Denver Public Health

Quality Improvement Plan - 2013

Status: Final
Prepared by the Quality Committee: March - July 2013
Approved by the Department Director: July 12, 2013
Implemented: August 1, 2013

Contents

I. Purpose, Vision, and Goals

Purpose

The purpose of the Quality Improvement Plan (QIP) is to provide context and framework for performance management and quality improvement (QI) activities at Denver Public Health (DPH).

Vision

The Quality Committee (QC) and Performance Management Team (PMT) will use the annual QIP to ensure success in creating a culture of quality improvement that is sustainable and aligned with the strategic plan and mission of DPH.

Goals

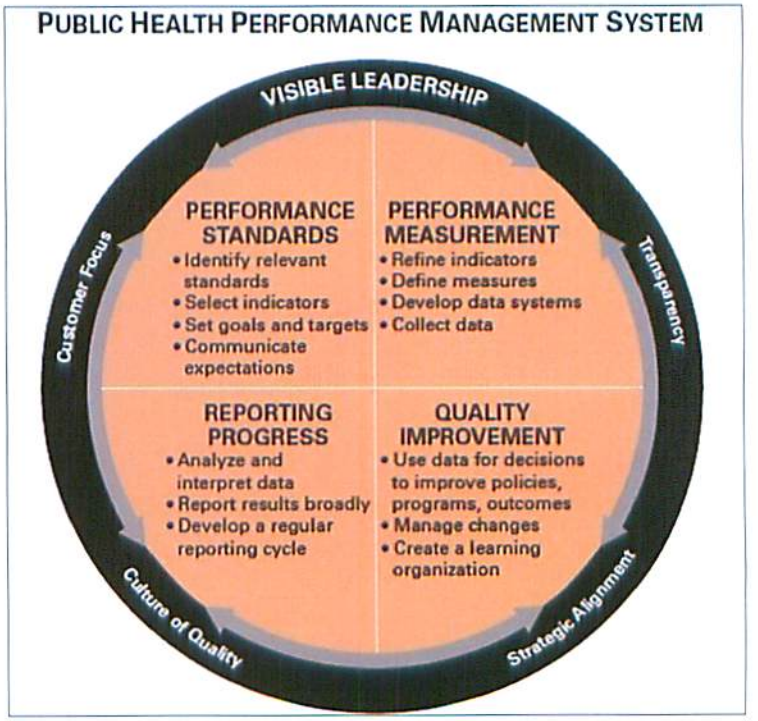
The QC and PMT's primary goals in supporting this vision are to:

- assure measureable departmental success with QI efforts
- use performance measures to evaluate effectiveness and drive the selection of QI work
- improve staff capacity to use QI and understand performance management
- use customer feedback for improvement planning
- implement effective communication strategies around performance management and QI

II. Organizational Structure

Performance Management Team (PMT): The PMT will support QI efforts by serving as the primary group responsible for implementing, monitoring and evaluating DPH's Performance Management (PM) System. The PMT will work primarily on building the infrastructure of the PM System in accordance with standard 9.1 of the Standards and Measures of the Public Health Accreditation Board (PHAB).

The Turning Point Public Health PM System model (see diagram) will be used in the development of the PM System for DPH. The PMT will assess how existing performance related systems, such as Quarterly Reports, Results Based Accountability, and onFocus (the electronic strategic plan tracking system) fit into the model. The PMT will utilize feedback from the QC, program directors and managers, and front-line staff in the planning efforts. Performance management training and support will be available for staff and regular communication on progress and changes will occur.



Quality Committee (QC): The QC will support QI efforts and activities by: developing and evaluating an annual QIP, meeting PHAB standard 9.2 regarding QI, providing training and support on QI projects, and providing recognition for QI projects and activities. Committee members will plan and participate in QI training activities and acquire knowledge in various QI tools and QI project facilitation methods in order to increase QI capacity throughout DPH. See the QC Charter for additional details (Appendix A).

Program Leaders: Program Leaders (Directors, Managers, Coordinators, Administrators, and Supervisors) will be asked to support QI efforts by providing feedback to the PMT and QC as needed and implementing QI activities. Program leaders will be asked to provide communication to staff on changes and QI updates as needed.

All staff: All DPH staff will be asked for feedback in the annual QI Assessment Survey, will be asked to participate in QI projects related to their work, and will be offered QI training and support.

III. Roles and Responsibilities

The roles and responsibilities of the Director, Associate Director, QI Coordinator, QC Members, Program Leaders, and All Staff are summarized in the 'QI Key Roles and Responsibilities' table (Appendix B).

IV. Staffing and Administrative Support

The QI Coordinator is specifically tasked to coordinate the development, implementation, evaluation and coordination of PM and QI activities within DPH. The QI Coordinator position is one full-time equivalent (FTE) position and is housed within Administration. The Associate Director provides direct supervision, support and leadership for the QI Coordinator. The QC is comprised of a multi-disciplinary team, with representation from each program area. Program leaders and staff within program areas may be asked to provide support on QI projects as needed.

V. Reporting Structure

QC members report to their respective program leaders and staff regarding updates and information related to QI. The Associate Director and QI Coordinator regularly report to the Core Leadership team on the status of PM and QI activities and request approval of the annual QIP from the Director. The Director reports to Denver Health leadership, the Denver Health Board of Directors, and the Manager of Denver Environmental Health on activities and accomplishments related to QI and PM as needed.

VI. Budget and Resource Allocation

The primary budget allocation is for the QI Coordinator position, which is paid out of the Accreditation Support Initiative (ASI) grant (11/2012-7/2013) from NACCHO (National Association of County & City Health Officials) and DPH Administration. The ASI grant funding

allowed for the development of the QI Coordinator position, in addition to funding QI training opportunities and resources. When applicable, QI support from the QI Coordinator will be written into future grants and QI grant opportunities will be actively pursued whenever possible.

VII. Scope

Each year, the PMT and QC will develop strategies and tactics to define the specific activities that will be undertaken in the upcoming year. The 2013 goals, strategies, and tactics for the QC are listed in Appendix D. Progress towards the goals, strategies, and tactics will be tracked in onFocus by the QI Coordinator. Project leads, target dates, and achievement indicators are assigned for each strategy and tactic.

Activities will be focused among these primary areas:

Training

The PMT and QC will plan and coordinate training for staff related to performance management, QI, customer satisfaction and related topics. There will be an evaluation component for all trainings and improvements made to based on the feedback. QI trainings will focus on using Lean process improvement methods, as Lean is the performance improvement framework used at Denver Health and DPH. Trainings will be conducted by the DPH Lean Black Belts, trainers from Denver Health's Lean Systems Improvement (LSI) department, and/or staff with advanced knowledge of QI. Online trainings, such as those offered from the Public Health Foundation, CO Train, or NACCHO may also be utilized.

Assessment and Evaluation

The QI Assessment Survey and Performance Management Self-Assessment will be sent annually to staff in the first quarter of the year. These assessments will help the PMT and QC plan for activities in the upcoming year. QC meetings will be evaluated for effectiveness using an online survey sent by the QI Coordinator at a minimum of once a quarter. The strategies and tactics of the QIP will be monitored regularly by the QI Coordinator and reported to the PMT and QC. The assessment and evaluation findings will be used to update the QIP annually and set strategies and tactics for the upcoming year.

QI Project Tracking

The DPH SharePoint site will be used to track QI projects, share QI project information, and post important links and documents related to performance management and QI.

QI Project Support

The QI Coordinator and QC will work to provide necessary QI support to all programs. Tools and resources will be collected and developed to help programs identify QI projects that align with the DPH strategic plan. The LSI department Lean project tools and resources will be utilized when needed. Technical assistance from the QI Coordinator will be provided upon request.

Recognition

DPH leadership, program managers and directors, and the QC will all be encouraged to recognize QI efforts and accomplishments. Recognition methods will include: the monthly 'Oppy award', email communication to all staff, posting/sharing information on the DPH intranet and internet sites, newsletter articles, and presentations/announcements at staff meetings and retreats. The executive leadership will recognize, support and encourage QI work during Gemba Walk Rounding and Quarterly Reviews.

Communication

The QI Coordinator, PMT, and QC will disseminate information regarding performance management and QI to staff and leadership. Communication methods used will be: emails, updates at meetings/retreats, posting on the SharePoint and DPH internet sites, information on visual management boards, postings on bulletin boards and newsletter articles. The Public Relations/Marketing Specialist will be consulted as needed to assist with communication plans.

Customer Satisfaction

The QC will be responsible for facilitating the process to update the customer satisfaction surveys in 2013. Program directors and managers will be responsible for reviewing the survey data and disseminating to staff. The QI Coordinator and QC will help by providing tools and advise on ways to analyze the data and look for QI opportunities after getting survey results. The QI Coordinator will work with the designated staff and web development group on a SharePoint solution to display the results. Continuous QI will be built into the customer satisfaction process and alternative methods of gathering feedback, such as focus groups, comment cards, and customer interviews will also be encouraged.

VIII. Evaluation of Quality Improvement Plan

The QIP will be evaluated based on the progress and success of the goals, strategies and tactics selected by the QC. Performance on these measures will be compiled and reported frequently to the QC and Core Leadership. An annual report will be completed at the end of each year to summarize the evaluation of the QIP.

IX. Approval of Quality Improvement Plan

Based on the recommendations from the QC and the Associate Director, the QIP will be revised annually to reflect program enhancements and revisions. Future goals, strategies and tactics will be based on recommendations from the annual plan evaluation and staff assessments. A revised QIP will be completed by the end of the first quarter in each calendar year. Approved this 12th day of July 2013 for the period of August 1, 2013 - December 31, 2013.

7/12/1

Bill Burman, MD, Director

X. Appendix

A. Quality Committee Charter
B. Roles & Responsibilities
C. QI 2013 Goals, Strategies, and Tactics
D. Glossary of Terms

Quality Committee Charter - 2013

Charge

The Quality Committee (QC) exists to oversee Denver Public Health's (DPH) continuous quality improvement (QI) efforts related to QI projects, staff QI training, customer satisfaction and related communications.

Primary Goals

- To improve the quality of all services and activities at DPH.
- To better prepare DPH to meet and sustain accreditation standards, measures and documentation related to quality improvement, staff training, and customer satisfaction.
- To improve staff capacity and skills related to developing, monitoring and evaluating quality improvement efforts and to contribute to the success of those efforts.
- To make quality improvement tools and techniques user friendly, participatory, and part of daily work.

Primary Activities

- Monitor and evaluate QI projects
- Provide and/or help coordinate technical assistance for QI projects
- Recognize individuals and teams and celebrate milestones and successes
- Plan, coordinate and evaluate staff QI training
- Plan and evaluate QC reporting and communications activities
- Monitor and evaluate customer satisfaction activities
- Evaluate and update the Quality Improvement Plan (QIP) annually

Composition/Membership

QC membership includes the QI Coordinator, Associate Director, and a select staff person from each program area. Various staff positions are represented on the QC and special effort will be made to ensure the QC remains as diverse as possible.

Appointment to the QC

Staff will become members of the QC through recommendations by program managers.

Term

Members serve for a minimum two-year period. Replacements can occur after two years, as managers deem appropriate. If a member is unable to fulfill a two-year term, a replacement will be recommended by the program manager. All new members will receive orientation from the QI Coordinator.

Membership Criteria

- Members will have an interest in and aptitude for QI and program evaluation.
- Members will commit to develop and promote continuous quality improvement throughout the department.

- Members will have a flexible and collaborative nature and be willing to be part of a developing concept.
- Members will be available to regularly attend meetings and to complete required work between meetings.

Roles & Duties

Associate Director
• serves as a QC member • reports on QC operations to the Core Leadership
QI Coordinator (Chair)
• develops and distributes meeting agendas • facilitates meetings • coordinates all QC operations • schedules meeting rooms and equipment • provides member orientation • reports on QC operations to the Core Leadership
Recorder - *This position rotates monthly among QC members.*
• takes minutes during meetings using the minutes template • posts minutes on the Quality Committee site
Members
• actively learn about QI • promote QI to other staff • complete respective assignments, as determined by the annual QIP and QC decisions • serve as a resource for QI projects, as assigned

Voting

QC members will attempt to reach a consensus on significant issues. If consensus cannot be reached, majority vote prevails.

Meetings

Meetings will be held twice a month, the first and third Friday from 9:00-10:00AM. Meeting frequency and times will be evaluated periodically and adjusted as needed to ensure proper time and resource use is allocated to meet QC goals.

Time Commitment

The estimated time commitment for QC members is anticipated to be 2 to 5 hours per month. This includes meetings and meeting preparation time.

QC Performance Measures

Goals, strategies and tactics will be set each year and progress towards these will be tracked and reported in onFocus, the Denver Health electronic tracking software. A list of the goals, strategies and tactics will be listed in the annual QIP (Appendix C).

QI Key Roles and Responsibilities

Activities	Director	Associate Director	QI Coordinator	QC Members	Program Leaders	All Staff
Sets vision and direction	X	X	X			
Writes and updates annual QIP		X	X			
Coordinates annual QIP evaluation		X	X			
Approves annual QIP	X					
Reports on QI activities to appropriate entities	X	X	X	X	X	X
Reports on QI activities to DPH Core Leadership Team		X	X			
Oversees development of annual QIP & related budget		X				
Nominates QC members					X	
Approves selection of QC members		X	X	X		
Track QI project proposals on SharePoint site			X	X	X	
Develops member orientation process and materials			X			
Organizes and facilitates QC meetings			X			
Coordinates technical assistance for QI projects			X	X		
Oversees planning & budget for QI activities		X				
Coordinates QI training			X	X		
Update customer satisfaction surveys and process			X	X	X	
Tracks and reports on customer satisfaction activity			X		X	
Utilize customer satisfaction data for QI			X		X	
Attends monthly QC meetings		X	X	X		
Assists with QI projects, as assigned	X	X	X	X	X	X
Promotes understanding and use of QI in department	X	X	X	X	X	X

Quality Committee – 2013 Goals, Strategies, and Tactics

Ref #	Goal		Pillar		Leader	Target Date
1.	Provide exceptional service to the patients, families, communities, and partners we serve.		Patient Experience		Judy Shlay	12/31/2013
Ref #	**Strategy**	**Metric Name**	**Metric Target**	**Metric Actual**	**Leader**	**Target Date**
1.1.	Utilize customer satisfaction surveys in all program areas	Survey response rate (DPH overall)	80.00%		Heather Weir	12/31/2013
Ref #	**Tactic**	**Achievement Indicator**	**Start Date**	**Score Date**	**Leader**	**Target Date**
1.1.1.	Review current surveys with each program and assess key drivers of customer satisfaction.	Updated survey implemented	5/1/2013	6/28/2013	Heather Weir	8/30/2013
Ref #	**Strategy**	**Metric Name**	**Metric Target**	**Metric Actual**	**Leader**	**Target Date**
1.2.	Make customer service a primary focus for all staff	Overall customer satisfaction (all DPH) - % Strongly Agree/Agree	90.00%		Heather Weir	12/31/2013
Ref #	**Tactic**	**Achievement Indicator**	**Start Date**	**Score Date**	**Leader**	**Target Date**
1.2.5.	Training on customer satisfaction	> 1 training on customer satisfaction per program	5/1/2013	6/28/2013	Heather Weir	10/31/2013
1.2.6.	Providing on-going feedback to staff on customer satisfaction, to include survey results, customer comments/emails/calls, etc.	Increase in the % of staff that indicate they have received information on customer satisfaction (based on the annual QI Assessment Survey). Customer satisfaction information on visual management boards.	5/1/2013	6/28/2013	Heather Weir	3/31/2014
Ref #	**Goal**	**Functional Area**	**Pillar**		**Leader**	**Target Date**
9.	Evaluate and continuously improve health department processes, programs, and interventions.	TBD	Patient Safety and Quality		Heather Weir	12/31/2013
Ref #	**Strategy**	**Metric Name**	**Metric Target**	**Metric Actual**	**Leader**	**Target Date**
9.1.	Develop Quality Improvement (QI) infrastructure to support a culture of QI				Heather Weir	12/31/2013
Ref #	**Tactic**	**Achievement Indicator**	**Start Date**	**Score Date**	**Leader**	**Target Date**
9.1.1.	Develop a Performance Management SharePoint site to share information and documents	SharePoint site completed and updated regularly	2/1/2013	2/14/2013	Heather Weir	2/14/2013
9.1.2.	Form a department-wide Quality Committee (QC) and have regularly scheduled meetings	> 95% of QC members rate overall meeting effectiveness as Good/Excellent (per the meeting effectiveness survey)	5/1/2013	6/28/2013	Heather Weir	12/31/2013
9.1.3.	Complete a QI Assessment for all staff regarding QI culture, QI interest, QI confidence, QI tool use and QI training needs.	> 80% response rate on QI Assessment	2/18/2013	4/12/2013	Heather Weir	3/31/2013

9.1.4.	Develop a written QI Plan (update annually)	2013 QI Plan completed and approved by Director	5/1/2013	6/28/2013	Heather Weir	7/31/2013
9.1.5.	Develop and implement a departmental QI project tracking system	QI project tracking system created and staff trained on use	5/1/2013	6/28/2013	Heather Weir	8/30/2013
9.1.6.	Conduct QI trainings for Quality Committee (QC) and staff	QI training provided to Quality Committee. QI support and training provided to programs (training will be focused around clinic/program QI projects).	5/1/2013	6/28/2013	Heather Weir	12/31/2013
9.1.7.	Encourage QI projects in all program areas	100% of programs to initiate at least one QI project	5/1/2013	6/28/2013	Heather Weir	12/31/2013
9.1.8.	Provide recognition to staff and programs for QI projects and efforts	QI 'Oppy' reward given each month. Communication about QI projects and successes communicated through meetings/email/display boards.	6/3/2013	6/28/2013	Heather Weir	12/31/2013

Performance Management and Quality Improvement Glossary of Terms

Accreditation

Accreditation for public health departments is defined as:

1. The development and acceptance of a set of national public health department accreditation standards;
2. The development and acceptance of a standardized process to measure health department performance against those standards;
3. The periodic issuance of recognition for health departments that meet a specified set of national accreditation standards; and
4. The periodic review, refining, and updating of the national public health department accreditation standards and the process for measuring and awarding accreditation recognition. *(Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA. May 2011).*

Alignment

Alignment is the consistency of plans, processes, information, resource decisions, actions, results and analysis to support key organization-wide goals. *(Baldridge National Quality Program, 2005).*

Community Health Assessment (CHA)

Community health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processed may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation. *(Turnock, B. Public Health: What It Is and How It Works. Jones and Bartlett, 2009).*

Community Health Improvement Plan (CHIP)

A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community *(Adapted from: United States Department of Health and Human Services, Healthy People 2010. Washington, DC; Centers for Disease Control and Prevention, National Public Health Performance Standards Program, www.cdc.gov/nphpsp/FAQ.pdf).*

Continuous Quality Improvement (CQI)

Continuous Quality Improvement is an ongoing effort to increase an agency's approach to manage performance, motivate improvement, and capture lessons learned in areas that may or may not be measured as part of accreditation. The primary goals are to improve the efficiency, effectiveness,

quality, or performance of services, processes, capacities, and outcomes. *(Public Health Foundation and the National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007).*

Cultural Competence
Cultural competence is a set of skills that result in an individual understanding and appreciating cultural differences and similarities within, among, and between groups and individuals. This competence requires that the draw on the community-based values, traditions, and customs to work with knowledgeable persons of and from the community developing targeted interventions and communications. *(National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf).*

Customer/Client Satisfaction
Customer or client satisfaction is the degree of satisfaction provided by a person or group receiving a service, as defined by that person or group. *(www.businessdictionary.com/definition/customer-satisfaction.html).*

Gemba Walk Rounding
Gemba Walk Rounding refers to leaders visiting program areas to review the visual management boards and discuss performance measures. Gemba Walks promote progress toward completion of annual improvement plans by ensuring that teams are regularly revising key performance indicators and/or process metrics, are creating and executing specific action plans to drive improvement, and are consistently and clearly communicating priorities and progress toward goals. *(Lean Systems Improvement, Denver Health).*

Infrastructure
Infrastructure denotes the systems, competencies, relationships, and resources that enable performance of public health's core functions and essential services in every community. Categories include human, organizational, informational, and fiscal resources. *(National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf).*

Lean
Lean is a systematic approach of continuous improvement, based on the Toyota Production System of lean principles and lean tools, used for the identification and elimination of waste. *(Lean Systems Improvement, Denver Health).*

Mission
A mission statement is a description of the unique purpose of an organization. The mission statement serves as a guide for activities and outcomes and inspires the organization to make decisions that will facilitate the achievement of goals. *(National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007).*

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. *(Public Health Accreditation Board. Standards and Measures Version 1.0. Alexandria, VA, May 2011).*

Public Health Accreditation Board (PHAB)

PHAB is the national accrediting organization for public health departments. A nonprofit organization,

PHAB is dedicated to advancing the continuous quality improvement of Tribal, state, local and territorial public health departments. PHAB is working to promote and protect the health of the public by advancing the quality and performance of all public health departments in the United States through national public health department accreditation. *(Public Health Accreditation Board. Guide to National Public Health Department Accreditation Version 1.0. Alexandria, VA, May 2011).*

Quality Committee (QC)

The Quality Committee (QC) exists to oversee continuous quality improvement (QI) efforts related to QI projects, staff QI training, customer satisfaction and related communications. It is a multi-disciplinary committee with representation from all program areas.

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 Plan (QIP)

The Quality Improvement Plan is a document which outlines how the department will conduct continuous quality improvement activities for the year.

Results Accountability

Results Accountability (RA) is a disciplined way of thinking and taking action that can be used to improve the quality of life in communities, cities, counties, states and nations. RA can also be used to improve the performance of programs, agencies, and service systems. (*Friedman, Mark, Trying Hard is Not Good Enough, 2005).*

Strategic Plan

A strategic plan results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. *(Swayne, Duncan, and Ginter. Strategic Management of Health Care Organizations. Jossey Bass. New Jersey. 2008).*

Technical Assistance (TA)

Technical assistance is an array of supports including advice, recommendations, information, demonstrations, and materials provided to assist the workforce or organizations in improving

public health services. *(National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf).*

Values

Values describe how work is done and what beliefs are held in common as a basis for that work. They are fundamental principles that organizations stand for. *(Swayne, Duncan, and Ginter. Strategic Management of Health Care Organizations. Jossey Bass. New Jersey.2008).*

Vision

Vision is a compelling and inspiring image of a desired and possible future that a community seeks to achieve. A vision statement expresses goals that are worth striving for and appeals to ideals and values that are shared among stakeholders. *(Bezold, C. On Futures Thinking for Health and Health Care: Trends, Scenarios, Visions, and Strategies. Institute for Alternative Futures and the National Civic League. Alexandria, VA. 1995; National Public Health Performance Standards Program, Acronyms, Glossary, and Reference Terms, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf).*

Visual Management Boards

Visual Management Boards provide a visual reminder of priorities and promotes progress toward annual improvement goals by making data on key performance indicators easily accessible, aligning area improvement efforts with key goals of the organization, assuring consistency of information , empowering team members to make the right decisions, and ensuring the team is working on value-added activities. *(Lean Systems Improvement, Denver Health).*