



**Ohio**  
Department of Health

# Quality Improvement Plan

CY 2014



# Quality Improvement Plan

*The Ohio Department of Health is committed to the ongoing improvement of the quality of services it provides. This Quality Improvement Plan serves as the foundation of this commitment.*

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6/30/2014  
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## Ohio Department of Health Summary

*ODH Governance and Components:* The ODH is a cabinet-level agency reporting directly to the governor and serves as a member of the Executive Branch of Ohio's government. ODH consist of three programmatic Divisions (Quality, Family and Prevention), and nine main offices, each having many bureaus and a wide variety of programs that are overseen by the Assistant Director of programs. The General Counsel reports directly to the Director of Health. The Assistant Director of Administration oversees the administrative offices (Office of Management Information Systems, Human Resources, Office of Financial Affairs, Office of Performance Improvement and Office of Public Affairs). All the organizational components are integral to carrying out the mission, vision and values of ODH.

*ODH Vision:* Optimal health for all Ohioans

*ODH Mission:* To protect and improve the health of all Ohioans by preventing disease, promoting good health, and assuring access to quality health care.

*ODH Guiding Principles:* ODH looks to the guiding principles for the Office of Health Transformation (a cabinet agency of which ODH is a member). In ***A New Day: Leading to Better Health***, Governor John Kasich, directed ODH to work in partnership with other agencies in transforming Ohio into a model of health and economic vitality with forward thinking, through the following solutions oriented strategies:

- **MARKET-BASED** - *Reset the basic rules of health care so the incentive is to keep people as healthy as possible.*
- **PERSONAL RESPONSIBILITY** - *Reward Ohioans who take responsibility to stay healthy – and expect people who make unhealthy choices to be responsible for the cost of their decisions.*
- **EVIDENCE BASED** - *Rely on evidence and data to complement a lifetime of experience, so doctors can deliver the best quality care at the lowest possible cost.*
- **TRANSPARENT** - *Make information about price and quality transparent, and get the right information to the right place at the right time to improve care and cut costs.*
- **VALUE**- *Pay only for what works to improve and maintain health –and stop paying for what doesn't work, including medical errors.*
- **PRIMARY CARE** -*Transform primary care from a system that reacts after someone gets sick to a system that keeps people as healthy as possible.*
- **CHRONIC DISEASE**- *Prevent chronic disease whenever possible and, when it occurs, coordinate care to improve quality of life and help reduce chronic care costs.*
- **LONG-TERM CARE** -*Enable seniors and people with disabilities to live with dignity in the setting they prefer, especially their own home, instead of a higher-cost setting like a nursing home.*
- **INNOVATION**-*Innovate constantly to improve health and economic vitality, and demonstrate to the nation why Ohio is a great place to live and work.*



## Definitions & Acronyms

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**Continuous Quality Improvement (CQI):** A systematic, department-wide approach for achieving measurable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of the processes or services provided. Applies use of a formal process (PDSA, etc.) to “dissect” a problem, discover a root cause, implement a solution, measure success/failures, and/or sustain gains.

**DMAIC:** a six sigma process model with the steps of define, measure, analyze, improve, control.

**Plan, Do, Study, Act (PDSA):** An iterative, four-stage, problem-solving model for improving a process or carrying out change. PDSA stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDSA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned.<sup>1</sup>

**Kaizan:** “break for the better”, a way to reorganize work flow to reduce bottlenecks, sequential processing, batch processing and reduce rework and waste.

**LEAN design:** have only what you need to do the job within your reach.

**Quality Improvement Committee (QIC):** The committee that spearheads and coordinates the organization’s CQI initiatives.

**Quality Improvement Plan (QIP):** A plan that identifies specific areas of current operational performance for improvement within the agency. These plans can and should cross-reference one another, so a quality improvement initiative that is in the QI Plan may also be in the Strategic Plan (PHAB Acronyms and Glossary of Terms, 2009).

**PDSA Project Team Charter:** Identifies objectives, success measures and barriers to implementation of the project.<sup>2</sup>

**PDSA Storyboard:** Summary of the PDSA steps and tools used by a CQI project team. It is representation of CQI team’s quality improvement journey.<sup>3</sup>

**Quality Culture:** The degree to which 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. In spite of leadership changes, the basics of QI are so ingrained in staff that they seek out the root cause of problems. They do not assume that an intervention will be effective, but rather they establish and quantify. Progress toward measurable objectives

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<sup>1</sup> Scamarcia-Tews, Heany, Jones, VanDerMoere & Madamala, Embracing Quality in Local Public Health: Michigan’s QI Guidebook, 2008)

<sup>2</sup> Bialek, Duffy, Moran, The Public Health Quality Improvement Handbook, 2009

<sup>3</sup> Scamarcia-Tews, Heany, Jones, VanDerMoere & Madamala, 2012



## Quality Improvement Plan

### ODH CQI Plan Development: Measuring our Current State as a Culture of Quality

This plan has been developed by the ODH Performance Improvement Manager in consultation with the ODH Quality Improvement Committee. As part of the ODH performance management system, the plan specifically operationalizes the quality improvement process which is part of the Turning Point Performance Management System Model for Public Health.

ODH used the Turning Point assessment<sup>4</sup> to gauge whether management thought that necessary components were in place to achieve results and continually improve performance. In a self-assessment survey of ODH management conducted in the summer of 2013, quality improvement process scored the highest of the four quadrants (Performance standards, performance measurement, quality improvement process, reporting of progress) depicted in the Turning Point model. We will know that this plan is successful, not only from improved outcomes and better process control, but also by increasing the highlighted scores in our next survey, by deliberately implementing tactics listed in this plan.

On a 3 point scale with 3= Always/Almost Always, 2= Sometimes, 1= Never/Almost Never

|   |      |
|---|------|
| <u>Quality Improvement</u>  | 2.00 |
| 1. One or more processes exist to improve quality or performance  |      |
| A. There is an entity or person responsible for decision-making based on performance reports (e.g., top management team, governing or advisory board)                     | 2.43 |
| B. There is a regular timetable for QI processes  | 1.71 |
| C. The steps in the QI process are effectively communicated   | 1.67 |
| 2. Managers and employees are evaluated for their performance improvement efforts (i.e., performance improvement is in employees' job descriptions and/or annual reviews) | 2.43 |
| 3. Performance reports are used regularly for decision-making   | 2.00 |
| 4. Performance data are used to do the following (check all that apply)   |      |
| A. Determine areas for more analysis or evaluation  | 2.00 |
| B. Set priorities and allocate/redirect resources   | 2.14 |
| C. Inform policy makers of the observed or potential impact of decisions under their consideration  | 2.14 |
| D. Implement QI projects  | 2.00 |
| E. Make changes to improve performance and outcomes   | 2.14 |
| F. Improve performance  | 2.14 |
| 5. The group (program, organization, or system) has the capacity to take action to improve performance when needed  |      |
| A. Processes exist to manage changes in policies, programs, or infrastructure   | 1.86 |
| B. Managers have the authority to make certain changes to improve performance   | 2.29 |
| C. Staff has the authority to make certain changes to improve performance   | 2.00 |
| 6. The organization regularly develops performance improvement or QI plans that specify timelines, actions, and responsible parties                                       | 1.71 |
| 7. There is a process or mechanism to coordinate QI efforts among groups that share the same performance targets  | 1.71 |
| 8. QI training is available to managers and staff   | 1.71 |
| 9. Personnel and financial resources are allocated to the organization's QI process (e.g., a QI office exists, lead QI staff is appointed)                                | 1.86 |
| 10. QI is practiced widely in the program, organization, or system  | 2.00 |

<sup>4</sup> Bialek, Duffy, Moran, Turning Point Performance Management Model; The Public Health Quality Improvement Handbook, 2009



# Quality Improvement Plan

## ODH Quality Improvement Plan 2014 Schedule of Implementation

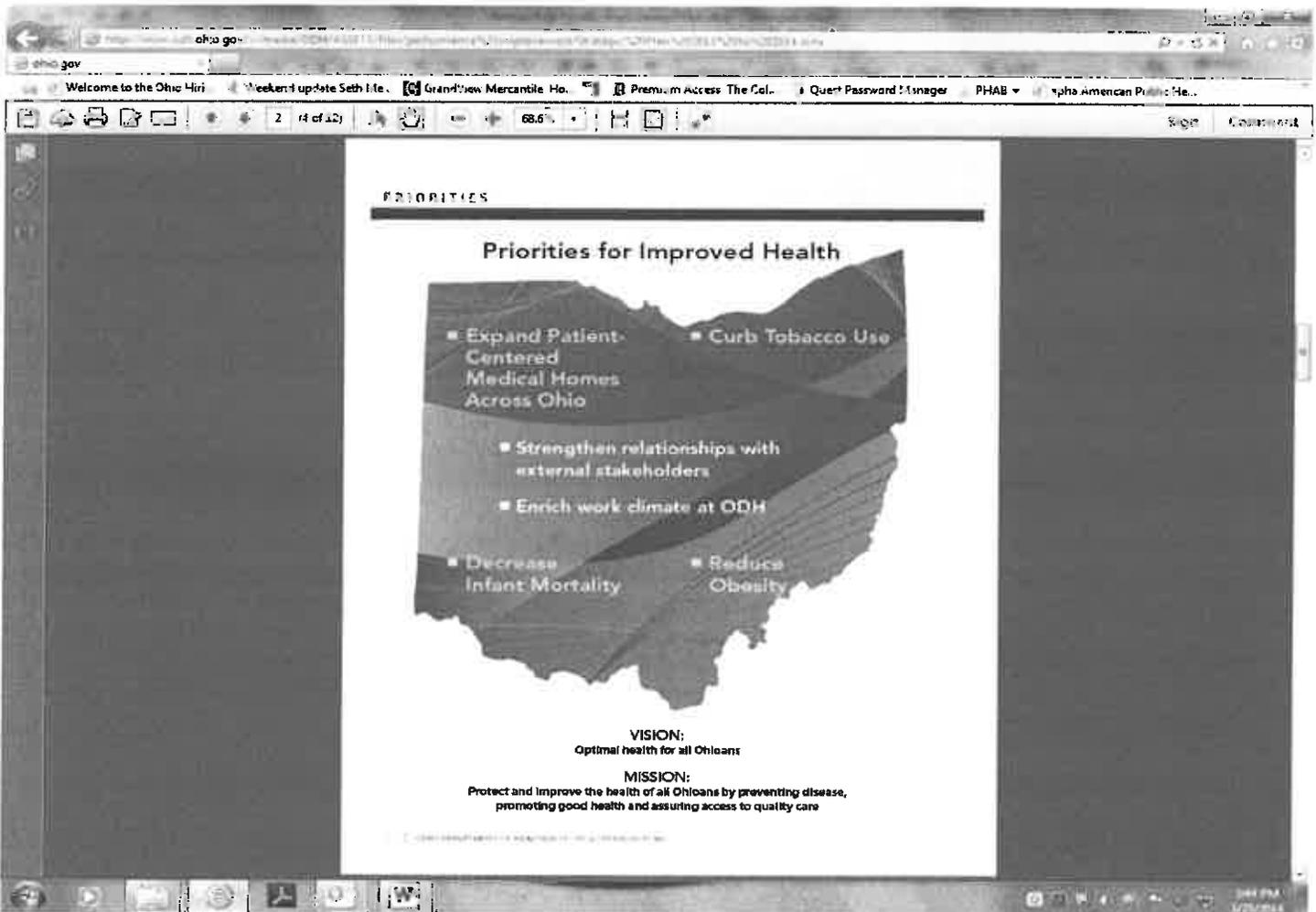
### Tactics (revised annually)

| Strategies to Building a QI Culture  | Turning Point QI Question     | SFYs 2014-2015 GOALS   | MEASURE   | TIMEFRAME   | PERSON RESPONSIBLE  |
|--|-------------------------------|--|---|---|---------------------|
| Continue to collect relevant data and ensure its quality Show linkages between data, QI activity, and outcomes | # 1, # D.E, #D.F, #5 and #5.c | Each of the three Divisions and Offices will support two CQI project charters, which tie to components of the strategic plan or the statewide health improvement plan. | 10 PDSA Storyboards completed                           | January 2014  | Division Leaders    |
| Offer organized trainings in QI  | #8                            | Train 100% of staff in basic CQI Fundamentals via online modules   | Certificate of Completion                               | End of Fall Quarter, 2014                                     | Human Resources     |
| In-house QI technical assistance is available as a formal but a separate function                              | #4, #5                        | Train QIC in PDSA via the Center for Public Health Practice  | Certificate of Completion                               | March 2015  | PIM                 |
| Communicate and celebrate all improvements with staff  | 5A                            | Reporting outcomes, Communication/recognition  | Visible sponsoring, coaching and mentoring of CQI teams | Kick off PDSA training March 2014                             | PIM                 |
| Review and revise ODH CQI plan and policy  | #B, #6, #7                    | Revise CQI Plan  | Reviewed and revised CQI Plan completed on time         | Reviewed by January each year and revised as within 3 months. | QIC                 |
| Share success stories throughout the organization<br><br>Celebrate successes                                   | #2                            | Develop CQI Recognition Program  | Teams recognized in agency public forum                 | Establish program and begin awards by September 2014          | QIC/Human Resources |
| Share success stories throughout the organization  | #10                           | Upload Storyboards in OPPD Intranet communication  | Verify in System<br><br>4-6 weeks                       | Monthly   | PIM                 |



## Transitioning From the Current State to a Quality Culture

The ODH Strategic Plan clearly defines the organization's strategic priorities as shown in the screen shot. Strengthening ODH infrastructure is a key focus area in the current strategic plan. By engaging all staff in CQI activities and fully implementing the CQI plan, we will not only achieve the two priorities to strengthen relationships with our external stakeholders while enriching the work climate at ODH but directly impact all priorities in a cross functioning manner.



This CQI plan has been developed using Public Health Accreditation Board (PHAB) documentation Domain 9<sup>5</sup> as a reference.

CQI training is implemented as a component of staff training and new employee orientation, to embed CQI in ODH structures, processes, services and activities, applying the PDSA models and using CQI tools and techniques to improve the public's health.

<sup>5</sup> Public Health Accreditation Board, Standards & Measures, Version 1.0, approved May, 2011



# Quality Improvement Plan

ODH has practiced quality improvement using various methods, such as PDSA, DMAIC, Kaizen and improvements as a result of program evaluation, after action reports, incident debriefings and LEAN design. Project teams have been comprised of Assistant Directors, to direct line staff. However, we are developing our formalized performance management model, with the quality improvement process standardized as PDSA, in which we deliberately use data for decision-making to improve policies, programs and outcomes, manage change and create a learning culture.

ODH is evolving in its use of CQI as a decision-making tool. We are committed to building a culture that engages all staff at all levels to work collaboratively in CQI teams to meet operational and service targets and reach desired health outcomes. Our desire is to create a CQI environment infused with innovative thinking based on data and facts to eliminate waste and increase efficiency. Executive leadership supports empowering teams to move from working in silos to initiating CQI projects so that CQI transcends the agency, not only vertically but horizontally.

The transition phase will incorporate elements of the human side and the process side to achieve a quality culture.

Using NACCHO's "Roadmap to a Culture of Quality,"<sup>6</sup> as a reference for evolution of a quality culture, ODH is transitioning from informal or ad hoc CQI activities (or little QI) to a Formal Agency-Wide CQI program by employing some of the transition strategies below in our plan. When we reach our vision of total emersion in a quality driven culture, the following hallmarks will be evident.

## Human Side

- Share success stories throughout the organization
- Develop internal and external learning communities
- Introduce all staff to Turning Point model and PDSA CQI model
- Communicate to all staff that CQI is within their reach
- Communicate and celebrate improvements
- Encourage small successes

## Process Side

- Continue to collect relevant data and ensure its quality
- Show linkages between data, QI activity, and outcomes
- Ensure that leaders request data before approving changes
- Continually utilize the QIC
- Routinely report CQI activities to leadership
- Integrate results into Strategic and State Health Improvement plan status reports
- Review and revise ODH QIP and policy

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<sup>6</sup> Roadmap to a Culture of Quality Improvement, NACCHO, 2012



## Performance Management and Quality Improvement Infrastructure

### Administrative Structure of the Program:

The Office of Performance Improvement (OPI) is under the direction of the Assistant Director of Administration. It is led by the Chief, and is staffed by the Performance Improvement Manager (PIM), who serves as the PIM for National Public Health Improvement Initiative (NPHII), and an Administrative Professional, who provides support to the office, the QIC, the Ohio Voluntary Accreditation Team (OVAT) and the ODH web page regarding performance management.

### ODH Quality Improvement Committee:

The Quality Improvement Team (QIC) was formed in 2011 to support the quality work of National Public Health Improvement Initiative (NPHII) grant to strengthen public health infrastructure and accelerate accreditation readiness. The Assistant Director of Administration and the PIM co-chair the QIC. They act as liaisons between ODH's Senior Leadership Team and the QIC in order to monitor CQI efforts at the ODH. The PIM sets the agenda for the QIC and provides status reports on QI activities to the Chief and Assistant Director. The Assistant Director or the Chief shares monthly progress reports with Senior Leadership Team.

Composition: Division Chiefs nominate members with the goal of at least one representative from each Division and Administrative Office within the ODH as listed.

- Family
- Prevention
- Quality
- Human Resources
- Management Information Systems
- Financial Affairs
- Legal Affairs
- Public Affairs
- Vital Statistics

Term: Members of the QIC will serve a two-year term with no more than half of the team rotating off the committee each year. Committee members may ask for consideration to serve consecutive terms, if desired.

Responsibilities: QIC members have the responsibility of assisting with creating policy and procedures as it relates to CQI and ensuring the alignment of the CQI goals with the ODH strategic plan. QIC will review and update the QIP on an annual basis. The QIC members will also plan and participate in CQI training activities, serve as coaches and PDSA facilitators to CQI teams and provide input to the PIM in the creation of tools to be used during the inventory of current and future projects.

QIC members will be expected to:

- attend regular monthly meetings (approx. 1.5 hours per month) to discuss CQI projects and activities;
- be available to provide support to the PIM with CQI related activities during their tenure;
- be engaged in the leading and facilitating of CQI project activities (up to 2 hours per month, as needed).



## **CQI Projects Identification**

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Any employee may suggest a process as a CQI project. The idea must be presented to a supervisor with a rationale as to why the identified process is worth examining through PDSA CQI methodology. Completion of the signed CQI Team Charter (attached) is to be submitted/emailed to the PIM prior to the project launch to plan support if needed and for cataloging and tracking by the QIC.

Considerations for projects may include the following:

- Alignment with agency's mission or strategic plan,
- Number of people affected,
- Financial consequence,
- Timeliness,
- Capacity,
- Availability of baseline data or present data collection efforts, and/or
- Alignment with PHAB Domains or prior review feedback.

## **Training**

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By 3/10/14 the Office of Human Resources (HR) will publish the CQI policy, "ODH Directive 45 - Quality Improvement" (attached) on the intranet.

### **New Staff:**

During new hire orientation, HR will conduct an overview of all policies. New hires must sign off on the Policy Acknowledgement form (HEA0331) which includes ODH Directive 45. The Policy Acknowledgement form states that "by signing below, I am aware of and responsible for completing the requirement of reviewing and following all policies outlined above. Failure to comply with State of Ohio Policies and Agency Directives may result in discipline."

The "Fundamentals of CQI" online training modules will be required training that is to be completed during the probationary period.

### **Existing Staff:**

Each ODH staff will be required to complete the Fundamentals of CQI within one year as required by the QI Policy. The Fundamentals of CQI are three online modules created by the Ohio State University Center for Public Health Practice. Completing these modules will fulfill all staff being trained in basic CQI.

As staff becomes engaged in CQI projects as project team members, they will be trained in the PDSA training cycle.

Training needs will be monitored and evaluated on an annual basis.



## **Budget**

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The operating expenses of the Office of Performance Improvement are supported by fees and indirect allocation. The Office of Performance Improvement has an education budget of \$2000 for SFY 14 funded by the National Public Health Improvement Initiative (NPHII) grant. This office is responsible to provide training in quality improvement using as many existing no cost resources as possible.

The Ohio Department of Administrative Services, Office of LEANOhio provides progressive levels of CQI training, including LEAN, Kaizen, and Six Sigma certification of yellow, green and black belts. Enrollment in this program is coordinated through the Chief of the Office of Performance Improvement who also serves as the ODH Lean Liaison. The Office of Workforce Development at The Ohio Department of Health also provides no cost training. The Center for Public Health Practice (CPHP) at the Ohio State University also offers training in quality improvement and are available to all staff as well as QIC members, and each staff has up to \$3500 per year to use through the State of Ohio Professional Development Fund.

## **Evaluation and Monitoring**

The Evaluation and Monitoring component of the ODH CQI initiatives will be the responsibility of the OPI in conjunction with the QIC.

All completed CQI projects will be finalized in PDSA Storyboard format.

Teams will have an opportunity to share their progress throughout the PDSA cycle with the QIC and their final story upon completion at monthly QIC meetings.

Within thirty days after project completion, team members will be surveyed to determine QI process learning, perceived contribution to the project, value gained from the project experience and share ultimate outcomes and lessons learned.

## **Communication**

The purpose of the communication component of this CQI plan is to highlight how ODH will share CQI stories, successes and all quality related news in order to strengthen our efforts to infuse CQI throughout the agency.

- Project storyboards will be posted in conference rooms and public areas throughout the agency.
- Project descriptions and results will be featured on the agency's website, and included in the annual report to the public.
- CQI projects completed within the past 12 months will report experiences and results at all-staff meeting.
- Team members will be recognized.
- The PIM will report CQI plan progress and highlight successes on the ODH intranet.

Attachments: PDSA Storyboard Template  
Continuous Quality Improvement Methodology  
CQI Project Team Charter



# Quality Improvement Plan

## Appendices:

Appendix A: ODH Directive 45 – Quality Improvement

Appendix B: Form HEA0331 – ODH Policy Acknowledgement Form

Appendix C: 2014 CQI Projects



## Story Board Template

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DIVISION/BUREAU/OFFICE

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DATE:

PROJECT TITLE:

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### **PLAN**

Identify an opportunity and Plan for Improvement

#### **1. Getting Started**

*Describe the problem and opportunity to improve:*

#### **2. Assemble the Team**

Team Leader:

Team Members:

#### **3. Examine the Current Approach**

Display SIPOC (System Input, Process, Outcome and Customer)

#### **4. Data collection and summary analysis on current process:**

#### **5. Use CQI tools to identify all possible causes of defect**

#### **6. Identify Potential Solutions**

#### **7. Develop an Improvement Theory and Action Plan**

### **DO**

Test the Theory for Improvement

#### **1. Implement the test improvement**

#### **2. Collect and summarize data findings**

### **ACT**

Standardize the Improvement and Establish Future Plans

#### **1. Standardize the Improvement or Develop New Theory**

#### **2. Establish Future Plans**

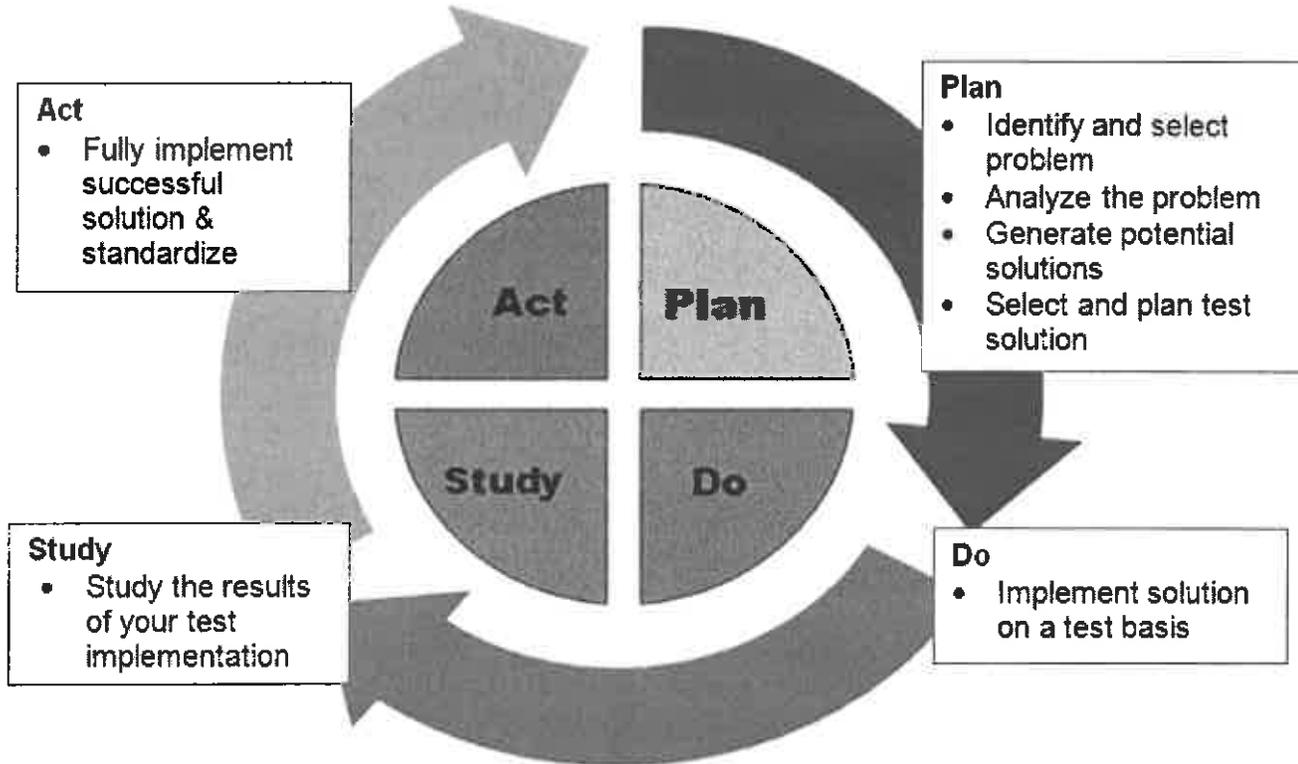
### **Study**

Use Data to Study Results of the Test

#### **1. Analyze results of trial and lessons learned**



## Continuous Quality Improvement Methodology





# Continuous Quality Improvement Methodology

## PLAN

### Step 1:

#### Identify and select problem

- Gather data
- Define the current situation – what we call the “as is” state
- Define the customer and the customer’s needs and expectations
- Define the desired situation – what we call the “desired” state. This becomes the aim of your project.

### Step 2:

#### Analyze the problem: Understand the process

- Map it
- Talk to customers/benchmark
- Identify potential causes
- Gather data to identify causes
- Analyze data

### Step 3:

#### Generate potential solutions

- Review information
- Ensure understanding of causes
- Brainstorm potential solutions
- Clarify potential solutions
- Evaluate solution

### Step 4:

#### Select & plan test solution

- Develop an improvement theory
- Develop implementation plan and measures to evaluate effectiveness

## DO

### Step 5:

Implement solution on a test basis - Collect data using key measures

## STUDY

### Step 6:

#### Study the results of your test implementation

- Ask those affected how the change is working
- Refine your improvement

## ACT

### Step 7:

#### Fully implement successful solution & standardize

- If the change is not working well, start the cycle over, refine the problem, test another solution
- Develop a monitoring system
- Celebrate!



## CQI Steps in the Process and Related Tools

|  | <b>Problem Solving Steps</b>  | <b>Tools/Techniques</b>  |
|--|---|--|
| <b>Plan</b><br><b>Step 1</b>   | <b>Identify and select problem</b><br>Review the background information<br>Gather data, as necessary<br>Develop an "as is" statement<br>Develop a "desired state" statement the AIM                             | Flow chart<br>Check sheet<br>Pareto chart<br>Brainstorming<br>Nominal group technique<br>Affinity diagram                |
| <b>Step 2</b>  | <b>Analyze the problem</b><br>Understand the process<br>Talk to customers/ Benchmark<br>Identify potential causes<br>Gather data to identify/verify causes<br>Analyze data                                      | Flow chart<br>Fishbone diagram<br>Check sheet<br>Run chart/Control chart<br>Histogram<br>Pareto chart<br>Scatter diagram |
|  | <b>Analyze causes to discover root cause</b><br>Identify the causes of the causes<br>Identify the root cause  | Brainstorming<br>Five whys   |
| <b>Step 3</b>  | <b>Generate potential solutions</b><br>Review Information<br>Ensure understanding of causes<br>Brainstorm potential solutions<br>Clarify potential solutions<br>Evaluate solutions                              | Brainstorming<br>Force field analysis<br>Run chart<br>Control chart<br>Criteria rating grid<br>Weighted voting           |
| <b>Step 4</b>  | <b>Select &amp; plan test solution</b><br>Develop an improvement theory<br>Develop implementation plan and measures to evaluate effectiveness   | Flowchart (new)<br>Run chart<br>Control chart<br>Gantt chart<br>Tree diagram   |
| <b>Do</b><br><b>Step 5</b>   | <b>Implement solution on a test basis</b><br>Collect data using key measures  | Whichever tools are needed   |
| <b>Study</b><br><b>Step 6</b>  | <b>Study the results of your test implementation</b><br>Evaluate your test<br>Ask those affected how the change is working<br>Refine your improvement   | Pareto chart<br>Histogram<br>Run chart/control chart   |
| <b>Act</b><br><b>Step 7</b>  | <b>Fully implement successful solution &amp; standardize</b><br>If the change is not working well, start the cycle over, refine the problem, test another solution<br>Develop a monitoring system<br>Celebrate! | Flow chart (new)<br>Control chart<br>Histogram<br>Gantt chart<br>Tree diagram<br>Gantt chart                             |
|  | <b>Repeat cycle for continuous improvement</b>  |  |



# Continuous Quality Improvement Team Charter

|  |
|--|
| <p><b>DATE:</b><br/> <b>Division:</b><br/> <b>Office/Bureau</b></p> <p><b>Project Name:</b></p> <p><b>Problem Statement:</b> what isn't working, how do you know?</p> <p><b>Project SMART Goal OR AIM statement:</b></p> <p>What are we trying to accomplish?<br/> <b>To:</b> [What is the goal, purpose, or outcome desired? Should be a measurable change]<br/> <b>For:</b> [Who benefits from the results? What is the scope?]<br/> <b>So That:</b> [What are the benefits from achieving this goal?]</p> <p>Is there a legal reference for this process? (ORC, OAC, Contract Deliverable?)</p> |
| <p><b>Executive Sponsors:</b> _____</p> <p><b>Team Sponsor:</b> (the individual(s) who 'owns' the existing process and has authority to approve changes)</p> <p>Team Leader:<br/> Process Team:</p>  |
| <p><b>Background:</b> (More detail about Problem Statement such as strategic importance, what has been happening, importance to customers)</p>   |
| <p><b>Boundaries:</b> (limits on scope of process change allowable as defined by the team sponsor, legal restrictions, budget, etc. you may not have any, or know of any yet)</p>  |
| <p><b>What the team has authority to do:</b> (authority to pilot improvements or make recommendations etc.)</p>  |
| <p><b>Related to which strategic priority or PHAB Standard:</b></p>  |



**Appendix C**

| Division/Office          | Project  |
|--------------------------|--|
| <p><b>Family</b></p>     | <p><b>Office/Bureau:</b> Children with Developmental and Special Health Needs<br/> <b>Project Name:</b> HMG Technical Assistance Consistency<br/> <b>Executive Sponsors:</b> DFCHS Chief<br/> <b>Team Sponsor:</b> Lea Blair<br/> <b>Team Leader:</b> Jeffrey Wynnyk<br/> <b>Process Team:</b> Shelly Palumbo, Cassandra Holloway, Madelyn Connell, Nathan Dedino, Sharon Marcum</p> <p><b>Office/Bureau:</b> Division Office<br/> <b>Project Name:</b> DFCHS Web Page Enhancement<br/> <b>Executive Sponsors:</b> DFCHS Chief<br/> <b>Team Sponsor:</b> Theresa Seagraves, MCH BG &amp; QI Manager<br/> <b>Team Leader:</b> Lillian Bouldware<br/> <b>Process Team:</b> DFCHS Bureau Web Reps</p>                         |
| <p><b>DQA</b></p>        | <p><b>Office/Bureau:</b> CON/BIOS/BLTCQ/BCHFS<br/> <b>Project Name:</b> Purple Light Ultra<br/> <b>Executive Sponsors:</b> Becky Maust<br/> <b>Team Sponsor:</b> Chip Glass, Tamara Malkoff,<br/> <b>Team Leader:</b> Chip Glass<br/> <b>Process Team:</b> Chip Glass, Joel Kaiser, Kathy Kimmet, Bridgette Smith, Bridget Smith, Steve Summers</p> <p><b>Office/Bureau:</b> BIOS<br/> <b>Project Name:</b> Long Term Care Facilities Initial Licensure Application Process<br/> <b>Executive Sponsors:</b> Rebecca Maust<br/> <b>Team Sponsor:</b> Tamara Malkoff<br/> <b>Team Leader:</b> Kathryn Kimmet, Dave Holston<br/> <b>Process Team:</b> Kaliyah Shaheen, Bridgette Smith, Charlene Valentine, Adria Goodwin</p> |
| <p><b>Prevention</b></p> | <p><b>Office/Bureau:</b> Environmental Health, Radiation Protection and Health Preparedness<br/> <b>Project Name:</b> Processing Payable Time<br/> <b>Executive Sponsors:</b> Will McHugh<br/> <b>Team Sponsor:</b> Will McHugh<br/> <b>Team Leader:</b> Rebecca Sandholdt, DPHP<br/> <b>Process Team:</b> Chad Lehman (BRP), Melanie Karst (BEH), Jennifer Flaughner (ES), Sean Keller (DPHP)</p>   |



# Quality Improvement Plan

|                              |  |
|------------------------------|--|
|                              | <p><b>Office/Bureau:</b> Bureau of HIV/AIDS, STD and TB<br/> <b>Project Name:</b> Retention in HIV Care<br/> <b>Executive Sponsors:</b> Will McHugh<br/> <b>Team Sponsor:</b> Kate Shumate<br/> <b>Team Leader:</b> Susan DiCocco<br/> <b>Process Team:</b> Kate Shumate, Tim Leonard, Sonia Muse, Laurie Rickert, Jennifer Snyder, Chris Ahrens, William Cartwright, Jamie Perez, Jennifer Landau and the HIV Cross-Part Care Continuum Collaborative (H4C) Response Team</p>   |
| <p><b>Administration</b></p> | <p><b>Office/Bureau:</b> OFA<br/> <b>Project Name:</b> Contract Management Process<br/> <b>Executive Sponsors:</b> Harry Kamdar, CFO, Lance Himes, General Counsel<br/> <b>Team Sponsor:</b> Paul Maragos, Procurement Chief<br/> <b>Team Leader:</b> Lawissa Tidrick<br/> <b>Process Team:</b> Harry Kamdar, Paul Maragos, Lance Himes, Steve Wagner, Sean Keller, Karen Hughes, Reggie Surmon, Will McHugh, Luz Allende, Christy Beeghly, Randy Beery, Patti Cross, Lisa Eshebacher, Jim Felton, Kelly Friar, Christine Grant, Bruce Hotte, Melanie Karst, Rick Levine, Maureen Murphy-Weiss, Anna Starr, Tina Turner, Allyson Van Horn, Dave Feltz, John Joseph, Carol Ray, Barb Richardson, Josh Weithe, Tom Wilson, Bobbi Burke</p> <p><b>Office/Bureau:</b> OFA<br/> <b>Project Name:</b> Invoice Processing Project<br/> <b>Executive Sponsors:</b> Harry Kamdar, CFO<br/> <b>Team Sponsor:</b> Tamara Harrison, Accounting Chief<br/> <b>Team Leader:</b> Lawissa Tidrick<br/> <b>Process Team:</b> Tamara Harrison; Bettie Fullum; Paul Maragos (Optional); Barb Richardson; Amadou Diallo (Optional); Chris Sargent; Jennifer McCauley (Optional); Pam Hill; John Hall; Reggie Surmon (Optional); Melissa Mathias; Susan Heller; Sean Keller (Optional); Bobbie Burke; Paulette Hayes; Tamara Malkoff(Optional); Bridgette Smith</p> |
| <p><b>OMIS</b></p>           | <p><b>Office/Bureau:</b> Office of Vital Statistics<br/> <b>Project Name:</b> Reduce Order Fulfillment Cycle Time Process<br/> <b>Executive Sponsors:</b> Bruce Hotte, CIO<br/> <b>Team Sponsor:</b> Judy Nagy, State Registrar<br/> <b>Team Leader:</b> Dan Burleson, Manager<br/> <b>Process Team:</b> Dan, Rena, Devon, staff of order fulfillment, customer service, special registration</p>  |



## Quality Improvement Plan

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|--|---|
|  | <p><b>Office/Bureau:</b> OMIS<br/><b>Project Name:</b> Help Desk Service Improvement<br/><b>Executive Sponsors:</b> Bruce Hotte, CIO<br/><b>Team Sponsor:</b> Henry Smith<br/><b>Team Leader:</b> Ron Ferencz<br/><b>Process Team:</b> OMIS Help Desk Staff</p> |
|--|---|



# Ohio Department of Health Policy Acknowledgement

| Policies/ ODH Directives   | Policies/ ODH Directives  |
|--|---|
| State of Ohio Policy- Barbara Wenzler Workplace Domestic Violence            | ODH Directive 20A - Standards of Appearance and Attire for Employees    |
| State of Ohio Policy- Drug Free Workplace                                    | ODH Directive 21B - License & Certification Verification                |
| State of Ohio Policy- Ethics Law and Related Statutes                        | ODH Directive 22A - Workplace Violence                                  |
| State of Ohio Policy- Nepotism   | ODH Directive 23A - Information Technology & Sensitive Equipment Mgmt.  |
| State of Ohio Policy- Political Activity                                     | ODH Directive 24B - Data Stewardship                                    |
| ODH Directive 1H - Policy Issuance   | ODH Directive 25 - Letters of Support                                   |
| ODH Directive 2A - Overtime Exempt Employee Timekeeping                      | ODH Directive 26B - Management and Security of ODH Authorized Equipment |
| ODH Directive 3C - Compensatory Time for Overtime Exempt Employees           | ODH Directive 28B - Incident Command System                             |
| ODH Directive 4B - Hours of Work   | ODH Directive 29B - Employee Leave Policy                               |
| ODH Directive 5F - Workplace Non-Discrimination and Anti-Harassment Policies | ODH Directive 30A - Family and Medical Leave Act                        |
| ODH Directive 6 - Nursing Mothers  | ODH Directive 31B - Standards of Employee Conduct                       |
| ODH Directive 7C - Use and Security of Agency IT Resources                   | ODH Directive 32 - Drug Free Workplace                                  |
| ODH Directive 8D - Parking   | ODH Directive 35 - Outside Employment                                   |
| ODH Directive 9A - No Smoking Policy   | ODH Directive 35 - Overtime Exempt Employee Compensation                |
| ODH Directive 10C - Vacation Leave for Exempt Employees                      | ODH Directive 36B - Motor Vehicle Use Policy                            |
| ODH Directive 11A - Leave Donation Policy                                    | ODH Directive 39 - Compensation for Employee Travel and Training        |
| ODH Directive 12A - Poll Worker Leave  | ODH Directive 40A - Mobile Computing Device Policy                      |
| ODH Directive 14 - Charitable & Fundraising Activities                       | ODH Directive 41A - Employee of the Month                               |
| ODH Directive 15A - Employee Performance Evaluations                         | ODH Directive 42A - Telework Policy                                     |
| ODH Directive 16A - Logo Use   | ODH Directive 43 - Asset Management Activities                          |
| ODH Directive 18B - Exempt Grievances  | ODH Directive 45 - Quality Improvement                                  |
| ODH Directive 19A - Training and Educational Release Time                    |   |

Policies and directives can be reviewed by clicking on the title above or by navigating to the ODHNet, [Policies/Forms](#) page.

By signing below, I am aware and responsible for completing the requirement of reviewing and following all policies outlined above. Failure to comply with State of Ohio Policies and Agency Directives may result in discipline. If you have any questions, please contact the Office of Human Resources.

Employee Signature \_\_\_\_\_ Employee Name Printed \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Witness Name Printed \_\_\_\_\_ Date \_\_\_\_\_



## ODH Directive 45 Quality Improvement

- Encl:**
- (1) CQI Project Informational Form
  - (2) CQI Methodology – PDSA Cycle
  - (3) Sample Storyboard

1. **Purpose.** The purpose of this directive is to establish procedures for the standardized implementation of continuous quality improvement practices throughout the agency to include all divisions, bureaus and programs.

2. **Policy.** The Ohio Department of Health (ODH) is committed to the ongoing review of its programs, processes and services toward improving their effectiveness, efficiency, outputs, outcomes and customer service. The ODH desires to enhance the current culture of quality within the department, through continuous quality improvement (CQI) at all levels. The use of continuous quality improvement methods and tools will improve program performance, operational performance, and increase innovation enabling the ODH to achieve its mission.

3. **Procedures (Governance).** To achieve the policy set forth in this directive, ODH will establish and complete the following:

**A. Establish and Maintain a Quality Improvement Committee (QIC)**

- a. **QIC Leadership** – The Assistant Director of the ODH will co-chair the QIC with the Performance Improvement Manager (PIM).
- b. **QIC Leadership Role and Responsibility** – The Co-Chairs of the QIC are designated as the liaison between ODH's Senior Management Leadership Team and the Quality Improvement Committee (QIC) in order to monitor CQI efforts at the ODH. The PIM will provide status reports on CQI projects and activities to the QIC Co-chair, who in turn, will report monthly at the Executive Staff weekly meeting. Executive Staff is composed of the Director, Assistant Directors, General Counsel, Chief of Staff and Chief Policy Officer.
- c. **QIC Members** – at least one representative from each Division and Office within the ODH.
- d. **QIC Members Roles and Responsibilities:**
  - creating policy and procedures as it relates to CQI and ensure the alignment of the CQI goals with the agency's mission;
  - reviewing the quality improvement plan annually and recommending revisions;
  - planning and participating in CQI training activities;

- providing input to the PIM in the creation of tools to be used during the inventory of current and future projects and ensure all projects are aligned with the agency mission;
- attending regular monthly meetings (approx. 1.5 hours per month) to discuss CQI projects and activities;
- providing support to the PIM with CQI related activities during their tenure
- engaging in the leading and facilitating of CQI project activities (up to 2 hours per month, as needed);
- serving a two-year term with no more than half of the team rotating off the committee each year (committee members may ask for consideration to serve consecutive terms, if desired);
- assisting with developing CQI forms, establishing standards for continuous quality improvement team charters, minutes and reports, reviewing of the reports of the continuous quality improvement teams, annual report of CQI activities to the Executive team and updating of the CQI Policy;
- acting as mentors and facilitators across the department for areas engaging in QI projects; and
- attending state and ODH sponsored QI training opportunities (e.g., PDSA, six sigma, QI tools) to ensure they can effectively mentor QI teams.

**B. Promote and Develop Continuous Quality Improvement Projects throughout ODH**

Continuous Quality Improvement will be adopted at all levels – department, division, bureau, section team wide, and with external partners in an effort to improve public health. Any ODH employee may initiate a CQI project by working with their supervisor to select a team and obtain executive sponsorship. ODH project teams will address programs, services and processes to increase efficiencies, effectiveness and improve outcomes. An ODH project team must:

- a. ensure project sponsors have committed the resources needed to complete the project;
- b. track and report progress on the QI project to the Office of Performance Improvement at the completion of major milestones or at regular reporting intervals.
- c. ensure the QI has sought out a member of the QI committee to acts as a mentor; and
- d. have each division and office submit a minimum of 2 QI projects annually to the Office of Performance Improvement.

**C. Establish Annual Training Objectives and Agency-Wide QI Standards.** To establish a culture of continuous quality improvement we must embed the methods into daily practice, program planning, decision-making, and goal setting.

- a. **The minimum standard of training for all ODH employees will be:**
  - ongoing training for all ODH staff in Plan Do Study Act (PDSA) CQI methodology and continuous quality improvement training as mandated by the department;

- ensuring all new employees receive initial QI training during their probationary period and have the ability to participate in at least 1 QI project within their first year of employment; and
- continuously promote QI by offering training opportunities and share team presentations following the completion of a successful project.

4. **Applicability.** This policy applies to all employees of the Department of Health. All employees shall follow procedures contained within the policy, and, in addition, all administrators, managers and supervisors shall enforce and comply with the policy and procedure established by this directive. The Office of Performance Improvement (OPI), as instructed by the Director of the ODH, will take the lead on coordinating CQI initiatives.

5. **Authority.** This directive is promulgated by the Director of Health pursuant to Ohio Revised Code sections 121.02, 121.07, 3701.03 and 3701.04 which authorize the director to create, promulgate and enforce rules for the safe, efficient, economic and proper operation of the agency. The Office of Performance Improvement is responsible for the drafting of this directive.

Approved:

  
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Theodore E. Wymyslo, M.D.  
Director

Date:

2/5/14

**Table of Effective Changes**

| Version | Effective Date | Superseded/Modified | Significant Changes |
|---------|----------------|---------------------|---------------------|
| 45      | 2/10/2014      | NA                  | First Issuance      |