Quality Improvement Plan
Erie County Department of Health
Erie, Pennsylvania
2019 - 2024

Public Health
Prevent. Promote. Protect.

Adopted on 10 · 25 · 2019
Revised on _____

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Quality Improvement Plan
Erie County Department of Health
Signature Page

This plan has been approved and adopted by the following individuals:

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Quality Improvement Plan
Erie County Department of Health

Table of Contents

The Erie County Department of Health is committed to the ongoing improvement of the quality of services it provides. This Quality Improvement Plan serves as the foundation of this commitment.

This plan includes the following topics:

Purpose & Introduction

Executive summary

The Erie County Department of Health is committed to providing high quality services to the community, in line with mission, vision, and values of the Department. Fostering a culture of quality improvement is a top priority for Department leadership. For this reason, quality improvement is at the basis of all the work that is done at the Erie County Department of Health. This plan outlines the efforts to improve quality culture within the Erie County Department of Health by setting measurable objectives that will be monitored and evaluated to identify gaps and improvements at all levels of the organization. The Department works diligently to ensure that the CHA, CHIP, Strategic Plan, Performance Management System, and WFD Plan concentrate on quality improvement. This is established and ensured through the execution of this plan.

Mission, vision & values

Mission

To preserve, promote, and protect the health, safety and well-being of the people and the environment of Erie County.

Vision

The people of Erie County enjoy good health in a safe and healthy environment.

Values

- Collaboration: We value our culture of participation, building strong partnerships across our Department and within our community.
- Integrity: we are committed to operating in a manner so that the Department is perceived to be credible, reliable and one on which the community can depend.
- Ethical: We are accountable, moral and just to ourselves, each other, and the public we serve.
- Quality: Through our individual and collective efforts, we deliver excellence and high value programs and services.
- Equality: We treat all persons – colleagues and clients – with respect, transparency and sensitivity.

Definitions & Acronyms

Introduction

A common vocabulary is used department-wide when communicating about quality and quality improvement. Key terms and frequently used acronyms are listed alphabetically in this section.

Definitions

Customer: (1) External: A person or organization that receives a product, service, or information but is not part of the organization supplying it. (2) Internal: the recipient (person or department) within an organization of another person's or department's output (product, service, or information.) (Embracing Quality in Local Public Health. Michigan's Quality Improvement Guidebook. 2012.)

Governing Body: The Governing Body of the Erie County Department of Health includes the County Executive and County Council. These positions are elected by Erie County voters.

NACCHO QI Self-Assessment Tool 2.0 Version: a self-assessment tool based on the QI Roadmap to a Culture of Quality, developed by NACCHO to assist in the assessment of the breadth of the six foundational elements of a culture of quality. (Roadmap to a Culture of Quality Improvement, NACCHO, 2019)

NACCHO Roadmap to a Culture of Quality Improvement: A tool to provide Local Public Health Departments with guidance on progressing through six phases or levels of QI integration until a culture of QI has been reached and can be sustained.

Performance Management: The practice of actively using performance data to improve the public's health. (Turning Point Performance Management National Excellence Collaborative. From Silos to Systems: Using Performance Management to Improve the Public's Health. Washington, DC: Public Health Foundation; 2003.)

Performance Management System: A system that is integrated into daily practice of the Agency at all levels which includes: 1) setting organizational objectives across all levels of the department, 2) identifying indicators to measure progress toward achieving objectives on a regular basis, 3) identifying responsibility for monitoring progress and reporting, and 4) identifying areas where achieving objectives requires focused quality improvement processes. (Public Health Accreditation Board (US). Guide to National Public Health Department Accreditation, Acronyms and Glossary of Terms Version 1.0. Alexandria, VA: The Board; 2011.)

Plan, Do, Study, Act (PDSA, also known as Plan-Do-Check-Act): An iterative, four-stage, problem-solving model for improving a process or carrying out change. PDSA

stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDSA 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 Culture: QI is fully embedded into the way the agency does business, across all levels, departments, and programs. Leadership and staff are fully committed to quality, and results of QI efforts are communicated internally and externally. Even if leadership changes, the basics of QI are so ingrained in staff that they seek out the root cause of problems. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives. (Roadmap to a Culture of Quality Improvement, NACCHO, 2012)

Quality Improvement (QI): Quality improvement in public health is 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. (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in Public Health. Journal of Public Health Management and Practice. January/February 2010)

Quality Improvement Plan: A plan that identifies specific areas of current operational performance for improvement within the agency and describes how the organization will integrate QI into programs and operations. (PHAB Acronyms and Glossary of Terms, 2009)

Storyboard: Graphic representation of an organization's quality improvement journey or a quality improvement project. (Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook)

Strategic Plan: A plan resulting from a deliberate decision-making process that defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. (Swayne, L.E., Duncan, W.J. and Ginter, P.M. Strategic Management of Health Care Organizations. Princeton, NJ: Jossey Bass; 2008.)

Vision, Mission, Services, Goals Dashboard Public Health Performance Management System (VMSG): a cloud-based, real-time, performance management system designed specifically to assist public health departments in the development, implementation and performance management of the Strategic and Operational Planning process.

Additional Acronyms

ECDH: Erie County Department of Health

HPQI: Health Promotion and Quality Improvement Division

PM Team: Performance Management Team made up of the Erie County Department of Health management team

QI Team: Quality Improvement team at Erie County Department of Health made up of Department staff and co-chaired by the Health Promotion and Quality Improvement Division Supervisor and one staff member

NACCHO: National Association of City and County Health Officials

PHAB: Public Health Accreditation Board

KCA: Knowledge Capital Alliance – administrators of VMSG

SMART Goal: A goal that is Specific, Measurable, Attainable, Relevant, and Time-bound.

CHA: Community Health Assessment

CHIP: Community Health Improvement Plan

VMSG: Vision, Mission, Services, Goals Dashboard Public Health Performance Management System

WFD Plan: Work Force Development Plan

Description of Quality in Department

Introduction

This section provides a description of quality efforts in Erie County Department of Health (ECDH,) including culture, roles and responsibilities, processes, and linkages of quality efforts to other department documents.

Description quality efforts

At this time, the ECDH has well established, formal QI in specific areas of the Department or Phase 4 of the NACCHO Roadmap to a Culture of Quality Improvement spectrum. This was assessed using the NACCHO QI Self-Assessment Tool 2.0 version. The completed Assessment may be found in Appendix A. Through this assessment process, the QI Team has developed a series of transition strategies that will ideally assist the ECDH in moving toward Phase 5: Formal Agency-Wide QI and eventually Phase 6: Quality Culture, within the Department, as outlined in the NACCHO Roadmap to a Culture of Quality Improvement.

Links to other Department plans

This QI Plan is based on the results of the NACCHO QI Self-Assessment Tool 2.0 version and aligns with the ECDH Strategic Plan Priorities as follows:

(1) Assuring "consistency, strength and retention of the knowledge base and staffing levels to support fulfillment of the ECDH mission" by outlining specific training for current staff in alignment with the ECDH Work Force Development Plan and providing guidance to ECDH leadership to track programming in a meaningful way which will provide evidence for long-term growth of the ECDH.

(2) Providing "long term sustainability of the ECDH through programming, fees for service, grants, other leveraged revenue streams and strengthened community level collaborations" by providing guidance and support in the development and tracking of performance metrics that will provide evidence of the need for additional investments in the ECDH.

(3) Creating "greater understanding of the value of the Erie County Health Department to the Erie County Community through raised awareness of programs and services and enhanced community level collaborations" by coordinating and supporting improvement efforts related to paid and earned media; providing guidance related to performance metrics; and utilizing data to identify partners and bolster support for 21st century public health practices.

Pursuit of these strategic priorities will ultimately support the ECDH mission to preserve, promote, and protect the health, safety and well-being of the people and the environment of Erie County, ideally resulting in the ECDH vision that the people of Erie County enjoy good health in a safe and healthy environment.

As the QI Self-Assessment Tool is completed on an annual basis, the ECDH Workforce Development Plan will be updated to include relevant quality improvement-related trainings. Quality Improvement processes such as PDSA will be utilized when developing the Community Health Improvement Plan (CHIP) based on the Community Health Assessment (CHA.) CHIP goals will be tracked through the performance management system as performance indicators. The Performance Management Team will use these indicators to identify quality improvement projects to focus on.

Quality improvement management, roles & responsibilities

Quality Improvement Team

The Quality Improvement (QI) Team provides ongoing leadership and oversight of quality improvement activities. The QI Team convenes every other week and more frequently if needed.

Responsibilities:

- Champion QI efforts throughout Department
- Identify quality improvement needs by evaluating department-wide QI efforts on an annual basis
- Review, revise and approve QI Plan (annually)
- Facilitate communication of improvements made through the QI processes
- Delegate QI projects and continued work as needed
- Make recommendations for improvement based on strategic plan priorities, performance management data, customer feedback, employee suggestions, training needs and other relevant data
- Monitor QI projects, act to solve problems, and support implementation of quality improvements system-wide
- Provide guidance and recognition to empower staff to improve quality of work
- Assure adequate resources are devoted to QI initiatives

The QI Team consists of the Health Promotion and Quality Improvement Division (HPQI) Supervisor and 15% of the current staff with equal distribution across all divisions and representation from both clerical/technical staff and professional staff. The HPQI Division Supervisor serves as the Co-Chair along with a staff member co-chair who is elected annually; members serve a one-year term, with no more than half of the team rotating off each year. Consecutive terms are allowable. Individual responsibilities are described below.

Table 1 below displays the QI roles and responsibilities of several additional staff groups outside of the QI Team.

Table 1: Roles and Responsibilities

Role	Responsibility
Department director	Provide vision & direction for QI program Allocate resources for activities Include budget allocation for QI programs annually Report to Board of Health quarterly
QI Co-chairs	Serve as co-chair and convene Quality Improvement Team Work jointly with Department Director to provide vision & direction Request resources for activities
Performance Management Team	Encourage a QI Culture by fostering an open environment for idea exchange Create a structure and guidance to activate ad hoc QI teams Recognize QI work going on in the Department Monitor and evaluate key indicators to identify QI project goals Advise QI Team Create a system of accountability for all staff to follow through with QI Work with QI Team to organize QI training for ECDH staff Facilitate QI teams as needed Assure QI-related performance and/or professional development goal for all division staff Encourage staff to incorporate QI efforts into daily work
Ad hoc QI Teams	Assemble ad hoc QI team once activated by PM Team Utilize PDSA cycle to complete QI project Communicate work to PM Team, QI Team, and ECDH Delegate for sustainability Dissolve ad hoc QI team

The QI Team strives for consensus on all decisions and agrees to abide by vote in absence of consensus. QI Team Co-Chairs provide administrative support (distribution of meeting agendas, summaries, and arrangements for meeting needs). Ad hoc QI teams are accountable to the PM Team.

Department Divisions

Division Directors are tasked with providing QI training for staff on an as needed basis; identifying and communicating divisional QI needs to the QI Team; facilitating divisional QI projects as needed; documenting QI projects; and sharing results of QI projects with the QI Team.

	All Health Department Staff All staff within the Erie County Department of Health will: participate in QI projects as requested, identify/nominate QI projects to his/her supervisor or to the QI Team, participate in QI training, incorporate QI concepts into daily work, and share results of QI work with the QI Team.
Quality improvement process	The Erie County Department of Health utilizes the Plan-Do-Study-Act (PDSA) process model for all QI projects organized within the Department. Each QI project that is initiated will utilize the QI Project Template, found in Appendix B, which assists staff in mapping SMART goals for the projects and how the PDSA cycle will be utilized. Appendix C of this document shows examples of completed projects, which utilized the QI Project Template.

Quality Goals, Objectives & Implementation

Introduction Table 2 presents the overall goals and implementation plan for QI. The overarching goals are drawn from ECDH Strategic Plan Priorities. Objectives and activities were developed by the QI Team and PM Team, with input from ECDH staff.

Table 2: Quality Improvement Goals

Goal	Objectives & Activities	Measure	Timeframe	Responsible
Strategic Priority 1: Assure consistency, strength and retention of the knowledge base and staffing levels to support fulfillment of the ECDH mission	By September 30, 2020, ensure that 100% of ECDH staff have attended a minimum of 4 hours of QI training approved by the QI Team	Percent of staff who have logged a minimum of 4 training hours into the ECDH training database	October 1, 2019 – September 30, 2020	QI Team; ECDH Staff
	By September 30 2019, implement Quality Culture Plan developed by QI Team to ensure all staff are trained in QI methods and have an understanding of how PHAB accreditation relates to their daily work. Plan may be found as Appendix D of this document.	ECDH reaches Phase 5: "Formal Agency-wide QI" of the NACCHO Roadmap to a Culture of Quality Improvement spectrum as indicated by the 2020 NACCHO QI Self-Assessment.	September 1, 2019 – August 30, 2020	QI Team; PM Team
	By August 30, 2020, 80% of ECDH staff will have completed the Ice House QI training program and completed a minimum of 1 project related to this training.	Percent of staff who have completed the training	September 1,2016 – August 30, 2020	ECDH Staff
	By September 15, 2020, the most updated version of the NACCHO QI Self-Assessment Tool will be utilized to assess quality culture within the Department and priority transition strategies will be established.	Assessment completed	August , 2020 – September 15, 2020	QI Co-Chairs
Strategic Priority 2: Provide long term sustainability of the ECDH through programming, fees for service, grants,	By January 30, 2019, ECDH will establish a process to activate ad hoc QI teams to pursue public health interventions beyond the current structural capacity of the ECDH. The process will ensure that diversity (skill, style, and experience) of the team is considered in member selection and distribution within and	Process for activation of ad hoc QI teams	November 30, 2019 – January 30, 2020	PM Team

other leveraged revenue streams and strengthened community level collaboration	across ECDH ad hoc QI teams. Further, the process will outline how teams will establish basic roles (e.g. leaders) and that requirements of members (e.g. time commitment) are agreed upon.			
	Support 3 quality improvement projects (at least 1 program and 1 administrative) in different divisions. Review documentation for project ideas, select project, leader & teams	QI project template documentation, storyboards	September 1, 2019 – August 30, 2020	Division Directors; QI Team; respective team members
Strategic Priority 3: Create greater understanding of the value of the Erie County Health Department to the Erie County Community through raised awareness of programs and services and enhanced community level collaborations	By December 31, 2019, initiate a process to communicate QI projects both internally and externally to recognize staff efforts and share the Departments work with the public	QI Team process created	October 1, 2019 – December 31, 2019	QI Team
	By March 30, 2020, develop a Department progress report on VMSG to be displayed on the website and shared with the governing body (County Executive and County Council) on a regular basis.	Progress Report developed	October 1, 2019 – March 30, 2020	PM Team
	By July 31, 2020, 100% of ECDH staff will be actively updating VMSG	Percent of staff logging into the VMSG Dashboard in the last 30 days	July 1, 2020 – July 31, 2020	ECDH staff; PM Team
	By April 1, 2020, create a plan to identify all of the department's internal and external customers, including customer segments (e.g. racial/ethnic groups, low-income)	Plan created	October 1, 2019 – April 1, 2020	PM Team; QI Team; ad hoc QI Team activated as necessary
	By September 30, 2020, integrate customer feedback into strategic planning process to inform prioritization criteria for strategic priorities	Complete Strategic Plan integrating customer feedback	January 1, 2019 – September 30, 2020	Department Director; PM Team; QI Team
Updating the ECDH Strategic Plan	QI Leadership will be represented in the updating or reconstruction of the ECDH Strategic Plan to provide a QI perspective.	QI Team members participating in Strategic Planning Process	October 1, 2019 – September 30, 2020	Department Director; QI Team

Projects

Introduction

This section describes the process for QI project identification, prioritization, and selection of team members. Information about current and past projects may be obtained from a QI Team member. Detailed project data is stored in the QI Team folder, accessed only by QI Team and PM Team members.

Project selection

Any staff member may recommend a project to the QI Team for consideration at any time by submitting an QI Project Template found in Appendix B outlining the proposed project to the ECDH Quality Improvement Team. Projects are selected by the QI Team first and foremost based on alignment with our mission and strategic plan priorities. Ideas are based on data obtained from internal and external customer feedback, program evaluations or after-action reports, and/or from Erie County Department of Health's performance management system. When multiple project ideas are presented, they will be prioritized by consensus of the QI Team in alignment with the Erie County Department of Health's Strategic Plan. If consensus cannot be reached, prioritization will become the responsibility of the PM Team.

When deemed necessary by the PM Team, an ad hoc QI Team will be activated. Ad hoc QI team members will be selected so that the scope of the problem/project is represented; teams will consist of five to seven members and represent affected departments, disciplines, and clients as needed.

Current projects

Information on current and past QI Team projects may be accessed in the *ECDH QI Template* folder in the shared Department Drive. An archive of past projects is maintained on the Department's shared drive under the *ECDH QI Template* folder. Templates used for projects are included in the same location. QI project data is also submitted through the VMSG Dashboard for performance management purposes.

Each project at the Department utilizes the ECDH QI Project Template to chart the project, which may be found in Appendix B. The template is updated throughout the project and completed for each cycle of PDSA. A list of project examples from September 2018 – August 2019 is available in Appendix C.

Training

Introduction

The Erie County Department of Health has identified several topic areas where staff struggle in relation to QI. The following section seeks to address these areas through additional training.

Training and support

The Erie County Department of Health has held several QI trainings for Department staff related to process improvements, PDSA, performance management, and entrepreneurial problem solving. The Department is committed to supporting all staff in developing their QI skills by providing training opportunities on a regular basis. The training schedule for October 2019 – October 2020 is outlined in Table 3.

Table 3: Quality Improvement Training Schedule

Goal	Objectives	Target Audience	Resources	Responsible
Establish a culture of quality within the Department	By 08/31/2020, all QI Team and PM Team members will participate in 2 live quality improvement trainings	QI Team and PM Team	NACCHO NNPHI Pitt School of Public Health	Department Director PM Team QI Team
	By 08/31/2020, all Division Directors will lead an ad hoc quality improvement team	Division Directors	QI Team	Division Directors
	By 08/31/2020, 80% of ECDH staff will have completed the Ice House QI training program	ECDH Staff	HR Ice House Program Facilitators	ECDH Staff and Supervisors
	By 09/30/2020, all staff will attend a minimum of 4 hours of QI training approved by the QI and PM Teams	ECDH Staff	QI Team and PM Team approved Trainers	QI Team; PM Team
	By 10/31/2020, the Department will hold a full-day off site retreat for ECDH staff to attend	ECDH Staff	QI Team Pitt School of Public Health	Department Director QI Team
	All new hires will complete VMSG Dashboard training modules	New Hire Staff	KCA Supervisors	Supervisors of new staff
	By 09/30/2020, each of the QI Co-Chairs will receive a minimum of 8 hours of QI training in addition to Department trainings	QI Team Co-Chairs	NNPHI NACCHO APHA	QI Team Co-Chairs

Several training topics for the Department were identified through the NACCHO Organizational Culture of Quality Self-Assessment. Trainings related to these topics will be identified by the PM Team and QI Team and made available to staff. These training topics may be found in Table 4. A list of current and proposed methods utilized for QI projects is located in the QI Toolbox, found in Appendix E.

Table 4: Quality Improvement Training Topics

Target Audience	Topic Area
All Staff	Orientation to Performance Management and QI
	Basic QI methods and tools
	Statistical and data analysis
	Collaborative tools (e.g. group brainstorming session)
	Storyboards and other visual communication methods
	SMART goals and using data to set goals
	Extracting lessons learned
	Plan-Do-Study-Act
	Standardized work (how to find it, use it, and update it)
	Basic methods of Lean Production
QI Team & PM Team	Develop training and mentorship skills of QI Team
	QI concepts, structure, roles, and basic methods
	Advanced QI methods and tools
	Using data and creating statistically valid tests
	Storyboards and other visual communication methods
	Extracting lessons learned
	Determining root cause
	SWOT Analysis
	Calculating return on investment (ROI) for QI Projects
	Plan-Do-Study-Act
	Standardized work (how to find it, use it, and update it)
	Effective Cause and Effect analysis
	Basic methods of Lean Production

Communication

Introduction

In order to support quality as a usual-way-of-business, quality-related news is communicated on a regular basis using a variety of methods to staff, Board of Health, and the general public. This section describes how quality and quality initiatives are shared.

Quality sharing

All Employees

- *Potty Press – Page 2* is a full-page posted in each of the restroom stalls at ECDH and updated each month. It is the literal "page 2" of the Potty Press which is an established staff newsletter. Each month, *Page* 2 focuses on a different PHAB Domain and how it relates to the day-to-day work of staff.
- *Words and Phrases* related to Quality and PHAB Domains are posted throughout the Department in the form of puzzles, games, and word searches and updated on a monthly basis to initiate discussion on the aforementioned topics.
- *Story Boards* of completed QI projects at any level will be showcased throughout the Department. Projects may be submitted to be posted by emailing the *ECDH Quality Improvement Team* email group.
- *Division Staff Meetings* reserve a space on the agenda to discuss the monthly PHAB Domain that is posted through the Potty Press as well as QI projects and topics.
- *ECDH Staff Meetings* reserve the *Active Accreditation* section of the agenda to discuss the monthly PHAB Domain that is posted through the Potty Press as well as QI projects and topics. In one ECDH Staff Meeting in the fall of each year:
    - QI projects completed within the past 12 months will report experiences and results; team members will be recognized
    - A QI Team representative will report QI Plan progress, evaluation results and subsequent changes
- *All Performance Management Team meeting documents (agendas, summaries) and QI Team documents (assessment, plan, data tools, storyboards, etc.)* will be maintained on the shared electronic drive for review by all staff members at any time

Public

- Project descriptions and results will be featured on the Department's website

County Executive

- The County Executive will receive at least two updates on quality initiatives annually, one of which will focus on the assessment report

Board of Health

- Board of Health members will receive at least two updates on quality initiatives annually, one of which will focus on the assessment report

Other

- In addition to these regularly occurring communications, the QI Team will seek avenues to share quality initiatives with other community partners and other state and national audiences as appropriate

Monitoring and Evaluation

Introduction

This section describes the monitoring and evaluation for the QI Plan and associated goals. The VMSG Dashboard is the main system utilized by the Erie County Department of Health in monitoring and evaluation of the QI Plan.

QI plan

The Quality Goals, Objectives, and Implementation section will be monitored using the VMSG Dashboard. The PDSA cycle will be utilized for all objectives and activities. Updates will occur on a monthly basis or more frequently and will be the responsibility of the team leads assigned in the VMSG Dashboard. The QI Team will review these on a quarterly basis to ensure projects are moving forward. Projects will be reviewed on the completion dates designated in the Quality Goals, Objectives, and Implementation section of this plan. Upon evaluation, the QI Team will work with responsible parties to identify and make any necessary adjustments moving forward.

In September of each year, the QI Team will conduct an evaluation of the QI Plan as a whole. This evaluation will consider findings from the quarterly monitoring meetings and identify revisions for the upcoming year. Evaluation will address:

- progress toward and/achievement of goals as outlined in the Goals, Objectives and Implementation section,
- effectiveness of meetings,
- effectiveness of the QI Plan in overseeing quality projects and integration within the Department,
- clarity of the QI Plan and its associated documents,
- satisfaction surveys, and
- lessons learned

Ad hoc QI teams

Ad hoc QI Teams will provide project progress reports to the QI Team once per quarter or as the ad hoc QI teams dissolve. All teams will have the option to develop and submit project storyboards at the conclusion of the project. Within one month of a project's finalization, all team members will be surveyed to determine QI process learning, perceived contribution to the project, value of the project experience and ultimate outcome, lessons learned, and to seek suggestions for overall Department QI efforts.

Revision of the QI Plan

The ECDH QI Plan is a fluid document that will be updated as needed or on an annual basis, in September, after the annual QI Assessment has been conducted. The contents of the Plan will be tracked in the VMSG Dashboard. Revisions to this text will be recorded by signature and date on the cover page of this document.

References & Resources

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.
Center for Public Health Quality	http://www.centerforpublichealthquality.org/ A national resource with training, toolkits, consultation, and technical assistance.
Center for Disease Control and Prevention	http://www.cdc.gov/stltpublichealth/performance/ Concepts, resources, and links about quality improvement and performance management.
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.
University of Pittsburgh	https://www.cphp.pitt.edu/training.html Center for Public Health Practice https://lms.marphtc.pitt.edu/ Mid-Atlantic Regional Public Health Training Center

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2019

Culture of Quality Self-Assessment

For additional information related to this document, contact Sarah Morgan at the

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Executive Summary

In 2019, the Erie County Department of Health (ECDH) conducted a Culture of Quality Assessment utilizing the National Association of City and County Health Officials (NACCHO) Organizational Culture of Quality Self-Assessment Tool 2.0. This tool was developed based on the NACCHO Roadmap to a Culture of Quality and rates public health departments on a scale from 1 (No knowledge or awareness of QI) to 6 (QI Culture.)

The tool includes a staff survey as well as a quality improvement (QI) leadership survey. QI leadership includes staff who are current members of the ECDH QI Team and current members of the ECDH Performance Management (PM) Team. There was a 100% response rate of all eligible participants for both the staff survey and the QI leadership survey. Results from both surveys were combined to rate and prioritize the NACCHO Roadmap to a Culture of Quality foundational elements.

The ECDH rated lowest in the "Leadership: Culture" and "QI Infrastructure: Performance Measurement and Use of Data" sub-elements. The "Continuous Quality Improvement: Planning for QI Projects" sub-element was also scored notably low, in an element that would have otherwise been the highest scored in the assessment.

The assessment also identified some topic areas where staff and QI leadership opinions differed greatly. This is particularly visible in sub-elements "Employee Empowerment: Knowledge, Skills and Abilities (KSAs)" and "Leadership: Resources and Structure."

The ECDH scored an overall 4.4 out of 6.0 in the Assessment. This equates to NACCHO Roadmap to a Culture of Quality Phase 4: Formal QI in Specific Areas of the Organization. The ratings were used to select and prioritize transition strategies from the tool. Careful consideration was given to sub-elements that scored lower or had notable gaps between the staff and QI leadership surveys. These transition strategies will be included in the 2019 – 2024 ECDH Quality Improvement Plan and tracked in the VMSG Performance Management Dashboard.

The ECDH plans to employ these transition strategies in an effort to move the Department to a 5.0 rating by the 2020 Culture of Quality Self-Assessment. This rating would equate to NACCHO Roadmap to a Culture of Quality Phase 5: Formal Agency-Wide Quality Improvement.

Background

The Organizational Culture of Quality Self-Assessment Tool, Version 2.0, was developed by the National Association of City and County Health Officials (NACCHO) to assist Public Health Departments in assessing their current culture of quality. The Erie County Department of Health (ECDH) is committed to continuously improving the quality of programs and services. Through annual assessment of the Department's culture of quality, coupled with identification of appropriate transition strategies, ECDH will continue to take a proactive approach to ensure the highest quality programs and services are being offered to the residents and visitors of Erie County.

The NACCHO Organizational Culture of Quality Self-Assessment Tool, Version 2.0 is based on the NACCHO Roadmap to a Culture of Quality. The Assessment score is on a scale from 1 (No knowledge or awareness of QI) to 6 (QI culture) which allows Public Health Department's to identify their current state of quality culture and monitor annual improvement. The phases of the NACCHO Roadmap to a Culture of Quality scale are outlined in Table 1 below.

Table 1: The QI SAT Leadership and Staff Scoring Scale Interpretation

Roadmap Phase	SAT Scale Score	SAT Scale Interpretation
Phase 1: No knowledge or awareness of QI	1	**Leadership:** The respondent feels that the statement never occurs in the agency.
		Staff: The respondent strongly disagrees that the statement occurs in their work unit or team.
Phase 2: Not Involved in QI Activities	2	**Leadership:** The respondent feels that the statement rarely occurs in the agency.
		Staff: The respondent disagrees that the statement occurs in their work unit or team.
Phase 3: Informal or Ad Hoc QI	3	**Leadership:** The respondent feels the statement occurs inconsistently or on an informal or ad hoc basis in some areas of the agency.
		Staff: The respondent slightly disagrees that the statement occurs in their work unit or team.
Phase 4: Formal QI in Specific Areas of the Agency	4	**Leadership:** The respondent feels the statement occurs informally in some areas and formally in other areas of the agency.
		Staff: The respondent slightly agrees that the statement occurs in their work unit or team.
Phase 5: Formal Agency-wide QI	5	**Leadership:** The respondent feels the statement occurs formally in all areas of the agency.
		Staff: The respondent agrees that the statement occurs in their work unit or team.
Phase 6: QI Culture	6	**Leadership:** The respondent feels the concept in the statement is fully integrated into the agency culture.
		Staff: The respondent strongly agrees that the statement occurs in their work unit or team.

Methods

The NACCHO Organizational Culture of Quality Self-Assessment Tool, Version 2.0 includes a staff survey as well as a leadership survey component. Each of the surveys were collected using Survey Monkey. The staff survey was sent to all current ECDH staff members who were not on extended leave (over two weeks of leave from the time of dissemination.) Once the staff survey was complete, the leadership survey data was sent to those considered Quality Improvement (QI) Leadership within the Department. Per NACCHOs definition of QI Leadership, this included all current ECDH QI Team members and all ECDH Performance Management (PM) Team members.

Scores for both surveys were averaged by sub-element and element using the Scoring Summary Sheet provided by NACCHO as part of the Organizational Culture of Quality Self-Assessment Tool, Version 2.0. The Scoring Summary Sheet provided an overall Culture of Quality score as well as scores for each of the following elements: Employee Empowerment; Teamwork and Collaboration; Leadership; Customer Focus; Quality Improvement Infrastructure; Continuous Quality Improvement.

Once all survey data was collected and scored, the Department identified priority areas to focus efforts. Transition Strategies were selected from a menu of options that were provided as part of the NACCHO Organizational Culture of Quality Self-Assessment Tool, Version 2.0. These Transition Strategies will be incorporated into the 2019 ECDH Quality Improvement Plan and monitored in the VMSG Dashboard.

Results

Scores of the staff survey conducted among all current ECDH staff were averaged and compiled in the Staff Scoring Summary available in Table 2 below. Each of the elements outlined in the Assessment is broken out into sub-elements and specific topics, which feed the average element and sub-element scores. The staff survey had a 100% response rate of all current ECDH staff who were not on extended leave.

Table 2: Staff Scoring Summary

	Sub-Element 1.1: Enabling Performance	4.7
1.1a	QI related expectations of staff are clearly defined (e.g. performance goals and standards, QI project participation).	4.5
1.1b	Formal or informal processes are followed to provide staff feedback on job performance (e.g. performance evaluations, ongoing feedback sessions).	4.7
1.1c	Staff are recognized for contributions and successes.	4.6
1.1d	Staff have appropriate opportunities to improve work processes (e.g. participate in QI projects, authority to implement improvements).	4.9
	Sub-Element 1.2: Knowledge, Skills, and Abilities (KSAs)	4.6
1.2b	Staff have the appropriate KSAs to meet QI related expectations of them.	4.5
1.2d	Staff have access to learning opportunities (e.g. trainings, conferences) to develop *QI related KSAs*.	4.6
1.2f	Staff have access to learning opportunities to improve *job-related KSAs*.	4.8
	Sub-Element 2.1: Collaborative Sharing and Improvement	4.3
2.1a	Staff share information (e.g. lessons learned, best or promising practices) across teams and work units.	4.1
2.1b	Staff collaborate on projects or ideas to improve performance through formal QI projects or other improvement methods.	4.5
	Sub-Element 3.1: Culture	4.3
3.1a	Senior leadership routinely communicates the organization's QI vision and goals to staff.	4.3
3.1c	Managers and supervisors use data in a non-punitive way to review performance with staff.	4.3
3.1d	Managers and supervisors encourage their staff to engage in QI opportunities to improve work.	4.6
3.1f	Senior leaders, managers, and supervisors address staff concerns about engaging in QI (e.g., extra work, fear of job loss).	4.0
	Sub-Element 3.2: Resourcing and Structure	4.1
3.2a	Senior leaders dedicate enough resources (e.g., staff time) to support and sustain QI initiatives.	4.1

Table 2: Staff Scoring Summary (Continued)

	Sub-Element 4.1: Understanding the Customer	4.5
4.1c	Specific efforts are made to understand the needs and values of different customer groups (e.g., populations with health inequities, new vs. tenured staff).	4.5
	Sub-Element 4.2: Meeting and Exceeding Customer Expectations	**4.1**
4.2a	My work unit/team regularly collects customer satisfaction data.	4.3
4.2b	My work unit/team uses customer satisfaction data to implement improvements (e.g. QI projects, making informal improvements).	3.9
	Sub-Element 5.1: Strategic Planning	4.5
5.1b	Strategies for achieving agency strategic plan goals are incorporated into operational plans at the work unit level.	4.5
	Sub-Element 5.2: Performance Measurement and Use of Data	4.2
5.2a	Staff contribute to the development of performance measures related to their work.	4.3
5.2c	My work unit/team tracks a mix of process and outcome measures to assess performance.	4.2
5.2f	My work unit/team sets benchmarks or targets for performance measures using past performance data and/or standards (e.g., Healthy People, State Health Improvement Plan).	4.2
5.2g	Defined protocols for collecting performance data (e.g. use of data collection instruments) are documented and followed.	4.1
	Sub-Element 5.3: Quality Improvement Planning	4.2
5.3a	Staff use performance data to identify QI projects.	4.2
	Sub-Element 6.1: Improving Standardized work	4.5
6.1a	Staff have access to documented standardized work processes (e.g. policies, procedures) that define critical steps.	5.1
6.1c	Documented standardized work processes reflect the way work is actually done.	4.4
6.1d	Formal QI methods (e.g. PDSA, Lean) are followed to continuously improve standardized work through QI projects.	4.1
	Sub-Element 6.3: Testing, Studying and Acting on Potential Solutions	4.4
6.3d	Lessons learned from QI projects are documented and adopted into standardized work processes, as appropriate.	4.4

Scores of the leadership survey conducted among current ECDH QI Team staff and ECDH PM Team staff were averaged and compiled in the Leadership Scoring Summary available in Table 3 below. Each of the elements outlined in the Assessment is broken out into sub-elements and specific topics, which feed the average element and sub-element scores. The Leadership survey had a 100% response rate of all current QI Leadership as defined by NACCHO.

Table 3: Leadership Scoring Summary

	Sub-Element 1.1: Enabling Performance	4.6
1.1a	QI related expectations of staff are clearly defined (e.g. performance goals and standards, QI project participation).	4.1
1.1b	Formal or informal processes are followed to provide staff feedback on job performance (e.g., performance evaluations, ongoing feedback sessions).	4.8
1.1c	Staff are recognized for successes and contributions.	4.5
1.1d	Staff have appropriate opportunities to improve work processes (e.g., QI projects, authority to implement improvements).	4.8
	Sub-Element 1.2: Knowledge, Skills, and Abilities (KSAs)	4.1
1.2a	The agency has defined QI related knowledge, skills, and abilities (KSAs) for various levels of staff.	*3.7*
1.2b	Staff have the appropriate KSAs to meet QI related expectations, based on their role (e.g. QI Council members, frontline staff).	3.8
1.2c	Strategies for increasing staff KSAs for QI are incorporated into agency level plans (e.g. workforce development, QI plan).	3.8
1.2d	Staff at all levels have access to learning opportunities (e.g. trainings, conferences) to develop *QI related KSAs*.	4.8
1.2e	New staff are oriented to QI related concepts and agency vision for QI.	3.9
1.2f	Staff have access to learning opportunities to improve *job-related KSAs*.	4.5
	Sub-Element 2.1: Collaborative Sharing and Improvement	4.3
2.1a	Staff share information (e.g. lessons learned, best or promising practices) across teams and work units.	4.0
2.1b	Staff collaborate on projects or ideas to improve performance through formal QI projects or other improvement methods.	4.7
	Sub-Element 2.2: QI Team Performance	4.5
2.2a	QI project team members are selected based on needed KSAs in a process to accomplish the team's objectives	4.0
2.2b	QI project teams' performance is tracked for progress and accomplishments.	4.8
2.2c	QI project team dynamics (e.g. conflict resolution, mutual respect) support effective collaboration to achieve team objectives.	4.6
	Sub-Element 3.1: Culture	4.1
3.1a	Senior leadership routinely communicates the organization's QI vision and goals to staff.	4.1
3.1b	Senior leadership routinely communicates the organization's QI vision and goals to key stakeholders (e.g. funders, community, local governing entity)	4.1
3.1c	Managers actively use data in a non-punitive way to review performance with staff.	3.8
3.1d	Managers encourage their staff to engage in QI opportunities to improve work.	4.5
3.1e	Senior leaders, managers, and supervisors make data-driven decisions.	3.9
3.1f	Senior leaders, managers, and supervisors address staff concerns about engaging in QI (e.g. extra work, fear of job loss).	4.1

Table 3: Leadership Scoring Summary (Continued)

	Sub-Element 3.2: Resourcing and Structure	4.6
3.2a	Senior leaders dedicate enough resources (e.g. staff time, training) to support and sustain QI initiatives.	4.5
3.2b	A QI committee representing all areas of the agency is empowered to support QI initiatives.	4.9
3.2c	A formally adopted agency QI policy and/or plan is implemented.	4.3
	Sub-Element 4.1: Understanding the Customer	4.4
4.1a	The agency collects data on external customer needs.	4.9
4.1b	The agency collects data on internal customer (i.e., staff) needs.	3.7
4.1c	Specific efforts are made (e.g. community engagement) to understand the needs of different customer groups (e.g. populations with health inequities, new vs. tenured staff).	4.4
4.1d	Customer needs and expectations inform customer satisfaction measures.	4.4
4.1e	The agency uses customer needs data in planning efforts (e.g. community health improvement plan, strategic plan, program planning).	4.6
	Sub-Element 4.2: Meeting and Exceeding Customer Expectations	4.5
4.2a	The agency collects customer satisfaction data.	5.1
4.2b	The agency uses customer satisfaction data to implement improvements (e.g. QI projects, making informal improvements).	3.9
	Sub-Element 5.1: Strategic Planning	4.6
5.1a	The agency tracks goals and objectives for each strategic priority defined in an agency strategic plan.	4.9
5.1b	Strategies for achieving agency strategic plan goals are incorporated into operational plans at the work unit level.	4.6
5.1c	The strategic plan guides resource allocation to achieve strategic priorities.	4.4
	Sub-Element 5.2: Performance Measurement and Use of Data	4.1
5.2a	Staff contribute to the development of performance measures related to their work.	4.1
5.2b	Work unit performance measures are aligned with the agency strategic plan.	3.9
5.2c	Work units track a mix of process and outcome measures to assess performance.	4.0
5.2d	Performance measures assess key aspects of performance (e.g. customer satisfaction, financial, internal processes, workforce, health outcomes)	4.3
5.2e	The agency tracks shared performance measures for collaborative efforts with community partners (e.g. community health improvement plan objectives).	4.1
5.2f	The agency sets benchmarks or targets for performance measures using past performance data and/or standards (e.g. Healthy People, State Health Improvement Plan).	4.1
5.2g	Defined protocols for collecting performance data (e.g. use of data collection instruments) are documented and followed.	3.8
5.2h	Staff follow defined protocols for reporting on performance to stakeholders (e.g. reporting frequency, format).	4.1
5.2i	An effective information system (e.g. spreadsheets, database, performance software) is used to analyze performance data over time.	4.3

Table 3: Leadership Scoring Summary (Continued)

	Sub-Element 5.3: Quality Improvement Planning	**4.4**
5.3a	Staff use performance data to identify QI projects.	4.2
5.3b	Unmet strategic plan goals and objectives are prioritized for QI projects.	4.1
5.3c	QI goals, objectives, and metrics defined in a QI plan are tracked for progress.	4.8
5.3d	An agency QI plan is evaluated and updated in a defined planning cycle.	4.7
	Sub-Element 6.1: Improving Standardized work	4.9
6.1a	Staff have access to documented standardized work processes (e.g. policies, procedures) that define critical steps	5.3
6.1b	Documented standardized work processes are reviewed and updated to reflect evidence-based, best, or promising practices.	4.8
6.1c	Documented standardized work processes reflect the way work is actually done.	4.5
6.1d	Formal QI methods (e.g. PDSA, Lean) are followed to continuously improve standardized work through QI projects.	4.8
	Sub-Element 6.2: Planning for Quality Improvement Projects	4.1
6.2a	QI project goals (i.e., Aim statements) clearly define the desired future state with time-specific measures and targets.	5.2
6.2b	Current standardized processes are analyzed (e.g., use of flowcharts) to identify inefficiencies and waste.	3.6
6.2c	Root cause analysis is conducted to understand the source(s) of performance gaps prior to identifying solutions.	3.4
6.2d	Evidence-based, best, or promising practices (internal and external) are considered when selecting interventions for improving quality.	4.3
	Sub-Element 6.3: Testing, Studying and Acting on Potential Solutions	4.7
6.3a	QI project interventions are successively tested on a small scale prior to adopting a change.	4.4
6.3b	Baseline data are accessible for all QI projects.	4.7
6.3c	QI project teams compare data collected from QI project interventions against baseline data to determine whether an improvement was made.	5.0
6.3d	Lessons learned from QI projects are documented and adopted into standardized work processes, as appropriate.	4.6

The Staff Scoring Summary and Leadership Scoring Summary were combined to average the final culture of quality score for the Department as a whole, 4.4 on a scale of 1.0 to 6.0. The Overall Scoring Summary also combines the Staff Survey and Leadership Survey scores in each element and sub-element. A complete table of each element and sub-element score for the Department is available in Table 4: Overall Scoring Summary.

Table 4: Overall Scoring Summary

QI SAT Scoring Summary		SCORE:		4.4	
ELEMENT	**SUB-ELEMENT**	**SUB-ELEMENT LEADERSHIP SCORE**	**SUB-ELEMENT STAFF AVERAGES**	**SUB-ELEMENT SCORE**	**ELEMENT SCORE**
1. Employee Empowerment	1.1 Enabling Performance	4.6	4.7	4.6	4.5
	1.2 Knowledge, Skills and Abilities (KSAs)	4.1	4.6	4.3	
2. Teamwork and Collaboration	2.1 Collaborative Sharing and Improvement	4.3	4.3	4.3	4.4
	2.2 QI Team Performance	4.5		4.5	
3. Leadership	3.1 Culture	4.1	4.3	4.2	4.3
	3.2 Resourcing and Structure	4.6	4.1	4.3	
4. Customer Focus	4.1 Understanding the Customer	4.4	4.5	4.5	4.4
	4.2 Meeting and Exceeding Customer Expectations	4.5	4.1	4.3	
5. QI Infrastructure	5.1 Strategic Planning	4.6	4.5	4.6	4.3
	5.2 Performance Measurement and Use of Data	4.1	4.2	4.1	
	5.3 Quality Improvement Planning	4.4	4.2	4.3	
6. Continuous Quality Improvement	6.1 Improving Standardized Work	4.9	4.5	4.7	4.5
	6.2 Planning for QI Projects	4.1		4.1	
	6.3 Testing, Studying and Acting on Potential Solutions	4.7	4.4	4.6	

As shown above, the ECDH rated lowest in the "Culture" and "Performance Measurement and Use of Data" sub-elements, under the "Leadership" and "QI Infrastructure" elements, respectively. Sub-element "Planning for QI Projects" under element "Continuous Quality Improvement" was also scored notably low, in an element that would have otherwise been the highest scored in the assessment.

The assessment also identified some topic areas where staff and QI leadership opinions differed greatly. This is particularly visible in sub-elements "Knowledge, Skills and Abilities (KSAs)" and "Resources and Structure" under elements "Employee Empowerment" and "Leadership," respectively. The above-mentioned elements and sub-elements were carefully considered when selecting transition strategies.

Discussion

The Department utilized the survey results to identify a series of transition strategies. The transition strategies selected for each element and sub-element are outlined in Table 5 below. The ECDH Quality Improvement Plan will employ the transition strategies below through a series of SMART (Specific, Measurable, Attainable, Realistic, Time-bound) goals which will include a full QI training plan for all staff.

Table 5: Transition Strategies

ELEMENT	SUB-ELEMENT	SELECTED TRANSITION STRATEGIES TO IMPLEMENT
1. Employee Empowerment	1.1 Enabling Performance	Staff are encouraged to identify quality concerns and suggested solutions aligned with strategic plan and performance
	1.2 Knowledge, Skills and Abilities (KSAs)	Provide staff with basic orientation to performance management and QI, emphasizing their importance and applicability to the organization
		Develop capabilities of internal trainers and mentors that are skilled in providing feedback and assessing deployment of skills
		Mentor employees and provide advanced QI training to those that need it, including advanced tools of quality, statistical and data analysis, as appropriate
2. Teamwork and Collaboration	2.1 Collaborative Sharing and Improvement	All staff increase use of collaborative QI tools for problem-solving including group brainstorming sessions and discussions
		Leaders provide staff the opportunity to share results achieved through various mechanisms (e.g. staff meetings, storyboards on display)
		Ensure that diversity (skill, style, and experience) of the team is considered in member selection
	2.2 QI Team Performance	Ensure for any teams formed that basic roles are established, (e.g., leader) and that requirements of members (e.g. time commitment) are agreed upon
		Ensure that diversity (skills, style, and experience) of the team is considered in member selection
		Require the use of data and information, and methods of goal setting, chartering and measurement in specific areas; extract lessons learned
3. Leadership	3.1 Culture	Leaders communicate to all staff and the governing entity the urgency for and benefits of QI, highlighting QI success stories in public health and other industries
		Provide all organization leaders training in QI concepts, structure, roles, & basic methods
		Communicate QI activities during team meetings and other open employee forums; personally communicate the strategic direction and annual improvement goals, plan, and the case for change to all members of the organization
	3.2 Resourcing and Structure	Include QI leaders as part of the organization's leadership team for setting directions, developing plans & resources, and tracking results
		Provide the structure for all organization members to receive QI training and get involved in QI
		Define a rigorous skills learning & development program of QI methods and begin foundational training for QI Team and PM Team

Table 5: Transition Strategies (Continued)

ELEMENT	SUB-ELEMENT	SELECTED TRANSITION STRATEGIES TO IMPLEMENT
4. Customer Focus	4.1 Understanding the Customer	Begin to identify all of the agency's internal and external customers, including customer segments (e.g. racial/ethnic groups, low-income)
		Integrate customer feedback into community, agency, and program planning processes (e.g. CHIP, strategic plan, action plans)
		Include work team members in problem solving customer issues
	4.2 Meeting and Exceeding Customer Expectations	Prioritize which programs/services in which to build a customer focus; Prioritization criteria could include the number of people served, easy wins, strategic priorities, and high-profile programs.
		Develop plans and actions for how the organization will start to use customer data in performance management, strategic and improvement planning (analyzing customer satisfaction data, prioritizing unmet customer needs, making improvements and reporting results)
		Develop and implement systems for receiving, resolving and correcting root causes to customer problems
5. QI Infrastructure	5.1 Strategic Planning	Evaluate the Department utilizing a SWOT analysis to utilize in prioritizing strategic initiatives
		Ensure that the CHIP and QI Plan are aligned with the strategic plan
		Cascade strategic plans to the annual improvement planning and project teams
	5.2 Performance Measurement and Use of Data	Visually communicate the measured results
		Learn to calculate Return on investment (ROI) for improvement activities
		Initiate improvement directions and actions for underperforming measures
	5.3 Quality Improvement Planning	QI Leadership team collects and analyzes organization data: Strategic directions, lowest scoring QI culture roadmap elements and transition strategies, customer data, team assessment data, organization scorecards and process values stream gaps
		Utilize Plan-Do-Study-Act improvement methods to achieve project goals
		Define cascaded measure(s), objectives, preliminary tactics, resources for the entire organization
6. Continuous Quality Improvement	6.1 Improving Standardized Work	Evaluate selected processes to ensure that they are defined and produce a reliable result
		Establish a formal approach for rolling out and training organization members on how to find, use, and update standardized work
		Train all organization members on the standardized work relevant to their work - how to find it, use it, and update it
	6.2 Planning for QI Projects	Provide skills and coaching in effective Cause and Effect Analysis
		Identify potential improvements by looking for ways to Eliminate, Combine, Re-sequence, or Simplify process steps
		Educate QI team members on how to develop a statistically valid test
	6.3 Testing, Studying and Acting on Potential Solutions	Train QI team members in how to effectively conduct tests, measure results, and analyze causes
		Make lessons learned sharing system usable throughout the organization
		Reward and recognize organization members for sharing both positive and negative learnings

Resources

National Association of County and City Health Officials (NACCHO). 2019. Roadmap to a Culture of Quality Improvement and Organizational Culture of Quality Self-Assessment Tool, Version 2.0. Retrieved from http://www.naccho.org/topics/infrastructure/accreditation/qi-culture.cfm.

Appendix B

ECDH QI Template

Erie County Department of Health

- Quality Improvement Projects -

Project Title – Cycle # - MM/DD/YYYY (The **Cycle #** is in reference to the number of times a project has gone through the Plan-Do-Study-Act cycle)	
Topic	
Improvement Goals	SMART goal

1. **Plan**	Problem: Team: Past Process: Solution: Training (if needed): Timeframe:
2. **Do** Record the strategies you have used to implement the plan	
3. **Study** Evaluate the improvements that you have made	
4. **Act** Consider next actions for further improvement	Improvement Goal(s) achieved? Barriers: Next Steps:
BEGIN NEW SHEET FOR NEXT ITERATION OF THE CYCLE	

Return Completed Forms to **ECDH Quality Improvement Team** email group

Appendix C
Summary of QI Project Examples

QI Team Project Examples (September 2018 – August 2019)	
Project Name	**Submission Date**
Quality Culture Implementation Plan	August 2019
Customer Satisfaction – Survey Literacy	July 2019
Visit Erie Partnership	July 2019
Bus Ridership Data Tracking	June 2019
Teen Driving Competition Testing Stages	April 2019
Baby and Me Tobacco Free Intake Process	September 2018

Quality Culture Implementation Plan – Cycle #1 - 08/30/2019	
Topic	Improving Quality Culture and PHAB Reaccreditation knowledge among staff
Improvement Goals	Increase NACCHO QI Self-Assessment Tool 2.0 score from 4.4. to 5.0 by September, 2020.

1. **Plan**	Problem: Staff have little understanding of the process and value of PHAB reaccreditation and of Quality Improvement Team: QI Team Past Process: Rely on QI projects and sporadic trainings to drive QI culture Solution: Utilize visual representations, active discussion and regular training to improve QI Culture Training (if needed): none Timeframe: August 2019 – October 2020
2. **Do**	Develop a plan to improve staff knowledge and understanding of QI and PHAB Reaccreditation to drive engagement in a QI Culture (see attached Plan)
3. **Study** Evaluate the improvements that you have made	The 2020 NACCHO QI Self-Assessment Tool 2.0 will be compared to the baseline results (2019). Baseline 2019 Score: 4.4 Target 2020 Score: 5.0 Actual 2020 Score:
4. **Act** Consider next actions for further improvement	Improvement Goal(s) achieved? Barriers: Next Steps:

Customer Satisfaction – Cycle 2 – 7/1/2019	
Topic	Customer Satisfaction Survey Literacy
Improvement Goals	Implement a Customer Satisfaction Survey at a 6th grade reading level by October 1, 2019.

1. **Plan**	Problem: We don't know the level of literacy of our current customer satisfaction survey. Team: Michelle Perry, Mary Johnson, Josh Skopow, Deb Shreve, Tonya Fetzner, Sue Carlson Past Process: Staff creates survey questions without measuring level of literacy. Solution: Use a literacy tool to evaluate the level of literacy of the survey, and revise questions if needed. Training (if needed): n/a Timeframe: Utilize tool to evaluate (July). Revise questions and utilize tool again (July-August-September). Obtain approval from Health Equity Team and Performance Management Team (September). Distribute revised survey (October).
2. **Do**	First evaluation indicated the survey is between an 8th and 12th grade reading level. Questions were revised.
3. **Study**	Second evaluation indicates the revised survey is now at a 6th grade reading level.
4. **Act** Consider next actions for further improvement	Improvement Goal(s) achieved? Yes Barriers: Next Steps: Begin distribution of revised survey.

Visit Erie Partnership – Cycle 1 - 07/05/2019	
Topic	Building Strategic Partnerships in Tourism
Improvement Goals	Initiate a minimum of 2 education campaigns with Visit Erie partner organizations by July 31, 2020.

1. **Plan**	**Problem:** Consultant in 2015 mentioned Environmental division is most understood division in ECDH, and ECDH needs to be at the table as a partner and be seen as the 'go to' organization for environmental support for tourism activities. **Team:** Environmental Management **Past Process:** N/A **Solution:** Form a partnership with a local Tourism Corporation **Training (if needed):** N/A **Timeframe:** July 2019- July 2020 (1st Cycle)
2. **Do**	❖ July 3 – David George met with Visit Erie to discuss a potential partnership ➢ Items discussed included adding link to 2020 Guide, joining 'Hello Erie' mobile app by adding link to Beach Status Map. Adding link to website for beach Status ❖ July 18 – Conference Call with Visit Erie. They agree to les us join and waive the initiation fee. ➢ Chelsey makes Tiny URL to fit more easily on map ❖ July 23 – Submitted Application to Partner with Visit Erie ❖ July 30 – Link to beach map is on Visit Erie Mobile App and Website
3. **Study**	❖ See if we have more hits on our Beach Status Map ❖ Visit Erie has reported less calls because of easy access to map.
4. **Act**	Improvement Goal(s) achieved? Yes, a partnership was formed with a tourism group Barriers: Next Steps: 1) Partner with Best of Erie Visitors Guide 2) Add a section on Local Foods, Local Markets, and which restaurants source locally

Bus Ridership Data Tracking – Cycle # 1- 06/20/2019 (The **Cycle #** is in reference to the number of times a project has gone through the Plan-Do-Study-Act cycle)	
Topic	Tracking Bus Utilization Rates among ECDH clients
Improvement Goals	To be able to provide a robust data set of at least 6 months of bus utilization rate data among ECDH clients to EMTA.

1. **Plan**	Problem: Tracking Data Team: Health Equity Team Past Process: No Previous Process Solution: Add field to insight Training (if needed): Review of field usage with CHS staff Timeframe: 07/01/2019-09/01/2019
2. **Do**	Add a field to the user defined tab in insight sent the following communication to CHS staff: This morning during our Health Equity team meeting we took a few minutes to plot out the bus schedules so that clients who are utilizing our new bus stop can be scheduled conveniently. The below times are when the bus should be coming by the health department Route 31- 9:15, 10:35, 1:15, 2:35 Route 32- 8:35, 9:55, 1:55, 3:15 We also asked Dan to add a field in insight to track bus usage. When you are scheduling a client please ask if they plan on riding the bus. This allows us to track bus ridership and make our clients aware of our new bus stop. On the registration tab under user defined there is now a check box entitled "Bus," if bus is checked that indicates that the client will be using the bus if it is not checked then we will know that the client does not use the bus. This data is going to come in handy if EMTA tries to take our bus stop away for underutilization
3. **Study**	From 7/1 to 7/31 126 unique clients came into clinic 13 of them were asked about bus usage 10.31% of clinical clients were asked
4. **Act**	Improvement Goal(s) achieved? No Barriers: Sample Size is not robust enough; question is not being asked with consistency Next Steps: Place track-it asking for more intuitive insight field for bus utilization; track bus utilization via customer satisfaction survey in addition to insight

Appendix C
Summary of QI Project Examples

Project: Event: Participant – TDC Testing Stages 1-4 Rotation Flow Cycle 1 - 04/30/2019	
Topic	**T**een **D**riving **C**ompetition Event - Participant Testing Stages 1-4 Rotation Flow
Improvement Goals	SMART goal: To establish accurate and timely movement of four student groups, start to finish, for each of four testing rotations. Normalize variances and have all groups end at the same time – ultimately four groups will end all four testing stage rotations at the same time without interference with one another.

1. **Plan**	Problem: Given four testing stages, and four rotating groups, students historically failed to remain as a cohesive group and they became scattered throughout the process. Team: The four student groups are identified as group A, B, C, and D. Groups were expected to stay together and wait for a signal to rotate to next test area. Past Process: This process, comprised of different students each year, failed to provide the necessary discipline. Solution: Each group will be provided an adult leader that will be in communication with a unification command leader, who will signal when all groups are to move to the next stage. Training (if needed): The group leaders and command leader met together in a meeting that reviewed the problems and presented the steps to be taken. Timeframe: Meeting was one week before the event.
2. **Do** Record the strategies you have used to implement the plan	1.) At registration, on site, four groups were identified. 2.) A lanyard with the student's group letter on the front, and map for test rotation on the reverse side, were provided to each participant. 3.) Each group leader was dedicated to one group for the duration of the event. 4.) The command leader coordinated all group leaders to act simultaneously via cell phones.
3. **Study** Evaluate the improvements that you have made	The attainment of some improved control was evident. It was the consensus of our management team that the 2019 TDC event was the best containment we have experienced – keeping the groups focused and together. There were a few incidents of some students separated following the conclusion of their testing, but it was determined that their group leader was aware.
4. **Act** Consider next actions for further improvement	Improvement Goal(s) achieved? It was agreed by all team members and group leaders that this year was the best controlled. Most every test stage rotation was by the clock. A *survey* was prepared by Geof and distributed to the group leaders to have some literal and numerical measureable results. The 2020 survey will be discussed next year in advance to improve responses. ** The Survey/Questionnaire form is attached ** (separate email) Barriers: The need for consistency from all group leaders and team members requires the same people to return the next year. But personnel do change. Next Steps: Put this year's procedures in a document and start discussion with team members a month earlier.

- Quality Improvement Projects -

Baby and Me Tobacco Free Intake Process – Cycle #1 - 05/02/2018>network 9-6-18 (The **Cycle #** is in reference to the number of times a project has gone through the Plan-Do-Study-Act cycle)	
Topic	B.M.T.F. phone calls/self-referral to switchboard/intake
Improvement Goals	SMART goal: Connect caller quickly to a live person who can give them appropriate information & schedule 1st visit.

1. **Plan**	Problem: Need to avoid caller being bounced around before being serviced. Team: Alex Whipple, Joe DiSanto, Sue Henry, Carol Hennen, Julie Cole, Tonie Cline, Mary King, Niki Knopsnyder Past Process: Training over 1 year ago, with no follow-up discussions Solution: Create specific Policy & Procedure to follow Training (if needed): B.M.T.F. refresher training scheduled on 5-14-18. Timeframe: 3 months, i.e. 8-30-18
2. **Do**	Discussed with all staff trained in BMTF creating an algorhythm to be followed by switchboard, then clerical, then BMTF-trained counselors.
3. **Study**	Sue Henry & Carol Hennen created first draft; then had all above review for any recommended changes. Forwarded to supervisor/director for BMTF who made changes based on staffing adjustments.
4. **Act**	Improvement Goal(s) achieved? 10-19-18 At least 2 calls have been promptly forwarded to Sue Henry and Carol Hennen and appointments scheduled. Barriers: Next Steps: Continue to observe process for efficiency.

Appendix D
QI Culture Plan

Quality Culture Implementation Plan

Goal: Increase the ECDH QI Culture Assessment rating to a 5.0 by September 2020. The baseline QI Culture Assessment overall is currently 4.4 in 2019.

Timeline: September 2019 – September 2020

Plan Components:

Domains

Each month one PHAB Domain will be highlighted at ECDH staff meetings, Division staff meetings and in the Potty Press. The domain number will correlate with the number of the month. *These communications should connect the PHAB Domains to the real work staff are doing on a daily basis.*

Potty Press Articles – The domain lead/champion will complete a short article based on accreditation narratives that highlight staff work (see Appendix 1). An additional page holder will need placed in each restroom.

ECDH Staff Meeting Agendas – Department ~~Director~~ Lead/Champion will discuss the domain for each month during every ECDH staff meeting to help staff connect the domain to their daily work. [Melissa would like there to be dialogue with staff.]

Division Staff Meeting Agendas – Division Directors will discuss the domain for each month during every division staff meeting to help staff connect the domain to their daily work.

Storyboards

As staff complete QI projects at any level they will complete storyboards that will be showcased throughout the department. A template will be provided for basic components. This will allow staff to show the department how they relate accreditation to their jobs.

Words & Phrases

QI Team will develop a graphic each month that relates back to the month's domain. This will be posted throughout the building, and also electronically. [There should be a budget for supplies, such as laminating.]

Training

A budget is requested to provide routine QI training for all staff.

All Staff – Whole-house, broad QI training in January and July.

QI/PM Teams – In depth training in January and July to piggyback the whole-house training.

One-Day Retreat – Annually in August the department will close for one full day so that staff can engage in a retreat related to Reaccreditation and Quality Improvement activities.

- Columbus Day was suggested as the Library is closed and could be used as a venue.
- Staff should be part of planning this event.

Appendix E
QI Toolbox

Affinity Diagram: Brainstorm and organize ideas by commonalities

Aim Statement: Describe expected accomplishments in a written, measurable, and time-specific way

Brainstorming: Creatively and effectively generate a high volume of ideas, without judgment

Customer Identification: Determine the customer groups associated with products and services, and identify customer needs and measures.

Fishbone Diagram: Narrow down root causes to problems (also called Cause & Effect Diagram)

Flowchart: Identify the steps and sequence of events in a process, to minimize duplication, address problem areas, and standardize work

Focused Conversation: Enable individuals and groups to process their thoughts in an orderly manner

Gantt Chart: Schedule a project's activities to show the most efficient way of organizing/sequencing activities, to maximize output in the shortest reasonable time

Kano Model: The Kano Model helps prioritize customer needs and requirements by grouping them into three categories: Expected/Must Haves, Nice to Have/Normal, and Exciters/Delighters

Lean: Identify and eliminate waste and standardize work processes with this customer-focused process improvement methodology

Kaizen: Examine wait time, duplicative work, and other waste with this facilitated group effort; you can also map current process and desired future process, and create plans to move from one to the other

Logic Model: Illustrate how a project, program, or policy is understood and intended to produce particular results (also called Line of Sight Model)

Objectives: Ensure objectives are Specific, Measurable, Attainable,
Relevant, and Timely; and are tied to goals and benchmarks

Pareto Chart: Shows relative frequency or size of problems, to find those that offer the greatest potential for improvement

PDSA: Plan-Do-Study-Act: Improve process or carry out change with four-stage, iterative model (Also called Rapid Cycle Improvement or Plan-Do-Check-Act [PDCA])

Swim Lane Map: Map out processes, decisions, and loops to delineate who is responsible for parts of a process, and where redundancies occur (also called Process Flow Diagram)

Quality Planning: Design a process that can meet established goals under operating conditions

Storyboard: Highlight and present key aspects of a quality improvement effort by documenting the project from beginning to end

SWOT Diagram: (Strengths-Weaknesses-Opportunities-Threats) Analyze internal and external factors that might contribute to success, or negatively affect work

This list has been adapted from the Minnesota Department of Health webpage with additional resources available at https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/index.html