Franklin County Health Department
Quality Improvement Plan
February 2016 - December 2020
*Updated June 2017
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I. Purpose

The purpose of Franklin County Health Department’s (FCHD) Quality Improvement (QI) Plan and Accreditation and QI Policy (Appendix 1) is to foster a culture of quality improvement through continuous improvement of programs, services and administration. This goal is also reflected in FCHD’s 2015-2020 strategic plan.

II. Overview of Quality in FCHD

FCHD developed its first Accreditation/Quality Improvement (QI) Team in June 2010. Later that fiscal year the QI Steering Committee was formed and developed a QI plan followed by an Accreditation and QI Policy that was approved by the Franklin County Board of Health. Several key staff members have been trained in QI methods and tools. A QI Coordinator was appointed and provided a basic introduction to QI training that was required of all staff during Fiscal Year 2011. FCHD’s QI Steering Committee will continue to develop staff knowledge of QI methods and tools. In September of 2014 FCHD developed two separate teams for Quality Improvement and Accreditation. Both teams with a representative from all departments within the agency. QI trainings to all staff have continued throughout each Fiscal Year since 2011, providing staff with tools, knowledge and templates to be a valuable member to the spread of an agency-wide culture of quality improvement.

III. Key Quality Terms

- Quality Improvement: “Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community” (Accreditation Coalition Workgroup, 2009).
- Continuous Quality Improvement (CQI): An ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities and outcomes. These efforts can seek “incremental” improvement over time or “breakthrough” all at once.
- Big QI versus little qi: Big QI denotes the macro effort toward quality improvement at the department level, while little qi represents small, discrete quality improvement efforts at the program level.
- Quality Assurance (QA): QA is a process that measures compliance with previously established standards and expectations, including the protocols of the Kentucky Public Health Practice Reference (PHPR) and the requirements of the Kentucky Department for Public Health (KDPH) Administrative Reference. See Table 1 for distinctions between QA and QI.

<table>
<thead>
<tr>
<th>Quality Assurance</th>
<th>Quality Improvement</th>
</tr>
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<tbody>
<tr>
<td>Reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Works on problems after they occur</td>
<td>Works on processes</td>
</tr>
<tr>
<td>Regulatory, usually by State or Federal law</td>
<td>Seeks to improve (culture shift)</td>
</tr>
<tr>
<td>Led by management</td>
<td>Led by staff</td>
</tr>
<tr>
<td>Periodic look-back</td>
<td>Continuous</td>
</tr>
<tr>
<td>Responds to a mandate or crisis or fixed schedule</td>
<td>Proactively selects a process to improve</td>
</tr>
<tr>
<td>Meets a standard (Pass/Fail)</td>
<td>To exceed expectations</td>
</tr>
</tbody>
</table>

("A Closer Look, QI Nuts and Bolts” ASTHO webinar presentation, 2010)

- QI Methods: A variety of practices exist to assist in QI efforts. The PDCA/PDSA or Shewhart Cycle was popularized by W. Edmonds Deming during the post WWII effort to reindustrialize Japan. Other popular methods include Lean, Six Sigma, Lean Six Sigma, DMAIC, Performance Excellence (4th Generation Management), Model for Improvement and Malcolm Baldridge National Quality Standards.
- PDCA/PDSA: The Plan-Do-Check-Act (PDCA) or Plan-Do-Study-Act (PDSA) method is the most widely used, simple approach for quality improvement projects. PDCA and PDSA may be used interchangeably. Figure 1 illustrates the PDCA cycle and Figure 2 displays the steps involved in each phase of the PDCA model.
- QI Tools: A variety of tools used to identify how processes, programs and services can be improved. Tools include prioritization matrices, flow charts, cause-and-effect or fishbone diagrams, Pareto charts, scatter diagrams, control/run charts, brainstorming, logic models, SWOT analysis and numerous others.

Figure 1: PDCA/PDSA Cycle

The ABC’s of PDCA, G. Gorenflo and J. Moran

Figure 2: Phases of the PDCA Model (Gorenflo and Moran, Public Health Foundation)
A team based approach that enables improvement to be made by stepping through all phases of the quality improvement cycle in an effective and rapid fashion. The Kaizen approach enables organizations to realize benefits greater than expected and within a much shorter timeframe.

IV. Organization Structure

FCHD’s QI Steering Committee will carry out the provisions of this QI Plan and FCHD’s Accreditation and QI Policy.

Membership and Rotation: The QI Steering Committee will be representative of all internal departments. Terms will not be limited, except as determined by the Public Health Director. Membership is composed of the following FCHD staff members:

- Judy Mattingly, Public Health Director III
- Jennifer Bardroff, Health Environmentalist III
- Peggy O’Shea, Health Education Coordinator
- Becky Casey, Administrative Specialist II
- Amber Carmack, Account Clerk III
- Leah Aubrey, Local Health Nurse II
- Brittan Parker, Public Health Services Manager
- Masy Sency, Local Health Nurse II
- Shannan Rome, HANDS Manager

Roles and Responsibilities: The QI Steering Committee will guide and evaluate QI efforts by:

- Participating in bi-monthly (every two months) meetings to review progress of quality improvement efforts
- Engaging in and facilitating QI efforts
- Incorporating QI concepts into daily work
- Collecting and reporting data for performance measures
- Promoting, training, challenging and empowering FCHD employees to participate in QI processes
- Identifying, monitoring, reviewing results from, and making recommendations on QI projects
- Identifying appropriate staff to participate in QI projects as needed
- Reviewing performance measures
- Reviewing program evaluation reports
- Reviewing after action reports (AAR) from outbreak investigations and emergency preparedness events and exercises
- Reviewing and revising the QI plan annually
- Preparing annual reports for staff meetings and the Board of Health
- Reviewing recommendations for improvement based on self-assessments of the Public Health Accreditation Board (PHAB) Standards and Measures and site visit reports
- Communicating selected QI results to the public
- Encourage all staff to participate in a QI project per the 2015-2020 FCHD Strategic Plan.

V. QI Training

During Fiscal Year 2015 and 2016 the QI Coordinator participated in a QI Leaders Academy consisting of learning and facilitating a new QI tool as well as assistance in writing a new annual QI Plan. During the week of February 22, 2016 a Contributor’s course training was offered to staff and trained 30 FCHD staff members with plan of training the other 25 staff members in FY 17. This training provided an adult learning technique of tell, show, do, recycle to help staff members work through a personal or work related mini QI project. In addition to this training Leadership Team was asked to participate in a one day QI planning session, where a training was held to help analyze data and prioritize goals for the next 18 months. FCHD hosts quarterly staff meetings where QI updates are provided and/or a specific QI tool is highlighted to prepare employees for participation in QI teams and enable them to incorporate QI techniques into their daily work. The QI Coordinator and/or members of the QI Steering Committee will provide just-in-time training to staff designated for specific QI projects. Additionally, new staff meet with the QI coordinator upon employment and efforts are made to provide just-in-time trainings to give them an overview of the agency’s QI efforts. They are also encouraged to review on-line QI modules that provide basic QI knowledge. In addition to these trainings, new staff will be included in any new trainings provided for all staff and will be included in the next QI contributors course.

VI. Identification of QI Projects

Priority for QI projects will be given to PHAB standards/measures that were either slightly or not demonstrated. The Public Health Director may request that a specific QI project be conducted. In addition, all staff members are encouraged to request the implementation of a QI project. These QI proposals will be discussed at QI Steering Committee meetings. Projects can be identified through an array of means, including suggestions, survey results, reports, team brainstorming, service statistics, financial records, program goals and objectives, community health improvement goals and objectives, strategic plan goals and objectives, health indicator goals and objectives, after action reports, performance management measures, internal assessments use of QI – Project idea worksheet (Appendix C) and many others.

Performance measures, strategic plan objectives, community health improvement plan goals and objectives, community health assessment results, etc. are used to identify and prioritize quality improvement projects and efforts. When either performance measures, strategic plan objectives, CHA, and QI failures trend to not meet a goal, etc. QI efforts will be enforced. Currently, the process includes discussion at QI steering committee meetings regarding these efforts and brainstorming occurs to see what QI efforts, if any, are needed. QI efforts are not initiated for all benchmarks missed as some missed benchmarks may be related to funding streams, changes in programs, etc. Once QI brainstorming efforts occur, it is brought to FCHD’s leadership team where it is prioritized to when this project should be implemented and a team is formed.

The current Quality Improvement Plan is posted on the agency website and is reviewed and updated annually.

VII. Customer Feedback

FCHD seeks customer feedback in all services that it offers. FCHD has created a general customer feedback survey that is accessible in print and on-line. Customer satisfaction feedback is gathered through survey monkey and analyzed as such. This feedback is used in programs and interventions to improve population based health promotion, protection and improvement efforts. In addition to customer satisfaction efforts, FCHD has some program specific surveys that are conducted and quality of life survey completed through the CHA implementation. Departments use these results in a series of different ways to plan for QI or performance improvement efforts. During the annual QI planning session all conducted survey results are compiled and provided to leadership for review and to use in consideration for quality improvement efforts.

VIII. Goals, Objectives and Measures

During the week of February 22, 2016 FCHD’s Leadership Team met and developed the following QI Plan based on data collected throughout the agency such as: Strategic Plan, CHA, CHIP, Satisfaction Surveys (employee and patient), County Health Rankings, etc. Below is the FCHD’s Leadership Team would like to focus on until June 30, 2017. Teams were delegated based on specialties within their departments and to help utilize all staff in participating in a formal QI project. Appendix A identifies QI projects completed from FY 2011 - FY 2016.

Each QI Team was given guidance from the Leadership Team and then created their own AIM statement. The AIM statements, goals and objectives for FY16 & FY17 can be found in Table 2 and 3.
2016 Quality Improvement Plan: FCHD

Table 2

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Drivers</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project: STD Reduction</strong></td>
<td>TO: Reduce STD rates in the next 18 months</td>
<td>BY: • Increasing STD case reporting • Improving STD education • Increasing STD prevention</td>
</tr>
<tr>
<td><strong>Measures/Targets:</strong></td>
<td>• TBD by the team</td>
<td></td>
</tr>
<tr>
<td><strong>Project Leader, Team Members:</strong></td>
<td>• TL: Sally • Leah, Jennifer, Kim, Flo (KSU rep), Susan, Ashley, Lisa H.</td>
<td></td>
</tr>
<tr>
<td><strong>Project: Sixth Grade Immunization</strong></td>
<td>TO: Increase Tdap, MCV, and Varicella vaccinations in the 6th grade population</td>
<td>BY: • Kaizen and partnership with the schools</td>
</tr>
<tr>
<td><strong>Measures/Targets:</strong></td>
<td>• Tdap - 75% improvement • MCV 55.6% improvement • Varicella 60.1% - 75% improvement</td>
<td></td>
</tr>
<tr>
<td><strong>Project Leader, Team Members:</strong></td>
<td>• TL: Michelle • Vicky, Kyle (school rep), Savannah, Natalie, Jeanette, Leann, Sally or Lisa H.</td>
<td></td>
</tr>
<tr>
<td><strong>Project: Workforce Development</strong></td>
<td>TO: Increase collection of service fees</td>
<td>BY: • Following the PDCA improvement process</td>
</tr>
<tr>
<td><strong>Measures/Targets:</strong></td>
<td>• Tdap - 75% improvement • MCV 55.6% improvement • Varicella 60.1% - 75% improvement</td>
<td></td>
</tr>
<tr>
<td><strong>Project Leader, Team Members:</strong></td>
<td>• TL: Michelle • Vicky, Kyle (school rep), Savannah, Natalie, Jeanette, Leann, Sally or Lisa H.</td>
<td></td>
</tr>
<tr>
<td><strong>Project: Maximize Revenue</strong></td>
<td>TO: Increase leadership potential/skills</td>
<td>BY: • Increasing participation in educational opportunities</td>
</tr>
<tr>
<td><strong>Measures/Targets:</strong></td>
<td>• Leadership institute attendance (10 to 20)</td>
<td></td>
</tr>
<tr>
<td><strong>Project Leader, Team Members:</strong></td>
<td>• TL: Sally • Leah, Jennifer, Kim, Flo (KSU rep), Susan, Ashley, Lisa H.</td>
<td></td>
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</tbody>
</table>

Leadership Team Members:
- Judy, Debbie, Cindy, Becki, Shannan, Lisa, LeAndra, Ken, Tammi, Lisa H., Sally, Michelle, Brittany, Marge

VIII. Monitoring and Reporting

All QI teams are responsible for developing a storyboard that depicts progress toward and steps taken to achieve the AIM statement. The QI Steering Committee will review the status of all QI projects at their bi-monthly meetings. QI teams are responsible for collecting and analyzing data related to their AIM statement. QI projects will be reported to the Board of Health at quarterly meetings. The QI Steering Committee will make recommendations for data collection methods and ensure that improvements are sustained. Additionally, in FY17 FCHD will be expanding its use of a software called Klipfolio to help monitor the QI plan.

IX. Communication and Recognition

All QI teams will communicate progress to the QI Steering Committee. Updates on QI projects may be provided in monthly internal News and Views, at quarterly staff meetings and in the quarterly Board of Health reports. Upon the completion of QI projects, storyboards will be displayed in common areas. When appropriate, QI results will be communicated with the public through press releases. QI projects will also be submitted for state and national conference sessions, poster sessions and awards when the QI Steering Committee and/or Board of Health deems appropriate. QI projects and QI efforts will also be submitted to national partners such as PQHIX and NACCHO Model Practice nominations when the QI Steering Committee deems appropriate.
**Project: Workforce Development**

**TO:** Develop FCHD’s current and future workforce by encouraging and providing leadership and education opportunities.

**FOR:** Community, Franklin County Health Department staff and future workforce.

**BY:**
- Providing focus groups – testing and feedback
- Partnering with local health education campuses
- Utilizing current staff’s potential
- Taking advantage of free education opportunities – applying for scholarships
- Making conference submissions
- Researching community resources and education

**SO THAT:**
- Personal and professional growth
- A strengthened employee sense of value and pride in the organization is achieved
- Job fulfillment and performance is improved

**CONDITIONS:**
- Merit system
- Budget constraints, staff willingness, time (staff coverage, availability of resources)

**STANDARDS:**
- What is to be measured and how?
  - Q1 Participation: Baseline 27, Target 55
  - Pride at work survey responses: Baseline 6, Target 0
  - Leadership institute attendance: Baseline 10, Target 20
  - Focus group participants: Baseline 9, Target 16
  - Becki’s report: Baseline TBD, Target increase

**Leadership Team Members:**
- Team Leader: Lisa
- Kendra, Becki, Tammi, Cheryl, Angie, Maribeth, Elvira

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**Project: Financial Stability**

**TO:** Decrease the difference between amount billed and amount collected.

**FOR:** FCHD, employees, Franklin County community.

**BY:**
- Confirming data and develop understanding
- Identifying root-cause issues
- Determining improvements
- Developing other measures as directed by the data and root-cause results
- Learning from each other

**SO THAT:**
- Plan for the future activities and budget
- Standardized process among departments

**CONDITIONS:**
- Billable amounts
- KRS for fees
- Can’t turn patients away
- Team stays positive

**STANDARDS:**
- What is to be measured and how?
  - Billable amounts for each department: Baseline TBD, Target TBD - Increased

**Leadership Team Members:**
- Team Leader: Cindy
- Ken, David, Margie, Priscilla, Gwen, Lisa, Amber M., Amber C., Vickie

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**Project: Increase Childhood Health**

**TO:** Increase the health of children.

**BY:**
- Reviewing evidenced based practices
- BMI collection in school aged children
- Partner with immunization project
- Collaborate with Health and Education CHIP workgroup

**Measures/Targets:**
- TBD by the team, Deadline June 30, 2018.

**Leadership Team Members:**
- TL: Debbie
- Kristi, Amy, Vicky P.

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**Leadership Team Conditions:**
- Within normal business hours and budget friendly

**Table 4: 2018 Quality Improvement Plan: FCHD**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared Drive Implementation</td>
<td>0</td>
<td>June 30, 2018</td>
</tr>
<tr>
<td>Internet drops</td>
<td>TBD</td>
<td>&lt;1 a month</td>
</tr>
<tr>
<td>Website Usability</td>
<td>TBD</td>
<td>80% Satisfaction</td>
</tr>
<tr>
<td>EHR Implementation</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**Drivers**

- **Measure**
  - **Baseline**
  - **Target**
- **BMI**
  - **Baseline**
  - **Target**
- **Implementation of 1 EBP in schools**
  - **Baseline**
  - **Target**

**Outcomes**

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**X. QI Program Review**

At least annually, the QI Steering Committee will assess the effectiveness of FCHD’s QI Plan and Accreditation and QI Policy and make revisions based on lessons learned during the year. This may be shared to staff through monthly internal News and Views, at quarterly staff meetings and in the quarterly BOH reports. This QI Plan will note measures of progress to date. In addition to the QI Plan, housing progress to date, dashboards will be housed on an online dashboard system – Klipfolio. This allows for any staff to see progress and measurements in all projects listed in the QI Plan. If a goal is not met in the time frame set for a QI project, that project can be carried over into the next fiscal year to allow for further actions to be taken.

**Additionally, continue 2016 Quality Improvement Plan Efforts.**
## Appendix A - 2011-2015 QI Plan & Projects

<table>
<thead>
<tr>
<th>QI Team</th>
<th>Process Addressed</th>
<th>AIM Statement</th>
<th>Measure of Progress (as of December 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girl Done: Salty Bruner, Maggie Bucklew, Mary Cook, Susan Nesselrode, Charlotte Ruble, Deanne Sutherland and Cindy Waddington. Facilitated by Fred Goins, Judy Mattingly and Julie Reynolds.</td>
<td>Repair request</td>
<td>By December 4, 2010 we will increase understanding of the repair request process from 22.3% to 52.2% and increase satisfaction with the repair request process from 38.9% to 68.9%.</td>
<td>By December 4, 2010 understanding was increased to 83.3% and satisfaction was increased to 94.4%.</td>
</tr>
<tr>
<td>The Laugh to Quit: Nicole Hule, Tamnie Bertram, Kendra Palmer and Karen Weller. Facilitated by Carrie Reschke and Maggie Bucklew.</td>
<td>Verification of professional licenses</td>
<td>By July 1, 2011 FCHD will have a process in place to consistently monitor and document all employees' trainings, certifications and/or license requirements.</td>
<td>By FY 12 a flow chart was designed to map out professional license verification for the personnel manager to follow.</td>
</tr>
<tr>
<td>FCHD Funded - Paula Alexander, Tamnie Bertram, Debbie Bell, Debbie Reming, Jennifer Bardroff and Shannon Rome. Facilitated by Judy Mattingly.</td>
<td>Grant applications</td>
<td>By June 30, 2012 we will increase grant funding from $38,475.84 in FY 10 to $42,323.42.</td>
<td>Decision tree for determining when to apply for grants has been developed along with a grant tracking form. This increased grant funding to $67,195.42 in FY 11, which already exceeds our AIM statement goal of a 10% increase. A grant funnel will be launched in Feb. 2012 and progress will be monitored.</td>
</tr>
<tr>
<td>There's No Place Like Home, Anita Napier, Aubrey Tol, Natalie Loney and Jennifer Sheets. Facilitated by Judy Mattingly.</td>
<td>Medication reconciliation process</td>
<td>By December 2012, decrease clinically significant medication issues from 16% to 10%.</td>
<td>Will verify baseline data as 16% in Feb 2012 pending review of 12 patient charts. Next steps will be to identify potential improvement theories.</td>
</tr>
<tr>
<td>Home Health Overtime: Karen Weiler, Anita Napier, and Paula Alexander. Other team members will be determined. Facilitated by Denise Bingham and Judy Mattingly.</td>
<td>Addressing processes leading to overtime</td>
<td>By____(date) decrease overtime for home health staff from____(baseline) to____(goal).</td>
<td>Project in beginning stages.</td>
</tr>
<tr>
<td>Same Day Scheduling: All Clinic Staff.</td>
<td>Same-Day scheduling</td>
<td>To decrease no-show rates to less than 5% by August 2011.</td>
<td>Same-Day scheduling was implemented and no-show rates plummeted below 1%. Goal met.</td>
</tr>
<tr>
<td>FCHD 007- Surveillance Team: Leah Aubrey, Salty Bruner, Kathy Miller, Tamnie Bertram, Michelle Seasay, Becky Case, Jennifer Bardroff and Priscilla Johnson.</td>
<td>Sharing of epidemiologic data with others.</td>
<td>Increase number of surveillance reports distributed from 1 to 4 by 7/31/15. Increase number of surveillance sites receiving reports from 0 to all by 10/31/14.</td>
<td>Entering second year of compiling data and distributing quarterly reports. Goal was met.</td>
</tr>
<tr>
<td>File 13: Amber Carmack, Amber Mathers, Kathy Miller, LeAnn Newsom, Charlotte Ruble, Angie Rege and Susan Nesselrode</td>
<td>Ineffective tracking of charts</td>
<td>By December 2015 we will have an accurate electronic account of all patients’ records and their status. (active, master card, closed files, do not)</td>
<td>In beginning stages - paused - staffing.</td>
</tr>
<tr>
<td>New Employee Orientation 101: Becky Case, Brittany Nagle, Maggie Bucklew and Cindy Waddington.</td>
<td>New hire orientation.</td>
<td>By June 30, 2015 a new employee orientation will be organized and implemented with all new hires.</td>
<td>Two employees have gone through new orientation process with more to follow. New checklist to be developed with the next new hire as forms and policies have been updated.</td>
</tr>
<tr>
<td>Employee Evaluation Oversight: Brittany Nee, Becky Case, Debbie Bell, Cindy Waddington, Julie Reynolds, Salty Bruner, Tamnie Bertram</td>
<td>FCHD employee evaluations.</td>
<td>To have FCHD's employee evaluation process standardized and consistent by FY16 among all of FCHD employees and departments.</td>
<td>New process developed and implemented on July 1, 2015. Will evaluate results FY 17 after one completed year of new evaluation process.</td>
</tr>
<tr>
<td>EnlistPigs - Rod Wheeler Advisory (BWA), Kendra Palmer, Wes Clark, Jerry Bardroff and John Lue.</td>
<td>Information distribution during BWA.</td>
<td>FCHD will provide accurate and timely information to affected businesses and community members when a BWA has been issued.</td>
<td>Developed an updated BWA checklist and handouts to be given to restaurants during BWA.</td>
</tr>
<tr>
<td>The Frankfurt 500-Kendra Palmer, Judy Mattingly, Becky Case, Jerry Bardroff, Wes Clark, Priscilla Johnson, Michelle Seasay and Brittany Parker.</td>
<td>Food Inspections</td>
<td>Decrease the number of past due food establishment inspections by 30% by January 1, 2016.</td>
<td>Completed - All 64 605 and 607 inspections have been caught up. Surpassed the goal of 30% and hit 100%.</td>
</tr>
<tr>
<td>PO Kaisse - Cindy Waddington, Teresa Ruble, Susan Nesselrode, Shameen Romeo, Debbie Bell, Brittany Parker and Interns: Morgan Norton and Elizabeth Bonnie.</td>
<td>PO Process</td>
<td>To implement an Electronic PO process by March 31, 2016.</td>
<td>In beginning stages.</td>
</tr>
<tr>
<td>Organized HANDS - Shameen Romeo, Morgan Norton.</td>
<td>Modular/Materials and Giveaway cabinet</td>
<td>To decrease amount of prep time associated with a visit.</td>
<td>Completed.</td>
</tr>
<tr>
<td>Chart Tools - Missy Serey, Michelle Seasay, Atiza Topas, Andrea Semones, Ashely Krutan, Stephanie Willard, Maribeth Lines, Vickie Cleaver, Anita Johnson, Kristi Holt, Natalie Loney, Sheila Poe</td>
<td>Charts moving from school to school.</td>
<td>Decrease the time it takes when a student moves schools within the district to receive their chart.</td>
<td>In beginning stages.</td>
</tr>
</tbody>
</table>
Appendix B - Charter Template

FCHD Team Charter

Team Charter: “Name”

Date:
To: What is the specific goal, purpose or outcome desired?

For: Who benefits from achieving the goal? What populations are targeted?

By: What is your basic approach to solving the problem?

High-level Outline:
1.

Specific Plan:

<table>
<thead>
<tr>
<th>What</th>
<th>Recipient</th>
<th>Who will provide</th>
<th>By when</th>
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So that: What are the benefits from achieving the goal?

Conditions: What requirements or limitations exist?

Standards: How will the team measure success?

What is to be measured and how? | Baseline | Target
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Team Members: (Name and Department)
Appendix C - Quality Improvement: Project Idea

Project Title:

Background

1. What has the situation been like in the past?
2. Who is the customer?
3. What is the problem now?
4. Quantify it (where do I have data).

Project Objectives

1. How would the customer’s experience be different once the situation has been improved?
2. What is the change in performance you want to achieve?
3. Quantify it (if you can).

Boundaries

1. What other offices or divisions within the agency and work process are within the scope of this effort?
2. What work is outside the scope of this effort?

Appendix D – Accreditation and Quality Improvement Policy

Franklin County Health Department
100 Glenns Creek Road
851 East-West Connector
Frankfort, Kentucky 40601

Policy IC-47

ACCREDITATION AND QUALITY IMPROVEMENT

Purpose

The Franklin County Health Department (FCHD) supports national public health accreditation. This accreditation establishes standards and benchmarks for the provision of essential public health services. Those that do the work are most knowledgeable about the processes and opportunities for improvement; their participation in Quality Improvement (QI) should therefore be actively encouraged. National public health accreditation should validate that this health department meets national standards, and that staff are accountable to the governing board of health (BOH), other policy makers and the community served.

"Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check (Study)-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.”

(Accreditation Coalition Workgroup, 2009)

Policy

An accreditation coordinator will oversee an internal accreditation/QI team. All employees will be engaged in QI according to the Plan-Do-Check (Study)-Act Model. Staff may be recruited to a QI project team or staff may request the implementation of a QI project based on the Public Health Accreditation Board (PHAB) standards/measures, quality assurance assessments, program goals and objectives or health indicator goals and objectives. QI project teams will share their progress and results at all staff meetings and at least quarterly with the BOH, for additional feedback and guidance.

Public Health Director

Date

Chair, Franklin County Board of Health

Date

Policy IC-47

Approved August 2011

Reviewed April 2014

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