



# Connecticut Department of Public Health Quality Plan

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*Striving for Excellence Daily in Everything We Do*

May 2015



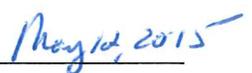
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Approved Commissioner Jewel Mullen MD, MPH, MPA

Date

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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 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

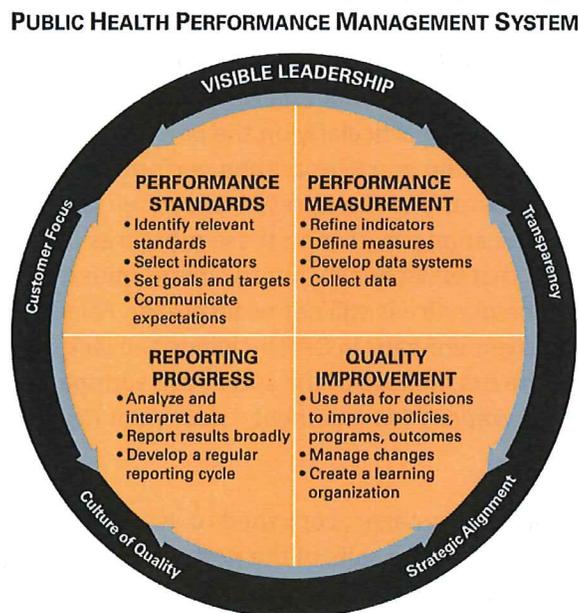
meeting the standards and measures in Domain 9 of the PHAB standards. Further, CT DPH sees the entire accreditation process as one that identifies opportunities for improvement across all the essential public health services

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.<sup>1</sup> 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**

<sup>1</sup> 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.<sup>2</sup> 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.

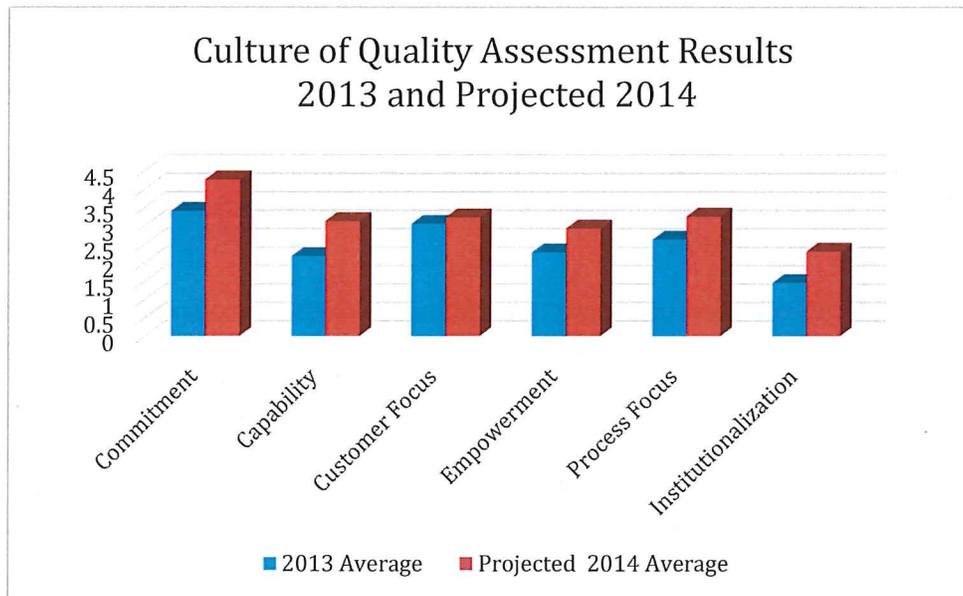
In February 2013, DPH leadership and managers convened to assess the DPH culture of quality. To inform this assessment, they reviewed the results of the performance management assessment. Participants then rated DPH to be on Exit 4 (of 6) on the *Roadmap to an Organizational Culture of Quality Improvement*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

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

<sup>3</sup> *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 standards*; 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](http://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<sup>™</sup> 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<sup>™</sup>, 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.<sup>4</sup>

Additionally, since CT DPH employs quality assurance and quality control practices throughout the laboratory, the tumor registry 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.<sup>5</sup> 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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<sup>4</sup> [http://journals.lww.com/jphmp/Fulltext/2010/01000/Defining\\_Quality\\_Improvement\\_in\\_Public\\_Health.3.aspx](http://journals.lww.com/jphmp/Fulltext/2010/01000/Defining_Quality_Improvement_in_Public_Health.3.aspx)

<sup>5</sup> <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
- 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\*](#).<sup>TM</sup> 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 Participants Per Training Type
Accreditation	48
Leadership	169
Lean	90
Quality Improvement/Performance Management	316
Results Based Accountability™	68
<b>Total Participation</b>	<b>691</b>

## 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 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.

## Customer/Staff Feedback

In addition to evaluating all quality improvement related training, PHSI seeks continuous feedback from staff informally. PHSI staff frequently attend staff meetings throughout DPH to assist them in understanding the performance management system, the SHIP, the strategic plan accreditation and the Performance Dashboard. Feedback is sought to determine how best to engage staff in these cross-cutting initiatives.

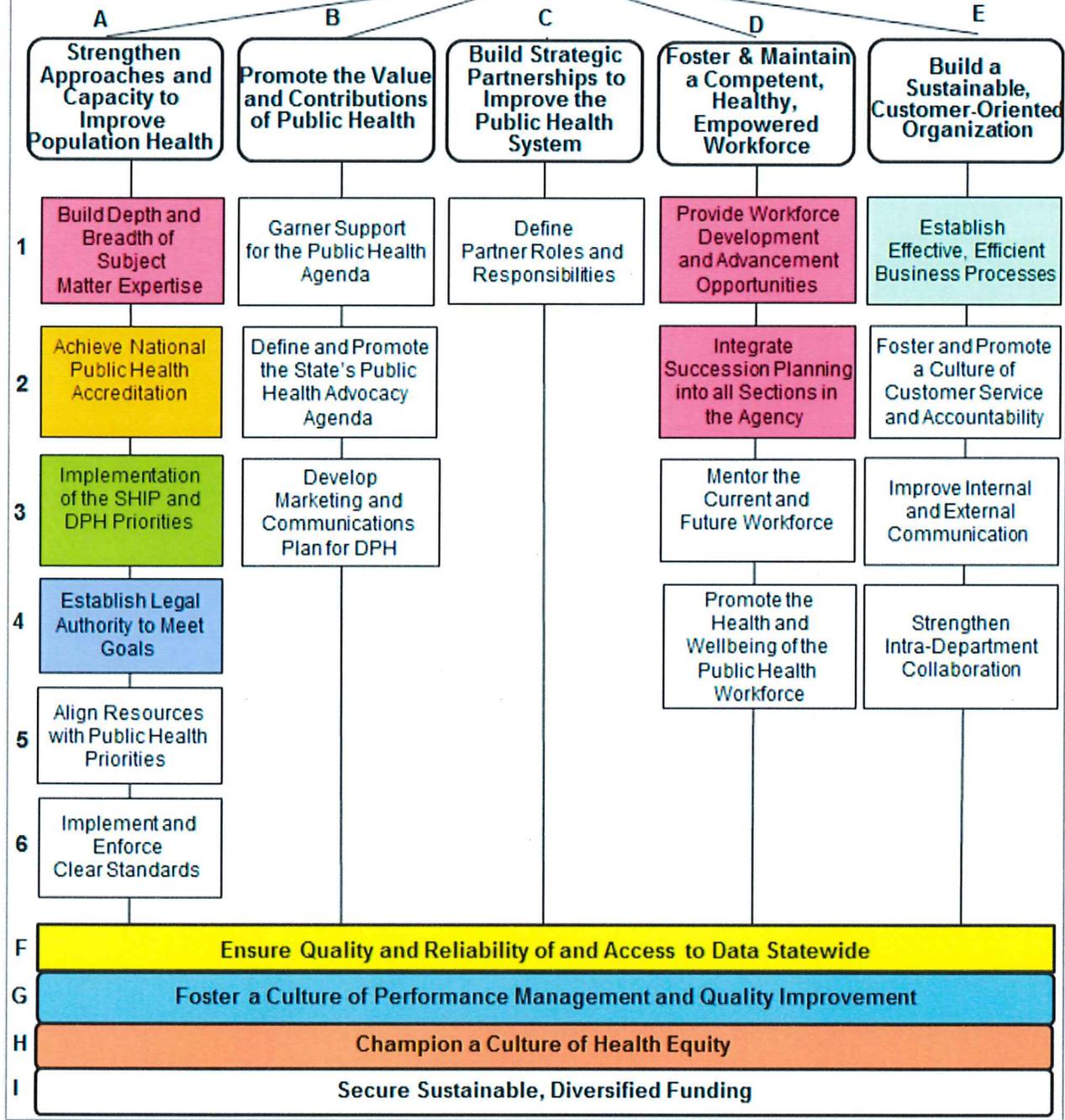
## Conclusion

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**

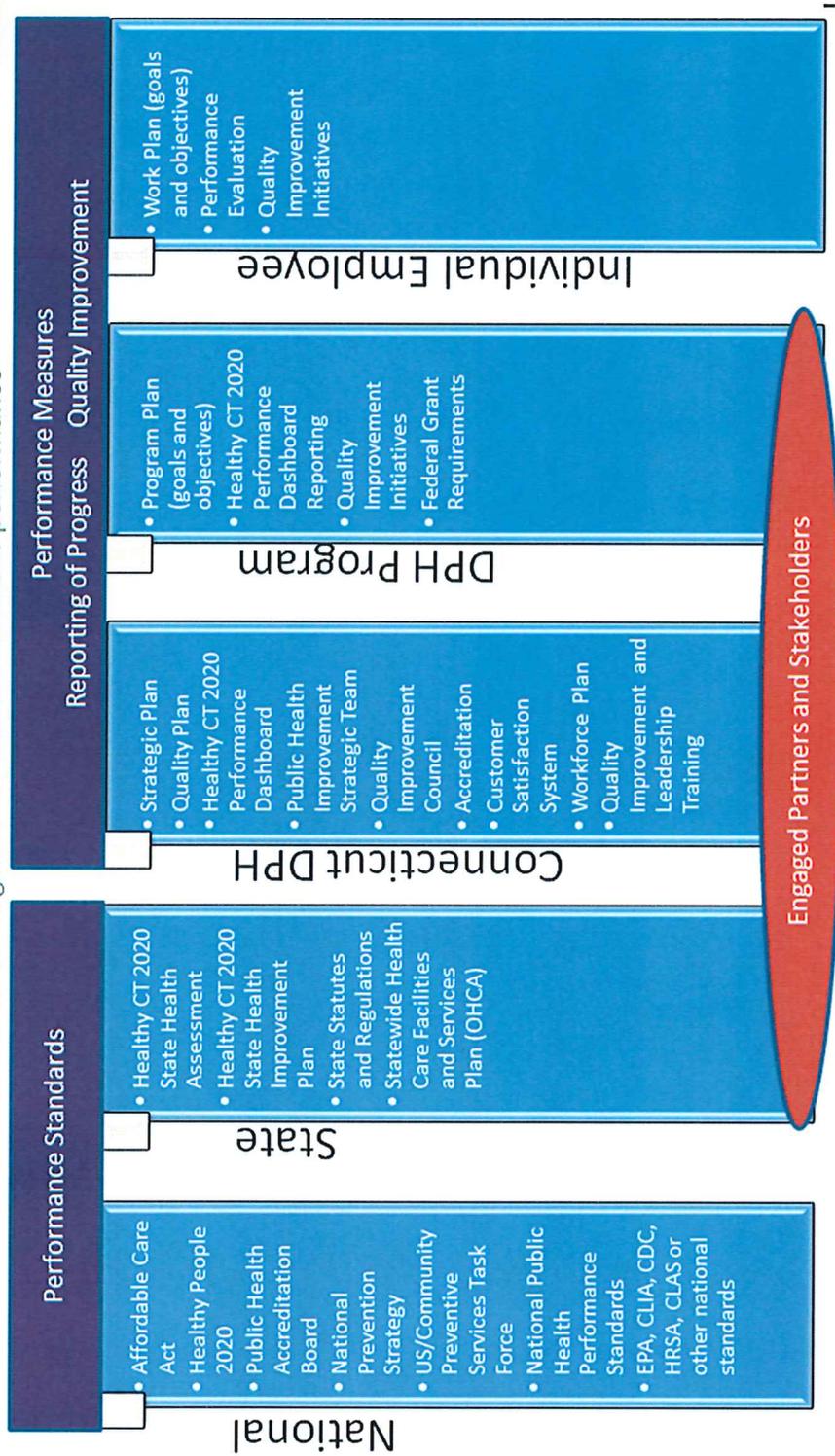
Revised  
10/20/14





# 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



## 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.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](http://www.ct.gov/dph/dashboard). [www.ct.gov/dph/dashboard](http://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](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 40<sup>th</sup> Annual Quality Congress in Anaheim, California, May 20, 1986. [pages.stern.nyu.edu/~djjuran/trilogy1.doc](http://pages.stern.nyu.edu/~djjuran/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 40<sup>th</sup> Annual Quality Congress in Anaheim, California, May 20, 1986. [pages.stern.nyu.edu/~djjuran/trilogy1.doc](http://pages.stern.nyu.edu/~djjuran/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 1<sup>st</sup> 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](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](mailto: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](mailto: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

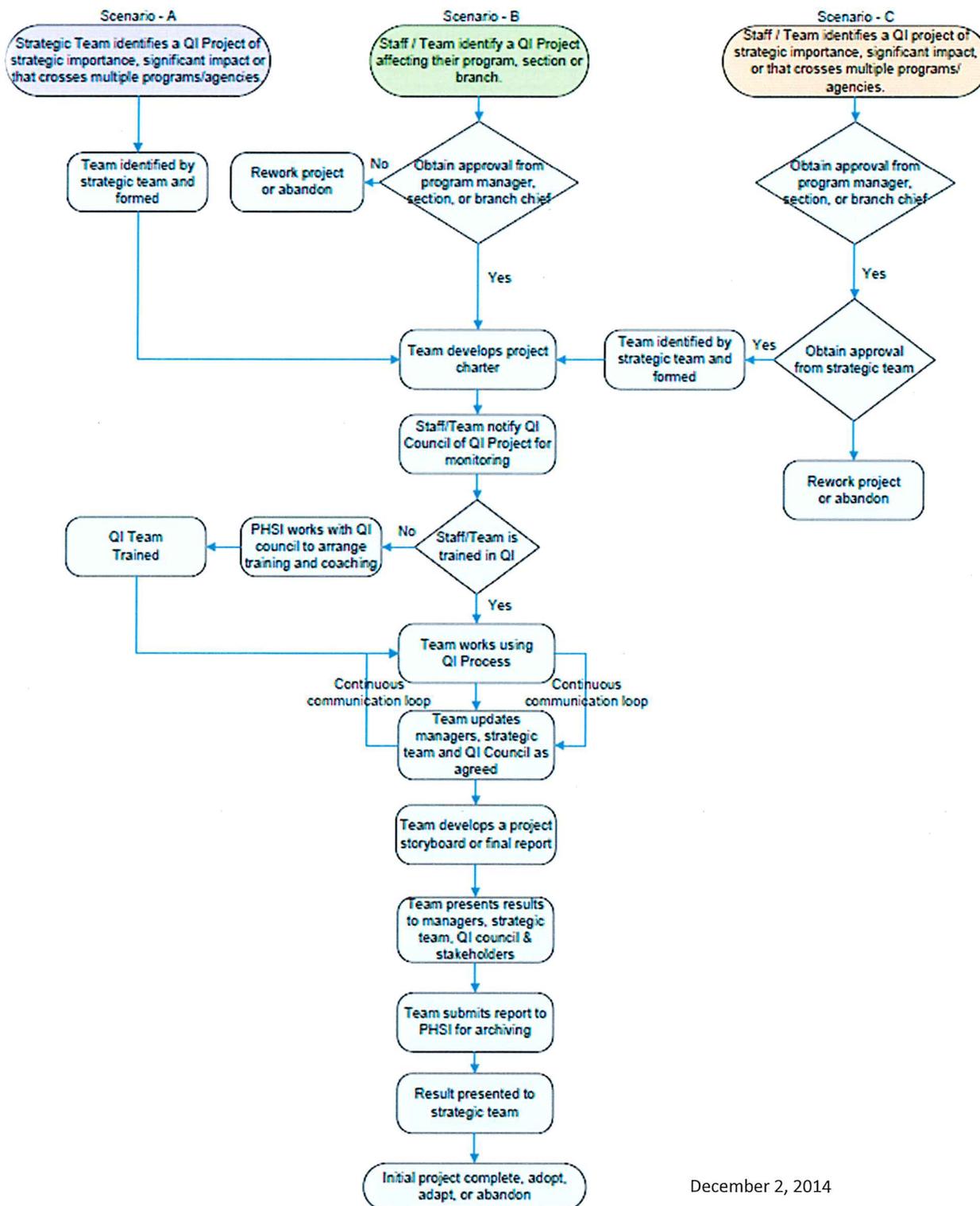
March 2015



## 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
<b>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)</b>		
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 <ul style="list-style-type: none"> <li>• 100% of new food inspector candidates will complete a microbiology class by 1/2016</li> <li>• 30% of Certified Food Inspectors will complete course by 1/2016</li> <li>• Risk Factor Frequencies will improve by 10% in 2016 and 20% in 2017</li> </ul>	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
<b>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)</b>		
<b>Measures/Activities</b>	<b>Person(s) Responsible</b>	<b>Time Frames</b>
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
<ul style="list-style-type: none"> <li>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</li> <li>All training will be tracked using the TRAIN learning management system.</li> </ul>	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	Performance Measures Efficiencies & Effectiveness			Comments/ Results
Name of Project	Brief Description	(or KPIs)	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	<ol style="list-style-type: none"> <li>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).</li> <li>2. Reduce the number of steps in preparing for a sanitary survey – from 14 to 9 steps (Target Date – 7/1/2014).</li> <li>3. Reduce the number of steps in the total sanitary survey process – from 86 to 68 steps (Target Date – 12/31/2014)</li> </ol>	<p>Time saved</p> <p>Reduced number of steps</p> <p>Reduced number of steps</p> <p>Reduced number of steps</p> <p>Quality enhancement of services or programs</p>	<p>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)</p> <p>Number of days to render a decision is 29 days on average ahead of deadline</p> <p>Reduced number of edit loops from 4-6 to 2-3.</p>
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.	<ol style="list-style-type: none"> <li>1. Number of days to submit draft CON decision to OHCA Director.</li> <li>2. Number of times draft CON decision is revised.</li> </ol>	<p>Time saved</p> <p>Reduced number of steps</p> <p>Quality enhancement of services or programs</p>	<p>Number of days to render a decision is 29 days on average ahead of deadline</p> <p>Reduced number of edit loops from 4-6 to 2-3.</p>

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.	<ol style="list-style-type: none"> <li>1. Number of steps needed to develop and execute a contract;</li> <li>2. Number of days (or months) of wait time during the contract process.</li> </ol>	<p>Reduced number of steps</p> <p>Time saved</p>	<p>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.</p>
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	<ol style="list-style-type: none"> <li>1. Number of days to issue payments</li> <li>2. Number of steps needed to issue payments</li> </ol>	<p>Time saved</p> <p>Reduced number of steps</p>	<p>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.</p>
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;	<p>Quality enhancement of services or programs;</p> <p>increased reach;</p> <p>organizational design improvements</p>	<p>Proposed improvements:</p> <ul style="list-style-type: none"> <li>• Hold case management meetings between investigation and legal units to decrease layers of approval</li> <li>• Develop a new streamlined contract for medical consultants</li> <li>• Formally engage Connecticut State Medical Board members and panelists in case analysis</li> </ul>

Name of Project	Type of QI Model	Brief Description	Performance Measures (or KPIs)	Efficiencies & Effectiveness	Comments/ Results
Last revised: 04/2/2015			<p>2. Average time required to secure physician consultants;</p> <p>3. Average time to complete an investigation from intake to dismissal</p> <p>4. Average time to complete an investigation from intake and referral to legal off</p>	<p>Time saved; quality enhancement of services; organizational design improvements</p>	<p>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.</p> <p>2) Decrease the average time required to secure physician consultants from 18 months to: 6 months by June 2014</p> <p>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.</p>

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) 2. The number of steps in the process (currently 140 steps).	Time saved Reduced number of steps	Team report out on 1/10/2014.
	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  % of CFI's who complete the FDA micro course by January 2016  % improvement in Risk Factor Frequencies in 2016 and 2017	Quality enhancement of services or programs  Quality enhancement of services or programs	No results to date. New initiative.



