



**Public Health**  
Prevent. Promote. Protect.

Wicomico County  
Health Department

# Performance Monitoring and Quality Improvement Plan Fiscal Year 2024

June 2023

Version 1

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## Introduction

Wicomico County Health Department (WiCHD) is committed to integrating the principles of performance management and quality improvement (QI) into all WiCHD programs, services and processes. This *Performance Monitoring and Quality Improvement Plan (PMQIP)* combines guidance and goals for both performance management and quality improvement, and provides a framework for the agency towards achieving a culture of continuous QI.

This PMQIP serves to address the most recent standards and measures regarding QI set forth by the Public Health Accreditation Board (PHAB). PHAB guidance for Domain 9 (*Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement*) outlines this plan. For additional information, refer to **Appendix A, PHAB Guidance**<sup>1</sup>.

## Key Quality Terms

Please see **Appendix B, Quality Key Terms**<sup>2</sup>, for a summary of common terminology and definitions used throughout this document.

## Culture of Quality

The WiCHD strives to embed a culture of quality within the health department. The agency's Quality Council has developed the following mission statement.

### Quality Council Mission

To grow a culture of quality improvement in the Wicomico County Health Department (WiCHD).

### Current and Future State of Quality

The Quality Council follows the framework provided by the National Association of County and City Health Officials (NACCHO) called "Roadmap to a Culture of Quality Improvement"<sup>3</sup>.



WiCHD is working towards achieving a Phase 6 of the Roadmap. An organization at a Phase 6 has staff who use QI daily, staff who can show QI's return on investment, staff who prioritize customers, and consider problems to be great opportunities to improve.

The Quality Council uses two assessment tools - the **QI Maturity Tool** and the **Public Health Performance Management Self-Assessment Tool**. During FY23, the Quality Council voted to change the frequency of these assessments from annually to biennially. Each assessment will be conducted in alternate years. For example, during FY23, the **QI Maturity Tool** was completed. In FY24, the **Public Health Performance Management Self-Assessment Tool** will be administered.

In March 2023, the Quality Council conducted a Culture of Quality Improvement Assessment throughout WiCHD using the **QI Maturity Tool**, developed by the Minnesota Public Health Research to Action Network to evaluate the Robert Wood Johnson Foundation Multi-State Learning Collaborative. The assessment was sent out via Google Forms to all staff. The assessment groups staff into four groups - senior managers, supervisors, public health professionals (positions that require at least a bachelor's degree), and front-line staff (positions that require a high school diploma). This allows us to align results with our workforce development survey, which also grouped staff into these categories. To review the assessment and data, refer to **Appendix C, Quality Improvement Assessment**.

The Public Health Foundations **Public Health Performance Management Self-Assessment Tool** was last completed in 2022. This assessment will be updated in FY24. The table below summarizes the key 2022 findings.

<b>Key Findings: 2022 Performance Management Assessment</b>		
<b>Key Concepts</b>	<b>Current Strengths</b>	<b>Current Weaknesses</b>
<b>Visible Leadership</b>	<ul style="list-style-type: none"> <li>Senior managers highest culture of quality score in latest assessment</li> <li>Senior managers show a commitment to performance improvement</li> </ul>	<ul style="list-style-type: none"> <li>Steering committee process new for senior managers</li> <li>All levels of leadership integral to communication of PM value and integration</li> </ul>
<b>Performance Standards</b>	<ul style="list-style-type: none"> <li>Many programs have standards as a part of grant-based funding</li> <li>Benchmarks include similar entities</li> </ul>	<ul style="list-style-type: none"> <li>National standards do not exist for all programs</li> <li>Relationship to public health frameworks planned for next phase</li> </ul>
<b>Performance Measures</b>	<ul style="list-style-type: none"> <li>Measures are clearly defined and documented</li> <li>Data is collected on a regular schedule</li> <li>Tapped existing sources of data for most measures in FY22</li> </ul>	<ul style="list-style-type: none"> <li>Data extraction not always user friendly</li> <li>Continue moving towards outcome/impact measures, in addition to capacity and process</li> <li>COVID baselines can be wildly different</li> <li>Lack of qualitative data - new PHAB reqs</li> </ul>
<b>Performance Reporting</b>	<ul style="list-style-type: none"> <li>Regular reporting on strategic plan and CHIP already happening</li> <li>Dept. dashboard aims to incorporate information from financials, health outcomes and customer satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>Reporting sometimes dependent on timelines and entities outside of program control</li> <li>Dashboard data reliant on spreadsheets for collection vs. data visualization system</li> <li>Process for communication throughout agency</li> </ul>
<b>Quality Improvement</b>	<ul style="list-style-type: none"> <li>Quality improvement plan, council and trainings well established at agency</li> </ul>	<ul style="list-style-type: none"> <li>Culture of QI stagnant at Phase 3</li> </ul>

For more details, refer to **Appendix D, Performance Management Assessment**.

Keeping the results of the quality improvement and performance management assessment in mind, we also assessed our current state versus our desired state by using the foundational elements and characteristics described in NACCHO's Roadmap.

Current State	Desired State
<b>EMPLOYEE EMPOWERMENT</b>	
Few QI Champions exist to lead QI projects and mentor staff. There has been turnover over the past several years with QI Champions leaving the agency. During FY23 the council was successful in recruiting three new members.	QC recruits and trains new QI Champions to help lead the QI charge at WiCHD.
The FY23 Culture of Quality Improvement Assessment shows senior managers have the highest scores and front line staff have the lowest scores.	All staff are aware and have knowledge of basic QI principles.
Some staff remain resistant to QI and view it as an added responsibility or a negative reflection on their work.	All staff view QI as an opportunity instead of a punishment, and look for ways to incorporate QI in their day to day work.
During FY23 the performance management system was refined and dashboards are now shared agency-wide. Annual 1:1 performance management meetings are held with each division along with key staff to develop performance measures.	All staff understand Performance Management and how to develop performance measures. QC and Key Staff can guide others in the PM process.
<b>TEAMWORK &amp; COLLABORATION</b>	
One or two teams may have convened to implement formal or informal QI projects.	All staff will be encouraged to increase use of collaborative QI techniques for problem solving including implementing QI Projects.
<b>LEADERSHIP</b>	
Senior Managers understand QI and its value to the agency's work. Supervisors may still demonstrate resistance.	Leaders continue to communicate to employees key messages including (1) QI is not about placing blame or punishment; (2) QI is a way to make daily work easier and more efficient; (3) QI is within reach of all staff and will get easier with practice.
<b>CUSTOMER FOCUS</b>	
During FY23 the customer satisfaction surveys (CSS) process was refined. The survey is now used agency wide, with two campaigns a year to push for responses. CSS data has been incorporated into the agency's performance management system.	A standardized survey is used across all departments and programs to collect customer satisfaction data.
Customer satisfaction data is beginning to be used to make improvements.	WiCHD uses standardized survey to assess potential improvements to programs/services.
<b>QI INFRASTRUCTURE</b>	
Agency has a Quality Council with QI champions representing 5 of the 8 main agency divisions.	QI Champions exist throughout every dept/program and every staff level within the agency. The QC is fully staffed and all staff have a basic knowledge of QI.

Departments/programs have process measures but not always outcome measures. Performance measures are not consistently linked to agency strategic priorities.	Key Staff understand Performance Management and create meaningful measures that align with the agency’s strategic plan and guide QI projects.
Performance data exists, but isn’t consistently used for decision making, performance monitoring, and QI project identification.	Senior Leadership will take the lead for performance management in their department, to model how to use performance data.
<b>CONTINUOUS PROCESS IMPROVEMENT</b>	
Performance data is inconsistently used as part of improvement projects.	QC will identify and sponsor “winnable” QI projects using agency performance data; QI efforts are linked to strategic priorities.

**Customer Satisfaction Survey (CSS)**

In Fiscal Year 2020, WiCHD developed and implemented an agency-wide customer satisfaction survey, based on satisfaction surveys already collected by some programs and other program feedback. The Quality Council also gathered data on what method would work best - electronic vs. paper surveys, with programs indicating that both methods should be offered. Programs also ranked the customer service attributes that would be most useful to their program. The highest ranking attributes were respect, courtesy & helpfulness, accessibility, overall satisfaction and convenience. The Quality Council created the survey questions around these areas, went through the required Institutional Review Board Process and piloted the survey during FY 2021.

In FY 2023, the CSS was updated to include two additional questions around the ease of understanding and the timeliness of the service/information needed, as well as allowing respondents to indicate which service was provided in addition to the department visited. The updated CSS was approved by the IRB on November 29, 2022. In addition to the updated survey, the Quality Council also identified customer focus as its All Staff Training for FY 2023. All staff were introduced to the principles of improving customer focus in a brief presentation. Following that, senior managers met with key staff members involved with CSS data collection, to document their individual CSS implementation process (as this may vary from division to division). CSS data was also incorporated into the agency’s performance management system, with the expectation that results are used for improvements in policies, programs and/or interventions. The annual CSS process cycle is available in **Appendix E, WiCHD Annual Customer Satisfaction Survey Process**.

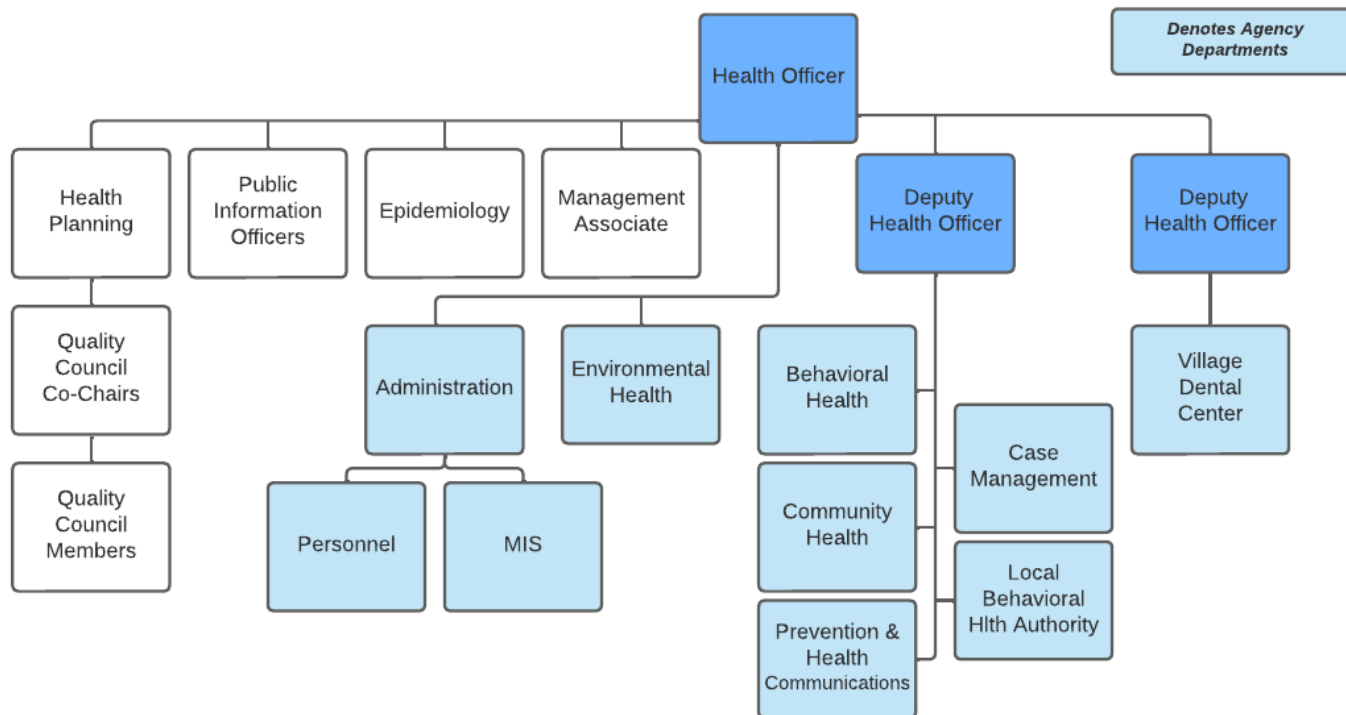
**Quality Improvement versus Quality Planning**

In addition to quality improvement (QI) projects, the Quality Council does quality planning (QP) projects. QI is used to improve an existing program, service or process. QP is used to establish a process which is either new or not stable. It is not always clear cut when to use QI versus QP. The QC uses the guidance below.

<p><b>Use QI:</b></p> <ul style="list-style-type: none"> <li>● If there are unexpected changes in #s</li> <li>● To improve timeliness or ease of processes</li> <li>● To decrease errors</li> <li>● To obtain consistent results</li> <li>● If specific targets are not achieved</li> </ul>	<p><b>Don’t Use QI:</b></p> <ul style="list-style-type: none"> <li>● If personnel problems exist</li> <li>● Staff aren’t using the same process</li> <li>● To develop a plan</li> <li>● If problems have pre-determined solutions</li> <li>● If solutions are evident</li> </ul>
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# Organizational Structure, Roles and Responsibilities

## Organizational Structure



WiCHD Performance Management and Quality Council activities are overseen by the Health Officer. Staff at all levels are incorporated in the performance management and quality improvement process including, but not limited to: collecting managing program data, suggesting program performance indicators, identifying potential QI projects, functioning as subject matter experts or participating in a QI Project Team.

### Quality Council Charter and Membership

The Quality Council (QC) consists of WiCHD members from all areas of the organizational structure. Staff interested in joining the QC complete an online interest form hosted on the agency’s intranet (private internal network). At the monthly QC meetings, the QC reviews submitted interest forms and consider the following factors: overall membership diversity, program/department representation, needed/desired skill sets, and candidate availability. Please refer to **Appendix E, Quality Council Charter** for additional information on membership, QC structure, and QC elected positions.

### Other Roles and Responsibilities

The Health Officer has empowered the Quality Council to provide the agency’s quality improvement efforts. The Quality Council is also responsible for maintaining and monitoring the performance management system.

PERFORMANCE MANAGEMENT STAKEHOLDERS	
Position	Responsibilities
Health Officer	<ul style="list-style-type: none"> <li>Leading member of performance management steering committee</li> </ul>
Senior Managers	<ul style="list-style-type: none"> <li>Comprise the remainder of the performance management steering</li> </ul>

	<p>committee</p> <ul style="list-style-type: none"> <li>Review performance progress quarterly and make recommendations for areas of improvement</li> </ul>
Program Managers and Supervisors	<ul style="list-style-type: none"> <li>Timely entry of quarterly performance data in collection instruments</li> <li>Escalate any changes in grant-based indicators to QC leadership</li> </ul>
Quality Council Leadership	<ul style="list-style-type: none"> <li>Responsible for the quarterly performance indicator data collection</li> <li>Publish and present quarterly PM data dashboard progress with senior management to elicit improvement recommendations</li> <li>Meet with senior managers annually to refine performance standards and measures</li> </ul>

<b>QUALITY COUNCIL ROLES</b>
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Position	Elected?	Responsibilities
Administrator	No	<ul style="list-style-type: none"> <li>Ex officio position filled the agency's Health Planner.</li> <li>Responsible for oversight of the QC including: convening regular meetings, setting agendas, coordinating training opportunities, implementing a QI recognition program, and leading the development, implementation and monitoring of an annual QI Plan.</li> <li>Serves as liaison between the QC and Agency Leadership.</li> </ul>
Co-Chair	Yes	<ul style="list-style-type: none"> <li>Up to two individuals elected for two year terms.</li> <li>Leads QC meetings and oversees QC projects</li> <li>Serves as a liaison between QC and Agency Leadership.</li> </ul>
QI Consultant	Yes	<ul style="list-style-type: none"> <li>Up to two individuals elected for a one year term.</li> <li>Responsible for responding to and following up with QI suggestions submitted through an online ticket system that do not meet QI or QP project criteria but are still an improvement.</li> </ul>
Secretary	Yes	<ul style="list-style-type: none"> <li>Up to two individuals elected for a one year term.</li> <li>Completes QC meeting minutes.</li> </ul>
Member	No	<ul style="list-style-type: none"> <li>Participates in monthly meetings.</li> <li>Assists in completion of QI projects and planning.</li> </ul>

<b>QI PROJECT TEAMS ROLES</b>
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Position	Responsibilities
Sponsor	<ul style="list-style-type: none"> <li>Either the Administrator or one of the co-chairs.</li> <li>Connects the project to overall agency strategic objectives and serves as a link to Senior Management.</li> <li>Reviews team progress and ensures accountability.</li> <li>Advocates for resources and overcomes barriers.</li> <li>Ensures the team follows QI process and uses appropriate QI tools.</li> </ul>

Team Lead	<ul style="list-style-type: none"> <li>● Facilitates the QI project.</li> <li>● Sets agenda, meeting schedule, and works with the team to ensure documentation.</li> </ul>
Team Members	<ul style="list-style-type: none"> <li>● Typically Quality Council members, but could include members of other key committees/groups within the agency.</li> </ul>
Subject Matter Experts	<ul style="list-style-type: none"> <li>● Not necessarily Quality Council members. They are individuals whose everyday work is directly affected by the QI project and typically they have an in-depth understanding of the processes/procedures in question (meaning they can offer useful improvement insight).</li> </ul>
Recorder	<ul style="list-style-type: none"> <li>● Assigned individuals that keep meeting minutes and manages documentation.</li> </ul>

### Staffing and Administrative Support

The WiCHD has 0.6 Full Time Equivalent (FTE) staff dedicated to QI and PM activities. The 0.6 FTE is split between two staff - the Health Planner (0.5 FTE) and the Special Assistant to the Health Officer/Deputy PIO (0.10 FTE).

### Budget and Resource Allocation

Other than salary for the 0.6 FTE staff, the Quality Council does not have a dedicated budget. Funding requests for PM, QI projects and training are submitted to the Health Officer for initial approval. If approved, the Administrator reviews resources and makes a final determination based on available funding.

## Performance Management Overview

Performance management occurs when an organization analyzes performance measures and standards to achieve desired results, including quality improvement, accreditation, funding opportunities, evidence-based decisions, and improved health outcomes. Simply, performance management is asking: *Where do you want to be? How will you measure it? Are you where you want to be? How can we improve if we aren't where we want to be?*

The WiCHD Performance Management system was developed using the *Turning Point Management Framework* developed by the Turning Point Performance Management National Excellence Collaborative (PMC). The system is grounded in four core components: Performance Standards, Performance Measurement, Reporting of Progress and Continuous Quality Improvement.

## PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM



### Performance Standards

Standards are general guidelines used to assess an organization's performance and guide direction. When available, WiCHD uses national standards, such as Healthy People 2030, Public Health Accreditation Board and National Public Health Standards when selecting key indicators and targets. Standards may also be determined by grant requirements, state requirements, requirements from other accrediting bodies, or county leadership. In some cases where no external standards are available, standards may also be developed by program leadership based on an improvement from baseline.

### Performance Measurement

Measures (or indicators) are strategically selected to reflect the capacities, processes and/or outcomes under each of the agency's performance standards. Each measure typically has a baseline value, which is the initial or most recent level of performance, and a target, which is the quantifiable amount of improvement to achieve from the baseline in a set time period. The majority of WiCHD performance measures are collected on a quarterly basis, unless otherwise noted.

### Reporting Progress

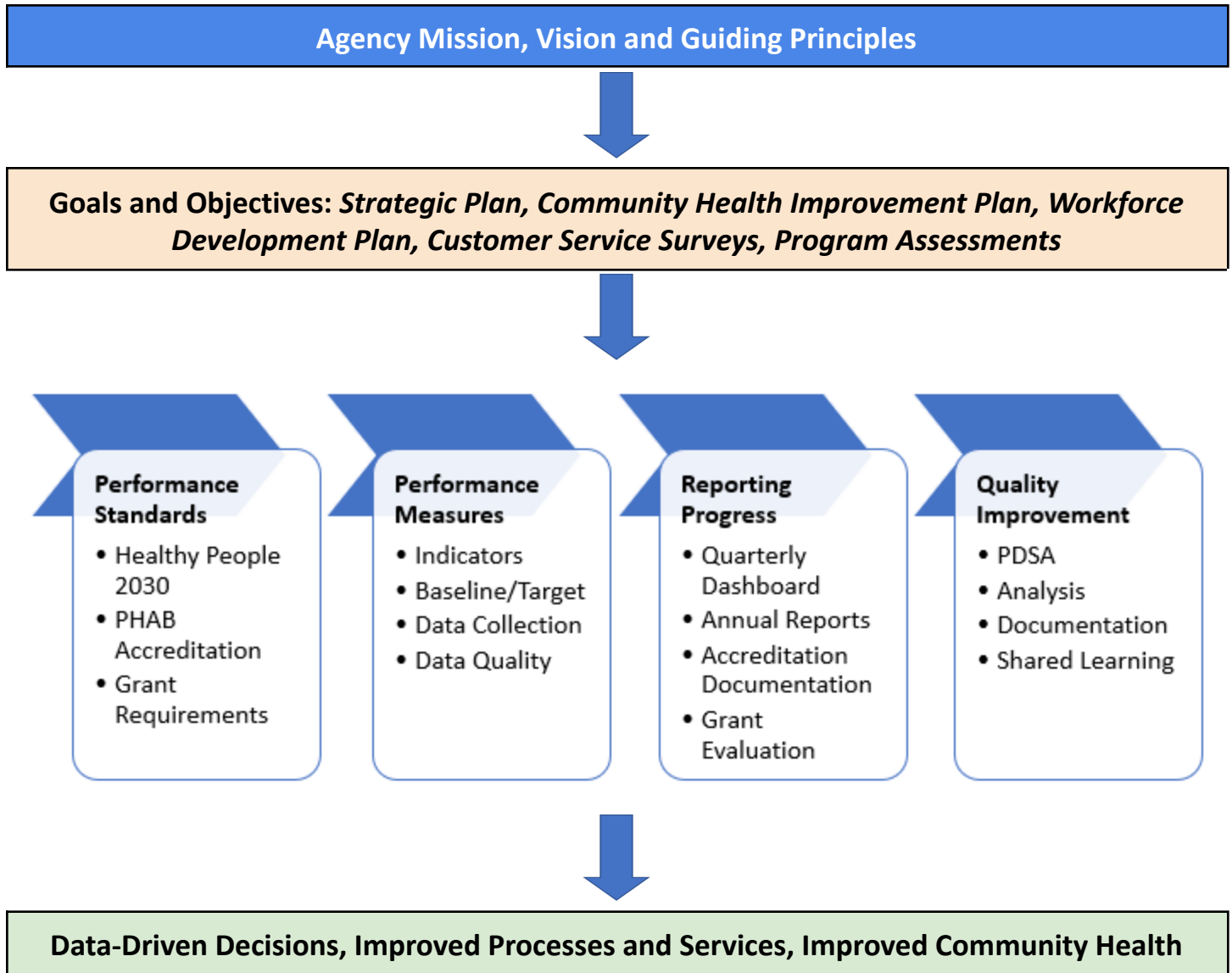
Each quarter, the WiCHD Quality Council leadership publish a comprehensive dashboard summarizing performance progress, including the programmatic and department-wide indicator data described above, as well as any contextual information provided by managers and supervisors related to the indicator data points. The dashboard is presented by the QC leadership to senior management at the end of the first month of each new quarter to both identify areas of improvement, but also to identify areas of success and progress throughout the department. Any follow up items are also noted in the dashboard document, with specific staff member(s) assigned to those items, and all follow up items are discussed at the subsequent senior management meeting to 'close the loop.'

To ensure transparency throughout the department, the WiCHD Performance Management dashboards are posted to an All Staff Google Drive each quarter. Due to the infancy of the PM system, performance data has not been shared with external stakeholders, but WiCHD anticipates using the dashboard and/or the some of specific indicators within it, in

communications with our local county Board of Health, county Executive office, the local health improvement coalition (LHIC), the department’s governing agency the Maryland Department of Health, and other community partners. Other regular reports incorporating performance data may include the WiCHD Annual Report, the WiCHD Community Health Indicators Report, and various grant applications and evaluation reports.

**Quality Improvement**

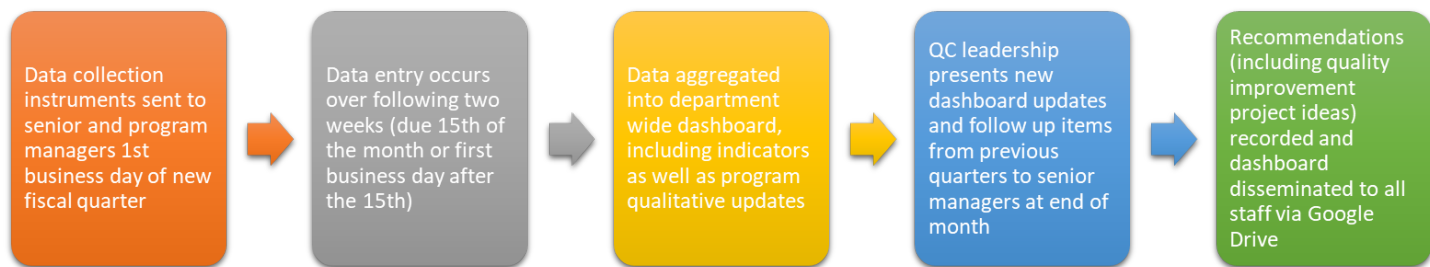
Data from the performance management process directly feeds into the continuous quality improvement process at the WiCHD. The formal process used by the WiCHD to identify improvement areas is detailed later in this plan.



**Performance Management Process**

**Quarterly Data Collection and Review**

The majority of WiCHD performance indicators are collected on a fiscal quarter basis. The fiscal year runs from July 1 through June 30 each year.



### Annual Review of Performance Standards and Measures

During the 3rd quarter of each fiscal year, the Quality Council leadership conducts one-on-one meetings with each of the department’s ten senior managers and designated program staff as a part of the annual performance management review. The goals of these meetings are to:

- Assess any changes to program goals for the upcoming fiscal year
- Review current performance measures and discuss progress towards targets (through the 3rd Quarter)
  - Measures consistently exceeding targeted goals should be considered for removal
  - Measures consistently not meeting targeted goals should be discussed, and potential reasons for not reaching target documented and/or referred to the Quality Council for a potential QI project
- Brainstorm measure(s) for any new department programs/grants
- Review qualitative data submitted to date (e.g., accomplishments, challenges, outreach, etc.)
- Review performance measurement principles with any new staff (if applicable)

Every other year, Senior Management also completes the Public Health Foundation’s Self Assessment Tool to gauge the agency’s performance management efforts. The individual assessment results are discussed with senior managers at their one-on-one meetings to highlight any gaps in their department’s performance management and to suggest improvements for the new fiscal year.

## Quality Improvement Training

The Quality Council (QC) has developed and implemented a two part training plan. The first part is training for new employees. Within six months of hire, all new employees are required to complete a half-day training - **Introduction to Quality Improvement**. This training was created by the QC and is provided either virtually or in-person. The training covers basic QI terms and principles, as well as QI tools such as process maps, fishbones, and run charts. The training also familiarizes staff with the NACCHO Roadmap to a Culture of Quality Improvement, WiCHD’s status on the Roadmap, and simple steps for reaching the next Roadmap phase. Additionally, the training provides an introduction to performance management and its relationship to QI.

The second part of the training plan is providing on-going training for all employees. After completing **Introduction to Quality Improvement**, all employees are required to complete an annual training planned by the QC. The annual training is intended to continue to build knowledge, skills and abilities in both quality improvement and performance management. Each fiscal year, the QC will plan the training, including determining the training topic, the trainer, the training mode (e.g. in-person, webinar, self-paced, etc.), the venue (if applicable), etc.

QC members also continue to learn via self-study. If time permits during the regular monthly meetings, QC members explore new QI tools and resources to expand their QI skills and knowledge. Additionally, pending available funding, each year the agency sends several QC members to national conferences such as the National Network of Public Health Institutes Open Forum for Quality Improvement and Innovation and/or the Public Health Improvement Training.

## Quality Improvement Methodology

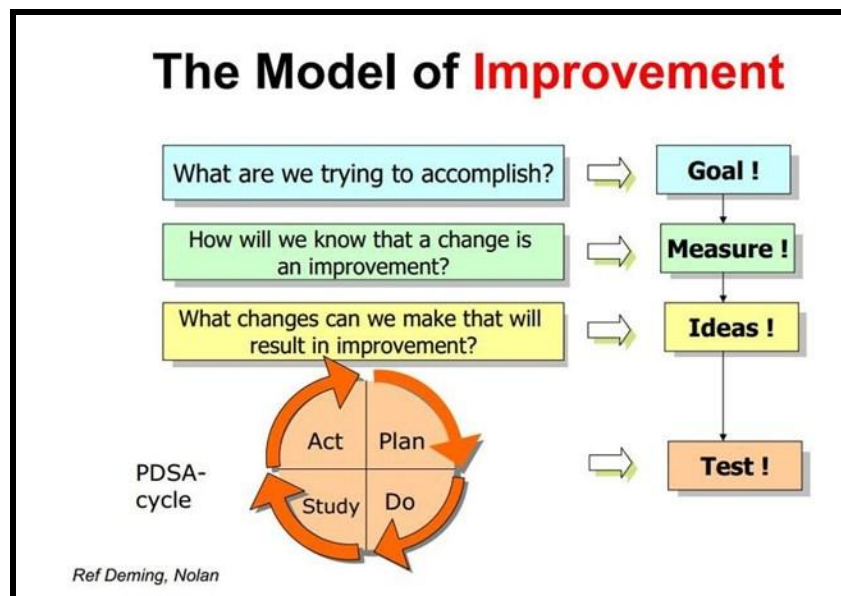
WiCHD uses the Model of Improvement with the Plan-Do-Study-Act (PDSA) method. The Model of Improvement has two parts.

1. Answers to three fundamental questions:
  - What are we trying to accomplish?
  - How will we know whether a change is an improvement?
  - What changes can we make that will result in improvement?

2. The Plan, Do, Study, Act (PDSA) cycle: tests and implements changes in actual work settings.

Going through the prescribed four steps in the PDSA method guides the thinking process into breaking down the process into steps, planning and implementing one change to the process, and then evaluating the outcome, improving on it, and testing again.

Common QI tools used with this model include process maps, fishbone diagrams, brainstorming, run charts, etc.



The Quality Council identifies QI projects two ways:

1. Through the Performance Management Process, and/or
2. Via the Ticket Submission Process

As noted in the **Performance Management Process** section above, performance data is reviewed quarterly. Through the data review process, QI may be initiated to help the program reach their target.

The ticket submission process allows any staff to submit an idea for improvement. The staff completes a Google form via the agency's intranet. The QC evaluates submitted project ideas using the Model for Improvement criteria. See **Appendix F, Ticket Submission Process**. Additional details can also be found in **Appendix G, Annual Planning Process**.

In FY23, the QC will implement a screening checklist to further assist in determining whether a proposed project is appropriate for a QI project. See **Appendix H, Screening Checklist for Quality Improvement (QI) Projects**.

## Quality Improvement and Performance Management Goals FY 2024

To review the evaluation for the FY23 goals, objectives and strategies, please see **Appendix I, Quality Improvement Plan Monitoring and Evaluation.**

GOAL 1		
Continue implementing and monitoring performance management health department-wide to achieve organizational objectives.		
Measurable Objective	Performance Metrics	Responsible Parties
1.1 At the end of each quarter, the QC will collect programmatic and health-department wide indicator data from each department and publish a comprehensive dashboard summarizing performance progress.	Documentation of the dashboard.	QC & Leadership
1.2 At the end of the first month of each new quarter, QC leadership will present the dashboard to senior management to identify areas of improvement, to determine whether to initiate a QI project on identified opportunities for improvement, and identify areas of success and progress throughout the department.	Meeting minutes. Documentation of the dashboard with feedback documented. QI projects initiated.	QC & Leadership
1.3 Complete at least 1 quality improvement project that is identified through the performance management system by March 2024.	Meeting minutes. QI Story Board.	QC & Leadership
1.4 At the end of the first month of each new quarter, the dashboard will be shared with all staff by posting to the All Staff Google Drive.	Date dashboard posted to Google Drive.	QC
1.5 By April 2024, the QC and Senior Management will complete the Public Health Foundation's Self Assessment Tool (completed biennially) to gauge the agency's performance management efforts.	Completed assessment.	QC & Leadership
1.6 Between February 2024 - March 2024, the QC will conduct one-on-one meetings with each of the health department's senior managers and their program staff as a part of the annual performance management review.	Documentation of meetings and data.	QC & Leadership
1.7 At least annually, communicate with the County Council regarding performance management and quality improvement initiatives and progress.	Documentation of communication.	QC & Leadership

GOAL 2		
Institutionalize Continuous Quality Improvement to strengthen the health department's culture of QI.		
Measurable Objective	Performance Metrics	Responsible Parties
2.1 The QC will provide the <i>Introduction to Quality Improvement</i> training either virtually or in-person to new staff three times per year.	Documentation of completed trainings.	QC

<b>2.2</b> 90% of new hires will complete <i>Introduction to Quality Improvement</i> training within 6 months of hire date.	Percent of newly hired staff trained	QC
<b>2.3</b> By 10/31/23 the QC will finalize planning for the annual all staff training in the <a href="#">core competencies for public health professionals</a> developed by the Council on Linkages between Academia and Public Health Practice.	Course created/selected.	QC
<b>2.4</b> By 12/31/23, all staff will complete the annual Quality Improvement training on core competencies.	Documentation of staff completing training	QC
<b>2.5</b> Biannually, every July and January, the QC will have a focused campaign/push to collect at least 300 customer satisfaction survey responses agency wide.	Process Map, gantt chart, and survey results	QC, Senior Management and Supervisors
<b>2.6</b> During FY24, the customer satisfaction survey campaigns/pushes will have a focus to survey the LEP population, with a goal of at least 75 (25%) of the 300 responses coming from LEP clients.	Process Map, gantt chart, and survey results	QC, Senior Management and Supervisors
<b>2.7</b> To create a transparent and engaging environment, the QC will continue current communication via quarterly health officer newsletters, emails, and quarterly meetings with Senior Leadership.	Newsletters, meeting minutes, email documentation	QC, Senior Management, and Supervisors
<b>2.8</b> The QC will complete 4 Quality Improvement (QI) and/or Quality Planning (QP) projects by 6/30/2024.	Completed storyboards.	QC
<b>2.9</b> By 6/30/24, the QC will develop and implement a plan to celebrate and encourage QI and QP successes.	Completed and implemented plan	QC

GOAL 3		
Strengthen infrastructure of Quality Council for QI and PM activities.		
Measurable Objective	Performance Metrics	Responsible Parties
<b>3.1</b> The QC will hold open houses, during their regular monthly meeting, three times per year - March, June and November.	Documentation of open house advertising; meeting minutes.	QC
<b>3.2</b> The QC will create 2 internal marketing materials to promote QC membership throughout the agency by 6/30/2024.	Marketing materials. Documentation of emails, newsletters, etc.	QC
<b>3.3</b> By 6/30/24, the QC will attend staff meetings to do outreach and QC recruitment to departments that do not have representation on the council.	Meeting minutes, new QC Members recruited	QC
<b>3.4</b> Once per quarter, the QC members will learn and practice new QI tools, such as the 7 basic QI tools in NACCHO's Roadmap.	Meeting minutes	QC

3.5 Review and revise governing documents (charter, plan, and policy) and QC diversity matrix by 06/30/2024.	Record of review	QC
3.6 As funding permits, send at least 2 QC members to the annual National Open Forum Conference, the annual Public Health Improvement Training (PHIT), and/or other similar training.	Number of staff trained	QC, Senior Leadership

## Implementation and Monitoring

Implementation and Monitoring is completed by the following:

- Monthly meetings with the Health Officer and QC leadership to review progress and discuss implementation tactics.
- Monthly meetings with Co-chairs and Quality Council Administrator to update the Quality Council’s plan progress tracker, plan for the council’s meeting, and develop content for the quarterly QI newsletter, and
- Quarterly meetings with Senior Management, Quality Council Administrator and Quality Council Co-Chairs to give updates and receive feedback regarding quality improvement and performance management.

## Communication

Regular communication to all staff about the QC activities is done through the following:

- Performance management dashboard,
- Quarterly meeting between QC leadership and Senior Management,
- Informational/educational QI article in the Health Officer’s newsletter, “Quarterly Connection”,
- Monthly meetings with QC leadership and the agency’s Health Officer,
- Quality Council Meeting Minutes, and
- Staff meeting updates.

## Evaluation of the Quality Improvement Plan and Activities

The Performance Monitoring and Quality Improvement Plan will be evaluated on a quarterly basis by the Quality Council. The evaluations will determine if the aspects of the plan are being followed, and if any improvements or revisions are necessary. The evaluation will include a summary of the progress toward goals/objectives of the plan. The outcomes accomplished by each QI Team will be reviewed including the process that was targeted, the performance indicators utilized, measurement outcomes and data aggregation, the assessment and analysis process, and the improvement initiatives implemented in response to the results of the QI project. To review the evaluation for the FY22 QIP Please see **Appendix H, Quality Improvement Plan Monitoring and Evaluation.**

**MEASURE 9.1.1 A:**

FOUNDATIONAL CAPABILITY MEASURE

## Implement the performance management system.

### **Purpose & Significance**

The purpose of this measure is to assess the health department's use of performance management practices in assessing performance and identifying and managing opportunities for improvement. A performance management system encompasses establishing and evaluating the achievement of goals, objectives, and improvements or actions across programs, policies, and processes. The design of the performance management system should consider community health needs and priorities, including health inequities or disparities, to demonstrate the work of the health department and public health system to improve health outcomes. An adopted performance management system fosters transparency by communicating across the department how the department will (1) ensure that goals are being met consistently in an effective and efficient manner and (2) identify the need to improve organizational results.

<b>MEASURE 9.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples 1 performance management system</b>	<b>Dated Within 5 years</b>
<p>a. Performance management goals <b>and</b> the associated objectives with time-framed and measurable targets.</p> <p>b. A description of how the performance management system operates, including the process for how staff will:</p>	<p><b>For required element a:</b> Goals are established by the health department and are intended to serve as the anticipated result or outcome the health department desires to achieve. Goals will have associated objectives (could be termed as measures or indicators). Objectives will be written in measurable and time-bound form, and can be used to assess the extent to which programs, policies, and processes are achieving intended results. Objectives could be written, for example, in SMART or SMARTIE (Specific, Measurable, Attainable, Relevant, and Time-bound and/or through an Inclusive and Equitable lens) form.</p> <p>The health department could, for example, set their performance objectives based on a combination of the following:</p> <ul style="list-style-type: none"> <li>• National, state, or other scientific guidelines (e.g., Healthy People 2030, state program requirements, or accreditation standards and measures).</li> <li>• Funders' performance or reporting requirements (e.g., outlined in grant requirements).</li> <li>• Benchmarks derived from peer organizations (e.g., neighboring health departments or health departments of similar size/characteristics).</li> <li>• Expectations of the public or leadership (e.g., public health performance objectives set by the governing entity).</li> <li>• Organizational or programmatic plans or workplans (e.g., targets established through strategic plan, health improvement plan, or workforce development plan; or targets established through program-level workplans).</li> </ul> <p>Documentation may demonstrate a sub-set of the goals and objectives in the performance management system through screenshot(s) or other documentation. The documentation does <b>not</b> need to show every goal and objective, but will reflect the breadth of the goals and objectives included in the performance management system.</p> <p><b>For required element b:</b> The description of the performance management system could be a description, policy, or plan (separate plan or integrated with the QI plan or other health department plan). It will describe how the following processes generally occur, but does not need to go into detail about each individual objective. For example, in describing how staff enter data into the system, it would be sufficient to list the methods used to collate data into the system without indicating which method applies to each specific objective. The description will include the process for how staff do each of the following:</p>		

<b>MEASURE 9.1.1 A: Required Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 performance management system	<b>Dated Within</b> 5 years
<p>i. Enter data in the performance management system.</p> <p>ii. Monitor data on performance.</p> <p>iii. Communicate results on a regular reporting cycle.</p> <p>iv. Use data to guide decision-making.</p> <p>v. Use data to facilitate continuous quality improvement.</p> <p>c. Linkages between the performance management system and strategic plan. (If the linkages are not evident in the example, they could be indicated in the Documentation Form.)</p>	<p>i. Enter data in the system. Performance measurement data can be derived from multiple data systems or data collection processes. Some could be directly transferred into the performance management system from another data source (e.g., if there is a connection to HR, financing, or surveillance data systems) or could be entered by staff.</p> <p>ii. Monitor data on performance. This could include, for example, how data are tracked to determine whether progress has been made towards meeting the objectives.</p> <p>iii. Communicate results on a regular reporting cycle. This could include, for example, regularly summarizing data on performance objectives (e.g., monthly, quarterly, or annually) and sharing this information with stakeholders (e.g., the health department director, members of the governing entity, staff, or members of the public). Documentation of progress reporting could include, for example, a dashboard accessible to others, quarterly reports sent to stakeholders, newsletters, meeting agendas and minutes, or presentations.</p> <p>iv. Use data to guide decision making. The health department could use performance management data analyses to, for example, guide decisions on where resources should be allocated or adjusted to improve efficiencies or effectiveness, or identify an unmet community need.</p> <p>v. Use data to facilitate continuous quality improvement. Monitoring progress in performance management data could lead to the identification of a quality improvement project, for example.</p> <p><b>For required element c:</b> Linkages with the strategic plan could be, for example, performance management goals and indicators tied to the strategic priorities. The performance management system does <b>not</b> need to link to all elements of the strategic plan, but it will show where linkages are appropriate for effective planning and implementation. A statement simply stating the performance management system is aligned to the strategic plan would <b>not</b> suffice. The Documentation Form may be used to clarify or describe linkages, for example, by indicating which specific priorities in the strategic plan are being tracked through the performance management system.</p>		

<b>MEASURE 9.1.1 A: Required Documentation 2</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 example (narrative of an example is acceptable)	<b>Dated Within</b> 5 years
<p>2. Implementation of the performance management system. The example must include customer feedback.</p>	<p>The documentation could address successes or unsuccessful implementation, including what was learned based on the implementation of the performance management system. It could describe, for example, how performance data were used to inform a health department decision that had positive effects on the department or community, or how monitoring the performance management data led to the implementation of quality improvement processes. In the context of this requirement, “customer” refers to the group impacted by the performance management goal. In this sense, customers could refer to partners or key stakeholders or, if it’s an administrative goal, the customers could be internal to the health department. The example could be tied to the quality improvement project (required within 9.1.3 A) or highlight another story of using customer feedback as part of performance management system implementation.</p>		

## MEASURE 9.1.2 A:

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Establish a process that guides health department quality improvement efforts across the department.

### **Purpose & Significance**

The purpose of this measure is to assess the plan to support quality improvement throughout the department. To make and sustain quality improvement gains, a sound quality improvement process and infrastructure for implementing that process is needed. A quality improvement plan serves as a roadmap to establish shared goals across the health department to foster a culture of quality.

<b>MEASURE 9.1.2 A:</b> <b>Required</b> <b>Documentation 1</b>	<b>Guidance</b>	<b>Number of Examples</b> 1 plan	<b>Dated Within</b> 5 years
<p>1. A quality improvement (QI) plan that addresses each of the following:</p> <p>a. List and description of key quality terms.</p> <p>b. Key elements of the QI structure, which must minimally include a description of roles and responsibilities of those responsible for the QI plan's implementation.</p> <p>c. Description of QI learning opportunities offered to all levels of department staff.</p> <p>d. Description of the process for identifying, prioritizing, <b>and</b> initiating QI projects.</p>	<p><b>For required element a:</b>  Inclusion of key QI-related terms is intended to create a common vocabulary and clear, consistent message regarding QI among staff, leaders, and other stakeholders.</p> <p><b>For required element b:</b>  In addition to roles and responsibilities of those responsible for the QI plan's implementation, the description could include, for example, organization structure for the QI process; membership and rotation of QI council/team members; descriptions of staffing or administrative support for the process; or descriptions of specific budget or resource allocation for the department's QI process.</p> <p><b>For required element c:</b>  Delivery methods for QI learning opportunities could include, for example, new employee orientation presentations, introductory online courses for all staff, more advanced trainings for lead QI staff, hands-on workshops, or participation in learning communities. QI learning opportunities could be integrated in the workforce development plan training list or schedule, which may be provided as a companion document.</p> <p><b>For required element d:</b>  The health department's QI plan will include the steps for: identifying or collecting ideas for QI projects (e.g., from the performance management system, customer feedback, or staff suggestions); prioritizing ideas for QI projects (e.g., using tools like prioritization matrices, project nomination ranking or rating worksheets, nominal group or multi-voting techniques, strategy grids, or The Hanlon Method); and initiating a QI project for a prioritized idea (e.g., establishing a QI team and developing a charter). These steps may be contained within the plan or an appendix to the plan. Health departments could consider incorporating an equity lens to identifying and prioritizing projects. When identifying projects, the health department might, for example, consider the impact of projects on populations potentially affected and might gather input from those who would be affected to assess whether the project would be responsive to their needs. The health department might also consider how to ensure potential QI projects are inclusive and open to the diverse perspectives of staff, partners, or community members. Prioritization processes could also include equity-based values or factors in weighting criteria of a prioritization matrix or other consideration about which projects would have the greatest impact on equity. Quality is defined by the communities served: there is no quality without equity.</p>		

MEASURE 9.1.2 A: Required Documentation 1	Guidance	Number of Examples 1 plan	Dated Within 5 years
<p>e. Goals and objectives with time-framed targets, related to the department's QI plan implementation.</p> <p>f. Description of how implementation of the QI plan is monitored.</p> <p>g. Communication strategies used to share with stakeholders about QI activities conducted by the health department.</p>	<p><b>For required element e:</b> The intent of this required element is for the health department to establish goals and objectives with time-framed targets pertaining to implementation of the QI plan itself. Goals and objectives related to specific QI projects or listing of QI projects would <b>not</b> meet the intent of this requirement.</p> <p>Goals and objectives could relate to, for example, QI training or learning opportunities offered for staff; the number or type of QI projects completed; the proportion of staff engaged in QI plan activities; communication of QI achievements or project outcomes to a variety of audiences; engagement of diverse teams in QI projects; or consideration of equity impact in selecting QI projects.</p> <p><b>For required element f:</b> The intent of this required element is to describe how the health department measures progress toward implementing the QI plan goals and objectives, as identified in required element e. Implementation of the QI plan could be monitored, for example, through the health department's performance management system, or by the QI Council/Team/Committee during their meetings.</p> <p><b>For required element g:</b> The QI plan will include a description of methods the health department may use to communicate its QI-related efforts to stakeholders. Stakeholders could be internal or external to the health department.</p> <p>Communications methods could include, for example, presentations with staff, members of the governing entity, or other health departments; QI newsletters; public display of QI storyboards; staff meeting updates or presentations; or other communications.</p>		

To view the **Standards & Measures for Reaccreditation, Version 2022**, go to <https://phaboard.org/wp-content/uploads/Standard-Measures-Version-2022-Reaccreditation.pdf>

## Appendix B. Key Quality Terms

<u>Accreditation.</u>	The development and acceptance of a set of national public health department (HD) accreditation standards; the development and acceptance of a standardized process to measure HD performance against those standards; the periodic issuance of recognition for HD that meet a specified set of national accreditation standards; and the periodic review, refining, and updating of the national public HD accreditation standards and the process for measuring and awarding accreditation recognition.
<u>Performance Management.</u>	Quality improvement is one part of performance management. Performance Management is a systematic process that helps an organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making. In practice, performance management often means actively using data to improve performance, including the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results.
<u>Plan-Do-Study-Act (PDSA).</u>	PDSA is a repetitive four-stage problem-solving model for improving a process or carrying out change. Three fundamental questions associated with PDSA are: what are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?
<u>Quality Improvement (QI).</u>	The use of a deliberate and defined improvement process that 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 which achieve equity and improve the health of the community.
<u>Quality Planning (QP).</u>	A set of methods and tools used to develop new processes or to revamp existing ones that will be able to meet established goals under operating conditions. At WiCHD, the distinction between QI and QP is that QI optimizes <i>existing</i> processes while QP <i>establishes</i> a process (either new or revamped).
<u>QI Culture.</u>	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.
<u>PMQI Plan (PMQIP).</u>	Describes what WiCHD is planning to do better. It is a living document that is updated annually, to reflect accomplishments, lessons learned, and changing organizational priorities.

*Note: Key Quality Terms are from the Public Health Accreditation Board. (2013). Acronyms & Glossary of Terms, Version 1.5. Retrieved from: [http://www.phaboard.org/wp-content/uploads/FINAL\\_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf](http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf)*

## Appendix C. Quality Improvement Assessment

### Maturity Tool & Rubric

The QI maturity tool measures quality improvement (QI) maturity. The QI maturity score corresponds to the Roadmap to an Organizational Culture of Quality Improvement produced by the National Association of County and City Health Officials (NACCHO).

#### Instructions

##### Step 1 of 2

1. Answer each question by selecting one response. (see questions on the next page)
2. Calculate the overall QI maturity score.
  - a. Value of each response
    - i. I don't know = 1
    - ii. Strongly Disagree = 1
    - iii. Disagree = 2
    - iv. Neutral = 3
    - v. Agree = 4
    - vi. Strongly Agree = 5
  - b. Respondents
    - i. Individual = calculate average (Responses values / 10)
    - ii. Multiple Respondents = calculate median (of responses to each question )

##### Step 2 of 2

1. After completing the QI maturity tool, find QI maturity score in table below.
2. Match QI maturity score to NACCHO Roadmap phase.
3. To identify current state of quality, go to identified phase # in NACCHO Roadmap.
4. Transcribe phase's "human characteristics" and "process characteristics" to describe current state.

KEY		
QI MATURITY SCORE	DESCRIPTION	NACCHO ROADMAP PHASES
0-2.9 (median=1.45)	Low QI (no knowledge, not involved, starting to get involved)	1,2
3.0-3.9 (median=3.45)	Medium QI (ad hoc QI)	3,4
4.0+	High QI (Borderline formal QI, formal QI, QI Culture)	5,6

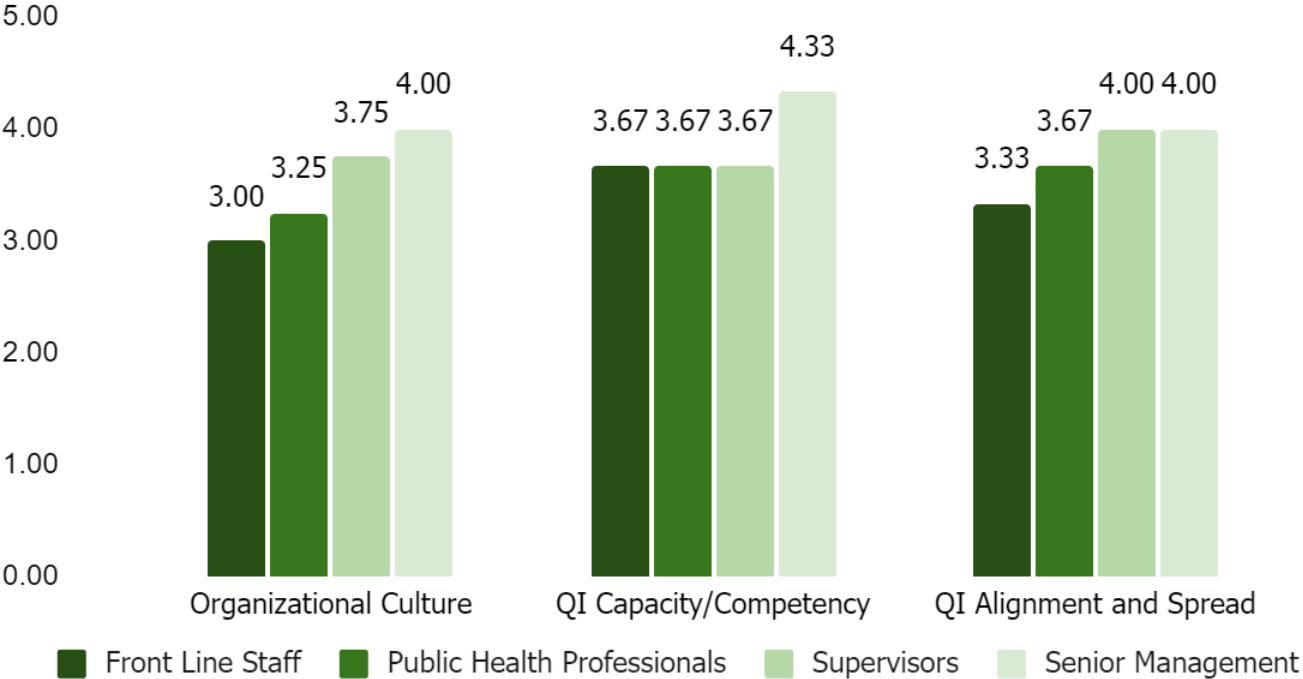
#### Learn more about this tool

These ten measures represent a subset of a much more extensive 37-item survey developed, tested, and administered nationally to top public health officials as a way to measure the QI maturity of individual health departments. The ten measures also demonstrate the QI maturity level within three themes: Organizational Culture, QI Capacity and Competency, and Alignment and Spread. For more information: Joly BM, Booth M, Mittal P, et al. (2012). Measuring quality improvement in public health: the development and psychometric testing of a QI Maturity Tool. *Eval Health Prof* 35(2), 119-47. Learn more from Minnesota Public Health Research to Action Network and Robert Wood Johnson Foundation.

See below for most recent findings on QI maturity score.

FY 2023 Quality Improvement Maturity Scores by Staff Level	
Total Responses = 115	Median Scores
<b>Overall (n=115; Response Rate = 58.7% )</b>	3.60
<b>Front Line Staff (n=44; Response Rate = 60.3%)</b>	3.20
<b>Public Health Professionals (n=43; Response Rate = 57.3%)</b>	3.50
<b>Supervisors (n=19; Response Rate = 51.4%)</b>	3.60
<b>Senior Management (n=9; Response Rate = 81.8%)</b>	4.10
<b>Organizational Culture Overall Scores</b>	
Staff members are routinely asked to contribute to decisions (agency-wide and/or within your program)	3.50
When trying to facilitate change, staff has the authority to work within and across program boundaries.	
Key decision makers (agency -wide and/or within your program) believe quality improvement is very important.	
Wicomico Health has a pervasive culture that focuses on continuous quality improvement.	
<b>QI Capacity &amp; Competency Overall Scores</b>	
Leaders (agency-wide and/or within your program) are trained in basic methods for evaluating and improving quality. (i.e. "Plan, Do, Study, Act")	3.67
Wicomico Health has a quality improvement plan	
Wicomico Health currently has a high level of capacity to engage in quality improvement efforts	
<b>Alignment &amp; Spread Overall Scores</b>	
Job descriptions for many individuals responsible for programs and services include specific responsibilities related to measuring and improving quality	3.67
Customer satisfaction information is routinely used by many individuals responsible for programs and services	
Wicomico Health has currently aligned our commitment to quality with most of our efforts, policies, and plans.	

# FY 23 (July 1, 2022 - June 30, 2023) Domain Scores by Staff Group



## 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.

Contents	
Using This Tool.....	1
Section I. Visible Leadership.....	3
Section II. Performance Standards.....	4
Section III. Performance Measurement.....	6
Section IV. Reporting Progress.....	7
Section V. Quality Improvement.....	8
Resources to Help, Take the Next Step, Definitions.....	10

### PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM



Developed in 2013, adapted from the 2003 Turning Point Performance Management System Framework

### 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 to 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](http://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 assessment.

4/8/2022 Completed by: Christina Gray, Lisa Renegar, Kelly Ward

4/14/2022 Shared with QC Members for input and comment

**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	<input type="checkbox"/>	x	<input type="checkbox"/>	Feel PM should be established first before can <u>be an always.</u>
2. Senior management demonstrates commitment to a quality culture	<input type="checkbox"/>	<input type="checkbox"/>	x	Scores were highest in QI assessment for Senior Mgrs ~almost 4, which has been consistent even with different <u>rating system.</u>
3. Senior management leads the group (e.g., program, organization or system) to align performance management practices with the organizational mission	x	<input type="checkbox"/>	<input type="checkbox"/>	Roles are reversed right now - expectation is QC is the lead; but next expectation is that Senior Mgmt will take lead; however, there are a few programs that are doing PM
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	<input type="checkbox"/>	<input type="checkbox"/>	Next fiscal year - integration into all staff meetings to review guidance. Also moving towards attending meetings to get more buy in from all levels of staff.
5. Performance is actively managed in the following areas (check all that apply)				
A. Health Status (e.g., diabetes rates)	<input type="checkbox"/>	<input type="checkbox"/>	x	
B. Public Health Capacity (e.g., public health programs, staff, etc.)	<input type="checkbox"/>	x	<input type="checkbox"/>	Funding, overhead, resources
C. Workforce Development (e.g., training in core competencies)	x	<input type="checkbox"/>	<input type="checkbox"/>	Workforce development plan is being operationalized Q4 of FY22, and will be continued through FY23.
D. Data and Information Systems (e.g., injury report lag time, participation in intranet report system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not sure what this means - revisit :)
E. Customer Focus and Satisfaction (e.g., use of customer/stakeholder feedback to make program decisions or system changes)	<input type="checkbox"/>	x	<input type="checkbox"/>	We are halfway through - regularly able to collect data by program, but need to integrate data into program decision making. This will be reported on Quarterly Dept Dashboard
F. Financial Systems (e.g., frequency of financial reports, reports that categorize expenses by strategic priorities)	<input type="checkbox"/>	<input type="checkbox"/>	x	All programs get reports about their budgets each month. Always room to improve: looking at budgets by strategic priorities
G. Management Practices (e.g., communication of vision to employees, projects completed on time)	x	<input type="checkbox"/>	<input type="checkbox"/>	There are a few programmatic PM measures related to project completion on time; communication of the vision could be improved.

H. Service Delivery (e.g., clinic no-show rates)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Possibly: Patagonia report to look at no-show rates. There was a QI ticket submitted at one time to look at this but submitted more as a complaint than an improvement process.
I. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/a for now.
6. There is a team responsible for integrating performance management efforts across the areas listed in 5 A-I	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	That's QC!
7. Managers are trained to manage performance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Senior managers were trained via the one on ones, but there is room to train other levels of managers (e.g, supervisors) and the one-on-ones were "step 1."
8. Managers are held accountable for developing, maintaining, and improving the performance management system	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not now - but the goal is that senior managers provide feedback and act as a <u>informal</u> steering committee when PM data is presented quarterly at their meeting.
9. There are incentives for effective performance improvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	State rules limit actual gift incentives; recognition would be the main incentive, but this is not across the board.
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)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	QI plan does some of this - we are also looking at systems that could collect PM data
11. A process or mechanism exists to align performance priorities with budget	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Many measures are tied into budget performance requirements, but there is limited flexibility.
12. Personnel and financial resources are assigned to performance management functions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PM isn't in position descriptions on the whole at this time.

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Most programs have performance measures associated with grants.
2. The performance standards chosen used are relevant to the organization's activities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3. Specific performance targets are set to be achieved within designated time periods	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Most are FY to FY, with a few exceptions.

4. Managers and employees are held accountable for meeting standards and targets	<input type="checkbox"/>	x	<input type="checkbox"/>	This is a new process (PM data). That will come once the senior managers review data on a quarterly basis. This has been going on informally but the PM system is the first time doing a formal Process.
5. There are defined processes and methods for choosing performance standards, indicators, or targets <sup>1</sup>				
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)	<input type="checkbox"/>	x	<input type="checkbox"/>	Couldn't use national standards for every program - but did incorporate when appropriate (e.g. PHAB, Healthy People and CARF accreditation). Not applicable to all programs.
B. The group benchmarks its performance against similar entities	<input type="checkbox"/>	x	<input type="checkbox"/>	Many programs will weigh against what the state average or expectation is for Wicomico County, but <u>not done in every program.</u>
C. Scientific guidelines are used	<input type="checkbox"/>	x	<input type="checkbox"/>	The agency uses many evidence-based practices, and when grant opportunities arise we have researched EBPs, but many times we are limited by what the grant requires.
D. The group sets priorities related to its strategic plan	<input type="checkbox"/>	x	<input type="checkbox"/>	We are getting ready to enter the next strategic planning cycle and plan. Once that is completed, those goals and objectives will be reported in the PM system. Report outs on the current SP have been put into the Annual Reports.
E. The standards used cover a mix of capacities, processes, and outcomes <sup>2</sup>	<input type="checkbox"/>	x	<input type="checkbox"/>	This is in progress. Will need to continue to move toward more outcomes/impact measures.
6. Performance standards, indicators, and targets are communicated throughout the organization and to its stakeholders and partners	x	<input type="checkbox"/>	<input type="checkbox"/>	We plan on reporting the department dashboard throughout the health department, possibly through a link as the Intranet is down at this time.
A. Individuals' performance expectations are regularly communicated	<input type="checkbox"/>	x	<input type="checkbox"/>	
B. The group relates performance standards to recognized public health goals and frameworks, (e.g., Essential Public Health Services)	x	<input type="checkbox"/>	<input type="checkbox"/>	This is an area we can improve in <u>next phase of developing PM system.</u>
7. The group regularly reviews standards and targets	<input type="checkbox"/>	x	<input type="checkbox"/>	We did this quickly to ramp up FY22 inaugural PM system; however, we will review on an annual (or as needed) basis as a part of the QI Plan
8. Staff understand standards and targets	<input type="checkbox"/>	x	<input type="checkbox"/>	We have started more training in this area, but definitely room to improve.

<sup>1</sup> 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](http://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](http://www.phf.org/resourcestools/Pages/Healthy_People_2010_Toolkit.aspx)

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

9. Performance standards are aligned across multiple groups (e.g., same child health standard is used across programs and agencies)	x	<input type="checkbox"/>	<input type="checkbox"/>	Not at this time, but not applicable since the standards used were specific to individual programs.
10. Training is available to help staff use performance standards	<input type="checkbox"/>	x	<input type="checkbox"/>	Headed in that direction - all staff training is set for late April
11. Personnel and financial resources are assigned to make sure efforts are guided by relevant performance standards and targets	x	<input type="checkbox"/>	<input type="checkbox"/>	

### 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	<input type="checkbox"/>	<input type="checkbox"/>	x	
A. Measures are clearly defined	<input type="checkbox"/>	<input type="checkbox"/>	x	Yes, and documented in a running PM spreadsheet
B. Quantitative measures have clearly defined units of measure	<input type="checkbox"/>	<input type="checkbox"/>	x	Yes, documented numerators and denominator definitions in spreadsheet
C. Inter-rater reliability has been established for qualitative measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/a at this time. PMs are quantitative.
2. Measures are selected in coordination with other programs, divisions, or organizations to avoid duplication in data collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/a - programmatic measures do not overlap.
3. There are defined methods and criteria <sup>3</sup> for selecting performance measures	<input type="checkbox"/>	x	<input type="checkbox"/>	Measure selection was individualized, but there <u>was</u> some criteria as in <u>how it link</u> to agency plans, mission, etc.
A. Existing sources of data are used whenever possible	<input type="checkbox"/>	<input type="checkbox"/>	x	
B. Standardized measures (e.g., national programs or health indicators) are used whenever possible	<input type="checkbox"/>	<input type="checkbox"/>	x	
C. Standardized measures (e.g., national programs or health indicators) are consistently used across multiple programs, divisions, or organizations <sup>4</sup>	<input type="checkbox"/>	x	<input type="checkbox"/>	
D. Measures cover a mix of capacities, processes, and outcomes <sup>5</sup>	<input type="checkbox"/>	x	<input type="checkbox"/>	

<sup>3</sup> 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>

<sup>4</sup> 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](http://www.phf.org/resourcestools/Pages/Healthy_People_2010_Toolkit.aspx).

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

4. Data are collected on the measures on an established schedule	<input type="checkbox"/>	<input type="checkbox"/>	x	Yes on a quarterly basis.
5. Training is available to help staff measure performance	<input type="checkbox"/>	x	<input type="checkbox"/>	Spot training - as needed.
6. Personnel and financial resources are assigned to collect performance measurement data	x	<input type="checkbox"/>	<input type="checkbox"/>	Health planner has PM <u>in job</u> description, but that's it at this time.

**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	<input type="checkbox"/>	x	<input type="checkbox"/>	This is the dept dashboard - can't do <u>an always</u> since we haven't published yet. But will be implemented shortly.
2. Information on progress is regularly made available to the following (check all that apply)				
A. Managers and leaders	x	<input type="checkbox"/>	<input type="checkbox"/>	PM is launching April 2022. The expectation is that the dept dashboard will be shared with all of the entities in A-E as needed.
B. Staff	x	<input type="checkbox"/>	<input type="checkbox"/>	
C. Governance boards and policy makers	x	<input type="checkbox"/>	<input type="checkbox"/>	
D. Stakeholders or partners	x	<input type="checkbox"/>	<input type="checkbox"/>	
E. The public, including media	x	<input type="checkbox"/>	<input type="checkbox"/>	
F. Other (Specify):	x	<input type="checkbox"/>	<input type="checkbox"/>	
3. Managers at all levels are held accountable for reporting performance				
A. There is a clear plan for the release of performance reports (i.e., who is responsible, methodology, frequency)	x	<input type="checkbox"/>	<input type="checkbox"/>	That function is with the QC leadership ("QC3") at this time. Reporting gaps will be addressed at the April senior manager meeting, and subsequent quarterly check ins.
B. Reporting progress is part of the strategic plan		<input type="checkbox"/>	x	That is what the annual report addresses, <u>but PM will</u> also report on strategic plan measures for the next cycle.
4. A decision has been made on the frequency of analyzing and reporting performance progress for the following types of measures <sup>6</sup> (check all that apply)				
A. Health Status	<input type="checkbox"/>	<input type="checkbox"/>	x	Annually
B. Public Health Capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monthly/quarterly

<sup>6</sup>See Section I, question 6 for examples of each type of measure.

C. Workforce Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quarterly
D. Data and Information Systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not sure what this category means
E. Customer Focus and Satisfaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quarterly
F. Financial Systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Monthly/quarterly
G. Management Practices	x	<input type="checkbox"/>	<input type="checkbox"/>	Not at this time.
H. Service Delivery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quarterly, but not many measures address this at this time.
I. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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)	<input type="checkbox"/>	<input type="checkbox"/>	x	All three of these areas are addressed in the PM dashboard.
6. Training is available to help staff effectively analyze and report performance data	<input type="checkbox"/>	x	<input type="checkbox"/>	This is done ad hoc at this time. Room to grow training through workforce development, as this is one of the core competencies.
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	<input type="checkbox"/>	<input type="checkbox"/>	They will be after the first round of reporting is complete in April 2022.
8. Personnel and financial resources are assigned to analyze performance data and report progress	x	<input type="checkbox"/>	<input type="checkbox"/>	Health Planner.
9. Leaders are effective in communicating performance outcomes to the public to demonstrate effective use of public dollars	x	<input type="checkbox"/>	<input type="checkbox"/>	This has not happened yet. However, anticipate some measures being of interest to our local county council to reflect the work completed with current staff capacity.

**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)	x	<input type="checkbox"/>	<input type="checkbox"/>	This is in the plan, as the senior mgrs will review data on a <u>quarterly</u> basis, as well as the annual review of current PM standards and measures.
B. There is a regular timetable for QI processes	<input type="checkbox"/>	x	<input type="checkbox"/>	The QI plan addresses larger initiative timelines, and there is a guideline on how we respond to individual QI tickets.

C. The steps in the QI process are effectively communicated	<input type="checkbox"/>	<input type="checkbox"/>	x	This is covered in the QI introduction, and how to submit tickets.
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	<input type="checkbox"/>	<input type="checkbox"/>	Not at this time, but a neighboring county has done this. Would suggest that Workforce Development committee takes a look at this as a part of their upcoming planning process
3. Performance reports are used regularly for decision-making	<input type="checkbox"/>	x	<input type="checkbox"/>	Not an agency wide practice, program to program dependent
4. Performance data are used to do the following (check all that apply)				
A. Determine areas for more analysis or evaluation	<input type="checkbox"/>	x	<input type="checkbox"/>	It will be, but not consistent at this time.
B. Set priorities and allocate/redirect resources	<input type="checkbox"/>	x	<input type="checkbox"/>	LEP data is reviewed and opportunities were explored;
C. Inform policy makers of the observed or potential impact of decisions under their consideration	<input type="checkbox"/>	<input type="checkbox"/>	x	Health officer and mgmt associate does a lot of this, especially during legislative season in Maryland (Jan-Apr).
D. Implement QI projects	x	<input type="checkbox"/>	<input type="checkbox"/>	Goal of presenting the dept dashboard is to identify QI projects.
E. Make changes to improve performance and outcomes	x	<input type="checkbox"/>	<input type="checkbox"/>	
F. Improve performance	x	<input type="checkbox"/>	<input type="checkbox"/>	
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	x	<input type="checkbox"/>	<input type="checkbox"/>	This is an area that is needed, but again we are limited to areas we can actually control, since we are a state agency
B. Managers have the authority to make certain changes to improve performance	<input type="checkbox"/>	x	<input type="checkbox"/>	
C. Staff has the authority to make certain changes to improve performance	x	<input type="checkbox"/>	<input type="checkbox"/>	Current QI assessment: staff reflected this as a neutral area. So, even if they have the ability, the perception from many is that they do not.
6. The organization regularly develops performance improvement or QI plans that specify timelines, actions, and responsible parties	<input type="checkbox"/>	<input type="checkbox"/>	x	Agency QI plan, and PM will be added to that plan with timelines and processes.
7. There is a process or mechanism to coordinate QI efforts among groups that share the same performance targets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/a.
8. QI training is available to managers and staff	<input type="checkbox"/>	<input type="checkbox"/>	x	Absolutely!
9. Personnel and financial resources are allocated to the organization's QI process (e.g., a QI office exists, lead QI staff is appointed)	<input type="checkbox"/>	x	<input type="checkbox"/>	health Planner and Quality Council.
10. QI is practiced widely in the program, organization, or system	<input type="checkbox"/>	x	<input type="checkbox"/>	Per the recent QI Assessment, the agency is at Phase 3 of the QI roadmap, which is ad hoc QI.

## 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](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](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/nphsp/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 of 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-1.0.pdf>)

## Appendix E. WiCHD Customer Satisfaction Survey (CSS) Process

WiCHD Annual Customer Satisfaction Survey (CSS) Process												
CSS Activity	Q1			Q2			Q3			Q4		
	July	August	September	October	November	December	January	February	March	April	May	June
Divisions collect CSS according to their implementation plan. Collecting CSS is a continuous process throughout the fiscal year.	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection	CSS Collection
QC Leadership monitors CSS responses daily, documenting in response log, getting translations as needed, and forwarding time sensitive comments to divisions.	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring	CSS Monitoring
QC preps emails, CSS links and QR Codes for Push #1 (QC promotes CSS collection)												CSS Push #1 Prep
CSS Push #1	CSS Push #1											
Performance Management Q4 Reporting and SM Review	PM Quarter 4 Review											
Previous Fiscal Year CSS Results Reported in WiCHD Annual Report			Annual Report CSS Results									
Semi-Annual Report of Current Fiscal Year				Report								
Performance Management Q1 Reporting and SM Review				PM Quarter 1 Review								
QC preps emails, CSS links and QR Codes for Push #2 (QC promotes CSS collection)						CSS Push #2 Prep						
CSS Push #2							CSS Push #2					
Performance Management Q2 Reporting and SM Review							PM Quarter 2 Review					
Senior Managers and their staff review CSS implementation plans and make revisions, if needed.								SMs & Staff Review CSS Impl. Plan				
CSS discussed at PM 1:1 reviews.									PM 1:1's			
Semi-Annual Report of Current Fiscal Year										Report		
Performance Management Q3 Reporting and SM Review										PM Quarter 3 Review		
Quality Council reviews CSS form to assess if changes needed.											Revise CSS Form if Needed	

### Quality Council Charter

#### 1. PURPOSE OF THE QUALITY COUNCIL

- 1.1. The Quality Council (QC) of Wicomico County Health Department (WiCHD) is responsible for the development, implementation and oversight of the WiCHD Performance Monitoring and Quality Improvement Plan. The QC supports WiCHD staff in building a culture of quality improvement throughout the organization. The QC will also provide leadership support and guidance for: building capacity for quality improvement, quality planning and performance management on all levels; communicating and sharing QC activities and resources; and recognizing efforts and successes.
- 1.2. The mission of the Quality Council (QC) is to grow a culture of quality improvement in WiCHD.

#### 2. DEFINITIONS AND ACRONYMS<sup>1</sup>

- 2.1. Accreditation. The development and acceptance of a set of national public health department (HD) accreditation standards; the development and acceptance of a standardized process to measure HD performance against those standards; the periodic issuance of recognition for HD that meet a specified set of national accreditation standards; and the periodic review, refining, and updating of the national public HD accreditation standards and the process for measuring and awarding accreditation recognition.
- 2.2. Performance Management (PM). Quality improvement is one part of PM. PM is a systematic process that helps an organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining decision making. In practice, PM often means actively using data to improve performance, including the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results.
- 2.3. Plan-Do-Study-Act (PDSA). PDSA is a repetitive four-stage problem-solving model for improving a process or carrying out change. Three fundamental questions associated with PDSA are: what are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?
- 2.4. Quality Improvement (QI). The use of a deliberate and defined improvement process that 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 which achieve equity and improve the health of the community.
- 2.5. QI Culture. 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.

<sup>1</sup> Public Health Accreditation Board. (2013). *Acronyms & Glossary of Terms, Version 1.5*. Retrieved from: [http://www.phaboard.org/wp-content/uploads/FINAL\\_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf](http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf)

- 2.6. Quality Planning (QP). A set of methods and tools used to develop new processes or to revamp existing ones that will be able to meet established goals under operating conditions. At WiCHD, the distinction between QI and QP is that QI optimizes existing processes while QP establishes a process (either new or revamped).
- 2.7. Performance Monitoring & Quality Improvement Plan. Describes what WiCHD is planning to do better by using and monitoring data to improve performance. It is a living document that is updated annually, to reflect accomplishments, lessons learned, and changing organizational priorities.

### 3. OVERSIGHT

- 3.1. WiCHD leadership oversees the QC and their work plan.

### 4. QUALITY COUNCIL (QC) STRUCTURE AND MEMBERSHIP

- 4.1. QC Membership Rotation. Due to the small nature of the council, membership does not rotate; however, analysis of Council diversity (position/role, department, gender, & race) happens annually through Council members submitting self-identifying demographics.
- 4.2. QC Size. The QC shall consist of no less than five (5) and no more than fifteen (15) members. A vacancy shall not prevent the QC from conducting business.
- 4.3. Meeting Frequency. The QC shall meet monthly for 1.5 hours. ***The current meeting schedule is in-person, in the Adkins Conference Room, the first Wednesday of the month, from 9:00 a.m. to 10:30 a.m.*** If needed, the QC may meet more frequently. Additional meetings may be held for specific QI, QP, and PM projects and/or planning.
- 4.4. QC Membership. All WiCHD staff, excluding the Health Officer and Deputy Health Officers are eligible to join the QC.
  - Interested staff submit a [Membership Interest Form](#) via a Google form link available on the agency shared Google drive.
  - Initial approval/denial is obtained from the Health Officer and if applicable, the Health Officer's designee(s).
  - The supervisor of the interested staff is given an opportunity to provide feedback to the Health Officer regarding approval/denial.
  - If membership is denied, the interested staff is notified.
  - If approved, the QC will review for final approval/denial.
  - The interested staff is notified of the final decision.

Additionally, the QC has the right to remove QC members when good cause is shown. This includes not adhering to the attendance requirement in section 4.8.

- 4.5. Voting Rights. Each QC member shall have one vote on each matter submitted to the QC. A quorum at any meeting consists of a simple majority of the membership present, with a minimum of at least three members. A quorum for an electronic vote consists of a simple majority of the entire QC membership.
- 4.6. Term. There are no term limits for QC members.
- 4.7. Member Resignation. Members wishing to leave the QC shall submit a written resignation letter or email to the QC Chair or Co-Chair(s) and QC Administrator.
- 4.8. Attendance Requirements. Members are required to attend a minimum of 75% of QC meetings in a calendar year. If a member does not meet the attendance requirement, continued membership will be assessed by the QC Chair or QC Co-Chair(s) and QC Administrator to determine ongoing participation.
- 4.9. Positions. The positions within the QC are flexible and scalable to needs and resources. Elected positions shall be made by a simple majority vote by January 15th of each calendar year. For all positions, there is no limit to the number of terms served. Individuals may concurrently serve in

more than one position. The following positions will be filled by QC members:

4.8.1. QC Administrator.

This is an ex officio position filled by the agency's Health Planner. Responsible for overseeing all aspects of the QC including but not limited to: convening regular meetings, setting meeting agendas, coordinating training opportunities, implementing a QC recognition program and leading the development, implementation and monitoring of an annual QI Plan. Serves as liaison between the QC and Agency Leadership.

4.8.2. QC Chair or QC Co-Chairs.

Up to two individuals each elected for a two year term. The individuals in these positions will be elected on alternating years, allowing for succession and mentoring. Responsible for leading the QC Meetings, overseeing QC projects, and serving as a liaison between the QC and Agency Leadership.

4.8.3. Secretary.

Up to two individuals elected for a one year term. Secretaries will alternate completing the monthly meeting minutes. Responsible for completing QC Meeting minutes no later than two weeks after each meeting.

4.8.4. QC Member.

Participates in monthly meetings and assists in completing QI, QC and PM projects and planning.

## 5. GUIDING PRINCIPLES

- 5.1. The QC will ground its work on QI methodology (i.e., PDSA) and employ QI tools to understand and improve processes and outcomes.
- 5.2. The QC's decisions will be data-driven and evidence-based, but it will also use and respect people's knowledge and experience.
- 5.3. The QC will facilitate processes that will be transparent and inclusive.
- 5.4. The QC will foster engagement and accountability within project teams.
- 5.5. The QC will focus on learning and improvement over judgment and blame, and value prevention over correction.

## 6. TEAM NORMS

- 6.1. The QC will establish, at a minimum, team norms for communication issues, decision-making, participation, attendance, confidentiality, and preparedness for meetings. QC expectations include:
  - Decisions will be made by consensus.
  - Keep an open mind.
  - Be respectful.
  - Maintain confidentiality.
  - Operate in the spirit of improvement. Practice what we preach. Be in the mindset of continuous change.
  - Be on time for meetings.
  - Do your homework.
  - Be clear about expectations for homework/preparation.
  - Distribute agendas to the team in advance of the meeting.
  - Ask the group ahead of time if there are any agenda items to add.
  - Stick to the agenda.
  - Bring information to and from the QC.

## 7. RESPONSIBILITIES & ANNUAL PLAN

- 7.1. Annually, QC members will update the Performance Monitoring & Quality Improvement Plan (PM/QIP).
- 7.2. As delineated by NACCHO<sup>2</sup>, the PM/QIP will be guided by: Leadership Commitment, QI Infrastructure (including finalizing a PM/QIP), Employee Empowerment and Commitment, Customer Focus, Teamwork and Collaboration (including actively participating in QI, QP and PM projects) and Continuous Process Improvement.
- 7.3 QC members are responsible to come prepared to meetings to actively participate and contribute in breakout groups that work on current/future projects.

## 8. COMMUNICATION PLAN

- 8.1. The QC Leadership will provide clear and consistent communication to QC members and to WiCHD staff about QI, QP and PM efforts by doing the following:
  - Recognizing QI, QP and PM Efforts
  - Documenting QI, QP and PM Project Activity
  - Reporting Regularly on QI, QP and PM Efforts and Achievements
  - Enhancing, Maintaining, and Promoting QI, QP and PM Resources and Tools
  - Organizing and Sharing QI, QP and PM Documents on Google Team Drive

<sup>2</sup> National Association of County & City Health Officials. (2012). Roadmap to a Culture of Quality Improvement. Retrieved from: <https://qiroadmap.org/qi-home>



# Wicomico County Health Department Quality Council

*MISSION: To grow a culture of quality improvement in Wicomico County Health Department.*

## TICKET SUBMISSION PROCESS

1. Staff submit improvement idea through intranet ticket system.
2. Assigned Quality Council(QC) staff review submission and conduct initial screening to assess whether improvement idea meets criteria for quality improvement (QI) project or quality planning (QP) project.
  - (a) QC makes phone/face-to-face contact with ticket submitter within 7 business days to discuss submission and advise submitter of the ticket process. Additionally, contacting other staff regarding improvement idea may be discussed, depending on the screening determination.
  - (b) If applicable, other staff are contacted to gather additional information to bring to the QC meeting.
  - (c) Initial screening determination is completed. Sections 1 and 2 of the Quality Council Ticket Review Form are completed.
3. Quality Council Ticket Review Form is forwarded to Health Officer for approval/disapproval to forward to Quality Council for further review and disposition.
4. The ticket is presented and reviewed at the next monthly QC meeting. QC determines whether to accept or not accept the ticket for either a QI or QP project. At times, ticket disposition will be deferred to gather additional information.
  - a. If ticket is accepted, QC staff are assigned to project. Ticket submitter notified of outcome.
  - b. If ticket is not accepted, ticket submitter notified with explanation.
  - c. If ticket is deferred, QC staff assigned to gather additional information. Submitter notified of outcome. Ticket to be reviewed at the following months QC meeting for disposition (accept, not accept, defer).



- Assess any changes to program goals for the upcoming fiscal year
- Review current performance measures and discuss progress towards targets (through the 2nd Quarter)
  - Measures consistently exceeding targeted goals should be considered for removal
  - Measures consistently not meeting targeted goals should be discussed, and potential reasons for not reaching target documented and/or referred to the Quality Council
- Brainstorm measure(s) for any new department programs/grants
- Review qualitative data submitted to date (e.g., accomplishments, challenges, outreach, etc.)
- Review performance measurement principles with any new senior managers (if applicable)

Prior to annual one-on-one meetings each year, Senior Management also completes the Public Health Foundation’s Self Assessment Tool to gauge the agency’s performance management efforts. The individual assessment results are discussed with senior managers at their one-on-one meetings to highlight any gaps in their department’s performance management and to suggest improvements for the new fiscal year. An aggregate-level executive summary of the assessment is provided to senior leadership at the July senior manager meeting each year.

#### 4. Identifying Potential Quality Improvement Projects

The QC has two methods of selecting potential QI projects.

- **Quarterly Performance Management Data Review:** Each quarter, the department-wide performance management dashboard is presented at the WiCHD senior management meeting (falling on the last Tuesday of January, April, July and October). At this meeting, senior managers are asked to review their department’s performance data and provide a brief report out using this standard script, including referrals for quality improvement projects:

***Based on my department’s performance measure data and contextual narratives submitted in the previous quarter:***

1. *I am proud of \_\_\_\_\_.*
2. *My department will work to improve \_\_\_\_\_ by doing \_\_\_\_\_.*
3. *I need help finding a solution or need additional resources for \_\_\_\_\_.*
4. *\_\_\_\_\_ should be referred to the Quality Council as a potential formal improvement project.*

NOTE: It is expected that not all all suggested improvements discussed at this meeting will meet the criteria for formal QI project referral; however, any action items not referred to the Quality Council will still have designated points of contact and follow ups on these action items will be documented at the following quarter’s senior management meeting.

- **Staff Submissions:** The QC maintains a ticket system through which staff can submit improvement ideas through the WiCHD intranet. Any improvement ideas submitted through the ticket process that meets criteria for a QI project will be assessed and then weighted using the prioritization matrix to rank these new ideas with that year’s wait listed projects. Exceptions may apply if the potential project is of an extremely urgent nature. See the TICKET SUBMISSION PROCESS for more details.

## Appendix I. Screening Checklist for Quality Improvement (QI) Projects

This checklist will help you determine whether a proposed project is appropriate for a QI project.

Consideration	Question	Yes	No
<b>PROCESS</b>	Is the improvement idea part of a process?		
	Is the process consistent and stable?		
<b>PURPOSE</b>	Is the primary aim or motive of the project either to: <ul style="list-style-type: none"> <li>• Improve the process/delivery of care of services for our external customers? <b>OR</b></li> <li>• Improve operations or efficiency of internal administrative processes? Remember, QI is not appropriate to address personnel/staff performance issues.</li> </ul>		
<b>PROBLEM STATEMENT</b>	Is the target problem clearly defined?		
<b>MEASURABLE</b>	Is the problem measurable?		
<b>DATA</b>	Is there baseline data available? <b>OR</b> Is baseline data able to be easily obtained?		
<b>CUSTOMER FOCUS</b>	Does the project have a customer focus (internal or external)?		
<b>FEASIBILITY</b>	Is it within our organization's control?		
<b>FUNDING/RESOURCES</b>	Does the project have the resources/funding needed?		
<b>IMPORTANCE</b>	Is it important to address this issue? Consider who it is important to.		
<b>LINKAGE TO AGENCY PLANS</b>	Is the improvement idea related to the agency's strategic plan or community health improvement plan?		
<b>EXTENT OF PROBLEM</b>	Does the problem span across the agency?		
<b>PROJECT TIMEFRAME</b>	Can the project be completed in a reasonable timeframe?		
<b>EMERGENCY</b>	Is there a sense of urgency?		
<b>SAFETY</b>	Is it a safety issue?		
<b>If most of the answers are "yes", then the project is likely appropriate for a QI project.</b>			

## Appendix J. FY23 Quality Improvement Plan Monitoring and Evaluation

The table below summarizes the progress made during FY23 on the PMQIP.

FY 2023 QUALITY IMPROVEMENT PLAN MONITORING AND EVALUATION					
KEY: • Not Started • Work in Progress • Response Pending (e.g. approval, surveys, etc.) • Revised/Abandoned • Completed					
GOAL 1: Continue implementing and monitoring performance management health department-wide to achieve organizational objectives	Quarter 1 Status (07/01/22 - 09/30/22)	Quarter 2 Status (10/01/22 - 12/31/22)	Quarter 3 Status (01/01/23 - 03/31/23)	Quarter 4 Status (04/01/23 - 06/30/23)	End of FY Notes
1.1 At the end of each quarter, the QC will collect programmatic and health-department wide indicator data from each department and publish a comprehensive dashboard summarizing performance progress.	Completed	Completed	Completed	Completed	
1.2 At the end of the first month of each new quarter, QC leadership will present the dashboard to senior management to identify areas of improvement, to determine whether to initiate a QI project on identified opportunities for improvement, and identify areas of success and progress throughout the department.	Completed	Completed	Completed	Completed	
1.3 At the end of the first month of each new quarter, the dashboard will be shared with all staff by posting to the All Staff Google Drive.	Not Started	Not Started	Not Started	Completed	
1.4 By April 2023, the QC and Senior Management will complete the Public Health Foundation's Self Assessment Tool to gauge the agency's performance management efforts.	Not Started	Not Started	Revised/Abandoned	Revised/Abandoned	Goal modified to be completed every other year. On the alternating years the Culture of QI Assessment will be done. Next PM assessment will be done by April 2024
1.5 During the fourth quarter (April 2023 - June 2023), the QC will conduct one-on-one meetings with each of the health department's senior managers as a part of the annual performance management review.	Not Started	Not Started	Work In Progress	Completed	
1.6 At least annually, communicate with the County Council regarding performance management and quality improvement initiatives and progress.	Not Started	Work In Progress	Completed	Completed	In the Fall, the FY22 Annual Report shared with the County Council.

<b>GOAL 2: Institutionalize Continuous Quality Improvement to strengthen the health department's culture of QI.</b>	<b>Quarter 1 Status (07/01/22 - 09/30/22)</b>	<b>Quarter 2 Status (10/01/22 - 12/31/22)</b>	<b>Quarter 3 Status (01/01/23 - 03/31/23)</b>	<b>Quarter 4 Status (04/01/23 - 06/30/23)</b>	<b>End of FY Notes</b>
2.1 The QC will provide the Introduction to Quality Improvement training either virtually or in-person to new staff three times per year.	Work In Progress	Work In Progress	Work In Progress	Completed	Trainings provided: 9/14/22, 1/25/23, and 5/25/23.
2.2 90% of new hires will complete Introduction to Quality Improvement training within 1 year of hire date.	Work In Progress	Work In Progress	Work In Progress	Completed	
2.3 By 12/31/22, the QC will finalize plans for the annual all staff training in an area of quality improvement and/or performance management.	Work In Progress	Completed	Completed	Completed	Training on Customer Satisfaction Survey completed in Dec & Jan (parts 1 & 2).
2.4 By 6/30/23, all staff will complete the annual Quality Improvement training.	Not Started	Work In Progress	Completed	Completed	99.47% (188 individuals) of staff completed part 1 of the training, "Improving Our Customer Focus". All 8 divisions completed Part 2 of the training.
2.5 By 3/31/23, the QC will complete the annual culture of QI assessment and utilize results to update the FY 2024 PMQI Plan.	Not Started	Not Started	Work In Progress	Completed	Survey distributed from 3/1/23 - 3/17/23. 115 responses received.
2.6 Biannually, the QC will have a focused campaign to increase customer satisfaction survey responses.	Work In Progress	Work In Progress	Completed	Completed	Due to training around customer focus, only one push was completed in February. Going forward the pushes will occur every July and January.
2.7 To create a transparent and engaging environment, the QC will continue current communication via quarterly newsletters, emails, and quarterly Senior Leadership updates.	Work In Progress	Work In Progress	Work In Progress	Completed	Updates provided in health officer quarterly newsletter. QC continues to meet quarterly with senior management.

<p>2.8 The QC will complete 4 Quality Improvement (QI) and/or Quality Planning (QP) projects by 6/30/2023.</p>	<p>Work In Progress</p>	<p>Work In Progress</p>	<p>Work In Progress</p>	<p>Completed</p>	<p>Completed following QP Projects:</p> <ul style="list-style-type: none"> <li>• All Staff Drive</li> <li>• BH Staff Billable Hours,</li> <li>• Workforce Development Committee - Implementation Plan</li> <li>• Inventory of Committees</li> <li>• Outreach Tracking</li> <li>• Assessment and Training Gantt Chart</li> </ul> <p>Completed following QI Project:</p> <ul style="list-style-type: none"> <li>• Customer Satisfaction Survey</li> </ul>
<p>2.9 The QC will develop and implement a plan to celebrate and encourage QI and QP successes.</p>	<p>Work In Progress</p>	<p>Work In Progress</p>	<p>Work In Progress</p>	<p>Work In Progress</p>	<p>Have template developed for QI Project Storyboards. Need to develop something for QP Projects.</p>
<p><b>GOAL 3: Strengthen infrastructure of Quality Council for QI and PM activities.</b></p>	<p><b>Quarter 1 Status (07/01/22 - 09/30/22)</b></p>	<p><b>Quarter 2 Status (10/01/22 - 12/31/22)</b></p>	<p><b>Quarter 3 Status (01/01/23 - 03/31/23)</b></p>	<p><b>Quarter 4 Status (04/01/23 - 06/30/23)</b></p>	<p><b>End of FY Notes</b></p>
<p>3.1 At least annually, the QC will conduct targeted recruitment to have representatives from each of the agency's departments.</p>	<p>Not Started</p>	<p>Not Started</p>	<p>Completed</p>	<p>Completed</p>	<p>At the 1/24/23 Senior Management Meeting QC leadership asked for help in recruiting members from departments not represented - Community Health, Dental, Developmental Disabilities, Environmental Health and LBHA.</p>

3.2 The QC will create 2 internal marketing materials to promote QC membership throughout the agency by 6/30/2023.	Not Started	Not Started	Completed	Completed	Open house held 3/1/23. 1 staff attended. Going forward, Open Houses will be held every March, June and November (to occur after new employee training). Paper copy of membership form with QR Code developed to hand out at new employee trainings.
3.3 Once per quarter, the QC members will learn and practice new QI tools, such as the 7 basic QI tools in NACCHO's Roadmap.	Work In Progress	Work In Progress	Work In Progress	Work In Progress	
3.4 Review and revise governing documents (charter, plan, and policy) and QC diversity matrix by 06/30/2023.	Not Started	Not Started	Completed	Completed	Completed in January 2023.
3.5 As funding permits, send at least 2 QC members to the annual National Open Forum Conference, the annual Public Health Improvement Training (PHIT), and/or other similar training.	Not Started	Not Started	Work In Progress	Completed	4 staff will attend the 5/8/23 Public Health Improvement Training (PHIT) in Washington DC. 6 Staff will attend the virtual PHIT 6/5/23 - 6/7/23

## References

- <sup>1</sup>Public Health Accreditation Board. (2022). Standards and Measures for Reaccreditation, Version 2022. Retrieved from: <https://phaboard.org/wp-content/uploads/Standard-Measures-Version-2022-Reaccreditation.pdf>
- <sup>2</sup>Public Health Accreditation Board. (2013). Acronyms & Glossary of Terms, Version 1.5. Retrieved from: [http://www.phaboard.org/wp-content/uploads/FINAL\\_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf](http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf)
- <sup>3</sup>National Association of County & City Health Officials. (2012). Roadmap to a Culture of Quality Improvement. Retrieved from: <https://qiroadmap.org/qi-home>