Cortland County Health Department Performance Management & Quality Improvement Plan 2023-2024

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Public Health
Prevent. Promote. Protect.
Cortland County Health Department

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Key Terms & Definitions

These following key quality terms are used agency-wide when communicating about quality and quality improvement.

Continuous Quality Improvement (CQI): A never-ending quest to improve processes and outcomes by identifying root causes of problems. This involves making gradual improvements to reduce variation and redundancies, improve quality of programs and services, and increase customer and community satisfaction. Uses improvement process like rapid cycle improvement through the use of successive Plan-Do-Check-Act (PDCA) cycles (NACCHO, QI Roadmap, 2023).

Culture of Quality: QI is fully embedded into the way the agency does business, across all levels, departments, and programs. Leadership and staff are fully committed to quality, and results of QI efforts are communicated internally and externally. Even if leadership changes, the basics of QI are so ingrained in staff that they seek out the root cause of problems. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives. (NACCHO, QI Roadmap, 2023).

Performance Management: Performance management is the practice of actively using performance data to improve the public's health. This practice involves the strategic use of performance measures and standards to establish performance targets and goals (Public Health Foundation, Performance Management Toolkit, 2022)

Performance Standards: 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 public's or leaders' expectations, or other methods. (Performance Management Toolkit, Public Health Foundation, 2022)

Performance Measurement: Development, application, and use of performance measures to assess achievement of performance standards. (Performance Management Toolkit, Public Health Foundation, 2022)

Plan-Do-Check-Act Cycle (PDCA): A quality improvement framework that aligns with public health practice (also called; Plan-Do-Study-Act Cycle, Deming Cycle, or Shewhart Cycle). PDCA is an iterative, four stage problem solving framework for improving a process or carrying out change. Plan – assemble a team, examine the current approach, identify root cause of the problem, identify possible solutions, and develop an improvement theory. Do – test the theory. Check – study the results. Act – standardize improvement, adapt the test, or develop a new theory (Public Health

Foundation, Introduction to Quality Improvement, 2020).

Quality Improvement (QI): Quality Improvement (QI) in public health is the use of a deliberate and defined improvement process, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes that achieve equity and improve the health of the community (NACCHO, QI Roadmap, 2023).

Acronyms

BOH- Board of Health
CCHD- Cortland County Health Department
CHIP- Community Health Improvement Plan
NACCHO- National Association of County and City Health Officials
PDCA-PLAN, DO, CHECK, ACT
PHAB- Public Health Accreditation Board
PM – Performance Management
QI- Quality Improvement

Purpose

The Cortland County Health Department (CCHD) is committed to ongoing performance management and quality improvement efforts. The purpose of the 2023-2024 Performance Management and Quality Improvement Plan is to facilitate systematic and department-wide activities that result in an organizational culture of continuous quality and performance improvement. This plan provides the framework by which the development, monitoring, and evaluation of improvement initiatives will be conducted, and is directly aligned with CCHD's Strategic Plan and Workforce Development Plan. This plan is also intended to provide the infrastructure for CCHD's Performance Management System. As a result of the goals outlined in this plan, CCHD will continually improve upon its delivery of public health programs and services, working towards the vision of *Healthy People in a Healthy Community.*

Culture of Quality

CCHD has assessed the organizational culture of quality regularly since 2016 using the Performance Management Self-Assessment Tool (2018, 2023) and Organizational QI Maturity Assessment Survey (2016, 2019, 2022). These tools assist CCHD in determining the current state of PM & QI activities within the department, areas where growth has occurred, and potential areas in need of improvement. The results of these surveys have informed CCHD's Strategic Plan and PM/QI Plan.

Performance Management Self-Assessment

A PM Self-Assessment has been completed by CCHD staff in 2018 and 2023. See Appendix A for results of the 2023 PM Self-Assessment. This tool is used to assess PM strengths and weaknesses across CCHD Divisions and Programs. In 2018, the assessment was completed by CCHD supervisors and in 2023 the assessment was completed by the Accreditation Team. The PM Self-Assessment is broken down into the five parts that align with the Public Health Performance Management System:

- **Visible Leadership:** Senior management commitment to a culture of quality that aligns performance management practices with organizational mission, regularly takes into account customer feedback, and enables transparency about performance between leadership and staff.
- **Performance Standards:** Establishment of organizational or system performance standards, targets, and goals to improve public health practices.
- **Performance Measurement:** Development, application, and use of performance measures to assess achievement of performance standards.
- **Reporting Progress:** Documentation and reporting progress in meeting standards and targets, and sharing of such information through appropriate

feedback channels.

- **Quality Improvement:** Use of a deliberate and defined improvement process that focuses on activities that address community needs and population health improvement.

Table 1 outlines a comparison between the CCHD PM Self-Assessments that occurred in 2018 and 2023. Note: in 2018 the assessment was completed by supervisory staff and in 2023 the assessment was completed by the Accreditation Team which includes all levels of staff.

Out of the indicator questions related to CCHD capacity for performance standards, performance measurement, and the reporting progress components of PM, CCHD shifted from 100% of these indicators "never" or "almost never" being done in 2018 to only 17%, 15%, and 14% "never" or "almost never" being done in 2023. This positive shift in indicators for these areas is most likely related to CCHD seeking Public Health Accreditation which requires Health Departments to create, implement, and track a Performance Management System.

Conversely, indicators questions related to CCHD capacity for visible leadership and quality improvement components of PM suggest a need to improve in these areas, with 100% of QI indicators being performed "always" or "almost always" in 2018 to 52% in 2023 and 68% of visible leadership indicators being performed "always" and "almost always" in 2018 compared to 16% in 2023. Unfortunately, due to COVID-19 leadership (administration and supervisory staff) capacity to commit time, resources, and communication to PM and QI was greatly reduced, which is reflected in the 2023 assessment. Additionally, administration and supervisory staff have had a transition period since the last assessment. These issues will ideally be addressed with the 2022-2024 CCHD Strategic Plan Priority #3, Goal #2: improve alignment, spread, and capacity for CCHD QI efforts by encouraging a collaborative approach to QI that engages staff at all levels.

Table 1. Performance Management Self-Assessment Indicator Summary (CCHD, 2018 & 2023)

Year		Visible Leadership (out of 19)	Performance Standards (out of 18)	Performance Measurement (out of 13)	Reporting Progress (out of 22)	Quality Improvement (out of 21)
2018	**Never**	3	18	13	22	0
	Sometimes	3	0	0	0	0
	Always	13	0	0	0	21
2022	**Never**	5	3	2	3	0
	Sometimes	11	8	8	16	10
	Always	3	7	3	3	11

Organizational QI Maturity Assessment Survey

An Organizational QI Maturity Assessment has been completed by CCHD staff in 2016, 2019, and 2022. See Appendix B for results of the 2022 QI Maturity Assessment Survey. The results of the survey can be compared to previous years to track CCHD's overall QI maturity, as well as QI maturity across three dimensions:

- **Culture:** values and norms related to QI that pervade how agency interacts with staff and stakeholders
- **Capacity & Competency:** skills, functions, and approach used to assess and improve quality
- **Alignment & Spread:** QI supports and supported by organization and is diffused within agency

Overall Organizational QI Maturity is determined by the sum of Likert Scale scores of each dimension and categorized into 5 Stages of QI Maturity which include;

- **Beginning (≤99):** Have not yet adopted formal QI projects, applied QI methods in a systematic way, or engaged in efforts to build a culture of QI.
- **Emerging (100-106):** Newly adopted QI approaches, with limited capacity. Limited QI culture and few, if any, examples of attempts to incorporate QI as a routine part of practice.
- **Progressing (107-120):** Some QI experience and capacity but often lack commitment, have minimal opportunities for QI integration throughout the agency and are less sophisticated in their application and approach.
- **Achieving (121-139):** Fairly high levels of QI practice, a commitment to QI, and an eagerness to engage in the type of transformational change described by QI experts.
- **Excelling (≥140):** High levels of QI sophistication and a pervasive culture of QI.

Table 2 outlines a comparison of QI Maturity Assessment Surveys in 2016, 2019, and 2022. In the first year QI Maturity was assessed (2016), CCHD scored in the "beginning stages" with a score of 89 out of 145 possible points. The first CCHD QI Plan was implemented in 2017, and in 2019 organizational QI Maturity was assessed again achieving a score of 111/145, moving CCHD into the "progressing" stage of QI Maturity.

In 2022, when QI Maturity was assessed, it appears that CCHD has plateaued in the "progressing" stage of QI. This plateau was identified during the 2022-2024 Strategic Planning process and may be attributed to staff and departmental focus on COVID-19 efforts from 2020-2022, additions of new staff, and transition period of administrative and supervisory positions in the department. This plateau will ideally be addressed with the 2022-2024 CCHD Strategic Plan Priority #3, Goal #2: improve alignment, spread,

and capacity for CCHD QI efforts by encouraging a collaborative approach to QI that engages staff at all levels. Organizational QI Maturity will be assessed on an annual basis as part of the Strategic Plan review process.

Table 2. Organizational QI Maturity Assessment Survey (CCHD, 2016, 2019, 2022)

Year	QI Maturity Score	Stage of QI Maturity
2016	89/145	**Beginning:** Have not yet adopted formal QI projects, applied QI methods in a systematic way, or engaged in efforts to build a culture of QI
2019	111/145	**Progressing:** Some QI experience and capacity but often lack of commitment, have minimal opportunities for QI integration throughout the agency and are less sophisticated in their application and approach
2022	109/145	**Progressing:** Some QI experience and capacity but often lack of commitment, have minimal opportunities for QI integration throughout the agency and are less sophisticated in their application and approach

Governance/Structure

Accreditation Team

The Public Health Director has charged the CCHD Accreditation Team with implementing and overseeing all department-wide planning, implementation, and evaluation initiatives including PM & QI efforts.

Membership

The Accreditation Team consists of department wide representation of staff at all levels; administration, management/supervisory, and front line. To ensure representation from across the department, the Accreditation Team is comprised of the following positions:

- Public Health Director
- Deputy Public Health Director
- Epidemiology Manager
- Epidemiology Public Health Fellow
- At least one representative from each division:
    - Administration
    - Environmental Health
    - Children with Special Needs
    - Health Education
    - Nursing

Division representation can be filled with either management or frontline staff. Supervisors are responsible for selection of appropriate staff members to represent their division on the Accreditation Team. All membership is approved by the Public Health Director.

Leadership Team

Leadership of the Accreditation Team is the responsibility of the Epidemiology Manager under the supervision of the Public Health Director/Deputy Public Health Director with support from the Epidemiology Public Health Fellow. The Leadership Team makes decisions regarding the overall direction of the Accreditation Team and guides the development of a culture of quality within the department.

Decision Making

Accreditation Team members will attempt to reach a consensus on significant issues. If consensus cannot be reached, a majority vote prevails.

Meetings

The Accreditation Team will meet monthly for approximately two hours. Additional meetings may be held under extenuating circumstances. Leadership will meet more regularly, as needed. Records and meeting minutes will be maintained for all meetings.

Time Commitment

The time commitment for Accreditation Team members is approximately three to five hours per month. This includes meeting and meeting preparation times as well as special assignments. Leadership time commitment is substantially greater.

Roles & Responsibilities

All CCHD staff, from front line staff to directors, and division supervisors to the Board of Health will participate in developing, implementing, and updating the 2023-2024 Performance Management and Quality Improvement Plan.

Board of Health

- Provides high-level oversight and accountability for PM & QI.
- Provides outside perspective on PM & QI initiatives and identifies public health services in need of QI and areas of focus from an outside community perspective, if needed.
- The BOH will be presented with PM updates quarterly and QI project outcomes and make recommendations.

Public Health Director

- Serve on the Accreditation Team.
- Submit, monitor, and report on Administrative Division performance measures.
- Approve Accreditation team members.
- Allocate resources for performance management.

Epidemiology Manager

- Coordinate preparation, monitoring, and review of Annual Reports, Strategic Plan, Workforce Development Plan, and Performance Management & Quality Improvement Plan, as well as all aligned Dashboards.
- Coordinate all departmental performance and quality operations.
- Lead Accreditation Team meetings and activities.
- Coordinate PM & QI Trainings.
- Organize and maintain Accreditation & Planning folder in departmental drive.

- Develop Performance Management System Dashboards.
- Provide oversight on the development and tracking of performance measures.
- Provide technical assistance in data collection for performance measures and quality improvement projects as needed.

Epidemiology Public Health Fellow

- Responsible for Community Health Improvement Plan monitoring and review.
- Responsible for day-to-day maintenance of all departmental Data Dashboards.
- Assist Epidemiology Manager with performance and quality operations.
- Record and distribute Accreditation Team meeting minutes.
- Provide technical assistance in data collection for performance measures and quality improvement projects as needed.

Leadership Team

- Set direction of PM and QI activities within the department.
- Provide consultation for PM & QI planning and activities.
- Oversee development, implementation, and revision of PM & QI Plan.
- Participate in professional development opportunities to actively learn about PM, QI, and change management including participation in external learning opportunities.

Accreditation Team

- Attend Accreditation Team meetings and complete assigned tasks.
- Be familiar with all departmental plans.
- Participate in revision, implementation, and evaluation of all departmental plans.
- Prioritize and select QI projects.
- Serve as facilitators of QI projects.
- Provide technical assistance for QI projects.
- Monitor and evaluate QI projects.
- Advocate and encourage culture of learning and QI among other staff and serve as a liaison from the Accreditation Team to other staff.

Management/Supervisors

- Facilitate implementation of PM and QI activities at the program level.
- Oversee setting of program level goals and objectives and selection of performance measures.
- Approve all submitted performance measures.
- Ensure regular monitoring of performance measures.

- Support program staff in their work with PM and QI activities.
- Foster a culture of quality at the program level.

All Employees

- Participate in PM and QI trainings to develop understanding of basic principles and tools.
- Identify areas of improvement within the department and suggest QI projects.
- Report training needs to Management/Supervisor or Accreditation Team.
- Contribute to the development, monitoring and evaluation of Performance Management System.

Performance Management Activities

Performance Management System Model and Framework

Performance Management is the "practice of actively using performance data to improve the public's health." PM occurs when there is a systematic effort to improve programs and processes across a department and monitoring progress towards identified goals. PM relies on data to determine if programs and services are having an impact on the health of people served by the department. Data collected from PM activities can help identify opportunities to improve the quality of programs and services provided to the community.

Cortland County Health Department utilizes the Turning Point Public Health Performance Management System as the framework for our Performance Management System. The framework outlines the key components of a successful performance management system:

- Performance Standards – "Where do we want to be?"
- Performance Measurement – "How will we know that we got there?"
- Reporting Progress – "How well are we doing?"
- Quality Improvement "How will we improve?"

The Performance Management System at CCHD is comprised of the Community Health Improvement Plan/Dashboard, Strategic Plan/Dashboard, and Programmatic Performance Management Dashboard.

Selection of Performance Goals, Objectives & Measures

The Cortland County Health Department selects and evaluates performance goals, objectives, and measures at the community level (Community Health Improvement Plan and Dashboard), organizational level (Strategic Plan and Dashboard), and programmatic level (PM & QI Plan and Dashboard). Performance Management alignment at each level is essential in order to improve public health in our community.

Community Health Improvement Plan

Community Health Improvement Plan goals, objectives, and measures are selected based on the results of the Community Health Assessment, input from partnering agencies in Cortland County, and alignment with the NYSDOH Prevention Agenda. See the Cortland County Community Health Improvement Plan Dashboard for more details on performance goals, objectives, and measures related to the Community Health Improvement Plan.

Cortland County Health Department Strategic Plan

Cortland County Health Department Strategic Plan goals, objectives, and measures are selected based on the results of the CCHD Strategic Planning process which includes an environmental scan of internal CCHD data. See the Cortland County Strategic Plan Dashboard for more details on performance goals, objectives, and measures related to the Strategic Plan.

Cortland County Health Department Program Performance

Program level goals, objectives, and measures are developed by supervisory and managerial staff in each program area with support from the Epidemiology Manager. Programs should keep a complete set of performance measures within their program to monitor all relevant programmatic goals, objectives, and funding requirements. However, performance measures that will be maintained in the department performance management system should align with Community Health Improvement Plan or Strategic Priorities, are those in most need of improvement, or those most fundamentally important to the program.

Each program must submit 2-4 performance measures to the Epidemiology Manager to review to ensure data can be consistently collected and is methodologically sound.

Program goals and objectives must be based on and aligned with national, state, departmental, or grant standards or requirements or be meaningful to program activities and staff. Performance measures must meet the following requirements: data is quantifiable and readily available, clearly ties to program objective it is intended to monitor, and provides actionable, useful information to improve processes.

Reporting & Evaluation of Performance Management Data

Performance Management System data will be collected quarterly by the Epidemiology Manager/Epidemiology Public Health Fellow from responsible parties (partner agencies, administration, management, program staff). Once collected, the data will be uploaded into the appropriate Performance Management Dashboard (CHIP, Strategic Plan, or Programmatic). Data will be collected on the following schedule:

- Year 1, Quarter 1: April 2023
- Year 1, Quarter 2: July 2023
- Year 1, Quarter 3: October 2023
- Year 1, Quarter 4: January 2024
- Year 2, Quarter 1: April 2024
- Year 2, Quarter 2: July 2024
- Year 2, Quarter 3: October 2024
- Year 2, Quarter 4: January 2025

Following collection of quarterly data, data will be analyzed by Epidemiology Manager/Epidemiology Public Health Fellow to determine progress towards yearly performance targets. Data will be presented, reviewed, and discussed quarterly with:

- Accreditation Team (required)
- Board of Health (required)
- Health & Human Services Committee (if needed)
- Supervisory Staff (if needed)
- Community members (if needed)

On the following schedule:

- Year 1, Quarter 1: May 2023
- Year 1, Quarter 2: August 2023
- Year 1, Quarter 3: November 2023
- Year 1, Quarter 4: February 2024
- Year 2, Quarter 1: May 2024
- Year 2, Quarter 2: August 2024
- Year 2, Quarter 3: November 2024
- Year 2, Quarter 4: February 2025

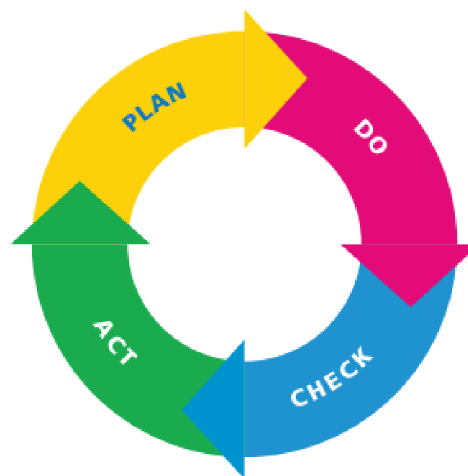
Community Health Improvement Plan quarterly data will be presented to partnering agencies and community members at relevant community coalitions utilizing the same schedule as above. Annually, the Performance Management System will be utilized to inform the CCHD Annual Report.

Quality Improvement Activities

Quality Improvement Model

Cortland County Health Department uses the Plan-Do-Check-Act (PDCA) model (also referred to as Plan, Do, Study, Act) for the formal QI method to guide all performance improvement efforts within the department. PDCA provides a data-based framework for QI that relies on scientific method. The PDCA model has four phases:

1. **Plan** – Investigate the current situation, fully understand the nature of the problem that needs to be solved, develop potential solutions to the problem that will be tested.
2. **Do** – Implement the action plan, collect and document data, document problems, observations, lessons learned, and knowledge gained.
3. **Check** – Analyze the effect of the intervention. Compare new data to baseline to determine if improvement was achieved and whether the measures in the aim statement were met.
4. **Act** –At this step, the improvement can be standardized, revised and tested again, or abandoned.



Quality Improvement Project Identification and Selection

Quality improvement project selection will be based on the need to improve programs or agency processes, objectives, and /or performance measures. The Accreditation Team is responsible for ensuring at least two QI projects are identified and selected annually.

QI projects can be identified in a number of ways, including, but not limited to:

1. Staff request via discussions with supervisory staff, the Public Health Director, or a member or the Accreditation Team or via the Quality Improvement Project Request Project Request Form.
2. When review of CHIP, Strategic Plan, or Performance Management quarterly data reveals a need for an improvement project.

After a QI project is selected, the Accreditation Team will discuss feasibility and potential impacts on health equity. If the team decides to move forward, a facilitator and

team leader will be assigned and they will begin the QI Project Procedures.

Quality Improvement Project Procedures

After a QI project has been identified and selected via the Accreditation Team, the below procedure should be followed. Utilize the QI Project Procedure Checklist, and keep it up to date regularly, to ensure you are following all steps in the procedure.

1. **Plan –** Investigate the current situation, fully understand the nature of the problem that needs to be solved, develop potential solutions to the problem that will be tested.

   Assemble the Team: QI facilitator and team leader (as identified by Accreditation Team) meet to fill out QI Team Charter and begin Storyboard Template (this should be regularly updated and revised throughout the process).

   Implement Communication Plan: QI facilitator and team leader email completed charter to Accreditation Team including proposed timeline. Confidential Secretary to the Public Health Director adds new QI project as action item on Supervisory and Board of Health agendas until project is completed, supervisory/management staff add QI project as item on division agenda until project is completed, Epidemiology Manager reports on QI project progress via Employee Newsletter until project is completed.

   Develop AIM Statement(s): The AIM statement defines what your team is trying to accomplish at the end of the improvement process. QI Projects may have more than one AIM statement. AIM statements will be revisited and revised throughout the planning process. AIM statements should be developed using the following SMART criteria: (1) Specific - what is the action or activity and target population? (2) Measureable - by how much will it improve? Can you measure it? (3) Achievable - can it be accomplished? Do you have the resources? (4) Relevant – does the action relate to what you want to accomplish? (5) Time-Bound – what is the timeline for change? When will it be accomplished?

   Describe Current Process: Utilize flow charts, value stream mapping, or another tool to understand the current process as a group and identify areas for improvement.

   Collect Data on Current Process: Baseline data must be collected in order to measure effectiveness of future improvements. Data collected should align with AIM statement. The facilitator and team leader can consult with Epidemiology Manager for assistance with determining appropriate data.

Identify Possible Causes: Utilize group brainstorming, cause/effort diagram, fishbone diagram, or the “5 Why’s” to determine root cause of problem.

Identify Potential Improvements: Utilize group brainstorming to identify strategies that can address the root cause. Select an improvement strategy to test. Discuss possible unintended consequences and/or impacts the strategy may have on health equity and develop countermeasures to address these. Revisit the AIM statement to ensure alignment with improvement strategy.

Develop Improvement Theory: Create a statement that articulates the effect that the team hopes the improvement will have on the problem. What do you plan to achieve as a result of the improvement strategy?

Develop Action Plan: Utilize the Action Plan Template to create an Action Plan that indicates what needs to be done, who is responsible, and timelines. The Action Plan should also outline what data is to be collected, how frequently, and who is in charge of collecting data in order to analyze the impact of the improvement strategy.

2. **Do** – Implement the action plan, collect and document data, document problems, observations, lessons learned, and knowledge gained.

   Implement the improvement. All team members to implement the improvement according to the Action Plan. Team leader to check in periodically, if necessary, during this time.

   Collect and document the data.

   Document problems, unexpected observations, lessons learned, and knowledge gained.

3. **Check –** Analyze the effect of the intervention. Compare new data to baseline to determine if improvement was achieved and whether the measures in the aim statement were met.

4. **Act –** At this step, the improvement can be standardized, revised and tested again, or abandoned. At this phase, there are three options to move forward:

   Adopt: If the measurable objective in the AIM statement has been met, the improvement can be standardized. Utilize run charts, control charts, or another method to establish a mechanism to measure and monitor improvement to ensure it is maintained.

Adapt: If the results did not quite reach the measurable objective in the AIM statement, if not enough data was gathered, or circumstances changed, the Action Plan can be adapted and the “Do” phase can be repeated.

Abandon: If changes made to the process did not result in improvement (did not even come close to the measurable objective in the AIM statement), consider the lessons learned and return to the “Plan” phase to develop a new Action Plan.

5. **Communicate Results:** After completion of the QI project, steps must be taken to ensure all stakeholders are informed of the results. This will assist with adoption of effective improvement strategies across programs/divisions and will help contribute to the overall culture of quality within the department.

Complete Storyboard: Finalize the Storyboard for the project using the Storyboard Template. Send the Storyboard to the Accreditation Team for feedback and make corrections/additions accordingly. The Storyboard (per the Template) should include:

1. Description of situation/problem
2. AIM statement
3. Proposed improvement strategy/intervention
4. What was done to address the problem
5. Analysis/evaluation of improvement strategies
6. Action taken to standardize improvement
7. Lessons learned

Present Results to Accreditation Team: Confirm with Epidemiology Manager the date of the next Accreditation Team meeting and prepare presentation of final results of QI project.

Present Results to Board of Health: Confirm with Public Health Director the date of the next Board of Health meeting to share final Storyboard and conduct question and answer period.

Share Results with Staff: Epidemiology Manager (or Team Leader) to share final results of QI Project at Supervisory Staff meeting. Supervisors to disseminate results at division staff meetings. Final results of QI project to be featured in employee newsletter.

Performance Management and Quality Improvement Goals, Objectives, and Measures

Goal #1 of the 2023-2024 Performance Management and Quality Improvement Plan Goals align directly with the 2022-2024 Strategic Plan Goal #3.2: "improve alignment, spread, and capacity for CCHD Quality Improvement Efforts by encouraging a collaborative approach to QI that engages staff at all levels." For the purposes of this plan, Strategic Plan Goal #3.2 will be referenced as QI Goal #1, however, tracking and review of this goal's process measures and objectives will occur under the umbrella of CCHD's Strategic Plan.

Goal 1: Improve alignment, spread, and capacity for CCHD Quality Improvement (QI) efforts by encouraging a collaborative approach to QI that engages staff at all levels *(goal, objective and interventions directly align with Strategic Plan Goal #3.2)*

Objective 1.1. By December 2024, increase the percentage of CCHD staff that state good ideas for QI in one program are adopted by other programs from the 2022 baseline of 59% to 70%.

Objective 1.2. By December 2024, increase the percentage of CCHD staff that state staff at all levels participate in QI from the 2022 baseline of 68% to 80%.

Objective 1.3. By December 2024, 100% of CCHD staff will be provided QI training when they are on boarded and at least once yearly.

Intervention #1. Review QI training materials and update QI training to reflect the current gaps in QI alignment and spread. Implement QI training when staff are on boarded and at least once yearly.

> **Process Measures:** % of newly on boarded staff to receive QI training (target= 100%), % of staff to complete yearly QI training) (target= 100%)

Intervention #2. Results of QI efforts to be reported to all staff via email, at supervisory meetings, at division meetings, and in the employee newsletter.

> **Process Measures:** # of QI project outcomes to be reported to all staff via email (target= 2 per year), # of QI project outcomes to be shared in employee newsletter (target= 2 per year), # of QI project outcomes discussed at supervisory staff meetings (target= 2 per year)

Intervention #3. Conduct at least two QI projects annually that have staff

representation from at least two divisions and staff at all levels.

Process Measures: # of QI projects conducted (target= 2 per year)**,** % of QI projects to include staff from at least two divisions (target= 100%)**,** % of QI projects to include staff at all levels (target= 100%)

Goal 2: Maintain a Performance Management and Quality Improvement Plan based on organizational policies and direction.

Objective 2.1. Review, and update as needed, annually the CCHD Performance Management and QI Plan that seeks to increase staff knowledge of QI and supports the development of the Plan, Do, Check, Act process.

Intervention #1. Monitor goals and objectives of QI Plan.

Process Measures: # of quarters PM & QI Plan goals and objectives reviewed (target=4)

Intervention #2. Conduct annual review of QI Plan.

Process Measures: # of annual reviews of PM & QI Plan (target=1)

Goal 3: Implement a Performance Management System to monitor achievement of organizational objectives.

Objective 3.1. By the end of April 2023, each program area will have selected at least two performance measures for the Performance Management System.

Objective 3.2. By December 2024, 100% of program area performance measures will be reported by supervisory staff and included in Performance Management System Dashboard.

Objective 3.3. By December 2024, dashboards and data collection systems for Community Health Improvement Plan, Strategic Plan, and Programmatic Performance Management will be updated at least quarterly.

Intervention #1. Supervisory staff to coordinate with Epidemiology Manager on selection and feasibility of performance measures for each divisional program area.

Process Measures: # of PM meetings with supervisors and Epidemiology Manager (target = 5), # of performance measures selected (target TDB).

Intervention #2. Design and maintain a functional PM system and CHIP/Strategic Plan/Programmatic dashboards utilizing Survey Monkey and Tableau Data Visualization Software. *This intervention aligns directly with Strategic Plan Goal #3.1 Intervention #1.*

Process Measures: % of CHIP intervention dashboards updated quarterly (target=75%), % of Strategic Plan intervention dashboards updated quarterly (target = 100%), % of Programmatic PM dashboards updated quarterly (target=75%).

Intervention #3: Present CHIP, CCHD Strategic Planning, and CCHD programmatic data on a quarterly basis to the BOH and at Supervisory Staff meetings to utilize BOH and Supervisory staff expertise, opinions, and suggestions to make changes to interventions of identified QI projects, if needed. *This intervention aligns directly with Strategic Plan Goal #3.3 Intervention #2.*

Process Measures: # of times CHIP/SP/PM data is presented to the BOH (target=4), # of supervisory meetings to include BOH opinion on CHIP/SP/PM (target=4), # of CHIP/SP/PM interventions changed or QI projects suggested based on data (target=1)

Training

All Cortland County Health Department staff members must participate in QI & PM training once when they are hired and at least once a year after that. Additionally, all staff will be provided with a copy of the Performance Management and Quality Improvement Plan as part of their orientation.

The purpose of QI & PM training is to provide all staff with the knowledge and tools needed to contribute to the overall culture of quality within the department. Monitoring of training will occur through CCHD's Workforce Development Plan.

References

References are not cited in-text for this plan. The following resources informed creation of this plan:

1. Jackson County Public Health. Performance Management and Quality Improvement Plan 2017-2018. 2018. https://www.naccho.org/uploads/full-width-images/Jackson-PM-QI-Plan-2017-2018.pdf
2. Gorenflo G and Moran W. The ABCs of PDCA. Public Health Foundation. http://www.phf.org/resourcestools/Documents/ABCs_of_PDCA.pdf
3. Public Health Foundation. Quality Improvement in Public Health. http://www.phf.org/focusareas/qualityimprovement/Pages/Quality_Improvement.aspx
4. Public Health Foundation. Performance Management Toolkit. http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/Performance_Management_Toolkit.aspx
5. American Public Health Association. Quality Improvement. 2020. https://www.apha.org/-/media/Files/PDF/factsheets/QualityImprovement_Fact_Sheet.ashx
6. National Association of County and City Health Officials. Roadmap to a Culture of Quality Improvement. https://qiroadmap.org/qi-roadmap/qi-home

Appendices

Appendix A. Performance Management Self-Assessment

Public Health Performance Management
Self-Assessment Tool

How well does your public health team, organization, or system manage performance? Use this assessment to find out if you have the necessary components in place to achieve results and continually improve performance. This self-assessment tool is a guide that was designed to be completed as a group, and can be adapted to fit an organization or system's specific needs. Using This Tool

This self-assessment tool will help public health teams, organizations, and systems identify the extent to which the components of a performance management system are in place. It is intended to generate group discussions about building and improving a performance management system. Use it to help manage performance and prepare for voluntary public health department accreditation, if desired. Developed by and for public health agencies, the tool is organized around five components (framework at right).

- Visible Leadership
- Performance Standards
- Performance Measurement
- Reporting Progress
- Quality Improvement

For each component, several questions serve as indicators of performance management capacity. These questions cover the elements, resources, skills, accountability, and communications to effectively practice each component.

Benefits of this Tool

- *Teams or programs* can use this tool to assess relative performance management strengths and weaknesses in their areas of work
- *Organizations* can use this tool to assess relative performance management strengths and weaknesses across divisions and programs
- *Systems* composed more than one organization can use this tool to assess how well they are managing across the different parts of the system

Choose the Best Response

Choose the response that best describes your current practice:

- *Never/Almost Never:* You rarely if ever do this (by choice or because you do not have capacity in place); what occurs is not the result of any explicit strategy
- *Sometimes:* You explicitly do this or have this capacity in place, but it is not consistently practiced
- *Always/Almost Always*: You have this capacity in place and consistently do this activity

In this tool, "you" does not refer to you as an individual. Rather, when answering questions, "you" can refer to the responding:

- Team, program, or division
- Organization as a whole
- Public health system under your jurisdiction where there is authority to control and influence — including government-al health departments (state, local, territorial, or tribal), other government agencies partnering in public health functions, and private system partners (non-profit, academic, or business)

Because performance management is a shared responsibility throughout a public health system, involvement of internal and external partners in examining ways to better manage performance is encouraged.

About the 2012-2013 Update

In 2012-2013, the Public Health Foundation (PHF) refreshed the Turning Point Performance Management Framework and related resources. This activity was funded through the Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support through the National Public Health Improvement Initiative. The update the Turning Point Framework was a field-driven process incorporating input from Performance Improvement Managers, users in the field, CDC and national partners. Visit the PHF website at www.phf.org/PMtoolkit for more information on the update.

Tips:

- ➔ ***Preview the entire tool and definitions before you begin.*** The detailed questions in Sections II - V may help you better understand performance management and more accurately complete Section I, Visible Leadership.
- ➔ ***Be honest about what you are currently doing or not doing to manage performance***. If you are doing very little in an area, it is better to say "Never" or "Sometimes" than to overstate the attention and resources allocated to it. For questions marked "Never," decision makers can determine the activity's relevance, and if appropriate, choose to shift priorities or invest resources. Using information for such decision making is a basic tenet of performance management.
- ➔ **If you are unsure how to answer a question, the leave it blank until you can find the answer**.
- ➔ **Use the *Notes* section at the bottom of each page.** Write down improvement ideas, insights, or any qualifications to self-assessment answers. Your individual or group responses will help you interpret the results and choose follow-up actions to the

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	☐	x	☐	Not much has been done in the past 3 years due to COVID-19. Previously, supervisor's reported into the PMS. Not all staff involved.
2. Senior management demonstrates commitment to a quality culture	☐	☐	X	
3. Senior management leads the group (e.g., program, organization or system) to align performance management practices with the organizational mission	X	☐	☐	
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	x	☐	☐	
5. Performance is actively managed in the following areas (check all that apply) A. Health Status (e.g., diabetes rates)	☐	X	☐	
B. Public Health Capacity (e.g., public health programs, staff, etc.)	☐	X	☐	
C. Workforce Development (e.g., training in core competencies)	☐	☐	X	
D. Data and Information Systems (e.g., injury report lag time, participation in intranet report system)	☐	X	☐	
E. Customer Focus and Satisfaction (e.g., use of customer/stakeholder feedback to make program decisions or system changes)	☐	X	☐	
F. Financial Systems (e.g., frequency of financial reports, reports that categorize expenses by strategic priorities)	☐	☐	X	
G. Management Practices (e.g., communication of vision to employees, projects completed on time)	☐	X	☐	
H. Service Delivery (e.g., clinic no-show rates)	☐	X	☐	Would need to define what this means (EI, rabies, immunizations)
I. Other (Specify):	☐	☐	☐	

[Type here]

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
6. There is a team responsible for integrating performance management efforts across the areas listed in 5 A-I	☐	x	☐	Accreditation Team is now responsible for this.
7. Managers are trained to manage performance	x	☐	☐	Need to add to workforce develppment
8. Managers are held accountable for developing, maintaining, and improving the performance management system	x	☐	☐	
9. There are incentives for effective performance improvement		X	☐	Need to define incentive
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 things)	X	☐	☐	
11. A process or mechanism exists to align performance priorities with budget	☐	x	☐	
12. Personnel and financial resources are assigned to performance management functions	☐	x	☐	

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	☐	X	☐	We are held accountable to the state for many measures
2. The performance standards chosen used are relevant to the organization's activities	☐	☐	X	
3. Specific performance targets are set to be achieved within designated time periods	☐	☐	X	State establishes timeframes
4. Managers and employees are held accountable for meeting standards and targets	☐	☐	X	
5. There are defined processes and methods for choosing performance standards, indicators, or targets[1]	☐	X	☐	

[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

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
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)	☐	X	☐	
B. The group benchmarks its performance against similar entities	☐	X	☐	
C. Scientific guidelines are used	☐	X	☐	
D. The group sets priorities related to its strategic plan	☐		X	
E. The standards used cover a mix of capacities, processes, and outcomes[2]	☐	X	☐	
6. Performance standards, indicators, and targets are communicated throughout the organization and to its stakeholders and partners	☐	X	☐	Yes, with CHIP and Strategic Plan
A. Individuals' performance expectations are regularly communicated	☐	☐	X	
B. The group relates performance standards to recognized public health goals and frameworks, (e.g., Essential Public Health Services)	☐	☐	X	
7. The group regularly reviews standards and targets	X	☐	☐	We will be doing this quarterly
8. Staff understand standards and targets	☐	X	☐	
9. Performance standards are aligned across multiple groups (e.g., same child health standard is used across programs and agencies)	X	☐	☐	
10. Training is available to help staff use performance standards	X	☐	☐	
11. Personnel and financial resources are assigned to make sure efforts are guided by relevant performance standards and targets	☐	☐	X	

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

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

1. The group (program, organization, or system) uses specific measures for established performance standards and targets	☐	X	☐	
A. Measures are clearly defined	☐	X	☐	
B. Quantitative measures have clearly defined units of measure	☐	X	☐	
C. Inter-rater reliability has been established for qualitative measures	X	☐	☐	
2. Measures are selected in coordination with other programs, divisions, or organizations to avoid duplication in data collection	☐	☐	X	CHIP
3. There are defined methods and criteria[3] for selecting performance measures	☐	X	☐	
A. Existing sources of data are used whenever possible	☐	☐	X	
B. Standardized measures (e.g., national programs or health indicators) are used whenever possible	☐	X	☐	
C. Standardized measures (e.g., national programs or health indicators) are consistently used across multiple programs, divisions, or organizations[4]	☐	X	☐	
D. Measures cover a mix of capacities, processes, and outcomes[5]	☐	X	☐	
4. Data are collected on the measures on an established schedule	☐	X	☐	State
5. Training is available to help staff measure performance	X	☐	☐	
6. Personnel and financial resources are assigned to collect performance measurement data	☐	☐	X	

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[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	☐	X	☐	
2. Information on progress is regularly made available to the following (check all that apply)				
A. Managers and leaders	☐	X	☐	
B. Staff	☐	X	☐	
C. Governance boards and policy makers	☐	X	☐	
D. Stakeholders or partners	☐	X	☐	
E. The public, including media	☐	X	☐	
F. Other (Specify):	☐	☐	☐	
3. Managers at all levels are held accountable for reporting performance	☐	X	☐	To the state / grants funders
A. There is a clear plan for the release of performance reports (i.e., who is responsible, methodology, frequency)	X	☐	☐	Not being done outside of funders
B. Reporting progress is part of the strategic plan	☐	☐	X	
4. A decision has been made on the frequency of analyzing and reporting performance progress for the following types of measures[6] (check all that apply)				
A. Health Status	☐	☐	X	
B. Public Health Capacity	☐	X	☐	
C. Workforce Development	☐	X	☐	
D. Data and Information Systems	☐	X	☐	
E. Customer Focus and Satisfaction	☐	X	☐	
F. Financial Systems	☐	☐	X	
G. Management Practices	☐	X	☐	
H. Service Delivery	☐	X	☐	Just numbers
I. Other (Specify):	☐	☐	☐	

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

[Type here]

	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)	X	☐	☐	
6. Training is available to help staff effectively analyze and report performance data	X	☐	☐	
7. Reports on progress are clear, relevant, and current so people can understand and use them for decision-making (e.g., performance management dashboard)	☐	X	☐	
8. Personnel and financial resources are assigned to analyze performance data and report progress	☐	X		
9. Leaders are effective in communicating performance outcomes to the public to demonstrate effective use of public dollars	☐	X	☐	

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	☐	☐	X	
A. There is an entity or person responsible for decision-making based on performance reports (e.g., top management team, governing or advisory board)	☐	☐	X	
B. There is a regular timetable for QI processes	☐	☐	X	
C. The steps in the QI process are effectively communicated	☐	X	☐	If you are part of a project, yes. If not, not really.
2. Managers and employees are evaluated for their performance improvement efforts (i.e., performance improvement is in employees' job descriptions and/or annual reviews)	☐	☐	X	
3. Performance reports are used regularly for decision-making	☐	X	☐	
4. Performance data are used to do the following (check all that apply)				

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
A. Determine areas for more analysis or evaluation	☐	X	☐	
B. Set priorities and allocate/redirect resources	☐	X	☐	
C. Inform policy makers of the observed or potential impact of decisions under their consideration	☐	X	☐	
D. Implement QI projects	☐	X	☐	
E. Make changes to improve performance and outcomes	☐	X	☐	
F. Improve performance	☐	X	☐	
5. The group (program, organization, or system) has the capacity to take action to improve performance when needed	☐	☐	X	
A. Processes exist to manage changes in policies, programs, or infrastructure	☐	☐	X	
B. Managers have the authority to make certain changes to improve performance	☐	☐	X	
C. Staff has the authority to make certain changes to improve performance	☐	X	☐	Staff may not be empowered to make changes themselves
6. The organization regularly develops performance improvement or QI plans that specify timelines, actions, and responsible parties	☐	☐	X	
7. There is a process or mechanism to coordinate QI efforts among groups that share the same performance targets	☐	X	☐	
8. QI training is available to managers and staff	☐	☐	X	
9. Personnel and financial resources are allocated to the organization's QI process (e.g., a QI office exists, lead QI staff is appointed)	☐	☐	X	
10. QI is practiced widely in the program, organization, or system	☐	☐	X	

Resources to Help

If you are ready to start working on better ways to manage performance, the following resources can help:

- **The Public Health Foundation's Performance Management Toolkit** (http://www.phf.org/PMtoolkit) – Access current current performance management resources applicable to public health, including:
    - **Talking Points: Achieving Healthy Communities through Performance Management Systems** – A communications document to help generate leadership, employee, and community buy-in
    - **Performance Management Applications in Public Health** – Examples of how health departments have been successful in applying a customized approach to strategically improve the performance of their agency to better serve and improve the health of the community
- **2003 Turning Point Performance Management Publications** – The Performance Management National Excellence Collaborative developed a package of resource materials specific to helping public health systems manage performance. Historical documents such as the *Guidebook for Performance Measurement and Performance Management in Action – Tools and Resources* contain information still relevant today. http://www.phf.org/resourcestools/Pages/Turning_Point_Project_Publications.aspx
- **Public Health Accreditation Board (PHAB) Materials** – *Locate the Standards and Measures document, glossary, assessment guide, readiness checklist, and other resources to help public health departments prepare for accreditation* http://www.phaboard.org/accreditation-process/accreditation-materials/

Take the Next Step

In public health, we continually strive for better health for all people. In the same spirit, we can continually strive for better ways to manage performance and learn from one another's efforts. Using this self-assessment, your group can identify areas of performance management which may need improvement, as well as areas that are already strong, and should be maintained leveraged to strengthen other areas.

This tool will help you answer the questions, *"Are we really managing performance?"* and *"Do we have specific components of a performance management system?"* However, it is only the first step to improving performance. As you complete this assessment, or as a next step, your team should also discuss other important questions:

- What are examples of work that fall within a performance management system? Do we call them performance management?
- For those components of performance management we are doing, how well are we doing them?
- In which areas do we need to invest more time and resources to manage performance more successfully?
- What can leadership and staff do to make the performance management system work?
- What steps could we try out this month (or this week) to improve our performance management system?

Definitions

Performance management is the practice of actively using performance data to improve the public's health. It involves strategic use of performance measures and standards to establish performance targets and goals. In alignment with the organizational mission, performance management practices can also be used to prioritize and allocate resources; to inform managers about needed adjustments or changes in policy or program directions to meet goals; to frame reports on the success in meeting performance goals; and to improve the quality of public health practice. Performance management includes the following components:

- **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 against targets between leadership and staff.
- **Performance Standards—**Establishment of organizational or system performance standards, targets, and goals to improve public health practices. (e.g., one epidemiologist on staff per 100,000 people served, 80 percent of all clients who rate health department services as "good" or "excellent"). Standards may be set based on national, state, or scientific guidelines, by benchmarking against similar organizations, based on the public's or leaders' expectations (e.g., 100% access, zero disparities), or other methods.
- **Performance Measurement—**Development, application, and use of performance measures to assess achievement of performance standards.
- **Reporting Progress—**Documenting and reporting progress in meeting standards and targets, and sharing of such information through appropriate channels.
- **Quality Improvement—**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. (Source: http://journals.lww.com/jphmp/Fulltext/2010/01000/Defining_Quality_Improvement_in_Public_Health.3.aspx)

Performance Management Components Can Be Applied to…

- Health Status
- Public Health Capacity
- Workforce Development
- Data and Information Systems
- Customer Focus and Satisfaction
- Financial Systems
- Management Practices
- Service Delivery

A performance management system is the continuous use of all the components above so that they are integrated into an agency's core operations (see inset above, right). Performance management can be carried out on multiple levels, including the program, organization, community, and state levels.

Performance improvement (or systems performance improvement) is defined as positive changes in capacity, process and outcomes of public health as practiced in government, private and voluntary sector organizations. Performance improvement can occur system-wide as well as with individual organizations that are part of the public health system. It involves strategic changes to address public health system (or organizational) weaknesses and the use of evidence to inform decision making. (Source: http://www.cdc.gov/nphpsp/performanceimprovement.html)

Performance indicators summarize the focus (e.g., workforce capacity, customer service) of performance goals and measures, often used for communication purposes and preceding the development of specific measures.

Performance measures are quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator (e.g., the number of trained epidemiologists, or the percentage of clients who rate health department services as "good" or "excellent").

Performance targets set specific and measurable goals related to agency or system performance. Where a relevant performance standard is available, the target may be the same as, exceed, or be an intermediate step toward that standard.

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 the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. (Source: http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1

[Type here]

Appendix B. Quality Improvement Maturity Survey Results

Quality Improvement Culture

In the category of QI Culture, from 2019 to 2022 there were increases in the percentage of employees who agreed that leaders work together for common goals (77% to 80%), that leaders are receptive to new ideas for improving (73% to 86%), and that staff are routinely asked to contribute to decisions (55% to 70%) (Figure 1). There were decreases in the percentages of employees who agreed that there is an impetus for improving quality driven internally (82% to 77%) and that staff work together to solve problems (84% to 80%) (Figure 1).

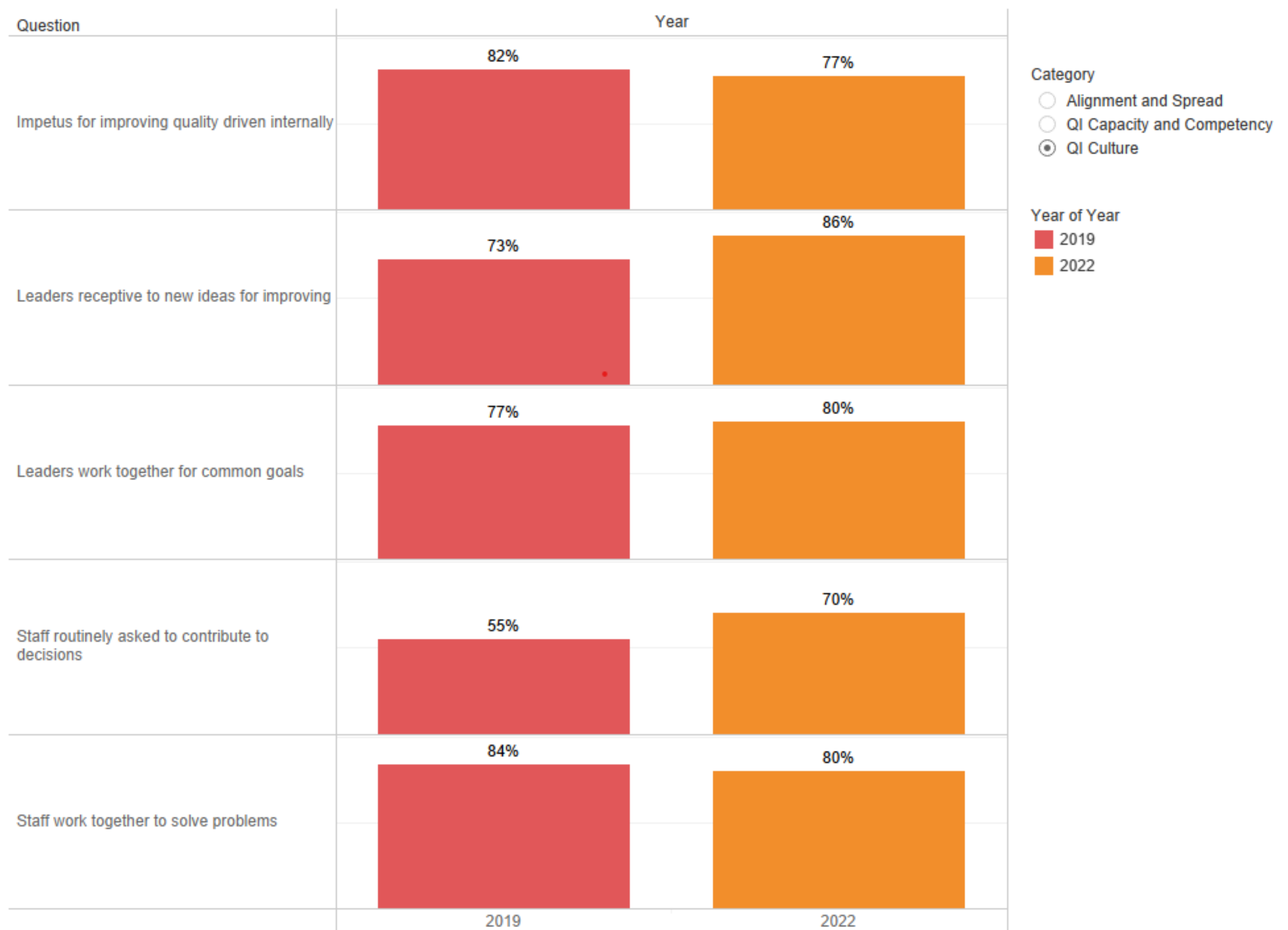

*Figure 1. Percentage of CCHD staff that **Agreed/Strongly Agreed with Statement** (2019 vs. 2022)*

Quality Improvement Capacity and Competency

In the category of QI Capacity and Competency, from 2019 to 2022 there were increases in the percentage of employees who agreed there is use of best practices to select quality improvement interventions (57% to 77%), that staff have skills to assess the quality of programs (61% to 68%), and that there is use of systematic methods to understand root causes of problems (50% to 61%) (Figure 2). Although these indicators all improved from 2019 to 2022, less than 80% of staff were in agreement indicating room for improvement moving forward. Additionally, the remaining eight indicators under the QI Capacity and Competency category experienced decreases suggesting an overall QI category of weakness (Figure 2).

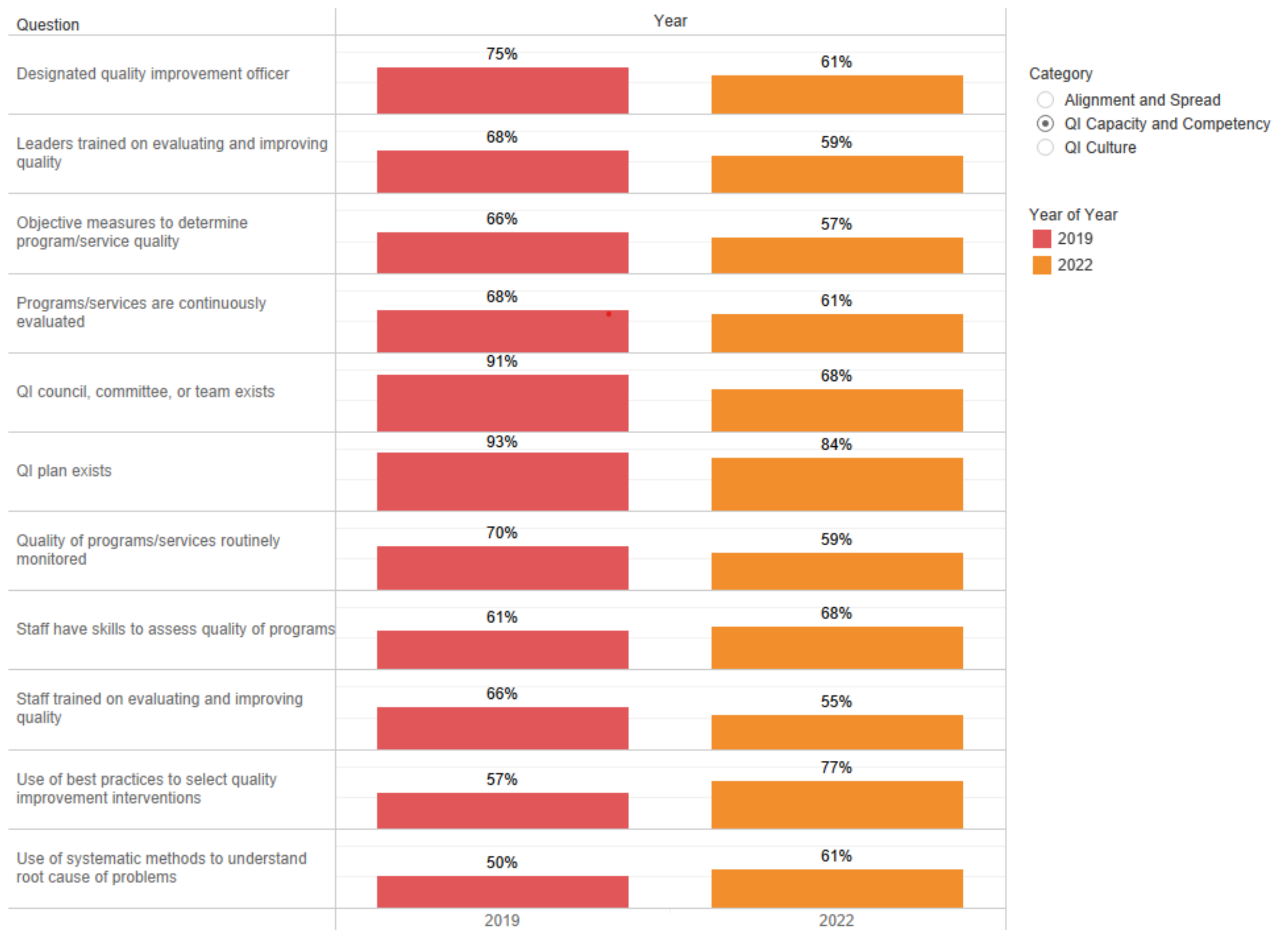

Figure 2. Percentage of CCHD staff that ***Agreed/Strongly Agreed with Statement*** *(2019 vs. 2022)*

Quality Improvement Alignment and Spread

In the Category of QI Alignment and Spread, there was an increase from 2019 to 2022 in the percentage of employees who agreed that staff have the authority to change practices/policy to improve services they are responsible for (39% to 57%) and that staff have the authority to work within and across programs boundaries when facilitating change (36% to 50%). Although these indicators all improved from 2019 to 2022, less than 80% of staff were in agreement indicating room for improvement moving forward. Additionally, the remaining eleven indicators under the QI Alignment and Spread Category experienced decreases suggested an overall weakness in the category of QI.

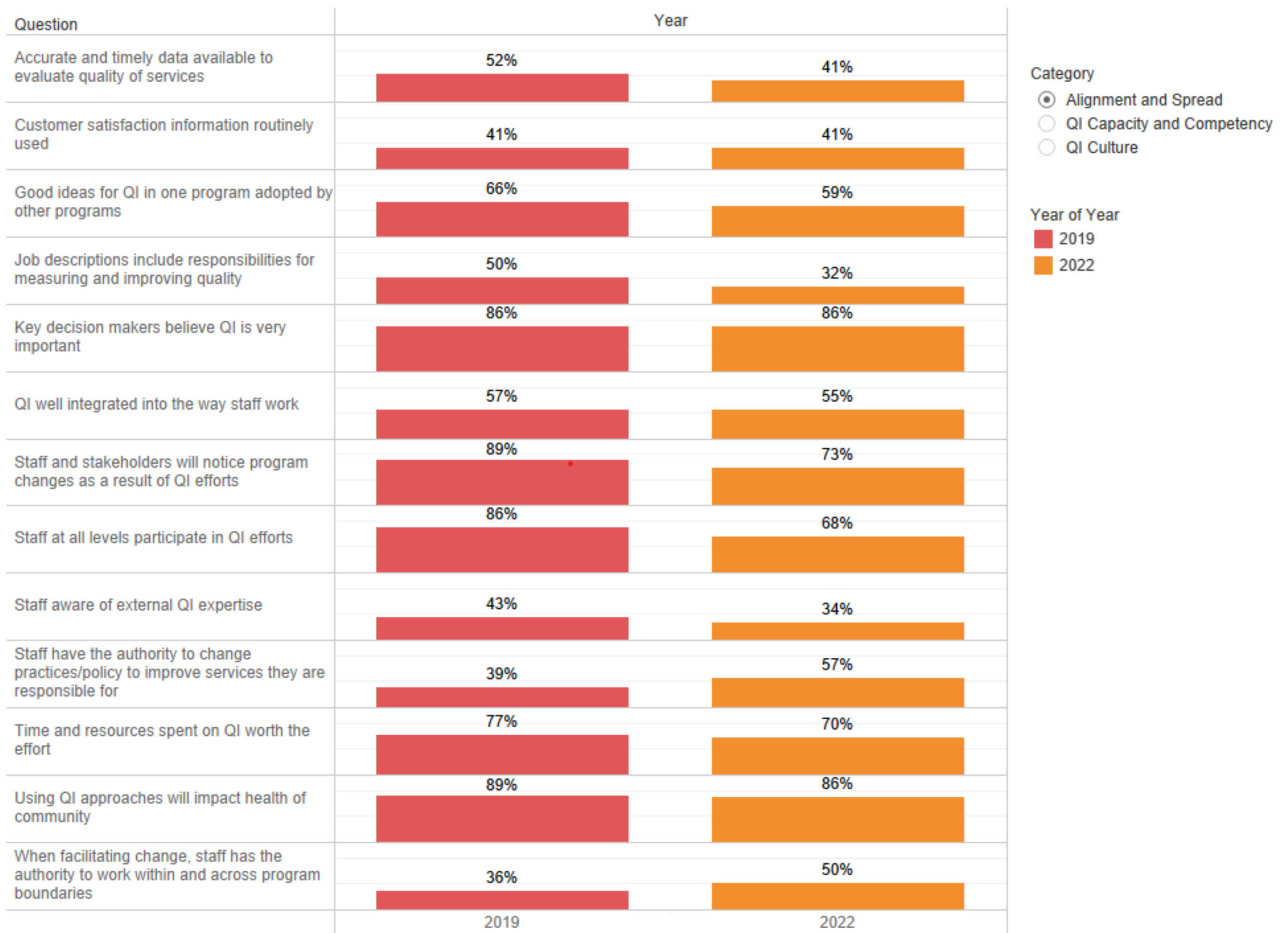

*Figure 3. Percentage of CCHD staff that **Agreed/Strongly Agreed with Statement** (2019 vs. 2022)*