Clermont County Public Health

Prevent. Promote. Protect.

Performance Management and Quality Improvement Plan

This plan has been approved and adopted by the Clermont County Board of Health on October 12, 2022

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Revision

Date	Section/Page Revised	Staff
October 2022	Merged Performance Management and Quality Improvement Plan	Maalinii Vijayan and Julianne Nesbit
March 2023	Page 22. Appendix C Removed language suggesting that the metric has to be tied to a project. Added language about the impact that the associated activities are making on the population they serve.	Maalinii Vijayan
01/03/2024	Appendix C – Updated the form to include the 2022 Reaccreditation requirements.	Maalinii Vijayan
09/20/2024	Updated the process to develop program performance measures utilizing RBA. Appendix D was created, and Appendix E was updated. An appendix to report on program performance measures was deleted. Staff responsible for tracking data will directly input the date in Clear Impact	Maalinii Vijayan

I. Executive Summary

The purpose of this plan is to outline the foundation and structure by which Clermont County Public Health (CCPH) conducts Performance Management (PM) and Quality Improvement (QI) activities. To achieve CCPH's mission of striving to improve the health of Clermont County by preventing disease, promoting health, and protecting the environment, we must continuously measure our performance and enhance programs and services. The PM and QI Plan is connected to the Clermont County Community Health Assessment (CHA), Clermont County Community Health Improvement Plan (CHIP), CCPH Strategic Plan (SP), and the agency's Performance Management System. This plan outlines the status of performance management and quality improvement within the agency, the roles and responsibilities of the Performance Management and Quality Improvement Committee (PM/QIC), the quality improvement process used, project selection, training, evaluation and monitoring, and communication. CCPH desires to reach a state where quality improvement is firmly rooted in the agency's culture. The Clermont County Board of Health (BOH) and CCPH Administration are dedicated to fully providing the resources necessary to implement this plan.

II. Mission, Vision, & Values

A. Mission

Striving to improve Clermont County by preventing disease, promoting health, and protecting the environment.

B. Vision

Healthy People, Healthy Communities, Healthy Clermont.

C. Values

Service – We believe in providing accessible and comprehensive services of exceptional quality.
Credibility – We believe in high standards of performance and adhering to evidence-based practices.
Integrity – We believe in being honest, fair, and reliable in our intentions and actions.
Responsibility – We believe in being accountable for our decisions and actions and taking ownership of our duties.
Equity – We believe all people have equal value and opportunity regardless of race, ethnicity, gender, sexual orientation, religion, zip code, health, or any other consideration, and we treat everyone with the same level of compassion and respect.

III. Key Terms and Definitions

The key terms are defined below to provide a common vocabulary.

Performance Management (PM): The practice of actively using performance data to improve the public's health. It involves strategically using performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results. (Turning Point Performance Management National Excellence Collaborative, 2003)

Performance Standards: Objective standards or guidelines used to assess an organization's performance. They may be set based on national, state, or scientific guidelines, by benchmarking against

similar organizations, based on the public's or leaders' expectations, or other methods. (Turning Point Performance Management National Excellence Collaborative, 2003)

Performance Measures: Quantitative indicators of capacities, processes, or outcomes. Used to assess how well an organization is achieving its desired objectives or performance standards. (Tews et al., 2012; Business Dictionary, 2017)

Quality Improvement (QI): The use of a deliberate and defined improvement process, such as Plan-Do-Check (Study)-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 quality indicators in services of processes that achieve equity and improve the community's health. (Tews et al., 2012)

For additional definitions, see Appendix A: Glossary of Key PM and QI Terms.

IV. Performance Management

According to the Public Health Foundation, Performance Management is the "practice of actively using performance data to improve the public's health." It is a systematic process highlighting a public health agency's vision, mission, and strategic goals. Performance management seeks to improve the effectiveness of a public health agency through streamlining processes, empowering employees, and striving for continuous quality improvement. Performance management initiatives in public health agencies produce measurable results that lead to improved performance outcomes. This promotes quality assurance, quality improvement, and continued quality planning.

A comprehensive performance management system is integrated into all levels of day-to-day activities in health departments. This system includes setting organizational objectives across all health district levels, identifying indicators to measure progress toward achieving these objectives regularly, identifying who is responsible for monitoring and reporting progress, and identifying quality improvement opportunities based on the data collected.

CCPH utilized a modified Turning Point Performance Management Model, Results Based Accountability and Clear Impact, and Tyler Technologies Employee Self-Service Software to develop and implement the performance management system.

The Turning Point model includes the components mentioned in Figure 1.

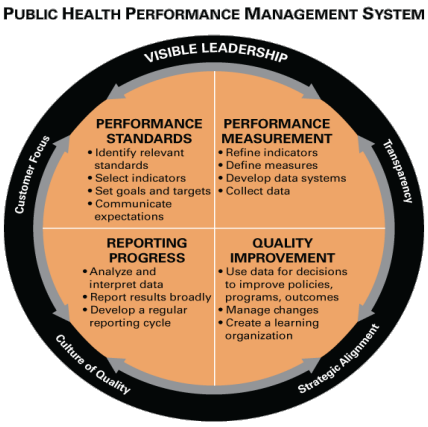

Figure 1 Turning Point Model

The following plans are the backbone of the CCPH that provide structure and guidance for performance management and quality improvement activities that ultimately impact the community's health.

Community Health Assessment (CHA) - The Clermont CHA aims to learn about the population's health, identify contributing factors to higher health risks or poorer health outcomes, and determine what assets and resources are available to improve the population's health status. See Clermont County CHA.

Community Health Improvement Plan (CHIP) – The CHIP is used to inform the strategic plan regarding health issues facing the community. The CHIP's goals, objectives, strategies, and activities that CCPH can assist in addressing are directly incorporated into the strategic plan. See Clermont County CHIP.

Strategic Plan: CCPH's three-year strategic plan results from an agency-wide process that sets the direction for where the agency should be going. It includes the agency's mission, vision, and values and sets forth specific priorities that have defined goals. It is used to help make decisions and assign resources. This is one of the key documents where objectives are developed that feed into the performance management system. See CCPH Strategic Plan.

Performance Management and Quality Improvement (PM/QI) Plan – The PM/QI Plan outlines the foundation and structure by which CCPH conducts performance management and Quality Improvement. The CCPH PM/QI Plan outlines the concepts of quality improvement used within the agency. It defines the structure of the PM/QI Committee and provides tools and resources to staff. Annually QI projects are submitted to the PM/QI Committee, and projects are selected that feed into the performance management system. The plan also outlines other agency-wide Performance Management activities, including the Program Performance Measures. The Program Performance Measures relate to larger strategic planning goals, or they may be measures based on agency, supervisor, or programmatic and grant deliverable expectations.

Workforce Development (WFD) Plan – The WFD Plan includes workforce training and development and is part of a comprehensive strategy for agency quality improvement. Fundamental to this work is identifying gaps in knowledge, skills, and abilities through the Assessment of both organizational and individual needs and addressing those gaps through targeted training and development opportunities. It can assure quality assurance and a competent workforce within the agency, which can also lead to an increase in meeting performance management goals. See CCPH Workforce Development Plan.

Individual Staff Goals – Individual staff goals are developed annually by staff in consultation with the supervisors. Goals could include a work plan to improve a process or a work plan focusing on individual development.

Customer Satisfaction Surveys – Customer satisfaction surveys are actively mailed for certain programs, and feedback is solicited on all programs. Surveys are reviewed at monthly Leadership Team Meetings for feedback that can be incorporated into programmatic, division, or agency improvements. Customer satisfaction surveys are available in paper copy and online.

Employee Satisfaction survey – An employee satisfaction survey is administered to all staff every three years. The purpose of the survey is to determine and measure the level of satisfaction. The survey collects insights on work-related issues like compensation, benefits, evaluations, policies, retention, and

many other factors**.** Survey results are reviewed at PM/QI committee and Leadership Team Meetings for feedback that can be incorporated into programmatic, division, or agency improvements.

Suggestion box – A suggestion box encourages employees to submit suggestions, comments, and complaints anonymously, although they can include their names if they want. The recommendations are reviewed at monthly Leadership Team Meetings for feedback that can be incorporated into programmatic, division, or agency improvements.

Performance Raises – The Board of Health and Health Commissioner is committed to rewarding staff for meeting performance measures; therefore, it is considered when raises and/or performance rewards (bonuses) are awarded. Each employee's supervisor considers the completion of staff goals as part of the overall employee annual performance evaluation. The supervisors determine raise amounts based on that performance from a pool of funds for each group of workers. Raises and performance rewards are dependent on the available budget and are not guaranteed from year to year.

CCPH recognizes that successful agencies operate with a systems-based approach. The figure below demonstrates the interrelatedness of large agency systems, responsible staff/teams, and timelines. A successful health department nurtures the integration of agency systems to maximize favorable program, process, and population health outcomes.

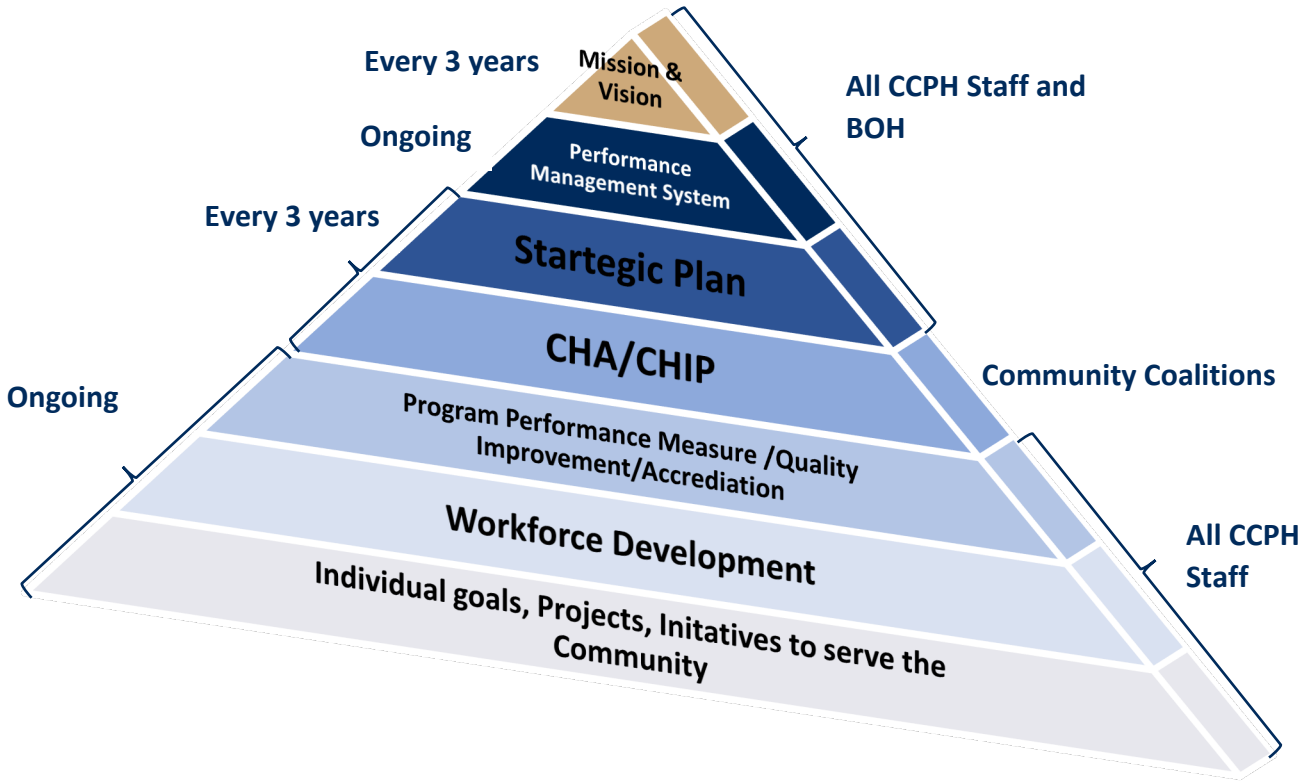

Figure 2 Pyramid demonstrating the interrelatedness of the agency system

V. Culture of Quality

A. Initial

In 2011, CCPH started down the path of Quality Improvement. While QI projects had previously been done to improve processes and systems, staff had no formal training or a defined process for conducting projects. CCPH received a grant from the Ohio Public Health Partnership in March 2011 to train key staff and identify and work through a QI project. This was the first formal QI project and focused on the lack of written Standard Operating Guidelines for the agency. Realizing the need for all staff to be trained in CQI, CCPH contracted with OSU Center for Public Health Practice to conduct onsite CQI training for all staff. In 2014, CCPH added the OSU Center for Public Health Practice CQI for Public Health: The Fundamentals training to the employee orientation requirements, ensuring all new employees are trained in CQI.

In 2009 CCPH staff started developing annual work plans to improve programs, divisions, and the agency. After 2011, staff was encouraged to take on larger group projects for work plans, with several focusing on QI projects. Projects focused on Women, Infants, and Children (WIC) clinics, rabies processes between the Nursing Division and Environmental Health, and Employee Evaluations. However, the formal process and documentation used with the first project were not continued. CCPH was good with the first round of Plan-Do-Study-Act (PDCA), but repeated follow-up through the cycle was not always carried out.

B. Current

In 2018 a decision was made to name a formal QI Coordinator. The QI plan was updated to document this, and several improvements were made to improve Staff engagement in QI. Additionally, an assessment was performed among the leadership Staff to assess the spread and formality of QI across the agency. National Association of County and City Health Officials (NACCHO) QI Self-Assessment Tool (SAT) 2.0 Leadership Version was utilized for the Assessment. The overall agency score was 4.5. The QI team identified transitional strategies using the NACCHO QI Roadmap and worked towards advancing the QI Culture. While initial progress in advancing the culture of quality at CCPH was rapid, COVID-19 response efforts led to suspending regular QI Committee meetings and QI project progress. CCPH also experienced high staff turnover. As a result, newer staff who were in the training period to build the necessary skills to do their day-to-day activities did not have opportunities to engage in PM and QI activities. To re-energize and direct performance & quality efforts moving forward, CCPH merged the Strategic Planning Committee, Quality Improvement Committee, and other leadership Staff involved in monitoring PM. The newly formed PM/QI Committee conducted a culture of quality self-assessment utilizing NACCHO's QI SAT 2.0 Staff version and Leadership Version in August 2022 and September 2022, respectively.

Scores of the staff survey and Leadership survey conducted among all CCPH staff and Leadership staff were averaged and compiled in the sub-element staff score and sub-element leadership score (available in Table 1 below). Each element outlined in the Assessment is broken out into sub-elements and specific topics, which feed the average element and sub-element scores. Both surveys had a 100% response rate of all CCPH staff and Leadership Staff who were not on leave during the August 26, 2022, staff in-service day (for staff survey) and September 27, 2022, Leadership meeting (Leadership survey).

The Staff Scoring Summary and Leadership Scoring Summary were combined to average the final culture of quality score for the CCPH as a whole, 4.7 on a scale of 1.0 to 6.0. The Overall Scoring Summary also combines the Staff Survey and Leadership Survey scores in each element and sub-element. A complete table of each element and sub-element score for the CCPH is available in Table 1.

Table 1: Overall Scoring Summary - 2022

QI SAT Scoring Summary					Score: 4.7
Functional Element	**Sub-Element**	**Sub-Element Leadership Score**	**Sub-Element Staff Score**	**Sub-Element Score**	**Element Score**
1. Employee Empowerment	1.1 Enabling Performance	5.3	4.8	5	4.9
	1.2 Knowledge, Skills, and Abilities (KSAs)	4.5	5.0	4.8	
2. Teamwork and Collaboration	2.1 Collaborative Sharing and Improvement	5.0	5.0	5.0	5.0
	2.2 QI Team Performance	5.0		5.0	
3. Leadership	3.1 Culture	4.8	5.0	4.9	4.8
	3.2 Resourcing and Structure	4.3	5.0	4.7	
4. Customer Focus	4.1 Understanding the Customer	4.6	5.0	4.8	4.7
	4.2 Meeting and Exceeding Customer Expectations	5.0	4.0	4.5	
5. QI Infrastructure	5.1 Strategic Planning	5.0	4.0	4.5	4.4
	5.2 Performance Measurement and Use of Data	4.4	4.0	4.2	
	5.3 Quality Improvement Planning	5.0	4.0	4.5	
6. Continuous Quality Improvement	6.1 Improving Standardized Work	5.3	5.0	5.1	4.6
	6.2 Planning for QI Projects	4.3		4.3	
	6.3 Testing, Studying, and Acting on Potential Solutions	4.0	5.0	4.5	

C. Future State

PM/QI Committee utilized the survey results to identify a series of transition strategies. The transition strategies selected for each element and sub-element are outlined in Table 2. CCPH PM/QI Committee will employ the transition strategies to reach the future state listed below.

- Moving from Phase 4 Formal QI Activities Implemented in Specific Areas to Phase 5: Formal Agency-wide QI
- Solidifying and improving protocols and procedures for our formal division-wide performance management system.
- Reviewing and refining program-level performance measures and improving our regular reporting process.
- Increasing QI knowledge and experience of PM/QI committee members developing them into more effective QI champions and QI project team facilitators.
- Encouraging and supporting new QI projects

Table 2: Transitional Strategies

Functional Element	Sub-Element	Selected transitional strategies to implement
1. Employee Empowerment	1.1 Enabling Performance 1.2 Knowledge, Skills, and Abilities (KSAs)	• Provide staff with a basic orientation to performance management and QI, emphasizing their importance and applicability to the agency. • Identify PM/QI knowledge, skills, and abilities among all staff and develop capabilities of internal trainers and mentors on PM/QI. • Mentor employees and provide advanced QI training to those that need it, including advanced tools of quality and data analysis, as appropriate.
2. Teamwork and Collaboration	2.1 Collaborative Sharing and Improvement 2.2 QI Team Performance	• Staff routinely form sharing sessions or use other mechanisms to exchange successes and lessons learned across divisions/programs. • Have leadership sponsor improvement projects and participation across programs and functions to encourage collaboration and sharing.
3. Leadership	3.1 Culture 3.2 Resourcing and Structure	• Provide necessary resources to support all improvement activities & projects. • Routinely report out on performance measures and activities to all staff. • Provide PM/QI leader(s) the training and development to become competent in foundational and advanced QI methods.
4. Customer Focus	4.1 Understanding the Customer 4.2 Meeting and Exceeding Customer Expectations	• Educate staff on the customer feedback process. • Routinely report out on the division/program level customer feedback results to all staff. • Encourage community engagement efforts and spread customer feedback processes across all divisions/programs.

5. QI Infrastructure	5.1 Strategic Planning 5.2 Performance Measurement and Use of Data 5.3 Quality Improvement Planning	• Educate staff at all levels of the agency on Clear Impact Scorecards and instill a better understanding of performance management system and the impact of their day-to-work on those measures. • Monitor and evaluate the merger of the Strategic Planning and Quality Improvement Committee and the Performance Management and Quality Improvement Plan.
6. Continuous Quality Improvement	6.1 Improving Standardized Work 6.2 Planning for QI Projects 6.3 Testing, Studying, and Acting on Potential Solutions	• Track results from implementation for a minimum of 2 years or until when the PM/QI committee decides to discontinue tracking. • Make lessons learned sharing system usable throughout the agency.

VI. PM/QI Committee Organizational structure/Governance

The PM/QI Committee is responsible for implementing and overseeing performance management and improvement efforts within CCPH.

A. PM/QI Executive Team

The leadership of the PM/QI Committee is the responsibility of the PM/QI executive team, which is comprised of the Health Commissioner, Assistant Health Commissioners, Director of Nursing, Epidemiologist, Special Projects Coordinator, and PM/QI Coordinator. The PM/QI executive team will invite other subject matter experts as deemed necessary. The PM/QI executive team makes decisions regarding the overall direction of the PM/QI Committee and guides the development of CCPH's quality culture. All PM/QI executive team members will show strong interest in PM/QI, have a deep commitment to developing and promoting a culture of quality throughout the department, and be available to participate in additional meetings and training.

B. Members

The CCPH PM/QI committee comprises 22 positions with representation from a cross-section of the division, including Directors/Supervisors and frontline staff:

- Health Commissioner
- Assistant Health Commissioners (Environmental Health and Community Health Services)
- QI Coordinator
- Special Projects Coordinator
- Epidemiologist
- Director of Nursing
- Communications Coordinator
- Fiscal Officer
- Division Directors

- BOH member
- Division/Program representative: At least one but no more than two representatives from each major program area:
    - Administration
    - Plumbing
    - Water and Waste
    - Environmental Health
    - Emergency Preparedness
    - Immunization
    - Communicable Diseases
    - WIC
    - Injury Prevention/Harm reduction

Members of the committee are selected on a volunteer basis. If more members volunteer than there are positions, a lottery system will be used to determine the candidate. Terms for the Health Commissioner, Assistant Health Commissioners, QI Coordinator, Special Project Coordinator, Epidemiologist, Director of Nursing, Communications Coordinator, Fiscal officer, and Division Directors are permanent. The division/program representative will serve a two-year term. Members can be re-elected to a position if no other candidates are interested in serving on the committee. See Appendix B for a roster of current PM/QI Committee members.

C. Team Operations

Decision-making: All members are voting members. The committee strives for consensus on all decisions and agrees to abide by a majority vote in the absence of consensus.

Meetings: Regular PM/QI Committee meetings will be held on the last Tuesday of March, June, September, and November for one to one and a half hours (10:30 am to 11:30 am). Additional meetings may be held as necessary for committee business. The PM/QI executive team will meet on the fourth Tuesday of January, February, April, May, July, August, October, and December for 30 minutes to an hour (10.30 am to 11.30 am). Records and minutes are maintained for all meetings. The PM/QI Coordinator will be responsible for setting meeting dates/times and agendas and moving the PM/QI Committee forward. The PM/QI Coordinator will also be responsible for taking meeting minutes and posting the minutes to SharePoint.

Time Commitment: The time commitment for regular PM/QI Committee members is anticipated to be three to five hours per month. This includes meetings, meeting preparation time, and providing technical assistance to QI teams. The time commitment for PM/QI Executive Team members is substantially greater, including additional meetings, work assignments, and training.

D. Roles and Responsibilities

Everyone has a role in CCPH performance management and quality improvement efforts. Specific roles and responsibilities are listed below.

PM/QI Committee:

- Champion performance management and quality improvement efforts throughout the agency
- Develop and revise/update the PM/QI Plan annually

- Make recommendations for QI Projects/programmatic metrics based on identified priority areas in the Strategic Plan, Community Health Improvement Plan, Community Health Assessment, or other internal processes or systems that could benefit from being addressed as a QI Project
- Monitor QI projects, act to solve problems, review recommendations from QI projects for feasibility and assist in implementing quality improvements
- Assure adequate resources are devoted to QI initiatives, including diverse and objective Staff on QI Projects
- Monitor timelines and assure QI Projects are completed on time unless documentation of extenuating circumstances is provided
- Report to the committee on program performance measures for their respective programs every quarter using the Program Performance Measure Report form (Appendix F).

Health Commissioner:

- Set vision and direction for PM and QI activities
- Provide consultation for PM/QI planning and activities
- Oversee the development, implementation, & revision of the PM/QI Plan
- Allocate resources for activities
- Report to Board annually
- Have staff report at all-hands meetings/newsletters or in-service day
- Encourages incorporation of QI concepts into daily activities and programmatic metrics
- Consult on PM/QI Committee member appointments

Assistant Health Commissioners (Environmental Health and Community Health Services):

- Ensure projects/plans meet PHAB requirements
- Facilitate the implementation of PM and QI activities at the program level
- Oversee setting of program-level goals and objectives and selection of program performance measures
- Update the program performance measures on the performance management system quarterly
- Ensure regular monitoring of program performance measures
- Support program staff in their work with PM and QI activities
- Foster a culture of learning and QI within respective programs
- Update the performance management system

Epidemiologist:

- Provide oversight for the development and tracking of program performance measures
- Provide technical assistance in data collection for performance measures and quality improvement projects as needed

QI Coordinator

- Coordinate monitoring and review of the PM/QI plan
- Ensure PM/QI plan and all PM/QI committee documentation meet PHAB Accreditation requirements

- Coordinate performance management and quality improvement training for both the PM/QI Committee and general staff
- Identify resources for PM/QI committee business
- Organize and maintain the Performance Management folder on the shared drive and share point
- Record and distribute meeting minutes
- Coordinate with QI teams' quarterly updates to the PM/QI Committee

VII. Quality Improvement Activities

CCPH uses the Plan, Do, Check, Act, also known as the Deming cycle (Figure 1) methodology for QI efforts. CCPH has several copies of the Public Health Foundation Public Health Quality Improvement Encyclopedia available for staff and team use in working through QI projects.

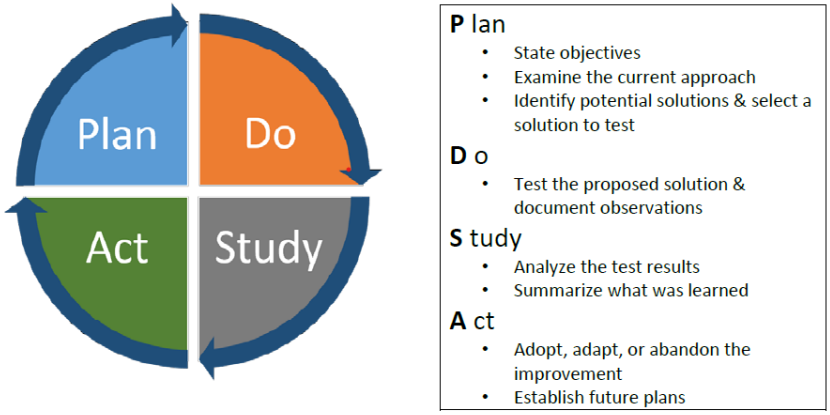

Figure 2. Plan, Do, Check, Act

A. QI Project Selection

Any staff member may recommend a project to the PM/QI Committee at any time on the QI Project Recommendation Form (Appendix C). QI projects may be identified in several ways including, but not limited to, recognition of an improvement opportunity by staff, recommendation by the PM/QI committee based on reviews of performance data, program evaluations, after-action reviews, performance as related to PHAB standards and measures, the Clermont County Community Health Assessment, the Clermont County Community Health Improvement Plan, the CCPH agency Strategic Plan, audit or compliance issues, or project recommendations from the Board of Health. Additionally, the CCPH leadership team reviews the customer satisfaction survey data and Staff Suggestion box monthly to identify potential QI projects.

The PM/QI Committee selects potential projects. The PM/QI Committee will use the ranking tool at the bottom of the QI Project Recommendation Form (Appendix C). Priority will be based on the number of projects received, alignment with the agency mission, vision, values, and Strategic Plan objectives, Performance Management system, the feasibility of the project, the complexity of the project, available resources for the project, availability of data for the project, and the potential internal and external impact the project may have. Additional consideration will be taken regarding one project from a program area (non-clinical), one from the administration area, and one from the population-based health promotion, protection, or improvement efforts to address a community health issue.

B. QI teams

Recommendations for team members can be made on the QI Project Recommendation Form; however, the PM/QI Committee will appoint members to the teams to ensure diverse perspectives, subject matter expertise, and resources are available to ensure team success. Teams will have three to seven members representing affected programs, divisions, disciplines, and clients as needed.

The QI teams will review the Appendix G QI Guide at their first meeting. QI project leader and team members should ensure the completion of the following at the required time frame: Team charter, Plan-Do-Study-Act checklist, QI storyboard, and QI project update. Within one meeting of a project's finalization, PM/QI Committee will survey all team members to determine QI process learning, perceived contribution to the project, the value of the project experience and outcome, lessons learned, and suggestions for overall agency QI efforts.

Sustaining QI project outcomes is essential. The QI team will monitor and report the QI project outcomes data for at least two years after closing the project. This data will also be reviewed bi-annually at PM/QI Committee meetings. Unfavorable outcomes will be addressed with program/process investigation and additional QI as needed.

C. QI training

CCPH has incorporated QI training goals and objectives within the agency Workforce Development (WFD) Plan. The WFD Plan includes goals, objectives, training descriptions, target audience, competencies addressed, resources/sources of training, and training schedules.

CCPH received a grant from the Ohio Public Health Partnership in March 2011 to train key Staff in CQI. Realizing the need for all staff to be trained in CQI, CCPH contracted with OSU Center for Public Health Practice to conduct onsite CQI training for all staff. In 2014, CCPH added the *OSU Center for Public Health Practice CQI for Public Health: The Fundamentals* training to the employee orientation requirements, ensuring all new employees are trained in CQI.

All PM/QI Committee Members (except the BOH member) and QI Project Team Leaders must take *the OSU Center for Public Health Practice CQI for Public Health: Tool Time*, unless they have already taken more advanced QI training. Note: The OSU training is currently down for maintenance. In the interim, PM/QI committee members will complete the following eLearning modules developed by the Population Health Improvement Partners: https://improvepartners.org/toolbox/toolbox-details/qi-videos-tools/

A review of QI concepts for all staff will occur annually during an employee in-service day.

VIII. Performance Management Activities

CCPH utilizes Clear Impact and Result Based Accountability (RBA) for performance management Activities. Clear Impact is a web-based performance management software that uses RBA to help government agencies, non-profits, communities, and foundations track the performance of their programs, measure the impact of their funding, and report on the progress of their missions to improve the lives of children, families, and communities worldwide. Initially, the Health Commissioner, Assistant

Health Commissioner of Community Health Services, and the Director of Nursing were primary license holders of the system. In the third quarter of 2023, ODH established a contract with Clear Impact that allowed local health departments to provide additional access to health department staff. CCPH expanded access to leadership staff and additional program staff responsible for tracking and reporting data in Clear Impact. Clear Impact provides the ability to create multiple scorecards. A scorecard is a canvas on which scorecard objects (Results, Indicators, Programs, and Performance Measures) are placed. CCPH has created scorecards for the CHIP, the CCPH Strategic Plan, and the Program Performance Measure.

A. Strategic Plan Monitoring and Review

CCPH 3 years Strategic Plan outlines the strategic priorities, goals, and objectives for CCPH and thus is an integral part of CCPH's performance management system. The PM/QI Committee will oversee the development of the strategic plan, and the PM/QI executive team will engage all staff and develop the plan. Once approved by the Board of Health, the strategic priorities, objectives, and performance measures will be entered into Clear Impact. The PM/QI committee will monitor the progress of strategic priorities, strategies, and activities through quarterly reviews. Progress notes will be added to the Clear Impact. In addition to evaluating progress towards the strategic priorities and objectives, an annual review at the September meeting will include consideration of revisions to the Strategic Plan, including new strategic priorities, objectives, and performance measures.

B. Program Performance Measure

Performance Measures simply give the means to know how well the agency/division/program provides those services and improves those lives. A good Performance Measure allows the staff to make changes and see whether those changes improve performance, that is, the ability to improve customers/clients' quality of life.

CCPH Program areas will utilize Appendix D Program Performance Measure worksheet to develop performance measures they would like to track and submit the Program Performance Measure Proposal form (Appendix E) to the PM/QI Committee. The PM/QI Committee will review all proposals to ensure that the measure (1) can be easily monitored, (2) is clearly and logically tied to performance management, and (3) has a strong rationale, i.e., those most in need of improvement, or those that are most fundamentally important to the program.

Once approved, the respective Branches' Assistant Health Commissioners will add the Program Performance Measure to the Clear Impact. The staff identified as responsible on the Program Performance Measure Proposal form (Appendix D) will collect and analyze data for each program performance measure. The designated staff is also responsible for entering the data into Clear Impact and adding notes to the 'Data Explanation' field if anomalies are noted. The PM/QI Committee can assist and support this process if needed.

At the September meeting, the PM/QI Committee will review the Program Performance Measures annually. If progress has been made and the activities are self-sustaining, the committee will consider revisions to the Measures. The committee will recommend QI to the programs/divisions if the data and notes indicate a negative trend.

IX. Communication

Communication of performance management and quality improvement activities conducted by CCPH will be accomplished through several methods, which may include, but are not limited to:

- Updates on program performance measures and QI projects at the all-hands meeting/newsletter at least quarterly
- Reports to the BOH
- Copies of the PM/QI plan, PM/QI Committee meeting minutes, and PM/QI Committee reports posted on the SharePoint
- Staff training sessions

X. Plan Monitoring and Evaluation

The PM/QI Plan will be regularly monitored and reviewed to ensure its effectiveness in guiding agency performance and quality improvement efforts. Monitoring of PM/QI plan objectives will occur at the timeframe listed in Appendix F PM/QI Plan objectives. Once every two years, the PM/QI Committee will conduct formal performance management and culture of quality self-assessment of CCPH leadership staff and general staff to solicit internal customer feedback on the system. Following this evaluation, the PM/QI Committee will review the PM/QI plan and make updates and changes to the plan as needed.

Appendix A Definitions

Accreditation: The measurement of health department performance against a set of nationally recognized, practice-focused and evidence-based standards; issuance of recognition of the achievement of accreditation within a specified time frame by a nationally recognized entity; and continual development, revision, and distribution of public health standards. The voluntary national accreditation program aims to improve and protect the public's health by advancing the quality and performance of Tribal, state, local, and territorial public health departments. (Public Health Accreditation Board website, http://www.phaboard.org/accreditation-overview/what-is-accreditation)

Baseline: An initial set of observations or data used for comparison. The basis against which change is measured. (Merriam-Webster dictionary; Tews et al., 2012)

Benchmark: A level of achievement against which organizations can measure their progress. A standard by which others may be measured or judged (National Performance Management Advisory Commission, 2010; Merriam-Webster dictionary)

Goal: A broad statement describing a desired future condition or achievement without being specific about how much or when. Often intangible or non-quantitative. (Moran & Duffy, 2012)

Indicator: A value, characteristic, or metric used to track the performance of a program, service, or organization, or to gauge a condition. Synonymous with the term "measure". (National Performance Management Advisory Commission, 2010)

Objective: A specific statement of a desired short-term condition or achievement; includes measurable end results to be accomplished within time limits. Objectives are narrow, focused, precise, and tangible. (Moran & Duffy, 2012)

Performance Management (PM): The practice of actively using performance data to improve the public's health. It involves strategically using performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results. (Turning Point Performance Management National Excellence Collaborative, 2003)

Performance Management and Quality Improvement (PM/QI) Plan: A document that provides basic guidance on how a health department will manage, deploy, and review quality and performance throughout the organization. The plan describes the processes and activities that will be put into place to ensure that performance and quality deliverables are produced consistently. (Kane, Moran, and Armbruster, 2010)

Performance Management System: A fully functioning performance management system that is completely integrated into health department daily practice at all levels includes: 1) setting organizational objectives across all levels of the department, 2) identifying indicators to measure progress toward achieving objectives on a regular basis, 3) identifying responsibility for monitoring progress and reporting, and 4) identifying areas where achieving objectives requires focused quality improvement processes. (PHAB, 2013a)

Performance Measures: Quantitative indicators of capacities, processes, or outcomes. Used to assess how well an organization is achieving its desired objectives or performance standards. (Tews et al., 2012; Business Dictionary, 2017)

Performance and Quality (PM/QI) Committee: A cross-sectional group of agency leaders and staff responsible for overseeing the implementation of performance management and quality improvement efforts.

Performance Standards: Objective standards or guidelines used to assess an organization's performance. They may be set based on national, state, or scientific guidelines, by benchmarking against similar organizations, based on the public's or leaders' expectations, or other methods. (Turning Point Performance Management National Excellence Collaborative, 2003)

PHAB: Public Health Accreditation Board. A national accrediting organization for public health departments.

Plan-Do-Study-Act (PDSA): An iterative four-stage problem-solving model for improving a process or carrying out change. PDSA is a cycle that should be used repeatedly for continuous change, made popular by W. Edwards Deming, who adapted the cycle from W. A. Shewhart's production process Plan-Do-Check-Act (PDCA). PDCA and PDSA are often used interchangeably. (Tews et al., 2012)

Qualitative: Data or information that is difficult to measure, count, or express in numerical terms; composed of words. (PHAB, 2013a; Tews et al., 2012)

Quality Improvement (QI): The use of a deliberate and defined improvement process, such as Plan-Do-Check (Study)-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 quality indicators in services or processes that achieve equity and improve the community's health. (Tews et al., 2012)

Quantitative: Data or information that can be expressed in numerical terms, counted, or compared on a scale. (PHAB, 2013a)

Results-Based Accountability (RBA): RBA is a disciplined way of thinking and acting to improve entrenched and complex social problems.

Scorecard: A scorecard is a canvas where other scorecard objects (Results, Indicators, Programs, and Performance Measures) are arranged. Scorecards allow you to create collections of similar information for reporting and presentations.

Storyboard: A visual depiction of a QI team's story, beginning at the "plan" phase and ending at the "act" phase. Graphics are essential when creating a storyboard with minimal complementary text. It should include key elements of all stages of the PDSA process. (Tews et al., 2012)

Strategic Plan: A 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 of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. (PHAB, 2013a)

Target: A desired number or level related to a performance measure. Targets are the performance objectives an organization is striving to reach. (National Performance Management Advisory Commission, 2010)

Appendix B Current PM/QI Committee Roster List

Position		Name	Term Start Date	Term End Date
Health Commissioner*		Julianne Nesbit	**Permanent**	
Assistant Health Commissioner of Environmental Health Services*		Tim Kelly		
Assistant Health Commissioner of Community Health Services *		Maalinii Vijayan		
QI Coordinator*		Maalinii Vijayan		
Special Projects Coordinator *		Tyler Braasch		
Epidemiologist*		Morgan Calahan		
Director of Nursing*		Tara Jimison		
Communications Coordinator		Keith Robinson		
Fiscal Officer		Katrina Stapleton		
Director of Environmental Health		Brian Williamson		
Director of Water and Waste		Robert Wildey		
WIC Director		Katherine Schneider		
BOH member		Dennis Brown	By vote of the BOH members	
Division/Program Staff	**Administration**	Amanda Myers	December 2023	November 2025
	Plumbing	Tim Kelly	Represents another permanent position	
	Water and Waste	Robert Wildey	December 2023	November 2025
	Environmental Health	Claudia Kadon	December 2023	November 2025
	Emergency Preparedness	Tyler Braasch	Represents another permanent position	
	Nursing Services	Tara Jimison	Represents another permanent position	
	Communicable Diseases	Morgan Calahan	Represents another permanent position	
	WIC	Kim Kretzer	September 2022	September 2024
**PM/QI Executive team*				

Appendix C QI Project Recommendation Form

Person suggesting the project:		
Briefly explain the problem and the need for this quality improvement project.		
List the division(s)/Program(s) affected	List the customer/stakeholders affected	Is any population disproportionately impacted by the problem *(If yes, explain)*
Key objective of the project		
Have you tried finding a solution in the past? If so, what did you try?		
Anticipated type of improvement result *(check all that apply)* ☐Enhanced program performance ☐Improved teamwork/communications ☐Increased efficiency ☐Improved quality of services ☐Reduced cost/waste ☐Increased customer satisfaction ☐Other:		
Does the project proposal stem from reviewing the data/performance measures that is already tracked? ☐Yes ☐No		
Check the location of the measure and explain the current trend of the measure: ☐Strategic Plan ☐CHIP ☐Program/Grant requirements ☐Program Performance Measure ☐Monthly financial report ☐QI scorecard ☐Monthly Permit Central Report ☐ Monthly CHS report ☐Customer satisfaction survey ☐Staff satisfaction survey ☐Staff suggestion box ☐Other: **Explain the current trend of the measure:**		
Measure(s) *Which primary quantitative indicators would demonstrate that performance had improved?*	Has baseline data been identified or collected? ☐Yes ☐No	
Resources needed *(training, financial, stakeholder input, etc.)*		
Who should lead this QI team?	Who should be on this team?	
Target Start Date	Target for completion of first improvement cycle ☐3 mo ☐6 mo ☐9 mo ☐1 yr ☐>1 yr	

For PM/QI Committee use ONLY					
Alignment with Performance Management	☐1	☐2	☐3	☐4	☐5
Feasibility	☐1	☐2	☐3	☐4	☐5
Complexity	☐1	☐2	☐3	☐4	☐5
Resources	☐1	☐2	☐3	☐4	☐5
Internal impact	☐1	☐2	☐3	☐4	☐5
External impact	☐1	☐2	☐3	☐4	☐5

Appendix D Program Performance Development Worksheet

Performance Measures simply allow you to know how well the agency/division/program provides those services and improves those lives. A good Performance Measure gives you and your staff the ability to make changes and see whether those changes improve your performance, that is, your ability to improve customers'/clients' quality of life.

How much did we do? How well did we do it? Is anyone better off?

- The most important Performance Measures tell us whether our clients or customers are better off due to receiving the services ("client Results," the lower left and right quadrants).
- The second most important measure will tell us whether the service or activity is done well (upper right quadrant).
- The least important measures are those that tell us what and how much we do. To answer the two most important questions – to identify candidates for the most important Performance Measures – take the following steps using the Data Quadrant that is derived from the intersection of quality and quantity and effort and effect.

Step 1 – The team discusses and answers the following questions for the program for which performance measure is being developed: What We Do? Whom We Serve? How We Impact? Note: If the program already tracks performance measure in Clear Impact, you may already have the response to the questions. Review the answers and make necessary updates.

Step 2 - How much did we do? *Upper Left Quadrant*
List the number of clients served. Distinguish different sets of clients as appropriate. Next, list the activities or services the department/division/program performs for its clients. Each activity or service should be listed as a measure.

Step 3 - How well did we do it? *Upper Right Quadrant*
For each service or activity listed in the upper left quadrant, choose those measures that will tell you if that activity was performed well (or poorly). The measures should be specific.

Step 4 – Is anyone better off? *Lower Left and Lower Right Quadrant (combined)*
Ask "In what ways are your clients better off as a result of getting the service in question? How would we know, in measurable terms, if they were better off?" Create pairs of measures (# and %) for each answer.
Note: Move to step 5 only if you have multiple performance measures and need to find the top 3 to 5 measures that you need to track in the performance management system. If not, the measure in the 'Is anyone better off?' quadrant is the final performance measure that you need to track. Complete Appendix E and submit it to the PM/QI coordinator.

Step 5 – Select the headline performance measure. Limiting the number of measures you use is key to ensuring your Performance Measures are useful. In most cases, you can select 3 to 5 "Headline Measures" from the list of candidate measures that you established with Appendix D. Usually, headline

measures only include measures from the upper right and lower right quadrants. List candidate Performance Measures and rate each as High (3), Medium (2), or Low (1) on each criterion: Communication Power, Proxy Power, and Data Power. The measure with the highest score will be the headline performance measure.

Communication power:

- Does this data measure whether your program is achieving the program outcome?
- Does this data measure how well we implement the program or are we doing things right?
- Does the data inform if clients are better off? Or are we doing the right things?
- Would you use this data if you were to talk about your program on an in-service day?

Proxy Power:

- Does this data say something of central importance about the result?
- Is this data a good proxy for other measures? Example: Measuring # of hospitalized COVID-19 cases can be a proxy power to the #of positives case, # of tests conducted, # of vaccinations

Data Power:

- Do you have quality data for this measure on a timely, consistent, and reliable basis?

What We Do?

Whom We Serve?

How We Impact?

How much we do? *#Customers served* *# Services/Activities* Example • # of outreach activities conducted • # of social media contacts • # of events	**How well do we do it?** *% Services/activities performed well* Example • # of people that were reached by events • % of people who signed up at the events • # of likes/shares in social media

Is Anyone Better Off? Or Are we doing the right things? Or What quantity/quality of change for the better did we produce?

#/% with improvement in:
Skills, Attitudes, Behavior, Circumstances

Example
# of new program participants

Selecting Headline Performance Measure

Candidate Measures	Communication Power	Proxy Power	Data Power	Total Points

Appendix E Program Performance Measure Proposal

<table>
<tr><td>☐ Administration
☐ Community Health Services
☐ Environmental Health Services</td><td colspan="2">Program Name:

Date:</td></tr>
<tr><td colspan="3">Describe the performance measure to monitor:</td></tr>
<tr><td colspan="3">Describe why it is important to monitor this performance measure:</td></tr>
<tr><td colspan="3">Rationale for Selection:
Aligns with: ☐National standards ☐State standards/priorities ☐Strategic Plan priorities ☐CHIP priorities
☐Program or grant priorities/requirements ☐Other, Specifically:
Is this a measure that can be quantified? ☐Yes ☐No
Is data for this measure readily available? ☐Yes ☐No
Will this measure give useful, actionable feedback? ☐Yes ☐No
If answered "no" to any of the above questions, outline a proposed process for achieving "yes" in Notes/Comments below</td></tr>
<tr><td rowspan="3">Outcome metrics</td><td>Current value</td><td>☐ Higher the better
☐ Lower the better</td></tr>
<tr><td>Baseline</td><td>Target</td></tr>
<tr><td colspan="2">If historical data is available, please list them below with the time frame:</td></tr>
<tr><td colspan="2">Data Source:</td><td>Frequency of collection & reporting:</td></tr>
<tr><td colspan="3">Staff Responsible:</td></tr>
<tr><td colspan="3">Notes/Comments:</td></tr>
<tr><td colspan="3">For PM/QI Committee use ONLY
Review date:
Proposal ☐Accepted ☐Advise modifications
Comments:</td></tr>
</table>

Appendix F: PM/QI Plan Objectives

Objective	Measure	Timeframe	Person Responsible
Review and update PM/QI Plan	Document updates to the 'Revisions' section	March	PM/QI Committee
Annually, support a minimum of 2 quality improvement projects	Team documentation; storyboards	Annually	PM/QI Committee
Review QI project progress	Attachment D Quarterly QI Project Update	March, June, September, and November	PM/QI Committee
Report the progress of program performance measures to the PM/QI Committee	Update the Performance Measures in the ClearImpact	March, June, September, and November	Respective Division/programs staff on PM/QI Committee
Review QI project data for a minimum of 2 cycles	Performance metrics in Clear Impact	June and November	PM/QI Committee
Evaluate the standardization of progress made by QI and Program Performance Measure	Performance metrics in Clear Impact	September	PM/QI Committee
Assure all new employees receive basic PM and QI training	Documentation of Training	Ongoing	PM/QI Coordinator and Fiscal Officer
Monitor the implementation of the transitional strategies	Documentation of PM/QI meeting minutes	March, June, September, and November	PM/QI Committee

Appendix G QI Guide (Separate document)

The QI Guide is a Separate Document that can be found in SharePoint