Data Collection & Analysis (Check Sheet, Bar Chart, Pie Chart, Run Chart)
- Five Whys/Five Hows
- Flowcharts
- Focus Groups
- Force Field Analysis
- Gantt Chart
- Pareto Diagrams
- PDCA
- Prioritization Matrix
- Storyboards
- SWOT Analysis

Each presentation has been housed on the agency's shared network drive, with the location communicated to staff for access at any time. In addition, a one-page handout on each tool has been made available on the shared drive. Several of these modules have been developed into web-based modules, similar in design to the QI 101 presentation described above, and will be available for both new and current staff.

Refreshers on these tools will be provided in a number of venues, including All Hands meetings held every other month, as well as in Division and/or Section meetings. Areas of focus for training at these meetings will be based on results of a QI training needs survey, completed annually in the first quarter of the year. In addition, as a part of the support to begin PDCA projects, the HDQC (or a designee from the QuIPM Committee) will review the tools used as a part of the PDCA process before they are implemented.

e. Position-Specific QI Training

The HDQC, with specific accountability for the implementation of the QI program, will attend trainings and conferences specific to QI as available and resources allow, assuring that skills are maintained and enhanced. In addition, the HDQC will continue to participate as a member of the NACCHO QI Leaders Group, in order to keep abreast of training opportunities.

New members of the Kane County Board/Board of Health will receive information on the KCHD's QI policies and activities as a part of their new board member orientation.

VI. Identification of Improvement Projects & Alignment with Strategic Plan

a. Project Selection Criteria

Improvement project selection will be based on improvement of processes, objectives, and/or performance measures as outlined within programs and that are tied to the agency Strategic

Plan and Performance Management system. In each calendar year, each of the six sections of KCHD (Community Health Resources, Administration, Public Health Nursing, Communicable Disease, Environmental Health and Community Health) will select and develop one PDCA project. After selecting a project, the PDCA workgroup will be expected to complete a QI proposal and project plan (Appendices A, B & C), to be submitted to the QuIPM Committee for discussion and approval. Each KCHD Section will be expected to be working on at least 1 PDCA project each calendar year, but may choose to work on multiple projects simultaneously. It is the expectation that the selected PDCA project for each section will be documented via the storyboard format, and that the finished storyboard be shared with staff and on the agency's website.

In addition, sections or workgroups may choose to develop improvement projects outside of the PDCA model, utilizing appropriate QI tools. While completion of a storyboard is not required for non-PDCA projects, documentation of the process, outcomes, lessons learned and future plans is required.

A list of PDCA projects selected by the sections of KCHD can be found in Appendix F of this document.

b. Agency and Division Level Goals and Objectives

On an annual basis, KCHD will conduct a process to identify agency and division-level goals and objectives (Performance Measures) as a part of the agency's performance management system. This process will include participation by staff in each division, and selected measures will be documented using the Performance Measure Data Description and Collection Form (Appendix D). Originals of these documents will be maintained by division Leadership, with copies provided to the HDQC so a central repository of measures is maintained.

Performance Measures will have a direct line of sight with the agency's Strategic Plan, the Community Health Improvement Plan or another recognized performance standard, and this information will be captured on the Performance Measure Data Description and Collection Form.

The list of selected Performance Measures is included as Appendix E of this document.

VII. Goals, Objectives, and Performance Measures for QI

Goals and objectives are based on the PHAB Standards and Measures, Version 1.0, released in 2011, and were selected as priority goals for this plan due to their connection with accreditation. Domain 9 requires evaluation and continuous improvement of health department processes, programs and interventions. Progress toward these goals are evaluated by the QuIPM Committee on a quarterly basis, and the results of this evaluation feeds in as a measure in the agency Performance Managment system.

Goal 1: Establish a quality improvement plan based on organizational policies and direction.
Objective: Develop an annual agency QI Plan that seeks to increase staff knowledge of

quality improvement and supports the development of PDCA implementation, while considering the importance of the PHAB accreditation requirements moving forward.

Measure: Approved 2012 KCHD QI Plan.

Key Strategies:
1. Creation of draft QI plan by the Health Data and Quality Coordinator.
2. Assessment of draft QI Plan by KCHD Accreditation Team for compliance with PHAB standards.
3. Review of QI plan by Assistant Director for Community Health Resources, QuIPM Committee, Leadership Team and Executive Director.
4. 2012 KCHD QI Plan approved by KCHD Executive Director.
5. Dissemination of approved plan to KCHD staff, Health Advisory Committee and publishing of document on KCHD website.
6. Mid-year and year-end evaluation of 2012 QI Plan for compliance with goals and initiatives described therein.

Goal 2: Implement quality improvement efforts

Objective: Based on the framework of the KCHD QI Plan, implement PDCA as a QI strategy at KCHD.

Measure: Achieve 100% compliance with development and completion of PDCA projects.

Key Strategies:
1. Health Data and Quality Coordinator will meet with each PDCA workgroup or representative at least twice monthly to provide training, technical assistance and support of PDCA project.
2. Health Data and Quality Coordinator will maintain an electronic database of PDCA project work for each workgroup and assure that it is available on the KCHD shared computer drive (S Drive) for review by all KCHD staff.
3. Health Data and Quality Coordinator will provide at least monthly updates to the Assistant Director for Community Health Resources on progress of PDCA projects.
4. All PDCA project workgroups will complete a storyboard at the completion of the project, as well as maintain progress notes during the process.
5. All sections will maintain a record of use of QI tools, both within the context of and independently from PDCA projects. This record will be submitted to the HDQC in advance of the twice-annual QI summary report.

Goal 3: Demonstrate staff participation in quality improvement methods and tools training

Objective: Provide an adequate level of QI training to all KCHD staff.

Measure: Train 100% of KCHD staff on QI Tools and QI processes as outlined in QI plan.

Key Strategies:
1. The Health Data and Quality Coordinator will create and maintain a training log of staff that have participated in QI Training, and will share a summary of that on a quarterly basis with the Assistant Director for Administration for use with the Workforce Development plan.
2. All staff will participate in a quiz of the material following training, as well as completing an evaluation of the effectiveness of the training/presentation. Results of both will be used to determine needs for additional training in each area.
3. The Health Data and Quality Coordinator will work with Assistant Director for Administration to assure that new employees receive orientation and initial QI training within six months of date of hire, as well as on-going training.

4. Self-study modules on at least 6 QI tools will be implemented in 2012.
5. The QuIPM Committee will be trained on and demonstrate competence with use of at least 6 QI tools (using the Train the Trainer modules) in 2012.
6. KCHD Leadership will show use of at least one QI tool in a Division/Section meeting on at least a quarterly basis, providing a brief refresher to staff as well as a hands-on practice example that directly relates to the work of the team.
7. Establish a baseline of KCHD staff that have included among their annual evaluation objectives at least one objective that is directly tied to the demonstrated use of QI tools or methodologies, with a goal of increasing this to 100% over time.

VIII. Monitoring of Quality Improvement

a. Collection, Analysis and Monitoring of Data

Data will be collected for each of the agency-level and division-level goals and objectives, if not already being collected. It will be the responsibility of each division to collect and monitor the data for their own goals and objectives, although assistance and support can be provided by staff in the Office of Community Health Resources as necessary. A summary of data points from each division will be submitted to the Health Data and Quality Coordinator on the 15th of the month (for the previous month), for inclusion in the agency's data repository and dashboard. If a measure has been identified to have its data reported on a quarterly basis, the data is to be reported by the 15th of the months of January, April, July and October. This data repository and dashboard will be made available for all staff on the agency's network shared drive.

A summary of data points by Division and for the entire department will be developed by the Health Data and Quality Coordinator on a quarterly basis. Quarterly meetings will occur with each Division Leadership team to review and analyze the results, identifying opportunities for improvement projects.

b. Reporting Progress Toward Achieving Stated Goals

Progress will be reported in division meetings on at least a quarterly basis. This reporting will include a update of the data dashboard, a summary of progress toward division-level goals, progress toward agency-level goals and objectives, and a summary of active PDCA projects (including QI tools used, timeline and action steps and data points being used/monitored for the project). KCHD will also maintain a hard copy progress report of PDCA projects, to be housed in the Aurora office, which members of the QuIPM Committee will update as the project progresses. Performance Management and Quality Improvement, including progress toward goals and objectives, will be on the agenda of at least 50% of All Hands meetings each year.

c. Actions to make improvements based on progress reports

The quarterly progress reports will be evaluated for improvement opportunities by both the KCHD Leadership Team and the QuIPM Committee. The QuIPM Committee may make recommendations or suggestions to the divisions on implementation of improvement projects, and will serve as technical assistance support as necessary. The QuIPM Committee's skills may be utilized to help divisions determine the tools needed to make

improvements, guide the implementation of those tools, and to determine if the issue is significant enough to warrant implementation of a PDCA project. Teams created within or across divisions will be responsible for implementing these improvement projects.

IX. Sustainability of Quality Improvement

a. Communication & Promotion

A number of methods will be used to assure that regular and consistent communication occurs regarding QI efforts within KCHD. These methods will include, but are not limited to:

- PDCA workgroup updates at All Hands meetings.
- Presentations and training at All Hands, Division, Section and Team meetings regarding QI project updates or QI tools.
- Minutes from meetings of the QuIPM Committee, Health Advisory Committee and Public Health Committee.
- Storyboard presentations at All Hands, Division, Section and/or Team meetings, as well as display of completed Storyboards in KCHD offices.
- At least quarterly e-mail communication from the Health Data and Quality Coordinator to all staff on QI efforts, both within KCHD and in the public health community.
- Inclusion of QI efforts in Health Matters newsletter at least twice in the calendar year.
- Inclusion in Kane County Board flash reports at least once annually.
- Inclusion of QI efforts on social media sources (Facebook and Twitter) at least once per quarter.
- Creation and display of “Stall Street Journal” specifically focused on QI at least every other month.
- Presentation of the approved QI Plan via either e-mail or at a staff meeting, including the expectations of the contributions of all KCHD staff; a link to the plan on the KCHD shared computer drive (S Drive) will also be provided, and KCHD staff will be encouraged to review and provide comment on the document.

b. Recognition

KCHD staff can, at any time, nominate an individual, team, or section for a Quality Improvement travelling trophy that is awarded at the end of each quarter. Nominations for the award will be reviewed by the QuIPM Committee in March, June, September and December meetings, and a winner selected by a majority vote. Any QuIPM Committee member nominated for the award will not participate in the review or selection of the awardee. If the voting results in a tie, consultation with the KCHD Senior Leadership team will assist in the selection of an awardee.

Nominations may be completed by a peer or supervisor, but the nomination form must identify the activity for which the individual/group is being nominated, and how this activity goes “above and beyond” the expectations of QI in their particular area. The names of quarterly awardees will be engraved on a plaque that will be prominently displayed in the KCHD offices.

c. Agency Policies

KCHD initially developed policies regarding QI and Performance Management in 2010, which were approved by the Executive Director in August 2011. These policies will be reviewed annually by the QuIPM Committee and modified as necessary to reflect changes in QI efforts.

After annual review and approval by the QuIPM Committee, the final policy will be forwarded to the KCHD Executive Director for approval. The approved QI policy will be maintained in the KCHD policy book, and an electronic copy will be maintained on the agency's shared network drive for access by staff.

X. Approval and Evaluation of Quality Improvement Plan

Annually, a draft QI Plan for the year will be developed by the HDQC and QuIPM Committee based on progress toward goals and evaluation of the previous year's plan. Once a draft is complete, it will be vetted through the Assistant Director for Community Health Resources, the KCHD Leadership Team, and the Executive Director, in that order. The Executive Director will provide final approval and signature, and the document will then be signed by the HDQC.

In December of each year, the QI Plan and activities will be evaluated by the QuIPM Committee. This evaluation will include:

- A review of the process and progress toward achieving goals and objectives
- Efficiencies and effectiveness obtained and lessons learned
- Customer/stakeholder satisfaction results
- A summary of QI projects and results of those projects, including but not limited to PDCA efforts
- A summary of how the results impacted the development of the QI Plan for the next year.

The results of this evaluation will be compiled by the QuIPM Committee and forwarded to the Executive Director for review and approval.

Based on the recommendations of the QuIPM Committee and the Executive Director, the plan will be revised annually to reflect program enhancements and revisions. Activities planned for the next year will be based on recommendations from the annual plan evaluation, and supported by the results of the annual staff QI Survey, which will be completed in the first quarter of the year.

Approved this 29th day of June, 2012 for the period of July 1, 2012 – June 30, 2013.

_____

Barbara Jeffers, Executive Director

Appendix A
Kane County Health Department
Quality Improvement PDCA Project Proposal

Adapted from Tacoma-Pierce County Health Department

Project title:		***Submitted by:***
Date submitted to QuIPM Committee:	***PDCA Matrix Completed & Attached:*** Yes ☐ No ☐	
Briefly identify or describe the program, project or process that should be addressed with an QI project:		
Priority: ☐ High ☐ Medium ☐ Low	***Please explain why you selected this priority level:***	

Departmental Implications

a. ***Which strategic initiative and/or CHIP priority does this project support, or how does this project support our mission and/or vision?***

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

c. ***What resources and support will be needed to complete the project?***

d. ***What potential impact could there be on other programs/activities if this QI project is conducted?***

What are we trying to accomplish? (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 QI team?	***Who should lead this QI team?***

Reviewed by QuIPM Committee on _____/_____/20_____
QuIPM Committee Response: ____ Approved ____Denied

QuIPM Committee Member Signature:_____

Appendix B
Kane County Health Department
Quality Improvement PDCA Project Plan

Adapted from Tacoma-Pierce County Health Department

Project Name:	**Project Leader:** *Who is leading this effort?*
Strategic Directions/Goals : *What does your Division Director/Admin Manager expecting this project to contribute to the Department's strategic plan?*	
Measure(s): *The PRIMARY quantitative indicator(s) which would demonstrate performance had improved & what your baseline data shows.*	**Target(s):** *How much improvement is expected or hoped for?*
Customer(s): *Who is/are the PRIMARY recipient(s) of the program's "product" or service?*	
Process(es) to be addressed: *What are the core work/service processes within the program?*	**Which of these will you focus on first?** *Which process(es) are most directly related to the PRIMARY measures and strategic directions? Where will you have the biggest impact?*
Division Director: *Who is the project leader accountable to? Who is responsible for guiding and resourcing the program's improvement efforts?*	
Constraints: *What time, space, financial, system, policy, organizational or other constraints should the program leader should be aware of?*	
Team Members: *Who will be active participants in your improvement efforts? All staff may be involved in some way, at some point, but who are your PRIMARY participants?*	
Support Resources: *Who are the internal or external analysts, facilitators, consultants that have been assigned to support your improvement efforts?*	
Target Start Date:	
Target date for completion of first improvement cycle:	

Reviewed by QuIPM Committee on _____/_____/20_____
QuIPM Committee Response: ____ Approved ____Denied
QuIPM Committee Member Signature:_____

Appendix C
Kane County Health Department
Quality Improvement PDCA Project Decision Matrix

Place an X in boxes where the criteria matches the potential project. Add up each column and place the total in the box at the bottom of each column.

	NAME OF POTENTIAL PROJECT	NAME OF POTENTIAL PROJECT	NAME OF POTENTIAL PROJECT
Has an existing process (if not, explore quality planning)			
Has existing data to indicate a problem exists (or data can be easily collected)			
Is connected to CHIP, Strategic Plan or program/grant requirements			
Has potential for rapid turnover (at least monthly)			
Project is on a manageable scale ("bite" vs. "elephant")			
Resources are available to support project's implementation			
We have ownership/control over the outcome of the issue			
Have discussed level of reach and potential need to include others			
Staff has demonstrated interest and engagement in the project			
TOTAL			

Appendix D
Kane County Health Department
Performance Measure Data Description & Collection Form

Year _____ Program _____

___ Division Level Measure ___ Agency Level Measure

Performance standard:	
Performance measure:	
Baseline measurement data and date(s) collected:	
Target or benchmark?	
What is the target/benchmark?	
Rationale for selection of this performance measure:	
Target population:	
Numerator:	
Denominator:	
Source of data:	
Who will collect the information?	
How often will the data be analyzed and reported?	
Definitions and other comments:	

Quarterly Reporting				
1st Qtr	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**Year Total**

Appendix D
Kane County Health Department
Performance Measure Data Description & Collection Form

Definitions/Clarifications

Performance standard: National standards, state-specific standards, benchmarks from other jurisdictions, or agency-specific targets to define performance expectations.

Target population: A description of the group of people that your measure covers. For example, will the measure report data for all Kane County residents or only clients that participate in your program? In many cases, this may be the same as the denominator.

Numerator: In a percentage or rate, this is the top number. For example, the numerator for the percent of Kane County adults who smoke cigarettes is the number of adults who currently smoke cigarettes.

Denominator: In a percentage or rate, this is the bottom number. For example, the denominator for the percent of Kane County adults who smoke cigarettes is the number of Kane County adults.

Target: This is the "goal" for the performance measure. What number are you trying to reach? Examples are a percent improvement from previous years or higher than the average rating for comparable local health departments.

Benchmark: This is a "gold standard" goal for a measure, usually set by an external organization. Examples of a benchmark are Healthy People 2010 objectives where the target setting method is listed as "better than the best".

Baseline data: The rate/percent/number that you will be comparing current data with to determine whether there has been a change.

Baseline date(s): When was your baseline data collected? For example, it could be from the previous year or an average from the previous three years.

Definitions: Do any of the words or phrases in your performance measure need further explanation or definition? Here's where you would put that information.

Rationale for selection: Performance measures should have a direct connection to a national performance standard, a CHIP priority, a strategic plan initiative, or the requirements of a program or grant. Measures should also be selected based on the evidence base. This connection should be expressed in this section.

Appendix E
Kane County Health Department
Agency and Division-Level Performance Measures

Division	Program	Measure	Baseline	2012 Target	Assigned Staff	Reporting Schedule
Disease Prevention	Communicable Disease	% of 24-hour reportable disease cases received on time	53%	60%	Sara Boline	Quarterly
Disease Prevention	Communicable Disease	# of days to close cases of Gonorrhea	31	19	Sara Boline	Quarterly review, monthly reporting
Disease Prevention	Communicable Disease	% of gonorrhea cases receiving counseling	19.5%	25%	Sara Boline	Quarterly
Disease Prevention	Communicable Disease	# of days to close cases of Chlamydia	38	23	Sara Boline	Quarterly review, monthly reporting
Disease Prevention	Communicable Disease	% of CD cases closed within 14 days	70.40%	75%	Kate Marishta	Quarterly
Disease Prevention	Communicable Disease	% of Pertussis cases with complete data entry	83.5%	90%	Sara Boline	Quarterly
Disease Prevention	Tuberculosis	% completion of expected DOT	96.6%	98%	Sara Boline	Quarterly
Disease Prevention	Tuberculosis	% of contacts with follow-up screenings completed per timeline	26%	40%	Sara Boline	Quarterly
Disease Prevention	Kane Kares	% relative decline in prenatal smoking status	18%	20%	Diane Ferriss	Quarterly
Disease Prevention	Kane Kares	% of time spend in toddlerhood visits on Life Course Development domain	14.6%	18%	Diane Ferriss	Quarterly
Disease Prevention	Public Health Nursing	% of newborn hearing screenings receiving RN intervention	57%	98%	Mary LaBee	Quarterly
Health Promotion	Food Program	% of food workers that have completed basic food safety training	83%	85%	Julie Wiegel	Quarterly
Health Promotion	Food Program	% of isolated FBI complaints investigated within 72 hours	100%	95%	Julie Wiegel	Quarterly
Health Promotion	Non-Community Well Program	% of non-compliant monitoring violations inspected within 30 days	99.5%	99%	Julie Wiegel	Quarterly
Health Promotion	Environmental Health	# of open burning complaints received	85	76	Julie Wiegel	Annual review, quarterly reporting

Division	Program	Measure	Baseline	2012 Target	Assigned Staff	Reporting Schedule
Health Promotion	Well & Septic Program	% of well & septic complaints investigated within 10 days	100%	98%	Julie Wiegel	Quarterly
Health Promotion	AOK	% of members have signed MOU	0%	90%	Michelle Turner	Quarterly
Health Promotion	Dental Program	# of dental offices implementing tobacco dependence guidelines	0	5	Muneeza Azher	Quarterly
Health Promotion	Community Health	% of CH-sponsored events, trainings & meetings that have evaluation & debriefing	0%	100%	Terry Roman	Quarterly
Health Promotion	Fit For Kids	# of endorsing organizations	13	20	Janie Maxwell	Annual review, quarterly reporting
Health Promotion	Fit For Kids	# of projects or policy changes implemented	29	35	Janie Maxwell	Annual review, quarterly reporting
Health Promotion	Community Health	% of meeting minutes disseminated within 10 days	0%	100%	Terry Roman	Quarterly
Health Promotion	Community Health	% of health indicators that have improved since last wellness screening	58%	50%	Michael Isaacson	Annually
OCHR	CHR-Quality Improvement	% of staff completed 6 QI training modules	40.32%	100%	Julie Sharp	Monthly
OCHR	CHR-Quality Improvement	% of QI Plan key strategies met/exceeded	0%	100%	Julie Sharp	Annual review, quarterly reporting
OCHR	CHR-Quality Improvement	% of PDCA projects seen to completion	57.14%	75%	Julie Sharp	Annually
OCHR	CHR-Quality Improvement	# of QI tools completed by KCHD	30	36	Julie Sharp	Quarterly
OCHR	CHR-Quality Improvement	% of performance measures remaining steady or improving	64.7%	85%	Julie Sharp	Quarterly
OCHR	CHR-Communications	% of Health Matters “opened” by recipients	23%	29%	Tom Schlueter	Monthly
OCHR	CHR-Communications	# of Facebook fans	138	175	Tom Schlueter	Weekly review, monthly reporting
OCHR	CHR-Communications	# of unique page views to website	8000	10000	Tom Schlueter	Monthly

Division	Program	Measure	Baseline	2012 Target	Assigned Staff	Reporting Schedule
OCHR	CHR-Epidemiology	% of Category 1 data requests responded to within 2 days	86%	90%	Uche Onwuta	Quarterly
OCHR	CHR-Epidemiology	% of partners reporting use of KCHD data	TBD	50%	Uche Onwuta	Annually
OCHR	CHR-Epidemiology	% of ILI newsletter “opens” by recipients	22.8%	30%	Uche Onwuta	Monthly
OCHR	CHR-Planning	% of CHIP strategies with an identified activity	40%	95%	Jackie Forbes	Quarterly
OCHR	CHR-Planning	# of presentations on CHA/CHIP results	0	10	Jackie Forbes	Annual review, quarterly reporting
OCHR	CHR-Planning	% of CHIP goals improving from baseline	0%	85% (2014)	Jackie Forbes	Annually
OCHR	CHR-PHERP	% of inventory items found in correct count & location	60%	95%	Jennifer Fearday	Quarterly
OCHR	CHR-PHERP	% of staff responding to Code Red	88.52%	96%	Jennifer Fearday	Monthly
OCHR	Admin-Finance	Budget Variance < +/- 5%	0%	10%	Kinnell Snowden	Annually
OCHR	Admin-Finance	% of months with 3-month cash on hand supply met	100%	100%	Kinnell Snowden	Monthly review, quarterly reporting
OCHR	Admin	% of employee evaluations completed in assigned month	96.88%	98%	Barbara Jeffers	Quarterly
OCHR	Admin	Average employee evaluation score	3.94	3.00	Barbara Jeffers	Annually
OCHR	Admin	% of employee files audited on a quarterly basis	0%	90%	Barbara Jeffers	Quarterly
OCHR	Admin	% of audited employee files complete with documentation	0%	90%	Barbara Jeffers	Quarterly

Appendix F
Kane County Health Department
2012 Quality Improvement PDCA Projects
(Appendix F Last Updated 12/5/2012)

Division of Disease Prevention

Communicable Disease Section

By December 2013, improve accuracy of Pertussis data entry into INEDSS by 30% (in order to more accurately discover disease outbreaks).

Public Health Nursing Section

By December 7, 2013, improve reporting of immunization coverage levels by 8% for Kane County children under the age of 19.

Division of Health Promotion

Community Health Section

By March 1, 2012, increase Community Health event evaluation scores by 20%.

Environmental Health Section

By June 30, 2013, increase the number of complete and accurately written food inspection reports from 45% to 95%.

Office of Community Health Resources

Administration Section

By August 1, 2013, improve the average employee scores of select Public Health Sciences Core Competencies by 20%.

Community Health Resources Section

By June 30, 2013, increase the number of monthly unique visitors to the KCHD website by 20%.