COLUMBUS PUBLIC HEALTH QUALITY IMPROVEMENT PLAN

COLUMBUS PUBLIC HEALTH

***SUBJECT**: 2013 Quality Improvement Plan*

***SCOPE**: Columbus Public Health, All Staff*

***TOTAL NUMBER OF PAGES:** 16*

***REVIEW FREQUENCY:** Annually*

***ORIGINAL DATE ADOPTED:** 5/29/2012*

***LATEST EFFECTIVE DATE:** 4/15/2013*

***REVIEW/REVISION DATE(S):** 4/15/2013*

***PRIMARY AUTHOR(S):** Renee Shalosky, MSN, RN, CPHQ*
Quality Team Members

Nancie Bechtel, RN, BSN, CEN, EMTB

BOARD OF HEALTH APPROVAL DATE: 4/16/2013

REFERENCE NUMBER: N/A

THE CITY OF COLUMBUS
MICHAEL B. COLEMAN, MAYOR
COLUMBUS PUBLIC HEALTH

SIGNATURE PAGE:

CPH Quality Team Chairperson
Clinical Quality Improvement Coordinator

Renee Shalosky, MSN, RN, CPHQ — 4 / 24 / 2013
Renee Shalosky, MSN, RN, CPHQ – Columbus Public Health — *Date*

Health Commissioner

Teresa Long MD — 5 / 14 / 13
Teresa Long, M.D., M.P.H. – Columbus Public Health — *Date*

Medical Director – Assistant Health Commissioner

Mysheika W. Roberts — 5 / 13 / 13
Mysheika Williams Roberts, M.D., M.P.H – Columbus Public Health — *Date*

Chief Operations Officer - Assistant Health Commissioner

Roger Cloern — 4 / 30 / 13
Roger Cloern – Columbus Public Health — *Date*

Chief Nursing Officer - Assistant Health Commissioner

Nancie Bechtel, RN — 5 / 13 / 2013
Nancie Bechtel, RN, BSN, CEN, EMTB – Columbus Public Health — *Date*

Division Director – Clinical Health

Carla E. Hicks — 4 / 29 / 13
Carla Hicks, RN, MBA – Columbus Public Health — *Date*

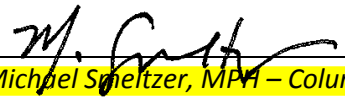
Division Director – Environmental Health

Keith L. Krinn — 5 / 1 / 2013
Keith Krinn, RS, MA, DAAS, CPHA – Columbus Public Health — *Date*

Director – Public Affairs and Communication

5 / 16 / 2013
Jose Rodriguez – Columbus Public Health — *Date*

Director – Planning and Accreditation



Michael Speltzer, MPH – Columbus Public Health

4 / 25 / 13

Date

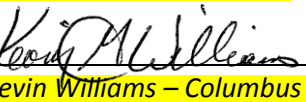
Director – Center for Epidemiology, Preparedness and Response

Michael Fielding, RS, MS – Columbus Public Health

5 / 2 / 2013

Date

Human Resources Officer



Kevin Williams – Columbus Public Health

4 / 26 / 2013

Date

Table of Contents

QUALITY IMPROVEMENT GLOSSARY

CHA (Community Health Assessment) – The CHA is a collaborative process conducted in partnership with other organizations and describes the health status of the population, identifies areas for health improvement, determines factors that contribute to health issues, and identifies assets and resources that can be mobilized to address population health improvement (Public Health Accreditation Board, 2011).

CHIP (Community Health Improvement Plan) – The purpose of the CHIP is to describe how a health department and the community it serves will work together to improve the health of the population of the jurisdiction that the health department serves (Public Health Accreditation Board, 2011).

Continuous Quality Improvement – An integrative process that links knowledge, structures, processes, and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes (Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012).

Evidence-based practice (EBP) – Entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected.

Goal – A statement of a desired future state, condition, or purpose. *(Agency for Healthcare Research & Quality, 1999).*

PHAB (Public Health Accreditation Board) – A nonprofit organization dedicated to improving and protecting the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments (Public Health Accreditation Board, 2012).

Performance Management – The practice of actively using performance data to improve the public's health. This practice involves strategic use of performance measures and standards to establish performance targets and goals. *(Turning Point, 2003)*.

Plan, Do, Check, Act (PDCA) – Four-step management method used in business for the control and continuous improvement of processes and products.

Objective – A measurable condition or level of achievement at each stage of progression toward a goal; objectives carry with them a relevant time frame within which the objectives should be met *(Agency for Healthcare Research & Quality, 1999)*.

Qualitative Data – Data composed of words, providing in-depth, contextualized, and meaning-driven descriptions of anything from an individual's experience to a community's history (Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012).

Quality Assurance – Guaranteeing that the quality of a product/service meets some predetermined standard.

Quality Improvement – Raising the quality of a product/service to a higher standard.

Quantitative Data – Data that is measured or identified numerically and can be analyzed using statistical methods.

S.M.A.R.T. – Acronym used to ensure evaluation and research objectives are S=Specific, M=Measurable, A=Attainable, R=Realistic, T=Timely (Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012).

SP (Strategic Plan) – A plan that sets forth what an organization plans to achieve, how well it will achieve it, and how it will know if it has achieved it. The SP provides a guide for making decisions on allocating resources and on taking action to pursue strategies and priorities (Public Health Accreditation Board, 2011).

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

Team Charter – Used to document a team's purpose and clearly define individual roles, responsibilities, and operating rules.

Team Facilitator – Not a member or leader of the Team; serves as an internal consultant/coach; keeps the Team focused on the meeting, process, & purpose; seeks opinions of all Team members; coordinates ideas; assists the Team in applying QI tools; summarizes key points; provides feedback to the Team.

Team Leader – Active member of the Team, provides direction & support; not responsible for all decision making or for the Team's success or failure; responsible to prepare for and conduct meetings, assign activities to Team members, assess progress, represent the Team to management, manage paperwork, and facilitate communication with the Team and the Sponsor.

Team Sponsor – A key leader in the organization; maintains overall responsibility, authority and accountability for the Team's efforts; monitors decisions and planned changes to assure they are aligned with the strategic goals of the organization; implements changes the Team is not authorized to make.

I. PURPOSE

The Columbus Public Health (CPH) Quality Improvement (QI) Plan exists within the context of the Mission, Vision, and Values Management Model. The QI Plan is created to enable CPH to more effectively achieve its stated mission:

"The mission of Columbus Public Health is to protect health and improve lives in our community."

The Values that drive the culture of CPH are:

1. Customer focus
2. Accountability
3. Research/Science-based
4. Equity and Fairness

The Goals that drive the culture of CPH are:

1. Identify and respond to public health threats and priorities.
2. Collaborate with residents, community stakeholders and policy-makers to address local gaps in public health.
3. Empower people and neighborhoods to improve their health.
4. Establish and maintain organizational capacity and resources to support continuous quality improvement.

QI activities at CPH are conducted to strive for the highest quality of services while meeting the needs and expectations of customers. The goal is to continuously improve the execution and design of processes across the 10 Essential Public Health Services (Center for Disease Control and Prevention, 2010):

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

QI activities at CPH also strive to systematically assess and improve care and service to meet the following 2012-2013 Strategic Priorities as outlined in the *CPH Strategic & Operational Plan, May 2012*:

- Reduce infant mortality
- Reduce overweight and obesity
- Stop the spread of infectious diseases
- Improve access to public health care
- Successfully implement the department reorganization plan

II. RESPONSIBILITY (see Culture of Responsibility Pyramid below – Figure 1)

Columbus Public Health is committed to improving quality in all of its services, processes and programs, and is seeking accreditation through the national Public Health Accreditation Board (PHAB). In order to accomplish both of these things, a formal structure is necessary to lead and guide these efforts.

The key to the success of the Continuous Quality Improvement (CQI) process is leadership. The Leaders support QI activities through planned coordination and communication of the results of QI initiatives. Leaders ensure that the Board of Health, staff and various stakeholders have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

The following describes the roles of Columbus Public Health leadership and staff to provide support to quality improvement activities.

A. The **Board of Health (BOH)** provides leadership, support and resources for Quality Improvement (QI) initiatives as follows:
   1. Establish QI as a Priority
   2. Approve the QI Plan
   3. Recognize Improvements

B. The **Strategic Advisory Team (SAT)** provides leadership, support and resources for QI initiatives as follows:
   1. Establish QI as Priority
   2. Approve the QI Plan
   3. Support QI Initiatives
   4. Reflect QI in the Strategic Plan
   5. Provide Oversight and Guidance for Operational Performance Management
   6. Provide Resources
   7. Maintain Departmental Quality
   8. Identify Areas Needing Improvement
   9. Recognize Improvements
   10. Participate in QI activities
   11. Report on QI activities to the BOH
   12. Incorporate QI concepts into daily work

C. The **Quality Team (QT)** is chartered by SAT to create, implement, monitor and evaluate the quality improvement efforts at Columbus Public Health and to support the Strategic Advisory Team in building a culture of continuous quality improvement throughout the Department.
   1. The QT's function is to support leadership and staff by providing training, resources and structures for quality improvement efforts. This includes:
      a. Developing and implementing the QI Plan
         1) Monitor plan performance; analyze performance gaps, and make recommendations for closing gaps

2) Review the QI plan at least annually and adjust as required to reflect current and emerging priorities

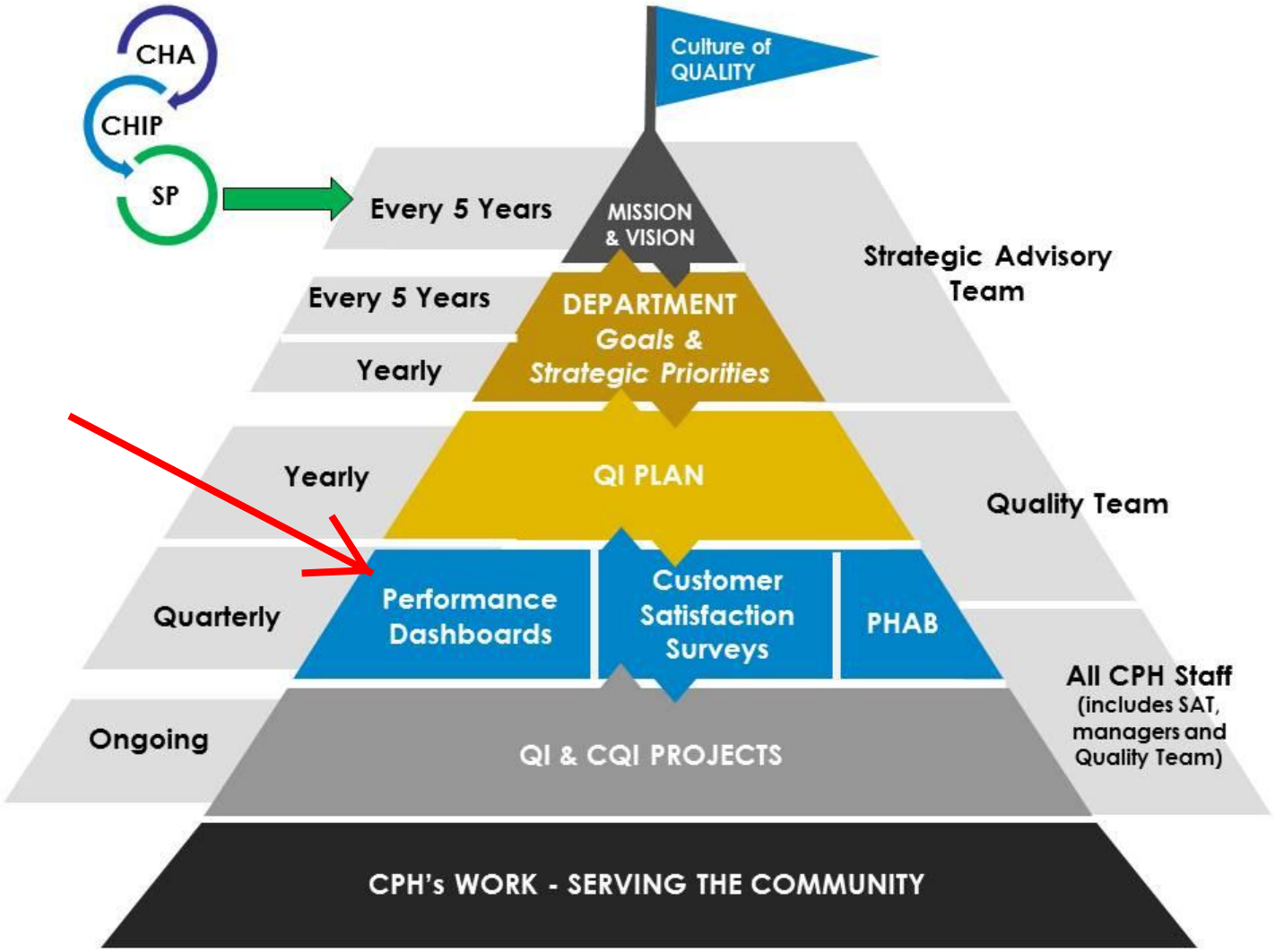
b. Set Yearly QI Goals and Objectives
c. Coordinating the selection of QI projects
d. Supporting QI Teams by:
    1) Providing guidance and technical assistance to staff engaged in QI projects.
    2) Recognizing QI efforts and celebrating successes
    3) Providing staff access to QI training materials and tools.
    4) Identifying and seeking resources needed to provide additional QI training.
e. Maintaining the QI Activity reporting system
f. Under the direction/advisement of SAT and/or the Accreditation Coordinator, the Quality Team will assess gaps in meeting PHAB standards and will help facilitate a plan to improve compliance.
g. Provides guidance to SAT/Program Managers regarding best practices in operational performance management, monitoring, and accountability.
h. Assist Program Managers with developing meaningful indicators and measures to monitor their operational performance and progress toward goals.
i. Updating SAT and Board of Health on QI activities
j. Communicating to all staff about QI efforts.

D. **Program Managers** provide leadership, support and resources for QI initiatives as follows:
    1. Identify and develop meaningful indicators and measures to monitor operational performance of their program/programs.
    2. Facilitate a plan to implement improvements for program measures that are not meeting their stated goal.
    3. Facilitating the implementation of QI activities and an environment of CQI at the program level
    4. Identifying and initiating problem solving processes and/or QI projects
    5. Overseeing QI projects in their area
    6. Participating in QI projects
    7. Scheduling staff time for QI projects
    8. Updating SAT on all QI activities
    9. Reporting progress of QI projects to the Quality Team
    10. Incorporating QI concepts into daily work

E. **All CPH Staff** are responsible for working with their supervisors and Quality Team members to identify areas for improvement and suggest improvement projects to address these areas. Other responsibilities include:
    1. Participating in QI projects, as requested by Division Directors or Program Managers
    2. Collecting and reporting data for QI projects
    3. Developing an understanding of basic QI principles and tools by participating in QI training
    4. Incorporating QI concepts into daily work

Figure 1:

CPH Culture of Quality Responsibility Pyramid:



This pyramid reflects the work, collaboration, oversight, and timeframes for reassessment that lead to a culture of quality at Columbus Public Health.

III. COLUMBUS PUBLIC HEALTH QUALITY TEAM

A. Membership includes:
   1. The Clinical Quality Improvement Coordinator (Chairperson), Accreditation Coordinator, Health Planner, Epidemiologist, and representation from departmental Divisions and Centers. (See *Appendix H* for the most recent QT membership.)
   2. SAT members are also invited to participate in all QT meetings.

B. Communication
   1. The QT meets monthly, or more often as needed.
   2. The QT Chairperson reports significant issues, findings, and actions to SAT.
      a. Significant issues, findings and actions are reported, as necessary, to appropriate leaders/individuals and/or other committees, particularly those that support aspects of the QI program.
      b. At a minimum, quarterly updates are provided to the Quality Team by the Team Leader or his/her designee and this information is reported using the QI Project Tracking Form found in *Appendix E*. The QT Chairperson/designee is responsible to share the updates with SAT on a quarterly basis.
      c. An evaluation of the QI initiatives is completed at the end of each calendar year.
         1) The evaluation summarizes the goals and objectives of the CPH Quality Improvement Plan, the QI activities conducted during the past year, including the targeted process, systems and outcomes; the performance indicators utilized; the findings of the measurement, data aggregation, assessment and analysis processes; and the QI initiatives taken in response to the findings.
         2) The QT Chairperson is responsible to complete the evaluation with the input and approval of the members of the QT.
         3) Once the evaluation is approved by the QT, it is submitted to SAT for review.

C. Quality Team Guiding Principles
   1. The QT will operate using the following principles:
      a. All work is grounded in CQI methodology including the use of CQI tools to increase understanding and facilitate the improvement of outcomes. (For an example of tools, see *Appendix D*).
      b. Decisions are data-driven and evidence-based in addition to using and respecting peoples' knowledge and experience.
      c. The customer perspective is central to decision-making striving to consistently meet or exceed customer expectations.
      d. Processes are transparent, collaborative and inclusive.
      e. Engagement and accountability are fostered with all persons involved in CQI efforts.
      f. The focus is on learning and improvement over judgment and blame, and values prevention over correction.

IV. QUALITY IMPROVEMENT

A QI philosophy recognizes that there are costs to everything one does or does not do. Until complete satisfaction is reached with public health funding levels and accomplishments, staff should continually seek quality improvements that reduce costs and improve outcomes. QI methods can help document evidenced based costs, identify outcomes of activities, and provide ways to make improvements that ultimately improve the health of all and meet the expectations of customers.

Three questions one should focus on when conducting QI activities are:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

(Scamarcia-Tews, Heany, Jones, VanDerMoere, & Madamala, 2012)

Meaningful measures and indicators are used to monitor both operational performance and progress on special initiatives such as strategic efforts or quality process improvements. Operational performance management and evaluation have been integral components of measuring program efficiency and effectiveness. CPH uses a "dashboard" set of measures to tie all operational performance measures into a more cohesive appraisal of department performance and progress. The Performance Dashboard system is housed in the City of Columbus Department of Finance.

Quality improvement activities emerge from a systematic and organized framework. This framework, adopted by Columbus Public Health leadership, is understood, accepted and utilized throughout the organization, as a result of education and involvement of staff at all levels.

Quality Improvement involves two primary activities:

- Measuring and assessing performance objectives through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the design of new services and/or improvement of existing services.

A. **Project Selection**: The suggestion for a QI project may originate from various sources.

1. Anyone in the health department can suggest a potential QI project by submitting the form found in *Appendix A* to the Quality Team.
2. Most projects will come from the managers based on data from their program and information from their staff. The decision to undertake an initiative is based upon agency priorities and project limitations.
3. SAT looks at data from three major sources to identify new projects, and then makes a referral to the Quality Team to evaluate the necessity of organizing a QI project. These sources of information are:
    a. PHAB Accreditation Domains;
    b. Customer Satisfaction Surveys; and
    c. Performance (Program) Management/Dashboards for the City of Columbus.

B. **Prioritization of Projects**: In order to ensure a comprehensive approach, the Quality Team examines QI opportunities for implementation based on the information from the following sources:

- Public Health Accreditation Board (PHAB) Standards & Measures
- Customer Satisfaction Surveys
- Performance Measure Dashboards
- Leadership (Managers and SAT)
- CPH staff

1. Tracking of prioritized QI opportunities is in the form of a log.
    a. QI opportunities may be specific and limited measures, entire projects, or program evaluations.
    b. QI opportunities may be identified by the QT or recommended to the QT by SAT/leadership or other staff.
    c. All opportunities listed in the log have SMART objectives and specifically assigned accountabilities.

C. **Project Formation**: Once the Quality Team receives information on the formation of a new QI team, the Team Sponsor/designee will assemble team members and develop the team charter.

1. The team charter is a crucial document that should be completed at the start of a QI team. It serves as a guide for the team through the process. However, this document is a living document and can be changed throughout the course of QI process.
    a. A copy of the Team Charter along with an explanation on how to fill it out is located in *Appendix C* of this document.

D. **Project Implementation**: The purpose of a QI project is to improve the performance of an existing process. The model utilized at Columbus Public Health is called Plan-Do-Check-Act (PDCA) Cycle (Gorenflo, 2010). Not all process improvement is a PDCA QI project. *Appendix B* is a decision making tool to assist in determining whether to undertake a formal QI project.

- **Plan** – The purpose of this phase is to investigate the current situation, fully understand the nature of any problem to be solved, and to develop potential solutions to the problem that will be tested.
- **Do** - This step involves implementing the action plan.
- **Check** - At this stage, data is again collected to compare the results of the new process with those of the previous one.
- **Act** - This stage involves two actions. The first is to decide, based upon the data collected in the Check phase whether to adopt the change theory, make slight changes to the theory, or to abandon the improvement theory and start over. The second action in this phase is to decide future plans. So if the team decided to adopt or adapt the improvement theory, it must indicate how it will monitor the gains going forward. If the improvement theory was abandoned, the team must decide on how it will continue.

At a minimum, quarterly updates are provided to the Quality Team by the Team Leader or his/her designee and this information is reported using the QI Project Tracking Form found in *Appendix E*.

Plan, **D**o, **C**heck, **A**ct Cycle

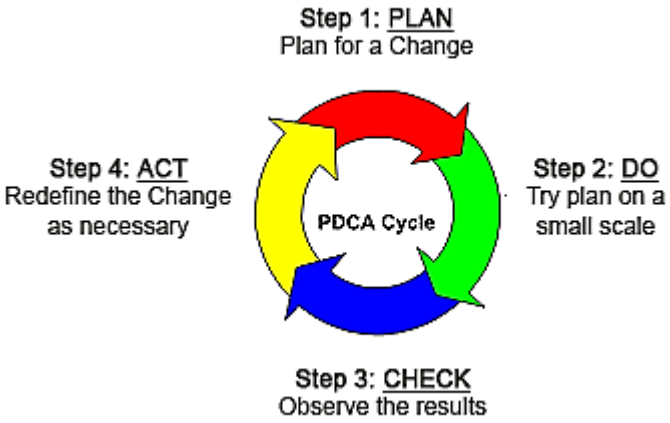


***Figure 2**: Diagram to illustrate the continuous process of quality improvement*
(Davenport, 2013)

E. **Project Summation**: Once the project is complete, each team needs to complete a Storyboard, which is a one page snapshot of the project in each step of the PDCA cycle. *Appendix F* contains a Storyboard Template. This Storyboard can be shared with staff, leadership and the Board of Health to demonstrate the projects completed in the health department.

F. **QI Education**: The Quality Team identifies and defines general goals and specific objectives to be accomplished each year. These goals include training of clinical, environmental and administrative staff regarding both continuous quality improvement principles and specific quality improvement initiative(s). Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities. (A calendar of planned/completed QI Training can be found in *Appendix G*.)

2013 CPH QUALITY IMPROVEMENT GOALS

CPH Strategic Goal #4:	Establish and maintain organizational capacity and resources to support continuous quality improvement.	
OBJECTIVES	**TIMEFRAME**	**RESPONSIBILITY**
1. At least quarterly, the Team Leaders/designee of all active QI teams will present a progress update to the Quality Team.	Quarterly	QI Project Team Leaders
2. By June 1, 2013, the QT chairperson/designee will provide QI activity updates at SAT meetings.	By June 1, 2013	Quality Team Chairperson/Designee
3. By June 1, 2013, the Quality Improvement link on the CPH Intranet home page will become the mode of communication used to report QI activities to all CPH staff.	By June 1, 2013	Clinical QI Manager
4. By Dec. 31, 2013, the scheduled events on the 2013 QI Training Plan will have all been implemented.	By December 31, 2013	Clinical QI Manager Workforce Development Manager
5. By Dec. 31, 2013, the 2014 Quality Improvement Plan will be approved by the Quality Team and submitted to SAT for final approval.	By December 31, 2013	Quality Team
6. By April 30, 2014, the annual evaluation of QI initiatives will be submitted to SAT by the Chair of the QT.	By April 30, 2014	Quality Team

References

Agency for Healthcare Research & Quality. (1999). *Health Care Quality Glossary.*

Center for Disease Control and Prevention. (2010, December 9). *National Public Health Performance Standards Program (NHPSP)*. Retrieved from CDC: http://www.cdc.gov/nphpsp/essentialServices.html

Davenport, P. a. (2013 , October 21). *Closing MyAchievement Gap.* Retrieved from http://level6leader.blogspot.com/2012/10/closing-achievement-gap-by-patricia.html

Gorenflo, G. a. (2010, April). *The ABCs of PDCA.* Retrieved from Public Health Foundation: http://www.phf.org/resourcestools/Documents/ABCs_of_PDCA.pdf

Public Health Accreditation Board. (2011). Standard 1.1: Participate in or Conduct a Collaborative Process Resulting in a Comprehensive Community Health Assessment. *Standards & Measures*, 10-19.

Public Health Accreditation Board. (2011). Standard 5.2: Conduct a Comprehensive Planning Process Resulting in a Community Health Improvement Plan. *Standards & Measures*, 118-133.

Public Health Accreditation Board. (2011). Standard 5.3: Develop and Implement a Health Department Organizational Strategic Plan. *Standards & MEasures*, 134-139.

Scamarcia-Tews, D., Heany, J., Jones, J., VanDerMoere, R., & Madamala, K. (2012, January). *Embracing Quality in Public Health: A Practioner's Quality Improvement Guidebook*.

Tague, N. R. (2004). *The Quality Toolbox, Second Edition.* Milwaukee: ASQ Quality Press. Retrieved from American Society for Quality.