QUALITY IMPROVEMENT PLAN

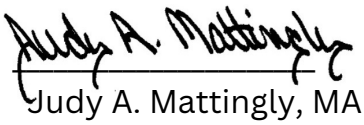
January 2020

Public Health
Prevent. Promote. Protect.
Franklin County Health Department

Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

ENDORSEMENTS AND REVISIONS

This plan has been approved and adopted by the following individual:



Judy A. Mattingly, MA
Pulbic Health Director

January 4, 2020
Date

Revisions:

Date	Description of Change	Pages Affected	Reviewed or Changed by
July 2021	Added FY20 and FY21 QI Plan and Charters		B. Parker
July 2022	Added FY22 QI Plan and Charters		B. Parker
December 2022	Updated key terms with PHAB definitions (Version 2022) added updated ICP-Policy		B. Parker
January 2023	Updated to include 2022-2027 Strategic Plan info.		B. Parker
August 2023	Updated PHAB Logo	Cover Page	B. Parker
August 2023	Updated FY23 QI Plan and Charters		B. Parker
November 2023	Updated Goal for plan on website		B. Parker
January 2024	Updated based off feedback from December All-Staff Meeting		B. Parker and All-Staff

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PHAB Version 2022- Requirements

Measure	Page(s)	Description(s)
9.1.2 RD1 A	6-9	Key Quality Terms and Descriptions
9.1.2 RD1 B	10-12	QI Structure
9.1.2 RD1 C	12	QI Training
9.1.2 RD1 D	13-14	Identification, prioritization and initiating QI projects
9.1.2 RD1 E	15-16	FCHD QI Goals and Objectives
9.1.2 RD1 F	19	Monitor of QI Plan
9.1.2 RD1 G	20	Communication

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PURPOSE

The purpose and guiding principles of Franklin County Health Department's (FCHD) Quality Improvement (QI) Plan and Accreditation and QI Policy (Appendix D) is to:

- Foster a culture of quality improvement through continuous improvement of programs, services and administration.
- Make data-driven and evidence-based decisions, but also use and respect people's knowledge and experience.
- Make the internal and external customer perspective central to its decision-making and strive to consistently meet or exceed customer expectations.
- Use processes that are transparent, collaborative and inclusive.
- Foster engagement and accountability with all persons involved in QI effort.
- Focus on learning and improvement, and value prevention and problem solving over correction.

Overview of Culture of Quality Improvement 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 continues to develop staff knowledge of QI methods and tools. In September 2014 FCHD developed two separate teams for Quality Improvement and Accreditation, both with representatives 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 valuable members of an agency-wide culture of quality improvement. Beginning in FY20, FCHD's QI Steering Committee shifted to FCHD Leadership team throughout the pandemic and endemic state.

In June of 2020 FCHD staff completed the NACCHO's QI self-assessment tool (SAT). To determine in which phase FCHD was in towards reaching a level of sustainable quality improvement implementation. Additionally, in December of 2024 FCHD staff completed the QI Maturity Tool – post pandemic. Results from both assessments can be found in Appendix E and F.

KEY QUALITY TERMS

Quality Improvement (QI): Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in Public Health. Journal of Public Health Management and Practice. January/February 2010)

Quality Improvement (QI) Tools: QI tools appropriate for a given improvement model will vary based on the method selected and the type or problem identified. QI tools could include, for example, flowcharting or process mapping to document the way in which the process under study is currently operating. QI tools could include, for example, brainstorming and Strengths Weaknesses, Opportunities and Threats (SWOT) or Strengths, Opportunities, Aspirations, and Results (SOAR) Analysis (Public Health Accreditation Board. Standards & Measures for Initial Accreditation, Version 2022. Alexandria, VA. February 2022).

Performance Improvement: Continual and systematic use of planning, monitoring and improvement activities to make intentional changes and improvement in public health capacity, processes, or outcomes (Public Health Accreditation Board. Summary of Recommendations from Performance Management & Quality Improvement Think Tank. July 2018).

Performance Management: Performance Management is a systematic process which helps an organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making. In practice, performance management often means actively using data to improve performance, including the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results (Public Health Foundation (PHF). Focus Areas: Performance Management. “Overview”. Accessed on June 21, 2021. PHAB Acronyms and Glossary of Terms Version 2022).

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.

KEY QUALITY TERMS

Continuous Quality Improvement (CQI): CQI is an ongoing effort to increase an agency's approach to manage performance and motivate improvement. It 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 Core Clinical Services Guide (CCSG)) and the requirements of the Kentucky Department for Public Health (KDPH) Administrative Reference.See Table 1 for distinctions between QA and QI.

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, simplest 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.

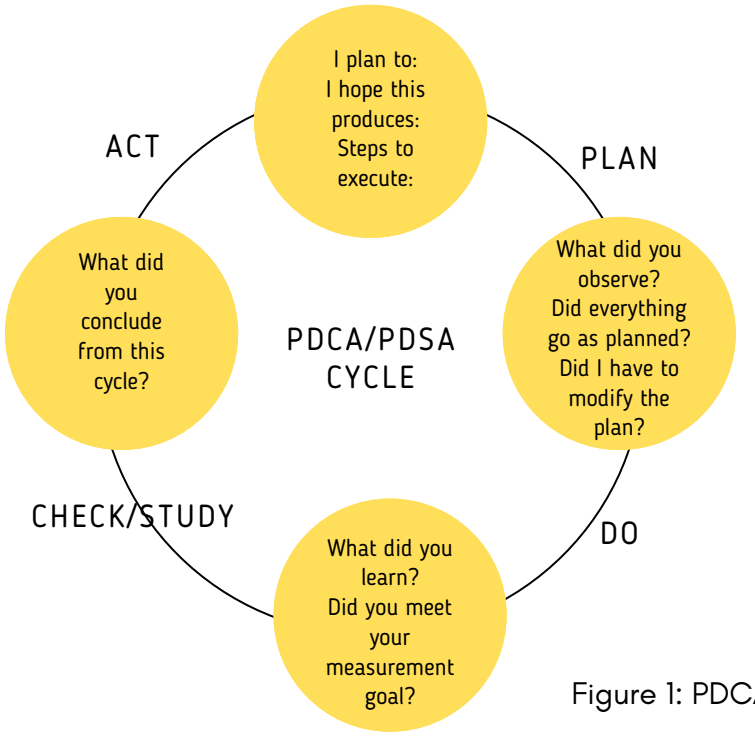


Figure 1: PDCA/PDSA Cycle

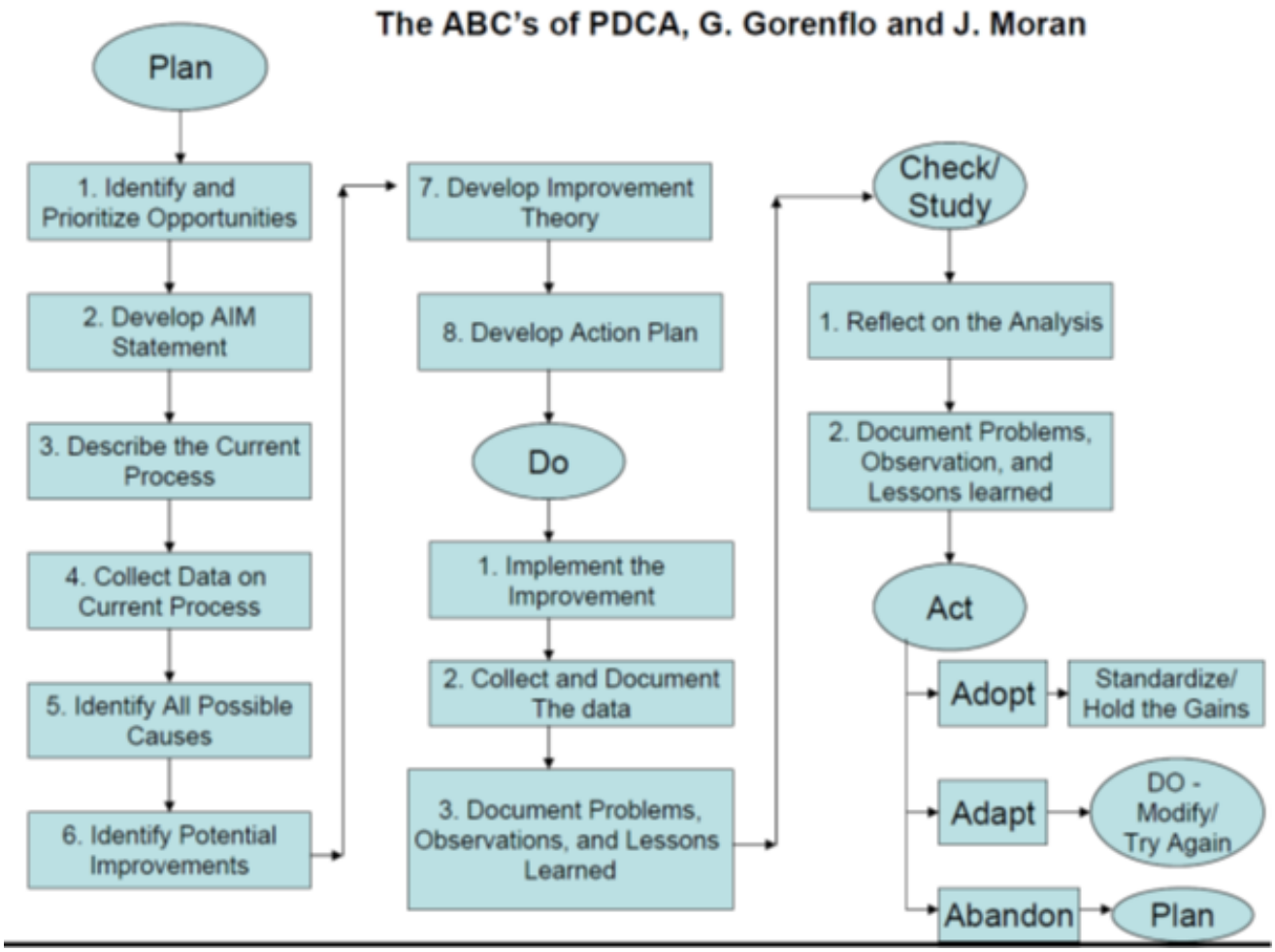


Figure 2: Phases of the PDCA Model (Gorenflo and Moran, Public Health Foundation)

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?

KEY QUALITY TERMS

Metrics: A collection of terms used in setting goals, indicators, measures, standards, baselines 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.
- Indicator: 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 time frame.

ORGANIZATIONAL 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 is made up of several FCHD Leadership Team members and they will be representative of all internal departments. Each representative will serve a minimum of a two year term, 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, Emergency Preparedness Manager
- Debbie Bell, Health Education Director
- Becki Casey, Human Resources Manager
- Leah Aubrey, Nurse Supervisor
- Brittany Parker, Deputy Director/QI & Accreditation Coordinator
- Michelle Searcy, School Nurse Supervisor
- Shannan Rome, HANDS Manager
- Greg Ramey, IT Manager

ORGANIZATIONAL STRUCTURE

Roles and Responsibilities

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

- Participating in monthly meetings with Leadership and then as needed individually 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
- Encouraging all staff to participate in a QI training per the 2022-2027 FCHD Strategic Plan

ORGANIZATIONAL STRUCTURE

Staffing and Administrative Support

The Public Health Director will function as the chair but defers the day-to-day activities to the Deputy Director/QI Coordinator. The QI Coordinator will be responsible for the development of agendas, meeting materials and the completion of meeting minutes when meetings are held outside of regularly scheduled Leadership Team meetings.

Resource Allocation

Resources for support of this plan will be budgeted annually as part of Cost Center 898.

QI TRAINING

FCHD hosts quarterly all-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.

Per the 2022-2027 FCHD Strategic Plan all FCHD staff will participate in in CPM Intro to CQI during all-staff meetings (6 – 15 minutes courses with completed exam and certificate). Each employee will have a certificate of completion on-file to be included with the FY24 annual trainings.

Additionally, employees will be provided with just-in-time trainings as needed and upon hire to FCHD per the FCHD Workforce Development Plan.

FCHD staff are also encouraged to attend national training courses such as NACCHO, NNPHI and Open Forum where QI efforts are presented.

IDENTIFICATION OF QI PROJECTS

Priority for QI projects will be given to PHAB standards/measures that are 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, annual fiscal year reports (calendar), BOH reports, 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, internal assessments, use of QI – Project Idea worksheet (Appendix C) and many others.

The table below discusses key concepts to be considered by QI teams that ensure projects ensure an equity lens is applied during project implementation. In addition, during the December 2023 all-staff meeting,it was discussed that all-staff should consider the following questions with implementation of new projects, programs, messaging etc.

What impacts will the decision have? How will it affect inequities?

- What current inequities exist around this issue?
- How does structural racism, or other systemic and instructional barriers, contribute to those inequities?
- Will any groups experience unintended impacts or greater burden, or be left out by this decision?
- Given the above, will the decision worsen or ignore existing disparities?
- Will any groups or communities disproportionately benefit from the decision?
- Are they the people who are facing inequities?
- Describe the potential unintended impacts on social, economic, and environmental factors affecting health.
- What data are you drawing on to come to this conclusion? Consider quantitative and qualitative data alike.

The current Quality Improvement Plan is posted on the agency website and is reviewed and updated annually.

IDENTIFICATION OF QI PROJECTS

Concept	Practical Application
1. Foster a culture of equity.	• Incorporate equity into all discussions about existing and future initiatives. • Similar to safety, striving for equity should be everyone's work.
2. To address a disparity, it must first be identified.	• Analyze data considering PROGRESS-Plus variables including race/ethnicity, preferred language, country of origin or neighborhood. • Investigate how race, ethnicity and sociodemographic data are locally collected.
3. Incorporate equity into the selection of measures, development of SMART aim, root cause analysis, key driver diagram, and study design.	• Incorporate equity into the selection of measures, SMART aim, root cause analysis, key driver diagram, and study design.
4. Families and community partners are critical stakeholders.	• Families and community partners should have a seat at the table to provide input on project design and planning. • Conduct qualitative work to allow family and community voices to inform SMART aims, key driver diagrams and change ideas.
5. Consider alternative comparison groups.	• The reference group can be selected based on specific criteria, such as size of group and performance of the group depending on the EF-QI measure.
6. Focus of work should be on the evaluation of root causes and modification of systems and processes.	• Be careful when analyzing race-stratified data and ensure you understand what the race variable is serving as a proxy for. • Approach disparities using systems thinking and QI tools to evaluate root causes and systemic contributors to problems. Avoid focusing on individual behaviors.
7. Adapt existing data visualization tools to emphasize disparity trends over time.	• Display run charts and statistical process control charts stratified by REaL data at a minimum and other characteristics as defined by project aims.
8. Approach dissemination of data from an equity perspective.	• Disseminate data and findings to all involved stakeholders using plain language summaries to increase community capacity-building. • Share lessons learned and best practices with other units and organizations, acknowledging limitations in generalizability.

GOALS AND OBJECTIVES

Goal 1: Monitor and Sustain FCHD Staff QI Culture		
Objectives	**Measures/Activities**	**Status**
By June 30, 2020 – FCHD staff will complete the NACCHO QI Self Assessment Survey.	• Create survey in a virtual platform. • Utilize staff time working from home to assist with full-time hours. • Take results and place in the QI plan.	Complete June 24, 2020
By March 30, 2024 FCHD staff will complete the QI Maturity Tool.	• Research best practices to complete the tool. • Create a survey in a virtual platform. • Discuss with staff during a staff meeting what to expect and when it is due.	In Progress
By June 30, 2024 all FCHD staff will participate in CPM Intro to CQI during all-staff meetings (6 – 15 minutes courses with completed exam and certificate). Each employee will have a certificate of completion on-file to be included with the FY24 annual trainings. (completed through TRAIN).	• Add to staff meeting agendas. • FCHD staff who attend meetings, walk through post-assessment evaluation/test. • Create list of all-staff that were trained – based off sign-in sheet from all-staff meeting.	Complete December 19, 2023
By June 30, 2025 all FCHD staff will have participated in at least one QI project within the agency.	• Utilize organizational chart and storyboards/teams since FY20 to create a baseline of staff who have participated in a team. • Use baseline captured to create future teams as needed. • Continue to include QI in all-staff's job descriptions with dedicated time annually.	In Progress

GOALS AND OBJECTIVES

Goal 1: Monitor and Sustain FCHD Staff QI Culture		
Objectives	Measures/Activities	Status
All QI teams will have a "why person" on the team – either FCHD staff or community partner.	• Invite one person to each team that is not a part of the current program/progress. • Utilize staff who aren't afraid to ask a lot of questions.	In Progress

Goal 2: Inform Staff, Community and Governing Entity of QI Efforts		
Objectives	**Measures/Activities**	Status
PM and QI will continue to be shared with Board of Health and in monthly staff News and Views as it is available.	• PM information is available the 1st regularly scheduled meeting of the fiscal year with BOH. • Share BOH reports with all-staff. • Place QI projects/storyboards in FCHD's Annual Report Calendars.	In Progress
By December 31, 2023 the QI Plan will be published on FCHD's website and can be found at: fchd.org/pack-plans	• Update plan from word to Canva. • Update cover page to match other agency wide plans. • Get updated plan as of December 2023, placed on the website. • Utilize the request/tracking form on the plan so we can keep track of who is downloading and utilizing the QI Plan.	Did not meet by December 31, 2023. Will upload by January 31, 2024.

QI PLAN DRIVERS AND OUTCOMES

2020 QUALITY IMPROVEMENT PLAN: FCHD

DRIVERS

Project: COVID-19 Drive Thru – Testing

TO: Conduct a COVID-19 drive thru testing event that decreases exposure points and addresses participant needs during COVID-19 testing event.

BY: Increasing patient thru-put times and when test results are received and FCHD staff exposure points.

Measures/Targets: Thru-Put Time, Exposure Points, Received Results

Project Leader, Team Members:
Team Leader: Sally
Leah, Judy, Brittany, Amber and Jenny

Project: COVID-19 Data Entry – Testing

TO: To decrease staff time with manual entries into Gravity testing portal post testing event.

BY:
- Using automation entry from on-line scheduling system into Gravity portal.

Measures/Targets:
Manual data entry time; success of automation

Project Leader, Team Members:
Team Leader: Amber
Greg, Ina, Brittany, Jenny, Judy, Leah

Project: HRSEP

TO: Increase HIV/HBV and HCV Testing in HRSEP participants.

BY:
- Following the PDCA improvement process

Measures/Targets:
- Daily testing rates
- Improvement in 30 days
- Confidence in testing

Project Leader, Team Members:
Team Leader: Wendy Harrod (DNP Intern)
Brittany, Sally, Jackie, Jennifer, Leah, Vicky, Susan, Angie, Amber

Project: School Health Billing

TO: Increase collection of service fees

BY:
- Creating a (auto) fillable CMS1500 form for school health billing

Measures/Targets:
- Fillable CMS 1500

Project Leader, Team Members:
Team Leader: Lisa
Brittany, Gwen, Savanah

Project: Purchase Order

TO: Improve PO Process

BY:
- Kaizen project

Measures/Targets:
- Electronic PO
- Shared Drive
- Late Payments

Project Leader, Team Members:
Team Leader: Cindy
Michelle, Rachel, Susan, Brittany, Becki, Debbie

Leadership Team Conditions:

- Teams can complete projects during normal business hours, results reported to QI Coordinator.

OUTCOMES

COVID-19 Response

Measure	Baseline	Target
Thru – Put Time	12 Min.	Decrease
Exposure Points	3	Decrease
Test Results	10 Days	Decrease
Manual Data Entry VS. Automation Data Entry	1:03; 1:12; 1:06 – Average 1:07	Automation Entry Success – no staff time used

Reduce Infectious Disease

Measure	Baseline	Target
Testing Completed	0%	Increase of 30%
Confidence in Testing	0%	Increase of 30%

Administrative

Measure	Baseline	Target
CMS1500 Manual Entry	5:30:36	Decrease by 50%
PO Process	TBD	TBD

2021 QUALITY IMPROVEMENT PLAN: FCHD

DRIVERS

Project: Unlock and Reset Account Email

TO: Limit disruptions due to locked out of e-mail by FCHD staff and IT staff.

BY: Follow PDCA Cycle

Measures/Targets:
- Test different theories/resources
- TBD by Team

Project Leader, Team Members:
Team Leader: Greg
Ina, Brittany

Project: COVID-19 Drive Thru Vaccine

TO: Decrease thru-put time during COVID-19 vaccine events.

BY: Following rapid QI/PDCA (during an event in some cases)

Measures/Targets:
- Include 15-minute waiting period, post vaccine
- Decrease by 20%

Project Leader, Team Members:
Team Leader: Jenny
FCHD Leadership Team, Frankfort Fire/EMS

Project: KYIR Data Entry – COVID-19 Vaccine

TO: Utilize an automation system to enter vaccine data into KYIR.

BY: PDCA Cycle

Measures/Targets:
- Within 24 hours
- Decrease/Minimize staff entry time

Project Leader, Team Members:
Team Leader: Greg
Ina, Leah, Amber, Judy, Brittany, (Other LHD's...shared process)

Leadership Team Conditions:

- Teams can complete projects during normal business hours, results and supporting documentation reported to QI Coordinator.

OUTCOMES

Infrastructure Technology

Measure	Baseline	Target
Test Different Software's (3 to be exact)	TBD (timed efforts)	TBD

COVID-19 Response - Vaccine

Measure	Baseline	Target
COVID-19 Vaccine Drive Thru	26.5 minutes (Dec 20)	Decrease by 20%
COVID-19 Vaccine KYIR Entry	TBD	Complete Automation

QI PLAN DRIVERS AND OUTCOMES

2022 QUALITY IMPROVEMENT PLAN: FCHD

DRIVERS

Project: Biometric Screening Automation

TO: Decrease staff time utilized in Biometric Screening events

BY: Following the PDCA Improvement process

Measures/Targets:
- Staff time entering billing
- How many services can be provided in one event
- Increase in $ amount earned per event

Project Leader, Team Members:
Team Leader: Greg
Ina, Brittany, Amber, Michelle, Cindy

Project: Grants/Cost Centers

TO: Utilize FCHD shared drive (new PO process) to create a grant folder cataloguing PO's by cost center

BY: Rapid QI

Measures/Targets:
- TBD annually and by grant

Project Leader, Team Members:
Team Leader: Michelle
Cindy, Debbie, Judy, Leah, Brittany

Project: Check Deposit

TO: Utilize Home Health Scanner in everyday deposits for FCHD.

BY: Rapid QI

Measures/Targets:
- Time saved through deposits
- Salary and gas saved

Project Leader, Team Members:
Team Leader: Michelle
Cindy, Savanah, Greg

Project: 360 Peer Review

TO: Update 360 peer review process based off feedback from FCHD Leadership.

BY: Continuing a PDCA improvement process from several years ago – adapting

Measures/Targets:
- Leadership feedback
- Update current process/review old QI project

Project Leader, Team Members:
Team Leader: Becki
Judy, Brittany, Michelle E., Cindy, Michelle S. Amber, Leah, Shannan, Jenny, Debbie

Project: Indeed Hire Advertisement

TO: Decrease need of multiple advertisements to fill a vacant position. (PM Goal to QI)

BY: Filling vacant positions, with qualified individuals.

Measures/Targets:
- Indeed performance
- Filling vacant positions (# of applicants)

Project Leader, Team Members:
Team Leader: Becki
Judy, Brittany, Michelle

Leadership Team Conditions:
- Teams can complete projects during normal business hours, results and supporting documentation reported to QI Coordinator.

OUTCOMES

Finance

Measure	Baseline	Target
Biometric Screening Event	20-30 screenings in 2.5 hours	Increase by 50%
Cost Center Grants Folder/Tracking	0	Grant folder created
Mobile Check Deposit Process	30 Minutes	Cut time by 50%

Administrative

Measure	Baseline	Target
Use of Indeed	Job ads ran 3 X's each	Run job ads Once
Feedback	10 questions	3 Questions

2023 QUALITY IMPROVEMENT PLAN: FCHD

DRIVERS

Project: HANDS Referrals

TO: Increase referral sources for HANDS.

BY: Increasing events attended and opportunities to share information about HANDS.

Measures/Targets:
- # of referral sources
- # of events attended

Project Leader, Team Members:
Team Leader: Shannan
Elvira, Brittney (DPH), Julie, Brittany

Project: Ready-Op WIC Messaging

TO: Use Ready-OP to mass-text WIC participants to schedule their recert appt.

BY:
- Endemic public health emergency state
- Use of Ready OP
- Recert WIC participants
- Reminding of appointment

Measures/Targets:
- Use of ReadyOP
- Recert appointments made
- Baseline TBD

Project Leader, Team Members:
Team Leader: Marisa
Greg, Leah, Charlotte, Amber

Leadership Team Conditions:
- Teams can complete projects during normal business hours, results and supporting documentation reported to QI Coordinator.

OUTCOMES

HANDS

Measure	Baseline	Target
Referral Resources	2	10

WIC Communication

Measure	Baseline	Target
Use of ReadyOP	TBD	Success in Text and Appt
# of Recerts	TBD	TBD

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/Leadership Team will review the status of QI projects. 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. Info graphs/data dashboards will be created in excel and/or Canva to depict QI data.

IMPLEMENTATION OF QI PLAN

The implementation of the Quality Improvement (QI) plan is monitored by the leadership team at the FCHD on an annual basis as an integral part of their commitment to continuous improvement. During the regular review of QI and Performance Management (PM) goals and plans, FCHD's leadership analyzes the progress made in executing the QI initiatives. To facilitate this process, FCHD employs a clear and visually informative graphic display for each goal, categorizing them as "not started," "in progress," or "complete." This visual tracking system allows for a quick and comprehensive assessment of the status of each QI project, ensuring transparency, accountability, and alignment with organizational objectives. By regularly evaluating progress and using these graphic displays, FCHD ensures that its QI efforts remain on course, enabling the department to consistently improve its services and enhance the overall health and well-being of the community it serves.

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, therefore further extending their reach to a wider audience.
QI projects and QI efforts will also be submitted to national partners such as PHQIX, PHAB, and NACCHO Model Practice nominations when the QI Steering Committee deems appropriate.

The QI Plan Outcomes and Drivers page(s) (Appendix) is updated on an annual basis by the FCHD Deputy Director. This updated information is then promptly reflected in the QI plan located on the shared drive and website, enabling both internal staff and external stakeholders to easily access and review the latest developments in FCHD's QI efforts.

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 – through Canva/Excel. This allows for all 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 - PDCA/PDSA PLANNING FORM

Public Health
Prevent. Promote. Protect.
Franklin County Health Department

Plan-Do-Study-Act Planning Form

Agency: **Franklin County Health Department (FCHD)**		Topic:	Change:
Cycle #		Start Date:	End Date:
Plan.	**I plan to:** (Here you will write a concise statement of what you plan to do in this testing. This will be much more focused and smaller than the implementation of the tool. It will be a small portion of the implementation of the tool.) **I hope this produces:** (Here you can put a measurement or an outcome that you hope to achieve. You may have quantitative data or qualitative data.) **Steps to execute:** (Here is where you will write the steps that you are going to take in this cycle. You will want to include the following: - The population with which you are working. - The time limit that you are going to do this study. Remember it does not have to be long, just enough to get your results: 3-6 weeks.		
Do	**What did you observe?** (Here you will write down the observations you have during your implementation. This may include reactions, families' reactions, FSW/ HV reactions, how it fits in with your system or flow of the patient visit.) **Did everything go as planned?** **Did I have to modify the plan?**		
Study.	**What did you learn?** **Did you meet your measurement goal?** (Here you would record how well it worked, if you met your goal.)		
Act.	**What did you conclude from this cycle?** (Here you will write what you came away with for this implementation, where it worked or not. And if it did not work, what you can do differently in your next cycle to address that? If it did work, are you ready to spread it across your entire practice?)		
	◯ Adapt	◯ Adopt	◯ Abandon

APPENDIX B - CHARTER TEMPLATE

Public Health
Franklin County
Health Department

Team Charter:

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. Confirm data and develop understanding
2. Root-cause issues
3. Communicating with schools
4. Developing other measures as directed by the data and root cause results

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 are you measuring, how and target)*

What is to be measured and how?	Baseline	Target

Team Members:

APPENDIX C - QUALITY IMPROVEMENT: PROJECT IDEA

Public Health
Franklin County
Health Department

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 QI POLICY

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

Policy ICP-6

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, performance management goals, 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.

Judy A. Mattingly — 12-20-22

Public Health Director — Date

Charles P. Bradshaw DMD — 12-20-22

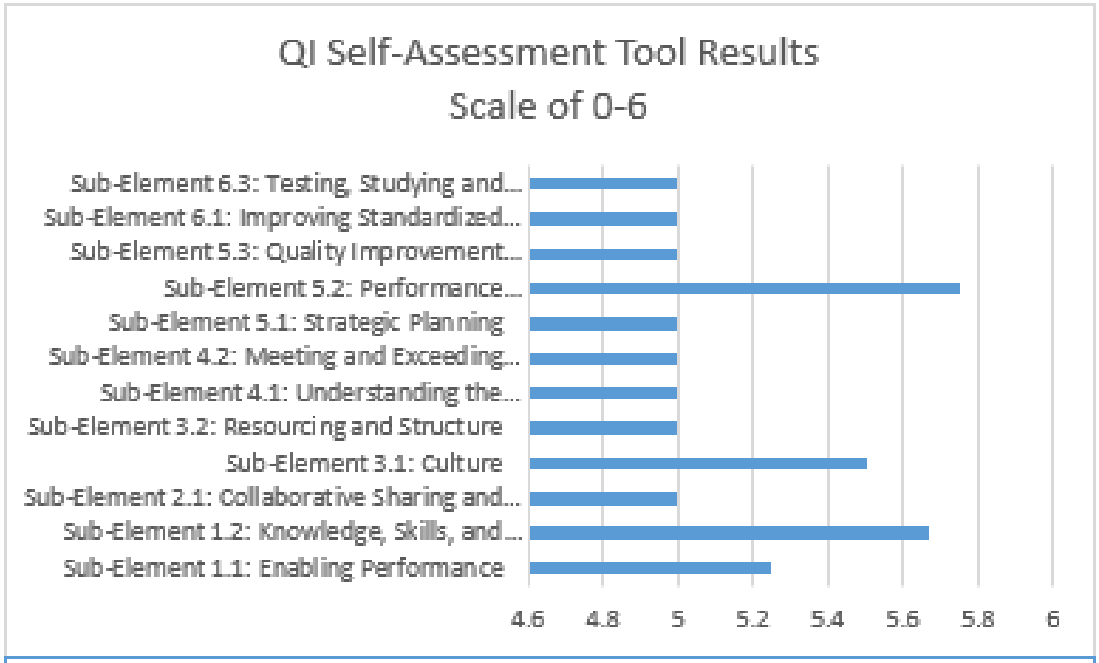
Chair, Franklin County Board of Health — Date

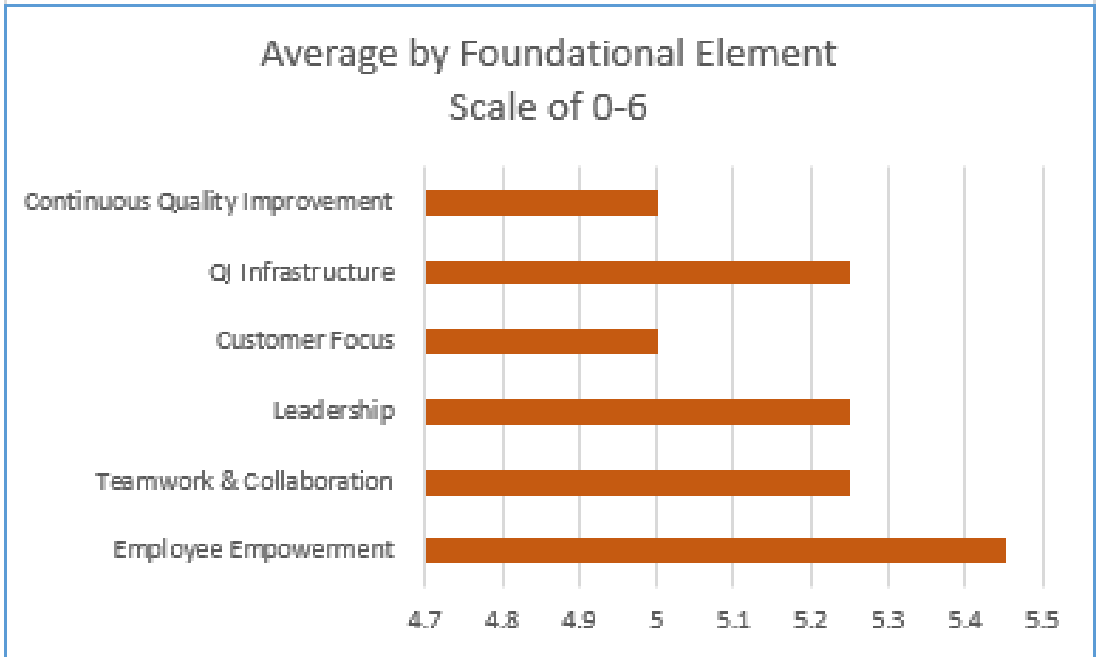
Approved August 2011
Reviewed August 2014-2021
Revised December 2022

APPENDIX E - NACCHO QI SELF-ASSESSMENT RESULTS

As part of the QI Roadmap tool, NACCHO offers improvement strategies tailored to move health departments' scores from one level to the next higher level. Strategies to move from level 5 to level 6 were presented to leadership team during the January 2023 Meeting and prioritized and provided input into developing QI goals and measures within the QI plan, Strategic Plan, and Workforce Development Plan.

Completed by 38 employees, June 2020





APPENDIX E - NACCHO QI SELF-ASSESSMENT

	Not Applicable	1 Strongly disagree	2	3	4	5	6 Strongly agree
	Enter your score for each statement in column "J". Embedded formulas will calculate each sub-element score.						
	Sub-Element 1.1: Enabling Performance						
1.1a	QI related expectations of staff are clearly defined (e.g. performance goals and standards, QI project participation).						
1.1b	Formal or informal processes are in place to provide staff feedback on job performance (e.g. performance evaluations, ongoing feedback sessions).						
1.1c	Staff are acknowledged for improving performance.						
1.1d	Staff have appropriate opportunities to act to improve work processes (e.g. participate in QI projects, authority to implement improvements).						
	Sub-Element 1.2: Knowledge, Skills, and Abilities (KSAs)						
1.2b	Staff have the appropriate KSAs to meet QI related expectations, based on their role (e.g. QI Council members, frontline staff).						
1.2d	Staff at all levels have access to learning opportunities (e.g. trainings, conferences) to develop *QI related KSAs*.						
1.2f	Staff have access to learning opportunities to improve *job-related KSAs*.						
	Sub-Element 2.1: Collaborative Sharing and Improvement						
2.1a	Staff regularly share information (e.g. lessons learned, best practices) across teams and work units.						
2.1b	Staff regularly collaborate on projects or ideas to improve quality and performance through formal QI projects or other improvement methods.						
	Sub-Element 3.1: Culture						
3.1a	Senior leadership routinely communicates the organization's QI vision and goals to staff.						
3.1c	Managers and supervisors actively use data in a non-punitive way to review performance with staff.						
3.1d	Managers and supervisors actively encourage their staff to engage in QI opportunities to improve work.						
3.1f	Senior leaders, managers, and supervisors address staff concerns about engaging in QI (e.g. extra work, fear of job loss).						

APPENDIX E - NACCHO QI SELF-ASSESSMENT

	Not Applicable	1 Strongly disagree	2	3	4	5	6 Strongly agree
	Sub-Element 3.2: Resourcing and Structure						
3.2a	Senior leaders dedicate enough resources (e.g. staff time) to support and sustain QI initiatives.						
	Sub-Element 4.1: Understanding the Customer						
4.1c	Specific efforts are made to understand the needs and values of different customer groups (e.g. populations with health inequities, new vs. tenured staff).						
	Sub-Element 4.2: Meeting and Exceeding Customer Expectations						
4.2a	The agency regularly collects customer satisfaction data.						
4.2b	The agency uses customer satisfaction data to implement improvements (e.g. QI projects, making informal improvements).						
	Sub-Element 5.1: Strategic Planning						
5.1b	Strategies for achieving strategic goals are incorporated into operational plans at the work unit level.						
	Sub-Element 5.2: Performance Measurement and Use of Data						
5.2a	Staff contribute to the development of performance measures related to their work.						
5.2c	Work units track a mix of process and outcome measures to assess performance.						
5.2g	Defined protocols for collecting performance data (e.g. use of data collection instruments) are documented and followed.						
	Sub-Element 5.3: Quality Improvement Planning						
5.3a	Staff use performance data to identify QI projects.						
5.3d	All staff are engaged in the implementation of the QI plan.						

APPENDIX E - NACCHO QI SELF-ASSESSMENT

	Not Applicable	1 Strongly disagree	2	3	4	5	6 Strongly agree
Sub-Element 6.1: Improving Standardized work							
6.1a	Staff have access to documented standardized work processes (e.g. policies, procedures) which define critical steps						
6.1c	Documented standardized work processes reflect the way work is actually done.						
6.1d	Formal QI methods (e.g. PDSA, Lean) are followed to continuously improve standardized work through QI projects.						
Sub-Element 6.3: Testing, Studying and Acting on Potential Solutions							
6.3d	Lessons learned from QI projects are documented and adopted into standardized work processes, as appropriate.						

APPENDIX F - QI MATURITY ALL-STAFF RESULTS, FY24

Public Health
Prevent. Promote. Protect.
Franklin County Health Department

Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board