The Division of Public Health (DPH) Quality Improvement Plan

Overview
DPH is committed to a quality improvement (QI) program as a way to enhance the organization’s performance and achieve desired results. A high-performing, quality improvement driven organization actively adapts the way it does business by:

- Continuously focusing on customer needs;
- Using data to reveal and analyze performance problems and concerns;
- Involving employees who know and are impacted by the improvement opportunity;
- Developing solutions and improvements based on analysis
- Embracing and engaging customers and stakeholders
- Implementing improvements based on data
- Monitoring and evaluating performance; and,
- Continuously making improvements over time.

Quality Improvement in Public Health
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 efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in Public Health. Journal of Public Health Management and Practice. January/February 2010).

This QI plan outlines the structure, roles and responsibilities, and activities to continuously improve performance in DPH. As depicted in figure 1, quality improvement activities in DPH are an integral part of our strategic planning and execution process.
Quality Improvement Activities

DPH identifies opportunities to improve and enhance services and performance through active planning and performance monitoring, which includes actively monitoring customer satisfaction. Quality improvement tools and techniques in a variety of group and team situations enable important data collection, problem analysis, and employee engagement which are keys to improving performance.

DPH uses the well-known “Plan – Do – Check – Act” (PDCA) cycle applied at the organizational level, relates to the strategic planning and strategy implementation process. Through the strategy map process, objectives and strategies are implemented, performance and results are monitored and analyzed via a balanced scorecard system and the organization takes action to reinforce positive outcomes, or explore new opportunities revealed through data analysis.

Quality improvement roles and responsibilities

The Division of Public Health Leadership Team

Division leadership body made up of sections chiefs, division deputies and the division director provide executive oversight for performance management and quality improvement in the Division of Public Health. Sets division goals and priorities, and reviews key performance indicators to monitor quality of performance of public health processes, programs, and interventions. By charter, authorizes a quality improvement council to manage and provide
guidance for quality improvement activities throughout the division. Reviews and approves of division Quality Improvement Plan.

The Division of Public Health Quality Improvement Council (QIC)
Division level body charged with managing and guiding quality improvement activities in the Division of Public Health. Encourages and fosters a supportive quality improvement environment; champions quality improvement activities, tools and techniques; and selects and supports agency quality improvement projects. The QIC develops quality improvement policy, procedures and plans aimed at improving organization performance. The QIC is chaired by a division deputy and is guided by its charter.

The Quality Improvement Facilitator Team
The Quality Improvement (QI) Facilitator Team is a group of volunteers with QI experience who are interested in quality improvement efforts. It is a resource to the QI Council and DPH providing QI experience and assistance facilitating process improvement teams and helping to implement continuous quality improvement processes throughout DPH.

Office of Performance Management
The Office of Performance Management is charged with organizing and supporting the process for implementing a division wide performance management system, workforce development activities, strategic plan, and activities that will lead to accreditation by the Public Health Accreditation Board. Supports and staffs the QIC and provides resources and support for division-wide QI efforts. Works with the QIC to develop quality improvement policies, procedures and plans to improve division performance.

Quality Improvement Council Charter
Mission Statement
The Quality Improvement Council (QIC) is chartered by the DPH Leadership Team to manage and guide division-wide quality improvement activities. The QIC will be a division resource providing guidance on quality improvement matters and will manage and may assign activities to the Quality Improvement Facilitator Team.

Appendix A -- QIC Charter and current QIC Members

Selecting Quality Improvement Projects
Quality improvement projects may be longer term, larger scale strategic efforts or they may be shorter term, smaller scale efforts such as process improvements. Regardless of scale, these projects should be approached with some similarity. There should be planning, data collection and analysis, testing and measuring of performance to ensure the changes will in fact be improvements, then continuous review and improvement over time.

DPH QI Plan updated (062316)
In general, quality improvement efforts should follow “project management” principles to provide structure to the activity. This will ensure clear purpose and scope, commitment of necessary resources, specified timeframes, expected level of effort, management sponsorship and support, clear decision/implementation authority, and anticipated outcomes.

**Agency Level QI projects** – Agency level projects should be approved only after review and consideration by the agency QIC. The QIC may be given final authority for implementation of project recommendations, or approval may be required from the DPH leadership team. Agency QI projects cross section lines, involve multiple offices and programs and address high priority agency initiatives or key services. These projects may be identified through performance indicator reviews or through strategic and operational planning that identifies a need for improvements or new initiatives.

These improvement opportunities will be addressed at the agency level and be afforded the support and resources that a high priority activity deserves. This includes agency level resource support such as facilitation and/or coaching/training from the OPM or QI Facilitator Team.

**Other agency QI projects** – Sections and programs/units are encouraged to initiate their own quality improvement projects. These projects should also follow project management principles and apply common quality improvement tools and techniques to help teams achieve their desired results. Sections, programs/units and sponsors desiring to pursue quality improvement efforts are encouraged to coordinate with OPM for advice and assistance.

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**Appendix B** – Quality Improvement Project Screening Criteria  
**Appendix C** – Quality Improvement Work Plan  
**Appendix D** – Project Charter Application

**Quality Improvement Training**

Various levels of quality improvement training is offered to DPH staff as indicated below:

--Quality Improvement (QI) Basics (in person orientation to principles of QI) 
--Quality Improvement Basics and Methods (online via DETRAIN Learning Management Sys) 
--Advanced Methods/Tools Training for QI Facilitators 
--Continuing training via self-contained QI Modules

**Strategic Priorities**

DPH Strategic Priorities (Promote Healthy Lifestyles; Improve Access to Quality and Safe Healthcare; Achieve Health Equity; and Improve Performance) are outlined in the DPH Strategic Plan. Progress on the Strategic Priority objectives are regularly monitored via performance dashboard reporting and this QI Plan provides a structure, resources, and an avenue to improve substandard performance using proven quality improvement methods. The current DPH Strategic Plan and Strategic Priorities are available by accessing the DPH SharePoint desktop icon, selecting the Performance Improvement Initiative tab and accessing the Shared
Documents folder. The link is:
http://wss.dhss.state.de.us/dph/PII/Shared%20Documents/Forms/AllItems.aspx

**Communicating Quality Improvement Activities**

Quality improvement activities are communicated throughout the organization using periodic e-newsletters (**The Buzz, The Bridge and QI Newsletter**), Quality Improvement Council meeting minutes, and progress reports from process improvement teams and posting of story board summaries.

**Monitoring and Assessing the Quality Improvement (QI) Plan**

The QI Plan will be monitored and updated by the QIC on an ongoing basis and will be assessed by the QIC for improvement opportunities on a yearly basis.

Appendix E – Glossary of Terms

### Updates to the Quality Improvement Policy and Plan

<table>
<thead>
<tr>
<th><strong>May 28, 2014</strong> – Yearly QI Plan review by the Quality Improvement Council</th>
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<tbody>
<tr>
<td><strong>Page</strong></td>
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<td>14</td>
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<td>16</td>
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</tbody>
</table>

| **October 8, 2014** – OPM |

--QIC member updates and QI Project Table updates (page 7 & Appendix C)

| **December 2, 2014** – OPM |

--QIC member updates to page 7.

| **May 26, 2015** – OPM |

--QI Project Table updates (Appendix C)

| **July 23, 2015** – OPM |

--QIC member term update and QI Project Table updates (page 7 & Appendix C)

DPH QI Plan updated (062316)
**September 23, 2015** – Yearly QI Policy and Plan review by the Quality Improvement Council

### QI Plan Updates

<table>
<thead>
<tr>
<th>Page</th>
<th>Update</th>
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<tbody>
<tr>
<td>3</td>
<td>Added, “workforce development activities,” under the Office of Performance Management paragraph.</td>
</tr>
<tr>
<td>4</td>
<td>Added the word, “Facilitator” between the acronym “QI” and word “Team” in last line of the third paragraph.</td>
</tr>
<tr>
<td>5</td>
<td>Added the words, “Policy and” between the words “Improvement” and “Plan” in the “Updates to the Quality Improvement Plan” heading.</td>
</tr>
<tr>
<td>6</td>
<td>Added new table annotating yearly review and subsequent updates to the QI policy and plan.</td>
</tr>
<tr>
<td>8</td>
<td>Deleted Fred MacCormack from and added Martin Luta to the Current QIC Members list in appendix A.</td>
</tr>
<tr>
<td>12</td>
<td>Added a new table titled, “Quality Improvement Project placed on hold or not implemented” to appendix C – The DPH Quality Improvement Work Plan.</td>
</tr>
<tr>
<td>11-14</td>
<td>Updated appendix C – The DPH QI Work Plan.</td>
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</table>

### QI Policy Updates

<table>
<thead>
<tr>
<th>Page</th>
<th>Update</th>
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<tbody>
<tr>
<td>7</td>
<td>Section VIII. Added this sentence to first paragraph, “The QIC will accept the adopted QI project storyboard template as the mechanism for QI project team leaders to document and provide ongoing project status updates to the QIC.”</td>
</tr>
<tr>
<td>9</td>
<td>Under the heading Membership, added the word “Facilitator” between the words “Improvement” and “Team” on the third line of the paragraph.</td>
</tr>
<tr>
<td>9</td>
<td>Under the heading Membership, added the words “front line” between the words “three” and “members” on the fourth line of the paragraph.</td>
</tr>
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</table>

**June 23, 2016** – OPM

-- QI Project Table updates (Appendix C)
Appendix A

Division of Public Health (DPH)
Quality Improvement Council Charter

In order to institutionalize quality improvement practices in DPH, this charter provides the framework and guidance to implement a Quality Improvement Council in DPH.

Mission Statement
The Quality Improvement Council (QIC) is chartered by the DPH Leadership Team to manage and guide division-wide quality improvement activities. The QIC will be a division resource providing guidance on quality improvement matters and will manage and may assign activities to the Quality Improvement Facilitator Team.

Responsibility
The Quality Improvement Council is responsible for:
1. Establishing division policy, procedures and plans for quality improvement processes and projects for the Division of Public Health
2. Selecting and supporting quality improvement projects
3. Monitoring and tracking of division quality improvement projects
4. Promoting and communicating quality improvement activities
5. Identifying “best practices” and sharing/promoting successful efforts
6. Encouraging and fostering a supportive quality improvement environment and champions quality improvement activities, tools and techniques

Process
1. The QIC reviews proposed projects, returns the project to the submitter for additional information or to manage at a lower level, or adds to the list of division level sponsored quality improvement projects.
2. The QIC approves of division level projects, prioritizes them and informs the leadership team.
3. The QIC will provide project management technical assistance and oversight.
4. Projects prioritized as Level 1 will be tracked by the QIC and will review/report progress, benchmarks, milestones, resource constraints and results at each QIC meeting.
5. Projects ranked as Level 2 or Level 3 will be reported quarterly.

Project Ranking Definition

- **Level 1** projects are **Essential** activities with the division’s highest level of commitment which may require current activities or resources to be adjusted.

- **Level 2** projects are **Important** activities, which are very important but must be considered against other ongoing activities if funds or resources are not sufficient.
• **Level 3** projects are **Beneficial** activities, which are beneficial to division programs, but will only be pursued if they do not infringe upon higher level priorities.

**Membership**
The QIC will be chaired by the DPH Deputy or Associate Deputy Director and permanent members will include the Chief of Administration and the Chief of the Office of Performance Management. Nominated members will include three additional leadership team members (section chiefs); two members of the Quality Improvement Facilitator Team; and, three members of the DPH team. New members will be nominated by the leadership team and invited to participate. Insofar as possible nominated members should include representation from Northern and Southern Health Services.

Nominated members will serve a minimum of two years and be replaced on a staggered time frame for continuity and to develop experience and expertise with this quality improvement function.

Meetings will be held at least every two months and generally last one hour.

*Office of Performance Management staff will provide administrative support to the QIC.***

**Current QIC Members**
Permanent Members:
- Paul Silverman – Associate Deputy Director
- Mark Letavish – Chief of Administration
- Dave Walton – Chief, Office of Performance Management

Nominated Members:
  Leadership Team Members
- Cort Massey – Deputy County Health Administrator, NHS - **Sep 2016**
- Kristin Bennett – Nursing Director, Community Services - **Jun 2016**
- Christina Pleasanton – Deputy Director, PH Laboratory - **Jan 2017**
  DPH Team Members
- April Cleveland – Trainer/Educator, EMS & PHPS - **Sep 2016**
- Shirley Hitchens – Clinic Manager, SHS - **Jan 2017**
- Nate MacCormack – Admin Specialist, Office of the Director - **Jan 2017**
  Quality Improvement Facilitator Team Members
- Martin Luta – Immunization and Disease Prevention - **Sep 2017**
- Lisa Moore – Program Administrator, HP & DP - **Jan 2017**
Appendix B

Quality Improvement Project Screening Criteria

Program or Activity: ____________________________________________________________

Step 1: What are we trying to accomplish? (A brief statement of the aim)

Step 2: How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project)
Long term

Medium term

Short term

Step 3: What changes can we make that will result in an improvement?
How did you identify this opportunity, with what data, from what source(s)? Brief description of the problem with any data currently available

Initial hypotheses and description of data needed to focus the project and the development of an intervention. Are you aware of benchmark data or best practices?

Impact/overlay with other programs and activities

Who are the stakeholders (internal and external) and what are their concerns

Division Implications
1. Is this program/activity essential to implementation of:
   a. Agency Strategic Plan
   b. Public Health Accreditation Board Standard
   c. A Governor’s Directive/Priority or Secretary’s Priority
   d. Division Director’s priority

   Explain the significance of this program/activity to the above:

2. Does this program/activity rank high in terms of risk-reward?*

   DPH QI Plan updated (062316)
A. Risk Impact** ______ B. Probability of Failure ______ Risk Factor (AxB) ______

Comments:
3. Does this program/activity satisfy the SMART criteria?*** ______
Is it:
   • Specific (Can it be defined as a discrete enterprise?)
   • Measurable (Can its performance be measured?)
   • Achievable (Can we do it?)
   • Relevant (Does it make a difference? Do we care?)
   • Time-Bound (Is it achievable with a reasonable amount of time?)

4. Are there any significant reasons why it should be included even though one or more of the above criteria is not met?

5. What is the proposed makeup of the QI Project Team?

6. What resources and supports will be needed to complete the project?

Notes:
*Risk Factor is a product of the importance of the activity and the likelihood of it failing (AxB). For example, if the activity rates a ten on the importance scale (i.e. very important) and it has a 60 percent (0.6) chance of failure, then its risk factor is 6. Once all items have been assigned a risk factor, one can either compare them directly or set criteria, such as all submissions with a risk factor greater than X will be considered.
**Impact factor is based on a 1-10 scale, with 10 signifying greatest impact. It is a function of the following criteria: public perception, compliance with laws and regulations, public health impacts, use of public resources, capacity to respond (preparedness) and customer service.
***All five SMART criteria must be met.
## DPH Agency Level I Quality Improvement Projects for 2015-2016

<table>
<thead>
<tr>
<th>Activity</th>
<th>Project Timeline</th>
<th>Project Lead Facilitator</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Data Request QI Project| Aug 2015—Apr 2016 Dec 2016 | **Leader:** Maridelle Dizon  
**Facilitators:** April Cleveland & Lisa Moore | -Request made by Tabatha Offutt-Powell June 2015 (QI Project Form  
-Approved by QIC July 22  
-First team meeting Oct 2015  
-On June 13, 2016 the QI team has encountered some project delays and has changed the project end date to Dec 2016 |
### Other Agency Level II & III Quality Improvement Projects for 2016-2017

<table>
<thead>
<tr>
<th>Activity</th>
<th>Project Timeline</th>
<th>Project Lead Facilitator</th>
<th>Comments</th>
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</tbody>
</table>

### Quality Improvement Projects Placed on hold or not implemented

<table>
<thead>
<tr>
<th>Activity</th>
<th>Project Timeline</th>
<th>Project Lead Facilitator</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Legislative Proposal QI Project | Aug-Dec 2015 | **Leader:** Jamie Mack  
**Facilitators:** Mike Rudis & Lisa Moore | Aug 8, 2015 – Decision made not to implement this QI project by Sponsor Dr. Rattay and Leader Jamie Mack due to informal quality improvements that were already implemented |
| New Castle County Health Unit (Hudson SSC) TB clinic workflow QI Project | Aug 2014-Nov 2015 | **Leader:** Adria Hartzel  
**Facilitator:** Christi Lancellotti & Laurie Smith | Aug 21, 2015 – Decision made by Sponsor Susan Keegan to place this project on hold due to project leader departure and other staff vacancies |
| Partnership Development QI Project | Sep 2014-Jul 2015 | **Leader:** Paul Silverman  
**Facilitators:** Fred MacCormack & Martin Luta | Sep 23, 2015 – Decision made by leader Paul Silverman to place project on hold due to accreditation process demands |
## Completed QI Projects

<table>
<thead>
<tr>
<th>Activity</th>
<th>Start Date</th>
<th>Project Lead</th>
<th>Facilitator</th>
<th>Date Completed</th>
<th>Comments Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSU Student Healthy Weight Project</td>
<td>Oct 2012</td>
<td>Leader: M. Carter Facilitator: F. MacCormack &amp; M. Luta</td>
<td>Mar 2013</td>
<td>-Part of DE Healthy Weight Collaborative</td>
<td></td>
</tr>
<tr>
<td>Sussex County Health Unit Immunization and Child Health Clinic Show Rate QI Project</td>
<td>Jul 2012</td>
<td>Leader: Kim Christie Facilitator: Anna Short</td>
<td>Jul 2013</td>
<td>-Increased appointment show rate from 65 to 75 percent</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-Storyboard completed Nov 2013</td>
</tr>
<tr>
<td>Sussex County Health Unit Fee Collection QI Project</td>
<td>Jul 2012</td>
<td>Leader: Nieca Lietzan Facilitator: Anna Short</td>
<td>Jul 2013</td>
<td>-Increased average monthly fee collection from $969.67 (Jan-Jun 2012) to $1,319.67 (Jan-Jun 2013)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-Storyboard completed January 2014</td>
</tr>
<tr>
<td>Competitive Grant Process Improvement Project</td>
<td>Dec 2012</td>
<td>Leader: M. Letavish Facilitator: M. Rudis &amp; R. Moody</td>
<td>Dec 2013</td>
<td>-Implemented two grant evaluation tools; agreed to assemble Grant Application Peer Review Group; agreed to re-assemble team to go over data collected using evaluation tools in one year</td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td>-Storyboard completed March 2014</td>
</tr>
</tbody>
</table>
### Completed QI Project (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Start Date</th>
<th>Project Lead</th>
<th>Date Completed</th>
<th>Comments Results</th>
</tr>
</thead>
</table>
| NHS WIC Scheduling Improvement QI Project     | Sep 2012   | Leader: J. Colantuano  
Facilitator: C. Carnley & L. Smith | Jun 2014       | -Using walk-in day appointments, wait time now averages 15 days for all three WIC sites  
-Storyboard completed June 2014 |
| Williams PH Clinic Improved Service QI Project | Nov 2013   | Leader: W. Smith  
Facilitator: Becky Moody and Mike Rudis | Dec 2014       | -Aim statement completed Nov 2013  
-Although team did not meet original Aim statement; collateral benefit was decreased client no-show rate from 37% to 19% through initiating Walk-in days.  
-Storyboard completed Jan 2015 |
| Disease Outbreak Prevention QI Project        | Sep 2014   | Leader: Martin Luta  
Facilitator: Mike Rudis and Becky Moody | Apr 2015       | -Sponsor Awe Maduka-Ezeh requested July 2014  
-AIM statement narrowed to complete response plan flowcharts  
-Storyboard completed Apr 2015  
-Storyboard updated with completion of response plans August 14, 2015 |
## Completed QI Project (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Start Date</th>
<th>Project Lead Facilitator</th>
<th>Date Completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sussex County Health Unit, Sexual and Reproductive Health real time charting using electronic medical record QI Project</td>
<td>Jul 2014</td>
<td>Leader: Nieca Lietzan Facilitator: Anna Short</td>
<td>Apr 2016</td>
<td>Request by Clinic Manager Anna Short on Jul 1 (QI Project Form) May 18, 2015: this project is delayed due to staffing shortages in SHS Storyboard completed Apr 2016</td>
</tr>
</tbody>
</table>
Appendix D

DPH Quality Improvement Project Charter Application – Level I Project

Program or Activity: ____________________________________________________________

1. Tell us about your proposed project. Please provide a brief description:

2. What are the benefits of this project as a potential focus of quality improvement?

3. How urgent is this issue? What would happen if we did nothing?

4. What are the obstacles? How easy will this project be to implement?

5. How does this issue impact our agency mission?
   - Public perception
   - Compliance with laws, regulations or standards
   - Public health
   - Use of public resources
   - Capacity to respond – preparedness
   - Customer Service

6. Division Implications
   Is this program/activity essential to implementation of:
   - Agency Strategic Plan
   - Public Health Accreditation Board Standards
   - A Governor’s Directive/priority or Secretary’s priority
   - Division Director’s priority

7. What changes can we make that will result in an improvement?

8. Please provide a brief description of the data available to address the issue identified. How did you identify this opportunity? What data did you use, and what is its source?

9. What are the relationships of this data to the project and the development of an intervention? Are you aware of benchmark data or best practices?

10. Who are the stakeholders (internal and external) and what are their concerns?
11. How will we know that a change is an improvement? (Potential measures of success, including implications for future improvements building off of this project)

12. Long term (longer than 24 months)

• Medium term (6-24 months)

• Short Term (less than 6 months)

13. Does this objective meet all of the SMART criteria?
• Specific (Can it be defined as a discrete enterprise?)
• Measurable (Can its performance be measured?)
• Achievable (Can we do it?)
• Relevant (Does it make a difference? Do we care?)
• Time-Bound (Is it achievable with a reasonable amount of time?)

14. Are there other significant reasons why this issue should be considered for the quality improvement plan?

15. Given these factors how does this issue rank in terms of importance to your program on a scale of one to ten, with ten representing the highest ranking?

16. What resources and supports will be needed to complete the project? Do you have any information that might help us estimate the cost of this project?

17. What is the proposed makeup of the QI Project Team?
Appendix E

Glossary of Terms

**Balanced scorecard:** A management system that provides feedback on both internal business processes and external outcomes to continuously improve strategic performance and results.

**Charter:** A written commitment approved by management stating the scope of authority for an improvement project or team.

**Facilitator:** A specifically trained person who functions as a teacher, coach and moderator for a group, team or organization.

**Goal:** A broad statement describing a desired future condition or achievement without being specific about how much and when.

**Indicators:** Established measures to determine how well an organization is meeting its customers’ needs and other operational and financial performance expectations.

**Just-in-time training (JITT):** The provision of training only when it is needed to all but eliminate the loss of knowledge and skill caused by a lag between training and use.

**Key performance indicator (KPI):** A statistical measure of how well an organization is doing in a particular area. A KPI could measure a company’s financial performance or how it is holding up against customer requirements.

**Key process:** A major system level process that supports the mission and satisfies major consumer requirements.

**Objective:** A specific statement of a desired short-term condition or achievement; includes measurable end results to be accomplished by specific teams or individuals within time limits.

**Performance standard:** The metric against which a complete action is compared.
**Plan-do-check-act (PDCA) cycle:** A four-step process for quality improvement. In the first step (plan), a way to effect improvement is developed. In the second step (do), the plan is carried out, preferably on a small scale. In the third step (check), a study takes place between what was predicted and what was observed in the previous step. In the last step (act), action is taken on the causal system to effect the desired change. The plan-do-check-act cycle is sometimes referred to as the Shewhart cycle, because Walter A. Shewhart discussed the concept in his book Statistical Method From the Viewpoint of Quality Control, and as the Deming cycle, because W. Edwards Deming introduced the concept in Japan. The Japanese subsequently called it the Deming cycle. Also called the plan-do-study-act (PDSA) cycle.

**Process improvement:** The application of the plan-do-check-act cycle (see definition) to processes to produce positive improvement and better meet the needs and expectations of customers.

**Process improvement team:** A structured group often made up of cross functional members who work together to improve a process or processes.

**Quality Improvement (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. (Riley, Moran, Corso, Beitsch, Bielek, and Cofsky. *Defining Quality Improvement in Public Health.* Journal of Public Health Management and Practice. January/February 2010.)

**Quality tool:** An instrument or technique to support and improve the activities of process quality management and improvement.

**Standard:** The metric, specification, gauge, statement, category, segment, grouping, behavior, event or physical product sample against which the outputs of a process are compared and declared acceptable or unacceptable.

**Strategic planning:** The process an organization uses to envision its future and develop the appropriate strategies, goals, objectives and action plans.

Unless otherwise indicated definitions in this glossary came from the American Society for Quality--online