POLICY AND PROCEDURE	
SUBJECT/TITLE:	Quality Improvement and Innovation Plan
APPLICABILITY:	All staff
CONTACT PERSON & DIVISION:	Performance Improvement and Accreditation Coordinator
ORIGINAL DATE ADOPTED:	06/09/2016
LATEST EFFECTIVE DATE:	11/07/2025
REVIEW FREQUENCY:	Every 5 years
BOARD APPROVAL DATE:	n/a
REFERENCE NUMBER:	800-015-P

A. PURPOSE

Canton City Public Health (CCPH) is committed to delivering high-quality public health services. The Quality Improvement and Innovation Plan establishes a clear, agency-wide approach for building a "culture of quality," empowering staff to improve services, and ensuring that data, stakeholder feedback, and best practices guide changes.

B. GLOSSARY OF TERMS

Board of Health (BOH): The Board of Health is the governing body responsible for overseeing public health policy, resource authorization, and strategic direction for CCPH. The BOH supports and advocates for quality improvement and innovation efforts by ensuring adequate resources are allocated and providing high-level oversight and guidance. The BOH regularly receives reports on quality improvement activities and outcomes from the Quality Improvement and Innovation Committee Chairperson as part of their meeting agenda, reinforcing their role in sustaining a culture of quality throughout the agency.

Division Leader: Division leader staff are responsible for all activities and direction of the respective division or agency unit. Division Leader staff include the following positions: APC Director, EH Director, Fiscal Manager, Laboratory Director, HPP Director, Nursing Director, THRIVE Project Manager, and WIC Director.

Division Leadership Team (DLT): The Division Leader positions, along with the health commissioner, performance improvement and accreditation coordinator, workforce development coordinator, and vital statistics administrative supervisor, make up the Division Leadership Team. The Team meets regularly to make decisions that affect CCPH and to review/approve new/revised policies.

Division-specific: Involves only a single division's activities or programs. Therefore, any changes made will only impact the single division.

Innovation: A systematic process that organizations use to create and implement new ideas, processes, or solutions where none currently exist. Innovation aims to address unmet needs or gaps by developing novel approaches that improve public health outcomes, increase efficiency, or enhance services.

Performance management system (PMS): The process of actively using performance data to improve the public's health. It includes the strategic use of performance standards, performance measures, progress reports and ongoing quality improvement efforts to ensure an agency achieves desired results. *[Ref: Turning Point, 2003].* CCPH's PMS is further detailed in 800-034-P policy.

Process: A particular method of doing something, generally involving a number of steps or operations.

Program: Term used to describe functions or services or activities carried out through the daily work of public health departments.

Program area project: A large or mini-QI project that involves a single program's functions.

Project completion: Projects are considered complete when the improvement strategies have been implemented (Do phase of PDCA complete), data has been collected and analyzed of the improved process state (Check phase of PDCA complete), and next steps have been determined (Act phase of the PDCA complete).

Quality tools (QI tools): Tools designed to assist a team when solving a defined problem or project. Tools will help the team get a better understanding of a problem or process they are investigating or analyzing. Tools used by CCPH are outlined in the appendix 800-015-12-A (Quality Improvement Toolbox) of this document.

Six Sigma: A method that provides an organization with tools to improve the capability of their business processes. This decreases process variation leads to defect reduction.

Strategic Plan (SP): CCPH's Strategic Plan is available on the agency's public website.

Workforce Development Plan (WFD Plan): CCPH's WFD Plan is defined in 800-050-P available on the agency's public website.

D. GOALS

- Foster a positive, quality-driven workplace culture.
- Equip all staff with the knowledge and tools for QI projects.
- Use measurable objectives and teamwork to achieve lasting improvements.
- Align QI and Innovation projects with strategic plans, performance metrics, and stakeholder needs.

E. CULTURE OF QUALITY

1. CURRENT STATE
   a) Quality improvement efforts have been limited. Largely due to disruption during the COVID-19 pandemic.
   b) The Quality Improvement and Innovation Committee (QIIC) has completed a few projects but has largely remained inactive, in part due to lack of projects.
   c) Recently, a Performance Management Committee was established to regularly review the performance management system with two main responsibilities.
      i) Report on progress to the Board of Health
      ii) Refer measures to the QI Committee when they are not meeting their targets
2. DESIRED FUTURE STATE
   a) CCPH desires to improve its culture of quality by actively engaging in regular QI activities and by meeting the goals defined in Section I.

F. QUALITY IMPROVEMENT ROLES

Role	Responsibilities
Board of Health (BOH)	Approves QII resources, oversees policy and

	progress, and receives reports.
Health Commissioner	Leads agency QII vision, allocates resources, supports staff, and the committee.
Division Leaders	Appoint QIIC members, recommend project team members, identify staff training needs, and champion QII work.
Division Leadership Team (DLT)	Reviews & approves QII Plan, integrates QII into plans/policies, decides on project publicity.
QII Committee (QIIC)/Chairperson	Develops/updates QII Plan, leads meetings, tracks project/documentation, ensures compliance, celebrates achievements, coordinates evaluations, and serves as staff mentor(s).
QII Project Teams (QIIPT)	Carry out QII projects (large or mini), use QII tools, follow Plan-Do-Check-Act cycle, analyze/report results.
QIIPT Consultants	Provide training and technical assistance, guide root cause analysis, ensure documentation, and facilitate meetings.
All Staff	Participate in QII training, suggest improvements, participate in projects, and integrate QI in daily work.

1. QII COMMITTEE (QIIC) MEMBERSHIP AND ROTATION
   a) QII Committee (QIIC) membership shall consist of the following:
      i) The QIIC Chairperson, as well as at least two additional staff members.
      ii) All staff are qualified for membership and must meet a minimum of <u>one</u> of the following qualifications:
         1. Have an interest in and aptitude for performance improvement planning, QI, innovation and/or program evaluation.
         2. Commit to developing and promoting continuous quality improvement throughout CCPH.
         3. Have advanced QI skill level or will have advanced QI skill level by completing training.
      iii) Staff become QIIC members by recommendation and division leaders' appointment.
      iv) The Performance Improvement and Accreditation Coordinator shall serve as the QIIC Chairperson.
   b) QII Project Team (QIIPT) membership shall consist of the following:
      i) Members are selected for the following needs for the QIPT:
         - QIIPT Consultant: This person is selected by the QIIC, usually a QIIC member. This person is competent in using QI and innovation tools and has the necessary QI skills. This person is responsible for scoping, preparing, and running the project. They will train team members in the elements of QI Tools and facilitates and captures the results of the project. This person fulfills the role of facilitator.
         - Fresh Perspective: Team members that have no prior knowledge of the process. This person can give new eyes and ask insightful questions. This is a full team member and expected to

participate fully in the project. For program area projects, this person is normally a member of another division that doesn't implement the program.

- Subject Matter Expert: Team members that have in-depth knowledge of the process to be improved as part of the project.

G. TRAINING

a) All new staff will be required to view a QI White Belt-level training video and will receive basic QII training at quarterly onboarding sessions.

b) During QIIPT meetings/events, the QIIPT Consultant will provide training on the specific QI and innovation tools to be used by the team, prior to using the tool. This will provide knowledge to the QIIPT members so the effort using the QI or innovation tool is effective. This training increases those members to an intermediate skill level.

c) staff at all levels will be provided with formal training when possible.

H. QUALITY IMPROVEMENT AND INNOVATION PROJECTS

1. QI PROJECT TYPES

a) **Large QI Projects:**
   i) Cross-division efforts addressing broad process improvements.
   ii) Involve a multi-division team and use full PDCA process.

b) **Mini-QI Projects:**
   i) Division-specific improvements.
   ii) Team may be limited to one division.
   iii) Simpler but should still be documented using QI forms and the PDCA cycle.

c) **Just-do-it Solutions:**
   i) Division-specific improvements.
   ii) Team may be limited to one division.
   iii) Should be limited only to very simple solutions

2. INNOVATION PJOECT TYPES

a) **Large Innovation Projects:**
   i) Cross-division initiatives that seek to address organization-wide gaps where no existing process is in place.
   ii) Require collaboration across multiple divisions or teams, including leadership and key stakeholders.
   iii) Involve the creation, piloting, and initial implementation of entirely new processes, programs, or models.
   iv) Utilize structured innovation and co-creation methods (e.g., design thinking, stakeholder workshops) in addition to the PDCA cycle.

b) **Mini-Innovation Projects:**
   i) Focus on developing new processes or solutions that address gaps specific to a single division, program, or team.
   ii) Implementation team is limited to the impacted division or group, with minimal cross-division involvement.

iii) Typically address more contained needs but are still fully documented and piloted before agency-wide adoption.
iv) Use rapid prototyping and feedback cycles, with structured documentation and assessment.

3. IDENTIFICATION OF POTENTIAL PROJECTS

a) QI Project ideas stem from performance data, strategic plans, staff suggestions, after-action reports, program audits, customer feedback, or accreditation needs.
   i) Any staff member may propose a QI project by submitting the simplified QI Project Proposal Form or equivalent email.
   ii) Projects linked to annual objectives or strategic priorities receive higher priority.
   iii) Division Leaders ensure that findings from audits or after-action reports prompt QI proposals.
b) Innovation project ideas occur when staff, customers, or leadership notice a need for which no formal process currently exists (e.g., a new service type, technology, or unaddressed stakeholder need).

4. PRIORITIZATION AND SELECTION PROCESS

a) All proposals reviewed using a formal "Project Selection Criteria Form."
b) QIC evaluates: Is it data-driven? Can CCPH directly control the process? Is it linked to required plans or audits? Does it offer measurable improvement potential?
c) Proposals may be:
   i) Accepted as-is,
   ii) Sent back for clarification/modification,
   iii) Or rejected if not meeting departmental priorities.
d) When a process exists, the proposal becomes a QI project
e) When a process does not exist, the proposal becomes an Innovation project

5. QI/INNOVATION PROCESS: PLAN-DO-CHECK-ACT (PDCA) CYCLE

a) Plan
   i) Identify specific problem/process for improvement.
   ii) Define measurable, time-bound objectives and identify baseline data.
   iii) Analyze causes— using QI tools (e.g., flowcharts, root cause diagrams).
b) Do
   i) Develop intervention plan.
   ii) Implement changes on a small scale ("test").
   iii) Document implementation steps.
c) Check
   i) Collect data, compare results to objectives.
   ii) Analyze effectiveness of changes.
   iii) Solicit feedback from staff/customers.
d) Act
   i) If successful: Standardize and fully implement the new process.
   ii) If goals are not met: Adjust intervention and return to the planning phase.
   iii) Document lessons learned and share them broadly.

5. PROJECT DOCUMENTATION
   a) All project records are kept on CCPH's SharePoint, organized and accessible for review or learning.
   b) Resource allocation (staff time, coordinator, administrative support) is provided by agency leadership.
   c) Appendices include templates for proposals, assessment, evaluation, and PDCA guides.

I. QUALITY PLAN GOALS

Goal/Area	Target Metric	How Measured	Data Source
Organizational Culture	At least one QII project per calendar quart	Number of projects initiated per quarter	QII project sheets
Organizational Culture	90% of QII projects completed	% of projects completed	QII Project Review
Project Quality	≥50% of project metrics achieved	% met in projects	QII Project Review Checklist
Communication Completion	90% communications completed	On-time completion	Communication monitoring

J. QII CULTURE

a) Participation: Every staff member is expected to engage in QII, whether through training, proposing ideas, or direct involvement in projects.
b) Recognition: Milestones, team efforts, and outstanding improvements are actively celebrated.
c) Cycle of Improvement: Plan updated approximately every five years, or more frequently if needs change.
   i) Effectiveness is reviewed after each full cycle, with lessons applied to the next period.

K. REVISION AND UPDATE OF THE QI PLAN

1. Every five years, the QIIC Chairperson will review and revise the QI Plan.
2. The (DLT) approves the QII Plan in accordance with policy 800-001-P.
3. Until the QII Plan is revised, approved, and effective, the expired QII Plan is in effect.

L. COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

A number of methods will be used to ensure regular and consistent communication of quality improvement activities. These methods include, but are not limited to the following:

- Staff: Reports at all-staff meetings and email updates.
- Board of Health: Quarterly written summaries of QII efforts

M. CITATIONS & REFERENCES

None

M. CONTRIBUTORS

The following staff contributed to the authorship of this document:

1. Robert Knight, Performance Improvement and Accreditation Coordinator

O. APPENDICIES & ATTACHMENTS

800-015-08-A: The ABCs of PDCA
800-015-09-A: Quality Improvement Toolbox
800-015-10-A: Innovation Process Guide

P. REFERENCE FORMS

800-015-01-F: QI Project Proposal Form
800-015-02-F: QI Project Selection Criteria Form
800-015-03-F: QI Project Review Criteria Checklist
800-015-04-F: QI Project Worksheet Form
800-015-05-F: QI Project Action Plan Form
800-015-06-F: QI Just-Do-It Solution Form
800-015-07-F: QI Project Team (QIPT) Post-Project Evaluation Form

Q. REVISION & REVIEW HISTORY

Revision Date	Review Date	Person	Notes on what changed
09/19/2018		T. Dzienis	Made general updates to reflect new agency name, frequencies, simplified structure, and that this is no longer the initial QI plan; Updated section H to reflect new plan culture of quality; added clarification of the different project types and teams; complete update to QI goals in section L; updated section J to reflect current training program; made other updates to reflect the QI program changes identified in the 2016-2017 QI Plan effectiveness assessment.
01/20/2021		Robert Knight	Updated plan for new period and to allow for a smaller QIC
08/12/2025		Robert Knight	Complete rewrite of the policy, reduction of forms and attachments

R. APPROVAL

This document has been approved in accordance with the “800-001-P Policy Development” procedure as of the effective date listed above.