THE CITY OF
COLUMBUS
MICHAEL B. COLEMAN, MAYOR

COLUMBUS
PUBLIC HEALTH

Quality Improvement Plan
2012

The following quality improvement plan has been based on the following resources:

1. *Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook*
2. *Mahoning County District Board of Health Quality Improvement Plan 2011*
3. *Center for Public Health Practice, College of Public Health, The Ohio State University*

Signature Page for the 2012 Quality Improvement Plan

Health Commissioner

Teresa C. Long MD

Teresa Long, M.D., M.P.H. – Columbus Public Health

5 / 21 / 2012

Date

Medical Director – Assistant Health Commissioner

Mysheika R. LeMaile-Williams, M.D., M.P.H. – Columbus Public Health

5 / 29 / 12

Date

Chief Operations Officer - Assistant Health Commissioner

Roger Cloern – Columbus Public Health

5 / 21 / 2012

Date

Chief Nursing Officer - Assistant Health Commissioner

Nancie Bechtel, RN, BSN, CEN, EMTB – Columbus Public Health

5 / 23 / 2012

Date

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Mission:

The mission of Columbus Public Health is to protect health and improve lives in our community.

Columbus Public Health
Protecting health, improving lives

Vision:

The Columbus community is protected from disease and other public health threats, and everyone is empowered to live healthier, safer lives.

CPH is the leader for identifying public health priorities and mobilizing resources and community partnerships to address them.

Values:

- **Customer Focus**: Our many, diverse customers, both in the community and within our organization, know that they will be treated with thoughtful listening and respect. They know that our first priority is the health and safety of our community, and we will do all that is within our abilities and resources to address their individual needs and concerns.

- **Accountability**: We understand that we are accountable for the health and safety of everyone in our community, and that as a publicly funded organization, we are all responsible for maintaining the public's trust through credible information, quality programming and services, and fiscal integrity. We know the scope of our programs and services and the critical role everyone plays in delivering our mission and achieving our vision.

- **Research / Science-based**: Credible science is the foundation of our policies and program decisions. The community knows that our decision-making is based on research and best practices, and is grounded in the most current scientific information available.

- **Equity and Fairness** – Our clients, partners and coworkers know that we will interact with them with fairness and equity, and that we strive to deliver our programs and services and operate in a manner that is just and free from bias or prejudice.

Departmental Goals:

1. Identify and respond to public health threats and priorities
2. Collaborate with residents, community stakeholders and policy-makers to address local gaps in public health.
3. Empower people and neighborhoods to improve their health.
4. Establish and maintain organizational capacity and resources to support continuous quality improvement.

Strategic Priorities:

- Reduce infant mortality
- Reduce overweight and obesity
- Stop the spread of infectious diseases

- Improve access to public health care
- Successfully implement the department reorganization plan

The organization continuously strives to assure that the ten essential public health services are provided in the community:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

The following Quality Improvement Plan serves as the foundation of the commitment of this agency to continuously improve the quality of the services it provides.

Quality - Quality services are services that are provided in a safe, effective, customer-centered, timely and equitable fashion.

Quality Improvement Principles - Quality improvement (QI) is a systematic approach to assessing services and improving them on a priority and ongoing basis. The Columbus Public Health approach to quality improvement is based on the following principles:

- **Customer Focus**. High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations.
- **Employee Empowerment**. Effective programs involve people at all levels of the organization in improving quality.
- **Leadership Involvement**. Strong leadership, direction and support of quality improvement activities by the Board of Health and Health Commissioner are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with our mission and strategic plan.
- **Data Informed Practice**. Successful quality improvement processes create feedback loops, using data to inform practice and measure results. Fact-based decisions are likely to be correct decisions.
- **Statistical Tools**. For continuous improvement, tools and methods are needed that foster knowledge and understanding. Continuous quality improvement organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.
- **Prevention Over Correction**. Continuous Quality Improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.
- **Continuous Improvement**. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and providers can almost always find an opportunity to make things better.

Background:
Columbus Public Health is committed to improving quality in all of its services, processes and programs, and is seeking accreditation through the national Public Health Accreditation Board (PHAB). In order to accomplish both of these things, a formal structure is necessary to lead and guide these efforts.

Leadership:
The key to the success of the Continuous Quality Improvement process is leadership. The following describes the roles of Columbus Public Health leadership to provide support to quality improvement activities.

Board of Health
The Board of Health provides leadership, support and resources for Quality Improvement (QI) initiatives as follows:

1. Establish QI as a Priority
2. Approve the QI Plan
3. Recognize Improvements

Strategic Advisory Team (SAT)
The Strategic Advisory Team (SAT) provides leadership, support and resources for QI initiatives as follows:

1. Establish QI as Priority
2. Approve the QI Plan
3. Support QI Initiatives
4. Reflect QI in the Strategic Plan
5. Provide Resources
6. Provide Guidance & Leadership
7. Maintain Departmental Quality
8. Recognize Improvements

Quality Team
The Quality Team provides ongoing operational leadership of continuous quality improvement activities. It meets monthly and consists of the following individuals:

Mike Smeltzer – Chair Planning and Accreditation Division Director	Rick Hicks – Planning & Accreditation
Cheena Kapoor-Cantlie – Clinical Operations Manager	Wayne Moore - EAP
Bonnie Baris – Sexual Health	Andrea Phillips – City of Columbus
Kathy Cowen – Assessment & Surveillance	Beth Ransopher – HR/Emergency Preparedness
Pete Denkowski – TB Program	Ellen Rapkin – Neighborhood Health
Laurie Dietsch - Planning & Accreditation	John Richter – Environmental Health
Kathie Dodson – Union Rep President	Lori Ruffin – Family Health
James Hicks – Union Rep Vice President	Renee Shalosky – Clinical QI Manager

A set core of individuals will remain on the quality team with the idea of rotating other staff through on a quarterly basis. This would provide long term consistency as well as diversity of staff to the quality team.

The Quality Team provides leadership, support and resources for QI initiatives as follows:

- Development and Implementation of the QI Plan
- Set Yearly QI Goals and Objectives
- Directs Selection of Projects
- Support QI Teams
  - ✓ Training
  - ✓ Tools
  - ✓ Mentors
  - ✓ Project Assistance
- Maintain QI Activity Reporting System
- Update Leadership and BOH

Managers

The Managers provide leadership, support and resources for QI initiatives as follows:

- Promote Utilization of QI
- Identify Potential QI Projects
- Oversee QI Projects in Their Area
- Participate in QI Projects
- Schedule Staff Time for Projects
- Update Leadership
- Report Progress of Projects to Quality Team

The Leaders support QI activities through planned coordination and communication of the results of QI initiatives. Leaders, through a planned and shared communication approach, ensure that the Board of Health, staff and various stakeholders have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

Budget and Resource Allocation:

Columbus Public Health values the process of Quality Improvement. The following are ways that CPH has budgeted or set aside resources in order to support this endeavor.

1. Hired one full time Clinical QI position
2. Hired one full time Accreditation Coordinator where a portion of their job is spent on quality improvement
3. Determined that one SAT member participate on the Quality Team
4. Dedicate staff time to participate on the Quality Team
5. Allow staff time to work on individual quality improvement projects
6. Collect and tabulate customer satisfaction surveys
7. Provide evidence based data collection methods in order to support quality improvement activities

A QI philosophy recognizes there are costs to everything one does or does not do. Until complete satisfaction is reached with public health funding levels and accomplishments, staff should continually seek quality improvements that reduce costs and improve outcomes. QI methods can help document evidenced based costs, identify outcomes of activities, and provide ways to make improvements that will ultimately improve the health of all and meet the expectations of customers.

There are three questions one should focus on when conducting QI activities:
1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

The Plan, Do, Check, Act (PDCA) cycle can be utilized in various situations to make improvements. The process summary found in this document refers to process improvement.

Project Selection

The suggestion for a QI project may originate from various sources.

1. Anyone in the health department can suggest a potential QI project by submitting the form found in Appendix A to the Quality Team.
2. Most projects will come from the managers based on data from their program and information from their staff. The decision to undertake an initiative is based upon agency priorities and project limitations.
3. The Quality Team looks at data from three major sources to identify new projects, makes suggestions to SAT who then direct programs to work on necessary projects.
    a. Accreditation Domains;
    b. Customer Satisfaction Surveys; and
    c. Performance (Program) Management/Dashboards for City of Columbus

The Quality Team discusses projects and tracks the progress of the new QI project teams. The Quality Team also supports these projects through training, mentorship and overall support.

Not all process improvement is a PDCA QI project. Appendix B is a decision making tool to assist in determining whether to undertake a formal QI project.

Project Formation

Once the Quality Team receives information on the formation of a new QI team, the Team Sponsor will assemble team members and develop the team charter. The team charter is a crucial document that should be completed at the start of a QI team. It serves as a guide for the team through the process. However, this document is a living document and can be changed throughout the course of QI process. A copy of the Team Charter along with an explanation on how to fill it out is located in Appendix C of this document.

Project Implementation

The purpose of a QI project is to improve the performance of an existing process. The model utilized at Columbus Public Health is called Plan-Do-Check-Act (PDCA).

- **Plan** - The first step involves identifying preliminary opportunities for improvement. After a decision is made to undertake a QI initiative, a QI project team is assembled. This team should consist of staff that will be directly affected by the outcomes of the project, with the exception of the team facilitator, who should have no vested interest in the process. At this point the focus is to analyze data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. This step requires the most time and effort. Affected staff or people served are identified, data compiled, and solutions proposed. (For an example of tools, see Appendix D). The last part of the Plan phase is to develop an improvement theory to test.
- **Do** - This step involves implementing the proposed improvement theory, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
- **Check** - At this stage, data is again collected to compare the results of the new process with those of the previous one.
- **Act** - This stage involves two actions. The first is to decide, based upon the data collected in the Check phase whether to adopt the change theory, adapt (make slight changes to the theory) or to abandon the improvement theory and start over. The second action in this phase is to decide future plans. So if the team decided to adopt or adapt the improvement theory, it must indicate how it will monitor the gains going forward. If the improvement theory was abandoned, the team must decide on how it will continue.

Regular updates are provided to the Quality Team and this information is entered into the QI Project Tracking Form found in Appendix E.

Project Summation

Once the process is complete, each team needs to complete a **Storyboard**, which is a one page snapshot of the project in each step of the PDCA cycle. Appendix F contains a Storyboard Template. This Storyboard can be shared with staff, leadership and the Board of Health to demonstrate the projects completed in the health department.

The Quality Team identifies and defines general goals and specific objectives to be accomplished each year. These goals include training of clinical, environmental and administrative staff regarding both continuous quality improvement principles and specific quality improvement initiative(s). Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities.

The following is a strategic plan goal for Columbus Public Health that relates to QI for the year 2012.

Strategic Goal #4: Establish and maintain organizational capacity and resources to support continuous quality improvement.

Strategic Goal:	Establish and maintain organizational capacity and resources to support continuous quality improvement				
Objective	**Activities**	**Critical Success Factors**	**Barriers**	**Timeframe**	**Responsibility**
By December of 2012, each program area will select at least one Performance Indicator to be measured in 2013 that will be entered into the city Dashboard system	• Write S.M.A.R.T. objectives for the strategic plan • Select objectives to be placed in the Dashboard system as a performance measure (PM) • Enter PM into Dashboard system • Work on PM • Regularly update progress in system	True S.M.A.R.T. objectives/PM written Objectives/PM tied to vision/mission	Objectives written poorly	By December 2012	Division Directors Program Managers Quality Team
Quarterly updates, as described in the QI Plan, will be provided to the Quality Team from the team leader of each active quality improvement project.	• QI Project selected • Team Leader submits Team Charter • Team leader submits quarterly update to the Quality Team • Team Leader submits Storyboard after completion of project	Identified QI Projects QI Plan with Appendices		Quarterly	Project Team Leader Quality Team
By December 2012, the Quality Team will identify, prioritize and select departmental	• Review program Dashboards • Identify and prioritize PHAB domains, standards and measures	PHAB Assessment Customer Satisfaction Data	Not collecting the right data	December 2012	Quality Team SAT

Focus Areas for 2013	• Review Customer Satisfaction Surveys • Identify focus areas based on data gathered • Suggest focus areas to SAT	Performance Measures Dashboards			
By December 2012, the Quality Team will define the entire process from selection to sharing of results of QI projects throughout the health department	• Assess current status • Determine various steps needed • Develop flow chart • Write up process • Submit to SAT	Quality Team Input SAT Input and Support Manager Support	Lack of Knowledge or Experience	December 2012	Quality Team SAT Managers
By August 2012, the Quality Team will create a QI Mentor list made up of staff names that can be mentors or provide support for QI project teams	• Identify mentor staff names • Provide training for the staff • Promote the service throughout the health department	QI Mentors Training for Mentors as needed	Staff Time	August 2012	Quality Team

Continuous Quality Improvement Activities. Quality improvement activities emerge from a systematic and organized framework. This framework, adopted by Columbus Public Health leadership, is understood, accepted and utilized throughout the organization, as a result of continuous education and involvement of staff at all levels. Quality Improvement involves two primary activities:

- Measuring and assessing performance objectives through the collection and analysis of data.

- Conducting quality improvement initiatives and taking action where indicated, including the design of new services and/or improvement of existing services.

Potential Quality Improvement Projects for 2012.
The following are a list of priorities identified as QI initiatives for 2012. These priorities have been identified by staff involved in recent quality improvement trainings as well as by the Quality Team and the SAT.

1. Improve the Customer Satisfaction Survey Process
2. Decrease Clinic Wait Times, Starting in the Sexual Health Clinic
3. Reduce Time from Lead Assessment to Formalized Report in Environmental Health
4. Increase communication, participation and coordination of CPH programs as it pertains to requested Community Wellness Events
5. Improve Efficiency of Dental Sealant Process

Prioritization of Projects Selected

The Quality Team will utilize the prioritization matrix[1] tool in order to prioritize potential projects for implementation in 2013. These will be based on the information from the following sources:

1. Public Health Accreditation Board (PHAB) Domains
2. Customer Satisfaction Surveys
3. Performance Measure Dashboards
4. Leadership (Managers and SAT)

In the future, the Quality Team shall also consider suggestions from staff in deciding priorities for QI projects.

[1] Goal/QPC, The Public Health Foundation. (2007). *The Public Health Memory Jogger II,(pp.105-115).* Salem NH: Goal QPC

Section 5 Performance/Program Measurement

The City of Columbus utilizes performance measures to help managers and employees identify and celebrate areas of success, as well as service areas that may need improvement. In 2006, the City of Columbus created the Office of Performance Management (OPM), which works with all city departments to manage the performance measurement system. Currently, 630 monthly, quarterly, and annual measures are grouped by program and/or operation into nearly 100 performance dashboards. These dashboards are available on the city's shared network drive, so that any employee or manager can view them. Each dashboard contains an overview where managers and OPM staff can quickly view the status of each measure as it relates to the assigned annual target. A colored "stop-light" system indicates whether the measure meets or exceeds the target (on green), is slightly below target (on yellow), or is significantly below target (on red).

Performance measures are reported in the city's Comprehensive Annual Financial Review (CAFR), annual operating budget, and in briefings prepared by the Office of Performance Management for the city's internal Columbus.Stat Panel. The Columbus.Stat Panel is comprised of directors of internal service agencies (Technology, Finance and Management, Human Resources, and Civil Service Commission) and members of the Office of the Mayor, including the Mayor's Chief and Deputy Chiefs of Staff. Modeled after the Baltimore Citi.Stat process, the Columbus.Stat program brings departmental leadership to internal management meetings to discuss performance measures, project updates, and progress on mayoral priorities.

Columbus Public Health currently reports data on 77 performance measures spanning multiple programs, offices and services. Performance measures typically fall within one of the four areas: efficiency, productivity, quality of service, and effectiveness. Measures include internal and external services, and continue to evolve and improve with time. As part of its quality improvement initiative, the department seeks to further improve its performance measures so that they better align with the department's recent reorganization. Through a planning process, Columbus Public Health has developed a new mission and vision, along with values, goals and strategic priorities.

It is the intent of the department's Quality Team, in conjunction with assigned staff from the city's Office of Performance Management, to work with managers and staff to revise and reorganize its performance measures for optimum effectiveness. The goal is to select the right measures (including developing new ones if necessary), and make them an integral part of the department's quality improvement initiative. The department's Quality Team, which includes a representative from each division and the Office of Performance Management, will work as a committee to assist in this effort-helping to determine the proper measures that align with each goal and strategic priority. Regular meetings of the Quality Team may be utilized to review measures in each area and through discussion, may be further refined.

Section 6 Evaluation

An evaluation is completed at the end of each calendar year. The annual evaluation is conducted by the agency and kept on file, along with the Quality Improvement Plan.

The evaluation summarizes the goals and objectives of the agency's Quality Improvement Plan, the quality improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings.

Evaluation Components

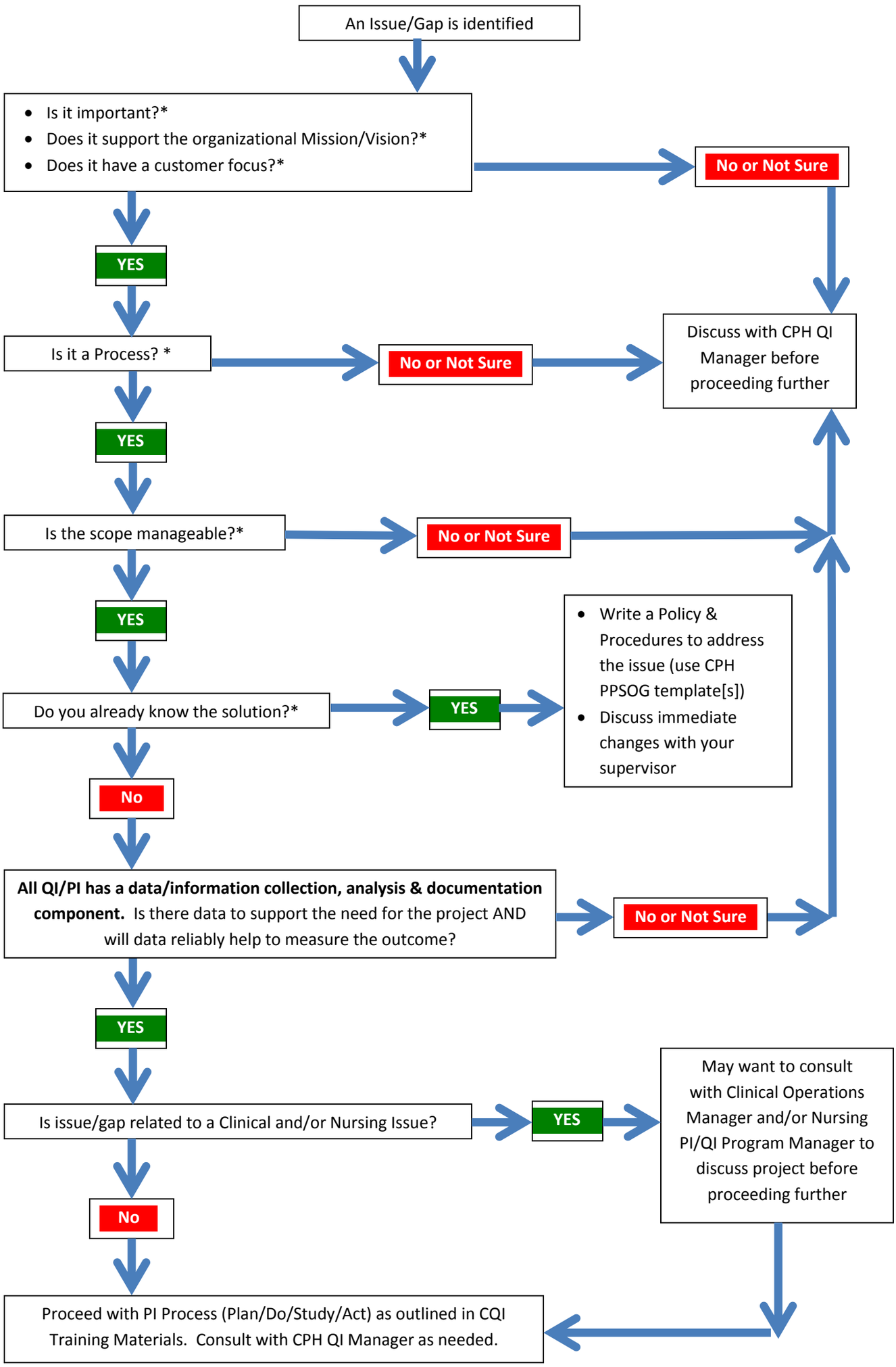
- Summarize the progress towards meeting the Annual Goals/Objectives.
- For each of the goals, include a brief summary of progress including progress in relation to training goal(s).
- Provide a brief summary of the findings for each of the indicators you used during the year. These summaries should include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes. Summarize your progress in relation to your Quality Initiative(s). For each initiative, provide a brief description of what activities took place including the results on your indicator. What are the next steps? How will you "hold the gains?" Describe any implications of the quality improvement process for actions to be taken regarding outcomes, systems or outcomes at your program in the coming year.)
- Recommendations: Based upon the evaluation, state the actions you see as necessary to improve the effectiveness of and changes to the QI Plan.

Appendix A	**QI Suggestion Form**

Problem/Opportunity Statement: (why the need for the project – what is the problem?)
Data: (is there data that supports/indicates the problem?)
Customers: (who are the customers?)
Do you want to be a part of this project? (If so, list name, email and phone number) Name: _____ Email: _____ Phone: _____

This form can be submitted to any Quality Team member or turned in at the front desk.

APPENDIX B
CPH DECISION-MAKING TOOL (ALGORITHM) FOR DETERMINING WHETHER A FORMAL QI/PI PROJECT IS WARRANTED AND POSSIBLE



Technical & Strategic Issues Questions from CQI Participant Materials, The OSU Center for Public Health Practice, College of Public Health, as distributed at CPH training on March 7, 2012.

APPROVED BY SAT ON 04/11/2012

APPENDIX C **CPH QI Team Charter**

Division/Program:	**Date:**
Problem/Opportunity Statement: (why the need for the project)	
AIM Statement/Mission: (what the team intends to do)	
Team Sponsor(s): (owns and has authority to approve changes)	**Team Leader:** (Leads team)
Customers: (defined and what needs are addressed)	
Boundaries: (limits on scope of process change allowable as defined by the team sponsor)	
Considerations (Assumptions/Constraints/Obstacles/Risks)	
What the Team has the Authority to Do: (authority to pilot improvements/or just recommend)	
Objectives: (SMART: Specific, Measurable, Achievable, Realistic, Time Frame) ____________________ ____________________ ____________________ ____________________	
Success Metrics: (how you measure the success of the improvement effort or the project)	
Key Milestones and Dates:	**Meeting Frequency & Duration:** (to be set by team)

Team Member Names:	**Phone Extension:**	**Email:**
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
________________	________________	________________
Facilitator:	**Timekeeper:**	**Note Taker:**

Team Charter Detail by Section:

Section 1. Problem / Opportunity Statement:	
What it does:	States why this effort was initiated and what will be affected by the outcome.
Why it is important:	Orients team and others to the true need for the effort. The source and analysis of the data that identified the problem or opportunity should be included and used as a baseline.
Example:	WIC applicants are complaining that it takes too much time to process their in-person application and there is a lack of privacy while giving information to the clerk.

Section 2. Performance Improvement AIM (Mission):	
What it does:	It describes what the team intends to do, providing the team with a focus and a way to measure progress. The aim should be derived from a known problem (data) and need for corrective action.
Why it is important:	Clarifies where the team is going and enables them to know when they get there. A well stated aim affords a team the opportunity to improve many aspects of the system or process related to the aim. TIP: Most successful improvement efforts have a succinct aim with a measurable stretch goal. The measure should be monitored over time and tracked in the form of a statistical process control chart.
Example:	AIM: To reduce the waiting time by 50%.

Section 3. Team Sponsor:	
What it does:	Identifies the senior leader that supports and/or initiated this effort.
Why it is important:	Established who in senior leadership cares about this effort and has overall operational accountability. The Sponsor will be expected to break down barriers and "go to bat" for the team.
Example:	Mary James, Health Officer

Section 4. Team Leader:	
What it does:	Identifies one individual who will guide the team to achieve successful outcomes and who will communicate to senior leaders.
Why it is important:	Established who will conduct team meetings, provide focus and direction, and will ensure productive use of team member's time. This person is not necessarily the same individual who will be "in charge" of the process, but should be a person who will "lose sleep" over the outcome.
Example:	Joe Smith, WIC Department Manager

Section 5. Customers (primary and other) and Customer Needs Addressed:	
What it does:	Identifies the primary (and other) customers of the product or service you provide and specifies the ways in which you meet their stated needs.
Why it is important:	Identifying customers early helps you decide if they need to be represented on the actual team. The identification of their needs and how well you are or are not meeting them must be continually assessed during the improvement process.
Example:	Applicant for WIC benefits.

Section 6. Scope (Boundaries):	
What it does:	Specifies the boundaries of the process you are involved in. They may be stated in time frames and/or process steps.
Why it is important:	Sets the stage; provides focus; identifies limits. Tip: Map out a 7-9 step high-level process flow for the scope you've defined. This will help you understand what you need to be successful, including validating team membership.
Example:	"The time the person arrives in the WIC Department to the time they have successfully filled out the application and leave."

Section 7. Considerations (Assumptions/Constraints/Obstacles/Risks)	
What it does:	Describes both positive and negative factors that must be discussed and understood prior to the work beginning. Assumptions: statements of requirements that must be accepted; Constraints: an element that might restrict or regulate project actions or outcomes; Obstacles: a factor that might impede progress; Risks: a course of action that might pose a hazard or cause loss.
Why it is important:	Clarifies expectations; requires people to reflect on the effort in a more thoughtful way; can redefine the work; may facilitate the removal of known obstructions in advance; gives credibility to teams (that they have considered possible issues).
Example:	Assumption: The WIC intake area can be rearranged to make for private booths

	Constraints: Information Technology solutions will not be entertained at this time (system upgrade planned in 2 years).

Section 8. What the Team has the Authority to Do:	
What it does:	Lists what authority the group has - the authority to pilot improvements/or just recommend
Why it is important:	It clarifies the expectations for the end result of the effort..
Example:	Group will recommend changes to the leadership for implementation OR Group will pilot improvements and report to leadership

Section 9. Objectives: (SMART: Specific, Measurable, Achievable, Realistic, Time Frame)	
What it does:	Listing out the specific and measurable objectives for the effort will help define the opportunities to improve.
Why it is important:	It enables the team to reach consensus on what will be addressed during the course of the effort. Tip: Group similar objectives and give them a descriptive title; for example, Eliminating Waste. Grouping objectives into change concepts facilitates creative thinking with improvement teams.
Example:	Eliminating Waste • Eliminate unnecessary waiting time • Reduce duplicative data entry

Section 10. Success Metrics (Measures):	
What it does:	Defines how you measure the success of the improvement effort or the project as a whole.
Why it is important:	Metrics help the team and sponsor to understand when and if an implemented improvement is meeting the desired goal. Tips: Be specific. Agree to definitions and data sources. It is ideal to have a balanced set of measures: satisfaction / costs / outcome. Identify one overarching measure that can be an assay for the entire effort – measure it over time and use a control chart. Keep it simple – use sampling.
Example:	Overall applicant cycle time to get service and complete an application will be reduced by 50% Obstacles: Departmental practices related to scheduling applicants differ widely. Risks: Changes may not conform to legal requirements

Section 11. Key Milestones and Dates:	
What it does:	Marks significant expectations and/or deliverables the team can expect.
Why it is important:	Holds the team accountable. Maps progress.
Example:	Current State Assessment due March 15th. Recommendations to be presented to senior leadership in 6 weeks.

Section 12. Meeting Frequency:	
What it does:	Indicates the meeting expectations the team can expect.
Why it is important:	Let's the team know the expectations for how often and how long they will meet so staff can plan accordingly.
Example:	Weekly for 1 hour. Or Every other Wednesday from

Section 13. Team Members and Area of Expertise:	
What it does:	Defines who will be on the team and why.
Why it is important:	Assure that all the people necessary to effect change will be involved. Tip: You may have people that you do not need on the core team however, they are key stakeholders and must be consulted with, and made aware of, changes. These individuals should be identified in the Charter. Refer to the high level process utilized to define the scope to verify that the team has representation from each major process step.
Example:	Team Member: Bill Bates – WIC Intake supervisor

*Taken from page 14 "Team Chartering" by John W. Moran and Grace L. Duffy
http://www.texas-quality.org/SiteImages/125/Newsletter/April%202010%20Newsletter.pdf