

Quality Improvement Plan

Benton County Public Health

Benton County Human Services, Public Health Unit
Implemented December 2014



Public Health
Prevent. Promote. Protect.

Benton County Human Services

Reviewed and Revised:

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Quality Improvement Plan

Benton County Human Services

Public Health Unit

Quality Improvement Plan

I. Purpose

To develop a Continuous Quality Improvement Committee, CQIC and a continuous quality improvement effort within Benton County Public Health.

This Quality Improvement Plan will align with the Benton County Public Health Strategic Plan and the local assessment and planning process. The mission and vision of the Benton County Public Health Unit will guide the design and implementation of the QI Plan.

II. Key Quality Terms

Community Health Improvement Plan (CHIP): A long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental, education and human service agencies, in collaboration with community partners, to set priorities and coordinate the target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way.

Continuous Quality Improvement (CQI): An intentional, ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities and outcomes. ¹

Continuous Quality Improvement Committee (CQIC): Team charged with primary responsibility of quality improvement in public health unit for direction of quality improvement efforts and projects.

Plan, Do, Study, Act (PDSA): A four step quality improvement method in which step one is to plan an improvement, step two is to implement the plan, step three is to measure and evaluate how well the outcomes meet the goals of the plan, and step four is to craft changes.

Quality Improvement Plan (QIP): Identified specific area of current operational performance for improvement. Strategic and QI 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.

SMART: Process of identification of S-specific, M-measurable, A-attainable, R-results-oriented, T-time bound objectives in quality improvement projects.

Strategic Planning: The process an organization uses of clarifying its mission and vision, defining its major goals and objectives, developing its long-term strategies for moving an organization.

III. Culture of QI

- A. Quality Improvement: A process that links knowledge, structures, and processes and outcomes to enhance quality throughout an organization.
- B. Vision: The Continuous Quality Improvement Committee (CQIC) will aid in implementing, maintaining and evaluating the CQI efforts at BCPH. The intent is to improve the level of performance of key processes and health outcomes in a systematic manner, utilizing the input and strengths of staff, leadership and the community.
- C. Goals: The CQIC goals in supporting this effort are:
 - 1. Identify, monitor, review and make recommendations on QI processes and efforts.
 - 2. Review the QI plan annually at minimum and make adjustments as required.
 - 3. Identify and meet QI training needs, support efforts to improve QI maturity score.
 - 4. Provide guidance, support, and resources for QI efforts.
 - 5. Recognize and acknowledge QI efforts.

IV. Structure

A. Continuous Quality Improvement Committee shall be comprised of interdisciplinary staff from PH. Ad hoc members will be added to the CQIC as necessary. Committee members will serve a two year term with a staggered rotation. The committee will meet on a regular basis and maintain records/minutes of all meetings. QI efforts will be centrally located for documentation and access by others in the F. drive.

1. Roles and Responsibilities

- Orientation of all staff to CQIC process, plan and resources.
 - Identifying staff QI training needs, providing access to training, and tracking attendance.
 - Facilitates CQIC meetings. Time spent in QI activities including time at meetings, working on projects or on reporting will be tracked in Nightingale Notes: Service “CQI” Cost center “Staff”.
 - Initiates problem solving processes and /or QI improvement projects.
 - Reporting to their supervisor, HHS director and/or appropriate entities their findings from their QI projects, state standard gaps and training without resources available.
 - Revising the QI plan based on findings from an annual review and QI projects.
- B. All employees are expected to continually look for ways to do their work better, share those ideas, contribute to the committee efforts and adapt to change.

V. Training

A. QI training will be provided to all BCPH staff in an effort to build the culture of CQI agency wide. At the end of the year, all training opportunities and employee participation will be reported in the annual report.

1. New employees

- One hour orientation with the CQIC.
- Online introductory course

2. Current employees

- Complete pertinent on-line trainings
- Hands on training via work on QI projects
- Organizational QI maturity 10 question subset
- Just-in-time trainings.

3. All employees

- Quality Improvement 101
- Trainings on PDSA
- QI tools (Affinity diagram, Fishbone, Interrelationship digraph, Radar charts).

VI. Project Identification and Alignment

QI projects will be selected based on need to improve program processes, objectives, and/or performance measures. Project proposals will have priority if data driven and if they are aligned with the department Strategic Plan, Community Health Improvement Plan, program strategic plans, program evaluations, customer satisfaction or cultural competency goals. The committee will also consider the availability of resources when determining the QI project.

The committee will utilize the QI project worksheet as a tool to guide the process (Attachment B).

A. QI Project Selection Criteria

Technical:

- Is it a process?
- Is the problem that is targeted for improvement clearly defined?
- Is the scope manageable?
- Can it be completed within the proposed timeframe?
- Can it be reliably measured?
- Is data available?

Strategic:

- Is it important? To whom?
- Does it align with one or more of the units plans?
- Does the project support the department mission, vision and values?
- Does it have a customer focus?
- Does the project have the potential to be replicated across programs or have an impact on other programs/activities?

Empowerment:

- Is it free from pre-conceived solutions?
- Is leadership prepared to implement?
- Is there probability of success?

VII. Goals, Objectives and Measures

The current goals were selected due to their direct correlation to advancing QI Maturity of staff in the Public Health unit. The CQIC will utilize SMART for all determination of objectives.

Organizational Goal: To Improve the QI culture in the organization

Organizational Objectives	Performance Measure
1. Raise the organizations QI Maturity score from a Low QI to Medium QI by 2016.	QI Maturity score
2. All Staff complete recommended trainings by 2015.	90% of staff completing recommended trainings.
3. Implement consistent customer satisfaction surveys throughout Public Health programs by 2015	100% of Public Health programs have implemented customer satisfaction surveys annually.

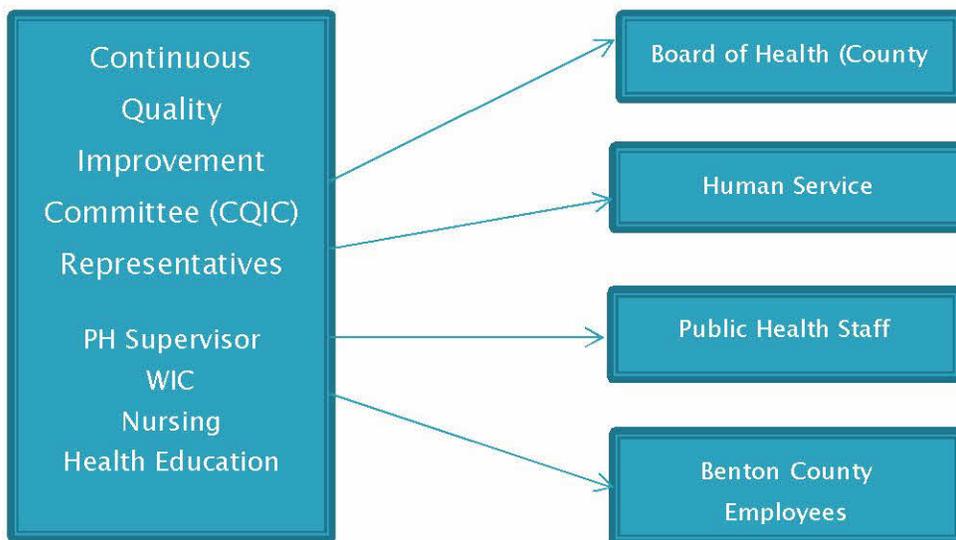
VIII. Monitoring the Plan and Assessing Effectiveness

The CQIC will assess staff QI maturity and progress on QI plan goals annually. The QI Maturity Assessment (See Attachment C) consists of a subset of 10 questions that represent the key domains of QI Maturity: Organizational Culture, Capacity & Competency, and Alignment & Spread. The assessment was sent by Survey Monkey in the fall of 2014, the response rate was 100% . Selected measures are shown below.

	Goal	Performance Measure	Data Source	2014	2015	Target
Organizational Culture	Staff members are routinely asked to contribute to decisions at my public health agency.	% of staff who agree	QI Maturity score	89%		95%
Capacity & Competency	My public health agency has a quality improvement plan.	% of staff who agree	QI Maturity score	11%		100%
Alignment & Spread	Customer satisfaction information is routinely used by many individuals responsible for programs and services.	% of staff who agree	QI Maturity score	0%		75%

IX. Communicating Quality Improvement Activities

The CQIC will communicate the QI Plan and QI activities in a variety of venues. An annual report shall be written summarizing the activities, process and outcomes. This report will be shared with the County Board and other appropriate entities, such as the HHS all staff meeting unit updates. CQIC will provide regular updates at staff meetings and on the County Blog at least quarterly.



X.

Attachment A:

CQIC Calendar

Month	Scope of CQIC meeting	Additional Activities
January		
February		
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Attachment B:

QI project worksheet

Program Area	Program Staff
Project Title	
Project Start Date:	
PLAN PHASE	
Describe the problem/situation	
Aim Statement (specific, measurable, achievable/action oriented, realistic, time sensitive)	
How will you measure improvement? What baseline data will you use?	
List potential improvement strategies	
Selected improvement strategy	

List process measures
List outcome measure(s)
DO PHASE
Test improvement strategy
STUDY PHASE
Study the results. What does the data indicate?
ACT PHASE
Describe the action you will take: 1. Adopt the change, or 2. Adapt the change and repeat the cycle, or 3. Abandon the project
Describe the key lessons learned

List any measures that will continue to be tracked, frequency and who will track the measures.

List the QI tools used for this project.

Project end date:

Attachment C:

Organizational QI Maturity

Ten-Question Subset

Quality Improvement (QI) Plan

The questions on this survey are drawn from a QI maturity survey developed to evaluate the Robert Wood Johnson Foundation [Multi-State Learning Collaborative \(MLC\)](#).¹ This select set of 10 questions was developed by the [Minnesota Public Health Research to Action Network](#) to represent the key domains of QI maturity.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	I don't know
Organizational Culture						
1. Staff members are routinely asked to contribute to decisions at my public health agency.	<input type="checkbox"/>					
2. When trying to facilitate change, staff has the authority to work within and across program boundaries.	<input type="checkbox"/>					
3. The key decision makers in my agency believe quality improvement is very important.	<input type="checkbox"/>					
4. My public health agency <i>currently</i> has a pervasive culture that focuses on continuous quality improvement.	<input type="checkbox"/>					
Capacity/Competency						
5. The leaders of my public health agency are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.	<input type="checkbox"/>					
6. My public health agency has a quality improvement plan.	<input type="checkbox"/>					
7. My public health agency <i>currently</i> has a high level of capacity to engage in quality improvement efforts.	<input type="checkbox"/>					
Alignment and Spread						
8. Job descriptions for many individuals responsible for programs and services at my public health agency include specific responsibilities related to measuring and improving quality.	<input type="checkbox"/>					
9. Customer satisfaction information is routinely used by many individuals responsible for programs and services in my public health agency.	<input type="checkbox"/>					
10. My public health agency <i>currently</i> has aligned our commitment to quality with most of our efforts, policies and plans.	<input type="checkbox"/>					

¹ Joly, B.M., Booth, M., Mittal P., & Shaler, G. Measuring quality improvement in public health: the development and psychometric testing of a QI Maturity Tool. *Eval Health Prof.*, 35(2):119-47.

For more information on this tool: www.health.state.mn.us/phap

QI PROJECT STORYBOARD

Benton County Public Health-Quality Improvement Summary

Program Area/Unit:

Project Title:

Team:

Project Start and End Dates:



PLAN

1. Describe the problem

2. Define the AIM

3. Identify Baseline Data

4. List Potential Improvement Strategies

5. Select Improvement Strategy

6. Develop process and outcome measures

DO

7. Test improvement strategy

STUDY

8. Study the Results

ACT

9. Adopt, Adapt or Abandon

10. Describe Lessons Learned

11. Identify on-going measures

