Quality Improvement Plan

Clermont County
Public Health

Prevent. Promote. Protect.

Quality Improvement Plan
Clermont County Public Health
Signature Page

This plan has been approved and adopted by the Clermont County Board of Health:

Clermont County Board of Health 09/09/2015

Quality Improvement Plan
Clermont County Public Health
Revision Page

Date	Section/Pages Revised	Responsible Staff
03/03/2016	Appendix A – Updated with 2016 QI Objectives Appendix C – Added name of person suggesting project to form Table of Contents - updated with page number changes	Julianne Nesbit
03/28/2017	Appendix A – Updated the 2017 QI Objectives	Julianne Nesbit

Quality Improvement Plan
Clermont County Public Health

Table of Contents

Clermont County Public Health is committed to the ongoing improvement of the quality of services provided. This Quality Improvement Plan serves as the foundation of this commitment.

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Purpose & Introduction

Executive summary

CCPH is dedicated to a culture of Quality Improvement. This plan is a part of CCPH's mission of "Striving to Improve Clermont County by Preventing Disease, Promoting Health, and Improving the Environment". The QI Plan is connected to the Clermont County Community Health Assessment, Clermont County Community Health Improvement Plan, CCPH Strategic Plan and the agency's Performance Management System. This plan outlines the status of quality improvement within the agency, roles and responsibilities of the Quality Improvement Committee, the quality improvement process used, quality goals and implementation, project selection, training, evaluation and monitoring, and communication. CCPH desires to reach a state where quality improvement is firmly rooted in the culture of the agency. The Clermont County Board of Health and CCPH Administration are dedicated to providing the resources necessary to fully implement this plan.

Mission, vision & values

Mission: Striving to improve Clermont County by preventing disease, promoting health, and protecting the environment.

Vision: Healthy People, Healthy Communities, Healthy Clermont.

Values:

Service – We believe in providing accessible, efficient, comprehensive services of exceptional quality.

Credibility – We believe in high standards of performance and adhering to principles.

Dependability – We believe in being honest, fair, and reliable in our intentions and actions.

Responsibility – We believe in being accountable for our decisions and actions, and taking ownership of our duties.

Respect – We believe in treating everyone with the same level of compassion and respect.

Ten essential services

Clermont County Public Health continuously strives to assure that the Ten Essential Services of Public Health are provided in our community:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health

problems.

5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Definitions & Acronyms

Introduction

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

Definitions

Continuous Quality Improvement (CQI): A systematic, department-wide approach for achieving measurable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of the processes or services provided; applies use of a formal process (PDSA, etc.) to "dissect" a problem, discover a root cause, implement a solution, measure success/failures, and/or sustain gains.

Plan, Do, Study, Act (PDSA, also known as Plan-Do-Check-Act, PDCA): 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 Assurance (QA): Guaranteeing that the quality of a product/service meets some predetermined standard.

Quality Improvement (QI): Raising the quality of a product/service to a higher standard.

Quality Improvement 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 (PHAB Acronyms and Glossary of Terms, 2009)

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)

Storyboard: Graphic representation of QI team's quality improvement journey. (Scamarcia-Tews, Heany, Jones, VanDerMoere & Madamala, 2012)

Acronyms

BOH – Board of Health
CCPH – Clermont County Public Health
CHA – Community Health Assessment
CHIP – Community Health Improvement Plan
CQI – Continuous Quality Improvement
QI – Quality Improvement
QIC – Quality Improvement Committee
WDP – Workforce Development Plan

Description of Quality in Agency

Introduction

This section provides a description of quality efforts in Clermont County Public Health, including structure, staffing, culture, processes, and linkages of quality efforts to other agency documents.

Description quality efforts

In 2011, Clermont County Public Health started down the path of Quality Improvement. While QI projects had previously been done in an effort to improve processes and systems, staff had no formal training or a defined process for conducting projects. CCPH received a grant from the Ohio Public Health Partnership in March 2011 to train key staff and identify and work through a QI project. This was the first formal QI project and focused on the lack of written Standard Operating Guidelines for the agency. Realizing the need for all staff to be trained in CQI, CCPH contracted with OSU Center for Public Health Practice to conduct onsite CQI training for all staff. In 2014, CCPH added the *OSU Center for Public Health Practice CQI for Public Health: The Fundamentals* training to the employee orientation requirements, ensuring all new employees are trained in CQI.

In 2009 CCPH staff started developing annual work plans in an effort to improve programs, divisions, and the agency as a whole. After 2011, staff was encouraged to take on larger group projects for work plans with several of those focusing on QI projects. Projects focused on WIC clinics, rabies processes between the Nursing Division and Environmental Health, and Employee Evaluations. However, much of the formal process and documentation that was used with the first project was not continued. CCPH is good with the first round of PDCA, but repeated follow up through the cycle is not always carried out.

The QI Committee has determined, in comparing CCPH's current status of QI with the *Roadmap to a Culture of Quality Improvement*, (NACCHO, 2012), that the agency is in Phase 3 which is defined as:

Phase 3: Informal or Ad Hoc QI

Executives and seniors leaders may value QI, but expectations are not consistently communicated to staff. Because some financial and human resources are dedicated to QI, a few staff have the knowledge, skills, abilities, resources, and support to lead small QI projects. Staff meet informally to solve problems and innovate, but opportunities for peer sharing are limited. Typically one or two staff are responsible for QI and performance management activities. While some performance data is collected, monitored, and shared, it is not used consistently for decision making. Staff may view QI as a passing fad or added responsibility.

CCPH desires to reach Phase 6 which is defined as:

Phase 6: QI Culture
Executives and senior leaders fully embrace quality and ensure the sustainability of the culture by maintaining necessary resources. Leadership turnover has minimal negative impact on the organizational culture. Performance management and QI are fully embedded into the way business is done at the individual, team, and organization levels. The use of formal and informal QI tools and methods to solve problems and create improvements is second nature to employees. Performance data drives all decision making across the organization. The organization is regarded as quality-driven and innovative. Employees are granted autonomy to fulfill their QI responsibilities. Staff understands how they contribute to the organization's overall mission, vision, and strategic plan.

CCPH is aware that this process will take time, dedicated staff and resources.

Links to other agency plans

The strategic priorities set forth in CCPH's Strategic Plan in conjunction with the Community Health Improvement Plan and Community Health Assessment provide a framework and direction for the activities of the QI Plan, which is a component of the overall performance management system. QI projects may be driven from objectives and strategies within the Strategic Plan and the Community Health Improvement Plan. Data within the Community Health Assessment may also drive agency or community QI projects.

Quality improvement management, roles & responsibilities

Quality Improvement Committee
The CCPH Quality Improvement Committee will consist of the Health Commissioner, Assistant Health Commissioner, two Division Directors or Supervisors, Epidemiologist, and four program/support staff members. All members are voting members. The QIC will meet at a minimum of quarterly and may meet more often as the group deems necessary to carry out the tasks of the QI Plan.

Annually the Health Commissioner will update the Board of Health on QI projects staff have completed and annually staff will present QI projects to all staff at the October annual In-service Day.

The Responsibilities of the QI Committee include:

- Champion QI efforts throughout agency
- Develop and revise/update the QI Plan annually
- Make recommendations for QI Projects based on identified priority areas in the Strategic Plan, Community Health Improvement Plan, Community Health Assessment, or other internal processes or systems that could benefit from being addressed as a QI Project

- Monitor QI projects, act to solve problems, review recommendations from QI projects for feasibility and assist in implementing quality improvements
- Assure adequate resources are devoted to QI initiatives including diverse and objective staff on QI Projects
- Monitor timelines and assure QI Projects are completed on time, unless documentation of extenuating circumstances is provided
- Assure that successful project outcomes become incorporated into CCPH Standard Operating Guidelines

Committee Member	Responsibility
Health Commissioner Appointment: Permanent	Provide direction and oversight for QI program Allocate resources for activities Report to Board annually Have staff report at In-Service Day Encourages incorporation of QI concepts into daily activities and work plans
Assistant Health Commissioner Appointment: Permanent	Ensure projects/plans meet PHAB requirements Meet Division Director Requirements below for Administration Division
Division Directors/ Supervisors (2) Appointment (1) : 2 year term Appointment (1) : 3 year term	Identify appropriate staff for QI teams Oversee QI efforts within division Assure QI-related performance and/or professional development goal for all division staff Encourage staff to incorporate QI efforts into daily work Facilitate QI teams as needed Provide administrative support to QIC on rotating basis
Epidemiologist Appointment: Permanent	Identify appropriate staff for QI teams Encourage staff to incorporate QI efforts into daily work Facilitate QI teams as needed Provide administrative support to QIC on rotating basis Provide input on overall evaluations measures Assist QI Teams with data collection/interpretation
Program/ Support Staff (4) Appointment (2) : 2 year term Appointment (2) : 3 year term	Identify appropriate staff for QI teams Encourage staff to incorporate QI efforts into daily work Facilitate QI teams as needed Provide administrative support to QIC on rotating basis

Members of the committee are selected on a volunteer basis. If more members volunteer than there are positions, then a lottery system will be used to determine the candidate. Terms for the Health Commissioner, Assistant Health Commissioner, and Epidemiologist are permanent. Terms for the Director/Supervisor staff and the Program Support/Staff will serve either a two year or three year term. This is to ensure institutional knowledge is retained but to allow others to become involved over time. Members can be re-elected to a position if there are no other candidates interested in serving on the committee.

The committee strives for consensus on all decisions and agrees to abide by majority vote in absence of consensus. The Health Commissioner will convene the first meeting of the QIC at which time a chair, vice chair, and secretary will be voted on. The chair will be responsible for setting meeting dates/times and agendas and moving the QIC team forward. The Vice Chair will be responsible for conducting meetings in the absence of the chair. The secretary will be responsible for taking meeting minutes and posting the minutes to SharePoint.

All staff within Clermont County Public Health will: participate in QI projects as requested, nominate QI projects, participate in QI training, and incorporate QI concepts into daily work.

QI Projects will be added to the quarterly All Hands Meeting agenda to provide updates on projects and lessons learned to all staff.

Each QI Project Team will report out on their project using a prescribed story board method at the annual In-Service Day.

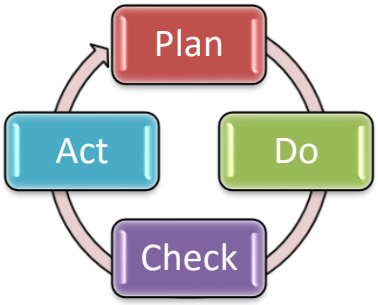
Quality improvement process

CCPH uses the Plan, Do, Check, Act, also known as the Deming cycle, methodology for QI efforts. This process has been in place since implementation of work plans. CCPH has several copies of the *Public Health Foundation Public Health Quality Improvement Encyclopedia* available for staff and team use in working through QI projects.

The four phases in the Plan-Do-Check-Act Cycle involve:

- **Plan:** Identifying and analyzing the problem.
- **Do:** Developing and testing a potential solution.
- **Check:** Measuring how effective the test solution was, and analyzing whether it could be improved in any way.
- **Act:** Implementing the improved solution fully.

These are shown in Figure 1 below.



There can be any number of iterations of the phases, as the solutions are refined, retested, re-refined and retested again.

How to Use the Tool

Step 1: Plan
First, identify your exact problem. Useful tools include Affinity Diagrams, Brainstorming, Cause and Effect Diagrams, Root Cause Analysis, and other data collection tools that can help identify the root of the problem. Once this is done, it may be appropriate to map the process. The final part of planning involves gathering additional information to start sketching out solutions.

Step 2: Do
This phase involves several activities:

- Generate possible solutions.
- Select the best of these solutions.
- Implement a pilot project on a small scale basis.

The *Public Health Foundation Public Health Quality Improvement Encyclopedia* has several tools that can be used to assist in generating ideas as well as commonly used tools for QI which can be found in Appendix A.

“Do" means "Try" or "Test". It does not mean "Implement fully." Full implementation happens in the "Act" phase.

Step 3: Check
In this phase, measure how effective the pilot solution has been, and gather any information from it that could make it better.

Depending on the success of the pilot, the number of areas for improvement identified, and the scope of the whole initiative, the phases may be repeated multiple times, incorporating additional improvements.

Step 4: Act
This phase is full implementation. However, the PDCA Cycle doesn't necessarily stop there. Other areas of improvement may need to be identified in the same process and the PDCA cycle repeated.

Quality Goals & Implementation

This section presents the overall goals and implementation plan for QI. The plan will be reviewed and objectives will be updated annually by the QIC. The Quality Goals and Implementation can be found in Appendix A.

Projects

Introduction

This section describes the process for QI project identification, selection, prioritization, and selection of team members. A brief description of the projects is included below. Additional information about current and past projects may be obtained from members of the QIC and past story boards will be stored in SharePoint.

Project selection

Potential projects are selected by the QIC. Priority will be based on the number of projects received, alignment with the agency mission, vision, values and Strategic Plan objectives, feasibility of the project, complexity of the project, available resources for the project, availability of data for the project and the potential internal and external impact the project may have. Additional consideration will be taken in regards to one project coming from a program area (non-clinical) and one coming from the administration area to meet PHAB documentation requirements. Sources of potential projects include internal and external customer feedback, program evaluations, after-action reviews, performance as related to PHAB standards and measures, the Clermont County Community Health Assessment, the Clermont County Community Health Improvement Plan, the CCPH agency Strategic Plan, audit or compliance issues, or project recommendations from the Board of Health.

Any staff member may recommend a project to the QIC for consideration at any time on the QI Project Recommendation Form (Appendix C). Additionally, project recommendations may be made by the QIC. Recommendations for team members can be made on the QI Project Recommendation Form; however, the QIC will appoint members to the teams to ensure diverse perspectives, subject matter expertise, and that resources are available to ensure team success. Teams will consist of three to seven members and represent affected programs, divisions, disciplines, and clients as needed.

Current projects

Current projects are listed under quality goals and implementation.

Training

Introduction

Clermont County Public Health has incorporated QI training goals and objectives within the agency Workforce Development Plan. The WFD Plan includes goals, objectives, training descriptions, target audience, competencies addressed, resources/sources of training, and training schedules.

Training and support

CCPH received a grant from the Ohio Public Health Partnership in March 2011 to train key staff in CQI. Realizing the need for all staff to be trained in CQI, CCPH contracted with OSU Center for Public Health Practice to conduct onsite CQI training for all staff. In 2014, CCPH added the *OSU Center for Public Health Practice CQI for Public Health: The Fundamentals* training to the employee orientation requirements, ensuring all new employees are trained in CQI.

All QIC Members and QI Project Team Captains must also take *the OSU Center for Public Health Practice CQI for Public Health: Tool Time*, unless they have already taken more advanced QI training.

A review of QI concepts for all staff will occur annually during an employee in-service day.

Evaluation and Monitoring

Introduction

This section describes the evaluation and monitoring for the QI Plan and projects.

QI plan

This QI Plan will be reviewed and evaluated by the QIC by October of each year. Evaluation will occur at a regularly scheduled meeting with discussion around:

- effectiveness of meetings,
- effectiveness of the QI Plan in overseeing quality projects and integration within the agency,
- clarity of the QI Plan and its associated documents,
- lessons learned,
- progress toward and/achievement of goals as outlined in the Goals, Objectives and Implementation section, and
- review of QI Team evaluations (see below).

Meeting minutes will document the evaluation process and note any agreed upon changes. Goals will be revised and corrective actions and revisions will be made after this annual review.

QI teams

QI Teams will provide project progress reports to the QI Council at each meeting. All teams will develop and submit project storyboards at the conclusion of the project and present on the projects at the annual In-Service day. Within one meeting 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 agency QI efforts.

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 CCPH Employees

QI Projects will be presented at the annual In-Service day. QI Teams will present their story boards and include lessons learned. Additionally, staff will be briefed about QI projects at quarterly All Hands Meetings. All QI Story Boards will be maintained on SharePoint.

Board of Health

Board of Health members will also receive an annual update on quality initiatives.

Public

Project descriptions and results will be included in the annual report to the public.

Other

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

References and Resources

The following is a list of resources CCPH staff and the QIC may use in conducting QI projects:

American Society for Quality http://asq.org
A membership organization whose mission is: *to increase the use and impact of quality in response to the diverse needs of the world.* Training, resources, certifications, and learning communities.

Association of State and Territorial Health Officials
http://www.astho.org
Membership organization for state health officials. Resources, links to QI and performance management tools.

Center for Public Health Practice, The Ohio State University College of Public Health
http://cph.osu.edu/practice
Live and online competency-based training and other organizational development resources.
https://www.cphplearn.org/
Learning content management system; searchable catalog.

Center for Public Health Quality http://www.centerforpublichealthquality.org/
A new, national resource with training, toolkits, consultation, and technical assistance.

Centers for Disease Control and Prevention
http://www.cdc.gov/stltpublichealth/performance/
Concepts, resources, and links about quality improvement and performance management.

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 http://mphiaccredandqi.org/Guidebook.aspx
Practitioners Quality Improvement Guidebook.
http://mphiaccredandqi.org/PMQITraining/Login.aspx
Performance Management/QI online course.

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/toolbox/program.cfm?id=25
Searchable QI literature, templates, examples, etc.
http://qiroadmap.org/
Roadmap to a Culture of Quality Improvement.

National Network of Public Health Institutes (NNPHI)
www.nnphi.org/api
Accreditation and performance improvement resources.

www.nnphi.org/npjpsp/resources
Public health improvement webinars and training.
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 Minnesota http://www.sph.umn.edu/programs/certificate/piph/
Public Health Certificate in Performance Improvement.

List of Appendices

The following documents are included as appendices to this plan:

Appendix A: Quality Goals and Implementation
Appendix B: Commonly Used QI Tools
Appendix C: QI Project Recommendation Form
Appendix D: QI Workbook

Appendix A: Quality Goals and Implementation

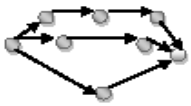
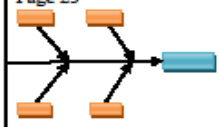
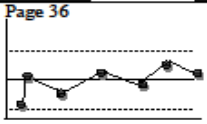
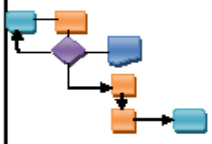
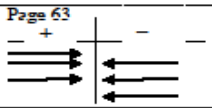
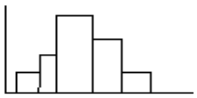
Goal	Measure	Timeframe	Person Responsible
Annually, support a minimum of 2 quality improvement projects.	Team documentation; storyboards	annually	QIC; respective team members
Assure all new employees receive basic QI training	Documentation of Training	annually	QIC
Annually, review and update the QI Plan	Plan revision documented	annually	QIC
By October 1, 2016, all position descriptions will include expectations for involvement in QI, including training and team participation.	Position descriptions with expectations; documentation of training and project participation	10/01/2016	Health Commissioner, Division Directors, Supervisors
Project #1: By January 31st annually, an immunization clinic plan will be developed by all staff involved in immunization clinics and approved by the Health Commissioner for the year to include immunizations for school aged children, seasonal influenza, international travel, and regularly scheduled clinics.	Team documentation; story board	July 2015 – October 2016	Team Leaders: Julianne Nesbit, Health Commissioner; and Angela Lipps, Immunization Nurse. Team Members: Denise Franer, Preventive Nurse; Carol Kisner, Nursing Administrative Assistant; Linda Fultz, Immunization Clerk II; Lindsay Jones Immunization Clerk I
Project #2: Evaluate Communicable Disease Protocol and set Program Standards for Quality Assurance By October 1, 2016.	Team documentation; story board	July 2015 – October 2016	Team Leader: Julianne Nesbit, Health Commissioner. Team Members: Angela Lipps, Immunization Nurse; Jan Napier, Communicable Disease Nurse; Tim Kelly, Assistant Health Commissioner; Jackie Lindner, Director of Nursing; Denise Franer, Preventive Nurse
Project #3: Improve the Hiring/Recruiting Process by October 1, 2016.	Team documentation; story board	January 2016 – October 2016	Team Leader: Trina Stapleton, Fiscal Officer. Team Members: Amanda Myers, Operations Manager; Robert Wildey, Director of Water & Waste; Jackie Lindner, Director of Nursing; Liza Armstrong, Breastfeeding Peer; Jan Napier, Communicable Disease Nurse

Project #4: Improve New Employee Orientation by October 1, 2016.	Team documentation; story board	January 2016 – October 2016	Team Leader: Amanda Myers, Operations Manager. Team Members: Trina Stapleton, Fiscal Officer; Carol Kisner, Nursing Administrative Assistant; Kelly Shepherd, Plumbing Inspector; Christian Jent, WIC Clerk; Doug Disbennett, SIT Water & Waste; Katie Bissler, SIT Environmental Health; Stephanie Humphries, Dietician.
Project #5: Evaluate Inventory Management Requirements and Potential Software Solutions by October 1, 2016.	Team documentation; story board	January 2016 – October 2016	Team Leader: Maalinii Vijayan, Emergency Response Coordinator. Team Members: Tim Kelly, Asst. Health Commissioner; Jackie Lindner, Director of Nursing; Betty Fitzpatrick, Clerk; Ashley Bonar, Clerk; Carol Kisner, Administrative Assistant.
Project #6: Evaluate and Improve the Call-In Inspection Process for Water and Waste and Plumbing by October 1, 2016.	Team documentation; story board	January 2016 – October 2016	Team Leader: Kevin Jester, Director of Plumbing. Team Members: Tom Racke, RS Water and Waste; Erica Watson, Clerk; Julia Richmond, Clerk; Kevin Kinzbach, Plumbing inspector
By October 12, 2016 present on Quality Improvement Projects at Staff In-Service Day.	Presentations conducted	October 10, 2016	Project Leaders
2017 Project #1: Evaluate and Improve the Public Health Complaint Process by October 1, 2017.	Team documentation; story board	January 2017 – October 2017	Team Leader: Sidney Spurlock, ERC. Team Members: Julianne Nesbit, Health Commissioner; Tim Kelly, Assistant Health Commissioner; Robert Wildey, Director of Water & Waste; Tyler Braasch, SIT; Julie Richmond, Clerk; Kelly Shepherd, Plumbing Inspector; Amanda Myers, Operations Manager; Doug Disbennett, RS; Maalinii Vijayan, Director of Environmental Health
2017 Project #2: Evaluate and Improve Employee Retention by October 1, 2017.	Team documentation; story board	January 2017 – October 2017	Team Leader: Katrina Stapleton, Fiscal Officer. Team Members: Julianne Nesbit, Health Commissioner; Tim Kelly, Asst. Health Commissioner; Amanda Myers, Operations Manager; Keith Robinson, Communications Coordinator; Katie Bissler, RS; Jackie Lindner, Director of Nursing; Tara Wilson, Epidemiologist; Katherine Schneider, WIC Director; Becky Bilby WIC Dietitian.

2017 Project #3: Review return on investment of Nursing Services and develop decision making tool by October 1, 2017.	Team documentation; story board	January 2017 – October 2017	Team Leader: Angela Lipps, Nurse Supervisor. Team Members: Julianne Nesbit, Health Commissioner: Jackie Lindner, Director of Nursing; Carol Kisner, Administrative Assistant; Denise Franer, Preventive Nurse; Katrina Stapleton, Fiscal officer; Tara Wilson, Epidemiologist; Tim Kelly, Assistant Health Commissioner; Linda Fultz, Immunization Clerk.
2017 Project #4: Evaluate and Reduce Cost of FSO/RFE Plan Review by October 1, 2017.	Team documentation; story board	January 2017 – October 2017	Team Leader: Maalinii Vijayan, Director of Environmental Health. Team Members: Scott Bradley, RS; Dan Warren, RS; Katie Bissler, RS; Sidney Spurlock, RS; Mackenzie Dickman, RS.
By October 9, 2017 present on Quality Improvement Projects at Staff In-Service Day.	Presentations conducted	October 9, 2017	Project Leaders

Appendix B: Commonly Used QI Tools

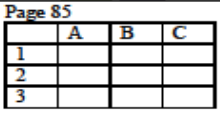
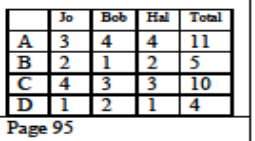
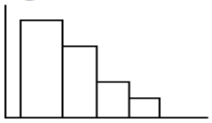
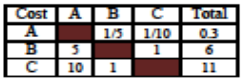
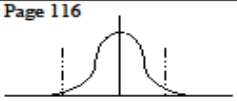
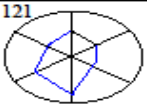
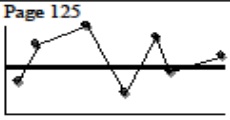
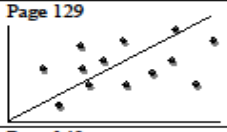
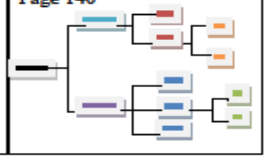
Quality Improvement (QI) Toolbox

QI Tool	*What the Tool Does*	*Public Health Memory Jogger II*
Activity Network Diagram/ Gantt Chart	Used to: Schedule sequential and simultaneous tasks • Gives team members the chance to show what their piece of the plan requires and helps team members see why they are critical to the success of the project. • Helps teams focus its attention and scare resources on critical tasks.	Page 3 
Affinity Diagram	Used to: Gather and group ideas • Encourages team member creativity by breaking down communication barriers. • Encourages ownership of results and helps overcome "team paralysis" due to an array of options and a lack of consensus.	Page 12 
Brainstorming	Used to: Create bigger and better ideas • Encourages open thinking and gets all team members involved and enthusiastic. • Allows team members to build on each other's creativity while staying focused on the task at hand.	Page 19 
Cause and Effect/Fishbone Diagram	Used to: Find and cure causes, not symptoms • Enables a team to focus on the content of the problem, not the problem's history or differing personal issues of team members. • Creates a snapshot of the collective knowledge and consensus of a team around a problem. • Focuses the team on causes, not symptoms.	Page 23 
Check Sheet	Used to: Count and accumulate data • Creates easy-to-understand data ~ makes patterns in the data become more obvious. • Builds a clearer picture of "the facts", as opposed to opinions of each team member, through observation.	Page 31 
Control Charts	Used to: Recognize sources of variation • Serves as a tool for detecting and monitoring process variation. Provides a common language for discussing process performance. • Helps improve a process to perform with higher quality, lower cost, and higher effective capacity.	Page 36 
Data Points	Used to: Turn data into information • Determines what type of data you have • Determines what type of data is needed	Page 52 
Flowchart	Used to: Illustrate a picture of the process • Allows the team to come to agreement on the steps of the process. Can serve as a training aid. • Shows unexpected complexity and problem areas. Also shows where simplification and standardization may be possible. • Helps the team compare and contrast the actual versus the ideal flow of a process to help identify improvement opportunities.	Page 56 
Force Field Analysis	Used to: Identify positives and negatives of change • Presents the "positives" and "negatives" of a situation so they are easily compared. • Forces people to think together about all aspects of making the desired change as a permanent one.	Page 63 
Histogram	Used to: Identify process centering, spread, and shape • Displays large amounts of data by showing the frequency of occurrences. • Provides useful information for predicting future performance. • Helps indicate there has been a change in the process. • Illustrates quickly the underlying distribution of the data.	Page 66 

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

Appendix B: Commonly Used QI Tools, *continued*

Quality Improvement (QI) Toolbox

Interrelationship Digraph	Used to: Look for drivers and outcomes • Encourages team members to think in multiple directions rather than linearly. • Explores the cause and effect relationships among all the issues. • Allows a team to identify root cause(s) even when credible data doesn't exist.	Page 76 
Matrix Diagram	Used to: Find relationships • Makes patterns of responsibilities visible and clear so that there is even distribution of tasks. • Helps a team come to consensus on small decisions, enhancing the quality and support for the final decision.	Page 85 
Nominal Group Technique	Used to: Rank for consensus • Allows every team member to rank issues without being pressured by others. • Makes a team's consensus visible. • Puts quiet team members on an equal footing with more dominant members.	Page 91 
Pareto Chart	Used to: Focus on key problems • Helps teams focus on those causes that will have the greatest impact if solved. (Based on the Pareto principle ~ 20 % of the sources cause 80% of any problem.) • Progress is measured in a highly visible format that provides incentive to push on for more improvement.	Page 95 
Prioritization Matrices	Used to: Weigh your options • Forces a team to focus on the best thing(s) to do and not everything they could do. • Increases the chance of follow-through because consensus is sought at each step in the process (from criteria to conclusions)	Page 105 
Process Capability	Used to: Measure conformance to customer requirements • Helps a team answer the question "Is the process capable?' • Helps to determine if there has been a change in the process.	Page 116 
Radar Chart	Used to: Rate organization performance • Makes concentrations of strengths and weaknesses visible. • Clearly defines full performance in each category. • Captures the different perceptions of all the team members about organization performance.	Page 121 
Run Chart	Used to: Track trends • Monitors the performance of one or more processes over time to detect trends, shifts, or cycles. • Allows a team to compare a performance measure before and after implementation of a solution to measure its impact.	Page 125 
Scatter Diagram	Used to: Measure relationships between variables • Supplies the data to confirm a hypothesis that two variables are related. • Provides a follow-up to a Cause & Effect Diagram to find out if there is more than just a consensus connection between causes and the effect.	Page 129 
Tree Diagram	Used to: Map the tasks for implementation • Allows all participants (and reviewers outside the team) to check all of the logical links and completeness at every level of plan detail. • Reveals the real level of complexity involved in the achievement of any goal, making potentially overwhelming projects manageable, as well as uncovering unknown complexity.	Page 140 

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

Appendix C: QI Project Recommendation Form

Proposed QI Project Recommendation:					
Person Suggesting Project:					
Does the Project comply with CCPH Mission:	☐ Yes ☐ No Striving to improve Clermont County by preventing disease, promoting health, and protecting the environment.				
Do you already have the solution to the problem?	☐ Yes ☐ No If Yes, briefly describe_____ _____				
Who is impacted by the problem/solution?					
What data are available to measure QI changes?					
Suggested Team Leader:					
Suggested Team members:	**name**				
Lines below are for QIC Team Review:	All categories will be given a 1-5 numbered ranking with 5 being the Most or Highest and 1 being the Least or Lowest. Scores are only used as a guideline in selecting projects; project selection is at the discretion of the QIC.				
Alignment with the mission and vision	☐1	☐2	☐3	☐4	☐5
Alignment with Strategic Plan	☐1	☐2	☐3	☐4	☐5
Feasibility	☐1	☐2	☐3	☐4	☐5
Complexity	☐1	☐2	☐3	☐4	☐5
Resources	☐1	☐2	☐3	☐4	☐5
Internal impact	☐1	☐2	☐3	☐4	☐5
External impact	☐1	☐2	☐3	☐4	☐5
Total:					

Appendix D: QI Workbook

The QI Workbook is a Separate Document that can be found in SharePoint