Agency Quality Improvement Plan

Version 1.0

2013-2014

Approved September 17, 2013

Rick Scott
Governor

John H. Armstrong, MD, FACS
Surgeon General and Secretary of Health

Florida Department of Health
Quality Improvement Plan
Fiscal Year 2013-2014

I. Purpose

The Agency Quality Improvement Plan provides a framework for selecting, implementing and measuring the impact of quality improvement initiatives that link to strategic priorities of the department. The plan presents an integrated agency approach to improvement designed to support a sustainable culture of quality.

II. Policy Statement

The Florida Department of Health is committed to systematically evaluating and improving the quality of programs, processes and services. An intentional focus on quality enables the department to achieve high levels of efficiency, effectiveness and customer satisfaction.

It is the policy of the Department to maintain an agency wide quality improvement program that engenders a culture of quality through (1) systematic identification of opportunities for improvement, (2) implementation of data-supported improvement initiatives, (3) sharing of best practices and (4) evaluating measurable impacts on strategic priorities.

The Agency Quality Improvement Plan will be updated annually. This plan is maintained by the Office of Performance and Quality Improvement; reviewed by the Performance Management Advisory Council and approved by the Chief of Staff.

III. Overview of Organization and Quality Program

Agency Overview

The Florida Department of Health Department is an executive branch agency, established in section 20.43, *F.S.* The agency is led by the State Surgeon General and Secretary for Health, who is directly appointed by Florida's Governor and confirmed by Florida's Senate. The Department's Executive Management Team also includes an Inspector General, General Counsel, Chief of Staff and three Deputy Secretaries to oversee the business and programmatic operations.

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The Florida Department of Health is an integrated agency composed of a state health office in Tallahassee; Florida's 67 county health departments (CHDs); 22 Children's Medical Services (CMS) area offices; 12 Medical Quality Assurance regional offices; nine Disability Determinations regional offices; and four public health laboratories. Partnerships with local county governments provide facilities for the 67 CHDs. There are over 200 health department sites throughout the state, providing a variety of services, and ranging from small to large in location size. Florida's integrated public health system allows for standardization of services across the state. Both statewide and local public health functions are addressed through this organizational structure.

The Florida Department of Health's focus on quality begins with its mission: Protect, promote and improve the health of all people in Florida through integrated state, county and community efforts; and is underpinned by our vision to be the healthiest state in the nation.

The Department's values embody a culture of quality:

***I**nnovation:*	We search for creative solutions and manage resources wisely.
***C**ollaboration:*	We use teamwork to achieve common goals & solve problems.
***A**ccountability:*	We perform with integrity & respect.
***R**esponsiveness:*	We achieve our mission by serving our customers & engaging our partners.
***E**xcellence:*	We promote quality outcomes through learning & continuous performance improvement.

The Department's organizational activities align to the single mission, vision and shared values. The agency's key objectives are outlined in the Agency Strategic Plan. The Quality Improvement Plan aligns to the following agency strategic objective:

> ***Agency Strategic Plan***
> *Objective 2.3.3A By June 30, 2013, and every year thereafter, 95% of activities identified in the Agency Quality Improvement Plan are complete based on established schedule.*

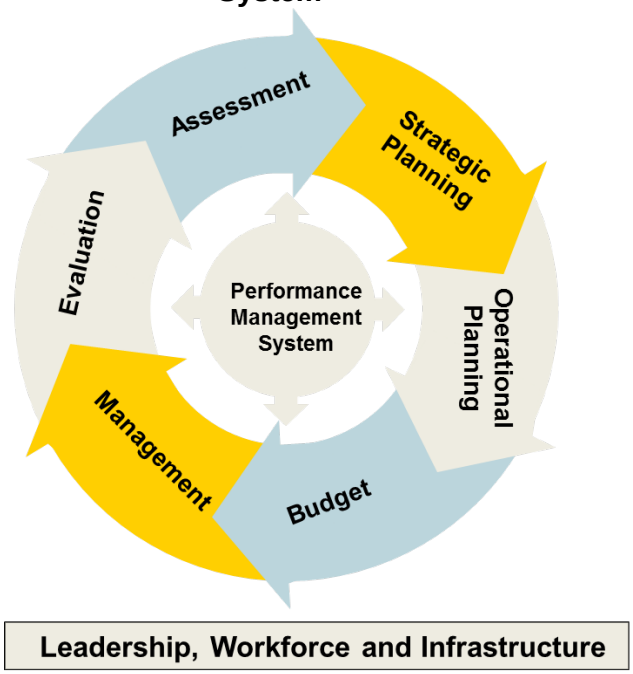
<u>Quality Program</u>

The Department has dedicated resources to quality improvement for over three decades. Since the 1980s the department's quality program has been primarily focused on county health department operations. Appendix A provides a historical summary of highlights for the quality program.

Building on past successes and lessons learned, in 2013, the Department adopted a Performance Management framework designed to establish a shared understanding and focus of the state's public health priorities. The system includes interacting and interdependent processes that are repeatable, use data and information for decision

making and support organizational learning. Figure 1 below provides a visual representation of key interelated processes that make up the system.

Figure 1
Florida Department of Health
Performance Management System



The Management component is the implementation of the operational and budget plans that have been developed to achieve agency priorities. Two critical components of the management process are (1) monitoring and measuring progress and (2) implementing improvements in processes.

IV. Quality Improvement Infrastructure

The Florida Department of Health is dedicated to ensuring the appropriate resources exist to build and sustain a culture of quality improvement which ensures that the processes the department deploys are efficient, effective and deliver quality products and services to our customers.

The Department's infrastructure for supporting a culture of quality and implementation of improvement initiatives throughout the agency includes:

1. Department **Senior Managers** are accountable for building and sustaining a culture of quality in the department.

2. **FDOH Performance Management (PM) Council** provides advice and guides the creation, deployment and continuous evaluation of the Department's performance management system. The following tasks pertain directly to the Agency QI Plan:
    a. Assess progress towards an agency sustainable culture of quality,
    b. Recommend agency-wide process improvement initiatives for the year, and

c. Review evaluation of implemented process improvement initiatives.

3. **Division of Public Health Statistics and Performance Management** is responsible for managing the Department's Performance Management System and leading processes related to health assessment, health improvement planning, strategic planning, measuring and monitoring performance.

4. **Office of Performance and Quality Improvement** is responsible for managing the Agency Quality Improvement Plan and supporting the implementation of the Department's Performance Management System.

5. **Division and County Health Department Quality Councils** are responsible for:
   a. Assessing progress towards a sustainable culture of quality within the unit,
   b. Selecting process improvement initiatives for the year,
   c. Reviewing evaluation of implemented process improvement initiatives, and
   d. Ensuring results of improvement initiatives are shared with the Office of Performance and Quality Improvement.

6. **Quality Improvement Team Leaders** are responsible for:
   a. Leading selected improvement initiatives,
   b. Ensuring evaluation of implemented initiatives, and
   c. Compiling results for sharing within division or CHD and across the agency.

V. 2013 – 2014 Quality Program Activities

The Department will maintain an agency wide quality improvement program that engenders a culture of quality through (1) systematic identification of opportunities for improvement, (2) implementation of data-supported improvement initiatives, (3) sharing of best practices and (4) evaluation of measurable impacts on strategic priorities. The Agency Quality Improvement Plan provides a framework for the program which is implemented by the agency's quality improvement infrastructure. The department has adopted a common terminology to support internal communication regarding the Quality Improvement Program (Appendix B).

Building on previous successes and lessons learned, the Quality Improvement Program will conduct the following activities during 2013-2014. The key tasks for these activities are provided in Appendix C.

Activity 1: Select and implement quality improvement projects for 2013-2014.

Activity 2: Disseminate resources and tools which support process improvement.

Activity 3: Disseminate process improvement results and best practices across the organization.

Activity 4: Evaluate impact of quality improvement efforts on agency strategic priorities.

Activity 5: Improve the department's Quality Improvement Program and develop recommendations for 2014-2015 program activities.

VI. Quality Communications Strategy

The DOH QI Program continued success is ensured by systematic sharing of information and knowledge, networking and reusing knowledge. The quality improvement program's communications strategy is a component of the department's internal communication strategy and seeks to use existing tools to communicate information and knowledge so that the organization can improve.

The following communication strategies will be implemented during 2013-2014 to ensure clear and concise internal communication regarding the Department's Quality Improvement Plan:

1. Utilize existing communication venues such as monthly conference calls, regional meetings, annual meetings, annual events such as Public Health Week, newsletters and email to:
    - Present QI Plan to Senior Leaders with the expectation that they will share in their organizational unit along with their Division or CHD QI Plan
    - Share quarterly updates on DOH quality improvement initiatives, both at the agency level and organizational unit levels, on monthly CHD calls and other Senior Leadership meetings
    - Share successes and lessons learned

2. Utilize a dedicated website or SharePoint site to:
    - Post QI Plan and quarterly updates
    - Post current QI tools, techniques
    - Provide access to evidence-based strategies
    - Post storyboards sharing the results of implemented projects

3. Utilize DOH Learning Management System to improve staff competencies in the areas of:
    - Team development and management,
    - Data analysis,
    - Problem solving,
    - Process management,
    - Process improvement,
    - Quality improvement tools and techniques,
    - Program evaluation, and
    - Customer satisfaction.

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Appendix A: DOH Quality Program Historical Highlights

The Department has dedicated resources to quality improvement for over three decades. Since the 1980s the department's quality program has been primarily focused on county health department operations. The following provides a historical summary of highlights for the quality improvement program.

- Mid 1980s Central Office Program conducted quality assurance visits to the local health departments

- In 1992, Florida adopted the Assessment Protocol for Excellence in Public Health (APEX) model to link community health status indicators (outcomes) with public health programs (processes) at both the state and local level.

- In 1992, the department embarked on a project to create a comprehensive Public Health Indicator Data System (PHIDS), an indicator warehouse of annual statistical data containing all major performance and health outcome indicator data used in plans and performance measurement systems of the Florida Department of Health. The system would continue to be enhanced and is now CHARTS.

- In 1995, Florida transition from a quality assurance system to a quality improvement system was documented in the American Journal of Public Health, October 1995, v. 85, # 10, pp.1448-9.

- In 1996, Florida Department of Health was created and several enhancements were made. A quarterly performance report was developed to integrate the performance measures contained in the quality improvement process, agency strategic planning objectives, performance based program budgeting and local contracts with county commissions.

- In 1998, the state began promoting the use of the Florida Sterling Criteria for organizational excellence. The criteria covers seven categories similar to Malcolm Baldrige criteria.

- In 1999, Florida piloted the National Public Health Performance Standards (NPHPS) State Assessment Tool and implemented a biennial Employee Satisfaction Survey Process

- In 2000, Florida re-engineered its QI process to include the use of local peer reviewers—successful local agency staff with expertise in a variety of areas. Considered an essential part of the QI team that reviews Florida's 67 county health departments, peer reviewers are usually selected from outstanding county health departments, have expertise in a variety of areas, and are very familiar with the processes and outcomes of local agencies. (FLACaseStudy document)

- Between 1994 and 2003, the state improved health outcomes in several areas, including a decrease in AIDS and TB case rates by over 50 percent. During that period of time, rates for young teen (ages 10-14) births decreased by almost 60 percent. While a number of factors contributed to these improvements, both indicators were among a set of 12 health status outcomes tracked and emphasized from 1994 to 2003 by the state's QI system. The state attributes these changes to a

movement away from a focus solely on quality assurance, to a more comprehensive quality improvement process. (FLACaseStudy document)

- In 2004-2005, Florida repeated the NPHPS assessments at the state and local county health departments

- In 2004, Florida began redesigning the QI process to develop a performance report that would help CHDs to assess performance and manage their improvement efforts on a continuous basis

- In August 2005, the Pilot Performance Improvement Process was deployed to twenty (20) selected CHDs, and each CHD completed the reporting tool designed to define organizational standards.

- In 2006, the annual CHD Performance Snapshot Process was implemented, resulting in the production of an annual performance report of key indicators for each of the 67 health departments each spring.

- In 2006 and 2007, statewide action plans were developed based on aggregate CHD performance. Areas for improvement included: performance improvement, strategic planning, employee satisfaction and customer satisfaction.

- In late 2010 through early 2011, the department conducted a comprehensive evaluation and justification review of its programs. In March 2011, the FDOH Evaluation and Justification Review, Findings and Recommendations Report was published.

- In May 2011, the State Surgeon General convened a DOH Performance Management Advisory Council, with membership from central office programs and representatives from all size CHDs. This council was charged with developing and implementing a plan to build and sustain the DOH Performance Management System.

- In 2011-2012, Florida Department of Health repeated the NPHPS assessments at the state and local county health departments to inform state and local health improvement planning efforts.

- In April 2012, the Department released the State Health Improvement Plan which includes five strategic issue areas: Health Protection, Chronic Disease Prevention, Community Redevelopment and Partnerships, Access to Care and Health Finance and Infrastructure.

- In 2012, the Department published a Workforce Development Plan.

- In 2013, the FDOH Strategic Plan was developed and implemented. The Workforce Development Plan was updated.

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Appendix B: Glossary of Quality Terminology

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)*
Accreditation **(Public Health Department)**	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. (Source: Public Health Accreditation Board. *Guide to National Public Health Department Accreditation Version 1.0.* Alexandria, VA. May 2011).
Action Cycle	A continuous process that links three activities: *Planning* – determining what will be done, who will do it, and how it will be done*, Implementation* – carrying out the activities identified in the planning stage, and *Evaluation* – determining what has been accomplished. The cycle repeats itself, offering a sustainable method to build upon accomplishments and position itself for even greater achievements. *(Source: Florida MAPP Field Guide – The Action Cycle, http://www.doh.state.fl.us/planning_eval/CHAI/Resources/FieldGuide/2008_Version/7ActionCycle.pdf)*
Analyze	To study or determine the nature and relationship of the parts of by analysis. *(Source: Merriam-Webster Online Dictionary)*
Balanced Scorecard	Translates an organization's mission and strategy into a comprehensive set of performance measures to provide a basis for strategic measurement and management, typically using four balanced views: financial, customers, internal business processes, and learning and growth. *(Source: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)*
Barriers	Existing or potential challenges that hinder the achievement of one or more objectives. *(Source: The Executive Guide to Facilitating Strategy: Featuring the Drivers Model. Michael Wilkinson. 1st 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. *The Community Indicators Handbook: Measuring Progress toward Healthy and Sustainable Communities.* San Francisco, CA: Redefining Progress; 1997).

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TERM	DEFINITION
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: National Public Health Performance Standards Program, *Acronyms, Glossary, and Reference Terms*, 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 *The Quality Toolbox*, 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: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)*
Competencies	Core competencies are fundamental knowledge, abilities, or expertise associated in a specific subject area or skill set. (Source: Nash, Reifsnyder, Fabius, and Pracilio. *Population Health: Creating a Culture of Wellness.* Jones and Bartlett. MA, 2011).
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. (*Roadmap to a Culture of Quality Improvement, Phase 6, NACCHO*)
Data	Quantitative or qualitative facts presented in descriptive, numeric or graphic form. *(Source: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)*
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 – A Framework for Program Evaluation)*
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. *Evidence-based Public Health: A Fundamental Concept for Public Health Practice.* 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: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)*

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TERM	DEFINITION
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: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)*
Key Business Functions	Critical responsibilities which are performed routinely to carry out the mission of the department. *(Source: adapted from BusinessDictionary.com)*
Key Business 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: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)*
Key Customer	Any individual or group that receives and must be satisfied with the service, work product, or output of a process. *(Source: Certified Manager of Quality/Organizational Excellence Handbook. Russell T Westcott, editor. 3rd Ed.)*
Key Customer Requirements	Performance standards associated with specific and measurable customer needs; the "it" in "do it right the first time." *(Source: The Quality Improvement Handbook, 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: The Executive Guide to Facilitating Strategy: Featuring the Drivers Model. Michael Wilkinson. 1st Ed.)* Objectives need to be **S**pecific, **M**easureable, **A**chievable, **R**elevant and include a **T**imeframe (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 The Executive Guide to Facilitating Strategy: Featuring the Drivers Model. Michael Wilkinson. 1st 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.

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TERM	DEFINITION
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: 2013 Sterling Criteria for Organizational Performance Excellence)*
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: 2013 Sterling Criteria for Performance Excellence)*
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. *Standards and Measures Version 1.0.* Alexandria, VA, May 2011).
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. Turning Point Guidebook for Performance Measurement, 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: Turning Point Performance Management, National Excellence Collaborative, 2004)*
Plan-Do-Check-Act	Also called: PDCA, plan–do–study–act (PDSA) cycle, Deming cycle, Shewhart cycle The plan–do–check–act cycle (Figure 1) 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)*
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. *(Acronyms and Glossary of Terms, Public Health Accreditation Board, version 1.0, September 2011)*
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.

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TERM	DEFINITION
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. Man and Epidemics. Princeton, N.J.: Princeton University Press, 1952; and (2) Institute of Medicine. The Future of Public Health. 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.* Journal of Public Health Management and Practice. January/February 2010).
Quality Tools	Seven Basic Tools: Seven Basic Tools - Quality Management Tools | ASQ Seven New Planning & Management Tools: Seven Management & Planning - New Management Tools | ASQ
Reporting (performance)	A process which provides timely performance data for selected performance measures/indicators which can then be transformed into information and knowledge.
Resources	Personnel, equipment, facilities, and funds available to address organizational needs and to accomplish a goal.
System	A network of connecting processes and people that together perform a common mission. *(Source: The Quality Improvement Handbook, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.)*
Targets	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.
Trend Analysis	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. *Population Health: Creating a Culture of Wellness.* Jones and Bartlett. MA, 2011).
Validate	To confirm by examination of objective evidence that specific requirements and/or a specified intended use are met. *(Source: The Quality Improvement Handbook, John Bauer, Grace Duffy, and Russell Westcott, editors. 2nd Ed.)*

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Appendix C: QI Program Activities and Tasks

The Department will maintain an agency wide quality improvement program that engenders a culture of quality through (1) systematic identification of opportunities for improvement, (2) implementation of data-supported improvement initiatives, (3) sharing of best practices and (4) evaluation of measurable impacts on strategic priorities. The Agency Quality Improvement Plan provides a framework for the program which is implemented by the agency's quality improvement infrastructure. The department has adopted a common terminology to support internal communication regarding the Quality Improvement Program (Appendix A).

The DOH Quality Program will adhere to the following schedule during 2013 -2014 year.

Task	Month
Department QI projects identified & communicated	July 2013
Division/CHD projects prioritized by local quality councils;	August 2013
Division & CHD QI projects selected	September 2013
Complete list of QI projects shared	September 2013
QI projects implemented	October 2013 – June 2014
Updates on DOH QI Plan and project implementation	October 2013, January 2014, April 2013, July 2014
Communication on QI project results	January 2014, April 2014, July 2014
Evaluation of completed QI projects	January 2014 – September 2014

Building on previous successes and lessons learned, the Quality Improvement Program will conduct the following activities during 2013-2014. The key tasks for each activity are provided below.

Activity 1: Select and implement quality improvement projects for 2013-2014.

- By July 31, 2013, the DOH Performance Management Council has prioritized department-wide opportunities for improvement.
- By September 30, 2013, DOH Divisions and CHDs have selected 2013-14 quality improvement projects. Project list is appended to Agency QI Plan.
- By June 30, 2014, all statewide QI projects will be completed.
- By September 30, 2014, all DOH Division and CHD QI projects will be completed.
- Quarterly, (October, January, April & July) progress on department QI projects is reported to the DOH Performance Management Council.

Activity 2: Disseminate resources and tools which support process improvement.

- By August 31, 2013, tools and resources to support the implementation of the Agency QI Plan have been posted to the website.
- By August 31, 2013, a list of available and applicable quality improvement trainings have been identified in the DOH Learning Management System.
- By August 31, 2013, key trainings for Senior Managers, QI Council Members and QI Team Leaders to complete have been provided.

- By June 30, 2013, at least 3 quarterly updates were made to the website hosting the DOH QI Plan and related resources.
- By December 31, 2013, information has been gathered on the value of existing resources and gaps.

Activity 3: Disseminate process improvement results and best practices across the organization.

- By September 30, 2013, the process to collect quality improvement results has been established.
- By October 30, 2013, the process to share best practices and results has been established.

Activity 4: Evaluate impact of quality improvement efforts on agency strategic priorities.

- By October 31, 2013, the process for sharing best practices and QI Project results developed and implemented.
- By June 30, 2014, the process for sharing best practices and QI Projects has been repeated at least twice to provide quarterly updates.

Activity 5: Improve the department's Quality Program and develop recommendations for 2014-2015 program activities.

- By July 1, 2013, the Agency Quality Improvement Plan is approved.
- By August 31, 2013, Divisions and CHDs have been oriented to the Agency QI Plan, Division/CHD QI Plan Template and available resources.
- By September 30, 2013, evaluation methodology and performance metrics are selected for the DOH Quality Program.
- By December 31, 2013, the Performance Management Council has approved a methodology for determining the impact QI Projects have had on program performance and the department's strategic objectives.
- By April 30, 2014, quarterly performance reporting on QI Program begins.
- By May 31, 2014, 2014-2015 DOH Quality Program activities have been selected.
- By June 30, 2014, the 2014-2015 Agency Quality Improvement Plan is approved.
- By September 30, 2014, evaluation of the 2013-2014 Quality Program is complete.

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Appendix D: QI Project Cycle for Department-Level QI Projects

The Department adopts the nationally recognized Plan-Do-Check-Act framework for quality improvement. (See *The ABCs of PDCA* by Grace Gorenflo and John Moran, available on the Office of Performance and Quality Improvement website.)

In order to identify an opportunity for improvement, measurement and monitoring of performance must be in place. Using the performance measurement information, the key steps to be implemented when conducting a quality improvement project are as follows:

1. **Plan:** Investigate the current situation, fully understand the problem to be solved, identify potential solutions that will be tested, and develop an action plan to implement selected solutions.

2. **Do:** Implement the action plan.

3. **Check:** Analyze the effect of the activities implemented. Compare the new data to the previous data; determine if improvements were achieved; note what was learned.

4. **Act:** Document results (intended and unintended) and lessons learned. Determine if the solution will be adopted, needs to be adapted or will be abandoned. (These choices are further described in Appendix D). A storyboard about the project should be completed and shared within the Division/CHD and with the Office of Performance and Quality Improvement.

The following outlines the process the Department will follow for selecting department-wide quality improvement projects.

PLAN: The Department will select agency-wide projects at least annually (July).

1. A summary of current performance will be compiled using performance data from the following sources:
   - Monthly DOH Performance Reviews (which address State Health Improvement Plan and Agency Strategic Plan Objectives)
   - CHD Performance Snapshot
   - Employee Survey Results
   - Workforce Assessment Results

2. A list of department-wide opportunities for improvement will be created and presented to the DOH Performance Management Council for discussion and prioritization.

3. Project Champions and Team Leaders will be selected for the department-level projects. Then team members will be selected. Team members should include staff knowledgeable about the problem, staff implementing the process, and possibly customers of the process, product or service.

4. Each department-level QI Project Team will complete a charter and a QI Project Screening Tool (templates available on the OPQI website). In order to complete these documents that team will need to establish team roles and responsibilities; schedule regular meetings, examine the current approach; analyze current performance data, identify possible causes, brainstorm and select best solution, and establish a timeline for the improvement activity.

PLAN *continued:*

5. The completed Project Screening Tool will be approved by the Champion and shared with the DOH Performance Management Council.

6. Each department-level QI Project Team will then create an action plan which communicates tasks, staff responsible, timeframes and performance measures to be collected. The plan should be finalized by the team and shared with the Champion.

DO:

7. The Team will implement the plan of action and the Team Leader will be responsible for documenting progress, reporting progress monthly and addressing any barriers for resolution with the Project Champion, as needed.

8. The team should be gathering data during the QI project on the process improvement.

9. At least quarterly updates will be provided to the DOH Performance Management Council on the agency-wide projects.

CHECK:

10. At the conclusion of the project, the performance data gathered should be analyzed and compared to the baseline data to determine if the improvement was achieved. Lessons learned and unanticipated results should also be documented. The analysis should be compiled into appropriate charts to demonstrate results.

ACT

11. Based on the analysis, the team should decide one of the following:
    i. Adopt the solution as the standard business practice
    ii. Revise the solution and re-test process improvement.
    iii. Abandon the solution and restart cycle.

12. Close the improvement project by completing the following:
    a. Present the project and results to colleagues and leadership.
    b. Document the project, key steps and results using the Story Board Template
    c. Identify next steps based on the team's decision.
        i. If adopting the solution, updates to process, policies or procedures may be needed; staff may need to be trained on the new process.
        ii. If revising the solution, determine the modification(s) needed, and then repeat the improvement process.
        iii. If abandoning the solution, review the data analysis and cause and effect diagrams. Identify new solutions and repeat process improvement cycle.

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Appendix D: QI Project Cycle for Department-Level QI Projects

Templates to be posted to the Office of Performance & Quality Improvement's Agency QI Plan website will include:

1. Project Selection Tool
2. NACCHO Toolbox: Tools & Templates Prioritization Methods
3. Team Charter Template and Example
4. Project Checklist
5. Project Action Plan Template
6. Seven Basic Tools: Seven Basic Tools - Quality Management Tools | ASQ
7. Seven New Planning & Management Tools: Seven Management & Planning - New Management Tools | ASQ
8. Storyboard Template & Example

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Appendix E: Summary of Selected QI Projects

Department-Level QI Projects

The department has selected the following department wide quality improvement projects for 2013-2014. Projects were recommended to and approved by the Performance Management Advisory Committee on July 31, 2013. Projects will be implemented between July 2013 and June 2014. Department-Level QI projects will be implemented using the Plan-Do-Check-Act framework (Appendix D). Specific quality tools will be selected during the project planning phase based on the needs of the individual project.

Project 1: Decrease the case rate of Tuberculosis through implementation of the Florida System of Tuberculosis Care.

Linkage: State Health Improvement Plan Objective HP1.2.3 and Agency Strategic Plan Objective 1.1.1C
Impact: Bureau of Communicable Disease, Tuberculosis Section and 67 County Health Departments

Project 2: Improve employee satisfaction with rewards and recognition through implementation of an agency employee rewards and recognition program.

Linkage: 2013-2014 Agency Workforce Development Implementation Plan, Deliverable #5
Impact: All department organizational units

Project 3: Improve customer engagement through implementation of agency customer service standards.

Linkage: Agency Strategic Plan Objective 2.3.2B
Impact: All department organizational units

Division and CHD QI Projects

Division and/or County Health Department specific quality improvement projects will be selected and the list will be appended to this plan by September 30, 2013. Implementation of the selected 2013-2014 projects will occur between October 1, 2013 and September 30, 2014.