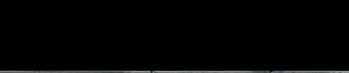




Oneida Community  
Health Services Department (OCHSD)  
Performance Management Plan  
2017-2018

APPROVALS

Review Due: Annual after last signature

 	<i>27 Feb 18</i>
Oneida Comprehensive Health Division Operations Director	Date
	<i>1/31/2018</i>
Oneida Comprehensive Health Division Medical Director	Date
	<i>1-31-2018</i>
Community / Public Health Officer	Date

Author:   
Community Health Nursing Supervisor  
And  
Performance Management Team

Date	Revisions
1/9/18	<p>Pg 7-Add Case Management Long Term Care, In Roles and Responsibilities:  1<sup>st</sup> bullet - add "at minimum", 4<sup>th</sup> bullet - "Review submission &amp; progress of QI projects submitted to QA/QI Committee", and combine bullets 5 &amp; 6.  Pg 8-Add Case Management Long Term Care, Carrie Lindsey to Staffing and Admin Support.  Pg 9-Change Quality Improvement to "QA/QI"  Pg-11-13- remove 2016-2017 Performance Measures and add statement after Plan Evaluation where to reference Performance Measures.  Pg 10- Add PM database as tracking tool.  Pg 21- Appendix D-Update 6<sup>th</sup> process to enter into database.  Pg 22- Appendix E-Remove survey questions 1, 7, 9, 11, and 12.</p>

**Performance Management Background**  
Public Health Performance Management System

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### Public Health Performance Management System

Performance management is a systematic process by which an organization involves its employees in improving the effectiveness of the organization, while also achieving the organization’s mission and strategic goals.

By improving performance and quality, public health systems can save lives, cut costs, and get better results. Performance management enables health departments to be more efficient, effective, transparent, and accountable.

The performance management model used by Oneida Community Health Services Department (OCHSD) was developed by the Turning Point National Excellence Collaborative on Performance Management.

According to the Public Health Foundation, performance management is the “practice of actively using performance data to improve the public’s health.”

### PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM



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

## Performance Management Background:

The model includes the following components:

Performance Standards are standards or guidelines used to assess an organization's performance. Standards are based on national, state, and scientific guidelines; and other methods, including benchmarking against similar agencies and setting benchmarks based on agency expectations. Performance standards can be descriptive (e.g., A system for communicable disease control is maintained) or numerical (e.g., At least 80% of health department clients rate services as "good"). Performance standards answer the question, "Where should we be?"

Performance Measures are quantitative measures of capacities, processes, or outcomes relevant to the assessment of a performance indicator (e.g., actual percentage of clients who rate health department services as "good"). To determine performance measures, OCHSD utilizes national tools containing pre-existing measures, e.g., Tracking Healthy People 2020, in addition to creating new performance measures based on agency need. Performance measures look at what actually happened compared to what was planned or intended.

Reporting of Progress is how performance data is shared with stakeholders. This report may include comparisons to national standards or benchmarks.

Quality Improvement (QI) is the process by which processes, policies, programs, and infrastructure are enhanced and improved upon by using program evaluation models such as Plan-Do-Check-Act and Rapid Cycle Improvement. Program evaluation is a key component of quality improvement since the success of programs must be measured in order to determine whether quality improvement action is warranted.

### **Purpose: Culture of Quality**

The goal of OCHSD is to develop and maintain a robust performance management system that involves the ongoing use of performance standards, performance measures, progress reporting, and QI principles, to have a positive impact on the public's health in the Oneida Community. This will be accomplished by:

- Setting specific performance standards that includes benchmarking (where possible) against similar agency, national, state, and scientific guidelines.
- Measuring capacity, process, or outcomes of performance standards.
- Reporting progress to stakeholders regularly.
- Integrating QI into agency operations through ongoing use of Plan-Do-Check-Act.

Performance management practices have been shown to measurably improve public health outcomes, create efficiencies working with partners, and help public health workers solve complex problems. Performance management practices can also be used to allocate resources, prioritize programs, change policies to meet goals, and improve the overall quality of public health practice.

### **Mission, Practical Vision and Strategic Direction**

#### **Our Mission**

Oneida Community Health Services Department (OCHSD) is a responsive leader in promoting health and preventing disease through collaborative efforts in assessing, planning, implementing, and evaluating services to meet the holistic health needs of the Oneida Community.

#### **Our Practical Vision**

Engaged Workforce  
Full Access to Health Records  
Public Health Accreditation  
Smoke - Free Campus  
Relevant Quality Services  
Engaged Partners  
Improved Health Outcomes  
Comprehensive Marketing Plan  
Workforce Retention Plan

#### **Our Strategic Directions**

Fostering Positive Leadership Culture  
Engaging and Empowering Our Workforce  
Educating and Promoting Holistic Health  
Enhancing Quality and Creditability

### Membership and Rotation

The Community/ Public Health Officer will select team members each plan year. Designated team members may participate on the team more than one year.

Members of the Performance Management Team (PMT) include:

- Community/ Public Health Officer or designee
- Representative from Community Health Nursing- Population Based Programs
- Representative from Community Health Nursing- Case Management
- Representative from Community Health Case Management- Long Term Care
- Representative from Health Promotion Disease Prevention
- Representative from WIC/ Nutrition
- Designated Quality Improvement Leader
- Other Public Health Accreditation stakeholders

### Roles and Responsibilities

#### Performance Management Team (PMT)

The PMT is responsible for oversight of performance management efforts and for promoting, training, challenging, and empowering OCHSD staff to participate in the ongoing process of QI. The PMT will:

- Review and update OCHSD Performance Management Plan at minimum annually.
- Define standards and measures that will be monitored during plan year.
- Link QI projects to performance management standards.
- Review QI projects to be submitted to CHD QA/AI Committee.
- Collaborate with CHD QA/QI Committee to provide oversight of implementation, evaluation, progress and communication of report on QI projects.
- Involve staff through encouragement, training, support, and celebration of accomplishments.
- Encourage and foster a supportive QI environment.
- Apply QI principles and tools to daily work.

**The Quality Improvement Leader will:**

- Work with the Community/ Public Health Officer to provide vision and direction for QI.
- Convene the PMT quarterly.
- Determine appropriate media outlets and messages to communicate selected performance results to the public.
- Participate on the Comprehensive Health Division Quality Improvement Committee

## Performance Management Plan Organizational Structure:

- Work with the PMT to deliver an updated OCHSD Performance Management Plan annually.
- Coordinate performance management and QI training.
- Encourage staff to incorporate QI concepts into their daily work.

### **Oneida Community Health Services Department (OCHSD) staff will:**

- Participate in planning, implementation and evaluation of QI projects, and report results to stakeholders.
- Identify, monitor and review results from QI projects by using PDCA model.
- Review program/ service evaluations and identify processes that need improvement.
- Conduct QI projects at the request of the Community/ Public Health Officer.
- Review the OCHSD Performance Management Plan annually and offer recommendations to QI workgroup as needed.
- Participate in designated QI training via webinars, conferences, or trainings.
- Apply QI principles and tools to daily work.

### **Staffing and Administrative Support**

The 2017-2018 PMT includes:

- [REDACTED], Community/ Public Health Officer
- [REDACTED], Health Promotion Disease Prevention Supervisor (designated Quality Improvement Leader)
- [REDACTED], Community Health Nursing Supervisor
- [REDACTED], Nutrition/ WIC Director
- [REDACTED], Community Health Manager
- [REDACTED], Case Management Supervisor
- [REDACTED], Health Promotion Specialist
- [REDACTED], RN- Community/ Public Health

### **Financial Commitment and Sustainability**

OCHSD will sustain performance management and QI work by funding staff training on a regular basis. In addition, resources will be provided to fund QI projects and initiatives to ensure the best possible outcomes for these projects.

### Employee Training

New employees will be required to review the power point presentation on performance management, and the Plan-Do-Check-Act Quality Improvement model, within the first year of hire. This training requirement aligns with the OCHSD Workforce Development Plan. Employees may be required to participate in additional trainings in performance management and QI as assigned.

QI activities will be included as a required activity for all staff. Employee involvement in QI activities will be assessed during the employee annual performance appraisal process.

### Reporting Progress

OCHSD is one of several departments within the Oneida Comprehensive Health Division. All departments report performance progress and QI projects through the Oneida Comprehensive Health Division Quality Improvement Committee, facilitated by the Safety & Quality Improvement Coordinator. Participation in this committee aligns common goals of QI and keeps OCHSD informed on other QI activities throughout the division.

Progress will be reported quarterly to staff, the Oneida Comprehensive Health Division QA/QI Committee, and other interested stakeholders. Other audiences may include:

- The Wisconsin Division of Public Health
- Other local health departments
- Grant funders
- Community members
- Other local governmental agencies
- Media

The following should be considered when developing a report:

- Is correct information presented?
- Is information presented accurately?
- Is information presented in a timely manner?
- What is the purpose of the report?
- Who is the critical audience?
- Despite complex performance measures results, is the report comprehensible?
- Who should review the report before it is released?

## Performance Management Plan Organizational Structure:

Since performance reports can be misinterpreted, it is important to provide some context so those reading the report can understand and appreciate what is being reported. Following are some useful strategies to help assure performance reports are accurate, understandable, and send the correct message.

- **Have the appropriate staff members and managers review performance data before it's reported out.** This gives everyone an opportunity to consider what explanations are needed, including causes, rationales, recommendations, and/or corrective steps.
- **Tie information and data to goals and objectives.** Goals and objectives provide a clear context, and identify what work is being measured against.
- **For results that may be worse than expected, include in the report an outline of a QI plan.** When goals are not achieved, it helps to demonstrate that critical thinking has taken place, and that QI steps should increase future performance.
- **The format of the report should be customized for the audience.** Charts, tables, and maps are generally user-friendly and easy to understand.
- **The performance management tracking log is a tool created in Microsoft Access that is used to track progress of all measures.** Performance Measure Owners update the tool quarterly to track progress throughout the year. The Designated Quality Improvement Leader will compile results entered into the database for the report. All Performance Management dashboards can be found in this database: <G:\Community Health Services\PLAN- Performance Management\CHS Performance Management.accb>.

### Plan Evaluation

The OCHSD Performance Management Plan will be reviewed and updated annually by the Performance Management Team. OCHSD staff will be surveyed to gather input at the end of the plan year. This feedback will be considered during the revision process.

Staff will complete a feedback survey annually asking staff to share their experience(s) with QI projects, including department strengths and weaknesses, QI barriers, training needs, confidence in leading QI projects, comfort in using QI tools/forms, and understanding of the OCHSD Performance Management Plan and concepts. The survey will also gather suggestions for future QI projects (Appendix C).

### Quality Improvement (QI) background

While performance measures and standards are part of a performance management system that can be captured within a tracking system itself, QI requires a broader explanation and plan in order to reach a thorough and consistent understanding among staff, the oversight committee, and OCHSD partners.

Basic principles for QI work include the following:

- Develop a strong customer (client) focus
- Continually improve all processes
- Involve employees
- Mobilize both data and team knowledge to improve decision-making

During the 2017-2018 plan years, OCHSD will utilize the Plan-Do-Check-Act model for QI projects.

### Plan-Do-Check Act as a Framework

The American Society for Quality suggests using Plan-Do-Check-Act (PDCA) in the following ways:

- As a model for continuous QI.
- To develop a new or improved process, product, or service.
- To collect and analyze data to verify and prioritize problems or root cause.
- To implement change.

In applying the PDCA cycle, ask these fundamental questions:

1. What is OCHSD trying to accomplish?
2. How will OCHSD know that a change is an improvement?
3. What changes can OCHSD make that will result in improvement?

### Plan

There are five steps in the planning stage:

- Identify the problem: Identify opportunities/ priorities that are meaningful and are identified by staff as an issue; should be supported by data.
- Assign workgroup: Identify who is going to work on the QI.
- Gather background/ research on the problem: Describe the current process using a flow chart, process map, and/or other useful tools. Identify root causes and potential solutions.
- Brainstorm solutions: Identify some possible solutions.

- Develop an improvement theory and aim statement: Pick one of the solutions identified. If we do X then Y will happen. Develop an aim statement to specify what success will look like; What? How much? By when? For whom?

### DO

Take small steps to implement the solution on a limited scale, collecting data along the way. Test the plan for a limited time, on a limited basis, and in a limited area. Follow the plan carefully to ensure minimal deviation. The goal is to show whether the changes are effective and to avoid widespread failure if they are not. Data should be collated prior to moving on to the next step.

### Check

Take time to determine if measurements used to determine success are adequate. If not, define required measurements and how/ where data can be found or developed. Analyze the data, and assess for success or unexpected outcomes.

### Act

There are two steps in the Act stage:

- Standardize or test a new theory: If the change resulted in the desired outcome, it can be fully adopted by standardizing and/ or expanding it to other areas of the agency. If the change did not result in improvement, abandon it and begin the PDCA cycle again.
- Establish Future plans: If some improvement resulted, adapt the change to achieve desired outcome and begin the PDCA cycle over again.



Plan what to accomplish over a period of time and what needs to be done to get there

Do what is planned

Check the results of what was done to see if objectives were achieved

Act on the information

PDCA Cycle Instructions/ worksheet (Appendix A) is available to guide staff through a QI project.

### Project Identification

OCHSD will complete at a minimum one (1) QI project each quarter.

Brainstorming sessions will occur periodically throughout the year during staff meetings. Nominal Group Technique may be used to determine QI projects.

Also, staff may recommend a QI project at any time. Recommendations will be communicated to the individual's supervisor who will assign a workgroup and an identified leader. In some cases, the workgroup may deem it unnecessary to move forward. In these cases, the workgroup will work to reach consensus. If there is discretion, the workgroup will make decisions based on majority vote.

### Project Selection and Prioritization

QI projects are selected based on data obtained from patient satisfaction surveys, event/ program evaluations, staff surveys, the community needs assessment and improvement plan, strategic goals, policies/ protocols, after action reports, chart audits/ compliance issues, and measures identified within the departmental performance management system. Project preference will be based on the following criteria:

Technical:

- ✓ Is it a process?
- ✓ Is the problem targeted for improvement clearly defined?
- ✓ Is the scope manageable?
- ✓ Can it be reliably measured?
- ✓ Can it be completed within the proposed timeframe?
- ✓ Is data available

Strategic:

- ✓ Is it important? To whom?
- ✓ Does it align with one or more of the department plans?
- ✓ Does the project support the department mission, vision, values?
- ✓ Does it have a customer focus?
- ✓ Does the project have potential to be replicated across programs or have an impact on other programs/ activities?

Empowerment:

- ✓ Is it within the Department's control?
- ✓ Is it free from pre-conceived solutions?

- ✓ Is leadership prepared to implement change?
- ✓ Is there probability of success?

Alignment:

- ✓ Community Health Needs Assessment
- ✓ Community Health Improvement Plan
- ✓ Strategic Plan
- ✓ Workforce Development Plan
- ✓ Performance Management Plan
- ✓ Public Health Emergency Plan (PHEP)
- ✓ Marketing Plan

One form is required when conducting a QI project. It is the responsibility of the designated workgroup project leader to complete this forms and report progress/ results.

1. Modified QI Results Form for the Comprehensive Health Division Quality Improvement Plan (Appendix B).

### Data Collection and Analyses

For individual projects, data will be collected and analyzed as indicated in the project plan. The designated workgroup project leader will have responsibility for all aspects of the project, including the collection and analysis of data.

Project data will be reviewed by appropriate OCHSD staff along with the PMT.

QI activities will be included in quarterly performance management progress reports, submitted to the Oneida Comprehensive Health Division Quality Assurance/Quality Improvement Committee. Upon initiation of QI projects, workgroup project leaders will enter the project into the Microsoft Access Database: <G:\Community Health Services\PLAN- Performance Management\CHS Performance Management.accb>. QI project progress will be documented and reported through this database. This quarterly report and filing system will serve as record of all formal QI projects completed by OCHSD.

Aim Statement: A concise, specific written statement that defines what the team hopes to accomplish with its QI efforts. Aim statement may also be referred to as a QA indicator.

Baseline: A quantitative level of performance which defines where the PM measure or QI indicator is currently. This number is used to measure progress or lack thereof. Baseline may also be referred to as status.

Goal: Desired result to be accomplished. In QI, goal may also be referred to a target. In a PM system, goals identify the desired result i.e. community members will be healthy. In a PM system, goals typically have one or more objectives to be achieved within a more or less fixed timeframe.

Indicator: In QI, this is a measurable variable used as a representation of an associated factor or quantity. In a PM system an indicator would be part of an objective to obtain a goal.

Objective: A statement identifying a specific indicator to measure progress toward a goal with its performance management system. Objectives should be written SMART.

Outcome: determination and evaluation of the results of an activity, plan, process or program and their comparison with the intended or projected results. In QI, outcome may be used to describe results of the QI project when comparing actual results to the set target/ goal. In a PM system, outcome may be used to describe results of progress toward set performance measures as well as progress toward established goals.

Performance Standard: A generally accepted, objective standard of performance such as a rule or guideline against which an organization's level of performance can be compared. WI 2020 Health Priorities or PHAB standards are examples. These may or may not be stated in quantitative terms.

Performance Measure: A quantitative indicator of performance that can be used to show progress toward a goal or objective. It is the specific number representation of a capacity, process, or outcome that is relevant to the assessment of performance. Examples include:

- Percentage of children with age-appropriate immunization levels at age two.
- Number of days between a lab report and client contact.
- Percentage of beaches sampled
- Percentage of WIC mothers who initiated breastfeeding.

Sometimes performance measures are confused with objectives. For our purposes, when we talk about performance measures, we are only referring to what is being measured, not the entire SMART objective.

SMART: Specific, Measurable, Achievable, Relevant, and Time-bound. For example, “By January 15, 2011, food service workers from Chinese restaurants located in Grand Traverse County will demonstrate a 20% increase in the ServSafe exam passing rate.”

Status: In a QI project, where the indicator is at currently. Status may also be referred to as baseline.

Target: the quantifiable amount of improvement to be achieved. For example, “from 85% to 95% of children receive...”. In QI, target may also be referred to as a goal.

A “crosswalk of terminology” has been created to demonstrate examples of the various definitions in different models.

Quality Improvement		Performance Management
OCHD QI Plan	PDCA	
QA Indicator	Aim statement	Quantifiable measure of an objective
SMART QA indicator	SMART Aim statement	Objective
Status	Baseline	Status
Goal	Target	Target measure
Outcome	Outcome	Outcome

### Recognition

Wood County Health Department Performance Management Plan 2014

Forest County Potawatomi Community Health Department Quality Improvement Plan 2015-2017

### References

Oneida Comprehensive Health Division Quality Improvement Committee/ Plan

QI training: “Embracing Quality in Public Health: A Practitioner’s Performance Management Primer”

<http://mphiaccredandqi.org/PMQITraining/>

American Society for Quality, <http://asq.org/index.aspx>

Embracing Quality in Local Public Health; Michigan’s Quality Improvement Guide Book-

<http://accreditation.localhealth.net>

Institute for Healthcare Improvement

<http://www.ihl.org/resources/Pages/AudioandVideo/default.aspx>

Institute for Wisconsin’s Health Public Health Quality Initiative

<http://www.instituteforwihealth.org/public-health-quality.html>

**Oneida Community Health Services Department QI Process  
PLAN-DO-CHECK-ACT (PDCA) Cycle- updated 03-29-16 MLM**

**Appendix A**

**Instructions/ worksheet**

**Steps of the PDCA Cycle**

Steps of the PDCA Cycle		
PLAN	<b>Step 1</b>	<b>Identify the problem/ QI project</b> 1. How does the project support our mission, vision or strategic directions? 2. Who are our stakeholders (internal/ external) and what are their concerns? 3. What resources/ support will be needed? 4. What potential impact could there be on other programs/ activities if this QI is conducted?
	<b>Step 2</b>	<b>Assemble a workgroup</b> > Who will participate in the QI project? > Who is the project leader on the QI project?
	<b>Step 3</b>	<b>Background/ research</b> > What existing data is there? > What might be the root cause of the problem? > Can you map out the process?
	<b>Step 4</b>	<b>Brainstorm solutions</b> > What are some possible solutions?
	<b>Step 5</b>	<b>Develop a theory of improvement-</b> select one solution to test > What one possible solution will you test? > What is your hunch/ prediction? (if we do <i>this...</i> , then <i>that</i> will happen) <b>Develop Aim Statement-</b> SMART when possible 1. What are we trying to accomplish? 2. How will we know that a change is an improvement? 3. What changes can we make that will result in improvement?
DO	<b>Step 6</b>	<b>Collect data-</b> test your improvement theory 1. Create & implement small scale test of change to process. 2. Collect, chart & display data 3. Document problems, unexpected observations & side effects
CHECK	<b>Step 7</b>	<b>Study the results of your test.</b> 1. Did your test work? How do you know? 2. Did the results match your theory? What does your data show? 3. Are there trends in your data? 4. Did you have unintended side effects? 5. Is there improvement? 6. Do you need to test the improvement under other conditions?
ACT	<b>Step 8</b>	<b>Standardize OR develop a new theory</b> > What actions will take place as a result of the QI project? > Will you need to educate staff on changes? > Will you need to update SOPs or procedures?
	<b>Step 9</b>	<b>Establish future plans</b> > Is there a need to retest down the road i.e. in 6 months? > Will you expand the study to another depart/ team?

Appendix B

Oneida Community Health Services Department  
 QI Project Results Report

Modified from the Oneida Comprehensive Health Division Quality Improvement Committee QI Results Report

QA Indicator	Criteria	Status	Goal	Timeline	Total	Actual	Action	Follow up
Measurable variable used as a representation of an associated factor or quantity. May or may not be SMART.	Specific data to be evaluated	Current measure	Desired measure	Evaluation period	# evaluated	# met criteria	Resulting actions	Future plans
				Do		Check	Act	
<b>Plan</b>								

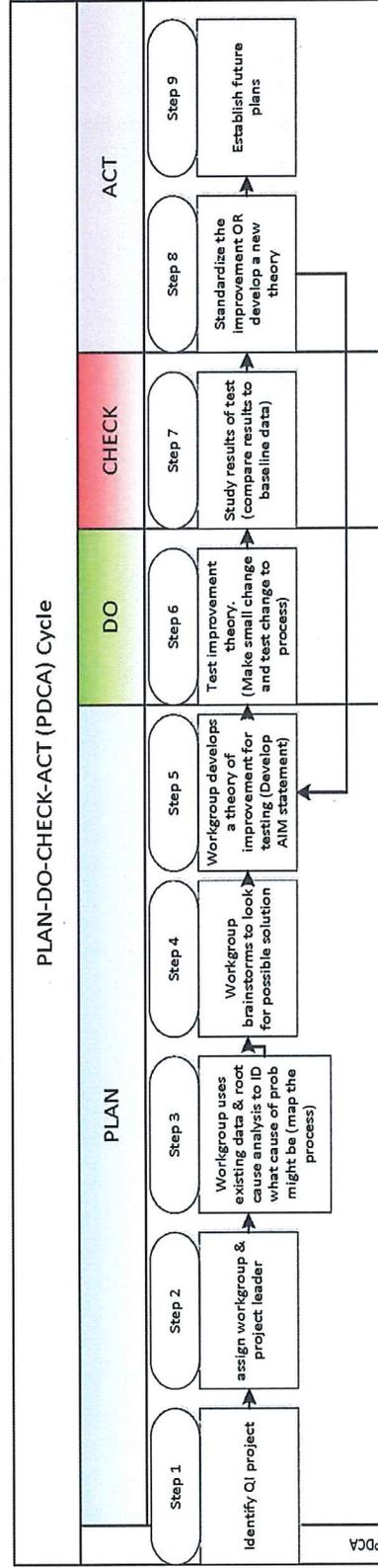
Example 1

QA Indicator	Criteria	Status	Goal	Timeline	Total	Actual	Action	Follow up
Number of employees compliant with flu vaccine or mask SOP	Observe employees that declined vaccination interacting with patients	Collecting Baseline	100%	03/01/16-03/07/16	11	11 (100%)	Resulting actions	Future plans
				Do		Check	Act	
<b>Plan</b>								

Example 2

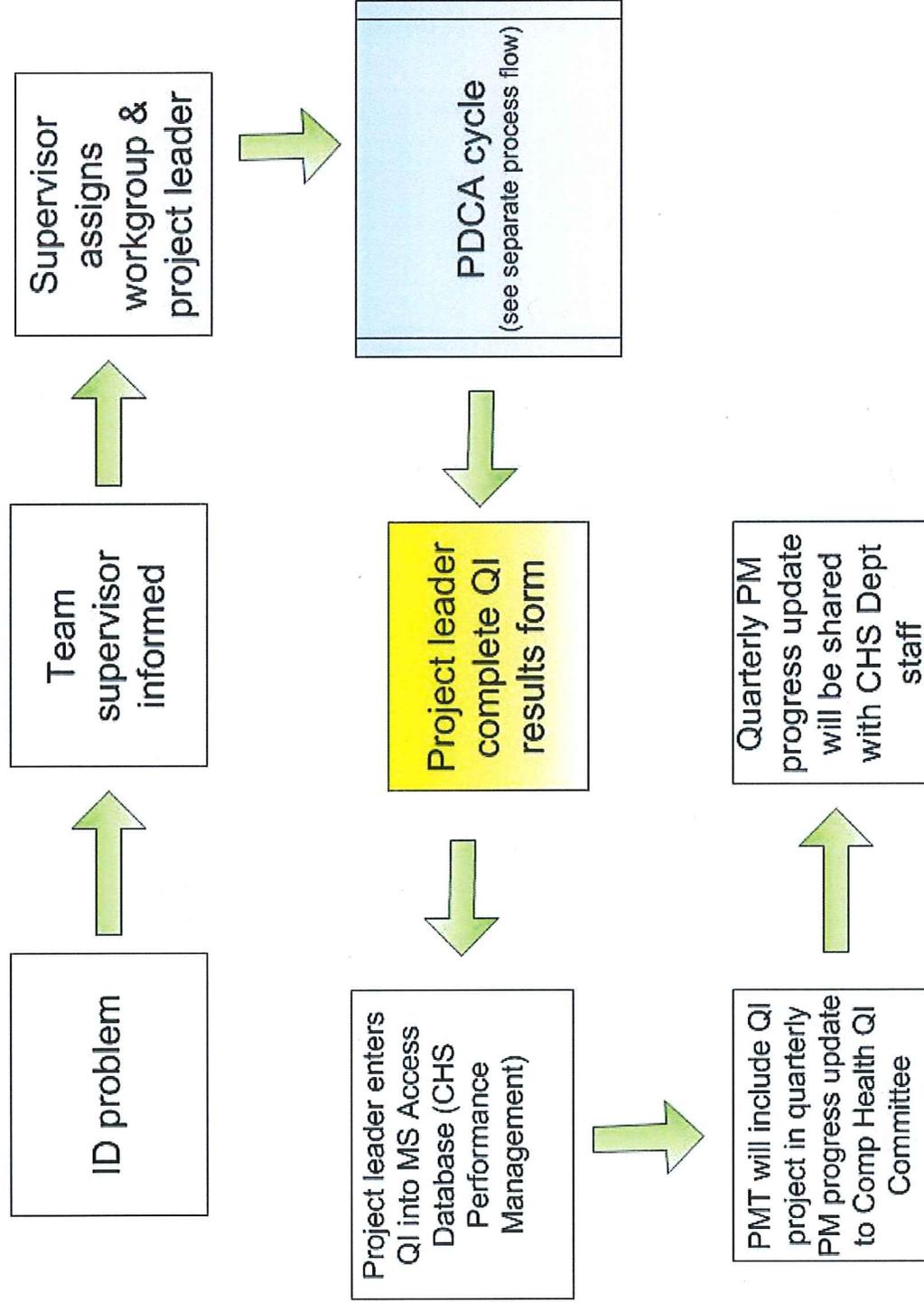
QA Indicator- SMART	Criteria	Status	Goal	Timeline	Total	Actual	Action	Follow up
By January 15, 2011, food service workers from Chinese restaurants located in Grand Traverse County will demonstrate a 20% increase in the ServSafe exam passing rate.	Total exams compared to exams with passing scores (food workers Chinese restaurants)	50%	70%	01/01/2010 – 12/31/2010	100	75% (75)	Continue outreach services	Repeat QI in 6 months
				Do		Check	Act	
<b>Plan</b>								

Appendix C



Appendix D

Community Health Services Department  
Quality Improvement Process- updated 04/29/16 MLJM



## Appendix E

### CHS staff Survey

The survey will ask staff to share feedback on their experience(s) with QI projects, including department strengths and weaknesses, QI barriers, training needs, confidence in leading QI projects, comfort in using QI tools/forms, and understanding of the OCHSD Performance Management Plan and concepts. The survey will also gather suggestions for future QI projects.

1. Have you reviewed the OCHSD Performance Management Plan?
2. Level of understanding of performance management (1-5 scale)?
3. What parts of the Performance Management Plan do you not understand?
4. Did you participate in a QI project this year?
5. If yes, [insert what.....]