Public Health
Prevent. Promote. Protect.
Greene County

QUALITY IMPROVEMENT AND PERFORMANCE MANAGEMENT PLAN

ABSTRACT

This document sets out a plan to evaluate and continuously improve the Health District's processes, programs, and interventions.

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		Board President	
		DC#:	PLA-01-ADM-1001-2015-9-QI
		Adoption Date	10/01/15
Revision #:	Brief Summary of Changes	Revision Date:	Last Modified By:
1.0	Original Draft	05/15/14	D. Brannen
2.1	Updated draft, updated authority, committee relationship, integrated SOG and forms for submission of QI projects, introductory training for staff	01/12/15	K. Bean
3.0	Updated draft – brought QI plan into alignment with accreditation requirements	04/02/15	K. Bean
3.1	Incorporated QI comments	4/27/15	K. Bean
3.1	Approval	10/1/15	M. Howell
3.2	3.2 Project Submission Form online link added; Project table updated with 'Status'; deleted word 'necessary' from steps that *may* be done to submit form; page numbers updated in Table of Contents	2/5/2016	D. Brannen
4.0	Updated goals and objectives Updated list of trainings and projects completed	3/5/2018	K. Bean
4.1	Updated objectives and tracking of actions taken toward the objectives	4/19/18	A.Steveley
4.2	Updated goals and objectives for 2019	1/17/19	K. Bean
4.3	Updated goals and objectives	1/16/2020	N. Stuby
4.4	Merged QI Plan with PM Plan updates were made to all sections of the plan	02/06/2024	J. Drew
4.5	Updated objectives and training	02/20/2024	J. Drew

Executive Summary

The Quality Improvement (QI) and Performance Management (PM) Plan guides the development, implementation, monitoring and evaluation of performance and quality through leadership commitment, QI infrastructure, continuous process improvement, capacity building, customer satisfaction, communication, and recognition of QI efforts.

This plan outlines the Health District's organizational commitment to and capacity for QI projects and will help us use continuous quality improvement to achieve our vision, of being the "trusted and recognized leader in public health emergencies, an advocate for the advancement of health equity, and a provider of programs and services that uphold standards of public health practices."

QI activities at the Health District are integrated into an organization-wide Plan-Do-Check-Act (PDCA) cycle which involves the Community Health Assessment, Community Health Improvement Plan and Strategic Plan. QI activities specifically strive to assess and improve quality and service in the priority areas identified in the Community Health Improvement Plan.

The desired future state of QI in the Health District is one where all employees understand the basics of QI, integrate its practice into daily operations, and are motivated to exceed customer expectations of quality and timeliness. To continue an organizational culture of quality, we proactively select and implement processes to improve and obtain a measurable increase in efficiency, effectiveness, performance, accountability, and health outcomes.
Improving our processes and services will achieve greater health equity and improve the health of the community (NACCHO, 2015).

The QI & PM Plan was designed to be in accordance with the Public Health Accreditation Board Standard 9.1.2: Establish a process that guides health department quality improvement efforts across the department.

Performance Management System Defined

A fully functioning performance management system that is integrated into daily practice includes: 1) setting objectives across all levels of the department, 2) identifying and measuring outcome and output indicators to assess progress toward achieving objectives, 3) operationalizing a system (i.e., dashboard) to monitor and report progress, and 4) engaging in focused quality improvement efforts when performance gaps are identified. The use of a performance management system not only facilitates the achievement of improved health outcomes by the ongoing monitoring of performance data, but it also supports accountability and quality efforts across the department. Greene County Public Health (GCPH) has elected to use Clear Impact to measure and analyze our agency-wide performance. Clear Impact uses Results-Based Accountability to develop and implement results and activities that will improve communities in Greene County. GCPH implements the PDCA cycle (Plan-Do-Check-Adjust)

when using the system. Clear Impact allows us to track our performance of programs, measure the impact, and report on the success.

Glossary of QI Terms & Acronyms

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

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

Continuous Quality Improvement – An integrative process that links knowledge, structures, processes, and outcomes to enhance quality throughout the organization. The intent is to improve the level of performance in key processes and outcomes (National Committee on Quality Assurance).

Evidence-Based Practice – Making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources while taking into consideration the characteristics, needs, values and preferences of those who will be affected. (Patient Safety and Quality: An Evidence-Based Handbook for Nurses, M. Titler, 2008)

Goal – A statement of a desired future state, condition, or purpose.

PHAB (Public Health Accreditation Board) – A nonprofit organization dedicated to improving and protecting the health of the public by advancing the quality and performance of Tribal, state, local and territorial public health departments (Public Health Accreditation Board, 2015).

Performance Management – The systematic process for helping the organization achieve our mission and goals. The practice of actively using performance data to improve the public's health. Performance management practices can be used to prioritize and allocate resources; to inform managers about necessary adjustments or changes in policies or programs; to frame reports on success in meeting performance goals; and to improve the quality of public health practice (Public Health Foundation, 2011). Performance management relies upon the following to "tell the story "About a program or service:

- Focus on the customer/community or client
- Internal processes and capacity FTEs, or time or skills
- Revenue/Expenditure
- Growth (databases, systems, training)

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

Objective – A measurable condition or level of achievement at each stage of procession toward a goal. Objectives usually carry a time frame within which the objectives should be met.

Quality Improvement – The establishment of a defined process to manage change and achieve quality improvement in public health policies, programs or infrastructure based on performance standards, measurements, and reports (Public Health Foundation, 2011).

Quality Improvement Council (QIC) – A group of Health District employees convened to create, implement, monitor, and evaluate the QI efforts at the agency. Members of the QI Council have also received advanced training in QI principles and project management.

QI Team – A team convened for the purpose of working on a specific QI project.

S.M.A.R.T.I.E. – Acronym used when ensuring objectives are **S**pecific, **M**easurable, **A**ttainable, **R**ealistic, **T**ime-based, **I**nclusive, and **E**quitable.

Strategic Plan – defines the outcomes the Health District plans to achieve over the following three years and details how the agency will achieve the outcomes listed in the plan. Serves as the basic plan for decision making and the allocation of resources.

Storyboard – An organized graphic way of documenting and showcasing the work of a QI team on improving a particular process. Uses simple, clear statements as well as pictures and graphs to describe a problem, summarize the analysis process, describe the solution and its implementation and display the results and next steps.

Standard Operation Guide (SOG) – A written list of steps, or procedures, to be carried out to complete a given operation.

Team Charter – Used to document a QI Team's purpose and clearly define project scope, goals, individual roles, and operating rules.

Team Roles (these are not mutually exclusive; one individual may fill multiple roles):

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

Leader – Active member of the QI Team, provides direction and support; not responsible for all decision making or for the Team's success or failure; responsible for preparation and conduct of meetings, assigns activities to team members, assesses progress, represents the Team to management, manages paperwork and facilitates communication with the Team and the Sponsor.

Sponsor – usually a work area supervisor or director who has authority over the area where the improvement project is taking place. May or may not be actively involved in the QI Team's efforts.

Champion – A key leader in the organization who sees the benefits of quality improvement; is assigned overall responsibility, authority, and accountability for the Team's efforts; monitors decisions and planned changes to assure they are aligned with the agency's mission, vision and strategic plan; implements changes the Team is not authorized to make. The Team Champion is usually the Health Commissioner and Deputy Health Commissioner.

Roles and Responsibilities

GCPH is committed to improving the quality of all its services, processes, and programs and is seeking reaccreditation through the National Public Health Accreditation Board (PHAB). To accomplish both goals, a formal structure is necessary to lead and guide QI & PM efforts within the agency.

The following describes the roles of the Health District's leadership and employees in providing support for QI & PM activities.

The Board of Health provides leadership, support, and resources for QI initiatives by:

1. Establishing QI as an agency-wide priority
2. Approving the QI & PM Plan
3. Recognizing improvements made through QI projects

The Quality Improvement Council (QIC) The QIC will have cross-departmental representation and include Deputy Health Commissioner, Directors/Supervisors, and employees and will have a chairperson selected by the Committee. Council members will be requested to serve two-year terms. No more than half of the team may rotate off the QIC each year.

To nurture a culture of QI throughout the agency, members will be rotated off the QIC and new members will be brought on annually. Administrative support (photocopies, distribution of meeting minutes and agendas, etc.) is rotated between members based on the assignment of roles within QIC.

The QIC provides ongoing leadership and oversight of QI activities and the PM system. The QIC meets bi-monthly, on the third Thursday morning of the month, and will:

1. Develop, approve, evaluate, and revise the QI & PM Plan, including establishing goals, priorities, and indicators of quality.
2. Review QI & PM Plan annually revise as needed, based on annual review.
3. Make recommendations for QI projects.
4. Monitor QI Projects and provide Team Facilitators with advanced training in QI techniques for QI Team projects.
5. Set yearly QI goals and objectives.
6. Under direction from the Leadership Team, the Accreditation Coordinator, or the Health Commissioner, assess gaps in meeting PHAB standards and help facilitate a plan for improvement.
7. A designated member of the QIC will give monthly status updates during the coordination meeting. These updates will consist of status updates on current QI

projects, tracking of projects, any administrative support needed, and lessons learned for the implementation of various QI projects at the Health District.

8. Assist Program Managers with developing meaningful indicators and measures using S.M.A.R.T.I.E. goals to monitor their operational performance and progress towards goals outlined in performance management plans.
9. Evaluate quarterly performance management activities and send potential areas for improvement to the Leadership Team.
10. Encourage, train, and empower all employees to participate in QI processes.
11. Communicate to all employees the progress and success of various QI projects at all-employee meetings, through emails, or with storyboards placed in common areas within the Health District and in the monthly newsletter.
12. Seek additional resources for QI training for Health District employees or conduct training.
13. Participate in QI Training.
14. The QI council will quarterly review reports from Clear Impact performance management systems to identify potential QI projects. A representative will then make recommendations to the leadership team.
15. Annually, the council will work with directors and supervisors to revise performance management metrics.

Quality Improvement Teams carry out QI projects and assume the following responsibilities:

1. Complete a QI Project Charter at the beginning of every QI Project.
2. Report QI project progress and remain accountable to the QIC.
3. Identify a Team Leader, Sponsor, and Facilitator prior to beginning a project.
4. Final Report out to leadership or all employees

Directors & Supervisors provide leadership, support, and resources for QI & PM initiatives as follows:

1. Identifying and initiating problem-solving processes that utilize QI tools and evidence-based practices.
2. Overseeing QI projects in their area
3. Participating in QI projects
4. Scheduling employee time for QI projects
5. Incorporating QI concepts into daily work
6. Work with employees on creating S.M.A.R.T.I.E. objectives and activities for the performance management system.
7. Review suggestions for QI projects quarterly that are brought to leadership by the council.

All Health District employees are responsible for:

1. Working with their supervisors and QIC members to identify areas for improvement and suggest QI projects to address these areas.
2. Participating in QI projects as requested by Directors/Supervisors

3. Collecting and reporting data for QI projects
4. Developing an understanding of basic QI principles and tools by participating in QI training
5. Incorporating QI concepts into daily work.
6. Utilizing the performance management tool to track program activities.

QI Training & Education at the Health District

Training for New Employees

All new hires will watch Quality Improvement Tools and Strategies through Ohio Train as part of the new employee orientation.

- TDH Quality Improvement Tools and Strategies 1119652 - Ohio TRAIN - an affiliate of the TRAIN Learning Network powered by the Public Health Foundation

Ongoing training in QI tools and concepts will be an integral part of Workforce Development at the Health District. QI training for specific programs or focus areas will be made available, as necessary. For a full list of employees trained in QI see Appendix H.

Reporting Out on QI Projects

To foster a culture of QI in our agency, we recognize the importance of communicating the successes and effects of QI projects to the management and the rest of the employees. To this end, each QI project team will create a storyboard or graphic representation of the project to share with all employees at quarterly employee meetings or in the internal newsletter. Upon request, the QI Team Leader will also present the project results to the coordination team or at the Board of Health Meetings. Lessons learned from QI projects completed in the prior year will inform the QIC's recommendations for revision to the agency's QI Plan. All QIC meeting minutes are available to employees on the SharePoint > Accreditation > Quality Improvement Council Folder.

Greene County Public Health QI & PM Goals and Objectives

GOAL: The desired future state of QI & PM at the Health District is one where all employees understand the basics of QI, integrate its practice into daily operations, and are motivated to exceed customer expectations of quality and timeliness. Our goal is to be an organization with a "culture of quality" with "continuous and ongoing efforts 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" (NACCHO, 2015).

The following QI objectives will allow the Health District to have measurable outcomes toward reaching this QI plan's goal. See Appendix A for the actions, persons responsible, timeline, and measures applicable to the objectives listed below.

Objective 1: Quarterly monitoring and annual revising of performance management implementation and measures.

Objective 2: To solicit ideas from employees biannually toward the improvement of daily operations.

Objective 3: Complete an internal review of the Phases of a Culture of Quality and identify two strategies by December 31, 2025.

Objective 4: Review customer feedback to determine and implement one quality improvement project to help us exceed customer expectations annually.

QI Projects

The following section explains the process for identifying, selecting, prioritizing, implementing, and tracking QI projects. The Accreditation Coordinator can provide additional information about current or past QI projects.

Project Identification & Prioritization

Priority for QI projects will be given to projects addressing one or more areas where PHAB standards/measures are not yet fully met. Consideration will also be given to alignment of the proposed project with the Health District's Strategic Plan, mission and vision, the capacity of the agency to take on the suggested QI project, the financial consequences (cost of employee time to complete project vs. potential financial benefit of QI project), and timeliness.

In addition, QI projects may be prioritized at the request of the Health Commissioner. To generate ideas for potential projects, employees or the QIC, may consider:

- Areas identified as needing improvement based on the Performance Management reports
- After-action reports generated following outbreak investigations and emergency preparedness events and exercises
- Client or Employee satisfaction surveys
- Employee suggestions
- Audit or compliance issues
- Incident Reports
- Performance Appraisals

Implementation

Potential QI projects can be brought to the QIC by any employee, the management, leadership team or intern. QI Projects are carried out following the Plan-Do-Check-Act cycle (PDCA) described below.

PLAN

1. To present a QI project for consideration, fill out the Project Submission form in Appendix B. Individuals are encouraged to meet with the supervisor in the affected work area before completing the form. Steps prior to filling out form may include:
    i. Identifying a problem or opportunity for improvement. Typical areas include time, cost or quality of work produced.
    ii. Defining the process that needs to be improved.
    iii. Defining the scope of the process: What is the first step of the process? What is the last step of the process?
    iv. Identifying metrics that can be used to measure current state and success of quality improvement projects.

2. Submit Project Submission Form to the QIC Chairperson.
3. A member of the QIC meets with the director or supervisor to discuss if this project is feasible and possible review status
4. Project presented to QIC at the next meeting.
5. After QI meeting, status update given to the individual submitting the project.
6. Baseline data collection if baseline data does not already exist
7. Assign QI project roles and responsibilities.
8. Assemble QI Team.
9. Complete Project Charter form, see Appendix C.

DO

10. QI project carried out by QI Team
11. QI Teams will provide progress reports to the QIC bi-monthly.
12. Once the project is complete, the QI Team is responsible for creating a storyboard or one-page summary of the QI project. For Storyboard Template see Appendix E.

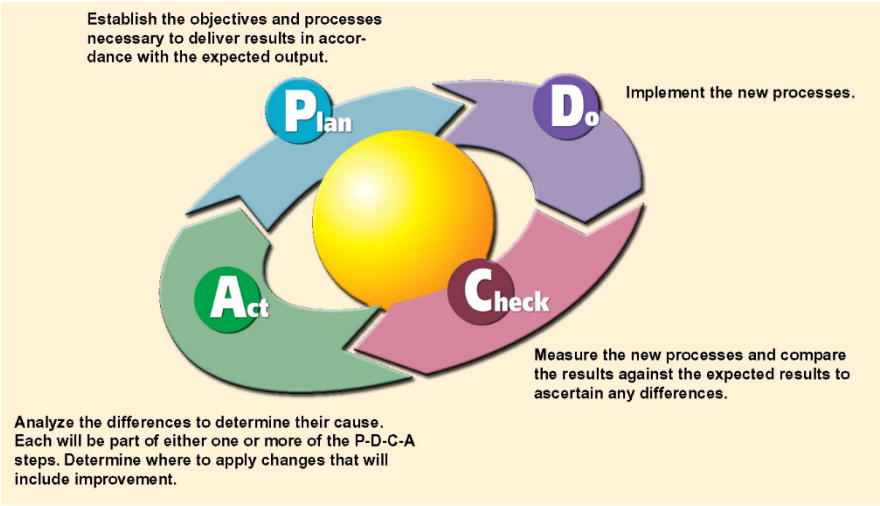
CHECK

13. QI team leader reports on the project progress at 30, 60 and 90 days post implementation.
14. QI Team completes QI Project Reporting Form (Appendix D) and submits form to QIC.

ACT

15. QIC makes recommendation to the Coordination Team to adopt or reject changes developed through QI process.

Fig. 1 PDCA Cycle Used for QI Projects



QI & PM Plan Management and Maintenance

This QI/PM Plan will be evaluated by the members of the QIC in February of every year. Evaluation will address:

- The effectiveness of QIC meetings
- The clarity of the QI & PM Plan and associated forms and appendices
- The effectiveness of the QI & PM Plan for overseeing projects
- Integration with the Health District mission, vision, Workforce Development and Strategic Plans.

The QIC will also review feedback from all members of QI Teams convened in the previous year to evaluate lessons learned and incorporate suggestions for overall agency QI efforts.

References

National Association of County and City Health Officials (NACCHO). Quality Improvement in Public Health. (2015). Retrieved April 8, 2015, from http://www.naccho.org/topics/infrastructure/accreditation/quality.cfm

National Committee on Quality Assurance. (n.d.). Retrieved on April 8, 2015, from http://www.ncqa.org/HomePage.aspx

Public Health Accreditation Board. About Us. (2013). Retrieved April 8, 2015 from http://www.phaboard.org/

Public Health Accreditation Board. Acronyms and Glossary of Terms, Version 1.0 (2011). Retrieved April 8, 2015, from http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf

Public Health Foundation. About Performance Management. (2011). Retrieved April 8, 2015, from, http://www.phf.org/resourcestools/Documents/About_Performance_Management.pdf

Creating SMARTIE Goals & Objectives Worksheet - National Council for Mental Wellbeing (thenationalcouncil.org)

Appendices

Appendix A: QI & PM Objectives

Appendix B: Project Submission Form

Appendix C: Project Charter Form

Appendix D: Quality Improvement Reporting Form

Appendix E: Storyboard Template

Appendix F: Sample Storyboard from Delaware General Health District

Appendix G: QI Projects

Appendix H: Employees Trained in QI

Appendix I: Performance Management Guidelines

Appendix J: Creating SMARTIE goals & Objectives

Appendix A: QI & PM Objectives

Objective 1: Quarterly monitoring and annual revising of performance management implementation and measures by December 31, 2024.

Strategies	Actions	Person(s) Responsible	Timeline	Measures
Quarterly Monitoring	Run quarterly PM reports	Accreditation Coordinator/ QI Council Leader	January – December 2024	4 quarterly reports.
Performance Management measures	Annually update PM measures	Accreditation Coordinator/Program Managers/Directors	Annually	Completed PM forms.

Objective 2: To solicit ideas from employees biannually toward the improvement of daily operations by December 31, 2024.

Strategies	Actions	Person(s) Responsible	Timeline	Measures
Bright Idea! Campaign	Develop QI form	Accreditation Coordinator (s)	Annually	Number implemented/ number of suggestions
	Create Bright Idea! Virtual survey	Accreditation Coordinator (s)	Annually	Forms Submitted
	Survey Link added to monthly newsletter and follow up with an email	Accreditation Coordinator (s)	Bi-annually	Newsletter Documenting Survey link and relaunch of the campaign.
	Check for submissions before each QI meeting	Accreditation Coordinator (s)	Bi-monthly	Forms Discussed in the QI meeting

Objective 3: Complete an internal review of the Phases of a Culture of Quality and identify two strategies by December 31, 2025.

Strategies	Actions	Person(s) Responsible	Timeline	Measures
Review NACCHO's Phases of a Culture of Quality to understand where GCPH is.	Review the phases with QIC and identify where we see GCHP.	Accreditation Coordinator (s) And QIC	Quarterly	Identify two strategies to implement in 2026. Resources - Roadmap to a Culture of Quality Improvement
Improve employees' knowledge of QI tools.	Include a section of the newsletter that discusses different QI tools that can be used.	Accreditation Coordinator (s)	Monthly	Increases knowledge of QI tools of employees by conducting pre and post surveys.

Objective 4: Review customer feedback to determine and implement one quality improvement project to help us exceed customer expectations.

Strategies	Actions	Person(s) Responsible	Timeline	Measures
Customer Satisfaction Survey	Develop promotion plan	PIO & QI Council	Annually	Surveys Completed
	Review Results	QI Council	Bi-annually	TBD Based on survey measures
	Select a QI project	QI Council	As Needed	Number of projects identifies
	Assign QI project team	QI Council Leader	As Needed	Teams identified
	Implement project	Assigned Project Lead	As Needed	Number of projects completed

Quality Improvement Project Submission Form

To initiate a quality improvement idea or project, complete this submission form. Submission forms can be emailed to any quality improvement council member and will be reviewed and either approved or declined within thirty days.

Employee Name:	**Date:**
Program:	
Idea/Project:	
What would you like to improve?	
Do you have information/evidence/data available to support the need to work on this project? Yes No	
If yes, please describe here:	
What kind of improvement will result? (Select all that apply):	

	Enhanced Employee Performance
	Improved Teamwork and Communications
	Improved Use of Resources
	Improved Working Conditions and Employee Morale
	Increased Efficiency
	Improved Quality of Services
	Increased Safety
	Reduced Cost
	Reduced Waste
	Satisfied Customers/Stakeholders
	Other:

What is the desired result? (Example: Reduced Turn Around Time)								
Who will benefit? (Check all that apply)		Program		Public		Employees		Other:

Which of the six areas of public health responsibility does this QI project align with? (Check all that apply)	
	Assure an adequate local public health infrastructure
	Promote healthy communities and healthy behavior
	Prevent the spread of infectious disease
	Protect against environmental health hazards
	Prepare for and respond to disasters and assist communities in recovery
	Assure the quality and accessibility of health services

Office Use Only (Do Not Write Below this Line)

QI Proposal Approval	Date Reviewed	Type of Review
Greene County Public Health QI Council:		☐ Expedited ☐ Full ☐ Exempt
Health Commissioner Team Champion:		☐ Approved ☐ Declined

This Form Available Online at: **https://www.research.net/r/QI_Project_Submission_Form**

LEANOhio Project Charter

Project/Event Title
Project Facilitator
Agency Greene County Public Health

Charter Last Updated Date:

Project Background

Problem/Opportunity Statement

SCOPE (DEFINE BOUNDARIES)	**First step in the process:**
	Last step in the process:

Project Goals

Project Boundaries

Performance Metrics: What measures will tell you if you are successful.	**Performance Metrics**			
	Current	**Goal**	**Final**	**% Change**

Projected Benefits

Project Team		
Team Champion:	Team Lead:	
Team Sponsor:		
Process Owner:		
Team Members:		
Subject Matter Experts:		

Project Sponsor and Process Owner Sign-Off: I am committed to supporting this project and implementing the team's improvements.	
Sponsor Signature:	
Process Owner:	

Also available as Excel file at: https://gchf.sharepoint.com/:f:/g/administration/accreditation/EoBJbZZWu6hFrQl-pHY4BZwBDxPZCJn2mTtbb2TjqGvLpw?e=h6bt9Z

Quality Improvement Reporting Form

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PLAN	**Agency:**	Greene County Combined Health District		
	Project Title:			
	Aim:			
	Impact:			
	Measures: (Include both process and outcome measures.)	**Outcome Measure:** **Process Measures:**		
	Team Members:			
	Month/Year:		**Reported By:**	

	Please summarize the key steps taken in the past month.		Describe the results of the action steps and what was learned from the process.	
DO	1.			CHECK
	2.			
	3.			
	4.			
	5.			
ACT		1. 2. 3. 4.		

What is the team most proud of achieving?

What were the costs incurred for conducting this QI project?	
Salaries and Fringe	$
Travel	$
Equipment	$
Supplies	$
Printing	$
Other:	$
TOTAL	**$**

APPENDIX D: STORYBOARD TEMPLATE

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POPULATION SERVED:

QI PROJECT TITLE:

PLAN

Identify an opportunity and Plan for Improvement

1. Getting Started
Start typing here

2. Assemble the Team
Start typing here

3. Examine the Current Approach
Start typing here

4. Identify Potential Solutions
Start typing here

DO

Test the Theory for Improvement

5. Develop an Improvement Theory
Start typing here

6. Test the Theory
Start typing here

CHECK

Use Data to Study Results of the Test

7. Check the Results
Start typing here

ACT

Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop New Theory
Start typing here

9. Establish Future Plans
Start typing here

Greene County Public Health
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Contact Tracing Response

COVID-19

July 2020 – September 2020

Team Members: Jennifer Barga, Kirsten Bean, Jillian Drew, Dee Owsley, Ashley Steveley ,Noah Stuby

PLAN

Problem Statement: There is an opportunity to increase the number of contacts interviewed so that we ensure notification of quarantine is made which will help in reducing the spread of COVID-19.

Current Process:

- Check Contact Tracing Queue (approximately 10 am and 2 pm)
- assign contacts (to myself only)
- Enter information from the queue into a contact screening form
- Call and attempt to complete the screening form
- Enter information into OCTS
- Request consent for text message symptom monitoring (if applicable)
- Add OCTS number to the screening form
- Fill out quarantine letter in pdf and sign (hit the fill button and fill in the person's name, address and date, and then hit the sign button, insert signature and save)
- Email quarantine letter and resources to contact (if applicable, for example a quarantine letter needed for an employer)
- Place screening form in the folder to email to Becky at end of tracing
- Update queue with any notes

Adapted with appreciation from MN Department of Health 3.2018

Opportunities for Change:

- If Becky is off, how do we know she's off and who do we send forms to or ask to mail out letters?
- Who backs up Mindy for calling no response and enters in OCTS if she is off or busy?
- Who backs up Nancy for monitoring OCTS for symptomatic contacts who need to be evaluated as probable cases?
- Can we text message contact for people under 30 who do not answer the initial call

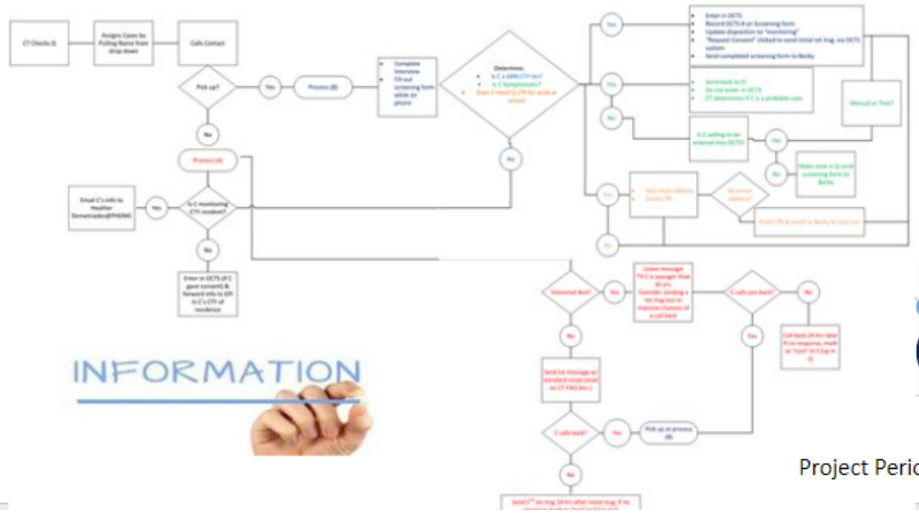
Study

The new contact tracing process including a text message for participants under the age of 30 was implemented after the process mapping was completed to incorporate the change. The first date of a positive case entered in the contact tracing queue was 6/10/20. Data collected will be for 7/1/20-7/15/20 and 9/1/20-9/15/20. This two-week study period was conducted before and after implementation. Results were as follows:

Performance Metrics: What measures will tell you if you are successful.	Performance Metrics		
	Current 7/20	Final 9/20	% Change
# of contacts lost to follow up (2-week sample based on date of positive test)	11	11	0
# of contacts named (2-week sample based on date of positive test)	115	116	
% of contacts interviewed (2-week sample based on date of positive test)	10%	9%	1%

DO

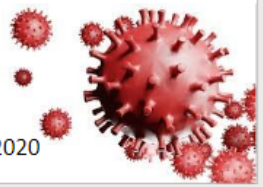
AIM Statement: The contact tracing teams aim is to increase the number of contacts interviewed based on the number named by cases by using text messaging.



ACT

Outcome: The improvement was limited but will help with future efforts. Additional staffing from the Ohio Department of Health (ODH) started at the end of September. The text messaging could not be done by ODH staff, per their policy. As the pandemic response shifts to the delta variant, there is an opportunity to continue to use text messaging as contact tracing increases again and review the data for outcomes.

#IN THIS TOGETHER Ohio



Project Period: July 2020 – September 2020

As of July 3, 2023, QI Project Forms are available on SharePoint at:

Administration Page > Accreditation > Documents > 1026-Accredtiation > Quality Improvement > QI Projects > 0-Project Forms

Public Health
Prevent. Promote. Protect.
Greene County

Performance Management Guidelines

Performance management is actively using performance data to improve the public's health. Performance management enables health departments to be more efficient in program delivery, create greater effectiveness with program outcomes, be transparent with program delivery and be accountable to those we serve. The performance management process involves employees to establish targets and goals to better understand accomplishments and priorities of programs, emphasize quality, improve problem solving, and build teamwork. Performance metrics are chosen for the purpose of driving program improvement. The data related to the performance measures is regularly collected and progress reporting is conducted at least two times per year for each program. Quality improvement is utilized to manage change and to ensure that performance goals and targets are met.

Phase 1: Program Review

Phase 2: Identify Program Standards

Phase 3: Develop Performance Measures

Phase 4: Report Progress

Phase 5: Quality Improvement

Phase 1: Program Review

Division:	Program:	Date:
How does the program support the health department's mission and how does it align with the operating principles?		
How does the program address at least one of the areas of need in the strategic plan, CHIP, or CHNA:		
What does the theory, evidence-based practice, and/or promising practice focus on:		
How is the program beneficial to the community:		
How does the program engage its target audience:		
How does the program collaborate with other community partners, stakeholders, or community members:		
What data is needed to sustain funding:		
Describe how your program maintains health equity and cultural competency:		

Phase 2: Identify Performance Standards

Are there set standards, targets, or goals required for the program? Are there any national, state, or organizational standards already in place? Is there a similar organization to benchmark data with? Is there required data already being reported? Are there existing metrics and data being submitted in program reports, deliverables, CQI projects, etc? What data drives the program? What data is needed to support evidence-based practice and/or promising practice?

Division:	**Program:**	**Date:**
Identify Performance Standard:		
Indicated by: ❑ Strategic Plan ❑ CHIP ❑ CHNA ❑ National standards ❑ State standards/priorities ❑ CQI project ❑ Grant Deliverables ❑ Other:_____		
Target or goal		
How will outcomes be communicated:		
Identify Performance Standard:		
Indicated by: ❑ Strategic Plan ❑ CHIP ❑ CHNA ❑ National standards ❑ State standards/priorities ❑ CQI project		
Target or goal:		
How will outcomes be communicated:		

Phase 3: Develop Performance Measures

What metrics correspond to core activities of the program? What data will influence change and create improvement? Is this data valuable to stakeholders, community partners, or community members? What is instrumental for positive outcomes? What tools are already in place to support efforts? Can the measure be translated to reflect new and growing initiatives?

Division:	**Program:**	**Date:**
Proposed Performance Measure:		
Target or goal:		
Baseline data:		
Trend Summary:		
Data source:		
Data collection: • **How will data be collected:** • **Frequency of data collection:** • **Frequency of data review and monitoring:** • **Person responsible for collecting and monitoring data:**		

Aligns with: ❑ Strategic Plan ❑ CHIP ❑ CHNA ❑ National standards ❑ State standards/priorities ❑ CQI project

❑ Grant Deliverables ❑ Other:_____

Rationale for selection:

Does the measure meet the following criteria?	Yes	No
Quantifiable	❑	❑
Readily available	❑	❑
Clear and specific	❑	❑
Easily monitored	❑	❑
Relevant	❑	❑
Accurate and reliable	❑	❑
Indicator of success	❑	❑

If you answered "NO" to any of the above criteria, please explain here:

How does this measure lead to program improvement:

Does this measure quality, capacity, process, or outcomes:

PMQI Committee Review

Review Date: ❑ ❑ Declined ❑Advise modifications

Comments:

Phase 4: Report Progress

Are we on track with the target or goal? Is performance getting better, worse, or staying the same? Is there baseline or trend data available to compare too? What are the challenges to data collection? What do we need to do differently? What would it take to achieve the target or goal? Are data sources verified? Are these the right targets or do they need to be modified or changed?

Division:	**Program:**	**Date:**
Review and analysis of Performance Standard compared to target or goal:		
Are there challenges to data collection:		
Analysis or theory for challenges:		
Ideas to simplify or improve process:		
Employee and stakeholder review and input:		
Recommended action:		

Phase 5: Quality Improvement

How can performance measure data be used to improve policies, programs, and outcomes? How can this measure contribute to higher level program outcomes? What are the opportunities for innovation and change? Are there any gaps to address?

Division:	**Program:**	**Date:**
Quality Improvement Initiative:		
Driven by:		
Target or goal of initiative:		
Implementation tool being used:		
Reported successes:		
Reported challenges:		