Indiana State Department of Health
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Cover Sheet for Example Documentation

PHAB Domain 9 Standard 2 Measure 1

Standard and Measures Version 1.5

Indiana State Department of Health

Accreditation Coordinator: Patricia Truelove
ptruelove1@isdh.in.gov
317-234-8167

Document Title:	Performance Management and Quality Improvement Plan
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Required Document:	1 – Quality Improvement Plan
Division Ownership:	The Office of Public Health Performance Management
Description of requirement:	This plan is to establish a framework for the Quality Improvement (QI) processes and outlining identified activities. It will be of this means that the QI team will evaluate possible QI projects. This plan addresses the following: a. Key Quality Terms – Pages 4, 15 b. Culture of quality current and future state – Page 5-6, 16 c. Key elements of QI structure – Page 7-10 d. QI Trainings available within agency – Page 14 e. Project identification and strategic alignment – Page 11-12 f. QI goals, objectives, and measures with time framed targets – Page 14 g. Data collection and analysis, progress reported, actions taken – Page 12 h. Regular communication – Page 13 i. Process to evaluate effectiveness – Page 13

INDIANA STATE DEPARTMENT OF HEALTH

PERFORMANCE MANAGEMENT & QUALITY IMPROVEMENT PLAN

JUNE 1, 2018 - JUNE 30, 2020

Indiana State Department of Health

Office of Public Health Performance Management

CONTENTS

Purpose

The Indiana State Department of Health (ISDH) is committed to ongoing performance improvement efforts. Performance management (PM) and quality improvement (QI) techniques are being utilized to varying degrees in the agency, and efforts have not been coordinated and monitored agency-wide. This plan outlines the strategy for implementing a formalized process throughout the agency. ISDH recognizes the importance of PM and QI tools in achieving its mission, vision and values as reflected in the 2018-2020 ISDH Strategic Plan (ISDH-SP). These tools are instrumental to maximizing public health resources to accomplish goals and improve outcomes.

Improving health outcomes in Indiana involves a structured and intentional approach that embraces the measurement of performance and continuously seeks opportunities to improve service delivery and organization effectiveness. The Performance Management and Quality Improvement Plan (PMQIP) sets the foundation for a culture of quality improvement that facilitates systematic activities for improving health of all Hoosiers.

This plan informs staff, divisions and programs on how to access support and resources for improvement activities. Any questions about this plan should be directed to the Office of Public Health Performance Management (ophpm@isdh.in.gov) or members of the ISDH Quality Improvement Team.

The culture of an organization is the embodiment of the core values, guiding principles, behaviors and attitudes that collectively contribute to its daily operations. Organizational culture is the essence of how work is accomplished.

Culture of Quality

Language

It is well established that language is a critical element of culture. To develop a culture of quality, it is necessary to develop a common and consistent vocabulary, and a glossary of common terms is provided in *Appendix A: Key Terms.*

Mission, Vision, Values

ISDH's focus on performance and quality begin with its mission, vision and core values as outlined in the ISDH-SP.

Indiana State Department of Health

Vision: *A healthier and safer Indiana*

Mission: *To promote, protect, and improve the health and safety of all Hoosiers.*

Core Values: *Integrity, Innovation, Collaboration, Excellence, Dedication*

Assessment of Performance System and Culture

ISDH regularly assesses its PM system and culture an ongoing basis. ISDH completes a formal assessment every two years using an abridged version of the National Association of County and City Health Officials (NACCHO) Roadmap to a Culture of Quality self-assessment tool. Participants of the survey include executive leadership, managers and supervisors, as well as non-supervisors/front-line staff. The results from the 2018 assessment were used to guide the development of the 2018-2020 PMQIP.

This assessment is grounded in six foundational elements critical to building a culture of quality: Employee Empowerment, Teamwork and Collaboration, Leadership Commitment, Customer Focus, QI Infrastructure and Continual Process Improvement. ISDH uses these foundational elements as guiding principles to achieve a culture of quality.

Current State and Desired QI Culture

According to the 2018 assessment, ISDH ranks overall as "Phase 3: Informal or Ad Hoc QI Activities" on the NACCHO Roadmap. This means discrete QI efforts are practiced in isolated instances throughout the agency, often without consistent use of data or alignment with the steps in a formal QI process. According to the roadmap, our agency characteristics are as follows:

"HUMAN" CHARACTERISTICS	"PROCESS" CHARACTERISTICS
• Staff infrequently share lessons learned.	• QI projects may be occurring only at the administrative staff level or at other isolated times.
• Staff may view QI as an added responsibility.	• Data are still not routinely used in agency operations and decision-making.
• Staff are anxious about implementing QI incorrectly or uncovering negative performance	• Discrete QI projects occur but are likely not fully aligned with formal steps of a QI model.
• Staff may be frustrated if efforts do not result in immediate improvement	• QI is not aligned with the organizations strategic plan or performance data.
• Basic QI training and resources are more readily available, but advanced QI training may still be limited.	• Multiple failed attempts to improve through QI projects may exist.
• Some QI champions are able to lead QI projects and mentor staff.	• QI efforts are often stalled due to emerging issues
• Loss of a QI champion often results in regression.	• Redundancies and variations in processes still exist.

Please see *Appendix B* for more results. ISDH aims to foster a QI culture that is fully embedded into the agency (Phase 6), whereby agency leadership and staff are fully committed to quality, and results of QI efforts are communicated internally and externally. As agency leadership changes, QI efforts continue through an established agency QI culture in which staff routinely seek out the root causes and solutions of challenge. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives.

Strategies Toward Desired QI Culture

The Quality Improvement Team ranks identified transition strategies to be addressed in the QI plan.

Foundational Element		Transition Strategies
Employee Empowerment	3.53	*Establish performance expectations and communicate roles for supervisors and work team members*
		PM/QI Council provides staff at every level with basic training in PM and QI
		Staff celebrate QI successes
		Leaders assess the source of any staff resistance and develop strategies to counter resistance through effective messaging, training and incentives
Teamwork and Collaboration	3.89	*QI champions lead functional QI teams in implementing discrete projects sponsored by PM/QI Council*
		Leaders provide staff the opportunity to share results achieved through various mechanisms
Leadership	3.56	*Leaders incorporate QI into the organization's value statement/guiding principles*
		Leaders communicate key messages to staff and begin to demonstrate concrete examples of messages: 1) QI not about placing blame or punishment; 2) QI is a way to make daily work easier and more efficient; 3) QI is within reach of all staff and will get easier with practice
		Leaders work with PM/QI Council to develop a plan for the change process using deliberate change management strategies including timelines, costs, short/long term goals, communication and training plans, and implication for staff and stakeholders
		Leaders work with PM/QI Council to continuously assess the culture of the agency including staff commitment and engagement and sustainability of progress toward building a QI culture
Customer Focus	3.02	*Identify the agency's customers and stakeholders to determine where customer satisfaction should be assessed*
		Identify existing customer satisfaction data and data needs
QI Infrastructure	3.24	*PM/QI Council develops a plan for establishing and implementing a PM system to monitor achievement of organizational goals and objectives*
		PM/QI Council begins to identify areas for improvement based on a gap analysis using performance data
Continuous Process Improvement	3.79	*All staff practice using the seven basic tools of quality in daily work to identify root causes of problems, assess efficiency of processes, interpret findings, and correct problems*
		The PM/QI Council identifies and sponsors "winnable" QI projects using agency performance data. QI efforts are linked to strategic priorities and identified from performance data to the extent possible.
		Identify and train all staff on formal QI model, such as PDSA or Lean, and the seven basic tools of quality

Structure, Roles and Responsibilities

ISDH recognizes the importance of staff in achieving a culture of quality. Each staff member has critical perspective on how processes can be improved and play a role in implementing a quality culture.

Agency Roles and Responsibilities	
All staff	*All individuals working for ISDH*
	✓ Staff members identify and suggest QI projects, participate in and implement improvement activities.
	✓ Identify and suggest areas of improvement or opportunities for development
	✓ Develop and participate in QI projects and activities
	✓ Participate in QI trainings
	✓ Incorporate PM/QI concepts and principles into daily work
	✓ Demonstrate familiarity with QI plan
	✓ Collect and manage quality and performance improvement data
	✓ Document and report on the process of QI projects and activities
	✓ Collaborate across divisions and programs to share knowledge
	✓ Be open to trying new ways to improve processes
	✓ Ask questions utilize mentorship and coaching
Supervisors/Managers	*Supervisors/Managers oversee the day-to-day implementation or QI projects and activities, as well as support the staff and provide access to training opportunities*
	✓ Carry out ISDH responsibilities
	✓ Identify staff QI training needs and provide access to training opportunities
	✓ Orient staff to QI process and QI Plan
	✓ Present proposals for QI projects and activities to directors
	✓ Ensure QI projects and activities align with division/office strategic plan
	✓ Complete written reports of QI project results
	✓ Initiate, implement and ensure oversight of QI projects and activities
	✓ Support staff in QI and data collection efforts
	✓ Recognize and reward staff for participating in QI efforts

Senior Leadership	*Senior leadership is comprised of the commissioner, chief medical officer, deputy commissioner, chief of staff, assistant commissioners and identified operational support directors*
	✓ Carry out the responsibilities of ISDH
	✓ Foster a culture of quality within the agency
	✓ Allocate and request necessary resources and funding to sustain and implement QI activities
	✓ Ensure QI efforts align with the SP or fulfill gaps/needs
	✓ Approve and sponsor QI projects/activities
	✓ Prioritize agency and commission wide QI projects and activities
	✓ Coordinate oversight of QI projects and activities with QI Team
	✓ Communicate QI efforts and success to governing entity.
QI Leaders	*QI leaders (formal and informal) supporting the robust infrastructure.*
	✓ Define QI vision
	✓ Incorporate quality into policies, plans, procedures and culture
	✓ Provide ongoing QI training opportunities, mentoring and coaching
	✓ Address questions and concerns about QI
	✓ Lead agency QI projects
Governing Entity	*The governing entity (governor's office and executive board) provides guidance to advise senior leadership regarding quality improvement efforts. They receive periodic updates on the progress.*
	✓ Support a culture of quality within the agency
	✓ Provide guidance and advice to senior leadership regarding QI efforts
	✓ Review progress and findings of QI efforts
	✓ Communicate constituents' concerns and comments to senior leadership
	✓ Communicate QI success stories to constituents
	✓ Fund QI efforts

Performance Management Committee

The Performance Management Committee (PMC) will monitor the ISDH-SP identified goals to inform QI Team of improvement opportunities.

Quality Improvement Team

Annually, the QI Team considers members for invitation to the team based on: stated interest, schedule availability, membership diversity and division representation. The QI Team makes all reasonable attempts to incorporate staff from different disciplines, backgrounds, divisions and commissions to ensure diverse staff are represented. Member-

ship requires a one-year commitment. At the end of that year, members may elect to remain on the team or withdraw. Specific responsibilities include:

- Provide support, guidance and objectivity for agency QI activities
- Guide selection of QI projects, monitor progress, and oversee implementation of goals and strategies
- Ensure QI projects results are communicated to appropriate internal staff and external stakeholders
- Provide project updates and reports to governing entity
- Sponsor or participate on QI Project Teams and assist in identification of team leads
- Review, monitor and report progress toward plan goals and objectives annually
- Review and contribute to PMQIP amendments and revisions
- Monitor QI metrics

Office of Public Health Performance Management

The health commissioner and deputy health commissioner empower the ISDH Office of Public Health Performance Management (OPHPM) to provide operational leadership of PM and QI efforts within the agency. OPHPM provides oversight of the SHA, SHIP, ISDH-SP, and PM, QI, workforce development and overall Accreditation activities as outlined by Public Health Accreditation Board (PHAB). OPHPM is responsible for the convening of the Accreditation Team (A-Team), Sub-Domain teams, Strategic Planning Committee (SPC), Performance Management Committee (PMC), and Quality Improvement Team (QI Team). OPHPM serves as a repository of tools, information and ideas. With the support of OPHPM, it is up to each program to fully integrate quality improvement in the way ISDH delivers the best public health services.

Quality Improvement Coordinator

OPHPM staffs the QI Coordinator who coordinates agency PM and QI efforts to ensure appropriate agency plans cross-link to support and strengthen a culture of quality and performance. The QI coordinator chairs the QI Team to facilitate sustained knowledge and guidance and to provide consistent coordination of improvement activities across the agency.

Specific duties include:

- Serve as subject matter expert for QI and PM
- Develop agenda, meeting materials, minutes and facilitate QI Team meetings
- Maintain QI projects documentation
- Engage and involve QI Team in all PMQIP updates and revisions
- Maintain communication protocols for staff to suggest QI initiatives
- Coordinate with executive leadership for internal and external customer communication as needed
- Maintain database of QI training records and staff training certificates

QI Project Teams

QI Project Teams are composed of staff who investigate proposed QI initiatives to plan and test potential solutions. Their responsibilities include:

- Complete all appropriate documentation for each QI project
- Report progress to QI Team at appropriate intervals
- Demonstrate commitment to regularly monitor progress
- Promote progress and project results at staff and governing meetings as appropriate
- Share success at annual opportunity

Performance Management System

Performance Management

The ISDH defines public health performance management as the practice of using data to improve the public's health. This involves strategic use of performance measures and standards to establish performance objectives and targets; regular measurement monitoring toward objectives; and engaging in quality improvement activities when desired progress is not achieved. Establishing a PM system is a proven way to enhance performance and achieve desired results. Each employee has a role in creating an ideal work environment and should actively engage in problem solving and improvement. Improving individual and program performance will increase our capacity to positively impact our customers.

An organization with a culture of performance management and quality improvement achieves employee empowerment, teamwork and collaboration, visible leadership, customer focus, strategic alignment and continual improvement. ISDH has adopted the following model of Performance Management adapted from the Turning Point National Excellence Collaborative on Performance Management including the following components:

- **Visible Leadership –** commitment of executive leadership to a culture of quality that aligns performance management practices with mission, taking into account customer feedback, and enabling transparency.
- **Performance Standards** – establishment of organizational standards, goals and targets to improve public health practice
- **Performance Measurement** – development, application and use of performance measures to assess achievement of standards
- **Reporting Progress** – documentation and reporting of progress in meeting standards and targets then sharing such information through regular feedback
- **Quality Improvement** – using performance data for decisions to improve policies, programs and outcomes; managing change; and creating a learning organization.

ISDH leadership and OPHPM engage staff at all levels of the organization in the development and maintenance of the PM system through a Strategic Planning Committee (SPC). The SPC follows a six-step strategic planning process to identify agency measures: 1) Organize; 2) Set mission and vision; 3) Scan environment; 4) Strategize; 5) Develop work plans; 6) Evaluate; and 7) Revise as needed.

Agency-level performance measures are established under the ISDH-SP priorities and objectives. It is the division and programmatic performance management is the responsibility of directors, managers, supervisors, coordinators and front-line staff following the State of Indiana Performance Management Policy found here: https://www.in.gov/spd/files/perf_management_policy.pdf.

Project Identification and Prioritization

Various types of continuous quality improvement (CQI) projects will be conducted, ranging from minor changes to existing processes, Rapid Improvement (Kaizen) Events, Lean A3 Problem Solving, Model for Improvement, or Plan-Do-Check/Study-Act (PDCA/PDSA) depending on size and scope of projects.

Projects may be identified in a number of ways, including, but not limited to:

- » Staff suggestion for improvement idea submitted to leadership or QI Team, surveys, and other avenues
- » Identification from agency plan implementation or reports (State Health Assessment/State Health Improvement Plan, Workforce Development Plan, etc.)
- » Identification of possible process improvement through review of ISDH-SP performance data
- » Stakeholder feedback and external performance assessments
- » As identified by governing entity

Project selection and prioritization criteria (*see Appendix C for Project Identification form*) will include, but not limited to:

- » Alignment with ISDH mission, vision and strategic plan
- » Staff QI knowledge

- Potential impact of solution
- Program, organization and staff timelines
- Stakeholder input
- Clearly defined process with SMART target for improvement identified
- Manageable scope

Alignment

The 2018-2020 ISDH-SP serves as the focal point for the ISDHs PM system. The ISDH-SP states the agency's mission, vision, and strategic goals serving as a roadmap for the ISDH over the next three years. Ensuring strategic priorities and objectives are met requires use of continuous data collection and monitoring. If metrics are not successfully met, agency QI processes can be utilized to discover root causes and possible solutions.

The 2017-2018 Workforce Development Plan highlights training goals and capacity for agency staff supporting developing in QI, PM and other topics supporting a culture of quality.

Data Collection, Monitoring and Reporting

ISDH will use tools available and familiar to staff, such as MS Office Suite applications, ArcGIS, and Tableau, to record and track performance management data. The PMC will work with staff to create and standardize data recording processes:

1. Programs submit data monthly or quarterly (as defined by the indicator)
2. Epidemiology Resource Center Data Analysis Team analyzes data and sends results to the QI Coordinator
3. QI coordinator document results, reviews data for completeness and prepares report
4. QI coordinator shares report with executive leadership and ISDH staff each quarter and the executive board annually.
5. Identified data also shared with the public through ISDH regular website updates, QI coordinator, and Data Analysis Team.
6. Measures NOT on target will be recommended for review by the QI Team.

Currently, identified measure owners are responsible for ensuring performance data collection processes are in place to track and regularly update data used to measure progress to goals. Data will be collected from a variety of sources. Performance measures are tracked using a template developed by the ERC Data Analysis Team. The SPC facilitates the identification and assessment of agency level goals and measures. The PMC will monitor the measures on a regular basis to assess potential QI opportunities.

After gathering data, PMC will analyze to determine if progress toward goals has been made. Identified owners will assess: 1) whether measure is on track; 2) whether measure has been met; 3) why objective was/was not met, action steps if needed; and 4) which QI trainings, tools or processes may help meet objective.

All QI Project Teams will complete appropriate documentation to be shared with staff and stakeholders. Documentation includes a description of the process, tools used, outcomes and lessons learned. Project storyboards will be displayed as appropriate.

QI Methodology

The ISDH will use a deliberate and defined process to identify and solve critical issues based on the ISDH-SP performance reports, customer feedback, and/or Culture of Quality self-assessment, and make improvements using Lean and PDSA methodologies and tools identified in Appendix C. The overall process steps include:

1. Identify/Select quality improvement project(s)
2. Designate a quality improvement project team
3. Develop an aim/challenge statement is developed
4. Develop measures
5. Identify gaps
6. Identify solution/change ideas
7. Test solution/change ideas
8. Sustain improvement
9. Share results

Regular Communication

Clear and consistent communication of QI and PM efforts is critical to building and sustaining a culture. Besides informing leaders and staff of QI practices and improvement efforts in the agency, it can help increase engagement and buy-in and facilitate progress toward building a QI culture. OPHPM will work with the executive team and Office of Public Affairs to ensure regular communication occurs.

OPHPM will ensure regular communication that includes:

- Regular reports on progress toward ISDH-SP goals and objectives
- Staff QI efforts acknowledged through monthly staff newsletter, posting on website and intranet, staff meetings and other communication mediums
- Storyboard for completed projects posted publicly and shared annually
- Completed documentation is archived and available in the QI shared network folder
- Update given at least annually to the governing entity provided by Executive Leadership or QI Team
- OPHPM hosts an annual Open House to share projects
- Share nationally as appropriate

Evaluation and Sustainability

The QI Team will evaluate the PMQIP annually. The evaluation determines if the plan is being followed and if any improvements or revisions are necessary. This evaluation includes a summary of the progress toward goals and objectives as well as activities conducted during the previous year.

The plan will be fully evaluated and revised every three years following the revision of the ISDH-SP to ensure this plan aligns with the ISDH strategic mission and vision.

QI Training

The ISDH regularly seeks to build its capacity for process improvement to advance the operational and strategic aims of the organization. A strong process capability will improve the quality and efficiency of the primary services that ISDH offers, facilitate programs that further the health of Indiana residents, and strengthen the case for public health accreditation.

Beginning in 2016, OPHPM, in partnership with Purdue Healthcare Advisors, facilitated the first cohort of Lean training. As a result, five staff members at various levels are poised to conduct their own Lean work in the agency. Additionally, the partnership has resulted in three completed Rapid Improvement Events, improving processes in three distinct areas of the agency. To continue building QI culture, seven additional staff (Cohort 2) received training later in 2017. (See Appendix D: Current Projects)

Regular training is provided to employees, typically through external sources. ISDH is identifying opportunities for regular training and internal curriculums to build sustainable training programs.

QI Program Goals and Projects

Goals, Objectives and Measures

The 2018-2020 ISDH-SP identifies the following PM/QI-related strategic priorities

Strategic Goal 2: Promote and provide transparent public health data				
Strategy	**Objectives**	Target	Indicator	Owner
Use a performance management system to monitor achievement of organizational objective	**Though 2020, ensure strategic metrics are reported as identified in the ISDH-SP**	100%	% strategic measures reported	OPHPM, Casey Kinderman Regulatory and Policy Compliance (**RPC**), Barb Killian
	Beginning Q4 of 2018 through 2020, create quarterly reports for me	9 reports	# published ISDH-SP progress reports	OPHPM, Casey Kinderman

Strategic Goal 5: Improve organizational health and be an employer of choice				
Strategy	**Objectives**	Target	Indicator	Owner
Foster a culture of organization excellence	**Achieve PHAB accreditation by Q4 2020 and maintain compliance**	Fully Demonstrated	PHAB Accreditation status	OPHPM, Patricia Truelove RPC, Barb Killian
	Track the number of divisions/ programs completing/participa-ting in QI activities through 2020	TBD (need baseline)	# division/programs completing/ participating in QI activities	OPHPM, Casey Kinderman
	Assess the number of QI projects annually through 2020	30	Count of QI projects	OPHPM, Casey Kinderman
	Move the agency from Phase 3 to Phase 4 on the Culture of Quality Self-Assessment by 2020.	Phase 4	Assessment results, response rate	OPHPM, Casey Kinderman

Appendicies

Appendix A: Key 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.

Best Practices – The best-known way to do something. Best practices are a) recognized as consistently producing results superior to those achieved with other means; b) can be standardized and adopted/replicated by others; and c) will produce consistent and measurable results. Replication required the adoption in a different process, area, or organization such that the results of the original application can be reliably reproduced. Best practices will evolve to become better as improvements are discovered.

Change Management – A structured approach to transitioning an organization from a current state to a future desired state.

Core Competencies – The key knowledge, skills and abilities required to succeed in performing a role.

External Customer – Stakeholders outside the organization that have requirements to satisfy but are dependent on the organization.

Improvement Activity – A systematic quality improvement activity or a project that includes an aim (goal) statement; a work plan with tasks, responsibilities and timelines; intervention strategy(ies); and measures for tracking change.

Internal Customer – Stakeholders within the organization or between organizations that have requirements to satisfy to deliver the service to the external customer.

Leaders – Anyone who directs the work of others, including senior managers, chiefs, directors, middle managers, supervisors and governing entities.

Lessons Learned – Knowledge generated through a formal method of exploring and understanding after doing something.

Learning Community - A group formed to advance the collective knowledge around a particular topic area in a way that supports the growth of knowledge among individual members of the group. Learning communities often include members that exhibit a diversity of skills, experience and expertise; have an objective of continually advancing collective knowledge, skills and abilities; and support mechanisms for sharing what is learned.

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.

Performance Measures – A quantitative tool to help understand, manage and improve what organizations do. Performance measures let us know: how well we are doing; if our processes are in statistical control; if we are meeting our goals; if and where improvements are necessary; if our customers are satisfied. They provide us with the information necessary to make intelligent decisions about what we do. A performance measure is composed of a number and a unit of measure. The number gives us a magnitude (how much) and the unit gives the number a meaning (what). Performance measures are always tied to a goal or an objective (the target)

Public Health Accreditation – A voluntary national program developed to measure health department performance against an established set of nationally recognized, practice-focused and evidence-based standards. This program is overseen by PHAB and modeled on the Ten Essential Public Health Services.

Quality Improvement (QI) – A formal, systematic approach (such as plan-do-check-act) applied to the processes underlying public health programs and services in order to achieve measurable improvements

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.

SWOT Analysis – A strategic planning method used to evaluate the Strengths, Weaknesses, Opportunities and Threats to determine strategic objectives. Strengths are characteristics of organization that give it an advantage over others; Weaknesses are characteristics that place the organization at a disadvantage relative to others; Opportunities are elements that the organization could exploit to its advantage; Threats are elements in the environment that could cause trouble for the organization. The analysis associates the internal and external data to develop strategies.

Value – Activities for which the customer is willing to pay for such as the product, service, and information

Waste – Anything that adds cost or otherwise consumes resources without adding value.

Appendix B: Culture Assessment

Organizational Culture of Quality Self Assessment Tool

Organization: Indiana State Department of Health

Date: February 14th,

FOUNDATIONAL ELEMENT	SUB-ELEMENT	TOPIC	TOPIC SCORE	SUB-ELEMENT SCORE	FOUNDATIONAL ELEMENT SCORE	SELECTED TRANSITION STRATEGIES TO IMPLEMENT DURING THIS PLANNING CYCLE	STRATEGY PRIORITY Level
1. Employee Empowerment	1.1 Enabling Performance	1.1.1 Creating Expectations and Getting Feedback	3.60	3.67	3.53	*Establish performance expectations and communicate roles for supervisors, and work team members*	medium
		1.1.2 Providing Resources	4.34			*PM/QI Council provides staff at every level with basic trainings in PM and QI*	medium
		1.1.3 Empowering Individuals and Teams	3.36			*Staff celebrate QI successes*	high
	1.2 Knowledge, Skills and Abilities	1.2.1 Assessment and Identification of Gaps	3.51	3.40		*Leaders assess the source of any staff resistance and develop strategies to counter resistance through effective messaging, training and incentives*	in progress
		1.2.2 Deployment and Execution of Plans to Close Gaps	3.54				
		1.2.3 Materials and Methods to Develop KSAs	3.18				
2. Teamwork and Collaboration	2.1 Team Performance	2.1.1 Vision, Values, and Goals	4.06	4.02	*3.89*		
		2.1.2 Roles and Relationships	3.85				
		2.1.3 Procedures and Performance	4.10			*QI champions lead functional QI teams in implementing discrete projects sponsored by QI/PM council*	high
	2.2 Communities	2.2.1 Awareness and Use of Communities	3.96	3.76			
		2.2.2 Sharing and Collaboration	3.60			*Leaders provide staff the opportunity to share results achieved through various mechanisms*	high
3. Leadership	3.1 Culture	3.1.1 Establishing the Environment	3.65	3.52	3.56	*Leaders incorporate QI into the organizations value statement/guiding principles*	high
		3.1.2 Modeling Behavior	3.62			*Leaders communicate to staff key messages and begin to demonstrate concrete examples of messages: 1) QI not about placing blame or punishment; 2) QI is a way to make daily work easier and more efficient 3) QI is within reach of all staff and will get easier with practice*	medium
		3.1.3 Coaching the Organization	3.22				
	3.2 Resourcing and Structure	3.2.1 Providing Resources	3.51	3.60		*Leaders work with PM/QI council to develop a plan for the change process using deliberate change management strategies including timelines, costs, short/long term goals, communication and training plans, and implication for staff and stakeholders*	high
		3.2.2 Providing Structure	3.48			*Leaders work with PM/QI council to continuously assess the culture of the agency including staff commitment and engagement and sustainability of progress toward*	in progress
		3.2.3 QI Training & Development	3.85				
4. Customer Focus	4.1 Understanding the Customer	4.1.1 Customer Data Collection and Analysis	3.09	3.06	3.02	*Identify the agency's customers and stakeholders to determine where customer satisfaction should be assessed (may be identified in SP)*	next plan cycle
		4.1.2 Use of Customer Data	3.05			*Identify existing customer satisfaction data and data needs*	next plan cycle
		4.1.3 Culture	3.07				
	4.2 Satisfying the Customer through the Value Stream	4.2.1 Understanding the Value Stream	2.60	2.47			
		4.2.2 Adding Value for Customers by improving Value Streams	2.43				
		4.2.3 External Use	2.23				
	4.3 Reprioritizing and Creating Programs and Services	4.3.1 Understanding Customer's Future Needs	3.78	3.53			
		4.3.2 Re-prioritizing Existing, and Developing New, Programs and Services	3.35				

5. Quality Improvement Infrastructure	5.1 Strategic Planning	5.1.1 Strategic Planning Process	4.18	4.00	3.24		
		5.1.2 Strategic Plan Implementation	3.45				
	5.2 Performance Measurement	5.2.1 Performance Measures and Standards	3.04	3.00			
		5.2.2 Data Analysis & Reporting	2.91				
	5.3 Annual Quality Improvement Planning	5.3.1 Collecting and Analyzing Data for QI Plan Development	3.00	2.88			
		5.3.2 Developing the Annual QI Plan	2.96			*PM/QI Council develops a plan for establishing and implementing a PM system to monitor achievement of organizational goals and objectives*	high
		5.3.3 Achieving Annual Improvements	2.64			*PM/QI Council begins to identify areas for improvement based on a gap analysis using performance data*	medium
	5.4 Administrative and Functional Process and Systems (e.g. HR)	5.4.1 Impact of Admin & Functional Processes (i.e. HR, Finance, Legal, IT)	3.05	3.10			
		5.4.2 Supporting QI Strategies	3.18				
6. Contiinual Process Improvement	6.1 Selecting and Applying Methods	6.1.1 Selecting Appropriate QI Methods	4.15	3.94	3.79	*All staff practice using the seven basic tools of quality in daily work to identify root causes of problems, assess efficiency of processes, interpret findings, and correct problems*	low
		6.1.2 Applying QI Methods Effectively	3.81			*The PM/QI council identifies and sponsors "winnable" QI projects using agency performance data. QI efforts are linked to strategic priorities and identified from performance data to the extent possible.*	low
	6.2 Planning for Process Improvements	6.2.1 Defining Improvement Objectives and Aim Statements	4.12	4.04		*Identify and train all staff on formal QI model like PDSA; or Lean; and the seven basic tools of quality*	medium
		6.2.2 Analyzing Current Work Processes to determine Root Causes	4.27				
		6.2.3 Identify Potential Improvements and Develop Improvement Hypotheses	3.89				
		6.2.4 Develop a Test Plan	3.95				
	6.3 Testing Potential Solutions	6.3.1 Test the Improvement Hypothesis	4.15	4.18			
		6.3.2 Study and Analyze the Results	4.24				
		6.3.3 Act on Findings	4.00				
	6.4 Extracting Lessons Learned	6.4.1 Gathering Knowledge from Subject Matter Experts	3.27	3.21			
		6.4.2 Extracting Learning from Experiences	3.33				
		6.4.3 Implementing and Sharing Learning	3.11				
	6.5 Sharing of Best Practices	6.5.1 Identifying, Validating, and Documenting Best Practices	3.80	3.83			
		6.5.2 Sharing and Replicating Best Practices	3.90				
	6.6 Effectively Installing Standardized Work	6.6.1 Developing Standardized Work	4.15	3.83			
		6.6.2 Teaching and Using Standardized Work	3.65				
	6.7 Process Management, Results and Continual Improvement	6.7.1 Managing Work Process Performance	3.18	3.48			
		6.7.2 Continually Improving Work Processes	3.67				

TOTAL SCORE:	**3.61**				NACCHO Roadmap to a Culture of Quality Phases		
					Total Score	**Roadmap Phase**	
					<2	Phase 1: No Knowledge of QI	
					2-2.9	Phase 2: Not Involved with QI Activities	
					3-3.9	Phase 3: Informal or Ad Hoc QI	
					4-4.9	Phase 4: Formal QI in Specific Areas of the Organization	
					5-5.9	Phase 5: Formal Agency-Wide QI	
					6	Phase 6: Culture of Quality	

INDIANA STATE DEPARTMENT OF HEALTH (ISDH)

Quality Improvement (QI) Project Proposal

To initiate a quality improvement project proposal or idea, complete this Quality Improvement Project Proposal form. There are two (2) parts to complete: project application and screening criteria. Completed forms and any questions can be submitted to the Quality Improvement Coordinator at OPHPM@isdh.in.gov.

PROJECT INFORMATION: Application

Project Name		
Program(s) Impacted		
Employee Name *(or name of person responsible/process owner)*		
Assistant Commissioner (AC)		*AC Approved?* ☐ **YES**
Proposed makeup of QI Project Team		
Stakeholders and Customers impacted by this project *(Describe Impact)*		
Requested month(s) to have event. *(Note: the average prep time required for a Rapid Improvement Event is up to 2 months.)*		

PROJECT INFORMATION: Application

Program or Activity:

What Are We Trying to Accomplish? *(A brief statement of the problem, its impact and SMART Aim)*

SMART AIM: *(See intranet for SMART Aim Worksheet)*

How Will We Know That a Change is an Improvement? *(Potential measures of success, including implications for future* improvements *building off of this project)*

What Changes Can We Make That Will Result in an Improvement? How did you identify this opportunity, with what data, from what source(s)? *(Please provide a brief description of the problem with any data currently available)*

PROJECT INFORMATION: Project Screening Criteria

How does this process relate to the agency's strategic priorities?

(Please check all that apply and provide a brief description)

☐Decrease disease incidence and burden

☐Improve response and preparedness networks and capabilities

☐Reduce administrative costs through improving operational efficiencies

☐Better use of information and data from electronic sources to develop and sponsor outcome driven programs

☐Improve relationships and partnerships with key stakeholders, coalitions, and networks throughout the State and the nation

For Internal Quality Improvement (QI) Team Use Only	
Date Received by OPHPM	
Date Reviewed	
Lean Practitioner (LP) Assigned	

Appendix D: Project Tools and Techniques

Aim Statement – A brief statement clarifying the goal or purpose of a quality improvement project. Statements answer questions about what the organization is seeking to accomplish, target population and specific numerical values to achieve.

Cause and Effect Diagram – A problem-solving technique used to understand the underlying causes of a specific issue and determine effective solutions. The visual, diagram-based technique establishes the relationship of how all possible causes combine to produce the effect. Cause and Effect Analysis is similar to Root Cause Analysis although broader in concept in that CEA drives practitioners to look for multiple cause and effect relationships rather than a single root cause.

Check Sheet – A tool used to record and compile data as it occur, so that patterns and trends can be identified.

Control Chart – A tool used to monitor performance over time by identifying and distinguishing common and special causes of variation.

Flow – An advanced improvement method that seeks to improve work process capacity or throughput and reduce cycle time. It accomplishes this via performing tasks one at a time (vs. batch processing), balancing the work content between people, reducing wait time between process steps, and performing tasks as they are needed.

Gemba Walk (or Genba) – Go and see where the work is accomplished; the action of going to see the actual process, understand the work, ask questions and learn.

Histogram – A graphical tool used to summarize frequency distributions over time.

If, Then Statement – A proposed explanation which is unproven. A hypothesis must be tested in to be validated. Proposed improvement solutions that are derived from analysis are hypotheses that must be tested to be shown to be correct.

Kaizen (rapid improvement event) – An improvement method for making rapid process improvements. Typical application consists of: prior planning followed by fully executing the process improvement cycle over a period of days; performed at the sub-process level or where the work is done (“gemba”); focused on making improvements by detecting and eliminating waste.

Lean – A collection of principles and methods that focus on identification and elimination of waste in producing a product or delivering service to customers.

Mistake-Proofing – An improvement method for minimizing human error within work processes.

Pareto Chart – A tool used to identify problems that offer the greatest potential for improvement by showing their relative frequency or size in a descending bar graph.

Plan-Do-Study-Act (PDSA) – A continuous quality improvement model for improving a process. Similar to the scientific method, PDSA steps involve the development of a hypothesis (Plan), an experiment or intervention (Do), evaluation or data analysis (Study/Act).

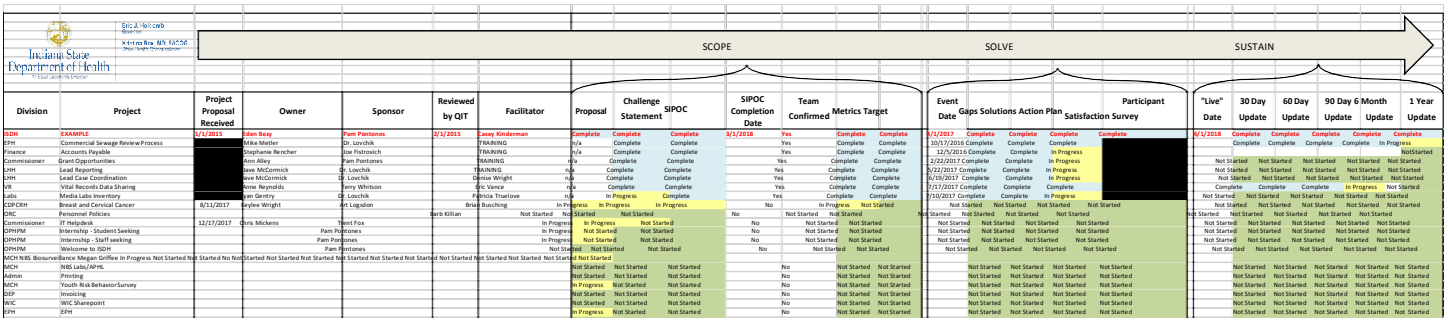
Process Mapping – An improvement method in which a process is depicted graphically with relevant data that enables understanding and analysis for improvement. Includes methods such as Value Stream Mapping and Sub-Process/Swim Lane Mapping.

Scatter Diagram – A graphical tool used to identify the possible relationship between the changes observed in two different sets of variables.

Standardized Work – Documented methods which define how work is done. Standardized work reflects the best-known way to do something and is documented in a way that enables it to be effectively used while work is performed, resulting in decreased variation and a basis for continual process improvement.

Visual Management – A technique for enabling people to effectively manage their work through easily seen and understood visual indicators which make an abnormal condition stand out by: a) showing the current condition; b) showing what the standard is; and c) linking to an action.

Appendix E: Current Projects



Division	Project	Project Proposal Received	Owner	Sponsor	Reviewed by QIT	Facilitator	SCOPE: Proposal	SCOPE: Challenge Statement	SCOPE: SIPOC	SIPOC Completion Date	SOLVE: Team Confirmed	SOLVE: Metrics Target	SOLVE: Event Date	SOLVE: Gaps Solutions Action Plan	SOLVE: Participant Satisfaction Survey	SUSTAIN: "Live" Date	SUSTAIN: 30 Day Update	SUSTAIN: 60 Day Update	SUSTAIN: 90 Day Update	SUSTAIN: 6 Month Update	SUSTAIN: 1 Year Update
SDH	EXAMPLE	1/1/2015	Eden Bezy	Pam Pontones	2/1/2015	Lacey Kinderman	Complete	Complete	Complete	3/1/2018	Yes	Complete	3/1/2017	Complete	Complete	3/1/2018	Complete	Complete	Complete	Complete	Complete
EPH	Commercial Sewage Review Process		Mike Metler	Dr. Lovchik		TRAINING	n/a	Complete	Complete		Yes	Complete	10/7/2016	Complete	Complete		Complete	Complete	Complete	Complete	In Progress
Finance	Accounts Payable		Stephanie Rencher	Joe Fistrovich		TRAINING	n/a	Complete	Complete		Yes	Complete	12/5/2016	Complete	In Progress						NotStarted
Commissioner	Grant Opportunities		Ann Alley	Pam Pontones		TRAINING	n/a	Complete	Complete		Yes	Complete	2/22/2017	Complete	In Progress		Not Started	Not Started	Not Started	Not Started	Not Started
LHH	Lead Reporting		Dave McCormick	Dr. Lovchik		TRAINING	n/a	Complete	Complete		Yes	Complete	3/22/2017	Complete	In Progress		Not Started	Not Started	Not Started	Not Started	Not Started
LHH	Lead Case Coordination		Dave McCormick	Dr. Lovchik		Denise Wright	n/a	Complete	Complete		Yes	Complete	9/19/2017	Complete	In Progress		Not Started	Not Started	Not Started	Not Started	Not Started
VR	Vital Records Data Sharing		Anne Reynolds	Terry Whitson		Eric Vance	n/a	Complete	Complete		Yes	Complete	7/17/2017	Complete	Complete		Complete	Complete	Complete	In Progress	Not Started
Labs	Media Labs Inventory		Evan Gentry	Dr. Lovchik		Patricia Truelove	n/a	In Progress	Complete		Yes	Complete	7/10/2017	Complete	In Progress		Not Started	Not Started	Not Started	Not Started	Not Started
CDPCRH	Breast and Cervical Cancer	8/11/2017	Keylee Wright	Art Logsdon		Brian Busching	In Progress	In Progress	In Progress		No	In Progress	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started
OHC	Personnel Policies				Barb Killian		Not Started	Not Started			No	Not Started	Not Started	Not Started	Not Started		Not Started	Not Started	Not Started	Not Started	Not Started
Commissioner	IT Helpdesk	12/17/2017	Chris Mickens	Trent Fox			In Progress	Not Started			No	Not Started	Not Started	Not Started	Not Started		Not Started	Not Started	Not Started	Not Started	Not Started
OPHPM	Internship - Student Seeking			Pam Pontones			In Progress	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started		Not Started	Not Started	Not Started	Not Started	Not Started
OPHPM	Internship - Staff seeking			Pam Pontones			In Progress	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started		Not Started	Not Started	Not Started	Not Started	Not Started
OPHPM	Welcome to ISDH			Pam Pontones			Not Started	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started		Not Started	Not Started	Not Started	Not Started	Not Started
MCH NBS Biosurveillance	Megan Griffee In Progress	Not Started	Not Started	No	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started							
MCH	NBS Labs/APHL						Not Started	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started
Admin	Printing						Not Started	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started
MCH	Youth Risk Behavior Survey						In Progress	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started
DEP	Invoicing						Not Started	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started
WIC	WIC Sharepoint						Not Started	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started
EPH	EPH						In Progress	Not Started	Not Started		No	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started	Not Started

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