Accreditation Learning Community
March 28, 2018
Meeting Summary

ALC Topics Calendar

	Topic
March	PHAB 6-Pack: Quality Improvement Plan
April	Adopting a Performance Management System
May	Effectively Managing Accreditation Teams/Documentation
June	Developing and Implementing Operational and Health Equity Policies to Support Public Health
July	Emergency Operations Plan and Supporting Documentation
August	Improving Access to Health Care

Accreditation Considerations for Shared Services and Mergers

In July 2016, PHAB published its "Accreditation Considerations for Shared Services and Mergers" as a tip sheet for local health departments considering or planning for major organizational changes. The guidelines clarify PHAB's policies and procedures regarding shared services and department mergers. In the case of shared services, local health departments may choose to apply as a single health department, using documentation from partners to demonstrate conformity with standards, or through a multijurisdictional accreditation application if two or more health departments formally share resources to provide essential services to both jurisdictions. Multijurisdictional applications must demonstrate a high degree of inter-dependence in order to be considered a legitimate application.

Health departments merging may impact accreditation status differently in different situations.

MERGER	ACTION/IMPACT
Accredited HD + Accredited HD	Report to PHAB
Non-Accredited HD + Non-Accredited HD	Merger plans should include accreditation considerations
Accredited HD + Larger Non-Accredited HD	Contact PHAB ASAP; some additional accreditation review may be necessary to ensure standards are met for entire population
Accredited HD + Smaller Non-Accredited HD	Consider how continued conformity with standards will be impacted; may not require additional accreditation review

PHAB Six-Pack: Quality Improvement Plan (Measure 9.2.1A)

The Quality Improvement Plan is one of the 6 major plans required for accreditation. Quality improvement activities conforming to Measure 9.2.2 requirements must be based on the agency QI plan.

In addition to the slides presented during the call, the following documents were provided to guide and support the discussion on developing an agency QI Plan:

-Documentation of DPH's QI Plan submitted to PHAB (included below)
-NACCHO example of an accredited local health QI Plan, LA County QI Plan
-Template for QI Plan developed by Ohio State University, shared through NACCHO

Next Meeting: Wednesday April 25, 1-2pm

Topic: Adopting a Performance Management System

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

RD 1 – Quality Improvement Plan

There are two combined documents presented to meet this measure. The first is the CT DPH Quality Plan from 2015 (which is a revision of the 2014 CT DPH Quality Plan) that is actively in use and guides all performance management and quality improvement activities in the department. Each of the required components of the plan can be found on the PDF numbered pages noted below. The second document is the Annual Goals, Objective and Measures from 2013-2014 which was an appendix of the previous CT DPH Quality Plan in 2014 that shows progress made in addressing objectives and activities for the previous federal fiscal year.

Requirement	**Location in Document –**
Key quality terms	See PDF Page 12 section Sharing a Common Quality Language and Appendix 2 –Glossary of Terms PDF Pages 30-32
Culture of quality and desired future state	See DPH Performance Management Framework and Culture of Quality Now and In the Future PDF Pages 8-10 See also Appendix 2 PDF page 28 for a visual depiction of the CT DPH Performance Management System
Key elements of the quality improvement effort's structure	See Governing and Reporting Structure- Overall Management Approach PDF Pages 13-19
Types of quality improvement training available and conducted	See Quality Improvement Training and Support DPH Pages 20-22
Project Identification, alignment with strategic plan and initiation process	See Alignment of Performance Management and Quality Planning with Department Key Initiatives PDF Pages 6-8, Quality Plan Annual Goals, Objectives and Measures –Appendix 6 PDF Pages 38-43. Alignment of objectives with the Strategic Plan are noted. Project Identification, Initiation and Approval Process –PDF Pages 19-20 and Appendices 4 & 5 Quality Improvement Conversation Starter and Quality Improvement Project Process Map PDF Pages 34-36.
Quality improvement goals, objectives, and measures with time-framed targets	See Annual Goals, Objective and Measures 2015 Appendix 6, PDF Pages 38-43
Approach to how the plan is monitored	See Monitoring the Quality Plan and Quality Improvement Activities PDF Pages 23-24 and Appendix 7 – Quality Improvement Project Inventory - Pages 44-47
Regular communication of quality improvement activities	See Communication Plan -PDF age 23 and two examples of Q-Tips a brief newsletter to share results of QI projects and activities PDF pages 49-50
Process to assess effectiveness of the quality plan	See Evaluating the Effectiveness of the Plan and Activities PDF page 24 describe the process. Appendix 7 shows the monitoring of QI projects - Quality Improvement Project Inventory - PDF Pages 44-47. The attached document at the end of the plan PDF pages 51-59 documents Annual Goals, Objective and Measures from 2013-2014 shows in yellow highlights the progress in meeting the goals and objectives from the federal fiscal year

Connecticut Department of Public Health
Quality Plan

Striving for Excellence Daily in Everything We Do

April 2015

Contents

Appendices

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First Completed January 2014
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Introduction - Why We Need a Quality Plan

The Connecticut Department of Public Health (DPH) Quality Plan (Q Plan) serves as an evolving guidance document that describes how DPH defines, manages, deploys, assures and monitors quality throughout the organization and identifies the processes and activities that will be put into place to ensure that quality services are consistently provided.

The plan also describes the overall management approach to quality planning and improvement and the performance management framework employed by DPH. It outlines a performance management plan aligned with the DPH mission and vision, its operational Strategic Plan, its State Health Improvement Plan and the pursuit of accreditation. Additionally, this plan provides an annual work plan which includes activities that both build our infrastructure of quality and details specific projects. This work plan is be updated annually.

The Q Plan details how we approach quality improvement in DPH. It also demonstrates our commitment to excellence and the delivery of quality services to the people of Connecticut. It is only through the careful measurement and monitoring of the effectiveness, efficiency and quality of the services we provide that we can be accountable and assured that we are providing the very best possible public health service to the state of Connecticut and its residents.

Components of the Plan

Alignment of Performance Management and Quality Planning with Department Key Initiatives

As noted above, this Q Plan is guided by and supports the mission, vision and values of the department and aligns with the operational Strategic Plan, the State Health Improvement Plan and accreditation efforts.

The DPH Mission is:

To protect and improve the health and safety of the people of Connecticut by:

- Assuring the conditions in which people can be healthy;
- Preventing disease, injury, and disability, and
- Promoting the equal enjoyment of the highest attainable standard of health, which is a human right and a priority of the state.

The DPH Vision is:

Healthy People in Healthy Connecticut Communities

The DPH Values are:

Performance-based - We strive to learn from our past efforts and use performance measures and data to focus our future efforts.

Equitable - We strive to foster policies and programs that promote fairness, social justice, equity, and cultural competence.

Professional - We strive to respect and uphold the high standards, skills, competence, and integrity of our professions.

Collaborative - We strive to work together and with others who share a similar vision for the mutual benefit of the community.

Accountable - We strive to be responsive and transparent to the public in our actions and communications.

Innovative - We strive to be creative and seek out new ways to solve problems.

Service-oriented - We strive to respect, listen and respond to our customers.

While all these values describe a quality organization, three do so explicitly: performance-based, accountable and service-oriented.

Strategic Plan Priorities

These values are further supported through our Strategic Plan which sets as one of its cross-cutting priorities to: *Foster a Culture of Performance Management and Quality Improvement*. Another quality related priority in the Strategic Plan is to *build a Sustainable, Customer- Oriented Organization.* Each of these priorities is being addressed by a workgroup or council that has been established or engaged through the strategic planning process. A copy of the most current DPH strategic map can be found in Appendix 1. The annual work plan for the Quality Plan aligns with the Strategic Plan and can be found in Appendix 6. Objectives that are both in the Strategic Plan and the Quality Plan are noted.

State Health Improvement Plan

The State Health Improvement Plan, *Healthy Connecticut 2020*, was published and disseminated in March 2014. The plan was developed under the guidance of the State Health Assessment/State Health Improvement Plan Advisory Committee with input from the Connecticut Health Improvement Planning Coalition. Healthy Connecticut 2020 is organized into seven broad focus areas. Each focus area is broken down into several areas of concentration for which there are goals, objectives and strategies that were developed by work groups. Additionally, DPH staff have aligned program performance measures with *Healthy Connecticut 2020* objectives. Progress in meeting these objectives and program performance measures is being monitored through the use of the *Healthy Connecticut 2020* Dashboard described later in this document. The Dashboard ensures that the State Health Improvement plan is integrated into the performance management system for DPH.

Accreditation

CT DPH is actively seeking to obtain and maintain national accreditation through the Public Health Accreditation Board (PHAB). PHAB assesses health departments against a set of standards that define expectations for all public health departments. The purpose of national accreditation is to continuously improve the quality of services and accountability of health departments to their stakeholders and communities. This Quality Plan seeks to assure that CT DPH is a performance based organization by

meeting the standards and measures in Domain 9 of the PHAB standards. Further, CT DPH sees the entire accreditation process as one that identifies opportunities for improvement across all the essential public health services

The alignment of these key initiatives is shown in a graphic entitled *Connecticut Department of Public Health Performance Management System: How it all Ties Together to Achieve Excellent Performance* in Appendix 2.

DPH Performance Management Framework and Culture of Quality Now and in the Future

The DPH has adopted the *Turning Point Performance Management* framework as the underpinning for performance improvement work in the department. This framework was developed by the Turning Point Performance Management National Excellence Collaborative in 2004 and has been adopted widely by public health practitioners around the country.[1] The framework, updated in 2013, is organized around each of the four components of a performance management system including:

1) Performance Standards, 2) Performance Measurement, 3) Reporting of Progress, and 4) Quality Improvement (Figure 1)

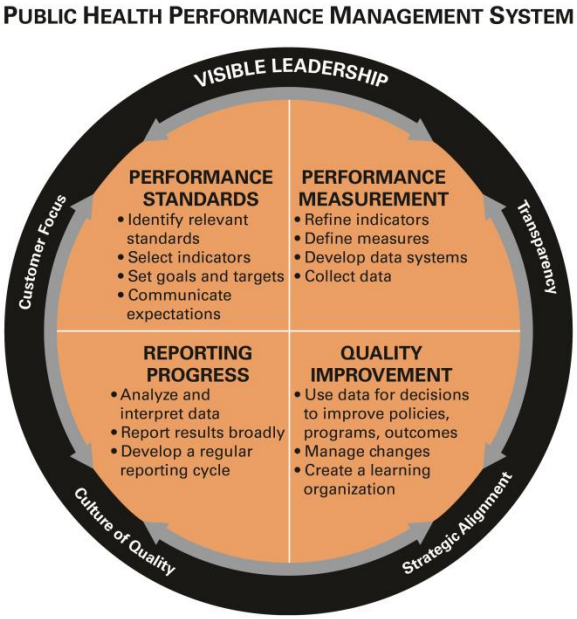

Figure 1: Turning Point Performance Management System Framework, Updated by the Public Health Foundation, 2013

[1] From Silos to Systems: *Using Performance Management to Improve the Public's Health*, prepared by the Public Health Foundation for the Turning Point Performance Management Excellence Collaborative, 2003.

This performance management framework also aligns with the *Quality Trilogy* approach to managing for quality created by JM Juran. [2] The trilogy consists of three processes: quality planning, quality control and quality improvement and was designed for business and manufacturing. This trilogy can be easily adapted and applied to public health. Quality planning includes determining the customer or population needs, developing programs or services that meet their needs, establishing goals to meet the needs and using evidenced based or proven processes that can work under the existing conditions. Quality control essentially combines performance standards and measurement to assure that we are setting standards then measuring and monitoring performance to know when we are and are not meeting targets. Quality improvement is taking action when we are not meeting targets by looking for causes, using quality improvement methods to make changes and assuring that the changes are making a difference. While this trilogy and the performance management model are consistent with sound public health practice, the field of public health has only recently begun to consistently and deliberately manage for quality.

Assessment of the Performance Management System and Culture of Quality

During the months of January and February 2013 the DPH conducted a performance management assessment to obtain a baseline of performance management practices throughout the organization. The assessment sought to determine what standards, measures, quality improvement and reporting practices and policies DPH already had in place as a foundation upon which to build. The tool assessed whether or not DPH had the necessary resources, capacities, skills, accountability and communications to be effective in each component. Further it looked to identify gaps in DPH's performance management system and assess staff quality improvement training and technical assistance needs.

A survey tool was adapted from the Performance Management Self-Assessment Tool developed by the *Turning Point Performance Management* National Excellence Collaborative. Through the survey, we learned that there was work to be done, particularly on the part of leadership, to communicate and demonstrate consistent expectations and practices around performance management. While most programs utilize performance standards and measures to drive their programming, there is room for improvement in terms of communicating progress on these measures both internally and externally. Additionally, the survey revealed that while quality improvement initiatives are being carried out across DPH and increasing in number, the practice is still not widespread. Finally, we learned that there are some specific performance improvement gaps in DPH including the lack of a systematic approach to obtaining customer feedback. The full findings of the survey are summarized in the report, *Connecticut Department of Public Health Performance Management Assessment Results, July 2013*, available upon request.

In February 2013, DPH leadership and managers convened to assess the DPH culture of quality. To inform this assessment, they reviewed the results of the performance management assessment. Participants then rated DPH to be on Exit 4 (of 6) on the *Roadmap to an Organizational Culture of Quality Improvement* developed by the National Association of County and City Health Officials[3] (NACCHO), indicating that some formal QI activities take place in the agency but not on a widespread basis.

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[2] Juran, JM, The Quality Trilogy: A Universal Approach to Managing for Quality. Presented at the ASCQC 40th Annual Quality Congress in Anaheim, California, May 20, 1986. pages.stern.nyu.edu/~djuran/trilogy1.doc

[3] Roadmap to a Culture of Quality Improvement: A Guide to Leadership and Success in Local Health Departments, National Association of County and City Health Officials, http://qiroadmap.org/

At that same meeting, leadership and managers utilized the culture of quality exercise- *Six Ingredients of a Quality Improvement Culture* developed by the Public Health Foundation to further assess its current culture of quality. The six ingredients included: commitment, capability, customer focus, empowerment, process and institutionalization. In small groups, using a scale of 0-5 (with 5 being the highest rating) leaders and managers rated DPH on each of the six criteria at the time of the assessment and projected how DPH would rate in a year. Scores were averaged for each criterion. A summary of the findings of that assessment are below. The full report, *Connecticut Department of Public Health Culture of Assessment Results, July 2013* is available upon request.

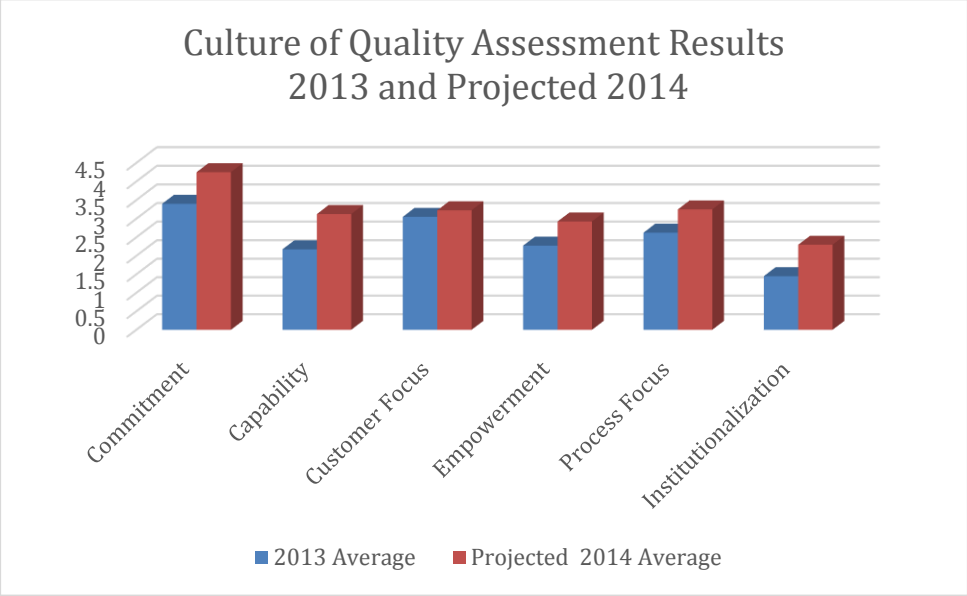

Figure 2: Results of an Assessment of the DPH Culture of Quality

Following the assessment, participants determined that leadership would work to improve staff empowerment and capability in order to strengthen the culture of quality. As a result, a leadership development program has been instituted in DPH which promotes collaborative leadership and empowerment of staff. Furthermore, it addresses how to lead change in an organization. This is vital to creating a cultural change in order to become a performance based organization. Capability will be addressed through ongoing quality training and technical assistance provided and/or coordinated through the Public Health Systems Improvement Unit. DPH will continue to assess its culture of quality and management of performance through the use of periodic repeat assessments.

Governor Malloy is actively promoting efficiency, quality and effectiveness across all state agencies by investing in training for all managers and supervisors in the basics of Lean approaches and methods. To date, 90 DPH supervisors and staff have attended this training. Through this initiative the DPH Performance Improvement Manager (PIM) has been certified in Lean and designated as the agency Lean coordinator. The DPH PIM supports teams throughout DPH that chose to use Lean methodologies to improve their work. Several DPH teams have and continue to participate in week-long Kaizen (continuous improvement) events led by expert consultants as part of the Governor's initiative. This support and direction from the Governor's office bolsters the performance aims of DPH.

Implementation of the DPH Performance Management System

The graphic entitled *Connecticut Department of Public Health Performance Management System: How it all Ties Together to Achieve Excellent Performance* found in Appendix 2 displays how DPH implements the four main concepts of the Turning Point Performance Management Framework (Page 3) (performance standards, performance measures, reporting of progress and quality improvement) in the work of the department.

The first two columns of the graphic labeled *National and State*, illustrate the use of the *performance standards* quadrant of the Performance Management Framework via a list of national and state standards used for quality planning. More specifically, DPH and its public health partners utilize national *performance standard*s; evidence-based practices and strategies such as *Healthy People 2020*, Public Health Accreditation Board, the National Prevention Strategy and the CDC Community Guide to inform state plans such as the *Healthy Connecticut 2020 State Health Improvement Plan*. Additionally these standards and practices are integrated into policies in the form of statutes and regulations that guide public health practice across the state.

Columns three through five demonstrate how the *performance measures, reporting of progress and quality improvement* quadrants of the Performance Management Framework are put into place at the department, and at program and individual employee levels. At the agency level, performance standards and evidenced based plans are carried out through objectives in the Agency Strategic Plan, the Quality Plan, the Workforce Development Plan, through accreditation activities and through the efforts of the Public Health Strategic Team and the Quality Improvement Council. Program performance measures are aligned with *the Healthy Connecticut 2020 State Health Improvement Plan* indicators where pertinent and their progress reported in the *Healthy Connecticut 2020 Dashboard*. Quality improvement initiatives are recommended when performance measure targets are not adequately met. Some agency sections or programs conduct activities outside the scope of the *Healthy Connecticut 2020 State Health Improvement Plan*, such as administrative, legal, human resources and other health-related program areas (such as newborn hearing screening). These areas also utilize these performance management concepts and are, or will be, represented in the *Healthy Connecticut 2020 Dashboard* going forward.

Across the bottom of the graphic are the agency's values which are integral to the performance management system.

Healthy Connecticut 2020 Dashboard

The **Healthy Connecticut 2020 Performance Dashboard** www.ct.gov/dph/dashboard is a web-based application that truly operationalizes the performance management system. The purpose of the dashboard is two-fold. First it provides a mechanism to publicly display progress in meeting the *Healthy Connecticut 2020 State Health Improvement Plan* objectives, including the actions of DPH programs to meet those objectives. Secondly, it is being adopted as a performance management tool among program staff and supervisors to monitor the work of programs within DPH to identify both successes and opportunities for improvement.

The dashboard depicts, in a simple visual format, how the residents of Connecticut are faring in areas such as heart disease, obesity, obtaining vaccinations, exposure to environmental risks and many more as identified in Healthy Connecticut 2020 State Health Improvement Plan. Currently there are more

than 250 population indicators and over 140 program performance measures in the dashboard.

The Performance Dashboard is built on the concepts of *Results Based Accountability*™ and specifically displays:

- **Results**-(or outcome or goal, e.g. All Connecticut children are lead free) is a population condition of well-being for Connecticut children, adults, families and communities, stated in plain language
- **Population Indicators** (e.g., prevalence of lead poisoning in children under 6 years of age) identify the health status of Connecticut residents for which DPH, other state and local agencies, and community partners all share responsibility.
- **Performance Measures** (e.g., percent of children under 3 years of age tested for lead) tell us whether DPH interventions that affect population indicators (e.g., prevalence of lead poisoning in children), are achieving objectives and if our agency's actions are helping to improve health.
- **Strategies** – (e.g. provide funding to local health departments to do outreach activities) are those that DPH and its partners are using to improve health to meet targets for improvement.

The Performance Dashboard is dynamic and is updated on a continuous basis. Staff from the Public Health Systems Improvement (PHSI) unit provides training for all DPH staff on *Results Based Accountability*™, developing program performance measures and how to use the dashboard as a management tool. PHSI staff have developed and disseminated documents describing responsibilities of all staff in using the dashboard and how managers and staff can use the dashboard to manage performance. These will be key components of a future "How to Kit" for the performance dashboard.

Sharing a Common Quality Language

It is vital to share a common understanding of quality-related terms and use consistent language throughout DPH to be clear in communications and to assure that all staff are working towards a common goal of excellence. To that end, one of the products of the quality cultural assessment was a quality vision statement. The quality vision is an aspirational, succinct statement describing our commitment to the provision of quality services.

DPH Quality Vision Statement

DPH: striving for excellence daily in everything we do

DPH staff articulated how they would realize this vision in an expanded statement. "In support of the Department's mission, we are committed to providing high quality public health services to those we serve. Staff will be supported and empowered to strive for excellence every day and equipped with systems and tools to integrate quality into everything they do. We will use data to monitor, evaluate, communicate and make adjustments to continuously improve the quality of our work to the benefit of our employees and those we serve."

The DPH quality vision and expanded statement are tools all staff can use to assure a common overall understanding of quality for the organization.

A glossary of commonly used quality and performance terms can be found in Appendix 3. As it is central to the performance improvement work of the department, the definition used for quality improvement is provided here.

Quality Improvement—In public health, quality improvement (QI) is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, that focuses on activities that address community needs and population health improvement. QI 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.[4]

Additionally, since CT DPH employs quality assurance and quality control practices throughout the laboratory and its many regulatory functions, it is important to describe the relationship between quality assurance and quality improvement. Quality assurance measures compliance against certain required standards.[5] Quality improvement methods can be used when non-compliance is noted to achieve best practice level performance.

Governance and Reporting Structure - Overall Management Approach

The following describes the organizational structure employed to align all strategic initiatives (Strategic Plan, State Health Improvement Plan, accreditation, performance management) and to assure a deliberate, coordinated and continuous process to maintain and improve the health of the population of Connecticut. These structures also facilitate involvement of DPH staff across the department, with the effect of enhancing communication and understanding at all levels of the agency.

Office of Public Health Systems Improvement

Charge

The Office Public Health Systems Improvement (PHSI) is responsible for directing, managing and coordinating all strategic planning, public health improvement planning, quality improvement and performance management and public health accreditation efforts for the department. The unit is staffed by a full-time manager, full-time contracts administrator, full-time performance improvement manager and contracted staff (as funding allows) to assist with accreditation, public health improvement planning and monitoring, and quality improvement.

Responsibilities

- Provide staff support to the Public Health Strategic Team (PHST) and the Quality Improvement (QI) Council
- Provide technical assistance to QI Teams and DPH staff carrying out quality improvement initiatives
- Monitor all quality improvement projects
- Coordinate and/or provide training on quality improvement tools and methods
- Coordinate and monitor strategic planning and implementation

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[4] http://journals.lww.com/jphmp/Fulltext/2010/01000/Defining_Quality_Improvement_in_Public_Health.3.aspx)

[5] http://www.hrsa.aquilentprojects.com/healthit/toolbox/HealthITAdoptiontoolbox/QualityImprovement/whatarediffbtwqinqa.html

- Coordinate and monitor *Healthy Connecticut 2020* State Health Improvement Planning and implementation
- Coordinate all accreditation planning and activities
- Develop and monitor the performance management system
- Manage the *Healthy Connecticut 2020 Dashboard*
- Assist DPH staff and programs in the development and monitoring of performance measures
- Develop, monitor, implement and update the agency Quality Plan
- Develop and assist in the implementation of a systematic process to assess and improve internal and external customer satisfaction
- Assist in the development and implementation of a workforce development plan

Budget

Funds for performance management activities sit primarily within the PHSI budget. State funds currently support the full-time manager and contracts administrator. Preventive Health and Health Services currently support the Performance Improvement Manager, four contract staff and contracted state health plan implementation activities. With the cessation of the National Public Health Improvement Initiative (NPHII), there will not be ongoing funds for the non- generally funded positions or for activities such as quality improvement training or to support the *Healthy Connecticut 2020 Dashboard.* Department leadership is supportive of performance improvement initiatives and continues to assist in identifying funding from existing funds.

Lean training and Kaizen events are supported through funds from the Connecticut Office of Policy and Management, at the direction of the Governor.

In-kind funds support staff working on planning and quality improvement activities throughout CT DPH.

Public Health Strategic Team

Charge

The Public Health Strategic Team (PHST) leads and assures the alignment of all major planning and strategic initiatives including: organizational strategic planning, State Health Assessment, State Health Improvement Planning, accreditation and performance management to maintain and improve the health of the population of Connecticut.

Responsibilities

- Identify *State Health Improvement Plan* priorities to be addressed by DPH
- Support implementation and monitor achievement of DPH priorities determined through the *Strategic Plan* and *State Health Improvement Plan*
- Promote the use of data to drive decision-making as well as plan and monitor programs
- Promote the use of evidenced-based practices and/or promising practices across the department
- Initiate and oversee quality improvement projects that address Department level priorities

- Promote a culture of quality throughout the organization by serving as role models, creating and communicating performance expectations, encouraging training and empowering staff to make necessary changes to improve quality
- Consider strategic and health improvement priorities identified through strategic initiatives when making budgetary and policy decisions
- Provide leadership and support DPH staff to carry out requirements to achieve accreditation
- Monitor implementation of the Quality Plan and make recommendations for change
- Assist in the development and implementation of the Performance Management system and Performance Dashboard and promote their use
- Advise the development of future state health assessments and monitor data over time

Structure

- The PHST is co-chaired by two members (to be determined)
- The PHST will be staffed by the Public Health Systems Improvement Unit who will coordinate meetings, develop agendas with the co-chairs and take minutes.
- Meetings will take place monthly for 1.5 hours at a regularly scheduled time which best accommodates the membership, with the schedule set well in advance.
- Periodic longer meetings maybe required to complete specific tasks such as strategic planning, priority setting etc.

Membership

- The PHST is comprised of senior leadership and strategic thinkers recruited to the team from across DPH. The inclusion of staff from across DPH widens the circle of communication and engagement across the agency. The team shall be comprised of 15-20 members including:
- Five – eight members from senior management – branch or section chiefs
- Five – eight members representing various sections from the department who have demonstrated leadership and strategic thinking
- Five -eight at-large volunteer members.
- Members should be able to commit to attending meetings on a regular basis and be able to carry out the team responsibilities.
- Members will serve a minimum two-year term beginning in January of even years but may extend their term with approval from the team.

Criteria for selection

Widening our circle- Representative from across and throughout DPH
Looking for innovation – Strategic, creative and innovative thinkers
New ideas grow from different points of view - people who will introduce variety into the process

Subcommittees

Subcommittees may be formed as standing committees or ad hoc committees as needed to complete substantive work (e.g. SHA/SHIP committee, customer service, workforce development). Subcommittees will report back to the PHST on activities and accomplishments.)

QI Council – Standing Subcommittee

The Quality Improvement Council assists in operationalizing quality improvement throughout DPH. It serves in an advisory capacity to the PHSI staff. The council takes direction from, and collaborates with the PHST to assure that quality improvement work aligns with all strategic initiatives including: organizational strategic planning, State Health Improvement Planning, performance management and accreditation.

Workforce Development – Standing Subcommittee

The Workforce Development Subcommittee exists to strategically develop a competent workforce to perform public health duties within the Department. It does so through: assessment of public health competencies of staff, the creation and implementation of a workforce development and training plan, the coordination of intern and mentorship opportunities and succession planning. The Committee is comprised of staff from throughout the Department who assists in implementation of workforce related activities. The Committee takes direction from and collaborates with the PHST to assure workforce related activities align with other department strategic initiatives.

Quality Improvement Council

Charge

The purpose of the Quality Improvement Council is to serve in an advisory and supportive capacity to the Department of Public Health (DPH) and specifically to the Public Health Systems Improvement (PHSI) unit and performance management staff to assure a culture and practice of performance management. Furthermore, the council will serve in an advisory capacity relative to public health accreditation preparation. The council takes direction from leadership and collaborates to assure that quality improvement projects and training aligns with other strategic initiatives such as: organizational strategic planning, state health improvement planning, accreditation and performance management to maintain and improve the health of the population of Connecticut.

Responsibilities

- Contribute to the development and ongoing refinement of the agency Quality Improvement Plan
- Advise PHSI on the development and ongoing refinement of the agency Quality Improvement Training plan
- Plan, assist with and attend staff quality improvement training
- Assist in the review and monitoring of quality improvement initiatives
- Provide guidance and technical assistance to quality improvement teams
- Monitor quality improvement projects in DPH
- Assist in the promotion of a culture of quality improvement in their own units and throughout the organization by serving as champions, role models and by using a variety of communication channels to increase the visibility of quality improvement

- Recommend participants of quality improvement projects for certificates of appreciation and recognition.
- Support and advise the department in activities to prepare for accreditation.
- Develop and assist in the implementation of a systematic process to assess and improve internal and external customer satisfaction
- Advise DPH in the development and implementation of a performance management system and the *Healthy Connecticut 2020 Dashboard*.

Structure

- The council is co-chaired by the Performance Improvement Manager and another representative from the DPH selected by the council. The selected co-chair will serve a two-year term beginning in January of even years. The co-chairs will schedule meetings and prepare agendas. They will take minutes or seek a minute taker at meetings.
- Meetings will take place every month at a regularly scheduled time which best accommodates the membership, with the schedule set well in advance.
- Members should be representative of the DPH with representation from each branch or section and from different levels within the organization. Members should have or have an interest in attaining basic knowledge or skills in quality improvement. Members should be able to commit to attending meetings on a regular basis and be able to carry out the council responsibilities.
- Membership will range from 11 to 15 members.
- Members will serve a minimum two-year term beginning in January of even years but may extend their term with approval from the council.

Quality Improvement Teams

Charge

Quality improvement teams convene to address specific quality improvement projects. Their work is time limited and focused on specific improvements. They may receive support from the Quality Improvement Council, PHSI, or peers with quality improvement experience.

Teams may form on their own to initiate projects or be convened via the PHST when addressing projects of significant impact or strategic importance to the department. Approval for quality improvement projects shall follow the DPH Quality Improvement Project Process map (See Appendix 5).

Connecticut Health Improvement Planning Coalition

Charge:

The Connecticut Health Improvement Coalition is a large advisory, advocacy and action body comprised of leaders from Connecticut organizations, who serve as community ambassadors and who will inform the overall implementation of the *State Health Improvement Plan* by sharing information from key networks and groups to facilitate action.

Membership:
Coalition members represent diverse local, regional and statewide organizations and agencies involved in addressing public health from a variety of perspectives.

Roles & Responsibilities:

- Participate in Action Teams and provide information from key sectors or constituencies to help inform action plan development
- Implement key *State Health Improvement Plan* strategies
- Inform Coalition Advisory Council and Action Teams on sustainability opportunities
- Inform Advisory Council on optimum communication strategies
- Inform on existing initiatives and local priorities which align with *State Health Improvement Plan* objectives
- Act as ambassadors and educators on *State Health Improvement Plan* and implementation initiatives

Working Principles:

- Collaboration, partnership and integrated approaches
- Data and evidence-driven decision making
- Open communication and transparency in all activities
- Work collaboratively, as a unified entity advocating for the interests of all Connecticut residents
- Support discourse, learning and leadership in health improvement

Term of Commitment:

- Membership is open to interested organizations and individuals and documented with completion of the Coalition Membership form
- The Coalition will host periodic conference calls between January and September

Advisory Council of the Connecticut Health Improvement Coalition

Charge:
The Advisory Council of the Connecticut Health Improvement Coalition provides guidance and oversight/ management of the *State Health Improvement Plan*, including coordinating implementation timelines and reporting/communication strategies in conjunction with DPH Leadership.

Membership:
The Advisory Council is comprised of approximately 30 Connecticut leaders, representing cross-sector entities that have a direct or indirect impact on health or determinants of health.

Council Members:

- Are action oriented
- Are in central positions that can facilitate change
- Are influential opinion leaders that provide expert advice
- Are committed to health equity
- Have a proven track record for collaborative problem solving and conflict resolution

Role & Responsibilities:

- Advise on implementation and coordination of plan activities
- Review and advise on refinement to plan objectives and strategies
- Serve as advocates for policies and system changes that can prevent or reduce health risk behaviors and lead to improved health outcomes
- Plan for sustainability and succession, and provide recognition
- Assist with identifying and engaging diversified funding streams
- Make strategic linkages
- Act as ambassadors and educators on the *State Health Improvement Plan* and implementation initiatives

Working Principles:

- Collaboration, partnership, and integrated approaches
- Data and evidence driven decision making
- Open communication and transparency in all activities
- Work collaboratively, as a unified entity advocating for the interests of all Connecticut residents
- Support discourse, learning, and leadership in health improvement

Term and Time Commitment:

- Staggered 2 and 3 year terms for 2015; thereafter, alternating 2-year terms
- Meetings will be monthly via a combination of conference calls and in-person meetings through September, 2015. Meeting frequency will be reassessed thereafter.

Project Identification, Initiation and Approval Process

As DPH strives to be a performance-based organization, all staff members are encouraged to identify and initiate quality improvement projects to improve processes, create efficiencies, increase effectiveness and improve health outcomes. Quality improvement projects may range from high level, department-wide initiatives to smaller programmatic improvements. Small scale quality improvement projects can be extremely valuable and may serve as the basis for larger successes.

Project Identification, Initiation and Approvals

Projects may be ***identified*** through a range of methods including but not limited to: using data to identify shortfalls in meeting program or health outcomes, examining daily processes that staff know can be improved upon, through formal evaluations that recommend improvements and through large-scale planning processes such as strategic or State Health Improvement Planning that identify priorities to be addressed.

Projects may be ***initiated*** at various levels within the organization and require various levels of ***approval*** and oversight.

1) Projects initiated at the program, section and branch levels and that address improvements at those levels shall be approved by the program manager, section and branch chiefs.

2) Projects that address DPH high priority issues that align with the agency *Strategic Plan*, the *State Health Improvement Plan* and/or which have significant agency impact and or impact multiple programs or services or agencies should be initiated and/or approved by the Public Health Strategic Team (PHST).

The process for initiating a quality improvement project is described for staff in simple terms in the Quality Improvement Conversation Starter (See Appendix 4. Once initiated, all projects large or small will be tracked and monitored through PHSI unit (see Monitoring the Quality Plan and Quality Improvement Activities Section of this document). Such tracking will allow DPH to monitor the progress and growth towards becoming a performance-based organization and to track improvements made. Furthermore, such monitoring can enhance collaboration between QI teams and avoid duplication of efforts. The QI Council and PHSI staff can provide technical assistance to quality improvement teams as needed. Quality improvement projects that address program level improvements will report progress to the Quality Improvement Council. Projects that cross programs, services or agencies and/or that align with the *Strategic Plan* or *State Health Improvement Plan*, will report progress to the Public Health Strategic Team (See Appendix 5 for a flow chart on QI project initiation, approval and process).

Quality Improvement Methods and Tools

Quality improvement teams all use the Plan, Do, Study, Act (PDSA) approach to quality improvement. Teams may use a variety of tools in their projects as appropriate. All are encouraged to use the standard DPH team charter which includes a project aim, team members' roles and responsibilities, performance measures, project scope and senior leadership sign off. Many use cause and effect diagrams, process flow maps, prioritization matrices, storyboards and other tools as needed. Teams that participate in Lean-Kaizen events create value stream maps, future state maps, project plans, key performance indicators and a presentation of their work at the end of the week-long training.

Whatever tools are used, teams are reminded how their work aligns with the performance management framework embraced by DPH. PHSI staff is available to provide technical assistance to teams in the use of tools and in carrying out the PDSA process. In the end it is the improvements that are made that matter and key that the tools selected work for the teams.

Quality Improvement Training and Support

The PHSI unit is responsible for coordinating and/or providing training on quality improvement and performance management for all staff. A quality improvement training needs assessment was conducted in January and February of 2013 as part of the *Performance Management Assessment* to inform the training plan below.

Introduction to a Culture of Quality

An on-line tutorial is slated for development by the end of 2015 for all new staff to complete upon hiring in order to orient them to the culture of performance improvement in DPH. This will become mandatory for all staff when our workforce development plan is completed to promote a common vision of quality. In 2013, 22 managers participated in a combined training and assessment of a culture of quality. Half of these attended a follow-up training entitled, *Building a Culture of Quality*

Improvement in an effort to take tangible steps to foster a culture of quality. An introduction of our culture of quality is integrated into our leadership development training; performance management training and training to use the *Healthy Connecticut 2020 Dashboard*. Links to web-based basic quality improvement training will be provided at the end of the tutorial for those who have a greater interest. Completion of this on-line training will be tracked through CT-TRAIN, our learning management system.

Basic Quality Improvement/Performance Management Training

PHSI staff is available to provide basic quality improvement training to staff upon request and in conjunction with quality improvement project technical assistance. As previously mentioned, links to basic quality improvement web-based training will accompany our introduction to a culture of quality tutorial. Ninety staff members attended a Basic Quality Improvement Tools and Methods workshop in 2012. Performance management training was offered to staff at a series of trainings to promote understanding of the concept and how aligns with the *Healthy Connecticut 2020 Dashboard*. Over 100 staff attended this training during 2014.

Quality Improvement Hands on Training and Coaching

The agency *Performance Management Needs Assessment* revealed that the most requested type of training by staff was hands-on training with a coach while carrying out a quality improvement project. In 2013, 13 staff participated in a quality improvement collaborative and received hands-on training. In 2014, two quality improvement teams, comprised of a total of 11 staff, were trained by PHSI using this hands-on approach. It is our intent to continue to offer this type of training to teams working together in a learning collaborative model at least once a year. PHSI staff is available to provide technical assistance to individuals and teams working on quality improvement projects.

Advanced and Continuing Quality Improvement Training

Many DPH staff are skilled in the basics of quality improvement and interested in advancing their current knowledge. Such training will be offered based on need, with at least one advanced quality improvement training per year. In 2013, 22 staff attended an advanced training session entitled, *Tools and Tips for Creating High Performing Public Health Programs and Organizations*. One session focused on using the 5 P's (Purpose, Populations, Professionals, Processes and Patterns) in a microsystem to develop quality improvement projects. The second session presented strategies to sustain quality improvement efforts and gains in an organization.

Results Based Accountability

As previously noted, the *Healthy Connecticut 2020 Dashboard* is built on the concepts of *Results Based Accountability*.™ All program staff contributing to the dashboard are being trained in these concepts so that they can develop program performance measures that align with population indicators and articulate the connection between daily work and health outcomes. In 2014 and 2015, 68 staff members were trained in *Results Based Accountability*. Such training will be ongoing until all programs have entered performance measurement data into the dashboard.

Lean Training Opportunities

We will continue to take advantage of Lean training opportunities offered through the Governor's initiative. This includes periodic offering of a three hour Lean Basics course and hands-on learning

through week-long Kaizen (continuous improvement) events. To date, over 90 DPH staff have completed the Lean Basics course. The Performance Improvement Manager is Lean certified and will lead quality improvement initiatives using Lean and other quality improvement methods as time allows. Two additional DPH staff have become Lean certified and will work together to support DPH staff to carry out Lean improvement initiatives. DPH staff continues to attend the Lean Basics course as it is offered.

Leadership Development and Organizational Change Training

Managers and leadership who participated in the culture of quality assessment recognize that transforming DPH to a culture of quality requires strong leadership and empowered staff. To that end, DPH is committed to providing leadership development opportunities to current and potential leaders. DPH will continue to work with Leadership Greater Hartford to provide this training as funds allow. Leadership Greater Hartford has been working to develop and inspire diverse leaders in the Hartford area for over 35 years. This Leadership Development training is a five-day program that explores personality types in the workplace, teaches the five exemplary leadership practices and shares successful strategies for leading change in an organization. Each participant receives a report of their 360-degree evaluation and develops a leadership development plan based on its findings in collaboration with a leadership coach. Participants explore the connection between leadership and quality services and are encouraged to serve as role models for other staff in this area. To date 117 staff members have participated in the leadership development program. It is the intention of DPH to continue the program, as funding allows, for any interested staff. Additionally, DPH is offering peer-to-peer leadership mentoring and leadership forums to sustain leadership development opportunities internally.

A summary of quality related trainings completed by staff since 2011 is provided below. The number of individual staff participating in training since 2011 is 299.

Summary of Completed Quality Improvement Training Since 2011	
Training type	**Number of Staff Per Training**
Accreditation	48
Leadership	169
Lean	90
Quality Improvement/Performance Management	316
Results Based Accountability ™	68
Grand Total	**691**

Annual Goals, Objectives and Measures

The overall Quality Plan outlining the DPH approach to performance management will be updated as needed. Each year an annual work plan will be developed with clear goals, objectives, measures and activities designed to move us closer to institutionalizing performance management in DPH. The goals are drawn from the DPH organizational *Strategic Plan* and from the objectives from the *National Public Health Improvement Initiative* grant from the Centers for Disease Control, despite the fact that it is no longer in existence. The goals are below. The annual work plan with specific objectives, activities, and measures are is in Appendix 7.

Goals

- *Foster a Culture of Performance Management and Quality Improvement*.
- *Strengthen Approaches and Capacity to Improve Population Health*
- *Build a Sustainable, Customer- Oriented Organization*

Monitoring the Quality Plan and Quality Improvement Activities

The PHSI staff is responsible for implementing and monitoring the overall *Quality Plan*, the annual work plan and quality improvement activities occurring throughout DPH.

PHSI staff will report progress on major milestones to the PHST on a quarterly basis. If barriers are encountered in reaching these milestones, the PHSI office will look to the PHST for support and recommendations.

The PHSI unit tracks all quality improvement projects through a project inventory. Quality improvement teams are invited to present their projects at monthly meetings of the Quality Improvement Council or the PHST dependent up the scope of the project in order to share their progress in reaching their performance targets.

An inventory of current quality improvement projects can be found in Appendix 7.

Communication Plan

Communication relative to quality activities takes several forms. Periodically, a brief communication entitled *Q-Tips* is emailed to all staff members. It provides succinct information about quality improvement tools, training and projects in a question and answer format. Relevant resources, tools and examples are attached to the emails.

Storyboards from quality improvement projects are displayed in hallways for all staff to view.

A *Quality Improvement Tool Kit* resides on the DPH intranet. It contains the Quality Plan, QI tools and resources as well as examples of complete quality improvement projects.

Updates on quality improvement and accreditation activities are provided at DPH Town Hall quarterly meetings which are open to all staff.

PHSI staff meets periodically with DPH sections to discuss components of the *Quality Plan*. These meetings enable small group discussion to help section staff understand how they connect to some of the more strategic initiatives in DPH.

Evaluating the Effectiveness of the Plan and Activities

In addition to monitoring whether or not the *Quality Plan* is being carried out as designed and that progress is being made to meet the objectives, we are evaluating effectiveness in several areas: quality improvement training, quality improvement initiatives and working to establish the link between leadership development and enhancing the culture of quality.

Quality Improvement Training

We are monitoring all quality improvement training through the CT-TRAIN learning management system and a tracking spreadsheet. CT-TRAIN allows learners to register on-line for courses, access a wide range of quality improvement training offerings and track personal learning. The tracking sheet details attendance of quality improvement courses by course offering as well as courses completed by individuals. We can use it to measure progress towards our training targets:

- 100% of programs entering performance measures into the Healthy Connecticut 2020 Dashboard are trained in performance management
- 25% of all staff will be trained in quality improvement within the last five years
- 10% of all staff will be trained in leadership development within the last five years

All training offerings are evaluated to determine if training objectives are met, to gauge learner satisfaction and to adapt training for future improvements.

Quality Improvement Projects

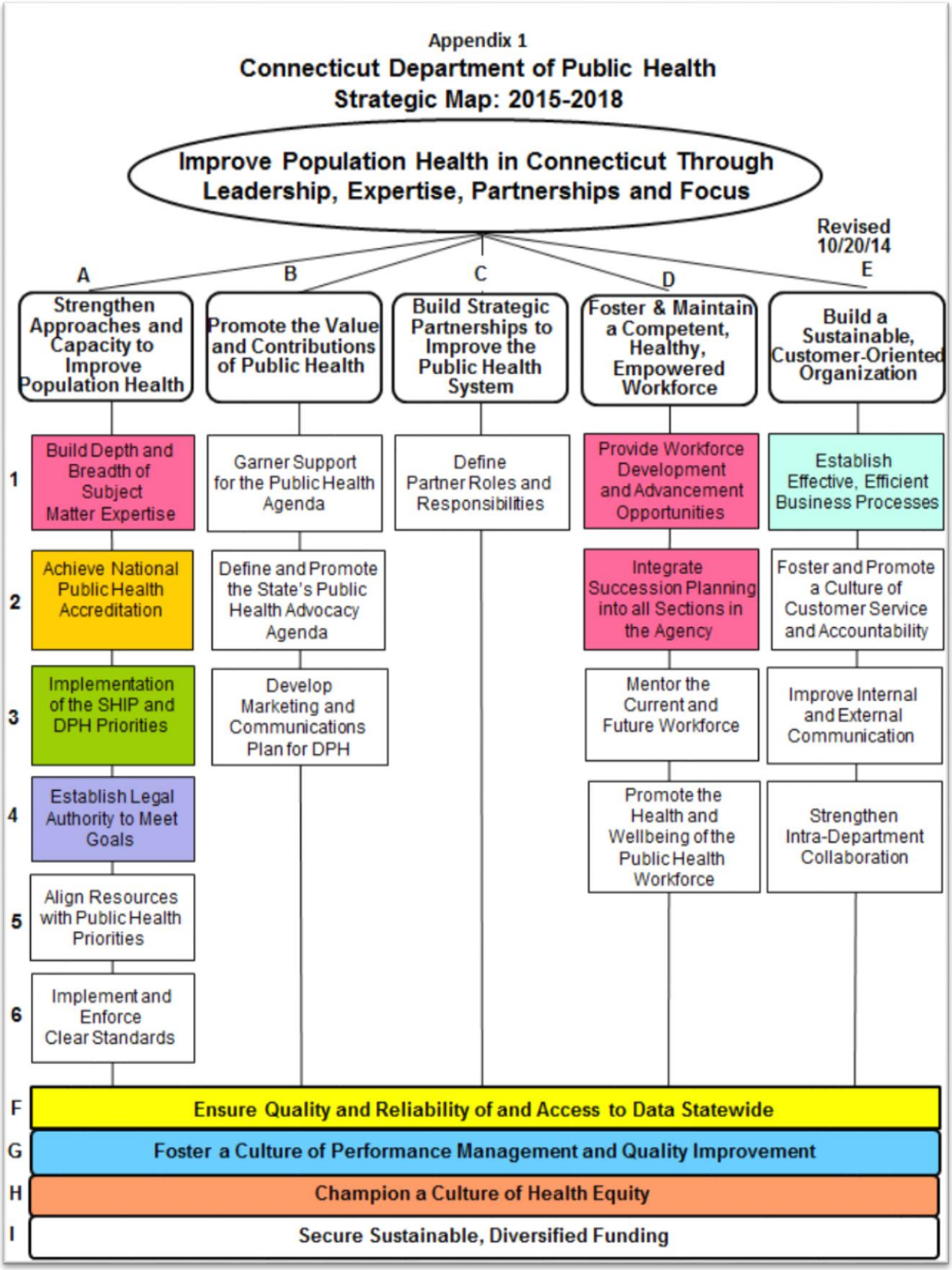
The PHSI tracks all quality improvement projects on a spreadsheet that includes links to each project's quality improvement tools and projects (See Appendix 7). The key performance indicators for each project are tracked to evaluate success.

Link between Leadership Development and an Enhanced Culture of Quality

While we cannot establish a causal link between the Leadership Development training and a move towards an enhanced culture of quality, we believe that the two are linked. We conducted a cross-walk between those participating in the Leadership Development training and those participating in quality improvement projects, accreditation activities and other cross agency initiatives which lead to an enhanced culture of quality in the agency. To date we have seen tremendous participation of those who completed the Leadership Development training program in these cross-cutting initiatives.

Conclusion

During the past few years, CT DPH has seen tremendous gains in its pursuit to become a performance based organization. The *Quality Plan* serves as a key document to stay the course and continue to monitor progress and implement necessary changes to continually improve agency performance.

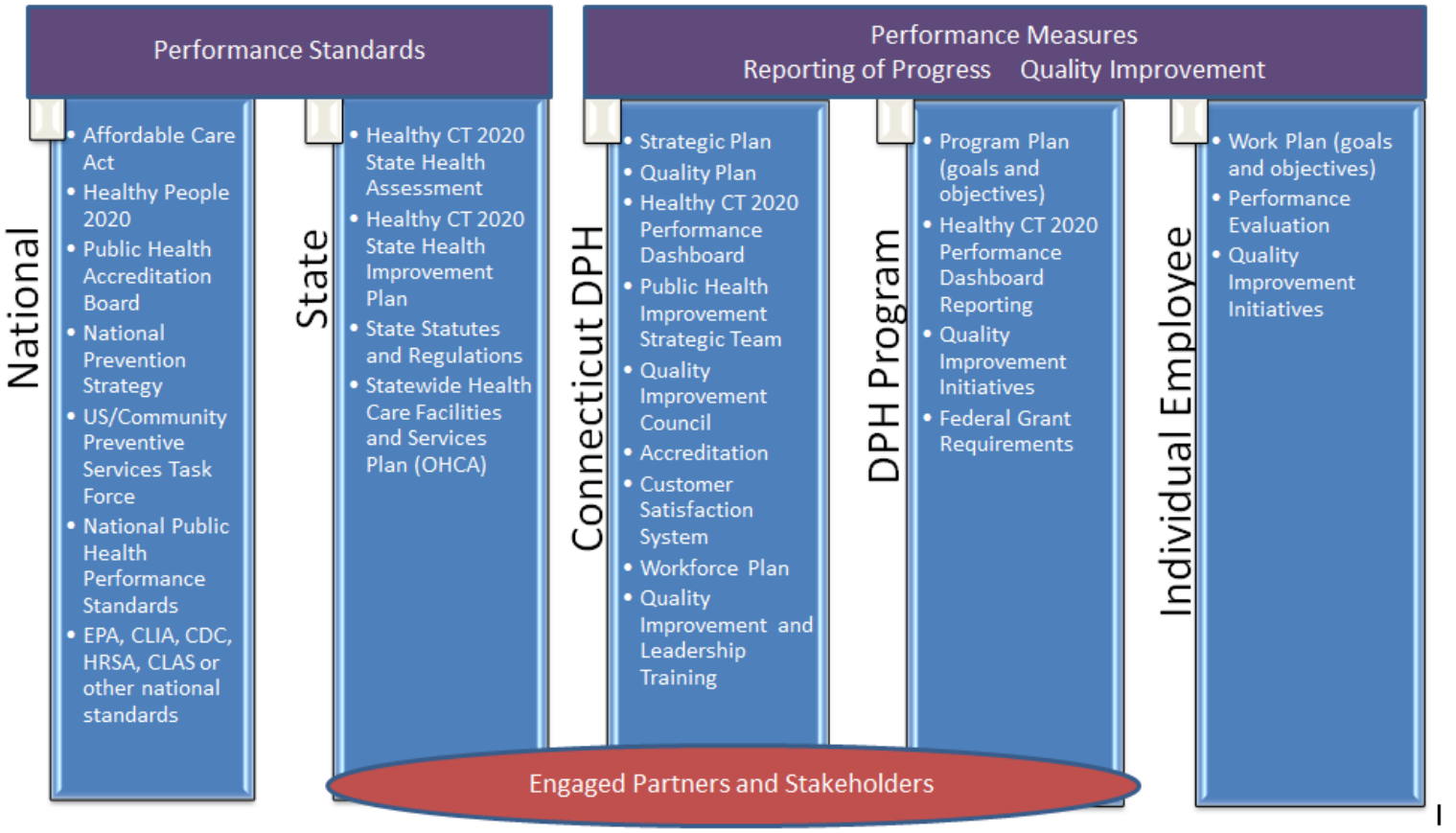

Appendix 1
Connecticut Department of Public Health
Strategic Map: 2015-2018
Improve Population Health in Connecticut Through Leadership, Expertise, Partnerships and Focus
Revised 10/20/14
A
B
C
D
E
Strengthen Approaches and Capacity to Improve Population Health
Promote the Value and Contributions of Public Health
Build Strategic Partnerships to Improve the Public Health System
Foster & Maintain a Competent, Healthy, Empowered Workforce
Build a Sustainable, Customer-Oriented Organization
1
Build Depth and Breadth of Subject Matter Expertise
Garner Support for the Public Health Agenda
Define Partner Roles and Responsibilities
Provide Workforce Development and Advancement Opportunities
Establish Effective, Efficient Business Processes
2
Achieve National Public Health Accreditation
Define and Promote the State's Public Health Advocacy Agenda
Integrate Succession Planning into all Sections in the Agency
Foster and Promote a Culture of Customer Service and Accountability
3
Implementation of the SHIP and DPH Priorities
Develop Marketing and Communications Plan for DPH
Mentor the Current and Future Workforce
Improve Internal and External Communication
4
Establish Legal Authority to Meet Goals
Promote the Health and Wellbeing of the Public Health Workforce
Strengthen Intra-Department Collaboration
5
Align Resources with Public Health Priorities
6
Implement and Enforce Clear Standards
F
Ensure Quality and Reliability of and Access to Data Statewide
G
Foster a Culture of Performance Management and Quality Improvement
H
Champion a Culture of Health Equity
I
Secure Sustainable, Diversified Funding

This graphic is a visual depiction of the CT DPH Performance Management System

Appendix 2

Connecticut Department of Public Health Performance Management System

How it all ties together to achieve excellent performance



Vision: Healthy People in Healthy Connecticut Communities

Organizational Values:

Performance-Based | Equitable | Professional | Collaborative | Accountable | Innovative | Service-Oriented

4-2-15

Appendix 3

Glossary of Terms

Community (State) Health Improvement Plan

A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities, coordinate and target resources. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges and opportunities that exist in the community to improve the health status of that community (Source -Adapted from: United States Department of Health and Human Services, *Healthy People 2010.* Washington, DC; Centers for Disease Control and Prevention, National Public Health Performance Standards Program, www.cdc.gov/nphpsp/FAQ.pdf http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf)

This definition of community health improvement plan also refers to a Tribal, state or territorial community health improvement plan.

Healthy Connecticut 2020 Performance Dashboard: The Performance Dashboard is an online database that displays in a simple visual format, how the residents of Connecticut are faring in health improvement target areas such as heart disease, obesity, obtaining vaccinations, exposure to environmental risks and many more as identified in Healthy Connecticut 2020 State Health Improvement Plan. www.ct.gov/dph/dashboard

Lean- The core idea of Lean is to maximize customer value while minimizing waste. Simply put, Lean means creating more value for customers with fewer resources. A lean organization understands customer value and focuses its key processes to continuously increase it. http://www.lean.org/whatslean/

Performance improvement (or systems performance improvement) is defined as positive changes in capacity, process and outcomes of public health as practiced in government, private and voluntary sector organizations. Performance improvement can occur system-wide as well as with individual organizations that are part of the public health system. It involves strategic changes to address public health system (or organizational) weaknesses and the use of evidence to inform decision making. (Source: http://www.cdc.gov/nphpsp/performanceimprovement.html

Performance management is the practice of actively using performance data to improve the public's health. It involves strategic use of performance measures and standards to establish performance targets and goals. In alignment with the organizational mission, performance management practices can also be used to prioritize and allocate resources; to inform managers about needed adjustments or changes in policy or program directions to meet goals; to frame reports on the success in meeting performance goals; and to improve the quality of public health practice. Performance management includes the following components:

- **Visible Leadership—**senior management commitment to a culture of quality that aligns performance management practices with the organizational mission, regularly takes into account customer feedback, and enables transparency about performance against targets between leadership and staff.

- **Performance Standards—**Establishment of organizational or system performance standards, targets and goals to improve public health practices. (e.g., one epidemiologist on staff per 100,000 people served, 80 percent of all clients who rate health department services as "good" or "excellent"). Standards may be set based on national, state or scientific guidelines, by benchmarking against similar organizations, based on the public's or leaders' expectations (e.g., 100% access, zero disparities), or by other methods.

- **Performance Measurement—**Development, application and use of performance measures to assess achievement of performance standards.

- **Reporting Progress—**Documenting and reporting progress in meeting standards and targets and sharing of such information through appropriate channels.

- **Quality Improvement—**In public health, quality improvement (QI) is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, that focuses on activities that address community needs and population health improvement. QI refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes which achieve equity and improve the health of the community. (Source: http://journals.lww.com/jphmp/Fulltext/2010/01000/Defining_Quality_Improvement_in_Public_Health.3.aspx)

A performance management system is the continuous use of all the components above integrated into an agency's core operations (see inset above, right). Performance management can be carried out on multiple levels, including the program, organization, community and state levels.

Performance measures are quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator (e.g., the number of trained epidemiologists, or the percentage of clients who rate health department services as "good" or "excellent").

Performance targets set specific and measurable goals related to agency or system performance. Where a relevant performance standard is available, the target may be the same as, exceed, or be an intermediate step toward that standard.

Quality Control is the process for meeting goals during operations (choose measures, measure performance, interpret the difference, take action). (Source Juran, JM, The Quality Trilogy: A Universal Approach to Managing for Quality. Presented at the ASCQC 40th Annual Quality Congress in Anaheim, California, May 20, 1986. pages.stern.nyu.edu/~djuran**/**trilogy1.doc)

Quality Planning is the process for preparing to meet quality goals (Identify customers and customer needs, develop services to respond, establish goals, develop process to meet goals, prove processes can meet goals under operating conditions. (Source Juran, JM, The Quality Trilogy: A Universal Approach to Managing for Quality. Presented at the ASCQC 40th Annual Quality Congress in Anaheim, California, May 20, 1986. pages.stern.nyu.edu/~djuran/trilogy1.doc_

Results-Based Accountability ™ - RBA, is a disciplined way of thinking and taking action that communities can use to improve the lives of children, youth, families, adults and the community as a whole. RBA can also be used to improve the performance of their programs, agencies and service systems. Connecticut Department of Public Health (DPH) has adopted the RBA framework for its Healthy Connecticut 2020 Dashboard and as such, the definitions below are adapted for that purpose.

- A **Result**-(outcome or goal) is a population condition of well-being for Connecticut children, adults, families and communities, stated in plain language.

- **Population Indicator** – (or benchmark) is a measure that helps quantify the achievement of a result. (e.g., prevalence of lead poisoning in children under 6 years of age). It identifies the health status of Connecticut residents for which DPH, other state and local agencies and community partners all share responsibility.
- **A Performance Measure -** (e.g., percent of children less than 3 years of age tested for lead) is a measure of how well a program, agency or service system is working. They tell us whether DPH interventions that affect population indicators (e.g., prevalence of lead poisoning in children), are achieving objectives, and if our agency's actions are helping to improve health.
- **Strategies** –are a coherent collection of actions that have a reasonable chance of improving results. In the dashboard they are those that DPH and its partners are using to improve health to meet targets for improvement.

(Source: Friedman, M Trying Hard Is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities. Booksurge 1st Edition, 2009

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 the mission, vision, goals and objectives. The plan provides a template for all employees and stakeholders to make decisions that move the organization forward. (Source: http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf

Unless otherwise stated the source of definitions is the Performance Management Self-Assessment Tool June 2013 http://www.phf.org/focusareas/performancemanagement/Pages/Access_the_Performance_Management_Self_Assessment_Tool.aspx

Appendix 4

Connecticut Department of Public Health Quality Improvement Conversation Starter

How to Get Started on a Project

The Public Health Systems Office and the Quality Improvement Council track all existing quality improvement and Lean projects. Please note the process for initiation, approval and monitoring of quality improvement projects in the attached **QI Project Flow Sheet**.

1) **If you want to start a project for your program area and would like some help** from the Performance Improvement Managers and/or the QI Council, please answer the questions below and send this page to Joan Ascheim at joan.ascheim@ct.gov.
   a. What is the issue or area you would like to see improved?
   b. Are you willing to take a lead role on the project? Please provide your name and/or any possible team member's names.

2) **If you have experience in implementing a quality improvement or Lean project** in your program area and are starting or have started a new one – complete a **QI Team Charter**, obtain approval from your supervisor/manager and send it to the Performance Improvement Manager, Joan Ascheim – joan.ascheim@ct.gov

3) **If you want to start a project that crosses programs, agencies, or is of strategic importance** it must be approved by the Public Health Strategic Team using the **DPH Quality Improvement Submission Form.**

Tips for Selecting a Project for Quality Improvement

- You can identify gaps between desired and actual performance (use data when available such as client surveys, health assessment data, audit findings)
- You have received feedback from clients or staff on needed changes
- The area in need of improvement is clearly defined
- The desired change is small scale and results can be seen in 3-6 months
- The Wow factor – something desperately needs improvement
- There are many steps to a process and some could probably be eliminated

Factors Needed to Ensure Success for a Quality Improvement Project

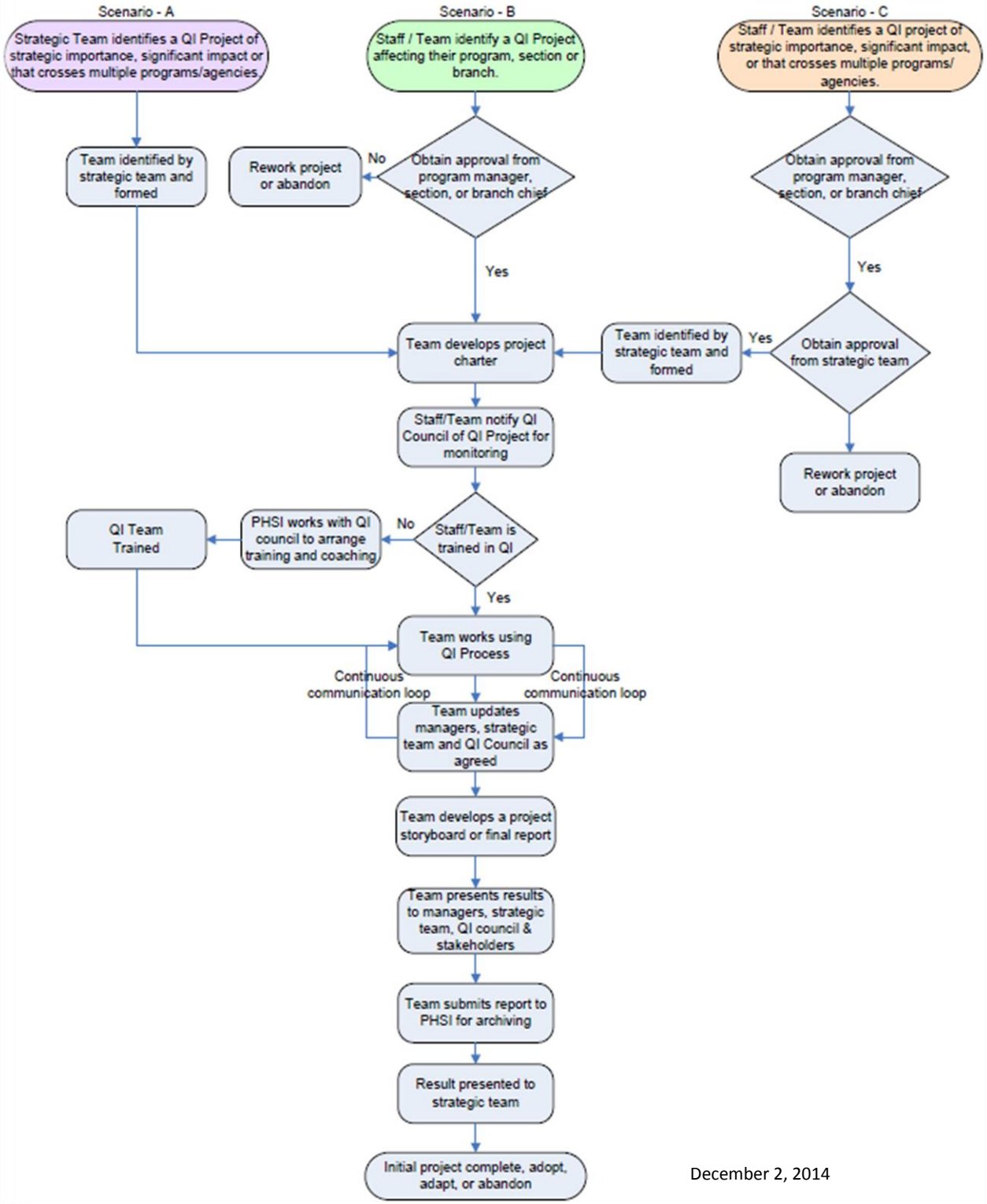
- There is low resistance from staff
- There is high support from managers/leaders
- You can measure the change
- There are other people willing to be team members
  There is a willing team leader

March 2015

Appendix 5

Connecticut Department of Public Health

How QI Projects are Initiated, Approved and Move Through the Process – Three Scenarios



December 2, 2014

Appendix 6

Annual Goals, Objectives and Measures

The agency quality and performance related goals and annual work plan for **2015** follow.

Goals

The goals for performance management for CT DPH come directly from the organizational Strategic Plan priorities. They are:

- *Foster a Culture of Performance Management and Quality Improvement*. (Cross-cutting Objective G from the Strategic Plan)
- *Strengthen Approaches and Capacity to Improve Population Health* (Strategic Priority A from the Strategic Plan)
- *Build a Sustainable, Customer- Oriented Organization* (Strategic Priority E from the Strategic Plan)

Objectives and Measures 2015

Objective 1 – Implement relevant and essential activities to achieve accreditation (Aligned Strategic Plan Objective A-2 Achieve National Public Health Accreditation)		
Measures /Activities	**Person(s) Responsible**	**Time Frames**
1.1 25% of PHAB documentation collected	Public Health Systems Improvement staff , Domain Teams	February 2015
1.2 State of Intent Submitted to PHAB	Public Health Systems Improvement staff	March 2015
1.3 50% of PHAB documentation collected	Public Health Systems Improvement staff, Domain Teams	May 2015
1.4 75% of PHAB documentation collected	Public Health Systems Improvement staff, Domain Teams	August 2015

1.5 Submit application to PHAB	Public Health Systems Improvement staff	September 2015
1.6 100% of PHAB documentation collected	Public Health Systems Improvement staff, Domain Teams	November 2015
Objective 2 - Identify gaps in meeting and/or conformity with PHAB and organize the agency workforce and documentation for accreditation and engage in quality improvement to address a deficiency in meeting a PHAB standard or measure. (Aligned Strategic Plan Objective A-2 Achieve National Public Health Accreditation)		
2.1 Develop a list of gaps in documentation following review by ASTHO consultant of the first 25% of documentation	Public Health Systems Improvement staff, Student intern	March 2015
2.2 Develop a list of gaps in documentation following review by ASTHO consultant of the first 50% of documentation	Public Health Systems Improvement staff, Student intern	June 2015
2.3 Develop a list of gaps in documentation following review by ASTHO consultant of the first 75% of documentation	Public Health Systems Improvement staff, Student intern	September 2015
2.3 Develop a list of gaps in documentation following review by ASTHO consultant of the first 100% of documentation	Public Health Systems Improvement staff, Student intern	December 2015
2.4 Address gaps and deficiencies identified for the first 75% of documentation	Public Health Systems Improvement staff, Student intern domain teams, appropriate DPH staff	December 2015

Objective 3 Identify and implement two or more performance or quality improvement initiatives (Aligned with Strategic Plan Cross-cutting Objective G Foster a Culture of Performance Management and Quality Improvement)		
3.1 Facilitate a quality improvement process with the food protection program	Public Health Systems Improvement staff Food Protection Quality Improvement Team	January –December 2015
3.2 Project will measure and report on progress towards performance measures • 100% of new food inspector candidates will complete a microbiology class by 1/2016 • 30% of Certified Food Inspectors will complete course by 1/2016 • Risk Factor Frequencies will improve by 10% in 2016 and 20% in 2017	Food Protection Quality Improvement Team Local Food Inspectors	January 2016 and beyond
3.3 Facilitate a quality improvement collaborative with the Asthma Program and providers to improve adherence to evidence based practice	Public Health Systems Improvement staff Asthma Program Community Health Centers School Based Health Centers	March – August 2015
3.4 Project will measure and report on progress towards performance measures	Performance Improvement Manager Asthma Program Community Health Centers School Based Health Centers	August 2015
3.5 Coordinate quality improvement collaborative focused on Healthy Hearts, Obesity and Healthy Aging	Public Health Systems Improvement staff Community Health Institute QI Teams	March –September 2015

3.6 Project will measure and report on progress towards performance measures	Public Health Systems Improvement staff Community Health Institute QI Teams	September 2015
Objective 4. -Implementation of a performance management system centered around the Healthy Connecticut 2020 (Aligned with Strategic Plan Cross-cutting Objective G Foster a Culture of Performance Management and Quality Improvement and Objectives A-3 Implementation of the SHIP and DPH Priorities)		
Measures/Activities	**Person(s) Responsible**	**Time Frames**
4.1 All SHIP related indicators and performance measures and performance measures are in the dashboard	Public Health Systems Improvement staff DPH Programs	March 2015
4.2 DPH staff holding dashboard licenses are trained to input data	Public Health Systems Improvement staff Results Based Leadership Group	March 2015
4.3 DPH dashboard administrators are trained in advance features of the dashboard	Public Health Systems Improvement staff Results Based Leadership Group	March 2015
4.4 Policies and procedures for using the Dashboard as a management tool are in place	Public Health Systems Improvement staff Commissioner's Office, Supervisors and Managers	June 2015
4.5 30% of DPH program indicators and performance measures are in the Dashboard	Public Health Systems Improvement staff License holders DPH Programs	September 2015
4.6 15% of programs are using the Dashboard as a management tool	Public Health Systems Improvement staff Commissioner's Office, Supervisors and Managers	December 2015
4.7 90 % of contracts have performance measures	Managers, Supervisors	December 2015

Objective 5 Provide ongoing performance management, quality improvement and leadership training and resources (Aligned with Strategic Plan Cross-cutting Objective G Foster a Culture of Performance Management and Quality Improvement)		
5.1 25% of all staff will be trained in quality improvement within the last 5years	Public Health Systems Improvement staff	December 2015
• Quality improvement training will be provided through various avenues including; coaching in quality improvement collaborative settings, lean basic training, lean certification, and new quality improvement topics • All training will be tracked using the TRAIN learning management system.	Public Health Systems Improvement staff, Student intern Contracted trainers	January – December 2015
5.1 10% of staff will be trained in leadership development within the last 5 years	Public Health Systems Improvement staff, Student intern Contracted trainers	January – December 2015
5.2 Develop a performance management tutorial for all staff available via TRAIN	Public Health Systems Improvement staff Communications	September 2015
5.3 Develop links to on-line quality improvement training and monitor staff participation through TRAIN	Public Health Systems Improvement staff Communications	September 2015
5.4 Quality Plan is updated	Public Health Systems Improvement staff	February 2015
5.6 Quality Improvement tool kit is available on intranet	Public Health Systems Improvement staff	March 2015

Objective 6 Implement a Customer Service System –(Aligned with Strategic Plan Objective E-2 Foster and Promote a Culture of Customers Service and Accountability)		
6.1 Policy and procedures drafted for customer services system	Public Health Systems Improvement staff QI Council Public Health Strategic Team	May 2015
6.2 Plan to implement customer services system completed	Public Health Systems Improvement staff QI Council Public Health Strategic Team	July 2015
6.3 Plan adopted and implementation begun	Public Health Systems Improvement staff Commissioners Branch and Section Chiefs	September 2015
6.4 Training for DPH staff on customers services system and delivery practices	Public Health Systems Improvement staff QI Council Public Health Strategic Team	October 2015

September 2014

Appendix 7
Quality Improvement Project Inventory
CT Department of Public Health

Last revised: 04/2/2015				
Name of Project	**Brief Description**	**Performance Measures (or KPIs)**	**Efficiencies & Effectiveness**	**Comments/ Results**
Drinking Water Assessments by DW Section Employees	Conducting a Lean project with the Public Health Systems Improvement Unit to decrease the time needed to assess/survey a public water system and decrease the time needed to report significant deficiencies/violations to affected public water systems	1. Reduce the number of days from the completion of the sanitary survey in the field and the date the report is issued – from 60 to 30 days (Target Date – 12/31/2014) (Tracking Quarterly).	Time saved	Reduced # of days from conducting a survey to issuing a report from 59-31 days. Reduced # of steps of the sanitary survey process from 86-68 (as of 12/2014)
		2. Reduce the number of steps in preparing for a sanitary survey – from 14 to 9 steps (Target Date – 7/1/2014).	Reduced number of steps	
		3. Reduce the number of steps in the total sanitary survey process – from 86 to 68 steps (Target Date – 12/31/2014)	Reduced number of steps	
Certificate of Need program in OHCA	Made changes -October - November 2011; conducted Lean (Kaizen) process in May 2013 to reduce the time required to draft CON decisions while at the same time improve their overall quality.	1. Number of days to submit draft CON decision to OHCA Director.	Time saved	Number of days to render a decisionis 29 days on average ahead of deadline Reduced numbe of edit loops from 4-6 to 2-3.
		2. Number of times draft CON decision is revised.	Reduced number of steps	
			Quality enhancement of services or programs	

Last revised: 04/2/2015					
Name of Project	**Type of QI Model**	**Brief Description**	**Performance Measures (or KPIs)**	**Efficiencies & Effectiveness**	**Comments/ Results**
Improve Contracting Process - Administrative Branch	Lean Kaizen	Administrative branch staff went through a Lean (Kaizen) Event in May 2013 to address contract processing delays.	1. Number of steps needed to develop and execute a contract;	Reduced number of steps	Determined that the contracting process is 4 to 5 hours of work and about 4 to 5 months of wait time. Working towards reducing the wait time. Reduced the number of steps from 92 to 36. Some improvements to be made will be electronic reviewing of documents and obtaining pre-approved templates from the AG's office for contracts that are the same for multiple agencies. The process is being independently evaluated. Project highlighted in October 23, 2013 report from the Governor's Office on Continuous Improvement.
			2. Number of days (or months) of wait time during the contract process.	Time saved	
Improve Accounts Payable Process - Administrative Branch	Lean Kaizen	Administrative branch staff went through a Lean (Kaizen) Event in May 2013 to address lateness in issuing payments to contracted service providers	1. Number of days to issue payments	Time saved	Able to save time with the new process: from 10-12 days to 3-4. Also, reduced # of steps in process: from 11 steps to 6. Project highlighted in October 23, 2013 report from the Governor's Office on Continuous Improvement.
			2. Number of steps needed to issue payments	Reduced number of steps	
Physician investigation and adjudication process Lean Event and QI Project	Lean Kaizen	Lean Kaizen event to improve the physician investigation and adjudication process through a Lean quality improvement, week-long process	1. Number of medical consultants to review cases;	Quality enhancement of services or programs; increased reach; organizational design improvements	Proposed improvements: • Hold case management meetings between investigation and legal units to decrease layers of approval • Develop a new streamlined contract for medical consultants • Formally engage Connecticut State Medical Board members and panelists in case analysis

Last revised: 04/2/2015					
Name of Project	**Type of QI Model**	**Brief Description**	**Performance Measures (or KPIs)**	**Efficiencies & Effectiveness**	**Comments/ Results**
			2. Average time required to secure physician consultants;	Time saved; quality enhancement of services; organizational design improvements	3 KPIs are: 1) Increase the pool of medical consultants to review cases from 0 to 30 per year by July 2014; As of 2/3/14: 3 previous Medical Board members, Added 1 new Medical Board member, 3 paid community consultants(2 with contract ready to go) , and 0 volunteers, Total of 7 consultants currently. In April 2012 27% of cases reviewed by a consultant. In April 2014 , 2% reviewed. 2) Decrease the average time required to secure physician consultants from 18 months to: o 6 months by June 2014 o 3 months by June 2015; Results pending 3) Decrease the average time to complete an investigation from intake to dismissal from 260 days to 129 days by July 2014; As of 1/7/14: 5 more cases dismissed since new MB reviewer on board (average of 282 days). In May 2014 the average was 413 days. The increase was due to cases pending in OLRC. 4) Decrease the average time to complete an investigation from intake and referral to legal office from 667 days to 386 days average by July 2014. By May 2014 the average was 242 days.
			3. Average time to complete an investigation from intake to dismissal		
			4. Average time to complete an investigation from intake and referral to legal off	Time saved; quality enhancement of services; organizational design improvements	

Last revised: 04/2/2015					
Name of Project	**Type of QI Model**	**Brief Description**	**Performance Measures (or KPIs)**	**Efficiencies & Effectiveness**	**Comments/ Results**
Establish submission schedule for abstracts and path reports from hospitals utilizing new case finding and auditing reports.	Lean Kaizen	Lean Kaizen event (1 week long) to improve the submission of tumor cases abstracts and path reports.	Hospitals adhere to submission schedule	Time saved Costs saved Increased reach Quality enhancement of data systems	Connecticut Tumor Registry worked with IT to improve hospital case submissions in November 2013. Data sources are the hospital registries; current submission rate varies depending on the facility. The goal is 100% submission rate.
Drinking Water State Revolving Fund Loan Process Improvement	Lean Kaizen	Lean Kaizen event (1 week long) to improve the process of providing low-interest loans to eligible public water systems in need of infrastructure improvements.	1. The number of days it takes from loan application to loan execution (currently 344 days average)	Time saved	Team report out on 1/10/2014.
			2. The number of steps in the process (currently 140 steps).	Reduced number of steps	
Certified Food Inspectors Training	PDCA	Improve competency of certified Food Inspectors (CFI) by requiring and providing access to a basic microbiology training course that relates to foodborne illness and disease	% of CFI candidates that complete the FDA online Micro course by January 2016	Quality enhancement of services or programs	No results to date. New initiative.
			% of CFI's who complete the FDA micro course by January 2016	Quality enhancement of services or programs	
			% improvement in Risk Factor Frequencies in 2016 and 2017		
Note: Formal QI: 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. (R. Bialek, L. M. Beitsch, A. Cofsky, et al, Journal of Public Health Management and Practice, 2010)					

: Q-Tips: Highlight on the Physician Investigation and Adjudication Process - Message (HTML)

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You replied to this message on 12/27/2013 1:45 PM.

From: DPH.Q.Tips

Sent: Thu 12/19/2013 11:48 AM

To: DPH-DL AllUsersList

Cc:

Subject: : Q-Tips: Highlight on the Physician Investigation and Adjudication Process

The DPH Physician Investigation Unit (PIU) and Office of Licensure, Regulation, and Compliance(OLRC) set out to improve the physician investigation and adjudication process through a Lean quality improvement, week-long process. This is the process employed when a complaint is filed against a physician. The team must determine if there is sufficient evidence to move the complaint forward. If so, a lengthy and complex process follows to gather all the necessary information so that an informed decision can be made regarding the case. Team members included: Diane Cybulski (Team Leader PIU), David Tilles (OLRC), Linda Fazzina (OLRC), Rosemarie Deschenes (PIU), Marcus Campbell (PIU) and Jolanta Gawinski (PIU).

Q: What did you set out to improve?

A: The team looked to improve the time it takes to process Medical Board petitions (complaints about physicians) through the investigation and legal process, as the current process is lengthy.

Q: What are some of the performance measures you set as a result of the process?

A: Three key performance measures were to :

- Increase the pool of medical consultants to review cases from 0 to 30 per year by July 2014
- Decrease the average time required to secure physician consultants from 18 months to:
  - 6 months by June 2014
  - 3 months by June 2015
- Decrease the average time to complete an investigation from intake to dismissal from 260 days to 129 days by July 2014

Q: What are some of the improvements you will make to reach your targets?

A: Improvements range from very small to major IT changes. A few include:

- Hold case management meetings between investigation and legal units to decrease layers of approval
- Develop a new streamlined contract for medical consultants
- Formally engage Connecticut State Medical Board members and panelists in case analysis

Tell us your quality or quality improvement story! We want to share your great work with all of DPH!

If you have questions or would like further information about quality improvement or quality planning, please contact Joan Ascheim at ext. 7626 or Susan Logan at ext. 7248.

Q-Tips

DPH.Q.Tips

DPH Q-Tip:Spotlight on the Office of Health Care Access' Quality Improvement Project - Message (HTML)

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Delete | Respond | Quick Steps | Move | Tags | Editing | Zoom | New Gro...

From: Logan, Susan on behalf of DPH.Q.Tips
Sent: Thu 12/5/2013 10:28 AM
To: DPH-DL AllUsersList
Cc:
Bcc: Logan, Susan
Subject: DPH Q-Tip:Spotlight on the Office of Health Care Access' Quality Improvement Project

Message | OHCA Fund_Revised_version 1.pdf (29 KB)

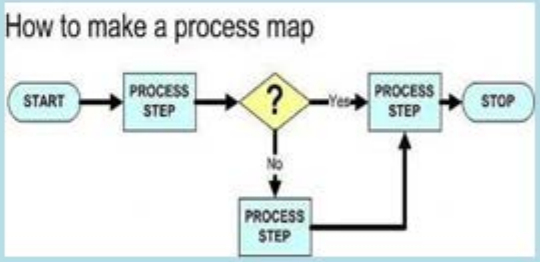
Q-tips is showcasing quality improvement (QI) projects happening throughout DPH. This week we bring you a QI project conducted by the Office of Health Care Access (OHCA) to improve the efficiency and effectiveness in which the OHCA Funding process works. Carmen Cotto (OHCA), the project team leader, and Tillman Foster (OHCA) worked to find ways to streamline and automate an existing process that was outdated, lengthy and cumbersome. They recruited assistance from Ron Ciesones (OHCA) for his expertise in flowchart design, and from Srinivasa Chalikonda (IT) and Danielle Pare (CORE) to work towards implementing the project's goals.

Q: What prompted this quality improvement (QI) project?

A: The OHCA Funding process was in need of an overhaul. This is a work process where 29 Connecticut hospitals submit payments to OHCA based on quarterly assessments. Carmen, the team leader, and the team saw CORE and the Hospital Reporting System as untapped resources to speed up the process of inputting data, creating spreadsheets and invoices, and handling late fees based on the assessments.

Q: How did the team use QI to be more efficient?

A: This was a good opportunity to try out QI methods and see if the process could be streamlined. Carmen originally thought of the concept of a business plan, but then she started looking through QI reference books for ideas about how to proceed. She chose the Plan, Do, Check, Act QI cycle as a structure for the project because the steps of each phase of the cycle were logical and made sense to her.



Q: What QI tools did the team use?

A: The primary tool that the team members used was a map (aka flowchart) of the process. They created an extensive process map that helped them see all steps in the process and where there was waste and opportunities for improvement. The other thing they did was a cost-benefit analysis of the full project. They estimate that with the new steps in place, they will be able to save 95.5 hours of production time annually.

If you have questions or would like further information about quality improvement or quality planning, please contact Joan Ascheim at ext. 7626 or Susan Logan at ext. 7248.

Q-Tips

DPH: Striving for excellence daily in everything we do

DPH.Q.Tips

This is the cover of the Quality Plan from January 2014 to show the date and authenticity. The annual work plan is excerpted to show how the goals and objectives for the Quality Plan are tracked and monitored for accomplishments. Please see report pages 24-29 for the work plan with the status of the objectives.

Connecticut Department of Public Health
Quality Plan

Striving for Excellence Daily in Everything We Do

January 2014

Contents

Appendices

This report was supported by the Cooperative Agreement 5U58CD001324-04 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

This is the annual work plan for 2013-2014. It is updated each year as an addendum to the Quality Plan. The highlighted text in the timeframe column shows the status of the objectives, measures and activities.

Appendix 5

Annual Goals, Objectives and Measures

The agency performance related goals and annual work plan for 2013-2014 follow.

Goals

The goals for performance management for DPH come directly from the organizational Strategic Plan priorities. They are:

- *Foster a Culture of Performance Management and Quality Improvement*.
- *Ensure Programmatic Excellence*
- *Build a Sustainable, Customer- Oriented Organization*

Objectives and Measures 2013-2014

The objectives and measures are those put forth in the DPH application for the National Public Health Improvement Initiative for Year 4 and will be update annually.

Objective 1 – Implement relevant and essential activities to accelerate accreditation readiness		
Measures /Activities	**Person(s) Responsible**	**Time Frames**
1.1 Complete an updated Year 2 Strategic Plan		February 2014 – Completed October 2014
• Hold an internal planning session to review year one accomplishments	Public Health Systems Improvement staff	
• Incorporate State Health Improvement Plan priorities into the Strategic Plan	Public Health Strategic Team	
• Delineate roles for DPH staff	Public Health Strategic Team	

1.2 Execute a charter for an external State Health Improvement Plan implementation council and establish the council		February 2014 –Drafted for council approval March 2015
• Establish a state health improvement council • Develop and execute a charter for the State Health Improvement Plan council	Public Health Systems Improvement staff Public Health Strategic Team	Established March 2015 Drafted March 2015
• Utilize a prioritization matrix to select at least 4 priorities to implement from the State Health Improvement Plan • Determine programs responsible for implementation	Public Health Systems Improvement staff Public Health Strategic Team	March 2014 – not completed. Anticipated new completion date of September 2015
Objective 2 – Complete an organizational self-assessment to identify gaps in meeting and/or conformity with PHAB and organize the agency workforce and documentation for accreditation and engage in quality improvement to address a deficiency in meeting a PHAB standard or measure.		
2.1 By September 29, 2014, establish processes for accreditation team development, documentation gathering, review and electronic filing.		Completed – October 2014

• Forms teams and team leaders to gather documentation for domains 5, 9, 11 • Establish electronic filing system for documentation • Pilot system for gathering, reviewing and updating documentation	Public Health Systems Improvement staff	November 2013- September 2014 – Completed November 2014 Completed November 2014 Completed November 2014
2.2 By September 29, 2014, develop a workforce development plan		
• Review needs assessments and reports to date on workforce needs • Utilize ASTHO workforce development template • Develop plan	Public Health Systems Improvement staff Human Resources CT Public Health Training Center	November 2013- September 2014 Not complete. Anticipated completion date September 2015
• Review customer satisfaction systems utilized around the country • Develop a DPH wide system with regular and routine methods for collection, analysis and review to improve services	Public Health Systems Improvement staff Student intern	January 2014 – September 2014 – Completed September 2014 Not complete – Anticipated completion date December 2015
Objective 3 Identify and implement two or more performance or quality improvement initiatives (drinking water surveys and certificate of need decisions)		

3.2 Number of steps to complete a report of an assessment of a public water system and to issue a report		
• Conduct a Lean process to develop an improved process to issue drinking water systems survey reports	Performance Improvement Manager Drinking Water Quality Improvement Team	September 2013 – March 2014 Completed May 2014
3.3 Completion time of a draft decision for certificate of need (CON)submitted to director		In process
3.4 Revision/edit loops of completeness letters and decisions for certificate of need		In process
3.5 Improved quality of utilization study, financial analysis, completeness letters and decisions for certificate of need		In process
• Develop, implement, and evaluate a checklist for CON process • Create, implement, and evaluate templates to standardize decisions • Create, implement and evaluate a desktop guide to standardized data quality in the CON database • Update, implement, and evaluate CON forms	Office of Health Care Access staff	November 2013 Completed January 2014 – created – still testing August 2013 – Done December 2013

Objective 4. Continue performance management activities -Implementation of a performance management IT system and performance management and quality improvement training.		
Measures/Activities	**Person(s) Responsible**	**Time Frames**
4.1 By September 29, 2014 the Performance Management IT system will go live for staff and the public		Completed September 2014
• After state health improvement priorities are set , population and program measures will be entered into the Performance Management IT system and launched on the DPH website	Epidemiologist Performance Improvement Manager	September 2013 to September 2014 In process
4.2 By September 29, 2014 100% of programs entering performance measures on the IT system will be trained in performance management		
• Performance management training will be provided to programs in small groups to assist them to identify standards and measures to populate the Performance Management IT system.	Epidemiologist Performance Improvement Manager	November 2013 to September 2014 Completed January 2015
4.3 By September 29, 2014 25% of all staff will be trained in quality improvement		
• Quality improvement training will be provided through various avenues including;	Epidemiologist	September 2013 to September 2014

coaching in quality improvement collaboratives, lean basic training, lean certification, and new quality improvement topics • All training will be tracked using the TRAIN learning management system.	Performance Improvement Manager Contracted trainers	Goal met Not all training is on TRAIN but is being entered with estimated completion date of June 2015
4.4 By September 29, 2014 10% of staff will be trained in leadership development		
• Leadership development training will be provided to supervisors and managers to empower them to be agents of change to enhance the DPH culture of quality	Performance Improvement Manager Leadership Greater Hartford	September 2013 to September 2014 Goal met