



**Florida Department of Health in Bradford/Union Counties
Quality Improvement Plan
Version 1.0
Fiscal Year 2017-2020**

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SECTION 1

INTRODUCTION

PHAB guidance on required documentation:

The Health Department must address key quality terms to create a common vocabulary and a clear, consistent message.

I. Purpose

The Quality Improvement (QI) Plan serves as a key component of the performance management system that describes the integration of quality improvement processes into (1) leadership structure, (2) staff training, (3) planning and review processes, (4) administrative and programmatic services, (5) sharing of practices, and (6) evaluation of measurable impacts on departmental priorities and public health objectives at the Florida Department of Health in-Bradford/Union Counties (DOH-Bradford/Union).

The DOH- Bradford/Union QI Plan presents a summary of the Department's QI Program and describes the department-wide approach to improvement, in alignment with the Florida Department of Health (Department) Agency Strategic Plan, Agency QI Plan, DOH- Bradford /Union Strategic Plan, and the Bradford/Union Community Health Improvement Plan (CHIP). The goal of the DOH-Bradford/Union QI Plan is to ensure the ongoing improvement of the Department and to implement the appropriate processes to attain/sustain a culture of quality following the key indicators identified in the National Association of County and City Health Officials (NACCHO) Roadmap.

II. Outcomes

Based on implementation of the QI program described in this plan, the health of Bradford and Union Counties citizens will be improved, operations of DOH-Bradford/Union will become more effective and efficient, employees will attain and maintain the competencies required to actively engage in quality improvement activities, and the Department will utilize a common set of tools, skills, and terminology to assess, monitor, and evaluate their culture of quality and performance. Leadership will ensure implementation of practices that will create a workforce culture of action, continuous improvement, and performance excellence.

III. Quality Terms

Please see Appendix 1, Quality Plan Key Terms, for a summary of common terminology and definitions used throughout this document.

SECTION 2

CULTURE OF QUALITY

PHAB guidance on required documentation:

The Health Department must address the current culture of quality and the desired future state of quality in the organization.

I. Mission, Vision, and Values

The Department's focus on quality begins with its mission "To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts." Its mission is underpinned by a shared vision "To be the healthiest state in the nation."

The Department's values exemplify a learning organization: Innovation: We search for creative solutions and manage resources wisely. Collaboration: We use teamwork to achieve common goals & solve problems. Accountability: We perform with integrity & respect. Responsiveness: We achieve our mission by serving our customers and engaging our partners. Excellence: We promote quality outcomes through learning and continuous performance improvement. The Department's organizational activities align with the single mission, vision, and shared values.

II. Current and Future State of Quality

The NACCHO Roadmap to a Culture of Quality Improvement defines organizational culture as:

"The culture of an organization is the embodiment of the core values, guiding principles, behaviors, and attitudes that collectively contribute to its daily operations. Organizational culture is the very essence of how work is accomplished, it matures over several years, during which norms are passed on from one "generation" of staff to the next. Because culture is ingrained in an organization, transforming culture to embrace QI when minimal knowledge or experience with QI exists requires strong commitment and deliberate management of change over time."

In May of 2017, the DOH-Bradford/Union Counties Performance Management (PM) Council engaged in the conduction of a formal department-wide culture of quality self-assessment utilizing the NACCHO Roadmap Self-Assessment Tool. Council members agreed on statement scores to achieve the overall self-assessment outcome. Results of the self-assessment reflected the current QI culture as a 5.06 Phase 5: Formal Agency Wide IQ. These results were shared with the State Health Office and used to develop the Agency QI Plan.

Council members then prioritized statement scores to identify and select greatest opportunities for improvement. Action plans were developed for selected improvement opportunities and goals associated with the action plans were incorporated into the current QI Plan. To support continued process improvement and development, a formal department-wide culture of quality self-assessment will be conducted every three years. Current action plans will be monitored and evaluated routinely during the established PM Council meetings. If/When the Council determines that action plan goals have been met and

the desired improvement obtained, additional opportunities may be incorporated into the QI Plan.

Selected opportunities for improvement are:

Priority 1 (current 2017): A formal proven technique is commonly used to capture knowledge. **UPDATE: We utilized the use of written communication in an intake form to capture information from external clients and used that information to enter it into a comprehensive database so explicit knowledge is gained about the subject. Also, we use team meetings for a discussion to determine what methods work and which don't and use the PDCA technique to make a plan of action for QI.**

Priority 2 (anticipated 2018): Knowledge is gathered first-hand directly from the source of the knowledge. **UPDATE: A systematic process has been employed to capture knowledge through intake forms, survey monkey, direct interaction with subject matter experts, interviews, client satisfaction surveys.**

Priority 3 (anticipated 2019): Current best practices are defined for all key work processes.

SECTION 3

QUALITY IMPROVEMENT STRUCTURE

PHAB guidance on required documentation:

The Health Department must address key elements of the quality improvement effort's structure.

I. Structure

The DOH- Bradford/Union Counties infrastructure for supporting a culture of quality and implementation of improvement initiatives throughout the Department includes:

- A. DOH- Bradford/Union Counties leadership team is accountable for building and sustaining a culture of quality in the Department through the following roles:
 - 1) Remove barriers associated with completing strategic goals as outlined in either the Strategic Plan, QI Plan, or Community Health Improvement Plan (within this document all three plans are referred to as Plans) and continuous performance improvement.
 - 2) Engage various stakeholder groups to promote involvement and obtain support for department strategic goals.
- B. The Quality Improvement Liaison is appointed by leadership and possesses the core competencies identified by the State Health Office. The liaison is responsible for the following:
 - 1) Serve as the point of contact between the Performance Management Council and Bureau of Performance Assessment and Improvement (BPAI).
 - 2) Lead the development of the annual QI plan and triannual self-assessment.
 - 3) Coordinate training identified in QI Plan.

- 4) Serve as the point of contact for reporting progress and sharing results of improvement initiatives, lessons learned, and practices that result in improved performance.
- C. The Performance Management (PM) Council is chaired by the health officer and comprised of the DOH- Bradford/Union Counties leadership team, QI Liaison, and Plan owners. It will operate in accordance with the team charter and is responsible for the following:
- 1) Select priority strategies for QI projects.
 - 2) Assess progress towards a sustainable culture of quality within the County Health Department (CHD) using the NACCHO Organizational Culture of Quality Self-Assessment Tool.
 - 3) Develop and implement a three-year Quality Improvement Plan.
 - 4) Develop, approve, monitor, and evaluate Plans, and QI projects.
 - 5) Conduct at least quarterly reviews of progress toward completion of Plans as well as QI projects.
- D. DOH- Bradford/Union Counties staff is comprised of all Department staff and is responsible for the following:
- 1) Participate in QI projects as appropriate.
 - 2) Develop understanding of basic QI processes and tools. Apply QI into daily work.

SECTION 4

QUALITY IMPROVEMENT TRAINING

PHAB guidance on required documentation:

The Health Department must address types of quality improvement training available and conducted within the organization.

I. Training Plan

Training in QI methodology and tools is critical for creating a sustainable QI program. QI training opportunities will be available and conducted through providers which may include Department personnel, TRAIN Florida, Public Health Learning Network, and the American Society for Quality (ASQ), Florida Sterling Council. The following are minimum DOH-Bradford/Union Counties training requirements, which will be verified with printed certificates of completion maintained by Personnel Liasion Bradford/Union and include:

- A. DOH- Bradford/Union Counties PM Council will complete Department's problem solving methodology training series by December 31st, 2017.
- B. DOH- Bradford/Union Counties QI Liaisons will be trained on how to utilize and conduct the Organizational Culture of Quality Self-Assessment tool with the CHD PM Council by March 2017.
- C. DOH- Bradford/Union Counties QI project team members will complete the Department's problem solving methodology training series in TRAIN Florida by June 30th, 2018 and complete the QI projects identified in this plan by June 30th, 2018 .
- D. All DOH- Bradford/Union Counties managers will complete the Department's problem solving methodology training series within 6 months after appointment to manager or end of current fiscal year, as appropriate.
- E. All DOH- Bradford/Union Counties staff that have not completed the Department's problem solving methodology training series in TRAIN Florida will complete the course by June 30th, 2018 and complete the QI projects identified in this plan by June 30th, 2018 .
- F. All new hire DOH- Bradford/Union Counties staff will complete the Department's problem solving methodology training series in TRAIN Florida within 6 months after hire date or end of current fiscal year, as appropriate.

II. Budget and Resource Allocation

Funding and additional resource allocation will be supported by the DOH- Bradford/Union Counties leadership team to promote QI training and the development of a culture of quality. DOH- Bradford/Union Counties promotes utilization of internal resources and telecommunications to support financial responsibility and appropriate usage of limited funding.

Training	Staff	Time	Average Cost per Participant
Department's PDCA Problem Solving Methodology Training Series	New hires, staff, managers, QI Liaison, QI Project Team members, PM Council members	4 hours	\$140.00 Staff time
Sterling Training	As appointed	24 hours	\$4300.00

SECTION 5

QUALITY IMPROVEMENT PROJECTS

PHAB guidance on required documentation:

The Health Department must address QI project identification, alignment with strategic plan and initiation process.

Note - For re-accreditation PHAB requires the Health Department to provide 1 Administrative and 2 Programmatic completed QI projects. One of the program examples must be a program area that focuses on population based health promotion, protection or improvement efforts to address a community health issue.

I. Project Identification, Alignment, and Initiation Processes

DOH- Bradford/Union Counties identifies opportunities for improvement utilizing key performance indicator data. Opportunities for improvement are prioritized based on alignment that supports objectives identified within either the Strategic Plan, CHIP, or other local emerging/priority areas. Project teams are established by the PM Council and team charters developed to determine the QI tools and methodology that will be utilized to structure the project. Action plans are developed by project teams to establish accountability for project monitoring and evaluation expectations.

Selected projects:

Administrative Project 1 – : Reducing clinic wait times : Improve patient cycle times from 72.3 minutes to 50 minutes by June 30, 2018. We will look at root causes for excessive patient cycle times and develop a countermeasure matrix with practical methods to reduce times with effectiveness and feasibility determined.

Program Project 1 – : Florida Healthy Babies Initiative: Reduce the number of infant mortalities by looking to reduce teen pregnancies, providing information on Safe Sleep for infants, and promoting early pre-natal care. Programs targeting at risk teens will be

presented in the schools, Safe Sleep will be promoted by Healthy Start and health care providers seeing newborns and infants under 1 year old.

Program Project 2 (population based) – : Heart Health Plus: Reduce the number of Heart related deaths in Union County by conducting educational programs that teach heart health, encourage exercise, and tobacco cessation. We will facilitate groups with a required attendance contract and promote Heart Health through community church involvement with a measurable result by monitoring weight and blood pressure.

Appendix 2 contains a table displaying the alignment between the QI Plan projects and the CHD Strategic Plan, the CHIP, Agency Strategic Plan, and the Agency QI Plan.

SECTION 6

QUALITY IMPROVEMENT GOALS

PHAB guidance on required documentation:

The Health Department must address quality improvement goals, objectives, and measures with time-framed targets.

QI PLAN AREA OF FOCUS	GOAL	MEASUREABLE OBJECTIVE	TIMEFRAME	OWNER
Structure	Establish a three-year QI Plan based on organizational strategic priorities and QI cultural opportunities for improvement.	Approved and Implemented 2017-2020 DOH- Bradford/Union Counties QI Plan by July 18, 2017.	June 15, 2017 to July 18, 2017	Quality Improvement Coordinator
Training	Provide introduction to Quality Improvement training to new hire staff.	100% of new hire staff will receive the Department's PDCA Problem Solving Methodology Training Series within 60 days of hire date or end of fiscal year for those hired between July 1, 2017 and April 30, 2020.	July 1, 2017 to June 30, 2020	Human Resource Training Specialist
Training	PM Council to complete process management training.	Appointed Team of PM Council members to complete Sterling Green Belt Training by December 31, 2018.	January 1, 2017 to December 31, 2018	Health Officer
Project	Completion of one administrative QI project and two programmatic projects over the three year span covered by this plan.	Completion of one administrative QI projects and two programmatic projects that are aligned with the Agency Strategic and/or QI Plan. Required deliverables posted to BPAI SharePoint site within 90 days of project completion.	July 1, 2017 to June 30, 2020	Quality Improvement Coordinator
Monitoring	Measure, monitor, and report progress on the goals and objectives of QI, Strategic, and CHIP Plans, and QI Projects.	Quarterly PMC meetings will be held between July 1 and June 30 annually. Meeting minutes and scorecard will be submitted to BPAI SharePoint site within 10 business days of the meeting.	July 1, 2017 to June 30, 2020	Quality Improvement Coordinator
Culture	Gather and incorporate feedback from customers, suppliers, and interfacing work processes into improvement activities.	Complete Customer Engagement QI Project to increase the number of feedback forms received monthly by June 30, 2018	July 1, 2017 to June 30, 2018	Quality Improvement Coordinator

SECTION 7

QUALITY IMPROVEMENT MONITORING

PHAB guidance on required documentation:

The Health Department must address approach to how the QI Plan is monitored; data are collected and analyzed, progress reported toward achieving stated goals and objectives, and actions taken to make improvements based on progress reports and ongoing data monitoring and analysis.

I. Monitor Implementation of Plans and QI Projects

Measuring, monitoring, and reporting of progress on the goals and objectives of plans and QI projects are the responsibility of the PM Council. To ensure routine monitoring, the DOH-Bradford/Union Counties PM Council will meet at least quarterly. Data to support evidence of progress will be gathered by the QI Liaison and included in the meeting minutes. The meeting minutes and information below will be submitted to BPAI within ten business days after meeting minutes are approved. The CHD and statewide reports will include the following information:

- A. Is Bradford/Union Counties PM Council meeting at least quarterly? Yes/No
- B. Are implementation plans for QI projects on track? Yes/No
- C. Short description summarizing progress of QI projects. (no more than a paragraph)

SECTION 8

QUALITY IMPROVEMENT COMMUNICATION

PHAB guidance on required documentation:

The Health Department must address regular communication of quality improvement activities conducted in the health department.

I. Communication

Success of the Department's QI program and progress towards a learning organization is ensured by systematic sharing of information, networking, and reusing knowledge gained. The PM Council, chaired by the Health Officer, will meet at least quarterly. Meetings will be documented using an agenda, sign-in, and meeting minutes. A quorum of two-thirds of members is required for the meeting. The following indicators will be reviewed during the meeting and indicator progress will be communicated to CHD staff, the Board of County Commissioners, other governing entities, and community partners as appropriate. The BPAI will receive documentation of the CHD PM Council meeting within ten business days after meeting completion. This will include:

Progress towards Strategic Plan, CHIP, and QI objectives.

- 1) Status of QI projects.
- 2) Practices that result in improved performance.
- 3) Quality of community engagement.
- 4) Activities undertaken to communicate QI activities with staff.

QI project sponsors will be responsible for sharing project results on a regular basis to keep staff apprised of QI project progress. It is the project sponsor's responsibility to ensure that QI projects are aligned with the CHD's strategic vision and mission. The PM Council will leverage the advantage of Florida's centralized and integrated local public health system by sharing resources and information with peers. The QI Liaison will serve as the point of contact for sharing results of improvement initiatives, lessons learned, and practices that result in improved performance using the following avenues:

- 1) Quarterly PM Council meetings (standing item on each meeting agenda).
- 2) Sharing/submitting information with BPAI, County Health Systems, and other appropriate state office programs.
- 3) Statewide/Community meetings or events.
- 4) Appropriate internal and external award nominations.
- 5) SharePoint.

SECTION 9

QUALITY IMPROVEMENT EVALUATION

PHAB guidance on required documentation:

The Health Department must address process to assess the effectiveness of the quality improvement plan and activities.

I. Review and Update the QI Plan

Annually, the Performance Management Council will review the DOH- Bradford/Union Counties QI Plan to identify strengths, opportunities for improvement, and lessons learned. This information will be reported through the QI Annual Evaluation report and provided to the BPAI by September 30 of each year. This evaluation process will inform planning for each subsequent year and will support a culture of continuous improvement and excellence.

APPENDIX 1

QUALITY IMPROVEMENT KEY PLAN TERMS

TERM	DEFINITION
Accountability	Establishing a systematic method to assure stakeholders (policy-makers and the public) that the organizational entities are producing desired results. Accountability includes establishing common elements that are applied to all participants. These should include clear goals, progress indicators, measures, analysis of data, reporting procedures, help for participants not meeting goals, and consequences and sanctions. (Source: American Society for Quality)
Analyze	To study or determine the nature and relationship of the parts of by analysis. (Source: Merriam-Webster Online Dictionary)
Barriers	Existing or potential challenges that hinder the achievement of one or more objectives. (Source: <i>The Executive Guide to Facilitating Strategy: Featuring the Drivers Model</i> . Michael Wilkinson. 1 st Ed.)
Benchmarking	Benchmarks are points of reference or a standard against which measurements can be compared. In the context of indicators and public health, a benchmark is an accurate data point, which is used as a reference for future comparisons (similar to a baseline). Also referred to as “best practices” in a particular field. Communities compare themselves against these standards. Many groups use benchmark as a synonym for indicator or target. (Source: Norris T, Atkinson A, et al. <i>The Community Indicators Handbook: Measuring Progress toward Healthy and Sustainable Communities</i> . San Francisco, CA: Redefining Progress; 1997)
Best Practice(s)	The best clinical or administrative practice or approach at the moment, given the situation, the consumer or community needs and desires, the evidence about what works for a particular situation and the resources available. Organizations often also use the term promising practices which may be defined as clinical or administrative practices for which there is considerable practice-based evidence or expert consensus which indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence. (Source: <i>National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms</i> , CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf)
Cause and Effect Diagram (Fishbone Diagram)	The fishbone diagram identifies many possible causes for an effect or problem. It can be used to structure a brainstorming session. It immediately sorts ideas into useful categories. (Source: Excerpted from Nancy R. Tague’s <i>The Quality Toolbox</i> , Second Edition, ASQ Quality Press, 2004)
Continuous Improvement	Includes the actions taken throughout an organization to increase the effectiveness and efficiency of activities and processes in order to provide added benefits to the customer and organization. (Source: <i>Certified Manager of Quality/Organizational Excellence Handbook</i> . Russell T Westcott, editor. 3 rd Ed.)
Core Competencies	Core competencies are fundamental knowledge, abilities, or expertise associated in a specific subject area or skill set. (Source: Nash, Reifsnyder, Fabius, and Pracilio. <i>Population Health: Creating a Culture of Wellness</i> . Jones and Bartlett. MA, 2011)
County Health Department’s Leadership Team	Members of the PMC are the County Health Department’s Leadership Team for the purpose of this plan. Refer to the PMC definition for more detail.

TERM	DEFINITION
Culture of Quality Improvement	Culture of quality improvement exists when QI is fully embedded into the way the agency does business, across all levels, departments, and programs. Leadership and staff are fully committed to quality and results of QI efforts are communicated internally and externally. Even if leadership changes, the basics of QI are so ingrained in staff that they seek out the root cause of problems. Staff do not assume that an intervention will be effective, but rather they establish and quantify progress toward measureable objectives. (<i>Roadmap to a Culture of Quality Improvement</i> , Phase 6, NACCHO)
Data	Quantitative or qualitative facts presented in descriptive, numeric or graphic form. (Source: <i>Certified Manager of Quality/Organizational Excellence Handbook</i> . Russell T Westcott, editor. 3 rd Ed.)
Department's PDCA Problem Solving Methodology	Plan-Do-Check-Act problem solving methodology is used when there is a need to identify and eliminate the cause of the problem. This is a simplified version with fewer steps than the <i>ABCs of PDCA</i> by Grace Gorenflo and John Moran.
Evaluate	To systematically investigate the merit, worth or significance of an object, hence assigning "value" to a program's efforts means addressing those three inter-related domains: Merit (or quality); Worth (or value, i.e., cost-effectiveness); and Significance (or importance). (Source: CDC – <i>A Framework for Program Evaluation</i>)
Evidence-based Practice	Evidenced-based practice involves making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision making, conducting sound evaluation, and disseminating what is learned. (Source: Brownson, Fielding and Maylahn. <i>Evidence-based Public Health: A Fundamental Concept for Public Health Practice</i> . Annual Review of Public Health)
Goal	A statement of general intent, aim, or desire; it is the point toward which management directs its efforts and resources in fulfillment of the mission; goals are usually nonquantitative. (Source: <i>Certified Manager of Quality/Organizational Excellence Handbook</i> . Russell T Westcott, editor. 3 rd Ed.)
Implement	To put into action; to give practical effect to and ensure of actual fulfillment by concrete measures (Source: Adapted from Merriam-Webster.com)
Indicators	Predetermined measures used to measure how well an organization is meeting its customers' needs and its operational and financial performance objectives. Such indicators can be either leading or lagging indicators. (Source: <i>Certified Manager of Quality/Organizational Excellence Handbook</i> . Russell T Westcott, editor. 3 rd Ed.)
Key Functions	Critical responsibilities which are performed routinely to carry out the mission of the department. (Source: Adapted from BusinessDictionary.com)
Key Processes	Processes that focus on what the organization does as a business and how it goes about doing it. A business has functional processes (generating output within a single department) and cross-functional processes (generating output across several functions or departments.) (Source: <i>Certified Manager of Quality/Organizational Excellence Handbook</i> . Russell T Westcott, editor. 3 rd Ed.)
Key Customer	Any individual or group that receives and must be satisfied with the service, work product, or output of a process. (Source: <i>Certified Manager of Quality/Organizational Excellence Handbook</i> . Russell T Westcott, editor. 3 rd Ed.)

TERM	DEFINITION
Key Customer Requirements	Performance standards associated with specific and measurable customer needs; the “it” in “do it right the first time.” (Source: <i>The Quality Improvement Handbook</i> , John Bauer, Grace Duffy, and Russell Westcott, editors)
Objective	Specific, quantifiable, realistic targets that measure the accomplishment of a goal over a specified period of time. (Source: <i>The Executive Guide to Facilitating Strategy: Featuring the Drivers Model</i> . Michael Wilkinson. 1 st Ed.) Objectives need to be Specific, Measureable, Achievable, Relevant and include a Timeframe (SMART) .
Operational (Action) Plan	An action plan with specific steps to implement and achieve the objectives. Plans usually include the following: key activities for the corresponding objective; lead person for each activity; timeframes for completing activities; resources required; and evaluation indicators to determine quality and effectiveness of the activities in reaching the strategy. (Source: Adapted from <i>The Executive Guide to Facilitating Strategy: Featuring the Drivers Model</i> . Michael Wilkinson. 1 st Ed.)
Opportunity for Improvement	Agents, factors, or forces in an organization's external and internal environments that can directly or indirectly affect is chances of success or failure. (Source: Adapted from BusinessDictionary.com)
Outcomes	Long-term end goals that are influenced by the project, but that usually have other influences affecting them as well. Outcomes reflect the actual results achieved, as well as the impact or benefit of a program.
Performance Excellence	An integrated approach to organizational performance management that results in 1) delivery of ever-improving value to customers and stakeholders, contributing to organizational sustainability; 2) improvement of overall organization effectiveness and capabilities; and 3) organizational and personal learning. (Source: <i>2013 Sterling Criteria for Organizational Performance Excellence</i>)
Performance Gap	The gap between an organization’s existing state and its desired state (as expressed by its long-term plans).
Performance Improvement	An ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, outcomes.
Performance Indicators	Measurement that relates to performance but is not a direct measure of such performance (e.g. the # of complaints is an indicator of dissatisfaction but not a direct measure of it) and when the measurement is a predictor (leading indicator) of some more significant performance (e.g. increased customer satisfaction might be a leading indicator of market share gain.) (Source: <i>2013 Sterling Criteria for Performance Excellence</i>)
Performance Management Council (PMC)	The PMC Team is made up of the Health Officer, the executive management team, the Accreditation Liaison, and the staff responsible for implementation of the Community Health Improvement Plan (CHIP), the Strategic Plan and the Quality Improvement (QI) Plan. The PMC Team conducts quarterly meetings featuring standing agenda items with reports from: CHIP, Strategic Plan, and Quality Improvement Plan. These reports are comprised of progress updates and meeting minutes documenting the input and collaboration with community partners.
Performance Management System	A fully functioning performance management system that is completely integrated into health department daily practice at all levels includes: 1) setting organizational objectives across all levels of the department, 2) identifying indicators to measure progress toward achieving objectives on a regular basis, 3) identifying responsibility for monitoring progress and reporting, and 4) identifying areas where achieving objectives requires focused quality improvement processes. (Source: Public Health Accreditation Board. <i>Standards and Measures</i> Version 1.0. Alexandria, VA, May 2011)

TERM	DEFINITION
Performance Measures or Metrics	Tools or information used to measure results and ensure accountability; specific quantitative representation of capacity, process, or outcome deemed relevant to the assessment of performance. (Source: Lichiello, P. <i>Turning Point Guidebook for Performance Measurement</i> , Turning Point National Program Office, December 1999)
Performance Report	Documentation and reporting of progress in meeting standards and targets and sharing of such information through feedback. The report should provide information in four categories: facts, meaning, assessments, and recommendations. (Source: <i>Turning Point Performance Management</i> , National Excellence Collaborative, 2004)
Plan-Do-Check-Act (PDCA)	Also called: PDCA, Plan–Do–Study–Act (PDSA) cycle, Deming Cycle, Shewhart Cycle. The Plan–Do–Check–Act cycle is a four–step model for carrying out change. Just as a circle has no end, the PDCA cycle should be repeated again and again for continuous improvement. (Source: ASQ.org)
Plan Owners	Person designated by Health Officer to bear responsibility for managing the CHIP, strategic plan, or QI plan.
Policy	Policy is a definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions or a high-level overall plan embracing the general goals and acceptable procedures especially of a governmental entity. (Source: <i>Acronyms and Glossary of Terms</i> , Public Health Accreditation Board, version 1.0, September 2011)
Population-based Health	Population-based health are interventions aimed at disease prevention and health promotion that effect an entire population and extend beyond medical treatment by targeting underlying risks, such as tobacco; drug and alcohol use; diet and sedentary lifestyles; and environmental factors. (Source: Turnock BJH. <i>Public Health: What It Is and How It Works</i> . Gaithersburg, MD: Aspen Publishers, Inc.; 1997)
Priorities	Strategically selected areas on which the department focuses resources (human, financial, other). In some instances, priorities are further identified as those responsibilities expressly assigned statutorily to the department.
Public Health	The science of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; control of community infections; education of individuals; organization of medical and nursing service for the early diagnosis and treatment of disease; and development of the social systems to ensure every individual has a standard of living adequate for the maintenance of health. The mission of public health is to fulfill society's desire to create conditions so that people can be healthy. (Sources: Winslow CEA. <i>Man and Epidemics</i> . Princeton, N.J.: Princeton University Press, 1952; and (2) Institute of Medicine. <i>The Future of Public Health</i> . Washington, DC: The National Academy Pres, 1988)
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. (Source: Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. "Defining Quality Improvement in Public Health". <i>Journal of Public Health Management and Practice</i> . January/February 2010)

TERM	DEFINITION
Quality Improvement (QI) Plan	<p>A QI plan describes what an agency is planning to accomplish and reflects what is currently happening with QI processes and systems in that agency. It is a guidance document that informs everyone in the organization as to the direction, timeline, activities, and importance of quality and quality improvement in the organization. The QI plan is also a living document and should be revised and updated regularly as progress is made and priorities change. The QI plan provides written credibility to the entire QI process and is a visible sign of management support and commitment to quality throughout the health department. (Source: Davis MV, Mahanna E, Joly B, Zelek M, Riley W, Verma P, Solomon Fisher J. "Creating Quality Improvement Culture in Public Health Agencies." <i>American Journal of Public Health</i>. 2014. 104(1):e98-104)</p> <p>The Public Health Accreditation Board requires a QI plan as documentation for measure 9.2.1 A of the <u>Standards and Measures Version 1.5</u>.</p>
Quality Improvement (QI) Program	<p>A quality improvement program consists of the enduring infrastructure and processes put in place to support the implementation of quality improvement plans and projects.</p>
Quality Tools	<p>Seven Basic Tools: Seven Basic Tools - Quality Management Tools ASQ</p> <p>Seven New Planning & Management Tools: Seven Management & Planning - New Management Tools ASQ</p>
Rapid Process Improvement (RPI)	<p>Typically, a five day event intended to take waste out of work processes by reducing defects, rework, and non-value added steps in the process structure. It is intended to provide a productive forum to address high-volume, low-complexity process problems.</p>
Reporting (performance)	<p>A process which provides timely performance data for selected performance measures/indicators which can then be transformed into information and knowledge.</p>
Resources	<p>Personnel, equipment, facilities, and funds available to address organizational needs and to accomplish a goal.</p>
Sustainability	<p>Sustainability gauges the likelihood that improvements can be maintained over time. It involves how well processes are defined and documented with the goal of being repeated, how outputs and outcomes of the process are measured and monitored, whether ongoing training of those process and standards for implementation is provided, and whether the standards for the process are reviewed periodically as a part of continuous quality improvement.</p>
System	<p>A network of connecting processes and people that together perform a common mission. (Source: <i>The Quality Improvement Handbook</i>, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.)</p>
Targets	<p>Desired or promised levels of performance based on performance indicators. They may specify a minimum level of performance or define aspirations for improvement over a specified time frame.</p>
Trend Analysis	<p>Trend analysis is a study design which focuses on overall patterns of change in an indicator over time, comparing one time period with another time period for that indicator. Trend analysis is not used to determine causation; rather associations can be drawn. (Source: Nash, Reifsnyder, Fabius, and Pracilio. <i>Population Health: Creating a Culture of Wellness</i>. Jones and Bartlett. MA, 2011)</p>
Validate	<p>To confirm by examination of objective evidence that specific requirements and/or a specified intended use are met. (Source: Florida Sterling <i>The Quality Improvement Handbook</i>, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.)</p>

APPENDIX 2

QI PLAN AND PROJECT ALIGNMENT TO CHIP, CHD STRATEGIC PLAN, AND AGENCY STRATEGIC PLAN

CHD QI Plan Goals	Community Health Improvement Plan Objective	CHD Strategic Plan Objective	Agency QI Plan	Agency Strategic Plan Strategy
Reduce Patient cycle time to increase good health practices	Obj..2.1 Increase the percentage of Bradford/Union County Residents who report seeing a doctor.	Obj. 2.1.2C Increase number of users at New River seeing a provider	TBD	2.1.1 2.1.2
Reduce infant mortality by decreasing teen pregnancies	Obj.3.1 Decrease the 3 year rolling birth rate for females age 15-19.	Obj. 1.1.1A Decrease births for 15-19 year olds Obj.1.1.1B Decrease percent of repeat births for mothers 15-19 Obj.1.2.1A Increase percent of infants who are breastfed	TBD	1.1.1
Decrease overall obesity to decrease diabetes and heart conditions	Obj. 1.4 increase physical activity and promote healthier food choices	Obj. 2.1.1A Reduce overall obesity rate to promote better health	TBD	2.1.1