Public Health
Prevent. Promote. Protect.

Youngstown City Health District

Performance Management Plan
November 2017

Contents

Introduction 2
Adoption of a Performance Management Process 2
Selection of Performance Management Standards & Measures 2
Performance Management Responsibilities 2
Alignment of Performance Management Systems 3
Next Steps 3
Appendix A – Turning Point Assessment Results 5
Appendix B – Performance Management Session Meeting Materials 6

Appendix C – Performance Management Dashboard 10

Introduction

Youngstown City Health District (YCHD) adopted a performance management system to identify and measure progress towards achieving departmental goals. The adopted performance management system enables the health department to consistently communicate progress towards achieving goals and objectives among staff, Board of Health, and partners/key stakeholders.

Adoption of a Performance Management Process

In order to develop the performance management process, YCHD conducted three (3-hour) planning meetings which were focused on: 1) Identifying a performance management/QI workgroup to develop and oversee implementation of the system, 2) Assess the current performance management processes already in place, and 3) Develop a comprehensive performance management dashboard which summarizes goals and objectives with time-bound performance metrics.

Over the course of three separate planning meetings held between September-November 2017, YCHD engaged staff at all levels to develop a performance management system. Initial meetings focused on assessing YCHD's current performance management system and processes by completing the Public Health Foundation's Turning Point Assessment[1], which is one framework of performance management. To assess the health department's current performance management status, the PHF Turning Point Assessment was completed by Management Team members and used as a baseline for developing cohesive performance management process across programs and staff (see Appendix A -Turning Point Assessment Results). The assessment revealed that while performance management systems in place consisted of ongoing reports to the Board of Health, individual staff performance evaluations, and metrics associated with state/federal/other grant reporting requirements.

Selection of Performance Management Standards & Measures

As a result of completing the Turning Point Assessment and after reviewing Public Health Accreditation Board (PHAB), Standards & Measures, Version 1.5, Youngstown City Health District developed a comprehensive performance management dashboard which would reflect the key performance measures within each division (see Appendix B-Performance Management Dashboard). The dashboard was developed using a "Results Based Performance Management Framework" developed by The Ohio State University, which shifts the focus of reporting from counts of activities towards results/outcomes to be achieved by the department. YCHD Management Team members wanted a system that would be structured simply to reliably and consistently track performance in key areas critical to assessing the health department as a whole, but flexible and adaptable to also incorporate programmatic requirements.

Performance Management Responsibilities

The Management Team, determined that given the limited number of staff within the department, it would serve as the performance management and quality improvement team, or "Quality Council". The Quality Council would ultimately be responsible for evaluating the

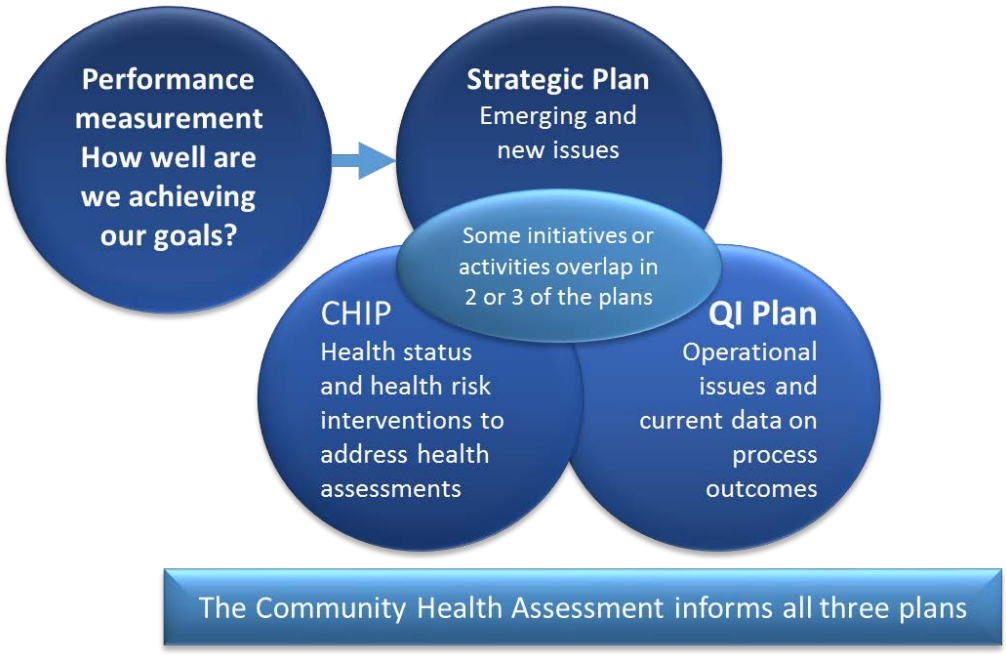
[1] Public Health Foundation, *Turning Point Framework*. Accessible online at: http://www.phf.org/resourcestools/pages/turning_point_project_publications.aspx.

performance management processes by completing the Turning Point Assessment on an annual basis and monitoring progress towards goals using the YCHD Performance Management dashboard. Overlap exists between the Management Team membership and CQI Team Roster so that based on progress towards achieving goals, QI projects may be identified and implemented.

Alignment of Performance Management Systems

YCHD recognizes that the ultimate goal of achieving the health department's mission and vision is to improve the overall health of Fairfield County residents. YCHD worked with a wide array of community partners, including local health care providers (hospitals), schools, and public safety, among others, through the Mobilizing for Action through Planning & Partnerships process to develop a comprehensive Community Health Assessment (CHA) and Improvement Plan (CHIP). Recognizing the health department as one key player and driver to improve the local public health system's performance, YCHD developed goals which would be feasible to accomplish, yet significantly impact community health indicators. YCHD identified performance management linkages between the community and health departments (see figure 2).

Figure 1. Integrated Performance Management Systems & Alignment of Plans/Processes



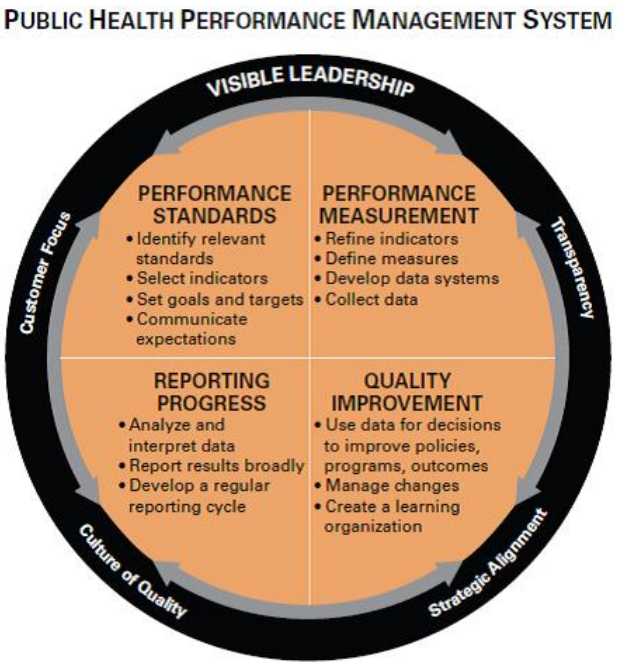
Next Steps

As a result of conducting an assessment of the current approach to performance management through the Turning Point Assessment, adopting a performance management framework and developing a dashboard with measureable standards and measures, the YCHD Management Team which is responsible for monitoring progress, determined that it would begin implementation. Several specific next steps were identified for the coming year, which include:

1. Focusing on implementing a customer satisfaction survey process which expands the current WIC client surveys to include all services.

2. Integrating program requirements, which may be federal/state requirements, or grant driven into the performance dashboard so that performance can be assessed comprehensively.
3. Obtaining baseline data-several of the performance measures still would need baseline data in order to set achievable targets.
4. Reviewing/revising the performance management system dashboard and processes, which might include assessing systems used among other health departments.
5. Developing a communication process and training to engage staff at all levels in use of the performance management system and sharing progress.

Appendix A – Turning Point Assessment Results



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

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

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.

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.

About the 2012-2013 Update

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

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

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
1. Senior management demonstrates commitment to utilizing a performance management system	☐	☐	☒	
2. Senior management demonstrates commitment to a quality culture	☐	☐	☒	
3. Senior management leads the group (e.g., program, organization or system) to align performance management practices with the organizational mission	☐	☐	☒	
4. Transparency exists between leadership and staff on communicating the value of the performance management system and how it is being used to improve effectiveness and efficiency	☐	☐	☒	
5. Performance is actively managed in the following areas (check all that apply) A. Health Status (e.g., diabetes rates)	☐	☐	☒	
B. Public Health Capacity (e.g., public health programs, staff, etc.)	☐	☐	☒	
C. Workforce Development (e.g., training in core competencies)	☐	☐	☒	
D. Data and Information Systems (e.g., injury report lag time, participation in intranet report system)	☐	☐	☒	
E. Customer Focus and Satisfaction (e.g., use of customer/stakeholder feedback to make program decisions or system changes)	☐	☒	☐	

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
F. Financial Systems (e.g., frequency of financial reports, reports that categorize expenses by strategic priorities)	☐	☐	☒	
G. Management Practices (e.g., communication of vision to employees, projects completed on time)	☐	☐	☒	
H. Service Delivery (e.g., clinic no-show rates)	☐	☐	☒	
I. Other (Specify):	☐	☐	☒	Quality indicators, Board of Health Reports, Quarterly Vital Statistics Reports, etc.
6. There is a team responsible for integrating performance management efforts across the areas listed in 5 A-I	☐	☒	☐	Supervisors assign one employee per division.
7. Managers are trained to manage performance	☐	☒	☐	Some trainings were completed in the past by OSU.
8. Managers are held accountable for developing, maintaining, and improving the performance management system	☐	☐	☒	
9. There are incentives for effective performance improvement	☐	☒	☐	Our budget limits our ability to offer incentives and raises are based on Union terms, but we do try to recognize employees when possible.
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)	☐	☐	☒	Data are reported monthly to the Board of Health in meeting packets.
11. A process or mechanism exists to align performance priorities with budget	☐	☒	☐	
12. Personnel and financial resources are assigned to performance management functions	☐	☒	☐	

Section II. Performance Standards - *Establishment of organizational or system performance standards, targets, and goals to improve public health practices. Standards may be set based on national, state, or scientific guidelines, by benchmarking against similar organizations, based on the public's or leaders' expectations, or other methods.*

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
1. The group (program, organization or system) uses performance standards	☐	☐	☒	
2. The performance standards chosen used are relevant to the organization's activities	☐	☐	☒	
3. Specific performance targets are set to be achieved within designated time periods	☐	☐	☒	
4. Managers and employees are held accountable for meeting standards and targets	☐	☐	☒	
5. There are defined processes and methods for choosing performance standards, indicators, or targets[2]	☐	☐	☒	
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)	☐	☐	☒	State subsidy, Community Health Improvement Plan uses national standards and evidence based practices, where applicable.
B. The group benchmarks its performance against similar entities	☐	☐	☒	
C. Scientific guidelines are used	☐	☐	☒	
D. The group sets priorities related to its strategic plan	☐	☐	☒	
E. The standards used cover a mix of capacities, processes, and outcomes[3]	☐	☐	☒	
6. Performance standards, indicators, and targets are communicated throughout the organization and to its stakeholders and partners	☐	☐	☒	
A. Individuals' performance expectations are regularly communicated	☐	☐	☒	

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

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

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
B. The group relates performance standards to recognized public health goals and frameworks, (e.g., Essential Public Health Services)	☐	☐	☒	
7. The group regularly reviews standards and targets	☒	☐	☐	
8. Staff understand standards and targets	☐	☒	☐	
9. Performance standards are aligned across multiple groups (e.g., same child health standard is used across programs and agencies)	☐	☐	☒	
10. Training is available to help staff use performance standards	☐	☒	☐	
11. Personnel and financial resources are assigned to make sure efforts are guided by relevant performance standards and targets	☐	☒	☐	Resource decisions are largely driven by the general fund.

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

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
1. The group (program, organization, or system) uses specific measures for established performance standards and targets	☐	☐	☒	
A. Measures are clearly defined	☐	☐	☒	
B. Quantitative measures have clearly defined units of measure	☐	☐	☒	

C. Inter-rater reliability has been established for qualitative measures	☐	☐	☒	
2. Measures are selected in coordination with other programs, divisions, or organizations to avoid duplication in data collection	☐	☐	☒	
3. There are defined methods and criteria[4] for selecting performance measures	☐	☐	☒	
A. Existing sources of data are used whenever possible	☐	☐	☒	
B. Standardized measures (e.g., national programs or health indicators) are used whenever possible	☐	☐	☒	
C. Standardized measures (e.g., national programs or health indicators) are consistently used across multiple programs, divisions, or organizations[5]	☐	☐	☒	
D. Measures cover a mix of capacities, processes, and outcomes[6]	☐	☒	☐	
4. Data are collected on the measures on an established schedule	☐	☐	☒	Data are tracked on a quarterly, monthly, and weekly basis, depending on grant and state reporting requirements.
5. Training is available to help staff measure performance	☐	☒	☐	
6. Personnel and financial resources are assigned to collect performance measurement data	☐	☒	☐	

[4] 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

[5] 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.

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

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

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
1. The group (program, organization or system) documents progress related to performance standards and targets	☐	☐	☒	
2. Information on progress is regularly made available to the following (check all that apply)				
A. Managers and leaders	☐	☐	☒	
B. Staff	☐	☐	☒	
C. Governance boards and policy makers	☐	☐	☒	
D. Stakeholders or partners	☐	☒	☐	
E. The public, including media	☐	☒	☐	
F. Other (Specify):	☐	☐	☒	
3. Managers at all levels are held accountable for reporting performance	☐	☐	☒	
A. There is a clear plan for the release of performance reports (i.e., who is responsible, methodology, frequency)	☐	☐	☒	
B. Reporting progress is part of the strategic plan	☐	☐	☒	
4. A decision has been made on the frequency of analyzing and reporting performance progress for the following types of measures[7] (check all that apply)				

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

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
A. Health Status	☐	☐	☒	
B. Public Health Capacity	☐	☐	☒	Environmental Health Cost Methodology
C. Workforce Development	☐	☐	☒	While our capacity and ability to make changes may be limited, we do well when working with what we've got. Our staff are loyal and committed.
D. Data and Information Systems	☐	☐	☒	
E. Customer Focus and Satisfaction	☐	☐	☒	
F. Financial Systems	☐	☐	☒	
G. Management Practices	☐	☐	☒	
H. Service Delivery	☐	☐	☒	
I. Other (Specify):	☐	☐	☒	
5. The group has a reporting system that integrates performance data from programs, agencies, divisions, or management areas (e.g., financial systems, health outcomes, customer focus and satisfaction)	☐	☐	☒	
6. Training is available to help staff effectively analyze and report performance data	☐	☒	☐	
7. Reports on progress are clear, relevant, and current so people can understand and use them for decision-making (e.g., performance management dashboard)	☐	☐	☒	
8. Personnel and financial resources are assigned to analyze performance data and report progress	☐	☒	☐	
9. Leaders are effective in communicating performance outcomes to the public to demonstrate effective use of public dollars	☐	☒	☐	

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

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
1. One or more processes exist to improve quality or performance	☐	☒	☐	
A. There is an entity or person responsible for decision-making based on performance reports (e.g., top management team, governing or advisory board)	☐	☐	☒	
B. There is a regular timetable for QI processes	☐	☐	☒	Yearly employee performance evaluations
C. The steps in the QI process are effectively communicated	☐	☒	☐	
2. Managers and employees are evaluated for their performance improvement efforts (i.e., performance improvement is in employees' job descriptions and/or annual reviews)	☐	☐	☒	
3. Performance reports are used regularly for decision-making	☐	☐	☒	
4. Performance data are used to do the following (check all that apply)				
A. Determine areas for more analysis or evaluation	☐	☐	☒	
B. Set priorities and allocate/redirect resources	☐	☒	☐	
C. Inform policy makers of the observed or potential impact of decisions under their consideration	☐	☒	☐	
D. Implement QI projects	☐	☒	☐	

	Never/ Almost Never	Some-times	Always/ Almost Always	Note details or comments mentioned during the assessment
E. Make changes to improve performance and outcomes	☐	☐	☒	
F. Improve performance	☐	☐	☒	
5. The group (program, organization, or system) has the capacity to take action to improve performance when needed	☐	☐	☒	
A. Processes exist to manage changes in policies, programs, or infrastructure	☐	☒	☐	
B. Managers have the authority to make certain changes to improve performance	☐	☒	☐	The city determines through ordinances and we are required by the state and union to make changes
C. Staff has the authority to make certain changes to improve performance	☐	☒	☐	
6. The organization regularly develops performance improvement or QI plans that specify timelines, actions, and responsible parties	☐	☒	☐	
7. There is a process or mechanism to coordinate QI efforts among groups that share the same performance targets	☐	☒	☐	
8. QI training is available to managers and staff	☐	☒	☐	We are just starting within individual areas.
9. Personnel and financial resources are allocated to the organization's QI process (e.g., a QI office exists, lead QI staff is appointed)	☐	☒	☐	
10. QI is practiced widely in the program, organization, or system	☐	☐	☒	

Resources to Help

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

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

Take the Next Step

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

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

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

Definitions

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

- **Visible Leadership—**Senior management commitment to a culture of quality that aligns performance management practices with the organizational mission, regularly takes into account customer feedback, and enables transparency about performance against targets between leadership and staff.
- **Performance Standards—**Establishment of organizational or system performance standards, targets, and goals to improve public health practices. (e.g., one epidemiologist on staff per 100,000 people served, 80 percent of all clients who rate health department services as "good" or "excellent"). Standards may be set based on national, state, or scientific guidelines, by benchmarking against similar organizations, based on the public's or leaders' expectations (e.g., 100% access, zero disparities), or other methods.
- **Performance Measurement—**Development, application, and use of performance measures to assess achievement of performance standards.
- **Reporting Progress—**Documenting and reporting progress in meeting standards and targets, and sharing of such information through appropriate channels.
- **Quality Improvement—**In public health, the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, that focuses on activities that address community needs and population health improvement. QI refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.
  (Source: http://journals.lww.com/jphmp/Fulltext/2010/01000/Defining_Quality_Improvement_in_Public_Health.3.aspx)

Performance Management Components Can Be Applied to…

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

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

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

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

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

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

Strategic Plan results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. (Source: http://www.phaboard.org/wp-content/uploads/PHAB-Acronyms-and-Glossary-of-Terms-Version-1.0.pdf)

Appendix B– Performance Management Dashboard

Division: Environmental Health					
Program/Service: Food					
Goals & Objectives: To reduce the occurrence of foodborne illness					
Outcomes	Performance Measures	Frequency	Data Source	Staff Responsible	Targets
Food service operators receive training on safe food handling practices.	# of follow up inspections		Inspection Reports		
	% of food complaints receiving follow up		Inspection Reports		
Facilities are inspected	# of inspections conducted		Inspection Reports		
	% of critical violations re-inspected on schedule		Inspection Reports		
	% of mandated inspections completed on time		Inspection Reports		
Division: Air Quality					
Goals & Objectives: To protect, promote and improve air quality					
Reduce Pollutants	% of ozone (silver dioxide) particulates	Quarterly	Inspection Reports		75%
Provide health education on air quality	# of trainings held on air quality topics	Quarterly	Hand tally		
Conduct inspections and reduce complaints	# of open buring inspections conducted	Quarterly	Inspection Reports		
	% of facility complaints received which receive follow up inspections	Quarterly	Inspection Reports		
Reduce asbestos	% of inspections performed according to NESHAK Rules	Quarterly	Inspection Reports		20% (required)
Division: Community Health Promotion & Improvement					
Service/program: CHIP					
Goals & Objectives: To contribute towards the implementation of the CHIP in collaboration with partners					
CHIP partners are effectively engaged and contribute towards CHIP implementation	# of community organizations actively participating				
CHIP milestones implemented on schedule	# of CHIP milestones assigned to YCHD completed on schedule				

Service/program: Access Health Mahoning Valley					
Goals & Objectives: Assure Access to healthcare services when otherwise unavailable					
Develop and implement mechanisms with partners to increase access to care	% of population covered by insurance	Annually			
	# of MOUs between partner organizations to increase access	Annually			
Division/program: Emergency Preparedness					
Goals & Objectives: Effective preparation and response to public health emergencies					
Train staff to respond effectively	% of staff who have completed NIMs required training within 90 days of hire	Quarterly	Personnel Records		100%
Conduct exercised to test readiness	# of exercises conducted by type	Annually	Hand Tally		
	% of emergency preparedness communications drills initiated by ODH responded to in accordance with requirements	Annually	County OPHS 24/7 Report		
Division: Nursing					
Program/service: Maternal & Child Health					
Goals & Objectives: Mothers and children are healthy					
Reduce the infant mortality rate	# of partnerships formed to address infant mortality	Monthly	Hand Tally		
	$ raised (mini-grant, fundraising, donations, HUB) to address infant mortality	Monthly	Budget		
Reduce the occurrence of low birth weight babies	% of mothers giving birth who report smoking during pregnancy	Monthly			
Reduce pre-term births	% of pregnant women receiving prenatal care in the first trimester	Monthly			3
Conduct maternal and child health outreach/educational events	# of outreach events conducted	Monthly	Hand Tally		
	# of outreach participants	Monthly	Outreach event sign-in sheets		
	# of outreach events conducted in targeted zip codes	Monthly	Hand Tally		
Service/program: Immunization					
Goals & Objectives: Population protected from vaccine-preventable communicable disease					
Conduct immunization outreach	# of broad outreach efforts conducted (public service announcements)	Monthly			

Deliver immunizations	# of doses delivered by type	Monthly			
Division: Administration					
Goals & Objectives: Effective management of public health resources (staff and budget)					
Funds maintained to support essential public health services	% of program costs subsidized out of general fund	Annually			
	% billing collection rate	Monthly			
YCHD maintains human resources required to meet its mission	Staff retention rate	Annually			
	% of employees completing trainings according to schedule	Annually			
	# of employees recognized throughout the year	Annually	Spotlight on staff meeting agenda		
	% of employees participating in 8 week health challenges	Annually			
Division: Vital Statistics					
Goals & Objectives: Vital Statistics documents issued correctly					
Issue vital statistics documents efficiently and effectively	# of vital statistics issued				
	# of vital statistics registered				
	# of vital statistics corrected				
	Total $ collected from vital statistics				

Appendix C- Charter

Quality Council Charter

November 2017

Purpose	
To support, nurture and maintain a culture at the Youngstown City Health District that fosters and values improvement.	
Scope	**Membership and Meetings**
In Scope: • Provides oversight to monitor implementation of the agency's critical plans and formal processes, such as, the Strategic Plan, Quality Improvement Plan, Workforce Development Plan, Strategic Communications Plan, and performance management processes. • Supports Quality Improvement (QI) teams by providing technical support/training as needed; Acts as quality champions by recognizing and celebrating QI efforts among divisions and teams. • Tracks quality improvement projects across all divisions with progress notes, timelines with completion dates, and type (administrative or programmatic), per PHAB requirements. • Implements improvements based on critical plan progress and performance. Recommendations for QI projects may be identified based on review/analysis of audit findings and deficiencies, corrective action plans, state/national surveys, or other performance data. In addition to specific assignments and responsibilities, members should commit to ongoing and focused environmental scanning – identifying the strategic position of the agency in regard to external factors and in comparison to relevant best practices in areas of expertise.	Meets on a monthly basis; Meeting Duration: 1-1.5 hours Membership: • Facilitated by the Accreditation Coordinator, the Council consists of a cross-functional, cross-divisional team of 6-10 staff who are appointed by the Health Commissioner and/or leadership team members. Members are capable of committing up to 4 hours monthly of effort, inclusive of monthly meetings. • Members shall serve terms of 24 months on a rotating schedule ensuring no more than 25% replacements in a six month timeframe.
Out of Scope: • Nonmaterial task-oriented quality activities • Members will oversee and provide guidance to support QI projects to teams, but teams will ultimately implement projects.	

Key Members	**Role**	**Responsibilities**
Accreditation Coordinator	Emily Frantz (Interim Chair)	Ensure council is sustained and active to foster a culture of quality while remaining within scope.
Erin Bishop	Health Commissioner	As a Quality Council member, participates in ongoing quality improvement activities, reviews and refines QI project plans, and monitors the progress of our Agency's strategic initiatives. All quarterly meetings will be two hours in duration. Quality Council members will agree to a standing meeting day and time (e.g., the third Wednesday of every month) and be expected to attend all meetings in their entirety.
Environmental Health	Tara Cioffi	
Vital Statistics	Toni Tell	
Minority Health	Leigh Greene	
Nursing	Anthea Mickens	
Expectations		

Effective planning, data-driven decision making, strategy monitoring & timely response, up-to-date status reporting, effective project management, appropriate collaboration and coordination among members, strategic workgroups and the senior leadership team.

Meeting Etiquette:

- Agenda and prior meeting' minutes with action items distributed at least 48 hours in advance
- Members review and prepare in advance
- Avoid use of electronic devices for purposes unrelated to meeting/agenda
- Respect meeting schedule and individual input

Quality Council meeting minutes will be included in the leadership team meeting packets.