Quality Improvement
and
Performance Management Plan

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Kane County Health Department

Signature Page

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12/22/2022

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1. Purpose, Vision, and Mission

PHAB related guidance: 9.1.2 - Establish a process that guides health department quality improvement efforts across the department

1.1. Purpose

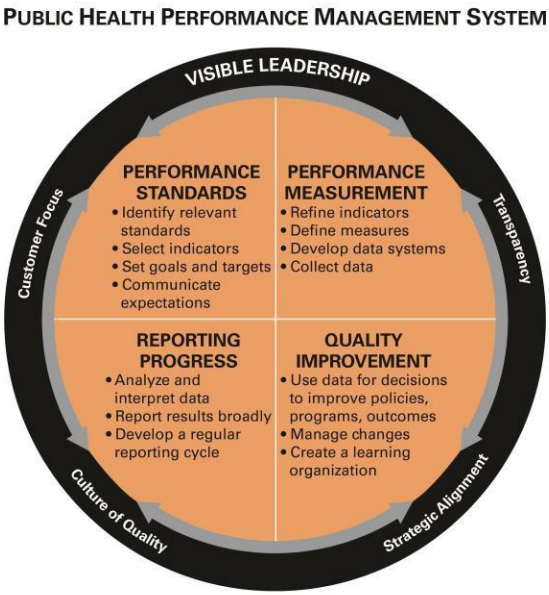
The purpose of the Kane County Health Department (KCHD) Quality Improvement & Performance Management Plan is to provide context and framework for quality improvement (QI) and performance management (PM) activities. KCHD utilizes the Turning Point Performance Management Framework, as described in Figure 1 provided by Public Health Foundation (PHF, 2018).

The QI/PM Plan provides the structure that supports the following:

1. Build an organization quality culture emphasizing customer-focused, equity-minded, and evidence-based practice, and continuous quality improvement.
2. Define and monitor KCHD performance measures.
3. Sustain and gain improvement with leadership, staff competence and skills.
4. Review selected programs evaluations and make recommendations for improvements.
5. Review after-action reports and make recommendations to the appropriate managers/leads.
6. Review recommendations for improvement from the national Public Health Accreditation Board (PHAB) accreditation process and ensure that appropriate recommended policy and process changes are implemented.
7. Review, evaluate and revise the QI plan every three years.

Figure 1

Performance Management Core Elements



Vision
KCHD shall have a culture where QI is embedded into the way the agency does business across the organization. Leadership and staff shall be committed to the quality and outcomes of QI efforts internally and externally.

Mission
Develop and implement a QI system that will integrate all programs and operational aspects of the organization.

2. Culture of Quality

PHAB related guidance: 9.1 – Build and foster a culture of quality.

2.1. Background and Concepts

2.1.1. Definition of Quality Improvement
"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, *et alli*, 2010).

Each year, goals, strategies and tactics will be developed by the QI committee to plan activities for the year. Plans are developed using the evidence-based transition strategies, or foundational elements, listed by the National Association of County and City Health Officials (NACCHO) Roadmap to a Culture of Quality Improvement (NACCHO, 2020). Implementing and advancing quality efforts at KCHD is based on these 6 elements of QI Culture:

1. **Leadership Commitment**
   Leadership is responsible for initiating and leading the process towards a culture of quality by dedicating resources to QI, communicating progress, defining clear expectations, and exhibiting visible support for QI.
2. **Employee Empowerment**
   Staff should be empowered by the assurance of necessary awareness, knowledge, skills, and support to allow incorporation of QI in daily work.
3. **QI Infrastructure**
   Systems and structure must be in place to support QI, and must be aligned with KCHD's mission, vision, and strategic plan. The main components of KCHD's infrastructure are the QI-PM Committee, the Performance Management System, and the QI Plan.
4. **Customer Focus**
   Customer Focus is at the core of quality, which means that understanding and meeting the community needs is a key component of programs and services provided by the KCHD.
5. **Teamwork and Collaboration**
   Performance expectations that are clear allow teams to jointly solve problems, implement QI projects, and collaboratively improve processes and find innovative solution.
6. **Continuous Quality Improvement**
   The ongoing quality effort aims at countering the notion of perfection, by implementing gradual improvement in processes to reduce waste and variation, with the purpose of increasing customer satisfaction. This is generally accomplished by using successive cycles of Plan-Do-Check-Act (PDCA).

The QI Roadmap identifies six progressive phases of QI integration into organizational culture, shown in table 1.

Table 1
Phases of QI Culture *(adapted from NACCHO QI Roadmap).*

Phases of QI Culture		
Phase 1	**No knowledge of QI**	QI is a passing phase, not relevant to PH practice; decisions not driven by data, customer satisfaction not a priority; process tend to be ineffective and inefficient.
Phase 2	**No QI Activity**	No time to implement QI, fear of blaming, anxiety due to limited QI knowledge, reactive improvements only.
Phase 3	**Informal or *ad hoc* QI**	Some data is collected, monitored, and shared, but not used consistently for decision making; few staff actually engaged in QI activities;
Phase 4	**Formal QI in some areas**	Existence of teams that lead QI projects; performance monitoring in some areas are linked to strategic plan; organization has a QI plan, but results of QI project are not always documented and shared; leaders manage resistance from staff.
Phase 5	**Formal agency-wide QI**	Staff and leadership committed to QI; QI incorporated in job descriptions; QI team meets on a regular basis; performance measures linked to strategic goals; existence of a centralized performance management system; decision making is driven by data.
Phase 6	**Culture of quality**	Leadership fully embrace QI; QI embedded at individual, team and organizational levels; staff has autonomy for QI responsibilities; staff understand how they contribute to the organization's mission, vision, and strategic plan.

The QI Roadmap provides guidance on progressing through the six phases. Organizational characteristics and transition strategies, categorized by the six foundational elements, are provided for each phase on the continuum to creating a culture of QI.

2.1.2. Steps to creating a culture of quality

- **Assess the culture of quality:** The KCHD leadership must assess the culture of quality in the department at least every three years, prior to revision of the QI-PM Plan. The assessment will be done using a validated assessment tool, such as the *NACCHO Organizational Culture of Quality Self-Assessment Tool Version 2*. This assessment tool is based on the six foundational elements identified in the QI Roadmap. KCHD might also opt to do an informal, high-level assessment by walking through the phases of QI Culture described above, prior to a formal assessment.
- **Plan for improvements:** Based on this assessment, and the phase of the QI Roadmap that the department is currently in, corresponding transition strategies will be identified with the goal of transitioning the KCHD to the next phase. The results of the assessment will be documented and the information will be utilized in the annual QI planning process.
- **Reassess:** Reassessment will be conducted using a simplified assessment tool annually, except on the years when the NACCHO Self-Assessment Tool is utilized. Assessment results will be compared to the previous years to determine whether improvement strategies are effective, and what further strategies are needed.
- **Manage change:** In order to successfully implement changes needed for improvement, attention will be devoted to both the process and the human aspects of change. Managing process change refers to working on the activities required to achieving a desired state, while managing human change is related to providing support and training to the people impacted by the change.

3. Key Quality Terms

PHAB related guidance: 9.1.2a – List and description of key quality terms.
To provide a common vocabulary and a clear, consistent message, the following key quality terms are defined below.

Continuous Quality Improvement (CQI): An ongoing effort to increase an agency's approach to manage performance, motivate improvement, and capture lessons learned in areas that may or may not be measured as part of accreditation. In addition, CQI is an ongoing effort to improve the efficiency, effectiveness, quality, and performance of services, processes, capacities, and outcomes. These efforts seek "incremental" improvement over time or "breakthrough" all at once. Among the most widely used tools for continuous improvement is a four-step quality model, the Plan-Do-Check-Act (PDCA) cycle (Public Health Accreditation Board [PHAB] Acronyms and Glossary of Terms, 2009).

Data and Quality Coordinator (DQC): Position created at KCHD in 2010, which is responsible for promoting individual and population health by leading public health informatics and quality improvement initiatives across all units in the Organization.

Health Equity: "Health equity is the realization by people of the highest attainable level of health. Achieving health equity requires valuing all individuals and populations equally, and entails focused and ongoing societal efforts to address avoidable inequalities by ensuring the conditions for optimal health for all groups" (Adewale Troutman).

Performance Improvement: The positive change in public health capacity, processes, or outcomes using clear and aligned planning, monitoring, and improvement activities **(**Measuring What Matters, NACCHO, 2018).

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

Performance Management System: Process of aligning multiple layers of performance assessment, planning, and improvement efforts. Without an effective PM system, organizations might find their performance improvement efforts disconnected (Measuring What Matters, NACCHO, 2018).

Performance Management Dashboard: A visual representation of the performance data being collected. The Dashboard is organized according to the Division that is measuring and tracking the data.

Performance Measurement: Use of quantitative metrics and indicators to collect data and track progress against strategy, goals, and objectives (Turning Point, 2003).

Performance Measures: Quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator (Turning Point, 2003).

Plan Do Check Act (PDCA) or Plan Do Study Act (PDSA): 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).

Public Health Accreditation Board (PHAB): A non-profit organization designated to oversee national public health department accreditation, based on a set of standards and measures for promoting a systematic approach for public health improvement.

Public Health Performance Improvement Network (phPIN): part of the National Network of Public Health Institutes (NNPHI), it is a learning community and peer exchange network committed to provide guidance in performance improvement in public health.

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

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

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

Quality Planning: A systematic process that translates quality policy into measurable objectives and requirements and lays down a sequence of steps for realizing them within a specified time frame. Quality planning is used in situations where a process does not yet exist, or a process needs a complete redesign.

Quality Improvement Tools (QI Tools): Tools designed to assist a team when solving a defined problem or project. Tools will help the team get a better understanding of a problem or process they are investigating or analyzing (The Public Health QI Handbook, Bialek et al, 2009). Tools used by KCHD are outlined in the Public Health Memory Jogger (Public Health Foundation, 2007), the Public Health QI Handbook, and the Public Health Quality Improvement Encyclopedia (Public Health Foundation, 2012).

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

4. QI Structure at KCHD

PHAB related guidance: 9.1.2b – Key elements of the QI structure, which must minimally include a description of roles and responsibilities for the QI plan's implementation.

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

Kane County Health Advisory Committee: The Kane County Health Advisory Committee will support the QI/PM efforts of the agency, providing consultation and feedback to KCHD staff regarding QI/PM efforts. The committee will inform the Kane County Board about QI/PM and make recommendations on policy change.

Kane County Public Health Committee: The Kane County Public Health Committee will support to the QI/PM efforts of the agency, providing consultation and feedback to KCHD staff regarding QI/PM efforts, and informing the Kane County Board about QI/PM and making recommendations on policy change.

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

QI Committee (QIC): The QI Committee will ensure the carrying out of QI efforts and activities, which include development and evaluation of an annual Quality Improvement Plan, meeting PHAB accreditation standards relative to QI, provision of QI updates to appropriate Section/Division, and support the work of department improvement projects. Committee members will plan and participate in QI training activities, and become skilled in the implementation of QI tools. Committee members will serve as section-level support to the KCHD Leadership Team in implementing, monitoring and evaluating the performance management system.

> ***Membership and Rotation***: The QI Committee will have a minimum of two members from each Division of KCHD (one leadership and one general staff), and the Data and Quality Coordinator (DQC). The membership term will be of two years unless otherwise decided by Division/Section leadership. The DQC will always be a member of the committee, serving as its facilitator. Additional members can be included at the discretion of the QIC.

Roles and Responsibilities: See Appendix B.

Staff and Administrative Support: The DQC position is specifically tasked with the development, implementation, evaluation, and coordination of all QI/PM activities within KCHD, involving 60-75% of the full-time equivalent (FTE) position. This position is a part of the Division of Community Health Resources and may be tasked for administrative support as needed. Additional staffing and/or administrative support may be provided by various positions based on operational needs.

Budget and Resources Allocation: Kane County Health Department dedicates a full-time position to the quality improvement process with a Data and Quality Coordinator, which is funded annually. Resources are identified

annually and incorporated into the next fiscal year during the budget process. Budget line items may be dedicated to QI/PM efforts, including the purchase of training materials, attendance to conferences, and securing services of expert consultation in the areas of QI and PM. Additionally, the KCHD Grants Management Specialist will actively seek awards for quality improvement related activities. Future planning will include analysis of cost, return on investment of implementation of quality improvement projects, and a more in-depth understanding of budget allocation specific to QI for staff members, members of the QI Committee, and the Leadership team.

5. QI Training

PHAB related guidance: 9.1.2c – Description of QI learning opportunities offered to all levels of department staff.

5.1. Required QI training for all staff

All newly hired KCHD staff (and interns as recommended by their immediate supervisors) are required to complete the basic QI training curriculum described below within 90 days of hiring, and the required additional training within one year from hiring date. Newly hired and current staff will be informed on the location of QI and PM materials and will be given time to review the materials and complete related worksheets to obtain a course completion certificate. Completed worksheets or certificates will be sent electronically or by internal mail to the Data & Quality Coordinator and to the Workforce Development Specialist for tracking purposes. Members of the QI Committee, KCHD leadership, and front-line staff are expected to have high-level QI capabilities. Training will be provided on QI/PM methodology.

Table 1
QI training requirements at KCHD

Basic Trainings *(required within 90 days from hiring)*	**QI-PM 101 Orientation**	Virtual, instructor-led training
	CQI for Public Health: The Fundamentals (Ohio State University)	Online training
	PHAB Orientation	Presentation in S Drive
	Basic QI Tools	• SMART Planning • Cause & Effect (Fishbone) Diagram • Data Collection & Analysis • Flowcharts • SWOT Analysis • Gantt Chart
Advanced Trainings *(required within 1 year from hiring)*	**Advanced QI Tools**	• PDCA • Brainstorming & Affinity Diagrams • 5 Whys & 5 Hows • Force Field Analysis • Prioritization Matrix • Storyboards • Voice of the Customer

Training Topics:

- Principles of QI
- Orientation to the QI/PM plan
- Performance Management
- Plan-Do-Check-Act Cycle
- QI Tools
- Accreditation/PHAB

5.2. Resources for QI Tools (click on links below to access resource)

- Presentations, worksheets and templates location in the shared drive (Appendix E- QI Resources Pathway):

Presentations: S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI_Training_Resources\000 QI Training-Resources for Staff\PRESENTATIONS
Templates: S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI_Training_Resources\000 QI Training-Resources for Staff\TEMPLATES
Worksheets: S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI_Training_Resources\000 QI Training-Resources for Staff\WORKSHEETS

- **Public Health Quality Encyclopedia (Public Health Foundation):** A resource for public health organizations containing information on 153 quality tools with examples derived from public health routine. Each KCHD Division shall possess two copies of this booklet.
- **The Public Health Memory Jogger (Goal QPC):** A paper booklet which contains basic information on 22 quality tools with a focus on public health. It is aimed at providing everyday support for the quality improvement process; each KCHD employee shall receive a copy of it. (Appendix C)
- **QI Training Checklist** (Appendix F): S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI_Training_Resources\QI Training Checklist_May2022.xlsx
- **Quality Tools website** :The American Society for Quality -ASQ- has a useful website with a variety of available QI Tools trainings, although the information is not tailored for Public Health. This website has been recommended by NACCHO QI Roadmap.
- **Public Health & QI Toolbox** : The Minnesota Department of Health offers a website with a variety of quality tools and other project management resources.

5.3. New Employee Orientation

Once a new employee is hired, the Director of the Division of Community Health Resources or the Executive Secretary sends a notification to the Data & Quality Coordinator and to the Workforce Development Specialist (WFDS). DQC will reach out to the new employee's supervisor to obtain details on the position, contact information, and for VMSG permissions required for that employee. A new account will be created in VMSG for the employee, and VMSG access and training instructions will be sent to the employee (Appendix D). At the same time, the WFDS will send to new employee communication on training requirements, including requirements for QI training, as listed in Table 1. This communication will prompt the new employee to reach out to DQC to schedule one-on-one QI-PM 101 Orientation. Once the orientation is provided, the new employee will complete the related worksheet and submit it to DQC for review. A certificate of completion will be sent to new employee and to the WFDS as well, for tracking purposes. The general and QI training requirements will be completed within the established timeframes, in a self-paced mode, by the new employee; training progress will be tracked by each employee through the QI Training Checklist (Appendix F). Completion is tracked by either IT

report (for videos), certificate of completion or acknowledgement sheet, or by completed worksheets. The process flow for new employee onboarding training can be found in Appendix G.

5.4. Advanced QI Training

Advanced training opportunities will be made available for QI Committee members, KCHD leadership, and for strategic positions, based on training needs assessments conducted though surveys or focus groups every 3 years, and as resources permit.

Additional opportunities for advanced training in the areas of QI and PM will be made available to the Data & Quality Coordinator as applicable and as resources permit. These may include, but are not limited to, webinars, off-site training opportunities, and participation in conferences, assuring that skills and competences are acquired.

6. Performance Management (PM)

6.1. KCHD Performance Management System

PHAB related guidance: 9.1.1 – A department-wide performance management system, including:

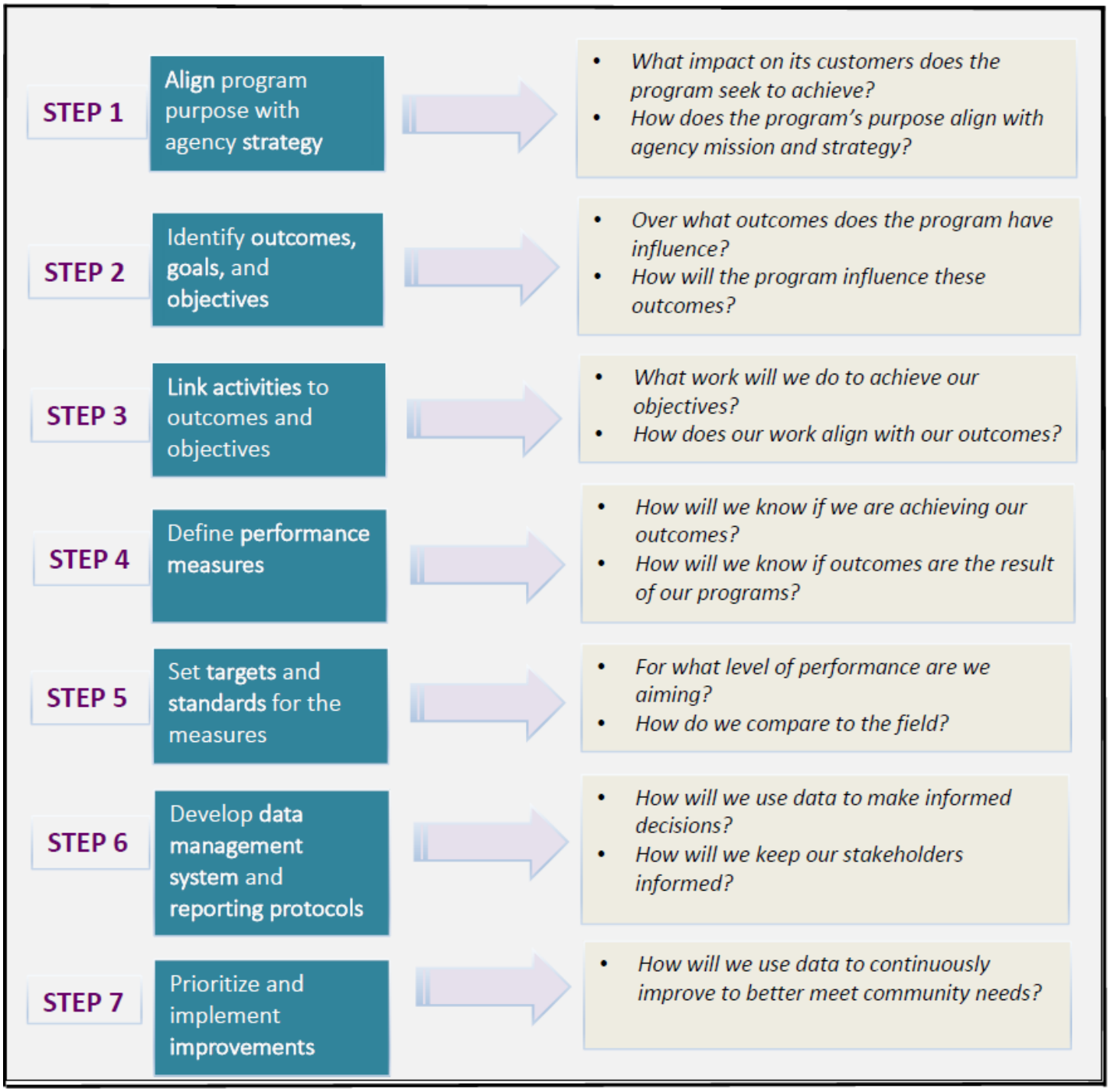
- *a) Performance management goals and the associated objectives with time-framed and measurable targets.*
- *b) A description of how the performance management system is operated, including the process for how staff will:*
  - *i. Enter data in the performance management system.*
  - *ii. Monitor data on performance.*
  - *iii. Communicate results on a regular reporting cycle.*
  - *iv. Use data to guide decision-making.*
  - *v. Use data to facilitate continuous quality improvement.*
- *c) Linkages between the performance management system and strategic plan.*

The purpose of performance management is to establish a system that ensures the collection of measures that are within the scope of influence of, while at the same time, are meaningful for, the organization and its customers. In order to achieve a successful agency-wide performance management, NACCHO recommends that steps are taken (*Measuring What Matters in Public Health*, NACCHO, 2018).

As described in Figure 2, the identification of standards and targets, the definition and refinement of measures, the collection, analysis, monitoring, and reporting of data, and the use of this data to make informed decisions on improvement are the core elements of a performance management system. The integration of these elements is essential for organization-wide quality improvement efforts, both individually and collaboratively.

Figure 2

Steps for successful agency-wide performance management (source: NACCHO, 2018)



6.1.1. Data Collection, Analysis, and Monitoring

Data represents a key component in the performance management process, as it empowers organizations for data-driven planning, improvement, and decision-making. Data for the performance measures will be collected and documented using KCHD' performance management system software, VMSG Performance Management Dashboard, a system by Knowledge Capital Alliance (KCA). This system, which has been designated as "Fully Demonstrated" by the PHAB, is a cloud-based system that is accessible at all times by all staff once a user login and password are obtained. The system is laid out in a cascading format based on the public health planning model, where programs, goals, objectives and activities are described in detail. Where applicable, timelines for deliverables are set, and for objectives and activities within each program, key staff members are identified and assume responsibility for keeping all information related to that measure up-to-date on at least a quarterly basis. On a monthly basis, the system is prompted to alert those individuals that have been assigned a task to go in and update information on their respective activities.

Implementation plans will be entered in VMSG for each of the Health Department's Plans and Divisions where applicable. Data on progress will be regularly collected and analyzed utilizing VMSG. Staff in the Division of Community Health Resources will provide assistance and ongoing support for this process. In a collaborative effort, the DQC will work with each of the Divisions to identify new performance measures, and to assist with existing measures within the system. The DQC will meet on a quarterly basis with each program/division to review the data being entered in, and to provide any additional support.

6.2. Equity Considerations

Social determinants of health are defined as the role that social, physical, and economic conditions in which people are born, live, work, and age, have in determining health outcomes of populations. With attention to their paramount role, performance management at KCHD will be operated through an equity lens. This entails intentional collection of data aimed at identifying health inequities and their root causes, and continued efforts to develop goals and objectives that allow upstream interventions towards more equitable health outcomes from the communities we serve (NACCHO, 2018).
KCHD is committed to putting equity at the center of performance management and quality improvement processes. For this purpose, and in alignment with recommendations from the National Commission to Transform Public Health Data Systems (Robert Wood Johnson Foundation, 2021), the collection, analysis, and sharing of data related to the Health Department's plans, programs, and services will be based on the following principles:

- Collecting data with adequate granularity across population groups (i.e., race, ethnicity, language ability, disability, gender identity, income, education, social position) and geographical levels that are useful at the community level, and can be aggregated and disaggregated.
- Utilizing analytical methods to work with and across data sets of quantitative and qualitative data, including historical data.
- Collecting data that are accurate and relevant at the community level to allow prioritizing and addressing local health challenges and to track progress towards healthier communities.
- Utilize methods for interpreting public health data that are inclusive of community input, with attention to messaging, communication, and narrative.

As described above, performance management at KCHD will be conducted utilizing disaggregated data as frequently as possible, and as resources permit. Disaggregated data is currently seen as a key tool to advance health equity; better information about different population groups is crucial to understanding the

circumstantial conditions impacting health outcomes, as well as to effectively measure the progress of interventions planned to address public health problems (Policy Link, 2018).

6.3. Alignment with Strategic Plan and Community Health Improvement Plan (CHIP)

Alignment between KCHD plans is essential to ensure that they are successfully executed. For this reason, the QI plan is a key tool to ensure proper alignment between CHIP, Strategic Plan, and KCHD Programs and Services through performance management and quality improvement efforts. Figure 3 illustrates the process of the integration between the goals and the population indicators from CHIP, which provide input for the Strategic Plan's priorities and goals, which in turn provide organizational-level direction to help programs develop objectives, activities, and measures.

Figure 3

Strategic alignment (source: NACCHO, 2018)

6.4. Data Reporting

KCHD Divisions/ Sections will share progress on performance measures, collected and documented in VMSG, with their respective team monthly, or at least on a quarterly basis. This reporting will include an update of the data dashboard, a summary of progress on performance measures, and identification of opportunities for quality improvement actions. During the Division meetings (with the DQC included), the group will review each of the Division performance measures and determine their status at least quarterly. Performance measures will be reviewed and revised as needed. Divisions will also share progress reports at QIC meetings. KCHD Divisions will take turns, providing up to 2 progress reports in each calendar year to the QIC. For those measures targeted for QI action, follow up items will be documented using the meeting minute's template (Appendix H). QI

Committee members will take the lead in implementing these QI action steps with the support of the division leadership and team. Technical assistance can be provided by the DCQ as needed.

7. QI Projects

PHAB related guidance: 9.1.2c – Description of the process for identifying, prioritizing, and initiating QI projects.
9.1.3 – Implementation of quality improvement (QI) projects that demonstrate the following:

a. How the opportunity for improvement was identified.
b. The measurable and time-framed objective(s) for how the project aims to address the opportunity for improvement.
c. Use of a QI method.
d. Use of QI tools to better understand or make decisions about:

i. The current process
ii. Root causes(s)
iii. Possible solutions
iv. Prioritization/selection of solutions for implementation
v. Description of the outcomes of the QI Project

7.1. Identification of opportunities for improvement

All levels of staff are entitled to identify areas for improvement during the regular performance monitoring of the programs and services they provide, and submit a proposal for a QI project to their supervisor. Ideas for QI project will be based on the need to improve program processes, objectives, and/or performance measures and are tied to the agency Strategic Plan and CHA/CHIP. Leadership and QI Committee may identify projects in a number of ways, including, but not limited to, identification during the quarterly reviews of PM Data. As performance measures are analyzed and presented by KCHD Divisions (Community Health Resources, Disease Prevention, Health Protection, and Finance and Facilities) during the QI Committee meetings, discussions will focus on needs to address an issue with a formal QI project. The process flow to QI Projects at KCHD is described in Appendix I.

7.2. Project Selection Criteria

Once ideas for QI projects are identified at the Division level, the team will utilize the PDCA Project Decision Matrix (Appendix J), which allows ranking different proposed QI projects against the following criteria:

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

After selecting a project, the PDCA workgroup will be expected to complete a Project Planning Proposal Form (Appendix J), to be submitted to the QI Committee for discussion and feedback, and for final approval.

7.3. Development of QI Projects

QI projects at KCHD will be developed utilizing the Plan-Do- Check (Study)-Act framework (PDCA). Appendix K contains a guide to using this model in the improvement process. Equity principles and tools will be incorporated in all steps of the PDCA cycle while teams are working on QI projects.

The QI Committee, through its members will be called upon to provide support and technical assistance in the development of QI proposals and project plans, and should be regularly updated on the project. Divisions should involve as many appropriate staff as possible in a PDCA project. All staff members, at each Division, should be involved in at least one QI project. The Division may opt to select one or more projects to allow involvement of all staff in QI Projects. Each KCHD Division will be expected to be working on at least one PDCA project each fiscal year, but may choose to work on multiple projects simultaneously.

It is the expectation that the progress from the selected PDCA project(s) for each Division will be documented via the QI Project Team Charter (Appendix L) on an ongoing basis; the purpose is to ensure all information pertaining to that specific project is collected, with special attention to tools used, outcomes, unexpected observations, and the lessons learned through the process. The final information documented in the team charter shall be used to compose a final report, which should be in a storyboard format (Appendix M). Each Division must complete at least one storyboard during the 3-year QI plan period (between January 2023 and December 2025). The finished storyboard will be shared internally, and when appropriate, externally. At the discretion of the KCHD Leadership team, the storyboards can be posted on the agency's website and submitted to the Public Health Performance Improvement Network (phPIN).

Ideally, working on PDCA projects should take a maximum span of six months, for the sake of sustaining the team's engagement. On the other hand, Divisions might work on shorter, simpler projects that are completed within a few weeks' time. A QI Project should engage, at a minimum, the staff member directly involved in the process, program, or service where improvement is intended, and their supervisor. While completion of a storyboard is not required for shorter projects, documentation of the process in all of its steps is still mandatory, using the QI Project Team Charter. A list of PDCA projects selected by the sections of KCHD can be found in Appendix N of this document.

8. Customer Focus

PHAB related guidance: 9.1.1- Implement the performance management system.

R.D 2: Example of implementation of the performance management system; the example must include customer feedback.

Customer focus is defined as how an organization listens to the voice of its customers, builds customer relationships, determines their satisfaction, and uses customer information to identify opportunities for innovation or improvement (Minnesota Department of Health, n.d.). Customer focus is a key element of quality, and, in public health, addressing this element requires understanding and meeting customer needs. Customer focus is also one of the foundational elements of a QI Culture according to NACCHO (NACCHO QI Roadmap, 2020). There are actions that can be taken in order to ingrain a customer-focused culture within KCHD, including, but not limited to,

- Ensuring that customer focus is incorporated into KCHD vision and values, in a direct line of sight with the Health Department's strategic plan.
- Assessing the level of customer-focused culture within KCHD, through established tools designed for this purpose, such as the Minnesota Department of Health Customer Focus Assessment Tool (Minnesota Department of Health, n.d.)
- Ensuring that customers are identified, understood, and engaged
- Ensuring leadership's commitment to customer satisfaction
- Ensuring that customer information is shared and actually utilized to create and improve programs.

For more information on customer satisfaction, refer to the Resources section in this plan.

The scope and purpose of customer-oriented processes within the Health Department are described in detail in KCHD's Customer Satisfaction Policy (Appendix O). The policy establishes that customer satisfaction from all programs and services offered by KCHD will be assessed at least quarterly, during one full calendar month. Partners and internal customers' satisfaction will be assessed at least once annually. KCHD will utilize multiple venues to apply customer survey, including online surveys, paper surveys, and focus groups. The Division of Community Health Resources will be responsible for analyzing data from customer surveys and sharing it with Division Directors and with the Executive Director; Division Directors shall be responsible for timely sharing survey results with respective teams. Sections and Divisions are required to identify at least one performance measure, to be added to KCHD performance management system, which is based on customer feedback.

9. QI-PM Goals, Objectives, and Activities

PHAB related guidance:

9.1.1a – Performance management goals and the associated objectives with time-framed and measurable targets.

9.1.2e – Goals and objectives with time-framed targets, related to the department's QI plan implementation.

The process to identify agency and division-level goals, objectives, and performance measures as a part of the agency's PM System is ongoing throughout the year. This process will include participation by all staff in each division, and selected measures will be documented and monitored through KCHD's PM system, VMSG Dashboard.

Performance Measures will have a direct line of sight with the organization Strategic Plan, the Community Health Improvement Plan, Healthy People 2030 Objectives, the QI Plan, the Workforce Development Plan as well as any other recognized performance standards that fall under PHAB criteria, and information will be captured and linked through VMSG 3-D planning.

QI and PM goals and objectives are based on the PHAB Standards and Measures, version 2022, as well as the PHAB Standards and Measures for Reaccreditation, version 2022. These goals, described below, are selected as priority goals for this plan in connection to the reaccreditation requirements.

Goal 1:	*Implement and run a performance management system at KCHD.*
Objective 1:	Between January 1, 2023, and December 31, 2025, all KCHD programs, services, and plans are monitored on at least a quarterly basis through the agency's performance management system (VMSG). **Activity 1:** 100% of KCHD programs have a corresponding operational plan in VMSG (deadline is December 2025) **Activity 2:** Monthly reports on VMSG user activity are submitted to and reviewed by the QIC.
Objective 2:	Between January 1, 2023, and December 31, 2025, each of the KCHD Divisions identifies at least 3 opportunities for improvement related to their processes, services, or programs. **Activity 1**: Identified opportunities for improvement are brought to the QIC for approval by each Division.

Goal 2:	*Steward a culture of quality within the KCHD.*
Objective 1	By December 31, 2025, there is a 50% increase in the rate of KCHD staff who completes all trainings in the QI training curriculum, from a baseline of 16% employees completing all QI trainings in 2023, to 24% in 2025. **Activity 1**: Training reminders will be sent quarterly to employees.
Objective 2:	By December 31, 2025, all newly-hired employees complete all basic QI training curriculum within 90 days from the day they were hired (baseline = 60% on December, 2022) **Activity 1**: Training requirements are sent to new employees within one week from hiring date (linked to Workforce Development Plan). **Activity 2**: QI Training Tracking sheet is updated monthly.
Objective 3:	By December 31, 2025, a minimum of 6 issues of the KCHD QI Newsletter are be published. **Activity 1**: QI Newsletter content is submitted to QIC for approval quarterly. **Activity 2**: Percentage of KCHD employees actively accessing QI Newsletter content is tracked monthly.
Objective 4:	Between January 1, 2023, and December 31, 2025, each KCHD Division completes a minimum of 3 Quality Improvement projects, based on the opportunities identified during performance management. **Activity 1**: QI Project team charters are completed (target: 12 team charters completed between January 2023 and December 2025). **Activity 2**: Each Division will complete at least one storyboard (between January 2023 and December 2025).

10. Monitoring progress of the QI-PM Plan

PHAB related guidance: 9.1.2f – Description of how implementation of the QI plan is monitored.

PHAB Domain 9 requires that health departments monitor and evaluate the implementation of goals, objectives, and activities described in the QI plan; for this reason, the KCHD QI operational plan, along with its activities and defined performance measures, will be tracked through VMSG. Progress toward these goals are to be shared with and evaluated by the QI Committee on at least a quarterly basis.

11. Communication

PHAB related guidance: 9.1.2g- Communication strategies used to share with stakeholders about QI activities conducted by the health department.

Regular communication about quality improvement initiatives and activities within the department is important to build awareness, to increase knowledge, to facilitate engagement, to strengthen the QI programs and to promote an overall culture of quality. Regular updates on the QI plan implementation, QI projects selection and progress, QI successes, and training activities will be provided using the following:

- Communication of QI efforts to be shared through the KCHD QI Newsletter, distributed at least twice yearly to the staff, Public Health Committee, Health Advisory Committee, partners and the community.
- Communications within the QI Committee, which will take place as needed through the QIC Bulletin.
- Presentations and training at Division, Section, and Team meetings, as well as at mandatory All Hands meetings, regarding QI project updates or QI tools
- Infographics summarizing QI projects
- Minutes from meetings of the QI Committee, Health Advisory Committee and Public Health Committee posted on the network shared drive
- Storyboard presentations at Division, Section and/or Team meetings, as well as display of completed Storyboards on KCHD website and throughout KCHD building; this may include one or more virtual murals to display ongoing and completed QI projects and initiatives at different KCHD Divisions.
- QI efforts may also be shared via posting of materials through various mediums including the Employee Newsletter, Social Media, KCHD Website, internal email, and other available methods, as appropriate.
- Divisions will allocate a time during All Hands meeting presentations to provide updates on their QI projects, QI bright spots, and other QI initiatives, as applicable.

Dissemination of the approved QI/PM Plan will happen via e-mail and/or at ALL Hands mandatory meetings; a link to the plan on the KCHD shared computer drive (S Drive) will also be provided, and KCHD staff will be encouraged to review and provide feedback on the document; the input provided will be utilized to improve the plan during the revision process.

12. Recognition

KCHD seeks to develop a culture of quality that encourages all staff to develop their own skills relative to quality improvement and performance management. Strategies for recognition are also designed to acknowledge the

efforts of all use of QI and PM. Recognition of QI/PM efforts include, but are not limited to:

- Providing regular updates and recognition of PDCA project team members and their work, at Division/Section meetings, and at All Hands Meetings,
- Sharing stories and "bright spots" of QI tool use at Division, Section and Team meetings, as well as at QI Committee meetings, and during All Hands Meetings,
- Using incentives and rewards, as resources allow and as recommended by the leadership and QI Committee, a QI Champion Acknowledgement Award will be selected on a quarterly basis.

12.1. The QI Champion Program

QI champions are individuals who inspire others to adopt QI practices and bring a spirit of QI into the organization. They cultivate this spirit by encouraging continuous improvement of programs and services through providing a strong endorsement for QI, and by participating in QI activities. They are the organization QI cheerleaders (Kane, 2016). QI Champions can be found across the organization, but also within our community partners. QI Champions typically demonstrate a combination, if not all, of the characteristics below:

- Generates support for the changes that need to be made
- Demonstrates accomplished QI training
- Encourages, coaches, reminds, and mentors others on QI matters, training, and tools
- Demonstrates commitment to monitoring success and benchmarking
- Continually works to address communication gaps
- Fosters collaboration among teams
- Helps the Health Department to overcome resistance to change
- Demonstrate outstanding problem-solving skills
- Continually pursues success for building a culture of quality
- Demonstrate ability to mobilize resources towards improvement
- Serves as a role model for their peers.

The above characteristics will be considered when nominating and selecting a QI Champion. QI Champions will be nominated quarterly using the KCHD QI Champion Nomination Form (Appendix P). Nominations will be submitted to the DQC; the QIC will review list of nominated candidates during QIC meetings quarterly, and, based on the above criteria, identify a QI Champion. QI Champions will awarded with a certificate of recognition during All Hands.

13. Agency Policies

KCHD has policies regarding Quality Improvement, Performance Management, and Customer Satisfaction (see Appendix O). The Executive Director approves these policies. Policies are to be reviewed every 3 years by the QI Committee and modified as necessary to reflect changes in QI/PM efforts. After review and approval by the QI Committee, the final step is for KCHD Executive Director to sign. The approved QI, PM, and Customer Satisfaction policies will be maintained in the KCHD policy book, and an electronic copy will be maintained on the agency's shared network drive for access by staff.

14. QI-PM Plan Revision & Approval

The QI-PM Plan will be regularly evaluated by the QI Committee, and recommendations for revision will be based on feedback received within the organization and progress made toward goals and objectives of the plan. The QI-PM will be formally reviewed every 3 years; the revision process will be preceded by an organization-wide QI culture assessment. Once a draft is complete, it will be reviewed by the Leadership Team, who will provide feedback for additional amendments or changes. The Executive Director will provide approval and signature of the final version.

15. Links to resources

- VMSG Performance Management Dashboard- Login Page
- KCA-VMSG Dashboard Training Videos
- Quality Improvement Tools – ASQ
- Public Health & QI Toolbox – Minnesota Department of Health
- NACCHO Organizational Culture of Quality Self-Assessment Tool or SAT
- Public Health Performance Improvement Network (phPIN)
- Public Health Foundation
- PHAB Standards & Measures for Reaccreditation- Version 2022
- Core Competencies for Public Health Professionals
- Foundational Public Health Services10 Essential Public Health Services
- NACCHO- Measuring What Matters in Public Health
- Measuring Customer Satisfaction: Nine Steps to Success- ASTHO

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Guide-to-PrioritizationTechniques.pdf Quality Improvement Plan Toolkit; Guidance and Resources to Assist State and Territorial Health Agencies in Developing a Quality Improvement Plan. Accessed online 9.23.16. Association of State and Territorial Health Officials: http://www.astho.org/Accreditation-andPerformance/Quality-Improvement/QI-Plan-Toolkit/Home/

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17. List of Appendices

Appendix A: Definitions/Clarifications

Appendix B: Roles and Responsibilities

Appendix C: The Public Health Memory Jogger- Quality Improvement Toolbox

Appendix D: VMSG Login and Training Instructions

Appendix E: Pathway to QI Resources and Materials in the S Drive

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Appendix N: List of Past PDCA Projects Storyboards

Appendix O: KCHD Quality Improvement Policy, KCHD Performance Management Policy, and KCHD Customer Satisfaction Policy

Appendix P: QI Champion Nomination Form

Appendix A

Definitions/Clarifications

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

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

Definitions: Do any of the words or phrases in your performance measure need further explanation or definition?

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

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

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

Target End Date: One year from the date, which you begin, tracking the measure.

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

Appendix B

Roles and Responsibilities

Executive Director

- Provide leadership for department vision, mission, strategic plan and directions related to QI effects.
- Allocate resources for QI programs and activities, assuring that staff has access to resources to conduct QI projects and training.
- Promote a continuous quality improvement (CQI) learning environment for KCHD.
- Advocate for QI culture, both to staff and external customers, through presentation and messaging.
- Report on QI activities to the Board of Health, Public Health Committee and Health Advisory Committee.
- Request the review of specific program evaluation activities or the implementation of QI projects.
- Review and provide final approval on document and as the QI/PM Plan and QI Policy.
- Apply QI principles and tools to daily work.
- Participate in efforts to implement, monitor and evaluate the PM system.
- Encourage staff to use online QI resources such as (PHQIX, NACCHO Toolbox, Etc.).

Division Directors

- Facilitate the implementation of QI activities at the Division level.
- Support Assistant Directors and Supervisors in QI activity work.
- Participate in QI project teams as requested or as required.
- Facilitate the development of QI project teams.
- Provide staff with opportunities to share results of QI efforts (findings, improvements, and lessons learned).
- Communicate with Assistant Directors and Supervisors to identify projects or processes to improve and assist with development of proposals for QI projects.
- Document QI efforts.
- Communicate regularly with Executive Director, Data and Quality Coordinator to share QI successes and lessons learned.
- Communicate regularly with division representatives of the QI Committee to stay updated on Committee work.
- Provide feedback to develop annual QI/PM Plan.
- Identify representatives for QI Committee.
- Communicate staff training needs to DQC.
- Encourage program staff to incorporate QI concepts into daily work.
- Apply QI principles and tools to daily work.
- Assure implementation, monitoring and evaluation of the agency's PM system.
- Encourage staff to use online QI resources (PHQIX, NACCHO Toolbox, Etc.)

Assistant Directors, Supervisors, and Managers

- Facilitate the implementation of QI/PM activities and an environment of CQI at the section/program level.

- Participate in and facilitate the development of QI/PM project teams.
- Assure staff participation in QI/PM activities.
- Orient staff to the QI/PM Plan processes and resources.
- Provide staff with opportunities to share results of QI efforts (findings, improvements, and lessons learned), including visual representations of work.
- Document QI efforts.
- Determine messages to communicate selected QI activities and results to staff, the public and other audiences (via Public Information Officer and with the support of the DQC).
- Keep Division Director apprised of QI/PM activities.
- Communicate regularly with section representatives of the QI Committee to stay updated on Committee work.
- Initiate problem-solving processes and/or QI projects.
- Encourage staff to incorporate QI concepts into daily work.
- Apply QI principles and tools to daily work.
- Assure implementation, monitoring and evaluation of the agency's PM system, including communication to staff.
- Encourage staff to use online QI resources (PHQIX, NACCHO Toolbox, Etc.)

Data & Quality Coordinator

- Coordinate, Support, and Guide QI/PM department-wide.
- Develop the QI/PM plan and evaluation with the input of the QI Committee and Leadership Team, assuring that it meets PHAB accreditation requirements.
- Counsel QI Committee members on the implementation of the QI program and serve as Committee Chair.
- Provide training, consultation, and technical assistance to QI project teams, the QI Committee and for other staff.
- Convene and facilitate the agenda and meetings for the QI Committee.
- Work with the Leadership Team to define and document QI issues.
- Support Assistant Directors and Supervisors in development of messages to communicate QI activities to staff, the public and other audiences.
- Provide technical assistance on the development, implementation, monitoring and evaluation of the agency's PM system.
- Assure communication of QI project results, including posting on KCHD website.
- Support dissemination of agency QI/PM efforts, including application to public health networks and presentation at local, state and national conferences and meetings.
- Assure documentation of all QI-related activities.
- Evaluate staff regarding QI participation and training needs and PM development and integration.
- Integrate QI principles in KCHD policies/protocols.
- Implement other strategies to develop a "culture of QI".
- Apply QI principles and tools to daily work.

All KCHD Staff

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

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

Quality Improvement Committee

- Attend monthly meetings of QI Committee (typically 1.5 hour/month) and complete assigned tasks.
- Provide QI expertise and guidance for PDCA project teams.
- Provide QI training and support to new and existing staff.
- Complete all required and suggested agency QI training modules.
- Serve as liaison between program-level QI project and agency, providing updates at All Hands, Division, or Section meetings.
- Assist in development of agency QI activities.
- Participate in the development, implementation, review and evaluation of the QI/PM Plan.
- Advocate for QI and encourage a culture of learning and QI among staff.
- Apply QI principles and tools to daily work.
- Provide support to the KCHD Leadership Team in implementation, monitoring and evaluation of the PM system, providing updates to the QI Committee and making recommendations for improvement projects based on PM results.
- Encourage staff to use online QI resources (PHQIX, NACCHO Toolbox, Etc.)

Kane County Health Advisory Committee

- Provide consultation and feedback to KCHD Leadership staff regarding QI/PM efforts.
- Make recommendations to Kane County Board on policy changes regarding QI/PM.
- Participate in orientation regarding QI/PM efforts and assist in development of QI/PM orientation materials for Kane County Board/Board of Health.

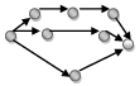
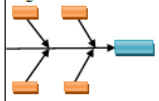
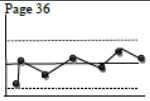
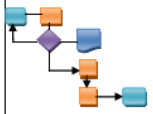
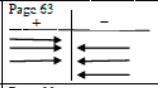
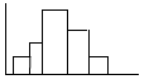
Kane County Board/Board of Health

- Provide oversight of QI/PM efforts by the KCHD
- Set policies to facilitate implementation of the QI plan and activities.
- Participate in orientation of QI/PM efforts.

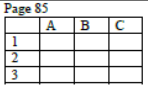
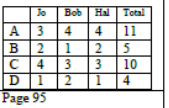
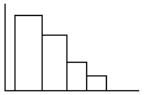
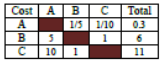
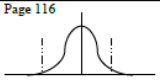
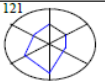
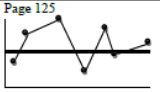
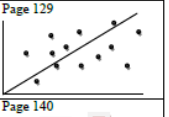
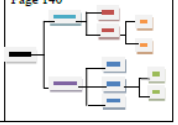
Appendix C

Public Health Memory Jogger

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)*

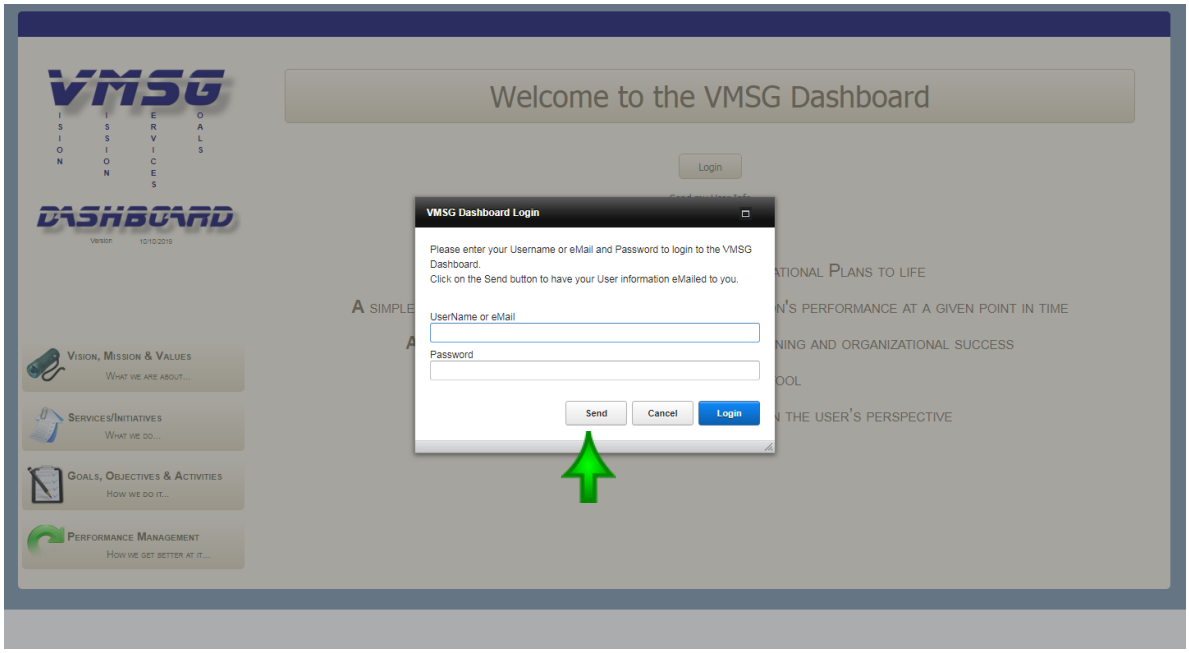
Interrelationship Digraph	Used to: Look for drivers and outcomes • Encourages team members to think in multiple directions rather than linearly. • Explores the cause and effect relationships among all the issues. • Allows a team to identify root cause(s) even when credible data doesn't exist.	Page 76 
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 

Appendix D

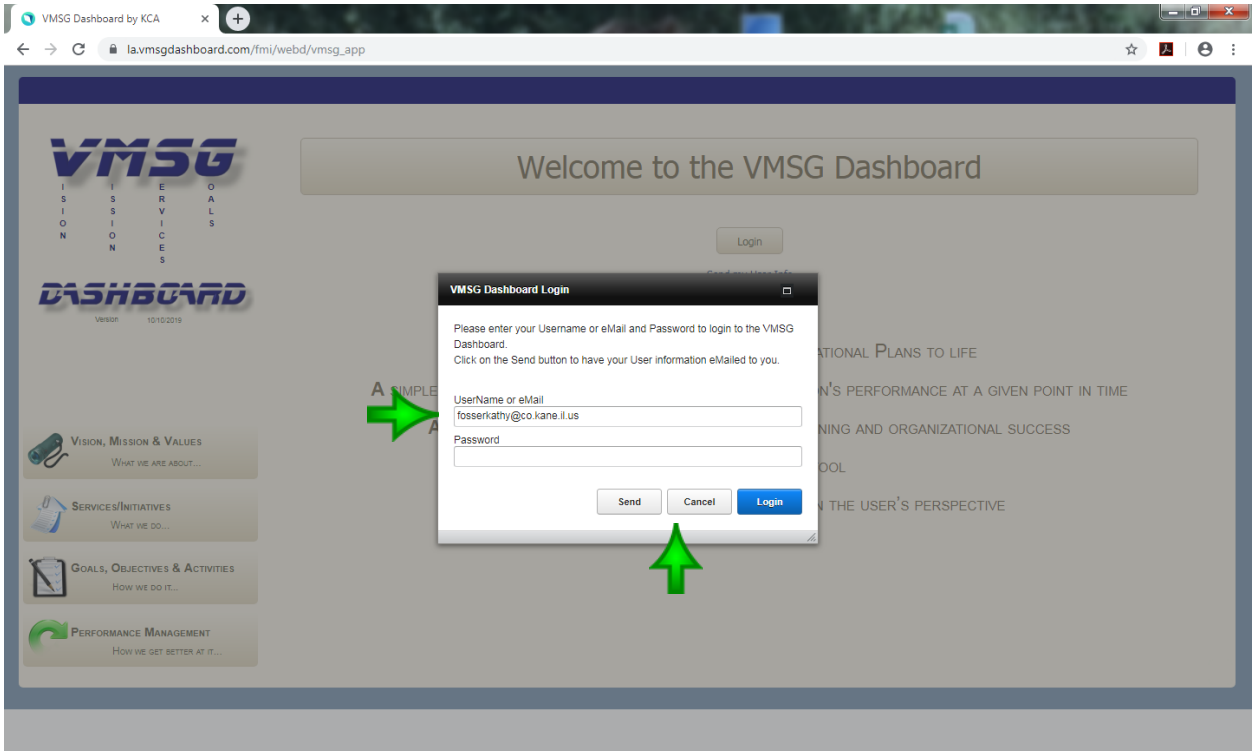
VMSG Log in Instructions

Directions for setting up your login and password in VMSG

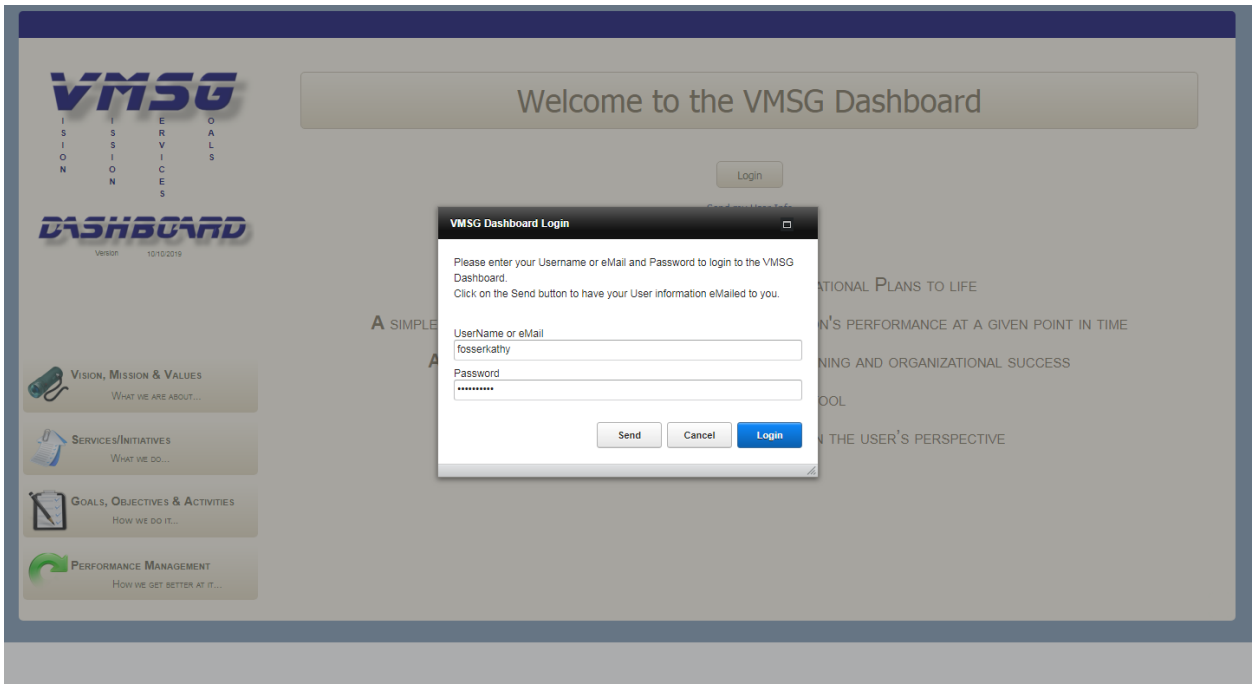
1. Enter “login.vmsgdashboard.com” in your browser (make sure to use Google Chrome)



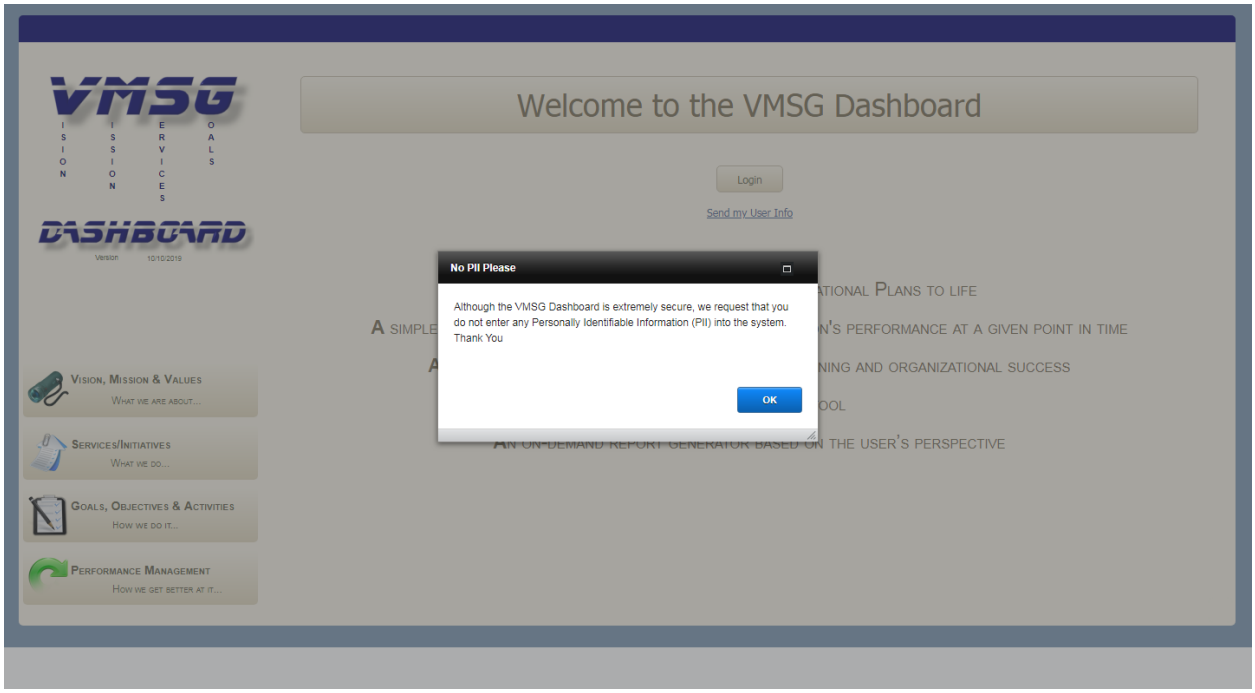
1. Do not enter any information at this screen
2. Hit SEND



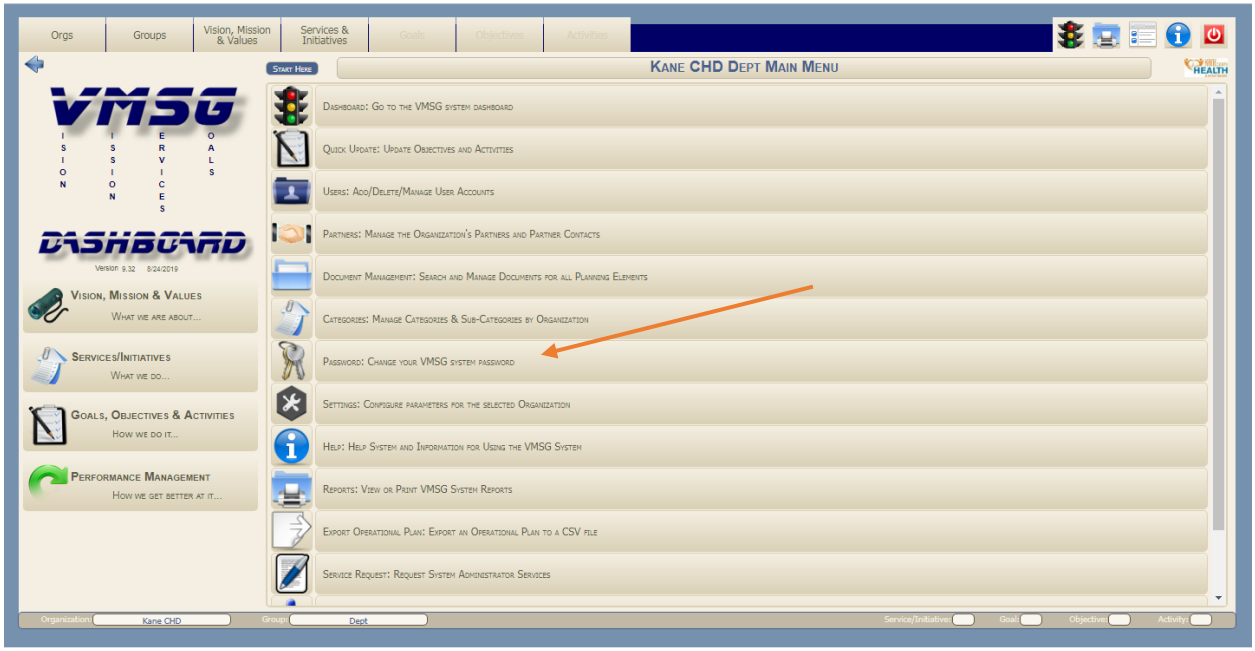
3. Enter your email address
4. Hit SEND
5. You'll get an email in your Outlook from KCA VMSG with your login and password information



6. Go back to “login.vmsgdashboard.com” and enter your login and password that were emailed to you



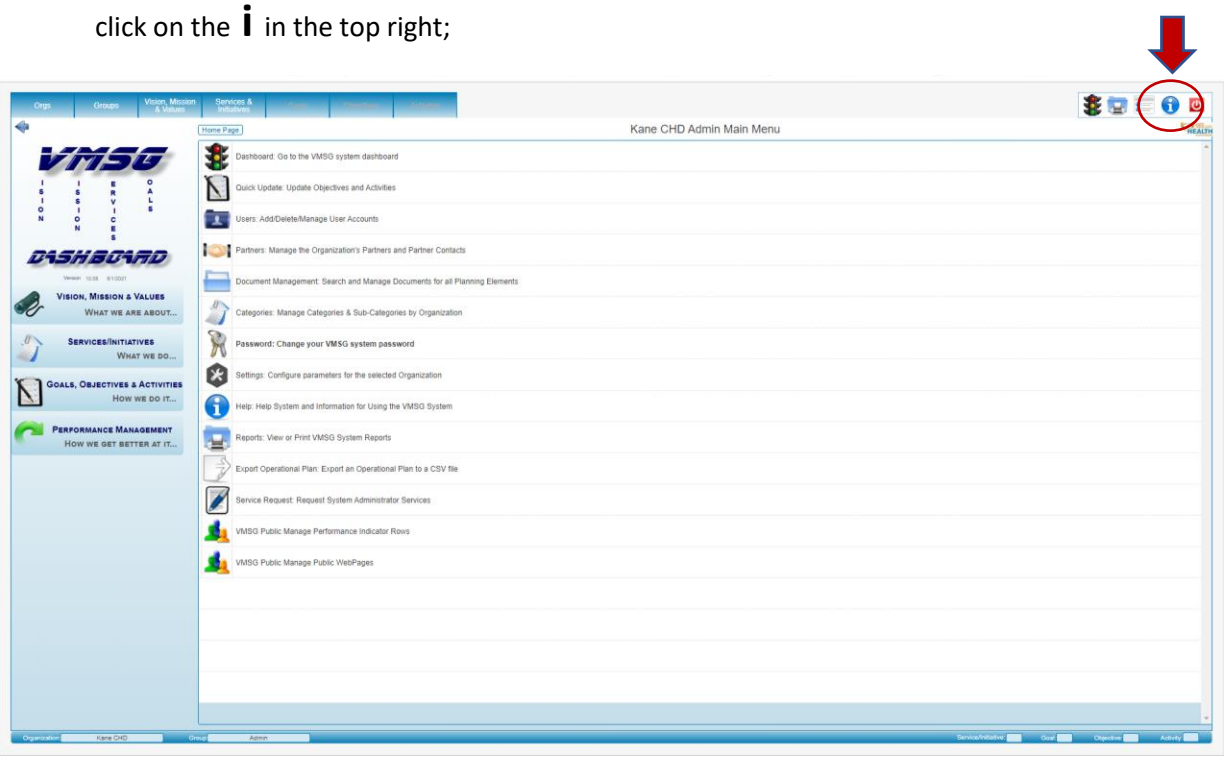
7. Hit OK for this screen



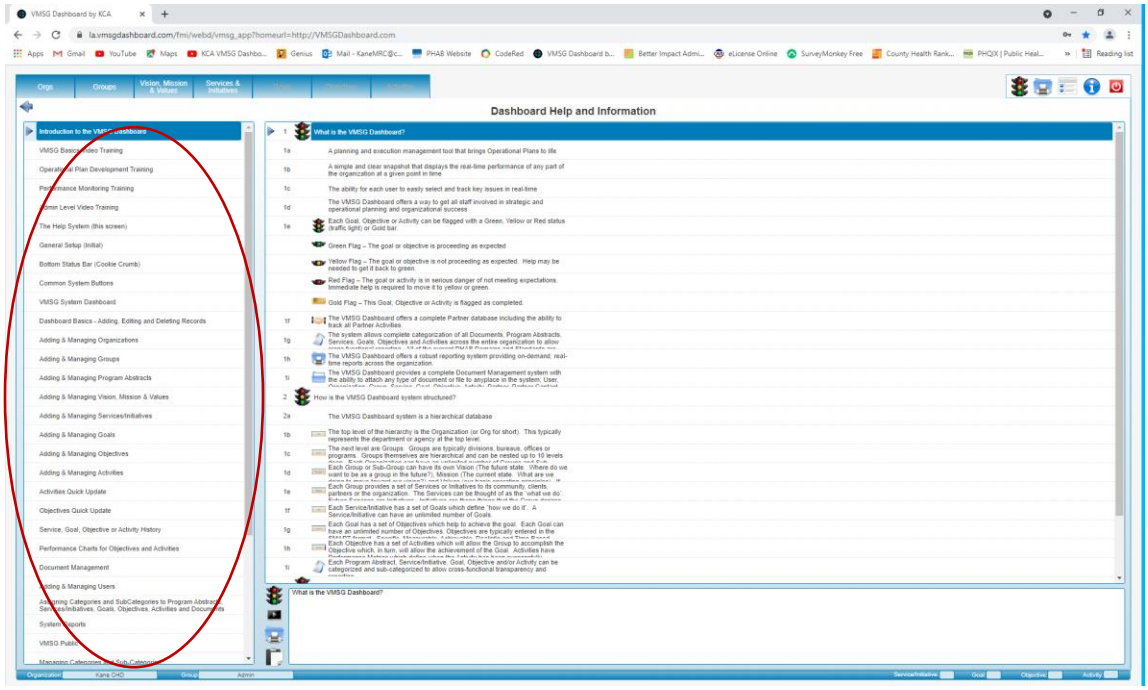
8. Once you are on the Main Menu, click on the “Password: Change your VMSG system password” button
9. Type in your current and new passwords to login, and start navigating the system.

VMSG Training Instructions

1. VMSG offers thorough and easy-access training directly built into the system. Once you are logged in, click on the **i** in the top right;

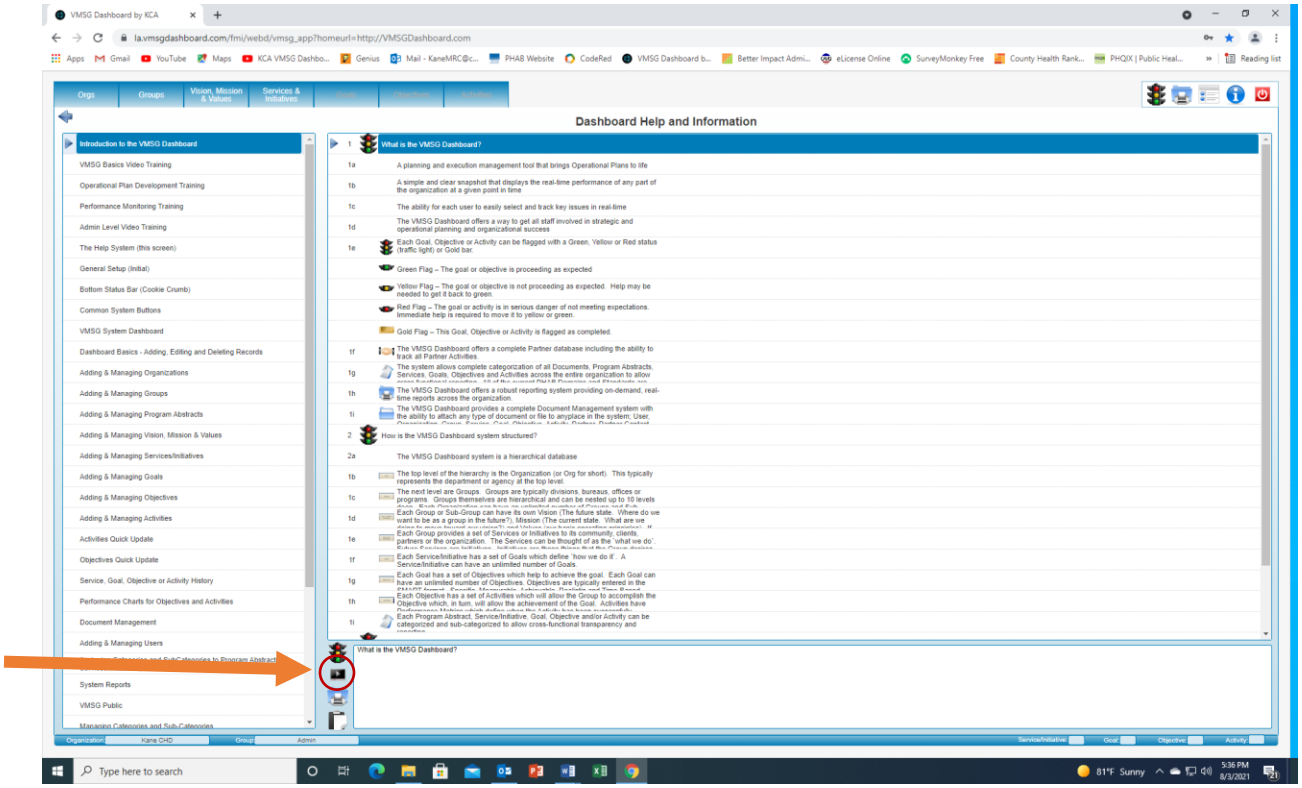


2. A list of trainings will appear on the left bar.



Users are recommended to watch the **four first videos** on that list within one month from first login. System administrators would also need to view the VMSG Administrator Training Video.

3. To watch the video for each training, click on the black box with the white arrow as shown below.



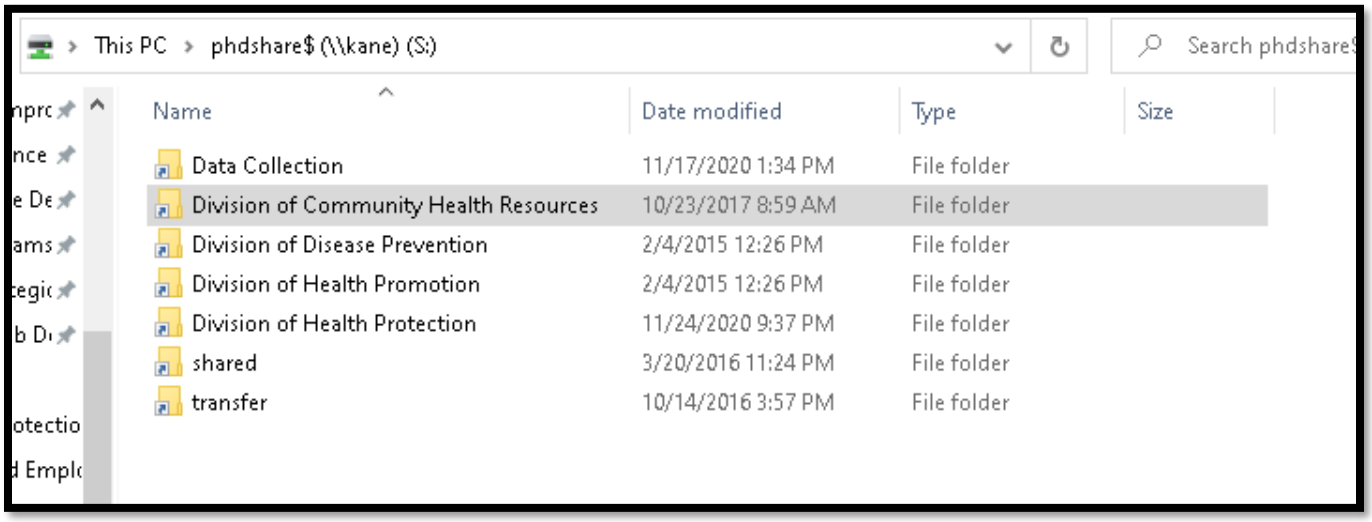
4. You may also access the VMSG Videos directly from their YouTube Chanel; to do so, simply click on the links below:

- VMSG Dashboard Intro & Overview - 48 minutes
  - VMSG Gen3 Intro Training
- VMSG Basics Training - 56 minutes
  - https://youtu.be/HF5U5Spn8O4
- VMSG Operational Planning Training - 54 minutes
  - VMSG Operational Planning Training
- VMSG Performance Monitoring Training - 25 minutes
  - VMSG Performance Monitoring Training
- VMSG Administrator Training - 30 minutes
  - VMSG Gen3 Admin Training

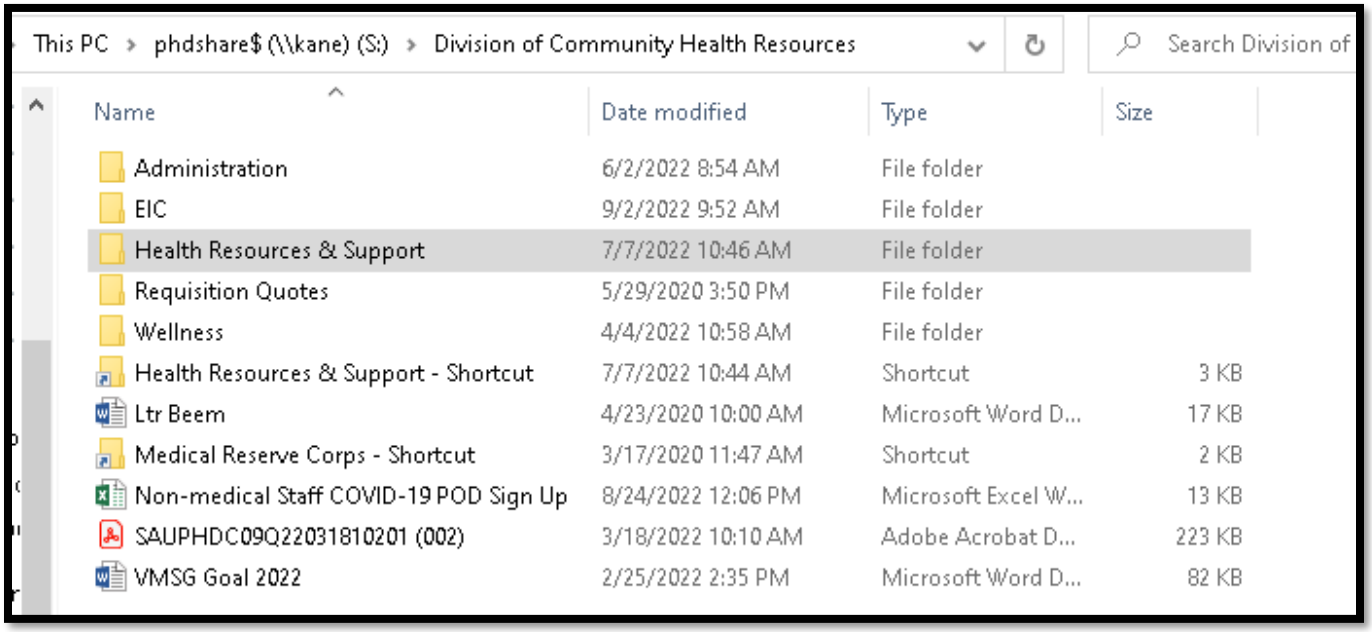
Appendix E

Pathway for Quality Improvement Resources and Materials in the S Drive

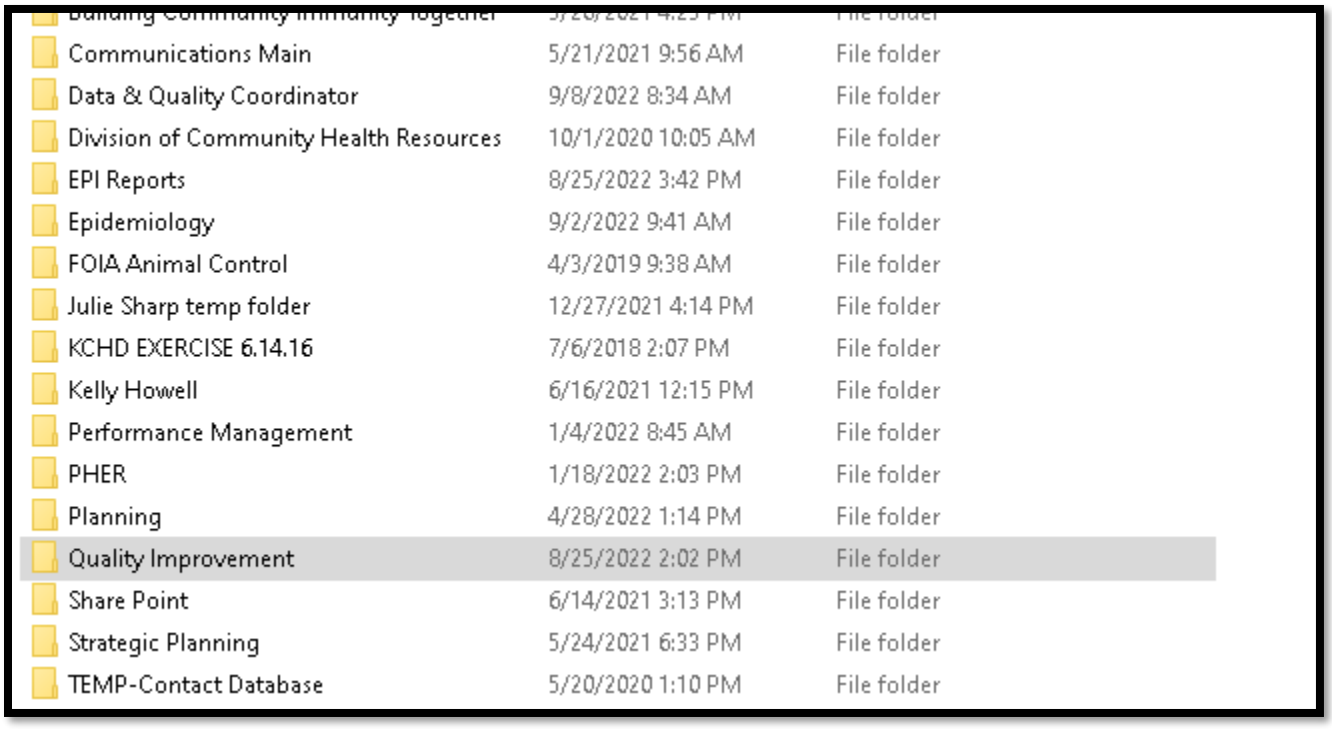
1. Open S Drive and go to Division of Community Health Resources



2. Go to "Health Resources & Support""



3. Go to “Quality Improvement”

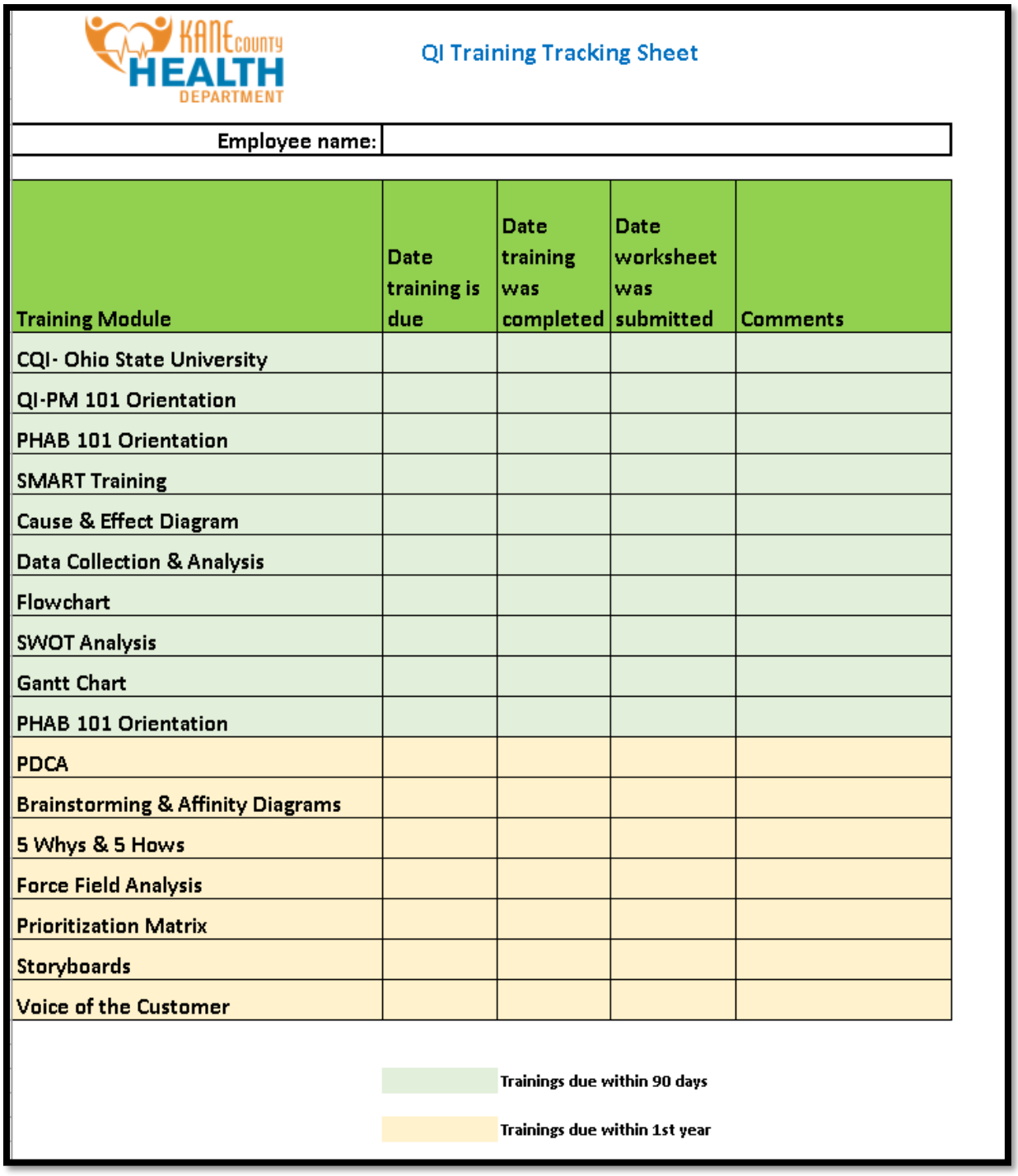


Topics to consider:

- **Customer Satisfaction**: contains information of all past and recent customer feedback efforts.
- **QI Committee**: contains information on all past and current activities, including meeting minutes.
- **QI Newsletter**: past and current content and issues can be found here.
- **QI Plan**: past and current versions of the QI-PM plan.
- **QI Training Resources**: contains all resources needed for QI training, along with templates and worksheets.
- **QI-PDCA Projects**: contains all resources related to QI projects, including storyboard template and team charter template.
- **Resources**: contains resources on QI in general.

Appendix F

QI Training Checklist



KANE county HEALTH DEPARTMENT

QI Training Tracking Sheet

Employee name:

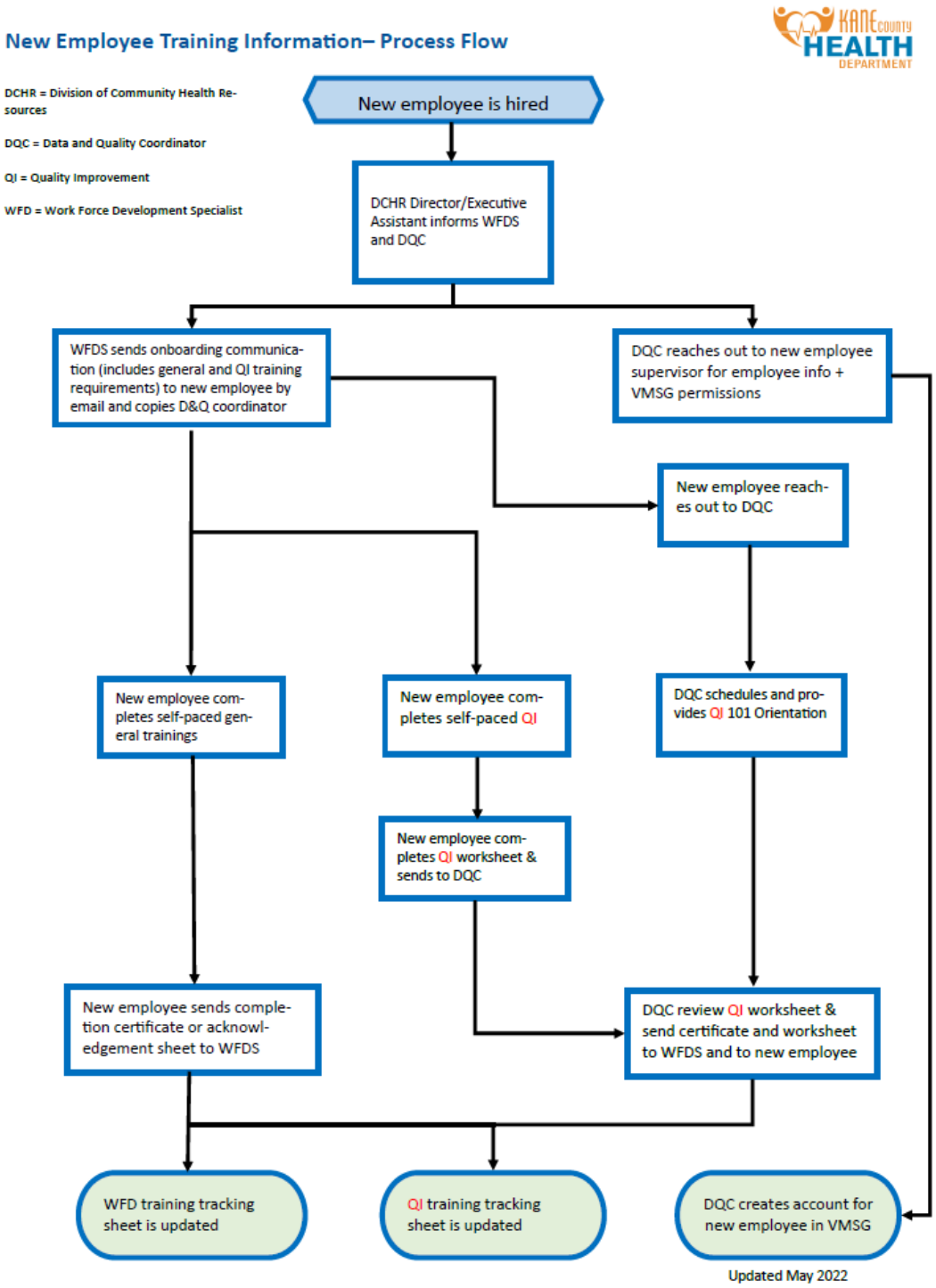
Training Module	Date training is due	Date training was completed	Date worksheet was submitted	Comments
CQI- Ohio State University				
QI-PM 101 Orientation				
PHAB 101 Orientation				
SMART Training				
Cause & Effect Diagram				
Data Collection & Analysis				
Flowchart				
SWOT Analysis				
Gantt Chart				
PHAB 101 Orientation				
PDCA				
Brainstorming & Affinity Diagrams				
5 Whys & 5 Hows				
Force Field Analysis				
Prioritization Matrix				
Storyboards				
Voice of the Customer				

Trainings due within 90 days

Trainings due within 1st year

Appendix G

New Employee Onboarding Process Flow

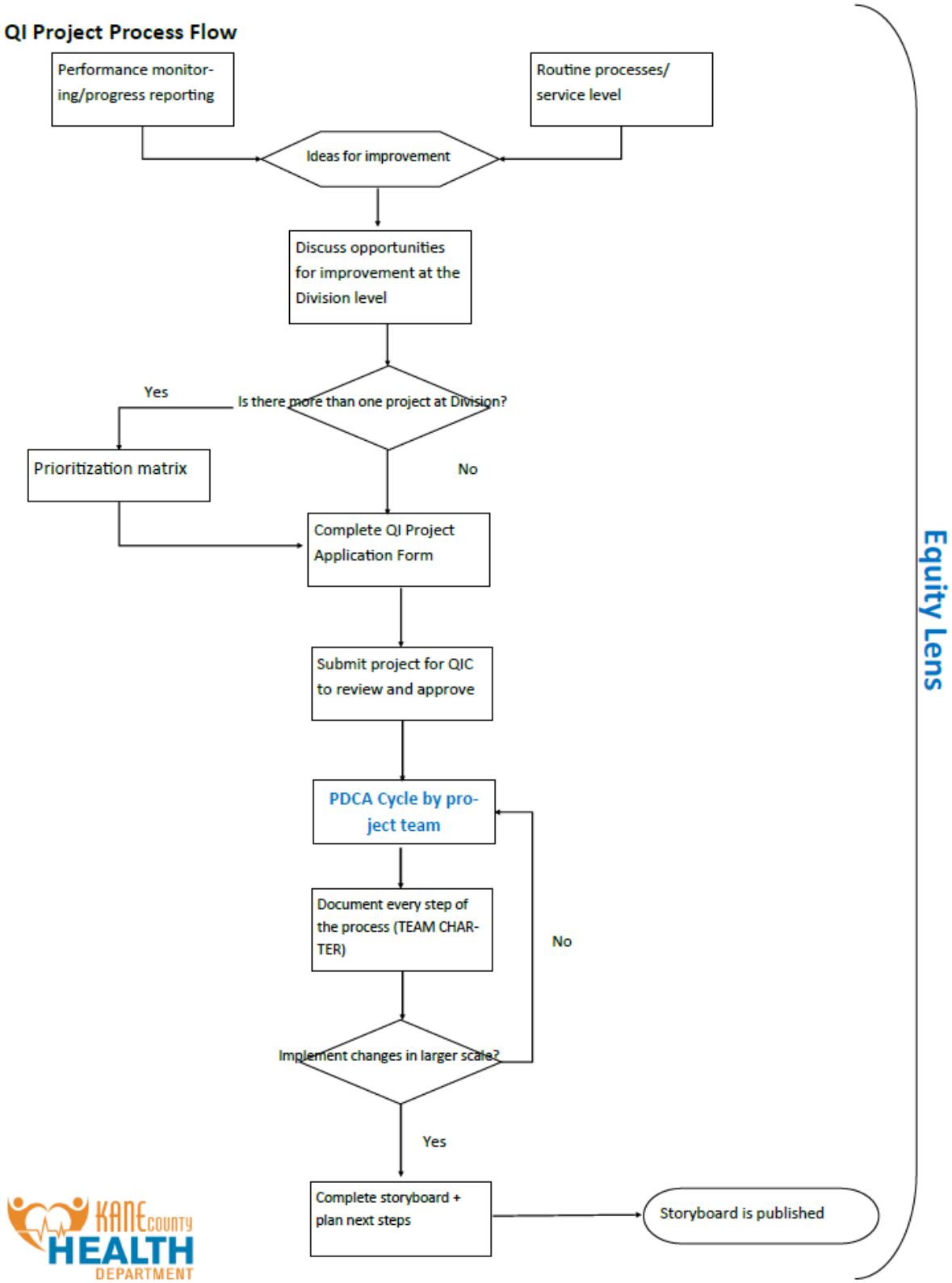


Appendix H

Meeting Minute Template

Meeting Name: **Date:** **Time:** **Location:** **Facilitator(s):**		**Present:** **Absent:** **Guests:**	
Agenda Item/ *Handouts*	**Discussion/Opportunities**	**Next Step/Follow Up**	**Responsible Person**
	.		
Next Meeting Date: **Next Meeting Time:** **Next Meeting Location:**			

Appendix I


QI Project Process Flow
Performance monitoring/progress reporting
Routine processes/ service level
Ideas for improvement
Discuss opportunities for improvement at the Division level
Is there more than one project at Division?
Yes
No
Prioritization matrix
Complete QI Project Application Form
Submit project for QIC to review and approve
PDCA Cycle by project team
Document every step of the process (TEAM CHARTER)
Implement changes in larger scale?
No
Yes
Complete storyboard + plan next steps
Storyboard is published
Equity Lens

Appendix J

QI Project Proposal Form

Appendix A
Kane County Health Department
Quality Improvement PDCA Project Proposal

Adapted from Tacoma-Pierce County Health Department

Project title:	***Submitted by:***
Date submitted to QI Committee:	***PDCA Matrix Completed & Attached:*** Yes ☐ No ☐
Briefly identify or describe the program, project or process that should be addressed with a QI project:	
Priority: ☐ High ☐ Medium ☐ Low	***Please explain why you selected this priority level:***
Departmental Implications ***a. Which strategic initiative and/or CHIP priority does this project support, or how does this project support our mission and/or vision.*** ***b. Who are the stakeholders (internal and external) and what are their concerns?*** ***c. What resources and support will be needed to complete the project?*** ***d. What potential impact could there be on other programs/activities if this QI project is conducted?***	
What are we trying to accomplish? (A brief goal statement)	
How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project) ***Long term:*** ***Medium term:*** ***Short term:***	
What changes can we make that will result in an improvement? (Initial hypotheses and description of data needed to focus the project and the development of an intervention).	
Who should be on this QI team?	***Who should lead this QI team?***

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

QI Committee Member Signature: _____

Kane County Health Department
Quality Improvement PDCA Project Decision Matrix

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

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

Updated June 2022

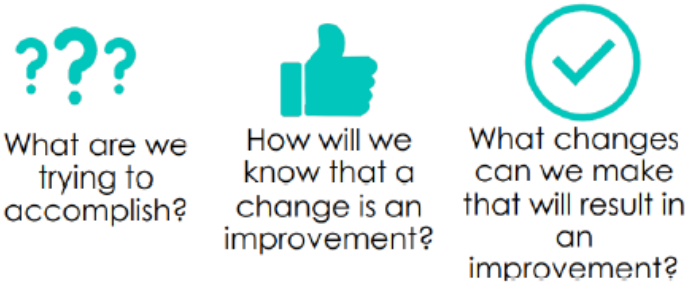
Appendix K

PDCA Roadmap

QI Projects- Using the PDCA (Plan-Do-Check-Adjust) model

What is PDCA?

First thing we need to do is ask ourselves these 3 questions:



Understanding PDCA steps

Stage	Step	Overview	Ask yourself	Tools	Suggested meeting guidance
Plan	1. Getting started	• Identify your problem/opportunity • Have data that support our selection • Identify & gather resources that will be needed.	What opportunities for improvement exist in our work?	Team charter	Initial meeting (Bi-weekly recommended)
	2. Assemble the team	• Identify participants (staff, customers, partners) • Draft a problem statement • Draft a SMART objective for the project. • Assign roles (leader, facilitator, scribe, document manager, meeting scheduler) • Create a project timeline • Organize information in a Team Charter.	Who can add value to this project? What is the objective of this project?	Team Charter SMART Objective Worksheet Role descriptions Sample Meeting Agenda	Initial meeting (Bi-weekly recommended)
	3. Examine the current approach	• Team fully explores existing process • Create flow chart • Explore data to establish baseline • Explore the root cause of the problem.	What do we know about the problem?	Team Charter Check Sheet Process mapping/flow chart Root Cause analysis tools (Fishbone, 5 Whys, Tree Diagram)	Meeting 1: baseline data and current process Meeting 2: root cause analysis (Bi-weekly recommended)
	4. Identify potential solutions	• Comprehensive review of all potential solutions • Look for model practices • Select potential solution (within scope of control) that can best address the cause.	What could be done to improve the problem?	Team Charter Solutions brainstorm (affinity diagram, tree diagram, prioritization matrix, cause/effect grid)	Bi-weekly recommended
	5. Develop an improvement theory	• Develop improvement theory • Include prediction of outcome when solution is tested in small scale • Develop strategy to test theory (who will be involved, resources needed, timeline)	What do we think will happen if we try this solution? What doe we need to implement it?	Team Charter Gantt chart	Bi-weekly recommended

2

Do	6. Test your theory for improvement	• Put your plan for improvement theory into place in a small scale • Document results	Are we carrying out the test as planned?	Team Charter Data collection sheets	Monthly meetings
Study	7. Use data to analyze results	• Examine data collected in step 6 • Compare results against baseline • Review overall team experience • Start storyboard	Did the change tested result in an improvement?	Team Charter Bar charts Tables Pie charts Storyboard template	Monthly meetings
Act	8. Standardize improvement or develop new improvement theory	• Adopt the change as standard Or • Adjust the change and test it again (restart from step6) Or • Abandon the change and develop a new theory (restart from step 5)	Should we standardize the change or do we need more information?	Team Charter Storyboard template	Monthly meetings
	9. Establish future plans	Plan on how to maintain gains Plan for additional PDCA cycles		Team Charter Storyboard template	Monthly meetings

Adapted from: Michigan Public Health Institute, Equity in Action Workshop, 2022

Resources for QI Tools:

In KCHD "S" Drive
Presentations
S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI_Training_Resources\QI Module_TOOLS Training Presentations
Templates
S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI_Training_Resources\QI_Training Handouts & Templates

Quality Tools website (American Society for Quality)

Public Health & QI Toolbox (Minnesota Department of Health)

Appendix L

QI Project Team Charter

QI Project Team Charter

Project name:	**Date created:**	**Division/Section:**

Problem statement:	
Team sponsor:	**Team leader:**
Team members	**Role in the project**
1.	Facilitator
2.	Meeting Scribe
3.	Data/Information Liaison
4.	Document Manager
5.	Meeting Scheduler
6.	Subject Matter Resources
7.	Equity Champion
8.	Other (specify)
QI Project Team Meeting Frequency:	
SMART Objective:	
Initial	
Revision 1	
Revision 2	
Final	

Customers for this QI Project	
Internal	External

Measures that will be used to track success (specify calculations when needed)

Improvement Theory	**If…**
	Then…

PDCA Timeline		**Date range**	**Progress notes**
Plan	1- Getting started		
	2- Assemble team		
	3- Examine current approach		
	4- Identify potential solutions		
	5- Develop improvement theory		
Do	6- Test theory		
Check	7-Check results		
Act/Adjust	8-Implement/Adjust/Abandon		
	9-Establish future plans		

Communication plan (reporting/sharing)

Appendix M

Storyboard Template

PDCA STORYBOARD

DIVISION/OFFICE: _____

SECTION: _____

MEMBERS: _____

PROJECT TITLE: _____

DATES OF PROJECT: _____

PLAN
Identify an opportunity and Plan for Improvement

1. Getting Started

2. Assemble the Team

3. Examine the Current Approach

4. Identify Potential Solutions

5. Develop an Improvement Theory

DO
Test the Theory for Improvement

6. Test the Theory

CHECK
Use Data to Study Results of the Test

7. Check the Results

ACT
Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop New Theory

9. Establish Future Plans

Appendix N

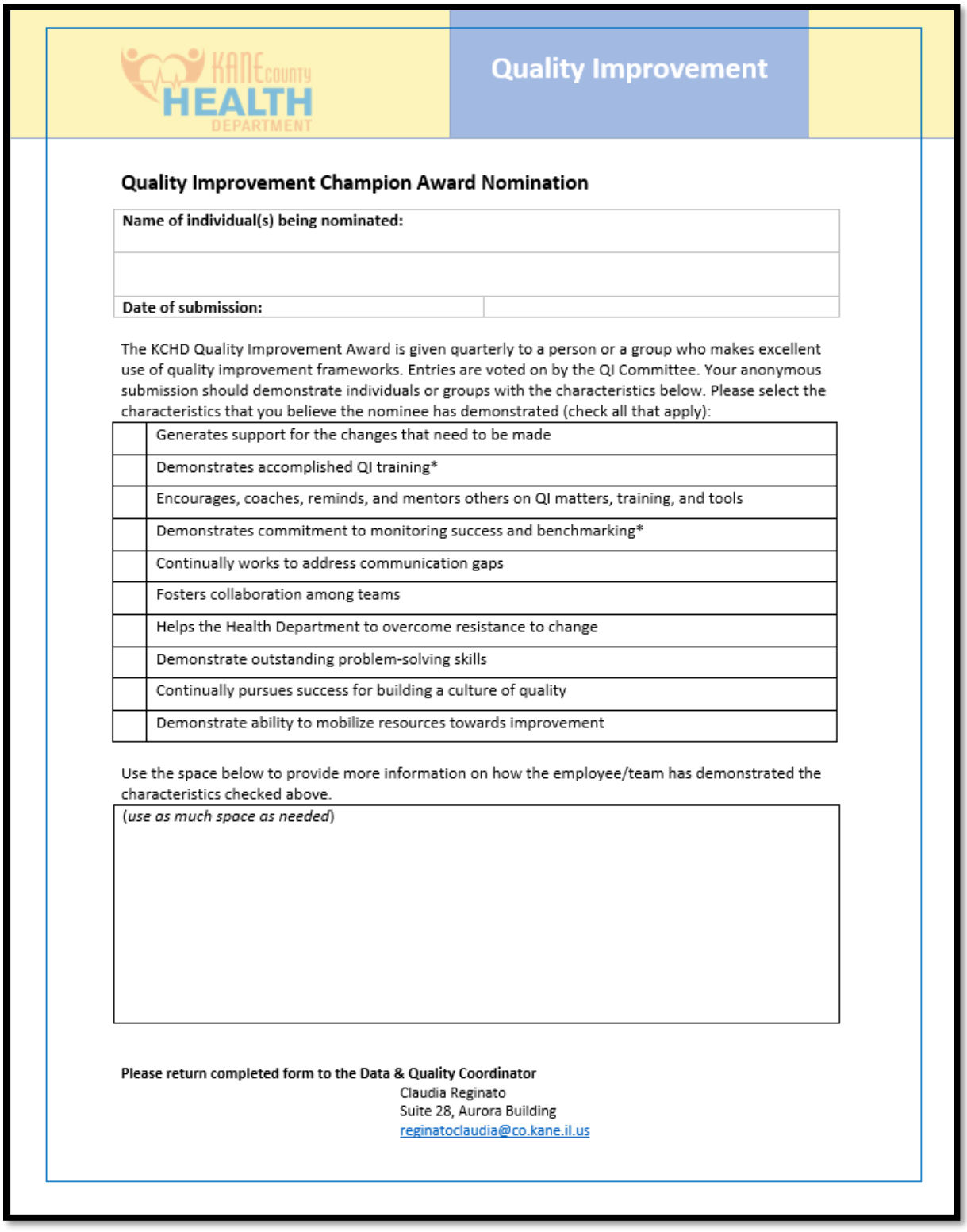
List of Past KCHD QI Projects
Different projects from various years can be found in this folder in the S drive:
S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI-PDCAs Projects

Appendix O

Quality Improvement Policy, Performance Management Policy, and Customer Satisfaction Policy
S:\Division of Community Health Resources\Health Resources & Support\Quality Improvement\QI_PM_Customer Satisfaction Policy

Appendix P

QI Champion Nomination Form



KANE county HEALTH DEPARTMENT

Quality Improvement

Quality Improvement Champion Award Nomination

Name of individual(s) being nominated:	
Date of submission:	

The KCHD Quality Improvement Award is given quarterly to a person or a group who makes excellent use of quality improvement frameworks. Entries are voted on by the QI Committee. Your anonymous submission should demonstrate individuals or groups with the characteristics below. Please select the characteristics that you believe the nominee has demonstrated (check all that apply):

	Generates support for the changes that need to be made
	Demonstrates accomplished QI training*
	Encourages, coaches, reminds, and mentors others on QI matters, training, and tools
	Demonstrates commitment to monitoring success and benchmarking*
	Continually works to address communication gaps
	Fosters collaboration among teams
	Helps the Health Department to overcome resistance to change
	Demonstrate outstanding problem-solving skills
	Continually pursues success for building a culture of quality
	Demonstrate ability to mobilize resources towards improvement

Use the space below to provide more information on how the employee/team has demonstrated the characteristics checked above.

(*use as much space as needed*)

Please return completed form to the Data & Quality Coordinator

Claudia Reginato
Suite 28, Aurora Building
reginatoclaudia@co.kane.il.us

Published by the Kane County Health Department, Division of Community Health Resources, 2022

For questions about this plan, contact
Claudia Reginato
reginatoclaudia@co.kane.**il.us**
(630) 232-5819