Public Health
Prevent. Promote. Protect.

Franklin County
Health Department

Franklin County Health Department

Quality Improvement Plan

February 2016 - December 2020

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I. Purpose

The purpose of Franklin County Health Department's (FCHD) Quality Improvement (QI) Plan and Accreditation and QI Policy (Appendix 1) is to foster a culture of quality improvement through continuous improvement of programs, services and administration. This goal is also reflected in FCHD's 2015-2020 strategic plan.

II. Overview of Quality in FCHD

FCHD developed its first Accreditation/Quality Improvement (QI) Team in June 2010. Later that fiscal year the QI Steering Committee was formed and developed a QI plan followed by an Accreditation and QI Policy that was approved by the Franklin County Board of Health. Several key staff members have been trained in QI methods and tools. A QI Coordinator was appointed and provided a basic introduction to QI training that was required of all staff during Fiscal Year 2011. FCHD's QI Steering Committee will continue to develop staff knowledge of QI methods and tools. In September of 2014 FCHD developed two separate teams for Quality Improvement and Accreditation. Both teams with a representative from all departments within the agency. QI trainings to all staff have continued throughout each Fiscal Year since 2011, providing staff with tools, knowledge and templates to be a valuable member to the spread of an agency-wide culture of quality improvement.

III. Key Quality Terms

- Quality Improvement: "Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community" (Accreditation Coalition Workgroup, 2009).
- Big QI versus little qi: Big QI denotes the macro effort toward quality improvement at the department level, while little qi represents small, discrete quality improvement efforts at the program level.
- Continuous Quality Improvement (CQI): An ongoing effort to increase an agency's approach to manage performance and motivate improvement. CQI is an ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities and outcomes. These efforts can seek "incremental" improvement over time or "breakthrough" all at once.
- Quality Assurance (QA): QA is a process that measures compliance with previously established standards and expectations, including the protocols of the Kentucky Public Health Practice Reference (PHPR) and the requirements of the Kentucky Department for Public Health (KDPH) Administrative Reference. See Table 1 for distinctions between QA and QI.

Table 1: QA versus QI

Quality Assurance	Quality Improvement
Reactive	Proactive
Works on problems after they occur	Works on processes
Regulatory, usually by State or Federal law	Seeks to improve (culture shift)
Led by management	Led by staff
Periodic look-back	Continuous
Responds to a mandate or crisis or fixed schedule	Proactively selects a process to improve
Meets a standard (Pass/Fail)	To exceed expectations

("A Closer Look, QI Nuts and Bolts" ASTHO webinar presentation, 2010)

- QI Methods: A variety of practices exist to assist in QI efforts. The PDCA/PDSA or Shewhart Cycle was popularized by W. Edmonds Deming during the post WWII effort to reindustrialize Japan. Other popular methods include Lean, Six Sigma, Lean Six Sigma, DMAIC, Performance Excellence (4th Generation Management), Model for Improvement and Malcolm Baldrige National Quality Standards.
- PDCA/PDSA: The Plan-Do-Check-Act (PDCA) or Plan-Do-Study-Act (PDSA) method is the most widely used, simple approach for quality improvement projects. PDCA and PDSA may be used interchangeably. Figure 1 illustrates the PDCA cycle and Figure 2 displays the steps involved in each phase of the PDCA model.
- QI Tools: A variety of tools used to identify how processes, programs and services can be improved. Tools include prioritization matrices, flow charts, cause-and-effect or fishbone diagrams, Pareto charts, scatter diagrams, control/run charts, brainstorming, logic models, SWOT analysis and numerous others.

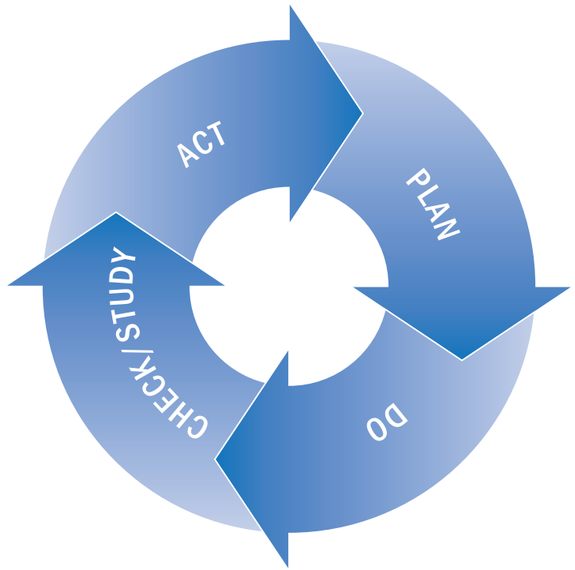

Figure 1: PDCA/PDSA Cycle

The ABC's of PDCA, G. Gorenflo and J. Moran

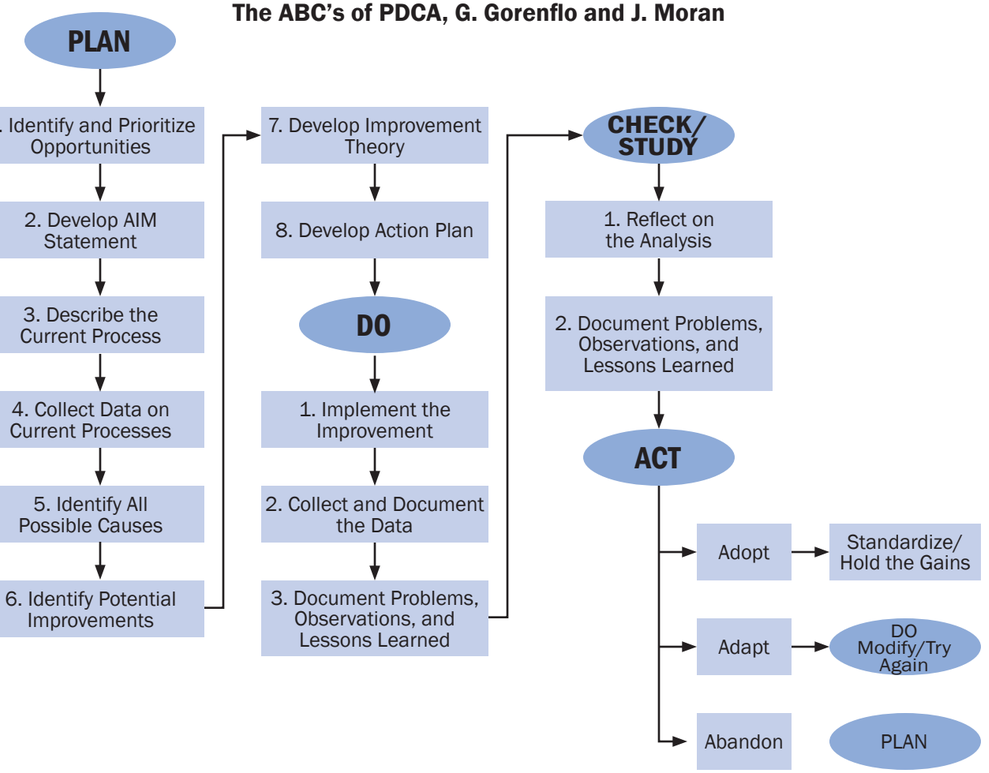

Figure 2: Phases of the PDCA Model (Gorenflo and Moran, Public Health Foundation)

- AIM Statement: A brief set of statements that clarify the goal or purpose of a quality improvement project. The statements answer the questions: What are you seeking to accomplish; who is the target population; what is the specific, numeric measure(s) you are seeking to achieve?
- Metrics: A collection of terms used in setting goals, indicators, measures, standards, baseline and benchmarks. The metrics are defined during the Plan phase of the PDCA model and are vital in monitoring the progress of quality improvement projects.
    - ► Measure: A basis for comparing performance or quality through quantification.
    - ► Indicators: A measure which helps quantify the achievement of a goal; end result which lets us know if we are achieving a goal; measurable; refers to populations, whether or not they receive services.
    - ► Standard: An established level of performance or quality; the minimum acceptable measurement expected or desired.
    - ► Goal: Broad, general statement of what will be achieved and how things will be different; what it takes to reach the vision (may not be measurable).
    - ► Benchmark: Target to be reached; a near-term standard with which an indicator or particular performance measure is compared to a level of performance established as a standard of quality.
    - ► Baseline: An initial measurement of population or program.
    - ► Performance measure: A measure of how well a program is working; work performed and results achieved; its efficiency and effectiveness; refers to client population/those who receive services; may relate to knowledge, skills, attitudes, values, behavior, condition or status (e.g., % of patients who keep appointment).
- Kaizen:
    - ► A team based approach that enables improvement to be made by stepping though all phases of the quality improvement cycle in an effective and rapid fashion. The Kaizen approach enables organizations to realize benefits greater than expected and within a much shorter timeframe.

IV. Organization Structure

FCHD's QI Steering Committee will carry out the provisions of this QI Plan and FCHD's Accreditation and QI Policy.

Membership and Rotation: The QI Steering Committee will be representative of all internal departments. Terms will not be limited, except as determined by the Public Health Director. Membership is composed of the following FCHD staff members:

- Judy Mattingly, Public Health Director III
- Jennifer Bardroff, Health Environmentalist III
- Debbie Bell, Health Education Coordinator
- Becki Casey, Administrative Specialist II
- Amber Carmack, Account Clerk III
- Leah Aubrey, Local Health Nurse II
- Brittany Parker, Public Health Services Manager
- Missy Sency, Local Health Nurse II
- Shannan Rome, HANDS Manager

Roles and Responsibilities: The QI Steering Committee will guide and evaluate QI efforts by:

- Participating in bi-monthly (every two months) meetings to review progress of quality improvement efforts
- Engaging in and facilitating QI efforts
- Incorporating QI concepts into daily work
- Collecting and reporting data for performance measures
- Promoting, training, challenging and empowering FCHD employees to participate in QI processes
- Identifying, monitoring, reviewing results from, and making recommendations on QI projects
- Identifying appropriate staff to participate in QI projects as needed
- Reviewing performance measures
- Reviewing program evaluation reports
- Reviewing after action reports (AAR) from outbreak investigations and emergency preparedness events and exercises
- Reviewing and revising the QI plan annually
- Preparing annual reports for staff meetings and the Board of Health
- Reviewing recommendations for improvement based on self-assessments of the Public Health Accreditation Board (PHAB) Standards and Measures and site visit reports
- Communicating selected QI results to the public
- Encourage all staff to participate in a QI project per the 2015-2020 FCHD Strategic Plan.

Staffing and Administrative Support: The Public Health Director will function as the chair, but defers the day-to-day activities to the QI Coordinator. The QI Coordinator will be responsible for the development of agendas, meeting materials and the completion of meeting minutes.

Resource Allocation: Resources for support of this plan will be budgeted annually as part of Cost Center 750. Cost Center 750 is supported by Franklin County Tax Dollars and Grant Monies received in a given Fiscal Year. Cost Center 750 includes accreditation and quality improvement efforts and annually averages about a $130,000 budget.

V. QI Training

During Fiscal Year 2015 and 2016 the QI Coordinator participated in a QI Leaders Academy consisting of learning and facilitating a new QI tool as well as assistance in writing a new annual QI Plan. During the week of February 22, 2016 a Contributor's course training was offered to staff and trained 30 FCHD staff members with plan of training the other 25 staff members in FY 17. This training provided an adult learning technique of tell, show, do, recycle to help staff members work through a personal or work related mini QI project. In addition to this training Leadership Team was asked to participate in a one day QI planning session, where a training was provided to help analyze data and prioritize goals for the next 18 months. FCHD hosts quarterly staff meetings where QI updates are provided and/or a specific QI tool is highlighted to prepare employees for participation in QI teams and enable them to incorporate QI techniques into their daily work. The QI Coordinator and/or members of the QI Steering Committee will provide just-in-time training to staff designated for specific QI projects. Additionally, new staff meet with the QI coordinator upon employment and efforts are made to provide just-in-time trainings to give them an overview of the agency's QI efforts. They are also encouraged to review on-line QI modules that provide basic QI knowledge. In addition to these trainings, new staff will be included in any new trainings provided for all-staff and will be included in the next QI contributors course.

VI. Identification of QI Projects

Priority for QI projects will be given to PHAB standards/measures that were either slightly or not demonstrated. The Public Health Director may request that a specific QI project be conducted. In addition, all staff members are encouraged to request the implementation of a QI project. These QI proposals will be discussed at QI Steering Committee meetings. Projects can be identified through an array of means, including suggestions, survey results, reports, team brainstorming, service statistics, financial records, program goals and objectives, community health improvement goals and objectives, strategic plan goals and objectives, health indicator goals and objectives, after action reports, performance management measures, internal assessments use of QI – Project Idea worksheet (Appendix C) and many others.

Performance measures, strategic plan objectives, community health improvement plan goals and objectives, community health assessment results, etc. are used to identify and prioritize quality improvement projects and efforts. When either performance measures, strategic plan, CHA, and CHIP initiatives are not met, trending to not meet a goal, etc. QI efforts will be enforced. Currently, the process includes discussion at QI steering committee meetings regarding these efforts and brainstorming occurs to see what QI efforts, if any, are needed. QI efforts are not initiated for all benchmarks missed as some missed benchmarks may be related to funding streams, changes in programs, etc. Once QI brainstorming efforts occur, it is brought to FCHD's leadership team where it is prioritized to when this project should be implemented and a team is formed
.
The current Quality Improvement Plan is posted on the agency website and is reviewed and updated annually.

VII. Customer Feedback

FCHD seeks customer feedback in all services that it offers. FCHD has created a general customer feedback survey that is accessible in print and on-line. Customer satisfaction feedback is gathered through survey monkey and analyzed as such. This feedback is used in programs and interventions to improve population based health promotion, protection and improvement efforts. In addition to customer satisfaction efforts, FCHD has some program specific surveys that are conducted and quality of life survey completed through the CHA implementation. Departments use these results a in a series of different ways to plan for QI or performance measure efforts. During the annual QI planning session all conducted survey results are compiled and provided to leadership for review and to use in consideration for quality improvement efforts.

VIII. Goals, Objectives and Measures

During the week of February 22, 2016 FCHD's Leadership Team met and developed the following QI Plan based on data collected throughout the agency such as: Strategic Plan, CHA, CHIP, Satisfaction Surveys (employee and patient), County Health Rankings, etc. Below are the four projects FCHD's Leadership Team would like to focus on until June 30, 2017. Teams were delegated based on specialties within their departments and to help utilize all staff in participating in a formal QI project. Appendix A identifies QI projects completed from FY 2011 – FY 2016.

Each QI Team was given guidance from the Leadership Team and then created their own AIM statement. The AIM statements, goals and objectives for FY16 & FY17 can be found in Table 2 and 3.

2016 Quality Improvement Plan: FCHD

Table 2

Drivers

Project: STD Reduction

TO: Reduce STD rates in the next 18 months
BY: • Increasing STD case reporting • Improving STD education • Increasing STD prevention
Measures/Targets: • TBD by the team
Project Leader, Team Members: • TL: Sally • Leah, Jennifer, Kim, Flo (KSU rep), Susan, Ashley, Ina

Project: Sixth Grade Immunization

TO: Increase Tdap, MCV, and Varicella vaccinations in the 6th grade population
BY: • Kaizen and partnership with the schools
Measures/Targets: • Tdap - 75% improvement • MCV 55.6% improvement • Varicella 60.1% - 75% improvement
Project Leader, Team Members: • TL: Michelle • Vicky, Kyle (school rep), Savanah, Natalie, Jeanette, Leann, Sally or Lisa H.

Project: Workforce Development

TO: Increase leadership potential/skills
BY: • Increasing participation in educational opportunities
Measures/Targets: • Leadership institute attendance (10 to 20)
Project Leader, Team Members: • TL: Sally • Leah, Jennifer, Kim, Flo (KSU rep), Susan, Ashley, Ina

Project: Maximize Revenue

TO: Increase collection of service fees
BY: • Following the PDCA improvement process
Measures/Targets: • Tdap - 75% improvement • MCV 55.6% improvement • Varicella 60.1% - 75% improvement
Project Leader, Team Members: • TL: Michelle • Vicky, Kyle (school rep), Savanah, Natalie, Jeanette, Leann, Sally or Lisa H.

Leadership Team Members:

Judy, Debbie, Cindy, Becki, Shannan, Lisa C., Kendra, Ken, Tammie, Lisa H., Sally, Michelle, Brittany, Margie

Leadership Team Conditions:

Outcomes

Reduce Infectious Disease

Measure	Baseline	Target
STD (chlamydia, gonorrhea, syphillis) cases from FCHD 007 Report	291 cases from July 2014 to Dec 2015	277 cases from Jan 2015 to June 2017
Immunization Rate Sixth Grade	Tdap 55.6% MCV 54.6% Varicella 60.1%	75% for all three vaccines

Workforce Development

Measure	Baseline	Target
Leadership Institute Attendance	10	20
QI Project Participation	27	55
Staff Satisfaction Survey — neutral to pride working at HD	6	0

Financial Stability

Measure	Baseline	Target
FY15 Amount Billed — Amount Paid	TBD	TBD FY17

VIII. Monitoring and Reporting

All QI teams are responsible for developing a storyboard that depicts progress toward and steps taken to achieve the AIM statement. The QI Steering Committee will review the status of all QI projects at their bi-monthly meetings. QI teams are responsible for collecting and analyzing data related to their AIM statement. QI projects will be reported to the Board of Health at quarterly meetings. The QI Steering Committee will make recommendations for data collection methods and ensure that improvements are sustained. Additionally, in FY17 FCHD will be expanding its use of a software called Klipfolio to help monitor the QI plan.

Table 3: Team Charters

Project: STD Reduction

TO: Reduce STD rates in Franklin County in the next 18 months
FOR: Community, Health Resources
BY: • Collecting and validating data • Conducting lessons-learned on past STD reduction efforts. • Identifying root-cause issues • Following PDCA Cycle
SO THAT: • A healthier community results • County health ranking is improved • Healthy People 2020 goals reached • Budgeted costs are reduced
CONDITIONS: • Number of sex partners • Kentucky State University population • Undocumented cases • Socioeconomic status • Current staff • Willingness to test/report

STANDARDS:

What is to be measured and how?	Baseline	Target
Surveillance data	291 cases	5% reduction
KDPH STD county rankings	TBD	TBD
Healthy People 2020 goal	TBD	TBD
Providers reporting	3	increase
Demographic Reports	TBD	TBD

Project Leader, Team Members:
• Team Leader: Sally
• Leah, Jennifer, Kim, Flo (KSU rep), Susan, Ashley, Ina, Jackie

Project: Sixth Grade Immunization

TO: Increase Tdap, MCV and varicella vaccinations in the 6th grade population in Franklin County
FOR: Community, Schools
BY: • Confirming data and develop understanding • Identifying root-cause issues • Communicating with schools • Developing other measures as directed by the data and root-cause results
SO THAT: • Meet Kentucky immunization recommendations for sixth graders • Prevent outbreaks of disease • Meet the Healthy People 2020 goal
CONDITIONS: • Religious exemptions • Medical exemptions • Use of Infinite Campus (IC) system • Parental decisions

STANDARDS:

What is to be measured and how?	Baseline	Target
Increase in valid certificates	TBD	Increase
Correct data entry in IC	TBD	Increase
Tdap immunization	TBD	75% Improvement
MCV immunization	TBD	75% Improvement
Varicella immunization	TBD	75% Improvement

Project Leader, Team Members:
• Team Leader: Michelle
• Vicky, Kyle Sexton (FCPS), Savanah, Natalie, Jeanette, LeAnn

IX. Communication and Recognition

All QI teams will communicate progress to the QI Steering Committee. Updates on QI projects may be provided in monthly internal News and Views, at quarterly staff meetings and in the quarterly Board of Health reports. Upon the completion of QI projects, storyboards will be displayed in common areas. When appropriate, QI results will be communicated with the public through press releases. QI projects will also be submitted for state and national conference sessions, poster sessions and awards when the QI Steering Committee and/or Board of Health deems appropriate. QI projects and QI efforts will also be submitted to national partners such as PHQIX and NACCHO Model Practice nominations when the QI Steering Committee deems appropriate.

Project: Workforce Development		
TO: Develop FCHD's current and future workforce by encouraging and providing leadership and education opportunities.		
FOR: Community, Franklin County Health Department staff and future workforce		
BY: • Providing focus groups – testing and feedback • Partnering with local health education campuses • Utilizing current staff's potential • Taking advantage of free education opportunities – applying for scholarships • Making conference submissions • Researching community resources and education		
SO THAT: • Personal and professional growth • A strengthened employee sense of value and pride in the organization is achieved • Job fulfillment and performance is improved		
CONDITIONS: • Merit system • Budget constraints, staff willingness, time (staff coverage, availability of resources)		
STANDARDS:		
What is to be measured and how?	Baseline	Target
QI Participation	27	55
Pride at work survey responses	6	0
Leadership institute attendance	10	20
Focus group participants	0	16
Becki's report	TBD	Increase
Performance evaluations		Increase
Project Leader, Team Members: • Team Leader: Lisa • Kendra, Becki, Tammie, Cheryl, Angie, Maribeth, Elvira		

Project: Financial Stability		
TO: Decrease the difference between amount billed and amount collected		
FOR: FCHD, employees, Franklin County community		
BY: • Confirming data and develop understanding • Identifying root-cause issues • Determining improvements • Developing other measures as directed by the data and root-cause results • Learning from each other		
SO THAT: • Plan for the future activities and budget • Standardized process among departments		
CONDITIONS: • Billable amounts • KRS for fees • Can't turn patients away • Team stays positive		
STANDARDS:		
What is to be measured and how?	Baseline	Target
Billable amounts for each department	TBD	TBD - Increased
Project Leader, Team Members: • Team Leader: Cindy • Ken, David, Margie, Priscilla, Gwen, Lisa, Amber M., Amber C., Vickie		

Table 4: 2018 Quality Improvement Plan: FCHD

Drivers

Outcomes

Project: FCHD IT Infrastructure		
TO: Increase the IT Infrastructure at FCHD in the next 18 months.		
BY: • Upgrades to internet and phone system • Implementation of Shared Drive • Updates to FCHD's website • Electronic Health Records		
Measures/Targets: TBD by the team. Deadline of June 30, 2018.		
Project Leader, Team Members: • TL: Ina Susan, Ken/Cindy, Amber M, Margie, Kendra		

Measure	Baseline	Target
Shared Drive Implementation	0	June 30, 2018
Internet drops	TBD	<1 a month
Website Usability	TBD	80% Satisfaction
EHR Implementation	TBD	TBD

Project: Increase Childhood Health		
TO: Increase the health of children.		
BY: • Reviewing evidenced based practices • BMI collection in school aged children • Partner with immunization project • Collaborate with Health and Education CHIP workgroup		
Measures/Targets: TBD by the team. Deadline June 30, 2018		
Project Leader, Team Members: TL: Debbie Kristi, Amy, Vicky P.		

Measure	Baseline	Target
BMI	TBD	TBD
Implementation of 1 EBP in schools	0	1

Leadership Team Members:
Judy, Brittany, Becki, Cindy, Tammie, Shannon, Anita, Ken, Amber M, Sally, Kendra, Margie.

Leadership Team Conditions:
Within normal business hours and budget friendly

**Additionally, continue 2016 Quality Improvement Plan Efforts.

X. QI Program Review

At least annually, the QI Steering Committee will assess the effectiveness of FCHD's QI Plan and Accreditation and QI Policy and make revisions based on lessons learned during the year. This may be shared to staff through monthly internal News and Views, at quarterly staff meetings and in the quarterly BOH reports. This QI Plan will note measures of progress to date. In addition to the QI Plan housing progress to date, dashboards will be housed on an on-line dashboard system – Klipfolio. This allows for any staff to see progress and measurements in all projects listed in the QI Plan. If a goal is not met in the time frame set for a QI project, that project can be carried over into the next fiscal year to allow for further actions to be taken.

Appendix A - 2011-2015 QI Plan & Projects

QI Team	Process Addressed	AIM Statement	Measure of Progress (as of December 2015)
Git-R-Done: Sally Brunner, Margie Bucklew, Mary Cook, Susan Nesselrode, Charlotte Ruble, Dwayne Sutherland and Cindy Weddington. Facilitated by Fred Goins, Judy Mattingly and Julie Reynolds.	Repair request	By December 4, 2010 we will increase understanding of the repair request process from 22.2% to 52.2% and increase satisfaction with the repair request process from 38.9% to 68.9%.	By December 4, 2010 understanding was increased to 83.3% and satisfaction was increased to 94.4%.
Too Legit to Quit: Nicole Hale, Tammie Bertram, Kendra Palmer and Karen Weller. Facilitated by Carrie Reschke and Margie Bucklew.	Verification of professional licenses	By July 1, 2011 FCHD will have a process in place to consistently monitor and document all employees' trainings, certifications and/or licensure requirements.	By FY 12 a flow chart was designed to map out professional license verification for the personnel manager to follow.
Git-R-Funded: Paula Alexander, Tammie Bertram, Debbie Bell, Debbie Fleming, Jennifer Bardroff and Shannan Rome. Facilitated by Judy Mattingly.	Grant applications	By June 30, 2012 we will increase grant funding from $38,475.84 in FY 10 to $42,323.42.	Decision tree for determining when to apply for grants has been developed along with a grant tracking form. This increased grant funding to $67,195.42 in FY 11, which already exceeds our AIM statement goal of a 10% increase. A grant toolkit will be launched in Feb. 2012 and progress will be monitored.
There's No Place Like Home. Anita Napier, Ashley Toll, Natalie Looney and Jennifer Sheets. Facilitated by Judy Mattingly.	Medication reconciliation process	By December 2012, decrease clinically significant medication issues from 16% to 10%.	Will verify baseline data as 16% in Feb. 2012 pending review of 12 patient charts. Next steps will be to identify potential improvement theories.
Home Health Overtime: Karen Weller, Anita Napier, and Paula Alexander. Other team members will be determined. Facilitated by Denise Bingham and Judy Mattingly.	Addressing processes leading to overtime	By _____(date) decrease overtime for home health staff from _____ (baseline) to _____(goal).	Project in beginning stages.
Same Day Scheduling: All Clinic Staff.	Same-Day scheduling.	To decrease no-show rates to less than 5% by August 2013.	Same-Day scheduling was implemented and no-show rates plummeted below 1%. Goal met.
FCHD 007- Surveillance Team: Leah Aubrey, Sally Brunner, Kathy Miller, Tammie Bertram, Michelle Searcy, Becki Casey, Jennifer Bardroff.	Sharing of epidemiologic data with others.	Increase number of surveillance reports distributed from 1 to 4 by 7/31/15. Increase number of surveillance sites receiving reports from 0 to all by 10/31/14	Entering second year of compiling data and distributing quarterly reports. Goal was met.
File 13: Amber Carmack, Amber Mathers, Kathy Miller, Leann Newton, Charlotte Ruble, Angie Alegre, and Susan Nesselrode	Ineffective tracking of charts.	By December 2015 we will have an accurate electronic account of all patient's records and their status. (active, master card, closed files, flu shot)	In beginning stages – paused – staffing.
New Employee Orientation 101: Becki Casey, Brittany Noe, Margie Bucklew and Cindy Weddington.	New hire orientation.	By June 30, 2015 a new employee orientation will be organized and implemented with all new hires.	Two employees have gone through new orientation process with more to follow. New checklist to be developed with the next new hire as forms and policies have been updated.
Employee Evaluation Overhaul: Brittany Noe, Becki Casey, Debbie Bell, Cindy Weddington, Julie Reynolds, Sally Brunner, Tammie Bertram	FCHD employee evaluations.	To have FCHD's employee evaluation process standardized and consistent by FY16 among all of FCHD employees and departments.	New process developed and implemented on July 1, 2015. Will evaluate results FY 17 after one completed year of new evaluation process.
EnviroPigs - Boil Water Advisory (BWA): Kendra Palmer, Wes Clark, Jenny Bardroff and John Lile.	Information distribution during BWA.	FCHD will provide accurate and timely information to affected businesses and community members when a BWA has been issued.	Developed an updated BWA checklist and handouts to be given to restaurants during BWA.
The Frankfort 500-Kendra Palmer, Judy Mattingly, Becki Casey, Jenny Bardroff, Wes Clark, Priscilla Johnson, Michelle Searcy and Brittany Parker.	Food Inspections	Decrease the number of past due food establishment inspections by 30% by January 1, 2016.	Completed – All 64 605 and 607 inspections have been caught up. Surpassed the goal of 30% and hit 100%.
PO Kaizen – Cindy Weddington, Tonya Ruble, Susan Nesselrode, Shannan Rome Debbie Bell, Brittany Parker and Interns: Morgan Norton and Elizabeth Boone.	PO Process	To implement an Electronic PO process by March 31, 2016.	In beginning stages.
Organized HANDs – Shannan Rome, Morgan Norton.	Module/Materials and Giveaway cabinet.	To decrease amount of prep time associated with a visit.	Completed
Chart Trails – Missy Sency, Michelle Searcy, Alicia Topass, Andrea Semones, Ashely Kratzer, Stephanie Willard, Maribeth Lines, Vickie Cleaver, Anita Johnson, Kristi Holt, Natalie Looney, Sheila Poe	Charts moving from school to school.	Decrease the time it takes when a student moves schools within the district to receive their chart.	In beginning Stages.

Appendix B - Charter Template

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FCHD Team Charter

Team Charter: "Name"

Date:

To: *What is the specific goal, purpose or outcome desired?*

For: *Who benefits from achieving the goal? What populations are targeted?*

By: *What is your basic approach to solving the problem?*

High-level Outline:

1.

Specific Plan:

What	Recipient	Who will provide	By when

So that: *What are the benefits from achieving the goal?*

Conditions: *What requirements or limitations exist?*

Standards: *How will the team measure success?*

What is to be measured and how?	Baseline	Target

Team Members: (Name and Department)

Appendix C - Quality Improvement: Project Idea

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QI - Project Idea

Project Title:

Background

1. What has the situation been like in the past?

2. Who is the customer?

3. What is the problem now?

4. Quantify it (where do I have data).

Project Objectives

1. How would the customer's experience be different once the situation has been improved?

2. What is the change in performance you want to achieve?

3. Quantify it (if you can).

Boundaries

1. What other offices or divisions within the agency and work process are within the scope of this effort?

2. What work is outside the scope of this effort?

Appendix D – Accreditation and Quality Improvement Policy

Franklin County Health Department
100 Glenns Creek Road
851 East-West Connector
Frankfort, Kentucky 40601

Policy IC-47 **August 2011**

ACCREDITATION AND QUALITY IMPROVEMENT

Purpose The Franklin County Health Department (FCHD) supports national public health accreditation. This accreditation establishes standards and benchmarks for the provision of essential public health services. Those that do the work are most knowledgeable about the processes and opportunities for improvement; their participation in Quality Improvement (QI) should therefore be actively encouraged. National public health accreditation should validate that this health department meets national standards, and that staff are accountable to the governing board of health (BOH), other policy makers and the community served. *"Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check (Study)-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)

Policy An accreditation coordinator will oversee an internal accreditation/QI team. All employees will be engaged in QI according to the Plan-Do-Check (Study)-Act Model. Staff may be recruited to a QI project team or staff may request the implementation of a QI project based on the Public Health Accreditation Board (PHAB) standards/measures, quality assurance assessments, program goals and objectives or health indicator goals and objectives. QI project teams will share their progress and results at all staff meetings and at least quarterly with the BOH, for additional feedback and guidance.

Public Health Director Date

Chair, Franklin County Board of Health Date

Policy IC-47

Approved August 2011

Reviewed April 2014

Reviewed _____ _____

Reviewed _____ _____

Reviewed _____ _____