KANE COUNTY HEALTH DEPARTMENT

FY2016 QUALITY IMPROVEMENT & PERFORMANCE MANAGEMENT PLAN

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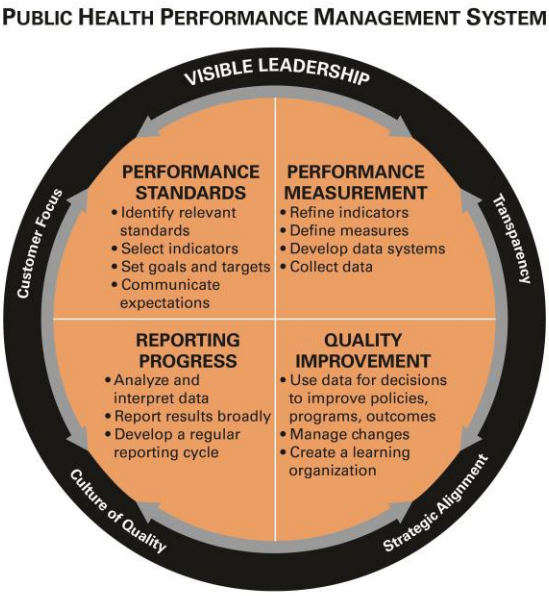
I. Purpose of the Quality Improvement & Performance Management Plan

The purpose of the Kane County Health Department (KCHD) Quality Improvement & Performance Management Plan (QI/PM Plan) is to provide context and framework for quality improvement (QI) and performance management (PM) activities at Kane County Health Department. KCHD utilizes the Turning Point Performance Management Framework as their performance management system, as described in the image below (Image source: Public Health Foundation).



Policy Statement, Performance Management Policy (9.1): KCHD will implement and maintain a performance management system, as outlined by the performance management system "Turning Point: Collaborating for a New Century in Public Health", published by the Public Health Foundation and the Robert Wood Johnson Foundation. This system will function in conjunction with the agency's annual budgeting process, the Community Health Improvement Plan (CHIP) and Strategic Planning. The performance management system will be reviewed and updated on an annual basis.

Policy Statement, Quality Improvement Policy (9.2): KCHD will implement a quality improvement system, including a plan, for all of its programs, interventions, and processes as a part of the agency's performance management system.

II. Key Quality Terms

So as to provide a common vocabulary and a clear, consistent message, the following key

quality terms are defined below.

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

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

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).

Public Health Quality Improvement Exchange (PHQIX) - The Public Health Quality Improvement Exchange (PHQIX) is an online community designed to be a communication hub for public health professionals interested in learning and sharing information about quality improvement (QI) in public health (Public Health Quality Improvement Exchange, 2012).

Quality Improvement (QI): The use of a deliberate and defined improvement process, such as Plan- Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. (Accreditation Coalition Workgroup, 2009).

Quality Improvement/Performance Management Committee: Agency-wide committee, organized by the Health Data and Quality Coordinator and the KCHD Leadership Team, to carry out QI activities, namely PDCA cycles. The QI Committee objectives include supporting PDCA cycles occurring at the section level, developing, 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): Builds on an assessment component in which a group of selected indicators (selected by an agency) are regularly tracked and reported. The data should be regularly analyzed through the use of control charts and comparison charts. The indicators show whether or not agency goals and objectives are being achieved and can be used to identify opportunities for improvement. Once selected for improvement, the agency develops and implements interventions, and re-measures to determine if interventions were effective. These quality methods are frequently summarized at a high level as the Plan-Do-Check-Act (PDCA) or Deming's Shewhart Cycle (PHAB Acronyms and Glossary of Terms, 2009).

Quality Planning (QP): 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 is need of 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).

III. Culture of Quality

KCHD is committed to fostering a culture of quality within the organization, and the development of this culture is outlined below. In order to assess the integration of a quality culture, KCHD evaluates their progress annually against the Roadmap to a Culture of Quality Improvement, developed by the National Association of County and City Health Officials (NACCHO).

2006 – KCHD participates in the Common Ground project, sponsored by the Robert Wood

Johnson Foundation. This project served to use business process analysis and redesign to develop toolkits for public health preparedness.

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

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

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

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

2011 - KCHD worked to remedy the gaps identified in Public Health Accreditation Board (PHAB) standards. Staff and leadership were surveyed on their training needs, as well as their level of engagement in QI. All staff participated in monthly QI training, correlated with the completion of six section-level QI projects. PDCA project results were displayed in June in a poster presentation event attended by all staff. KCHD's first QI Committee was formed in March, with the goals of overseeing the implementation of the QI Plan, assisting in implementation of PDCA projects, and developing skills through completion of "Train-the-Trainer" modules on QI tools. Additionally, KCHD received support from the Kane County Health Advisory Committee (HAC) through the development and implementation of the QI and Accreditation framework as well as the QI Plan. The HAC is comprised of representatives from healthcare and academia and serves to provide consultation and support to KCHD as well as be a liaison to the Kane County Board.

2012 – KCHD continued to build a culture of quality with the development of the agency's first performance management (PM) system. Using the Turning Point model, KCHD assessed the department's capabilities, trained staff on the system, and developed the first set of performance measures. These measures were monitored on at least a quarterly basis, with internal reporting occurring on the same schedule. PDCA projects were selected based on opportunities identified in the PM system, and many were directly integrated with

the CHIP and Strategic Plan. As a means to communicate progress, the first annual report dedicated to QI was released this year. KCHD was nationally recognized for their QI efforts in 2012, with the receipt of a Model Practice Award from the National Association of County and City Health Officials (NACCHO), and inclusion of two QI projects into the Public Health Quality Improvement Exchange (PHQIX). As KCHD expanded their QI culture into a broader PM system, the QI Committee structure was changed.

2013 – With the selection of new PDCA projects, the membership of the QI Committee was rotated to include new members. These members took the lead role on the PDCA project implementation that began in December 2012. A series of web-based training modules of 14 QI tools was released to KCHD, with a requirement of all staff completing a specific set of six. As an additional means of communication, a quarterly QI-focused newsletter was developed and released by the QI/PM Committee beginning in 2013 (4 issues). Finally, with the conclusion of the first year of the PM system, a decision was made to integrate the PM system with the county fiscal year. As a result, the QI Plan and PM system measures were extended for a "fifth quarter" through fall 2013. Also during this period, each section completed a process to identify and develop a new set of performance measures that aligned with key outcomes of each program. The expectations for these measures included representation of all programs, at least one customer-facing measure per section, and inclusion of measures developed for the agency budget. This QI/PM Plan was also realigned to match the PM system, and all rolled out on December 1, 2014, for county fiscal year 2015.

2014 – KCHD continued to build a QI culture and created a QI resource database for staff with recommended national websites and documents to utilize as a reference. Additionally, staff completed annual PDCA projects and participated in all-staff QI activities. KCHD also facilitated an annual performance management process with each staff member to increase buy-in and understanding of performance management impact on agency effectiveness. In August of 2014, the health department conducted All-Staff PDCA training. Finally, KCHD reviewed its current process to receive customer feedback and improve upon previous systems to develop practices and procedures throughout the agency.

The future state of quality at KCHD includes the following:

- Continued growth of the QI & PM systems at KCHD, assuring participation in both systems by all employees of the department,
- Demonstrated competence by all staff in a wide range of quality improvement tools,
- Increasing use of quality improvement tools and methodologies in daily work tasks by individuals and by teams at meetings,
- Additional exploration and use of Quality Planning in the QI/PM system,
- Integration of Quality Planning into existing systems of Quality Improvement and Quality Control,
- Sustained or increasing levels of engagement and participation regarding QI/PM as evidenced through annual staff QI surveys,
- Completion of at least one PDCA project for all sections at least annually, and
- QI & PM not only impact daily operations, but serve to improve population level outcomes and indicators, as described in the Community Health Improvement Plan (CHIP) and Strategic Plan.

2015 - KCHD was awarded two Model Practice Awards at the National Association of County and City Health Officials (NACCHO) annual conference in Kansas City July 7-9. The awards were for Assessing and Improving Routine Food Inspection Report Completeness and Implementing Quality Improvement Projects with Medical Providers to Increase Smoking Cessation among Low Income Patients. In conjunction with PHQIX, KCHD created a video highlighting QI Culture at KCHD. The video highlighted the building of a culture of quality and the health department, and had key components such as the success of the use of QI training modules, an all-staff meeting which trained staff on PDCAs using a paper airplane activity, and how quality improvement tools are being used with partners outside of the health department. The video was featured on the front page of the PHQIX website. In January, the health department created four games to help learn about quality improvement terminology, tools, the Quality Improvement and Performance Management Plan, and the Public Health Quality Improvement Exchange. Quality Improvement efforts were highlighted throughout the year in the health department's employee newsletter. The QI 101 training was revamped to help address the best methods to train new staff members. Additionally, KCHD provided accreditation support and guidance to neighboring counties and also sat in on the Illinois Department of Public Health's (IDPH) accreditation site review portion with community members.

IV. Governance of Quality Improvement Plan

a. Organizational Structure

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

KCHD Leadership Team: The KCHD Leadership Team will support the efforts of the 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 also be asked to participate in QI training activities, become skilled in the implementation of QI tools, and to provide concrete feedback and evaluation of QI training and PDCA projects. Leadership Team members will serve as the primary group responsible for implementation, monitoring, and evaluation of the agency's PM system.

Kane County Health Advisory Committee: The Kane County Health Advisory Committee will provide bi-directional 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/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.

b. Membership and Rotation

QI Committee members will be representative of each of the three Divisions/Offices of KCHD, and will assure that each Section within the Division/Office is represented. In addition, each Division/Office will be represented by one member of the Leadership Team and two members of the staff to participate (for a total of nine members, not including the HDQC, representing the Office of Community Health Resources).

Committee members should be considered with a minimum of one of the criteria below: 1) expressed interest in committee participation, 2) assurance that all KCHD employees have an opportunity to participate in the QI Committee, and 3) identified lead for a PDCA project. The major goal for Committee participation is to develop champions of QI and PM, and this can be done best if Committee members have an expressed interest in the Committee. However, it is also important to consider that KCHD desires to have all staff be champions of QI and PM, so a balance must be met between those with a high desire to participate and the need to have all staff take a turn on the Committee. While it is not required that Committee members are project leads for PDCA, this should be a consideration in selecting members. The HDQC will work with Division Leadership to select QI Committee members.

QI Committee members will typically serve a term of two years. These terms may be shortened or extended based on agency/operational need, so long as each Division/Office has three representatives, one from the Leadership Team, and two from staff, and that each Section is represented. The Health Data and Quality Coordinator will always be a member of the committee, serving as its facilitator.

Roles and responsibilities of QI Committee members can be found in the next section of this document.

c. Roles and Responsibilities

Executive Director

- Provide leadership for department vision, mission, strategic plan and direction related to QI efforts.
- 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 a 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 documents such 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 (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 and Health 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 HDQC.
- Encourage program staff to incorporate QI concepts into daily work.
- Apply QI principles and tools to daily work.
- Assure implementation, monitoring and evaluation of the agency's 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 HDQC).
- 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.)

Health Data & Quality Coordinator (HDQC)

- Coordinate, support, and guide QI/PM department-wide.
- Develop the annual 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 PHQIX 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 HDQC.
- 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.

d. Staffing and Administrative Support

The Health Data and Quality Coordinator position is specifically tasked with the development, implementation, evaluation and coordination of all QI/PM activities within KCHD, comprising 60-75% of the full-time equivalent (FTE) position. As this position is housed within the Office of Community Health Resources, the Support Associate for that Office may be tasked for administrative support as needed. Additional staffing and/or administrative support may be provided by the Assistant Director for Community Health Resources, the members of the QI Committee, or the Executive Director.

e. Budget and Resource Allocation

The primary budget allocation for this program is for the Health Data and Quality Coordinator position, which is paid out of local funds. Additionally, the KCHD grant writer will actively seek awards for QI related funding. As resources allow, budget line items may be dedicated to QI/PM efforts, including the purchase of training materials, attendance at conferences, and securing the services of expert consultation in the areas of QI and PM. Future planning in this area will include analysis of cost, return on investment of implementation of quality improvement projects, and a more in-depth understanding of budget allocation specific to QI for staff members, members of the QI Committee, and the Leadership team.

V. Training

a. New Employee Orientation

As a part of the new employee orientation process, all newly hired KCHD staff and interns will be provided an orientation to the QI/PM systems by the HDQC with support from their direct supervisor, including assignment to an existing PDCA workgroup. New employees will be provided orientation to the PDCA process, as well as completed projects. They will be informed on the location of QI and PM materials (network shared drive) and be given time to review those materials as a part of their orientation. New employees will complete QI 101 Orientation which will consist of an initial (1 hour) training, followed by a (1/2 day) "hands on" training once they have become more familiar in their role. Employees should also complete training modules for Aim Statements, Cause & Effect (Fishbone) Diagrams, Data Collection & Analysis, Flowcharts and SWOT Analysis. These web-based training modules will include the completion of a worksheet on the material, which will be reviewed by the HDQC.

b. Advanced Training for Lead QI Staff

Members of the QI Committee and KCHD Leadership teams are expected to have higher-level QI skills, and as such, will be provided additional training on QI tools and methodologies. A series of "Train-the-Trainer" modules are available for this group, and include:

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

These modules are housed on the agency's network shared drive, with the location communicated to the QI Committee and KCHD Leadership team. These modules are available for use as self-study or for hands-on training during QI Committee meetings. QI Committee members are strongly encouraged to practice use of these tools within their sections, reporting back the results and the product created from the training session.

Additional opportunities for advanced training in the areas of QI and PM will be made available to the QI Committee and KCHD Leadership team as applicable and as resources permit. These could include, but are not limited to, webinars, off-site training opportunities, and participation in conferences.

c. On-going Staff Training

Web-based training modules have been developed and are available to use as a refresher or for new employees. Those indicated in bold text are required for completion by all KCHD staff, while completion of the remaining training modules is strongly encouraged for all staff.

- **Aim Statements**
- Affinity Diagrams
- Brainstorming
- **Cause & Effect Diagrams**
- **Data Collection & Analysis** (Check Sheet, Bar Chart, Pie Chart, Run Chart, Pareto Diagram)
- Five Whys/Five Hows
- **Flowcharts**
- Force Field Analysis
- Gantt Chart
- **QI 101/PDCA**
- Prioritization Matrix
- Storyboards
- **SWOT Analysis**
- Voice of the Customer

Links to each presentation and the corresponding worksheet have been housed on the agency's shared network drive, with the location communicated to staff for access at any time. In addition, a one-page handout on each tool has been made available on the shared drive.

Refreshers on these tools can be provided in a number of venues, including All Hands, Division, Section, and/or Team meetings. Areas of focus for training at these meetings will be based on results of a QI training needs survey, completed annually, or at the request of the KCHD Leadership team. In addition, as a part of the support to begin PDCA projects, the HDQC (or a designee from the QI Committee) will review the tools used as a part of the PDCA process before they are implemented.

Reinforcement of training has also been identified as critical to the use of these tools, and KCHD will utilize a number of strategies for this reinforcement. These strategies include utilizing QI Committee members in a cross-silo format to provide training and technical assistance (as an outside third party), sharing stories of QI tool use in "what's working" sections of meetings, using QI tools with our partners and in the community, and using Line of Sight to help people connect daily QI tool use to bigger picture strategies such as those in the Community Health Improvement Plan (CHIP) and Strategic Plan.

Additional opportunities for training in the areas of QI and PM will be made available to staff as applicable and as resources permit. These could include, but are not limited to, participation in webinars, off-site training opportunities and participation in conferences.

d. Position-Specific QI Training

The HDQC, with specific accountability for the implementation of the QI program, will attend trainings and conferences specific to QI as available and as resources allow, assuring that skills are enhanced and that KCHD remains abreast of current topics in QI/PM. In addition, the HDQC will participate as a member of the NACCHO QI Leaders Group, in order to be aware of training opportunities and contribute to national efforts to integrate QI/PM in public health.

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

VI. Identification of Improvement Projects & Alignment with Strategic Plan

a. Project Selection Criteria

QI project selection will be based on the need to improve program processes, objectives, and/or performance measures and are tied to the agency Strategic Plan and PM system. Projects may be selected in a number of ways, including, but not limited to, identification by Leadership and QI Committee during quarterly reviews of PM data.

On an annual basis, each of the six sections of KCHD (Community Health Resources, Administration, Public Health Nursing/Communicable Disease, Environmental Health and Community Health) will select and develop at least one PDCA project. After selecting a project, the PDCA workgroup will be expected to complete a QI proposal and project plan (Appendices A, B & C), to be submitted to the QI Committee for discussion and feedback.

The QI Committee can also 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. While it is ideal that each section's PDCA project involve as many section staff as possible (optimal state: include all section staff), the section may opt to select a project that involves only a small group, so long as the remaining staff remain engaged in other QI activities.

Each KCHD Section 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 selected PDCA project for each section will be documented via the storyboard format, and that the finished storyboard be shared with staff. At the discretion of the KCHD Leadership team, the storyboards may also be posted on the agency's website and submitted to the Public Health Quality Improvement Exchange (PHQIX).

In addition, sections or workgroups may choose to develop improvement projects outside of the PDCA model, utilizing appropriate QI tools. While completion of a storyboard is not required for non-PDCA projects, documentation of the process, tools used, outcomes, and lessons learned should be completed, either in the form of progress notes, meeting minutes or through the use of PDCA worksheets (completing applicable sections).

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

b. Agency and Division Level Goals and Objectives (Performance Measures)

Annually, KCHD will conduct a process to identify agency and division-level goals and objectives (Performance Measures) as a part of the agency's PM system. This process will include participation by all staff in each division, and selected measures will be

documented using the Performance Measure Data Description and Collection Form (Appendix D). Originals of these documents will be maintained by division Leadership, with copies provided to the HDQC so a central repository of measures is maintained on the agency shared drive.

Performance Measures will have a direct line of sight with the agency's Strategic Plan, the Community Health Improvement Plan, Healthy People 2020 Objectives or another recognized performance standard, and this information will be captured on the Performance Measure Data Description and Collection Form.

The list of selected Performance Measures is included as Appendix E of this document. Additional information about PM can be found in KCHD policy 9.1 and protocol P35.

VII. Goals, Objectives, and Performance Measures for QI/PM

Goals and objectives are based on the PHAB Standards and Measures, Version 1.5, released in 2014. These goals were selected as priority goals for this plan due to their connection with accreditation. Annual goals and objectives will always be based on the current version of PHAB and will be updated accordingly if changes occur throughout the year.

PHAB Domain nine requires evaluation and continuous improvement of health department processes, programs and interventions. Progress toward these goals is to be evaluated by the QI Committee on a quarterly basis, and the results of this evaluation are included as a measure in the agency PM system.

Goal 1: Establish and maintain a quality improvement plan based on organizational policies and direction.

Objective: Develop an annual agency QI/PM Plan that seeks to increase staff knowledge of quality improvement and supports the development of PDCA implementation, while considering the importance of the PHAB accreditation requirements moving forward.

Measure: Approved KCHD QI/PM Plan.

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

Goal 2: Implement quality improvement efforts.

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

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

Key Strategies:
1. HDQC will meet with each PDCA project lead at least monthly to provide training, technical assistance and support of PDCA project.
2. HDQC will maintain an electronic database of PDCA project work for each workgroup and assure that it is available on the KCHD shared computer drive (S Drive) for review by all KCHD staff.
3. HDQC will provide at least monthly updates to the Assistant Director for Community Health Resources on progress of PDCA projects.
4. All PDCA project workgroups will use standard documentation for their projects, including the PDCA Decision Matrix, PDCA Project Proposal, PDCA Project Plan, progress notes maintained using the PDCA Outlines (Steps 1-9) and the completion of a storyboard at the conclusion of the project.
5. All sections will maintain a record of QI tool used, both within the context of and independently from PDCA projects. Sections will report QI tool use monthly at QI Committee meetings.
6. Communication of QI efforts will be completed via posting of materials at least once a month through various mediums including the Employee Newsletter, Social Media, KCHD Website, PHQIX, internal email, and other available methods.
7. Upon approval by the project leads and members, storyboards displaying successful PDCA work will be published to the KCHD website and/or displayed throughout the Health Department.

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

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

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

Key Strategies:
1. HDQC will create and maintain a training log of staff that have participated in QI Training, and will share a summary of that on a quarterly basis with the KCHD Leadership team and QI Committee.
2. All staff will complete a worksheet of the material following training, as well as completing an evaluation of the effectiveness of the training/presentation. Results of both will be used to determine needs for additional training in each area.
3. 95% of staff will have completed the six required QI training modules by the end of the plan year.
4. 25% of staff will have completed all of the available (13) QI training modules by the end of the plan year.
5. An annual survey of staff will be conducted to assess need for training, and specific areas of focus.

6. KCHD Leadership will assure that new employees receive orientation and initial QI training (using web-based modules) within six months of date of hire, as well as on-going training.
7. The QI Committee will demonstrate competence with use of at least 4 QI tools during the year.

Goal 4: Use a performance management system to monitor achievement of organizational objectives.

Objective: Implement a fully functioning performance management system that is completely integrated into health department daily practice at all levels and includes organizational objectives, indicators of progress, monitoring and reporting of progress, and identifying areas where quality improvement can help achieve objectives.

Measure: Adopt and fully implement a Performance Management system.

Key Strategies: 1. Annual assessment of Leadership using the Turning Point self-assessment.
2. Develop an annual QI/PM Plan that outlines the framework for the Performance Management system, is reviewed by the QI Committee and Leadership Team, and is signed by the KCHD Executive Director
2. Annual selection of performance measures by staff in all KCHD Sections/Divisions, which align with the Strategic Plan, CHIP or other set of standards.
3. Provide quarterly update of a performance management dashboard in each Section/Division.
4. Quarterly dissemination of PM data to all staff and discussion in at least one Division-level meeting annually.
5. At least annual training/refresher to all KCHD staff (at the section or division level) on PM conducted during the year.
6. At least annual discussion of the Performance Management system with the governing entity (Health Advisory Committee and/or Kane County Board).

Goal 5: Implement a systematic process for assessing customer satisfaction with health department services.

Objective: Collect, analyze, draw conclusions and take actions based on customer feedback.

Measure: Quarterly collection of customer data from all KCHD programs.

Key Strategies: 1. Review and approve the Customer Satisfaction Policy and previous efforts surrounding customer satisfaction.
2. Review the Customer Satisfaction Survey to identify if current tools are an appropriate means to measure customer satisfaction.
3. Revise Customer Satisfaction Policy to reflect the needs of the agency and/or individual programs.
4. Identify and create a process for implementing the Customer Satisfaction Survey.
5. If necessary, revise the Customer Satisfaction Policy to reflect changes to the survey and implementation process.
6. Disseminate a standard customer satisfaction tool to all external customers (non-partnerships), at least twice per year, that receive services from KCHD.

7. Create actionable improvement steps resultant from surveys in at least 50%of KCHD sections on an annual basis.

In addition to these goals, agency performance measures will be developed specific to the areas of QI/PM.

VIII. Monitoring of Quality Improvement/Performance Management

a. Collection, Analysis, and Monitoring of Data

Data will be collected for each of the KCHD Performance Measures by the program/division indicated on the Performance Measure Data Description and Collection Form (Appendix D). Assistance and support for this process can be provided by staff in the Office of Community Health Resources as necessary. A summary of data points from each division will be submitted to the Epidemiologist on the 15th of the month (for the previous month), for inclusion in the agency's data repository and dashboard. For measures reported on a quarterly basis, the data is to be reported by the 15th of the months of March, June, September and December (unless measure is on an alternate reporting schedule indicated on the Data Description and Collection Form (Appendix D)). This data repository and dashboard will be housed and available for all staff on the agency's network shared drive. Once updated, an e-mail will be sent to all staff from the Epidemiologist, notifying them of the available updates.

Quarterly meetings will occur with each Division Leadership team and their QI Committee representatives to review and analyze the results, identifying opportunities for improvement projects. As a part of this meeting, Divisions will also report whether each performance measure is on-target or far/significantly off-target.

b. Reporting Progress Toward Achieving Stated Goals

KCHD Divisions and Sections will report progress on performance measures to their respective staff on at least 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. QI/PM, including progress toward goals and objectives, will be on the agenda of at least one All Hands meeting each year.

c. Actions to Make Improvements Based on Progress Reports

During the quarterly meeting between representatives of OCHR (including the HDQC), Division leadership and Division QI Committee members, the group will review each of the Division performance measures and determine their status. For those measures in which QI action is required, an action plan/Gantt Chart will be developed to guide the completion of this work. QI Committee members should take the lead on implementing these QI action plans, with the support of their Division team members and leadership. Technical assistance can be provided by OCHR as needed. The results of these QI efforts are to be reported at the next quarterly meeting.

IX. Sustainability of Quality Improvement

a. Communication & Promotion

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

- PDCA workgroup updates at All Hands meetings,
- Presentations and training at Division, Section, and Team meetings regarding QI project updates or QI tools,
- 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.
- Communication of QI efforts will be completed via posting of materials through various mediums including the Employee Newsletter, Social Media, KCHD Website, PHQIX, internal email, and other available methods.
- Inclusion in Kane County Board flash reports at least once annually.
- Dissemination of the approved QI/PM Plan via e-mail or at a staff meeting, including the expectations of the contributions of all KCHD staff; a link to the plan on the KCHD shared computer drive (S Drive) will also be provided, and KCHD staff will be encouraged to review and provide comment on the document.

b. Recognition

As 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. Strategies designed to recognize QI/PM efforts include, but are not limited to:

- Providing regular updates and recognition of PDCA project teams and work completed at Division/Section meetings,
- Sharing stories and “bright spots” of QI tool use at Division, Section and Team meetings, as well as at QI Committee meetings, and
- The use of incentives and rewards as resources allow and are recommended by the Leadership team and QI Committee.

c. Agency Policies

KCHD initially developed policies regarding QI and Performance Management in 2010, which were approved by the Executive Director in August 2011. These policies are to be reviewed annually by the QI Committee and modified as necessary to reflect changes in QI/PM efforts. After annual review and approval by the QI Committee, the final policy will be forwarded to the KCHD Executive Director for approval. The approved QI and PM 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.

X. Approval and Evaluation of Quality Improvement Plan

Annually, a draft QI/PM Plan for the fiscal year will be developed by the QI Committee based on progress toward goals and evaluation of the previous year’s plan. Once a draft is complete, it will be vetted through the Assistant Director for Community Health Resources, the KCHD

Leadership Team, and the Executive Director, in that order. The Executive Director will provide final approval and signature.

In the fourth quarter of each fiscal year, the QI/PM Plan and activities will be evaluated by the QI Committee and the KCHD Leadership team. This evaluation will include:

- A review of the process and progress toward achieving goals and objectives,
- Efficiencies and effectiveness obtained and lessons learned,
- A summary of QI projects and results of those projects, including but not limited to PDCA efforts,
- Progress on performance measures related to QI/PM,
- Effectiveness of the agency's PM system, including the results of the annual survey completed by Leadership (Turning Point Performance Management Self-Assessment),
- Effectiveness of the agency's QI training program, including the results of the annual QI Training Needs survey, and
- A summary of how the results impacted the development of the QI/PM Plan for the next year.

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

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

Approved the 11th day of NOVEMBER 2015, for the period of December 1, 2015 - November 30, 2016.

Barbara Jeffers, Executive Director

Reviewed by Kane County Health Advisory Committee the 22nd day of March 2016.

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 an QI project:		
Priority: High Medium Low	***Please explain why you selected this priority level:***	

Departmental Implications

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

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

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

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

What are we trying to accomplish? (A brief goal statement)

How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project)

Long term:

Medium term:

Short term:

What changes can we make that will result in an improvement? (Initial hypotheses and description of data needed to focus the project and the development of an intervention)

Who should be on this QI team?	***Who should lead this QI team?***

Reviewed by QI Committee on_____/_____/20____

QI Committee Member Signature: _____

Appendix B
Kane County Health Department
Quality Improvement PDCA Project Plan

Adapted from Tacoma-Pierce County Health Department

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

Reviewed by QI Committee on_____/_____/20_____

QI Committee Member Signature: _____

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

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

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

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

Year _____ Program _____

___Division Level Measure ___Agency Level Measure

Performance standard:	
Performance measure:	
Baseline measurement data and date(s) collected:	
Target or benchmark?	
What is the target/benchmark?	
Rationale for selection of this performance measure:	
Target population:	
Numerator:	
Denominator:	
Source of data:	
Who will collect the information?	
How often will the data be analyzed and reported?	
What essential service does the data fall under?	
Does this align with a Healthy People 2020 objective?	
Does this align with KCHD's vision and mission? (Y/N)	
Definitions and other comments:	

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

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

Definitions/Clarifications

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

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

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

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

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

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

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

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

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

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

Appendix E
Kane County Health Department
Performance Measures - FY2016 (12/1/2015 - 11/30/2016)

Monthly Indicators by Division

CH	CH M1 - Childcare Trainings	Number of childcare providers trained in the area of health and safety program from Childcare Nurse Consultant of Childcare Resource and Referral Network	Number of childcare providers trained		
CH	CH M2 - Social Media	Number of social media engagements	Number of social media engagements		
CH	CH M3 - MIECHV Caseload	Percent of active cases in Elgin MIECHV caseload	Number of MIECHV home visits slots filled with families	Number of MIECHV home visits slots available for families	Provides specific expectation of joint Elgin MIECHV caseload achievement. Grant requires achievement of this target, as well as AOK/CHIP priority. This goal is selected by the community collaboration with agreement of all 3 MIECHV partners.
CH	CH M4 - MIECHV Referrals	Percent of MIECHV referring agencies that meet their referral volume goal on a rolling quarter basis	Number of referring agencies that meet their referral volume goal on a rolling quarter basis	Number of referring agencies that routinely refer to the CI home visit system	This assists in reaching the MIECHV grant, CHIP, and AOK Strategic Plan early childhood priority and is necessary to maintain full caseload capacity for Elgin home visit programs.
CH	CH M5 - Developmental Screenings	Number of screenings reported to Kane County	Number of monthly screenings reported		Improving the number of developmental screenings is a direct connection to the AOK Early Childhood Network strategic plan.
OCHR	OCHR M1 - CodeRed	Percent of KCHD staff that is available to arrive to the health department within the 2 hour timeframe for every after hour CodeRed drill.	Number of KCHD that acknowledged their availability to arrive to the health department within the timeframe (2 hours).	Number of KCHD Staff available that month	Public Health Emergency Preparedness Grant Deliverable, Staff participation in CodeRed drills demonstrates the ability for KCHD to mobilize its first responders to respond to a public health emergency.
OCHR	OCHR M10 - HM Subscribers	Number of Health Matters subscribers	Number of Health Matters subscribers		Increasing subscribers shows that more people have access to the KCHD monthly health messages; direct ties to Effective Communications strategic plan initiative
OCHR	OCHR M2 - Website	Number of unique visitors to kanehealth.com	Total number of unique visitors each month		Increasing visitors shows that more people are visiting the website; direct ties to Effective Communications strategic plan initiative
OCHR	OCHR M3 - HM	Percent of Health Matters recipients reported to have open the newsletter	Total number of HM recipients who have opened the newsletter	Total number of HM recipients	The higher the percentage of "opens" equates to a greater number of newsletter readers, and demonstrates reach of KCHD communications.
OCHR	OCHR M4 - Required QI	Percent of staff that have completed the required QI training modules	Number of staff that have completed the 6 required QI trainings	Total number of KCHD staff	KCHD strategic plan identifies "mission focused culture" as an initiative, and quality as a value. In order to promote both, KCHD staff must be knowledgeable in QI tools and methodologies. Completed training modules is also identified as a strategy in the 2015 QI/PM Plan to create a culture of quality at KCHD.
OCHR	OCHR M5 - All QI	Percent of KCHD staff that have completed all 13 of the available web-based QI training modules	Number of KCHD staff that have completed all 13 of the available QI training modules	Total number of KCHD staff	KCHD strategic plan identifies “mission focused culture” as an initiative, and quality as a value. In order to promote both and serve as a resource for staff, QI Committee Members must be knowledgeable in QI tools and methodologies.
OCHR	OCHR M6 - QI Committee	Percent of QI committee members that have completed all 13 of the available web-based QI training modules	Number of QI committee members that have completed 100% of the QI training modules	Number of QI committee members	KCHD strategic plan identifies “mission focused culture” as an initiative, and quality as a value. In order to promote both and serve as a resource for staff, QI Committee Members must be knowledgeable in QI tools and methodologies.
OCHR	OCHR M7 - FB Reach	Average daily reach, or the average number of people who "saw" post on Facebook each month	The number of users who saw a KCHD post during the reporting period		We are looking for a 10% increase of average daily reach by November 30, 2016
OCHR	OCHR M8 - ILI Newsletter	Percent of recipients that open the ILI surveillance newsletter each week	Number of recipients that open the ILI surveillance newsletter	Number of ILI surveillance newsletter recipients	Providing the main means of communications for influenza surveillance in the county. Its effectiveness depends on the ability to provide attention-grabbing information while maintaining accurate contact lists.
OCHR	OCHR M9 - ILI Schools	Number of schools that, on average, report weekly influenza data throughout the month	The average number of schools that report weekly data during the month		Accurate estimates of the influenza-related absenteeism as many schools as possible should be reporting data, which requires follow-up and reminders as wall as maintaining accurate contact lists.

Quarterly Indicators by Division

CH	CH Q1 - Tobacco Policies	Number of tobacco-free policies in Kane County	Number of tobacco-free policies passed		Tobacco Grant Deliverable, Strategic Plan, Healthy People 2020, CHIP
DP	DP Q1 - GC Counseling	Percent of high risk Gonorrhea cases with valid contact information who were counseled	Number of high risk cases of Gonorrhea reached for counseling	Number of high risk cases of Gonorrhea with valid contact information	Per IDPH memo entitled "Treatment Recommendations for Neisseria gonorrhoeae" from April 6, 2011; "Given the heightened concern over the further development of gonoccal antibiotic resistance coupled with continuing high rates of gonorrhea in Illinois... counseling should include discussion of notifying and referring of sexual partners and risk reduction measures to preclude re-infection with gonorrhea or acquisition of another STD." Therefore by implementing this strategy we hope to decrease re-infection of patients.
DP	DP Q2 - NFP/KK Caseload	Total percentage of caseload capacity	Number of clients enrolled in program	Caseload capacity	Element 12 of the Nurse-Family Partnership Model Elements references the requirement of nurse home visitors to achieve and maintain full caseloads.
DP	DP Q3 - NFP/KK Breastfeeding	Total percent of NFP/KK clients breastfeeding at 6 months postpartum	Number of clients breastfeeding at 6 months postpartum	Number of clients 6 months postpartum	Breastfeeding initiation by clients is 86%, but drops significantly by 6 months postpartum. Continuation of breastfeeding provides health benefits to mothers and babies, and benefits society.
EH	EH Q1 - Property Complaints	Percent of property maintenance complaints that are responded to within 10 business days	Number of property maintaining complaints responded to within 10 business days	Number of property maintenance complaints received	Improves service to the community, ensures complaints are responded to within a timely manner, and ensures KCHD complies to defined internal expectations
EH	EH Q2 - Well/Septic Complaints	Percent of well and septic complaints investigated within 10 business days	Number of well and septic complaints investigated within 10 business days	Number of well and septic complaints	Grant requirement, and to ensure prompt investigation of well and septic complaints to reduce the risk of illness that can be associated with a failing septic system or non-compliant well system.
EH	EH Q3 - Education Inspection	Percent of all Category IB and IIB (High Risk) Food Service Establishments that have an education inspection in place of the 3rd routine inspection	Number of IB and IIB Food Service Establishments receiving an educational 3rd inspection in place of a routine inspection	Number of Category IB and IIB Food Service Establishments	This is an opportunity for Kane County Environmental Health Staff to provide training and education to food service establishments and their employees on key areas of food safety that may include hand washing, temperature control, and cross contamination. It is also a performance measure required by IDPH. This measure continues and improves the EH 2014 PDCA.
EH	EH Q4 - Educational Presentations	Number of educational EH presentations offered CFY 2016	Number of EH education presentations completed		This is an opportunity for Kane County Environmental Health Staff to provide education to the general public, other governmental agencies, groups, schools, etc. on environmental issues of importance to them.
EH	EH Q5 - Presentation Attendance	Number of attendees at educational EH presentations offered during CFY 2015	Number of attendees at educational EH presentations offered during CFY 2015		This is an opportunity for Kane County Environmental Health Staff to provide education to the general public, other governmental agencies, groups, schools, etc. on environmental issues of importance to them.
EH	EH Q6 - FBI Complaints	Percent of FBI complaints investigated within 72 hours	Number of FBI complaints investigated within 72 hours of receipt	Number of FBI complaints	Internal protocol to ensure all possible cases of foodborne illness are investigated to prevent or contain an outbreak of foodborne illness
OCHR	OCHR Q1 - PHEP	Percent of PHEP materials that are found in the correct locations and quantity from the WASP Inventory List	Number of PHEP materials found in the correct locations and quantities from the WASP Inventory List	Number of PHEP materials randomly selected for audit (20)	Helps meet many capabilities in preparedness grants by ensuring adequate supplies are tracked and audited when needed for trainings, drills, exercises, or an actual emergency event
OCHR	OCHR Q2 - Communications Campaigns	Communications campaigns planned at least one week ahead of event using campaign planning tool	Number of planned campaigns at least one week one week ahead of an event using campaign planning tool		Comm. Campaigns raise awareness of health issues and KCHD, as well as providing a framework in which to better frame our health messages
OCHR	OCHR Q3 - QI Communications	Number of communications which highlight KCHD QI efforts	Number of communications which highlight KCHD QI efforts		Successful implementation of the QI Plan is pivotal to the success of QI at KCHD, a process that ties directly to the agency Strategic Plan, Mission, and Values
OCHR	OCHR Q4 - Domain Meetings	Percent of PHAB domain team meetings scheduled and taking place	Number of Domain Team meeting that took place	Number of Domain Teams Meetings scheduled	Successful implementation of the QI Plan is pivotal to the success of QI at KCHD, a process that ties directly to the agency Strategic Plan, Mission, and Values. PHAB standard 9.2: Develop and implement quality improvement processes integrated into organizational practice, processes, and interventions.
OCHR	OCHR Q5 - QI Strategies	Percentage of key strategies met or exceeded in QI Plan	Number of strategies met or exceeded	Number of strategies	Successful implementation of the QI Plan is pivotal to the success of QI at KCHD, a process that ties directly to the agency Strategic Plan, Mission, and Values.
OCHR	OCHR Q6 - AAR Completion	Percent of incidents with completed hotwashes and AARs	Number of incident/event level 2 or higher (12/1/2015 to 11/30/2016) that have a completed AAR	# of incident/event level 2 or higher (12/1/2015 to 11/30/2016)that require an AAR	PHEP Grant 2.1.22, PHAB 2.2.3 Part 2 and 3, MCMORR Tool
OCHR/Admin	OCHR/Admin Q1 - Evaluations	% of employees who received performance evaluations (within 15 business days after their evaluation period.	Number of KCHD staff who received evaluation during assigned evaluation month	Number of KCHD staff due for evaluation in particular month	Provides direct correlation to Mission-Focused Culture Strategic Planning Initiative, assures employees have documentation of their performance, individualized learning/continuing education plans and future expectations.
OCHR/Admin	OCHR/Admin Q2 - Grants	The financial and non-financial (in-kind) grants awarded	Total dollar amount of grants awarded		KCHD will secure resources to further the mission of the organization and better serve the residents of Kane County.
OCHR/Admin	OCHR/Admin Q3 - Employee Satisfaction	Percent of KCHD employees that are satisfied with services provided by the Office of Community Health Resources.	Number of employees that are satisfied with services provided by the Office of Community Health Resources.	Total number of KCHD employees at time of survey, other than OCHR staff	It is the KCHD policy that customers of KCHD deserve exceptional service through interactions that demonstrate KCHD values.

Appendix F

Kane County Health Department

2015 Quality Improvement PDCA Projects

(Appendix F to be updated by March 2016)

Division of Disease Prevention Communicable Disease Section

Public Health Nursing Section

Division of Health Promotion Community Health Section

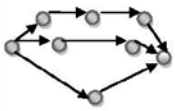
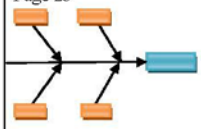
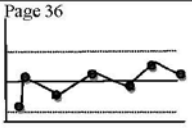
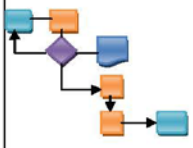
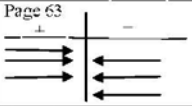
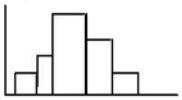
Environmental Health Section

Office of Community Health Resources Administration Section

Community Health Resources Section

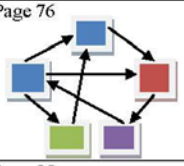
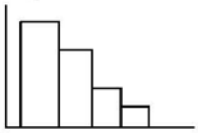
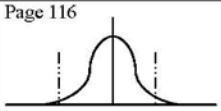
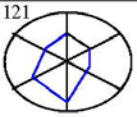
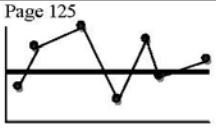
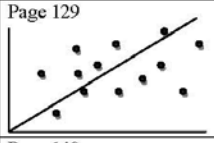
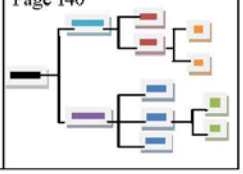
Appendix H
Kane County Health Department
QI Toolbox

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)*

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 A B C 1 2 3
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 Jo Bob Hal Total A 3 4 4 11 B 2 1 2 5 C 4 3 3 10 D 1 2 1 4
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 Cost A B C Total A 1/5 1/10 0.3 B 5 1 6 C 10 1 11
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 

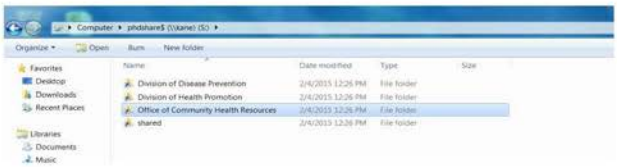
Developed from *The Public Health Memory Jogger II (2007)*

Appendix I
Kane County Health Department
QI Resources

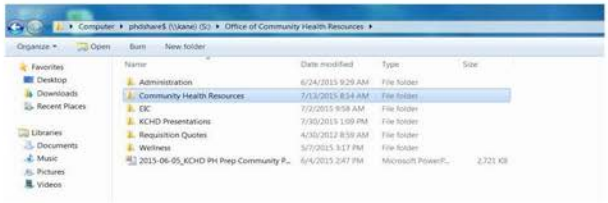
Quality Improvement Resources "Cheat Sheet"

1. Open (S:) Drive

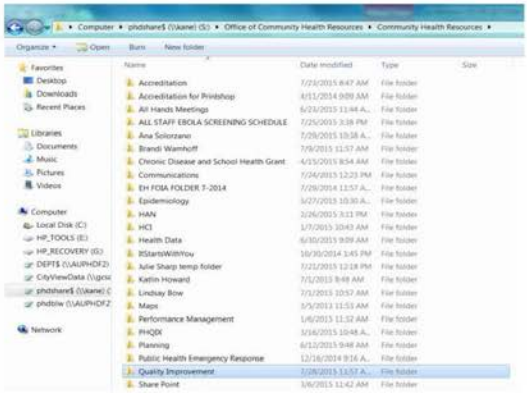
2. Go to "Office of Community Health Resources"



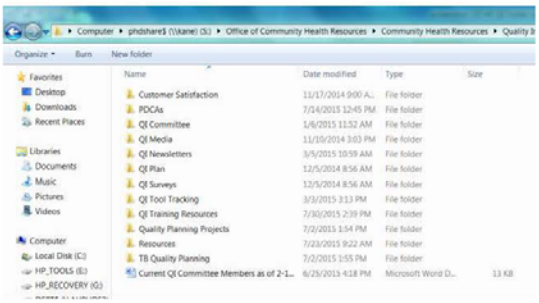
3. Go to "Community Health Resources"



4. Go to "Quality Improvement"



5. Quality Improvement Resources



Description

PDCA's: All things related to Plan Do Check Act. Projects by division, tips and tricks, and PDCA steps

QI Newsletters: Archived QI newsletters, feel free to read over!

QI Plan: Quality Improvement and Performance Management plan for current and past years

QI Tool Tracking: Broken down by division, each staff member can track any QI Tools used (flowchart, fishbone, etc.), here

QI Training Resources: Links to web based training modules, training review worksheets, QI resource library, handouts, and templates (Gantt Chart, Affinity Diagram, etc.)

QI Committee: QI Committee meeting minutes

Resources: Various resources including webinars, NACCHO "Intro to QI", and QI toolbox

Quality Improvement Resources: Websites

Adapted from Center for Public Health Quality

- **American Society for Quality (ASQ)** is a leading quality improvement organization that offers technologies, concepts, tools, and training to create better workplaces and communities worldwide.
- **Association of State and Territorial Health Officials (ASTHO)** is the national nonprofit organization representing public health agencies in the United State, the U.S. Territories, and the District of Columbia, and over 100,000 public health professionals these agencies employ.
- **Institute for Healthcare Improvement (IHI)** is a not-for-profit organization leading the improvement of health care throughout the world. IHI offers information, tools, and resources to health care professionals who want to improve care.
- **National Association of County and City Health Officials (NACCHO)** is the national organization representing local health departments. NACCHO offers reports, tools, and resources to support local health department quality and performance improvement efforts.
- **National Network of Public Health Institutes - Quality Improvement Section** features a variety of tools and resources - including presentations, examples and guides - on many QI topic areas.
- **NC State University Industrial Extension Service (IES)** was established in 1955 to help NC businesses prosper. IES provides QI initiatives to 650 businesses and healthcare organizations annually to increase productivity, efficiency, and quality. Most recently IES has begun to apply Lean methodology in health care organizations.
- **Public Health Foundation (PHF)** is dedicated to achieving healthy communities through research, training, and technical assistance. PHF provides a variety of tools and resources to help state and local public health agencies with performance management and quality improvement.
- **Public Heath Quality Improvement Exchange (PHQIX)** is a centralized communication hub dedicated to supporting quality improvement efforts in public health practices throughout the United States.
- **The Community Guide** is a free resource that summarizes the effectiveness, economic efficiency, and feasibility of interventions in order to help communities choose programs and policies to improve health and prevent disease.
- **The Public Health Accreditation Board (PHAB)** is dedicated to raising the standard for public health by working with leading public health experts from the field to develop a voluntary national accreditation program that will help public health departments assess their current capacity and guide them to become even better providers of quality service, thus promoting a healthier public.