
District Health Department & Home Health Agency

Serving Harrison, Nicholas, Scott & Bourbon County Home Health

# Performance Management Plan

# &

# Quality Improvement Plan

June 2017

# Key Terms

**Accountability**
Subject to the obligation to report, explain or justify something; responsible; answerable.

**Accreditation**
Public health department accreditation is the development of a set of standards, a process to measure health department performance against those standards, and reward or recognition for those health departments who meet the standards.

**Aim Statement**
A written, measurable, and time-sensitive description of the accomplishments a group expects to make from its improvement efforts. The AIM Statement answers the question: ñWhat are we trying to accomplish?ò

**CHA (Community Health Assessment)**
The CHA is a collaborative process conducted in partnership with other organizations and describes the health status of the population, identifies areas for health improvement, determines factors that contribute to health issues, and identifies assets and resources that can be mobilized to address population health improvement.
*Public Health Accreditation Board, 2011*

**CHIP (Community Health Improvement Plan)**
The purpose of the CHIP is to describe how a health department and the community it serves will work together to improve the health of the population of the jurisdiction that the health department serves.
*Public Health Accreditation Board, 2011*

**Continuous Quality Improvement (CQI)**
An ongoing effort to increase an agencyôs approach to manage performance, motivate improvement, and capture lessons learned in areas that may or may not be measured as part of accreditation. Also, CQI is an ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, and outcomes. These efforts can seek ñincrementalò improvement over time or ñbreakthroughò all at once. Among the most widely used tools for continuous improvement is a four-step quality model, the Plan-Do-Check-Act (PDCA) cycle.

**Effectiveness**
The degree to which a decided, decisive, or desired effect is achieved; the degree to which desired objectives are achieved and a valid result is produced.

**Efficiency**
Accomplishment of, or ability to accomplish, a job with a minimum expenditure of time and effort.

**Evaluation**
To judge or determine the significance, worth, or quality of.

**Evidence**
The available body of facts or information indicating whether a belief or proposition is true or valid.

**Evidence-Based Practice (EBP)**
Entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected.

**Improvement Theory**
A hypothesis that includes what the data will show and what outcome is expected.

**Organizational Culture of Quality Improvement**
The use of a deliberate and defined improvement process, supported by the organization, and focused on activities that are responsive to community needs and improving population health. It refers to a continuous and on-going effort to achieve effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.

**Performance Management System**
A fully functioning performance management system that is completely integrated into WEDCO District Health Department and Home Health Agencyôs 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.

## Performance Standards
Performance Standards are organizational or system standards, targets, and goals to improve public health practices. Standards may be set based on national, state, or scientific guidelines, benchmarking against similar organizations, the publicôs or leadersô expectations, or other methods.

**Plan-Do-Check-Act (PDCA)**
An on-going, four-step management method used for the control and continuous improvement of processes and projects. WEDCO District Health Department and Home Health Agency uses the PDCA method for all QI Projects.

**Quality Culture**
QI is fully embedded into the way the agency does business, across all levels and programs. Leadership and staff are fully committed to quality, and results of QI efforts are communicated internally and externally. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives.
*Roadmap to a Culture of Quality Improvement, NACCHO, 2012.*

**Quality Improvement (QI)**
An integrative process that links knowledge, structures, processes, and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes within an organization.

**Quality Improvement Plan**
A structured plan to promote, support, and implement a culture of quality within the organization. The QI Plan defines the roles and responsibilities of the QI Team, Leadership, and staff; states the vision of the organization related to quality; identifies the goals and objectives of the plan; outlines how improvement is measured; and describes how the plan is monitored, reviewed, and updated.
**Quality Improvement Project Team**

A group of multi-skilled employees charged with the oversight and responsibility of developing, implementing, evaluating, and reporting QI Projects to improve a process or develop new ones that support the Health Departmentôs Quality Improvement and Performance Management System.

**Quality Improvement Roadmap**
A guide that describes six key phases on a path to a QI culture, outlining common characteristics for each phase and strategies an agency can implement to move to the next phase. Incorporating principles of change management, the roadmap identifies these characteristics on both the human and process aspect of change within an agency.
*Culture of Quality Improvement, NACCHO, 2012.*

**Quality Improvement Team**
Quality Improvement Teams may be made up of WEDCO District Health Department and Home Health Agency employees along with anyone needed to support a QI project. A QI Team may or may not include Quality Improvement Team Members.

**Quantify**
The numerical measurement of processes or features.

**Reporting Progress**
Reporting Progress is the documentation and reporting of how standards and targets are met, and the sharing of such information through appropriate feedback channels.

**SMART Goals**
Goals which are Specific, Measurable, Attainable, Realistic, and Timely.

**Standardize**
The process of developing and implementing a set of criteria applied in a consistent and systematic manner.

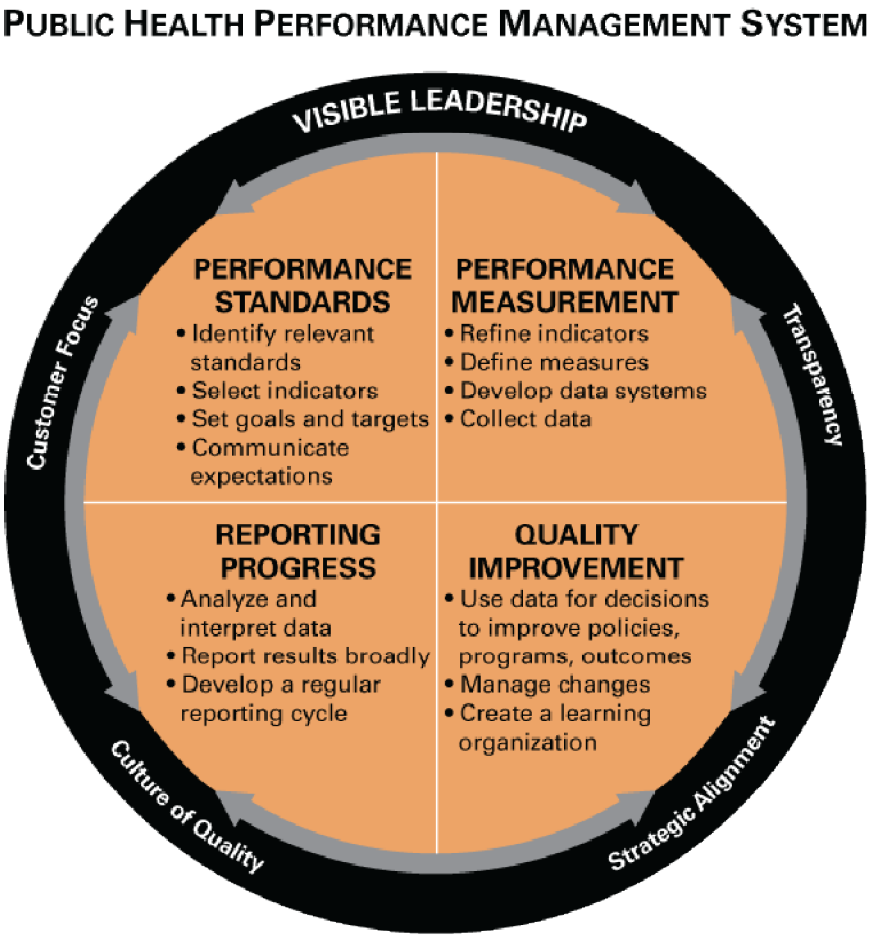
**Strategic Plan**
A plan that sets forth what an organization plans to achieve, how well it will achieve it, and how it will know if it has achieved it. The SP provides a guide for making decisions on allocating resources and on taking action to pursue strategies and priorities.
*Public Health Accreditation Board, 2011*

**Storyboard**
Graphic representation of a QI Teamôs quality improvement journey.

# Performance Management Plan

June 2017

The Public Health Foundation describes Performance Management as the ñpractice of actively using performance data to improve the publicôs healthò. The performance management model used by WEDCO District Health Department and Home Health Agency is based on the tool developed by Turning Point National Excellence Collaborative on Performance Management. Following is the Turning Point Model and descriptions for each component of the model:



# Performance Management Purpose

It is the goal of WEDCO District Health Department and Home Health Agency to develop and maintain a performance management system that includes all of the above components of the model. In order to achieve this goal, WEDCO District Health Department and Home Health Agency will:

- Set specific performance management objectives for each of these core programs and include benchmarking (when possible) against similar agency, national, state, or scientific guidelines.
- Measure capacity, process, or outcomes of performance objectives.
- Report progress to local and district boards of health and other stakeholders on a regular basis.
- Incorporate performance management objectives with the agencyôs current Quality Improvement Plan to continuously monitor and improve of the agencyôs operations.

According to the Public Health Foundation, performance management practices have been shown to measurably improve public health outcomes, create efficiencies working with partners, and help public health workers solve complex problems. Other benefits of adopting a performance management system include better allocation of resources, prioritization of programs, changes of policies to meet current agency goals, and improve the overall quality of public health practice.

By adopting a Performance Management System, WEDCO District Health Department and Home Health Agency hopes to improve health, increase efficiency, and create other benefits for our community including:

- Better use of the dollars invested in public health.
- More accountability by funding agencies and the taxpayerôs dollar.
- Reduce duplication of services.
- Obtain a better understanding of the agencyôs accomplishments.
- More of an emphasis on quality of services vs. quantity of services.
- Become more effective at problem solving.

# Performance Management Plan

1. Identification of Performance Management (PM) Coordinator

   The Public Health Director will appoint a PM Coordinator either from existing staff or through the agency recruitment process. The PM Coordinator will lead the agencyôs efforts in its performance management plan.

2. Identify Performance Standards for Core Programs

   Staff assisted in the identification of the agencyôs core programs and performance standards. Each core program became a sub-committee with relevant staff assigned to that committee. The core programs are identified as:

   - Community Health Centers
   - Communicable Disease (TB, Immunizations, HIV)
   - Population-Focused Health (Wellness, Diabetes Education, Tobacco Education, CHA/CHIP)
   - Home Health
   - Administration (Human Resources, Financial, Accreditation)
   - Preparedness/Safety
   - Environmental Services

3. Development of Performance Management (PM) Team

   The PM Coordinator along with the Public Health Director identified existing staff members to serve on the agencyôs performance management team. The Performance Management Team will meet quarterly each year during the following months: July, October, January, April.

The initial PM Team members are:

| Name | Title |
|---|---|
| Dr. Crystal Miller | Public Health Director |
| Tina Bennett | Director of Administrative Services |
| Rachel Kendall | Human Resources/ Accounting Supervisor |
| Amber Broaddus | Accreditation Coordinator/ PM Coordinator |
| April Thomas | Public Health Services Manager |
| Sherrie Tibbs | Clinic Nurse Administrator |
| Gene Thomas | Environmental Director |
| Rene Rawlins | Home Health Director of Nursing |

4. Setting Performance Standards and Objectives for each Core Program

   Each of the core programs identified in #2 above are required to identify at least two performance management objectives to measure for each health department fiscal year. The current performance measures are included as an appendix at the end of this document. All performance standards will use SMART objectives (specific, measureable, attainable, realistic, and timely). A copy of these objectives is also kept in the possession of the PM Coordinator.

5. Data Collection, Monitoring , Measure and Tracking

   The collection of data for the performance standards will vary (excel reports, e-reports, logs, etc.). Staff/ Department are responsible for the data collection, monitoring and reporting of the performance standards. Sub-committee members are required to continuously monitor and measure progress of the performance objectives for the core program(s) in which they are assigned. Tracking of performance standards will be done using Klipfolio.

6. Reporting and Sharing Performance Objectives

   Progress on performance measures and objectives will be discussed and reported among staff at agency staff meetings, to the local and district boards of health on an annual basis. Reports may also be shared with community members, partners, grant funders, other local public health agencies, state public health agencies, other local governmental agencies and the media. When reporting progress beyond the agency staff, the appropriate staff and managers will review performance data before it is reported out. This will allow for the most accurate, understandable performance reports. These reports may include charts, tables, and maps that are generally user-friendly and easy to understand.

7. Identification of success/improvement strategies for Performance Objectives

   The subcommittee determines if additional improvement strategies are needed to increase the success of reaching the objectives. Each subcommittee should incorporate the Plan-Do-Check-Act Cycle of the Quality Improvement Plan if additional improvement strategies are needed. When goals are not achieved, the subcommittee should demonstrate that critical thinking has taken place and quality improvement steps are taken to increase performance in that area in the future.

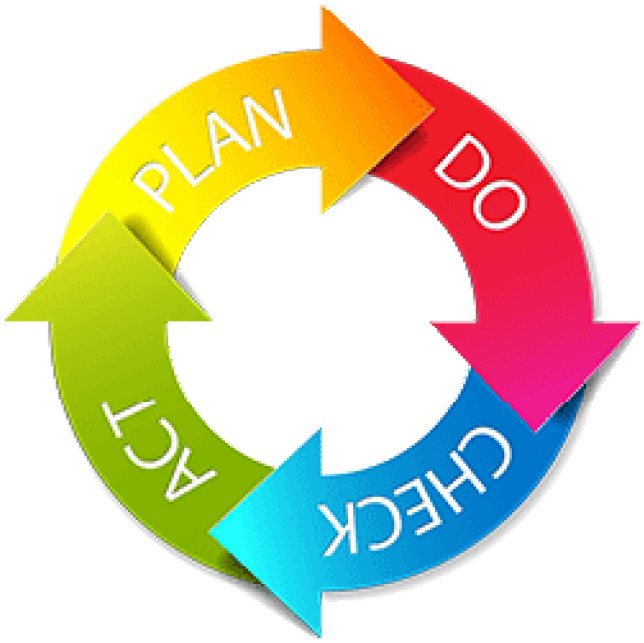
8. Completing Agency Performance Management Self-Assessment

   The agency PM Team completes a PM self-assessment every two years. The assessment tool used is the Performance Management Self-Assessment Tool by Turning Point Performance Management National Excellence Collaborative, 2004. A copy of the self-assessment template is included as an appendix to this document.

9. Review and revision of the written plan will be done on an annual basis by the PM Team Members.

   WEDCO District Health Department and Home Health Agency staff will be provided with access to any revisions made to the plan.

# Quality Improvement Plan




June 2017

# Quality Improvement Purpose

The WEDCO District Health Department and Home Health Agency Quality Improvement (QI) Plan exists within the context of the mission, vision, values, and priorities of the 2013-2018 Strategic Plan. The QI Plan is created to enable WEDCO District Health Department and Home Health Agency to more effectively achieve its stated mission:

*To be a voice, partner and leader in building stronger, healthier and safer communities for all, where we live, work and play.*

The goals that drive the culture of WEDCO District Health Department and Home Health Agency are:

- Strengthen cooperative agency systems
- Strengthen communications
- Strengthen workforce
- Improve community health through collective impact
- Strengthen data use

QI activities at WEDCO District Health Department and Home Health Agency are conducted to strive for the highest quality of services while meeting the needs and expectations of the community. The goal is to continuously improve the execution and design of processes across the 10 Essential Public Health Services (Center for Disease Control and Prevention, 2010):

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.

QI activities at WEDCO District Health Department and Home Health Agency also strive to systematically assess and improve care and service to meet the following 2018-2022 Community Health Improvement Plan priorities:

- Substance Abuse
- Chronic Disease
- Obesity
- Tobacco use

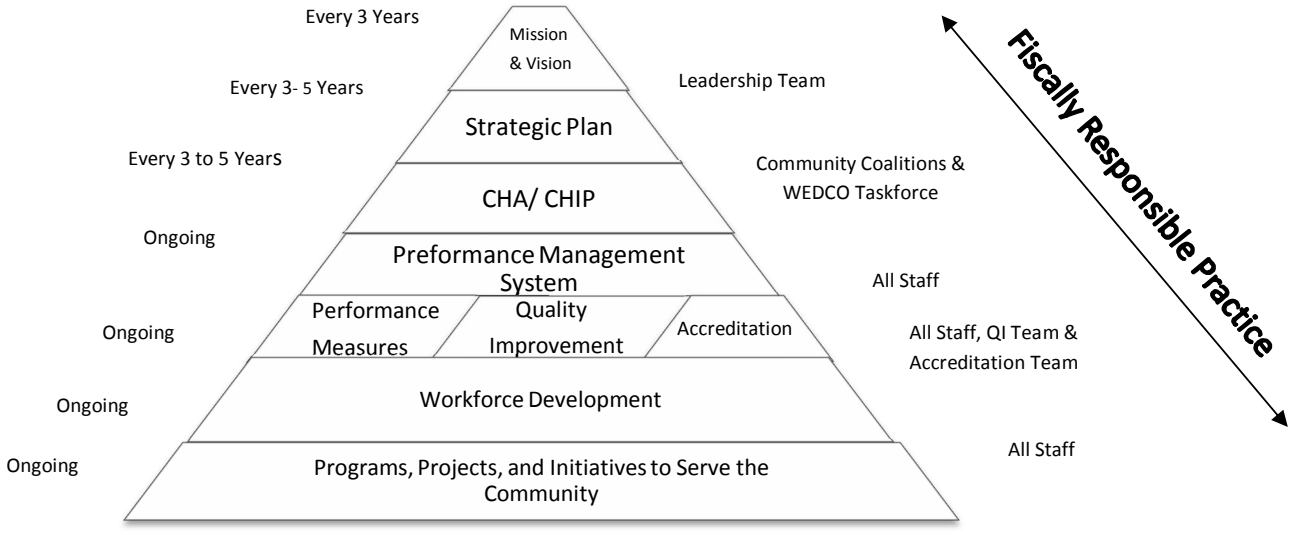
# Culture of Quality and Desired Future State

WEDCO District Health Department and Home Health Agency acknowledges the importance of quality improvement within an effective performance management system which includes a culture of quality, ongoing QI activities ï both programmatic and administrative, and continued learning within the organization. Additionally, evolving environments in public health along with Public Health Accreditation Board standards and recommendations will be this planôs focus to be an effective 21st century health department.

Continuing to strengthen WEDCO District Health Department and Home Health Agencyôs QI culture includes the formation of a QI Team, creation of a written QI plan, implementation of QI activities, assessment of the effectiveness of the QI plan and its activities along with updating the QI plan on an as needed basis.

The future state of quality at WEDCO District Health Department and Home Health Agency includes the following:

- Continued growth of the QI & PM systems at WEDCO District Health Department and Home Health Agency, assuring participation in both systems by all employees of the department
- Demonstrated competence by all staff in a wide range of quality improvement tools
- Advanced agency QI maturity as evidenced by completed maturity assessments
- Data driven decision making to include program planning and prioritization.




Pyramid demonstrating the interrelatedness of agency systems

WEDCO District Health Department and Home Health Agency recognizes that successful agencies operate with a systems-based approach. The figure above demonstrates the interrelatedness of large agency systems as well as responsible staff/teams, timeline, and fiscal practice. A successful 21st century health department nurtures integration of agency systems to maximize favorable program, process, and population health outcomes.

# Quality Improvement Structure

Quality Improvement provides ongoing operational leadership of continuous quality improvement and accreditation activities at WEDCO District Health Department and Home Health Agency.

The Public Health Director has charged the multidisciplinary QI Team with carrying out the purpose and scope of the QI program in the department. The QI Team is responsible for oversight of QI efforts and for promoting, training, challenging, and empowering staff to participate in the ongoing process of QI.

The WEDCO District Health Department and Home Health Agency QI Team will guide and evaluate the QI process by:

- Identifying, monitoring, and evaluating quality improvement projects
- Providing support to QI project teams
- Encouraging and fostering a supportive QI culture
- Implementing at least one QI project within the QI Team annually

QI Team will make every effort to come to consensus on issues requiring a decision. However, if consensus cannot be reached, the QI Team will make decisions by a majority vote.

The QI Team will meet at least quarterly and maintains records and minutes of all meetings. These minutes are then presented for review and acceptance by QI Team members. At least annually, the QI Team will provide a report of the QI program to the Boards of Health.

**Membership**

| Name | Title | Program |
|---|---|---|
| Dr. Crystal Miller | Public Health Director | Administration |
| Tina Bennett | Director of Administrative Services | Administration |
| Rachel Kendall | Human Resources/ Accounting Supervisor | Administration |
| Amber Broaddus | Accreditation Coordinator | Accreditation, QI/PM, NEP, General Public Health |
| April Thomas | Public Health Services Manager | Chronic Disease, Tobacco, Wellness, General Public Health |
| Sherrie Tibbs | Clinic Nurse Administrator | WIC, STIs, Reproductive Health General Public Health |
| Gene Thomas | Environmental Director | Environmental Health |
| Rene Rawlins | Home Health Director of Nursing | Home Health |

# Quality Improvement Training

**New Employee Orientation**

As part of the new employee orientation process, new employees are required to review the following information:

- Quality Improvement Quick Guide: Public Health Foundation. Click here to view this guide and webinar.
- WEDCO District Health Department and Home Health Agency Quality Improvement Plan.
- CDC Performance Management and Quality Improvement. Click here to view this guide.
- Additional QI training as described in the WEDCO District Health Department and Home Health Agency Workforce Development Plan

**Advanced Training for QI, Accreditation, and Leadership Teams**

As part of the QI Team, members are given the Public Health Foundation Public Health Quality Improvement Encyclopedia and are provided additional training on QI tools and methodologies. These include, but are not limited to:

- Aim Statement
- Affinity Diagrams
- Brainstorming
- Cause & Effect Diagrams
- Data Collection & Analysis (Check Sheet, Bar Chart, Pie Chart, Run Chart)
- Flowcharts
- Gantt Chart
- Storyboards
- Quality Improvement webinars

**QI Project Team**

Each QI project team will receive training and technical support at a minimum at the project kick-off meeting and at an interim point as determined by the project lead.

**Ongoing Staff Training**

At least annually, all staff are provided a QI training which may include:

- Basic QI tools
- Research on QI topics
- Applicable completed QI projects
- Integration of QI practice

# Identification of Projects and Alignment with Strategic Plan and Performance Management Plan

**Project Selection**

QI projects will be selected based on the need to improve program processes, objectives, and/or performance measures that align with the department plans and performance management system. Projects may be identified in a number of ways, including, but not limited to project ideas by staff, identification by the Leadership Team or QI Team, results of QI maturity assessment, and by staff during quarterly reviews of performance data. Projects will be programmatic and administrative in nature.

QI team members will decide to accept a proposal, request more information or modifications, or reject the proposal based on the QI Project Selection Criteria below. QI team members are available to offer technical assistance to staff to develop project proposals. Project proposals will have priority if they are data driven and if they are aligned with the department Strategic Plan, the Community Health Improvement Plan, program work plans, program evaluations, Accreditation, customer satisfaction, or ethical & cultural competency goals. A QI team member will be assigned to each accepted QI project.

The QI Team will oversee quality improvement initiatives within the department. WEDCO District Health Department and Home Health Agency expects at least two full scale quality improvement projects and two small scale quality improvement projects to be addressed annually. To further develop QI Team competency, increase engagement, and promote action-based meetings, the QI Team will complete at least one quality improvement project annually to be worked on during QI Team meetings.

**Alignment**

The QI Plan identifies how the department will build capacity for improvement and implement improvement activities so that department and community health outcomes can be achieved. The following plans are the backbone of the WEDCO District Health Department and Home Health Agency that provide structure and guidance for quality improvement activities that ultimately impact the communityôs health.

- Public Health Emergency Response Plan (PHERP)
- Community Health Improvement Plan
- Strategic Plan
- WEDCO District Health Department and Home Health Agency Workforce Development Plan
- WEDCO District Health Department and Home Health Agency Performance Management Plan

In addition to advancing the objectives contained in these plans, the QI Plan will also promote compliance with contract and grant requirements across all department programs.

# Monitoring the Quality Improvement System

**Monitoring the QI Plan**

The WEDCO District Health Department and Home Health Agency QI Plan undergoes extensive management at all levels of the agency on a quarterly and annual basis through reporting from the QI Team to the QI Coordinator.

**Data Collection and Monitoring**

Data will be collected for each performance measure and each QI project. It will be the responsibility of each lead staff member as identified in the performance management plan, for collecting and monitoring data for their own measure. It will be the responsibility of each project team leader to collect and monitor data for their own QI project. Assistance and support will be provided by the director and/or Accreditation Coordinator as requested.

QI project data will be reviewed at least quarterly at the QI Team meeting.

Additional considerations for data collection, analysis, and monitoring include:

- For individual projects, data will be collected and analyzed as indicated in the project plan. Staff directing the project will have responsibility for all aspects of the project including the collection and analysis of project data. This information may be presented in the form of a storyboard.
- Project data will be reviewed by appropriate WEDCO District Health Department and Home Health Agency staff along with QI Project Teams and QI Team members.
- Data from all projects will be collected and analyzed by appropriate WEDCO District Health Department and Home Health Agency staff and this information will be summarized on the QI storyboard and stored on the internal shared drive.
- All data reporting will be included in the project documentation and QI project outcomes will be discussed in the annual QI summary report.
- Outcomes of QI projects completed within two years will be reviewed bi-annually at QI Team meetings to assure project sustainability.

**Actions to Make Improvements Based on Progress Reports**

Based on progress reports, the Leadership Team and/or the QI Team may make recommendations or suggestions regarding implementation of QI projects and/or determine if a performance measure issue is significant enough to warrant the implementation of a QI project.

**Sustaining QI Project Outcomes**

Sustaining QI project outcomes is essential. Response by all staff, the QI Team, and QI Project Teams to monitoring data and addressing unfavorable outcomes will be critical. QI project outcomes data will be monitored for at least two years after the QI project has closed. This data will be reviewed bi-annually at QI Team meetings. Unfavorable outcomes will be addressed with program/process investigation and additional QI as needed.

**Communication of QI**

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

| Key Message | Mode of Communication | Target Audience |
|---|---|---|
| Opportunities to apply QI tools and methods | QI Team Meetings and when applicable, All Staff/Program Meetings | Staff |
| QI outcomes, lessons learned, resources | QI Team Meetings, All Staff/Program Meetings, Board of Health Meetings | Staff, Board of Health |
| QI training opportunities | QI Team Meetings, QI Project Team Meetings, All Staff Development training | Staff |
| QI branding, definitions, and value | Storyboards, visuals | Staff |
| Progress on QI Team goals and objectives | Storyboards, visuals, QI Team meetings | Staff |
| QI 101 | Online Training Modules | Staff |
| Annual QI Project Summary | QI Team Meetings, All Staff Meetings, Board of Health Meetings | Staff, Board of Health |

**Review of the Process and the Progress Toward Achieving Goals and Objectives**

Process and progress toward achieving goals and objectives will be documented on the WEDCO District Health Department and Home Health Agency QI work plan. The WEDCO 2017-2020 QI work plan focuses on three goals: promote continuous process improvement, sustain quality improvement project outcomes, and continue to build a culture of quality. The work plan is reviewed at least quarterly by the Leadership Team and QI Team. Progress is also monitored through the agency performance management system to assure that progress is being made. At least annually, analysis of work plan strategies is completed to determine next steps.

**Reports on Progress**

The WEDCO District Health Department and Home Health Agency Leadership and QI team are responsible for the ongoing evaluation of the QI Plan goals and objectives, including review of progress reports and data-monitoring and analysis. The QI Plan is reviewed at least once per year and QI Work Plan is reviewed quarterly. Both the QI Plan and Work Plan can be revised as needed to reflect QI project activities and those requiring modification.

## APPENDICES

### Performance Management System

- Performance Management Objectives Overview (FY 2018)
- WEDCO District Health Department and Home Health Agency Performance Management Objectives Form Template
- WEDCO District Health Department and Home Health Agency Performance Management Objectives Progress Report *(This form is used to track and report progress on each performance metrics on a quarterly basis)*
- WEDCO District Health Department and Home Health Agency Performance Management Opportunities for Improvement Template
- Performance Management Self-Assessment Template (*WEDCO District Health Department and Home Health Agency completed the first self-assessment in 2017, a copy is kept on file with the PM Coordinator)*

### Quality Improvement Plan

- QI Project Planning and Definition
- QI Project Report *(Used to report on the QI project)*

## Performance Management Objectives Summary/ Overview FY18

| Program | Measure | Target | Monitoring | Reporting |
|---|---|---|---|---|
| Administration | By June 30, 2018 25% of agency job descriptions will be updated with new or updated training requirements. | 25% | Rachel Kendall | Tina Bennett |
| | By June 30, 2018 75% of progress towards the 2013-2018 Strategic Plan will be reported. | 75% | Amber Broaddus | Amber Broaddus |
| | By June 30, 2018 100% of agency staff will have received Quality Improvement and Performance Management training. | 100% | Amber Broaddus | Amber Broaddus |
| | By December 31, 2017 100% of all required accreditation documentation will be uploaded to the shared drive. | 100% | Amber Broaddus | Amber Broaddus |
| Community Health Centers | By June 30, 2018 Community Health Centers will have created a baseline for HPV vaccinations and other services provided to the community. | 100% | Janie Martin | Sherrie Tibbs |
| | By June 30, 2018 Each Community Health Center will maintain a quarterly average of 95% overall customer satisfaction rating. | 95% | Janie Martine | Sherrie Tibbs |
| Environmental Health | By June 30, 2018 restaurant inspections will be 100% completed with 0 overdue. | 100% | Natasha Collins | Gene Thomas |
| | By June 30, 2018 Environmental staff will address and remedy 100% of complaints received. | 100% | Gene Thomas | Gene Thomas |
| Preparedness/ Safety | By June 30, 2018 WEDCO District Health Department and Home Health Agency will test the all staff call down list with 90% responding within one hour. | 90% | Gene Thomas | Gene Thomas |
| Home Health | By June 30, 2018 Home Health will have 50% of all clerical forms will be available and utilized electronically. | 50% | Rene Rawlins | Rene Rawlins |
| | By June 30, 2018 Home Health will decrease medical supply cost by 10%. | 10% | Rene Rawlins | Rene Rawlins |
| Communicable Disease | By June 30, 2018 ERRT members will attend all required ERRT trainings, and complete 4 hours of CEUs annually. | 100% | Gene Thomas | Gene Thomas |
| | By June 30, 2018 Harrison County Syringe Exchange Program (SEP) will increase community use of SEP by 10%. | 10% | Amber Broaddus | Amber Broaddus |
| | By June 30, 2018 the Harrison County Syringe Exchange Program (SEP) will increase the number of HIV/HCV community screenings by 5%. | 5% | Amber Broaddus | Amber Broaddus |
| Community Health Promotion | By June 30, 2018 Go 365 will increase number of screening events by 10%. | 10% | Adam Lawrence | April Thomas |
| | By June 30, 2018 Go 365 will increase the number screenings performed by 10%. | 10% | Adam Lawrence | April Thomas |
| | By June 30, 2018 the Community Resource will be 100% completely updated and available for community partners and stakeholders. | 100% | April Thomas | April Thomas |
| | By June 30, 2018 all program managers and community health staff will have completed training in MAPP. | 100% | April Thomas | April Thomas |
| | By June 30, 2018 HANDS para home visits will increase by 10%. | 10% | Libby Ritchey | April Thomas |
| | By June 30, 2018 HAND professional home visits will increase by 10%. | 10% | Libby Ritchey | April Thomas |
| | By June 30, 2018 a taskforce to address the goals of the Community Health Improvement Plan will be created and hold regular meetings. | 100% | April Thomas | April Thomas |

# Performance Management Objectives


**Program:**

**Team Members:**

| Cost Center | SMART Performance Objective | Target | Person Responsible: Monitoring | Person Responsible: Reporting to PM |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |


District Health Department & Home Health Agency
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# Performance Management Objectives Progress Report

| | |
|---|---|
| Core Program: | |
| PM Objective: | |
| Unit of Measurement | |

| Date | Description of Activity | % or # of activities reached |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| Please include any special comments or circumstances below: | | |
| | | |

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# Performance Management Opportunities for Improvement

If you did not meet the goal for your PM Objective, please complete this form. Include any cause and effect, Fishbone Diagrams that you may have used.

| | |
|---|---|
| **Month/Year** | |
| **Core Program:** | |
| **PM Objective:** | |

| | |
|---|---|
| **#1. Lessons Learned /** Why did you not meet your goal? | |

| | |
|---|---|
| **#2. Are you going to continue working toward strategy and goal?** **If yes, please complete boxes 3 and 4* | YES or NO |

| | |
|---|---|
| **#3. Opportunities for Improvement / Next Steps** What additional or different strategies can you implement to help you meet your goal? | |

| | |
|---|---|
| **What additional tools would you need to implement your new strategies?** | |

# Public Health Performance Management
# Self-Assessment Tool Template


**Updated by the Public Health Foundation in June 2013**

*The full version of the completed tool is in the possession of the Accreditation Coordinator .*

June 2017

**Section I. Visible Leadership** - *Senior management commitment to a culture of quality that aligns performance management practices with the organizational mission, regularly takes into account customer feedback, and enables transparency about performance between leadership and staff.*

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| 1. Senior management demonstrates commitment to utilizing a performance management system | | | | |
| 2. Senior management demonstrates commitment to a quality culture | | | | |
| 3. Senior management leads the group (e.g., program, organization or system) to align performance management practices with the organizational mission | | | | |
| 4. Transparency exists between leadership and staff on communicating the value of the performance management system and how it is being used to improve effectiveness and efficiency | | | | |
| 5. Performance is actively managed in the following areas (check all that apply) A. Health Status (e.g., diabetes rates) | | | | |
| B. Public Health Capacity (e.g., public health programs, staff, etc.) | | | | |
| C. Workforce Development (e.g., training in core competencies) | | | | |
| D. Data and Information Systems (e.g., injury report lag time, participation in intranet report system) | | | | |
| E. Customer Focus and Satisfaction (e.g., use of customer/stakeholder feedback to make program decisions or system changes) | | | | |
| F. Financial Systems (e.g., frequency of financial reports, reports that categorize expenses by strategic priorities) | | | | |
| G. Management Practices (e.g., communication of vision to employees, projects completed on time) | | | | |
| H. Service Delivery (e.g., clinic no-show rates) | | | | |

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| I. Other (Specify): | | | | |
| 6. There is a team responsible for integrating performance management efforts across the areas listed in 5 A-I | | | | |
| 7. Managers are trained to manage performance | | | | |
| 8. Managers are held accountable for developing, maintaining, and improving the performance management system | | | | |
| 9. There are incentives for effective performance improvement | | | | |
| 10. A process or mechanism exists to align the various components of the performance management system (i.e., performance standards, measures, reports, and improvement processes focus on the same | | | | |
| 11. A process or mechanism exists to align performance priorities with | | | | |
| 12. Personnel and financial resources are assigned to performance management functions | | | | |

**Section II. Performance Standards** - *Establishment of organizational or system performance standards, targets, and goals to improve public health practices. Standards 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.*

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| 1. The group (program, organization or system) uses performance standards | | | | |
| 2. The performance standards chosen used are relevant to the organization's activities | | | | |
| 3. Specific performance targets are set to be achieved within designated time periods | | | | |
| 4. Managers and employees are held accountable for meeting standards and targets | | | | |

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| 5. There are defined processes and methods for choosing performance standards, indicators, or targets[1] | | | | |
| A. National performance standards, indicators, and targets are used when possible (e.g., National Public Health Performance Standards, Leading Health Indicators, Healthy People 2020, Public Health Accreditation Board Standards and Measures) | | | | |
| B. The group benchmarks its performance against similar | | | | |
| C. Scientific guidelines are used | | | | |
| D. The group sets priorities related to its strategic plan | | | | |
| E. The standards used cover a mix of capacities, processes, and outcomes | | | | |
| 6. Performance standards, indicators, and targets are communicated throughout the organization and to its stakeholders and partners | | | | |
| A. Individuals' performance expectations are regularly | | | | |
| B. The group relates performance standards to recognized public health goals and frameworks, (e.g., Essential Public Health | | | | |
| 7. The group regularly reviews standards and targets | | | | |
| 8. Staff understand standards and targets | | | | |
| 9. Performance standards are aligned across multiple groups (e.g., same child health standard is used across programs and agencies) | | | | |
| 10. Training is available to help staff use performance standards | | | | |
| 11. Personnel and financial resources are assigned to make sure efforts are guided by relevant performance standards and targets | | | | |

[1] For guidance on various methods to set challenging targets, refer to the "Setting Targets for Objectives" tool (p. 93) in Baker, S, Barry, M, Bechamps, M, Conrad, D, and Maiese, D, eds. *Healthy People 2010 Toolkit: A Field Guide to Health Planning*. Washington, DC: Public Health Foundation, 1999. www.health.gov/healthypeople/state/toolkit. Additional target setting tools are available in the State Healthy People Tool Library at http://www.phf.org/resourcestools/Pages/Healthy_People_2010_Toolkit.aspx

## Section III. Performance Measurement - *Development, application, and use of performance measures to assess achievement of performance standards.*

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| 1. The group (program, organization, or system) uses specific measures for established performance standards and targets | | | | |
| A. Measures are clearly defined | | | | |
| B. Quantitative measures have clearly defined units of measure | | | | |
| C. Inter-rater reliability has been established for qualitative measures | | | | |
| 2. Measures are selected in coordination with other programs, divisions, or organizations to avoid duplication in data collection | | | | |
| 3. There are defined methods and criteria[3] for selecting performance measures | | | | |
| A. Existing sources of data are used whenever possible | | | | |
| B. Standardized measures (e.g., national programs or health indicators) are used whenever possible | | | | |
| C. Standardized measures (e.g., national programs or health indicators) are consistently used across multiple programs, divisions, or organizations[4] | | | | |
| D. Measures cover a mix of capacities, processes, and outcomes[5] | | | | |
| 4. Data are collected on the measures on an established schedule | | | | |
| 5. Training is available to help staff measure performance | | | | |
| 6. Personnel and financial resources are assigned to collect performance measurement data | | | | |

[3] For a list of criteria and guidance on selecting measures, refer to Lichiello P. *Guidebook for Performance Measurement*. Seattle, WA: Turning Point National Program Office, 1999:65.

http://www.phf.org/resourcestools/Documents/PMCguidebook.pdf

[4] For examples of sources of standardized public health measures, refer to "Health and Human Services Data Systems and Sets" (p. 103) in the *Healthy People 2010 Toolkit: A Field Guide to Health Planning* at http://www.phf.org/resourcestools/Pages/Healthy_People_2010_Toolkit.aspx.

[5] Donabedian, A. The quality of care. How can it be assessed? *Journal of the American Medical Association*. 1988;260:1743-8.

**Section IV. Reporting Progress** - *Documentation and reporting progress in meeting standards and targets, and sharing of such information through appropriate feedback channels.*

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| 1. The group (program, organization or system) documents progress related to performance standards and targets | | | | |
| 2. Information on progress is regularly made available to the following (check all that apply) | | | | |
| A. Managers and leaders | | | | |
| B. Staff | | | | |
| C. Governance boards and policy makers | | | | |
| D. Stakeholders or partners | | | | |
| E. The public, including media | | | | |
| F. Other (Specify): | | | | |
| 3. Managers at all levels are held accountable for reporting | | | | |
| A. There is a clear plan for the release of performance reports (i.e., who is responsible, methodology, frequency) | | | | |
| B. Reporting progress is part of the strategic plan | | | | |
| 4. A decision has been made on the frequency of analyzing and reporting performance progress for the following types of measures[6] | | | | |
| A. Health Status | | | | |
| B. Public Health Capacity | | | | |
| C. Workforce Development | | | | |
| D. Data and Information Systems | | | | |
| E. Customer Focus and Satisfaction | | | | |
| F. Financial Systems | | | | |
| G. Management Practices | | | | |
| H. Service Delivery | | | | |
| I. Other (Specify): | | | | |

[6]See Section I, question 6 for examples of each type of measure.

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| 5. The group has a reporting system that integrates performance data from programs, agencies, divisions, or management areas (e.g., financial systems, health outcomes, customer focus and satisfaction) | | | | |
| 6. Training is available to help staff effectively analyze and report performance data | | | | |
| 7. Reports on progress are clear, relevant, and current so people can understand and use them for decision-making (e.g., performance management dashboard) | | | | |
| 8. Personnel and financial resources are assigned to analyze performance data and report progress | | | | |
| 9. Leaders are effective in communicating performance outcomes to the public to demonstrate effective use of public dollars | | | | |

**Section V. Quality Improvement (QI)** - *In public health, the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, that focuses on activities that address community needs and population health improvement. QI refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.*

| | Never/ Almost Never | Some-times | Always/ Almost Always | Note details or comments mentioned during the assessment |
|---|---|---|---|---|
| 1. One or more processes exist to improve quality or performance | | | | |
| A. There is an entity or person responsible for decision-making based on performance reports (e.g., top management team, governing or advisory board) | | | | |
| B. There is a regular timetable for QI processes | | | | |
| C. The steps in the QI process are effectively communicated | | | | |
| 2. Managers and employees are evaluated for their performance improvement efforts (i.e., performance improvement is in employees' job descriptions and/or annual reviews) | | | | |
| 3. Performance reports are used regularly for decision-making | | | | |
| 4. Performance data are used to do the following (check all that apply) | | | | |
| A. Determine areas for more analysis or evaluation | | | | |
| B. Set priorities and allocate/redirect resources | | | | |
| C. Inform policy makers of the observed or potential impact of decisions under their consideration | | | | |
| D. Implement QI projects | | | | |
| E. Make changes to improve performance and outcomes | | | | |
| F. Improve performance | | | | |
| 5. The group (program, organization, or system) has the capacity to take action to improve performance when needed | | | | |
| A. Processes exist to manage changes in policies, programs, or infrastructure | | | | |

| | | | | |
|---|---|---|---|---|
| B. Managers have the authority to make certain changes to improve performance | | | | |
| C. Staff has the authority to make certain changes to improve performance | | | | |
| 6. The organization regularly develops performance improvement or QI plans that specify timelines, actions, and responsible parties | | | | |
| 7. There is a process or mechanism to coordinate QI efforts among groups that share the same performance targets | | | | |
| 8. QI training is available to managers and staff | | | | |
| 9. Personnel and financial resources are allocated to the organization's QI process (e.g., a QI office exists, lead QI staff is appointed) | | | | |
| 10. QI is practiced widely in the program, organization, or system | | | | |


District Health Department & Home Health Agency
Serving Harrison, Nicholas, Scott & Bourbon County Home Health

# Quality Improvement/Quality Planning Project Definition Document

| | |
|---|---|
| **Project Name:** *1 - 3 word identifier* | **Sponsor(s):** *Who Is governing and resourcing this project? (Division, Program, Manager or Exec Leader)* |
| **Problem/Opportunity:** *1-3 sentence description of the problem/opportunity (without assumption of cause or solution) and why it is important (Impact an Program or Division/Agency strategic goals)* | |
| **Type of Problem/Opportunity:**<br>☐ QI (cross-programmatic or larger scope process improvement<br>☐ QI (single program or smaller scope process improvement)<br>☐ QP (new process/service design) | |
| **Overall Objective):** *1 sentence declaration as to what the project team is to do without assumption of cause or solution. {A.k.a. mission statement, purpose statement, etc. ). (Remember S.M.A.R.T. =direction+ measure/what you are improving+ target+ timeframe).* | |
| **Performance Measure(s):** *The quantitative indicator{s) which would demonstrate performance had improved. More than 2-3 measures may indicate lack of focus. (i.e., %, number, count, average, etc. )* | **Target(s):** *How much improvement is expected/hoped for?* |
| **Process(es) to be addressed:** *Describe the boundaries/scope (i.e., the "start" and "stop") of the process(es).* | **Customer(s):** *Who is/are the PRIMARY recipient(s) of the "output" or service?* |
| **Team Leader:** *Who is primarily responsible for the conduct and success of this project? {May coincide with the process owner)* | |
| **Team Facilitator:** *Who will be assisting the leader with QI methods and tools ond group process facilitation? (Tip: Start with division's QC representative)* | |
| **Team Members:** *Who will be active participants on the project team? Ensure representation of process steps and other key stakeholders. For projects of smaller scope, you may not have team members other than lead and/or process owner)* | |
| **Constraints:** *Are there time, space, financial, system, policy, organizational or other constraints that the team leader and members should be aware of?* | **Resource Requirements:** *What resources are available* to *the team to support completion of its mission? (Time, IT, budget, CHAP£ staff support, etc.)* |
| **How do you think you will proceed with analyzing this problem for root cause (QI) or customer need (QP)?** *(Tip: Consult with your QC representative if needed)* | |
| **Target Start Date:** | |
| **Target End Date:** | |
| **Process Owners:**<br><br>*Who will be primarily responsible for maintaining process performance after completion of the project?* | |

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District Health Department & Home Health Agency

Serving Harrison, Nicholas, Scott & Bourbon County Home Health

# Quality Project/ Activity Summary Report

**Title of Project:**

**Overall Objective for Project:**

**Division/ Area Reporting**

**Lead Staff:**

**Start Date:**

**Complete Date:**

**Initial report to QC Date:**

**Report back to QC Date(s):**

| | |
|---|---|
| **Method Utilized:** | o QI (cross-programmatic or larger scope process improvement<br>o QI(singleprogramorsmallerscopeprocessimprovement)<br>o QP (new process/service design) |
| **Analysis Summary:** | If QI: What root causes were identified? If OP: What key customer needs were identified? |
| **Analysis tools Utilized:** | o Flow<br>o Charts<br>o Pareto<br>o Diagram<br>o Histogram<br>o Cause-Effect<br>o Diagrams Data<br>o Collection Matrix<br>o Qualitative Survey<br>o Affinity Diagram<br>o Benchmarking |
| **Change Summary:** | Briefly describe changes made and how they address either identified root causes or customer needs: |

| | **Measure #1** | **Measure#2** | **Measure#3** |
|---|---|---|---|
| **Statement of measure:** *(A %, number, count, average) (e.g. Percent of high risk pregnant women with prenatal visit in 1st trimester)* | | | |
| **Target Population:** *(e.g. All pregnant women)* | | | |
| **Numerator:** *(Fill this out if your measure is a %} (e.g.# high risk pregnant women with 1st trimester prenatal visit)* | | | |
| **Denominator:** *(Fill this out if your measure is a %) (e.g. # of high risk pregnant women)* | | | |
| **Source of data:** *(e.g. Clinic visit records)* | | | |
| **Baseline:** *(e.g. 85%)* | | | |
| **Target or Goal:** *( e.g. 90%)* | | | |

| | Measure #1 | Measure#2 | Measure#3 |
|---|---|---|---|
| **Results:** *{e.g. 90%}* | | | |

**Did you reach your target or goal for your objective? Y/ N**

- If yes, how will you sustain or continue improving?

- What ongoing measures did you put in place? Specify.

- Who is primary owner of the process and responsible for monitoring the measure(s) and how frequently will this be done?

- What tools will you use for ongoing evaluation of the process (i.e., process control)?

| | | |
|---|---|---|
| LogicModels | Trend/RunCharts | Control Charts |
| Histogram | BoxPlots | Other: |

If no, what variables were involved in not reaching your goal?

What is your plan to address the variables that prevented you from reaching your target or goal?

If project is complete, please provide an abstract regarding your project for the Monday Mail. The abstract should include all the following descriptive:

**Title of Project**

**Project Description, including Problem and QI Activities**

**Objective**

**Results**

**Contact Information**

June 2017