# Performance Management and Quality Improvement Plan

2017-2020

3/27/2017
Lane County Public Health
PMQI Council

Last updated 6/27/17

PUBLIC HEALTH
Prevent. Promote. Protect.

LANE COUNTY OREGON

## Table of Contents

    A) Glossary of Performance Management and Quality Improvement Terms

    B) LCPH Modernization Assessment Findings

    C) PMQI Charter

    D) PMQI Council Roster

    E) Performance Measure Proposal Form

    F) Performance Measures

    G) QI Project Proposal Form

    H) QI Project Report Form

    I) List of PMQI trainings

    J) All Staff Quality Culture Survey

Lane County Public Health
Performance Management and Quality Improvement Plan
2017-2020

## Purpose, Vision, and Guiding Principles

**Purpose**: The Performance Management and Quality Improvement (PMQI) Plan will monitor important aspects of Lane County Public Health's programs, systems, and processes; compare current performance with the previous year's performance, as well as state and national benchmarks; and identify opportunities for improvement in management, service delivery, and support activities.

**Vision**: Lane County Public Health (LCPH) is committed to developing a culture of quality throughout our organization. The Performance Management and Quality Improvement Council will use the PMQI Plan as a guide to create, implement, and maintain sustainable improvement efforts that align with the Public Health strategic plan.

**Guiding Principles:** The Council will operate using the following principles:

- Foster a culture of quality improvement (QI) and promote the use of QI methods and tools.
- Make data-driven and evidence-based decisions, but also use and respect people's knowledge and experience.
- Make the internal and external customer perspective central to its decision-making and strive to consistently meet or exceed customer expectations.
- Use processes that are transparent, collaborative, and inclusive.
- Foster engagement and accountability with all persons involved in the QI effort.
- Focus on learning and improvement, and value prevention and problem solving over correction.

## Key Terms and Definitions

**Performance Management:**
The use of performance measurement information to help set agreed-upon performance goals, allocate and prioritize resources, inform managers to either confirm or change current policy or program directions to meet those goals, and report on the success in meeting those goals. *(Turning Point Guidebook for Performance Management, 2010)*

**Performance Standards:**
Generally accepted, objective standards of measurement such as rules or guidelines against which an organization's level of performance can be compared.

*(Turning Point Guidebook for Performance Management, 2010)*

**Performance Measures:**
The specific, quantitative representations of a capacity, process, or outcome deemed relevant to assessing performance
*(Turning Point Guidebook for Performance Management, 2010)*

**Quality Improvement**
In Public Health, the use of a deliberate and defined improvement process, such as Plan-Do-Study-Act, which focuses 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.
*(Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook, 2013)*

For additional PMQI terms and definitions, see the Glossary in Appendix A.

## Culture of Quality

**Current State**
As an agency, we do a good job of recognizing the need to improve and working to change, but we have not always done this as part of a formal process.  Employees follow basic principles:

1) Focus on the situation, issue, or behavior, not on the person
2) Maintain the self-confidence and self-esteem of others
3) Maintain constructive relationships
4) Take initiative to make things better
5) Lead by example
6) Think beyond the moment

Lane County Public Health has limited resources to provide quality services.  Assessing LCPH using standards outlined in the Oregon Public Health Modernization Manual found that we have about 40% of total staffing and funding needed to fully implement the foundational programs and capabilities. The gap in funding is estimated to be $9.93m annually.   See Appendix B for the Public Health Modernization Assessment Findings.

Current Agency Status on the *Foundational Elements of QI Culture* (NACCHO, 2012):
1) *Leadership Commitment* – senior leadership is committed to developing and sustaining a QI culture.  The Public Health Manager, Health Officer, and supervisors from each section are members of the PMQI Council.

2) *QI Infrastructure* – the PMQI Council formed in December 2015 and meets monthly.  The Council is developing the Performance Management System and wrote the PMQI plan.
3) *Employee Empowerment and Commitment* – results of the October 28, 2016 all-staff Quality Culture Survey indicate that LCPH employees are currently at different levels of awareness and involvement with QI.  Some sections have been doing QI projects and discussing them at meetings, and/or have had QI training, while others have not.
4) *Customer focus* – we value customer service, and need to improve our efforts to collect customer feedback.  Several sections have implemented customer satisfaction surveys, but methods are inconsistent and results are not usually reported beyond the section level.
5) *Teamwork and collaboration* – we have workgroups that include members from different sections: PMQI, Leadership Team, Workforce Development, Public Health Wellness Committee, National Public Health Week Planning Committee, All-Staff Meeting Planning Committee, and the Public Health Equity Committee.
6) *Continuous Process Improvement* – the Maternal and Child Health section performs continuous process improvement; other sections are not doing this yet.

**Future State**

| Traditional Organization Culture | Quality Improvement Culture |
| --- | --- |
| Moving away from: | Moving toward: |
| • Internal focus<br>• Quantity<br>• Product<br>• Opinion<br>• Crisis management<br>• People as commodities<br>• Autocratic decision making<br>• Trial & error<br>• Seat-of-the pants | • Customer focus<br>• Quality<br>• Process<br>• Data, facts<br>• Continuous improvement<br>• People as resources<br>• Empowered teams<br>• Scientific method<br>• Rational problem-solving |

**Table 1:** Traditional Culture v. Quality Culture (Graham, R., 2011).

LCPH will work more upstream and have blended funding with primary care.  We will tie Public Health metrics to Coordinated Care Organization (CCO) metrics, and our strategic plan will align with Oregon's Public Health Modernization requirements.

Future Status on the Foundational Elements of QI Culture:
1) *Leadership Commitment* – the Public Health Manager will dedicate financial and human resources to QI, use change management, and communicate progress to employees.
2) *QI Infrastructure* – The PMQI Council will implement our Performance Management System, lead QI efforts, evaluate efforts, report progress, and recommend next steps.
3) *Employee Empowerment and Commitment* – employees at all levels and across all sections will have taken QI training, feel empowered to propose and implement QI projects, and will have adopted a QI mindset in their daily work.
4) *Customer Focus* – all sections will regularly collect, report, and act on customer feedback.

5) *Teamwork and Collaboration* – leadership will support frequent cross-sectional opportunities for collaboration.
6) *Continuous Process Improvement* – all sections will perform continuous process improvement.


## PMQI Organizational Structure/Governance

The Organizational Structure and Governance of the PMQI Council are outlined in the PMQI Council charter (Appendix C).

**Performance Management and Quality Improvement Council**
The Public Health Manager charged the PMQI Council with planning, implementing and overseeing performance management and quality improvement efforts within Lane County Public Health.

**Membership**
The PMQI Council has representatives from across the division at various levels of leadership and practice, including each of the six sections within Lane County Public Health.   Membership includes the following, unless otherwise determined to meet specific needs:

Leadership Team
        Public Health Manager
        Senior Health Officer
        Section Supervisors
Accreditation Coordinator
At least two staff representatives from two different sections, outside of leadership and Administration

Staff become members of the PMQI Council through appointment by the Public Health Manager in consultation with the Council Chair and the respective Section Supervisor. Members of the Public Health Division's Leadership Team and the Accreditation Coordinator are permanent members of the Council.  Other members serve for two years and may be reappointed for additional terms. If a member is unable to serve a full two-year term, a replacement will be approved by the Public Health Manager and PMQI Council chair. The PMQI Council chair is appointed by the Public Health Manager, in consultation with the PMQI Council. See Appendix D for a roster of current PMQI Council members and roles.

**Operations**

*Decision-making*: PMQI Council members will attempt to reach a consensus on significant issues. If a member cannot support the emerging consensus of the group, the member is obligated to offer an alternative or work with the group to develop another option that all can support.

*Meetings*: Meetings will be held monthly on the 3rd Monday for 90 minutes. Additional meetings may be held as necessary for Council business.

*Time Commitment*: The time commitment for PMQI Council members is anticipated to be three to five hours per month. This includes meetings and meeting preparation time.

**Roles and Responsibilities**

All staff have a role in Lane County Public Health's performance management and quality improvement efforts. Specific roles and responsibilities are listed below.

PMQI Council Chair
- Generate agendas with Council members
- Facilitate meeting discussion
- Ensure that tasks are assigned

Minutes Taker:
- The Administrative Assistant for the Public Health Division is responsible for taking minutes at the PMQI Council meetings.

PMQI Council Members
- Participate in developing meeting agendas
- Set organizational objectives across all levels of the Public Health Division in alignment with the Community Health Assessment and Community Health Improvement Plan
- Identify indicators to measure progress toward achieving objectives on a regular basis in alignment with the Community Health Assessment and Community Health Improvement Plan
- Identify responsibility for monitoring progress and reporting
- Identify areas where achieving objectives requires focused quality improvement processes
- Develop and implement a quality improvement plan and improvement processes
- Provide visible leadership for ongoing performance management
- Apply an equity lens in all quality improvement efforts to help all Sections of Public Health ensure that interventions are focused on improving health equity in Lane County.
- Serve as a liaison between the PMQI Council and staff

All Lane County Public Health Staff
- Develop an understanding of basic PM and QI principles and tools through participation in PM and QI training
- Identify areas for improvement and suggest improvement actions
- Report training needs to the PMQI Council
- Contribute to the development, monitoring, and evaluation of the Performance Management System

## Performance Management Activities

### Performance Management System Model and Framework

Lane County Public Health has adopted the updated Turning Point Public Health Performance Management System as the framework for its performance management system (see Figure 1). As described by the Public Health Foundation (2015),

"The updated Public Health Performance Management System Framework (shown here) depicts the practices by which performance management can be achieved. Continuous integration of these practices into the core operations of an organization enables performance management to produce long lasting benefits. The core practices within the circle must be supported by visible leadership in order to sustain a culture of performance excellence.

The five components are defined as:

- **Visible Leadership** is the commitment of senior management to a culture of quality that aligns performance management practices with the organization's mission, regularly takes into account customer feedback, and enables transparency about performance between leadership and staff.
- **Performance Standards** are the establishment of organizational or system standards, targets, and goals to improve public health practices. Standards may be set based on national, state, or scientific guidelines, benchmarking against similar organizations, the public's or leaders' expectations, or other methods.
- **Performance Measurement** is the development, application, and use of performance measures to assess achievement of performance standards.
- **Reporting Progress** is the documentation and reporting of how standards and targets are met, and the sharing of such information through appropriate feedback channels.
- **Quality Improvement (QI)** is the establishment of a program or process to manage change and achieve quality improvement in public health policies, programs, or infrastructure based on performance standards, measures, and reports."

## PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM



**Figure 1**. Turning Point Performance Management System Framework as updated by the Public Health Foundation (Public Health Foundation, 2015).

### Performance Goals, Objectives, & Measures
Selecting and measuring goals and objectives enables the PMQI Council to assess Lane County Public Health's performance.

*Performance Measure Selection*
Division-level goals and objectives align with the Public Health Strategic Plan, the Health and Human Services Strategic Plan, and the Community Health Improvement Plan (CHIP). The PMQI Council will develop performance measures for strategic objectives, with review by the Public Health Administrator.

Management and staff in each section area develop section-level goals, objectives, and measures. In this first year of establishing the formal division-wide performance management system, each section will submit at least one performance measure for the PMQI Council to monitor.

Performance measures will be submitted to the PMQI Council using the Performance Measure Proposal form (Appendix E). The PMQI Council will review all proposed measures to ensure that the measure (1) can be easily monitored, (2) is clearly and logically tied to a goal and objective, and (3) has a strong rationale.  See Appendix F for our initial list of performance measures.

### *Collecting, Analyzing, Monitoring, and Reporting Data*
Staff identified as responsible in the PMQI tracking sheet will collect and analyze data for each of the LCPH Performance Measures. The PMQI Council will provide assistance and support for this process as needed. On a quarterly basis, the PMQI Council will review all applicable division and section-level performance measures.  Annually, the Council will compile a summary report of performance measure data to present to the Public Health Administrator, the Health and Human Services Director, and the Public Health Advisory Committee. The Council will also share results with LCPH staff in the Public Health Newsletter and through other cross-sectional opportunities as available.

## Strategic Plan Monitoring and Review
The Strategic Plan outlines the strategic priorities, goals, and objectives for Lane County Public Health at the division level and thus is an integral part of LCPH's Performance Management System. The PMQI Council will monitor progress toward strategic objectives through (1) quarterly reviewing progress against the strategic action plan and (2) reporting on division-wide strategic performance measures.  Annually, the PMQI Council will review the Strategic Plan and write a progress report to share with the Public Health Administrator, the Health and Human Services Director, and the Public Health Advisory Committee. In addition to evaluating progress towards strategic goals and objectives, the annual review will consider new goals and objectives to add to the Strategic Plan. Following the annual review, the PMQI Council will develop an updated strategic action plan for the upcoming year. The Council will share a summary of the Strategic Plan review with LCPH staff through the Public Health Newsletter and cross-sectional opportunities as available.

## Quality Improvement Activities

### Quality Improvement Model

Lane County has adopted the Plan-Do-Study-Act (PDSA) model (Figure 2) as the formal QI method to guide all performance improvement efforts within the division.
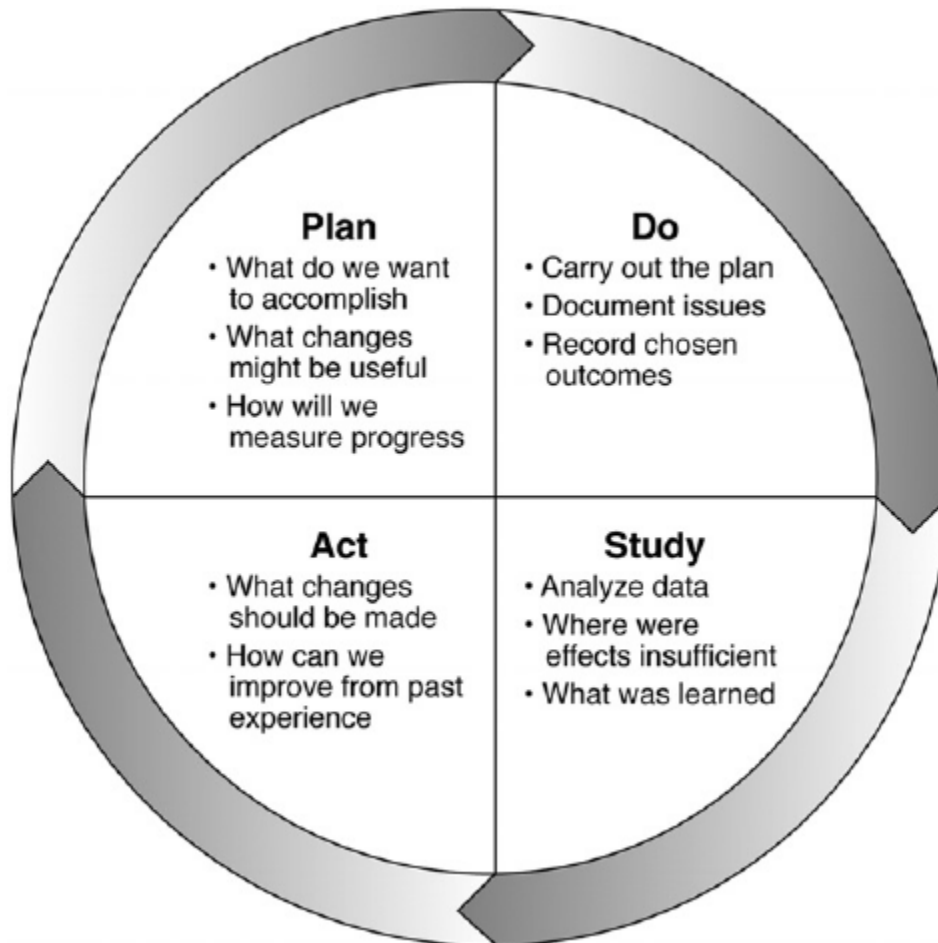


**Figure 2**. Plan-Do-Study-Act Cycle (Kheraj R., Tewani S.K., Ketwaroo G, & Leffler D.A., 2012).

### QI Project Identification and Selection

QI projects may be identified in a number of ways including, but not limited to, staff proposal, PMQI Council recommendation, or the Public Health Manager's request. We will use the QI Project Proposal form (Appendix G) to submit recommendations for potential projects. During this first year of establishing a formal division-wide quality improvement system, PMQI Council members will propose QI projects. In the future, once PMQI Council members gain greater skill and confidence in QI methods, any staff member will be able to propose a project with PMQI Council members available to offer technical assistance to staff in developing project proposals. The PMQI Council will review proposals and select which ones to place on the agenda to present and discuss. The Council may approve a proposal, return it for additional work, or defer

it. Approval for a proposed project depends on multiple factors including the capacity of the division to carry out the project and alignment with division objectives and plans. To prioritize QI project proposals, the PMQI Council will address the following questions:

**Technical**
- Is the specific problem clearly defined?
- Is the scope of the proposed project manageable?
- Can we measure the desired improvement?
- Can we feasibly collect relevant data?
- Can we complete the project within the proposed timeframe?

**Strategic**
- Does the project align with the strategic plan or other public health division priorities, such as the Community Health Improvement Plan?
- Are the expected benefits significant?

**Capacity**
- Is the ability to make change within the team's control?
- Are the resources needed to implement change available?

**Equity**
- Will the project help improve access, increase opportunity, or remove barriers for disadvantaged populations?

## Project Monitoring and Reporting

For each QI project, a PMQI Council member will facilitate the PDSA process and bring questions back to the Council for technical assistance as needed. We will use the QI Project Report Form (Appendix H) to guide and document each QI process and serve as the team's final report. Upon completing a project, the team facilitator and/or team leader will present the report at a PMQI Council meeting. The PMQI Council may continue to monitor one or more performance measures established during the project to ensure sustained improvement. QI project teams may be asked to develop a storyboard or present their project at an all-staff meeting.

**Training**
In 2017-2018, the following training on performance management and quality improvement will be provided to LCPH staff in an effort to build the foundation for quality-focused culture. See Appendix I for a list of PMQI trainings.

**PMQI Council Members**
- Basic principles of performance management
- Principles of QI and using the Plan-Do-Study-Act cycle

- Basic QI tools

**All Staff**
- Basic principles of performance management
- Principles of QI and using the Plan-Do-Study-Act cycle
- Orientation to the PMQI plan

In January 2018, training needs will be evaluated and a training plan for 2018-2019 will be developed.

## Goals, Objectives, and Measures for the Performance Management System

The following are the goals and objectives for developing and implementing Lane County Public Health's performance management system. The goals are based on the national accreditation standards set forth by PHAB in Domain 9 of *PHAB Standards and Measures version 1.5.* They align with the emphasis on data in the Public Health Division's Strategic Plan, the Data and Analytics pillar of the Health and Human Services Strategic Plan, and objectives to measure performance under CHIP Initiative 3, Collaborative Infrastructure. The PMQI Council will monitor progress toward these goals and objectives.

**Goal 1: Implement a performance management system to monitor achievement of organizational objectives.**

**Objective 1.1:** By March 2017, the PMQI Council will develop measures that are section- and division-specific and include programmatic and administrative areas.
*Measure*: % sections that have begun monitoring performance on measures by the end of June 2017.

**Goal 2: Improve division capacity to engage in QI efforts.**

**Objective 2.1:** By March 31, 2017, adopt the final Performance Management and Quality Improvement Plan that provides a framework for implementing PM and QI activities at Lane County Public Health.
*Measure*: A written PMQI plan approved by the PMQI Council and Public Health Administrator

**Objective 2.2**: By January 2019, ≥90% of LCPH staff will have completed training about the Plan-Do-Study-Act cycle.
*Measure*: % of staff members recorded in the LEAP training system as having completed PDSA training.

**Goal 3: Implement formal QI efforts at Lane County Public Health.**

**Objective 3.1:** By December 2017, Lane County Public Health will have completed at least two QI projects under the QI plan.
*Measure*: # of QI projects with final project report submitted to PMQI Council

**Objective 3.2:** By December 2018, all PMQI members will have experience working on a QI project.
*Measure*: % of PMQI Council members who worked on a QI project during 2017-2018

**Objective 3.3:** By December 2019, at least two QI projects will have been proposed by LCPH staff who do not serve on the PMQI Council.
*Measure*: # of QI project proposals submitted by non-PMQI Council staff.

**Objective 3.4:** By December 2019, at least two new staff will be appointed members of the PMQI Council and replace outgoing members.
*Measure*: # of new members appointed to the PMQI Council before January 1, 2020.

**Goal 4: Advance the culture of quality within Lane County Public Health.**

**Objective 4.1:** By December 2017, increase sharing and collaboration about QI activities with all staff by at least 20%.
*Measure*: Average staff score on the annual Quality Culture Survey in response to the statement, "There are cross-sectional forums for sharing and discussion of audit and quality outcomes." Baseline average 2.03 out of 5.0.

## Communication

Lane County Public Health will communicate about performance management and quality improvement through:
- Updates on performance measures and QI projects at section staff meetings at least quarterly
- Reports and updates to staff included in the newsletter
- Presentations to the Public Health Advisory Committee
- Progress reports to County and Health and Human Services leadership
- Updates included in annual Board of Health reports
- Copies of the PMQI plan, PMQI Council meeting minutes, and PMQI Council reports posted on the shared network drive
- Staff training sessions

## Monitoring and Evaluation

The PMQI Council will evaluate the division Performance Management System annually, including the PMQI plan. This evaluation will include an annual all-staff Quality Culture Survey

(Appendix J), formal performance management self-assessment, and review of progress toward performance management goals and objectives. Following this evaluation, the PMQI Council will review the PMQI plan and make updates and changes to the plan as needed.

## References

Graham, R. (2011). CQI In Public Health: The Fundamentals, CQI Module 1: CQI Introduction & Principles, Center for Public Health Practice, College of Public Health at the Ohio State University.  Retrieved from www.cph.osu.edu/practice.  Accessed 5/18/16.

Lichiello, P. (2010). Turning Point Guidebook for Performance Measurement. University of Washington Turning Point National Program Office. Web. <http://www.phf.org/resourcestools/Documents/PMCguidebook.pdf>. Accessed 12/23/16.

Kheraj R., Tewani S.K., Ketwaroo G, & Leffler D.A. (2012). Quality Improvement in Gastroenterology Clinical Practice.  *Clinical Gastroenterology and Hepatology 10*, 1305-1314. Retrieved from https://www.researchgate.net/figure/230697685_fig1_Figure-2-Plan-Do-Study-Act-cycle-Adapted-from-Langley-GL-Nolan-KM-Nolan-TW-et-al

Moran, J.W. and Duffy, G.L. (2012). Public Health Quality Improvement Encyclopedia.  (E.E. Reineke & M.L. Beaudry, Eds.).  Washington, D.C.: Public Health Foundation.

National Association of County & City Health Officials (2012).  Roadmap to a Culture of Quality Improvement.  Retrieved from http://qiroadmap.org/wp-content/uploads/2013/01/QIRoadmap.pdf Accessed 5/16/16.

Public Health Foundation.  *About the Performance Management System Framework.* http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/PM_Toolkit_About_the_Performance_Management_Framework.aspx. Accessed 12/20/16.

Tews, D., Heany, J., Jones, J., VanDerMoere, R., & Madamala, K. (2013). Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook. Michigan Public Health Institute.

### *Model and Inspiration for Plan Form and Content*
Jackson County Health & Human Services Performance Management and Quality Improvement Plan, 2015-2016

# Glossary of Performance Management and Quality Improvement Terms

**Affinity Diagram**
A tool used to group large amounts of ideas, issues, items, or observations into categories for further analysis. *(Public Health Quality Improvement Encyclopedia, 2012)*

**AIM Statement**
A tool used to restrict the problem statement to a discrete issue on which the improvement team will focus.  It directs team attention to the real issue so they do not lose time addressing extraneous ideas/issues.  *(Public Health Quality Improvement Encyclopedia, 2012)*

**Arrow Diagram**
A tool to diagram a sequence of events or activities and their interconnectivity; it is used for scheduling and especially for determining the critical path through activities.  *(Public Health Quality Improvement Encyclopedia, 2012)*

**Brainstorming**
A creative technique designed to generate a large number of ideas during a short period of time. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Cause and Effect Diagram** (also known as an *Ishikawa Diagram* or a ***Fishbone Diagram***)
A tool that displays multiple potential causes for a problem.  It can be used to organize the results from an Affinity Diagram and helps identify stakeholder ideas about the causes of problems.  It allows the user to immediately categorize ideas into themes for analysis or further data gathering. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Control and Influence Matrix**
A conceptual tool that provides focus for picking an improvement area.  It guides a team toward improvement areas where they have both control and influence.  By focusing on these areas, the team can quickly make an impact. *(Public Health Quality Improvement Encyclopedia, 2012)*

**5 Ss**
A tool to create workplace organization and standardization.  The five steps of this tool are to Sort, Simplify, Shine, Standardize, and Sustain. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Five Whys**
This tool is designed to explore the cause and effect relationships underlying a problem and determine the problem's root cause.  By repeatedly asking the question "why?", the team can follow a logical progression from the effect back to the original cause.  Asking the question five times is only a guideline; sometimes it requires more repetitions and sometimes it requires fewer. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Flowchart**
Flowcharts depict all of the steps in a process from start to finish; each step is depicted by a shape.  Arrows connect the shapes to show the sequence of steps.  A flowchart is made up of

three basic shapes: an oval depicts the starting and ending points, a square identifies an activity, and a diamond represents a decision point.  Advanced flowchart symbols include shapes such as a half-sheet of paper to represent a document, a half-circle to depict a delay in a process, and a hexagon to represent preparation.  *(Public Health Quality Improvement Encyclopedia, 2012)*

**Lean**
Producing the maximum sellable products or services at the lowest operational cost while optimizing inventory levels.  It focuses on reducing cycle time and waste.  *(Public Health Quality Improvement Encyclopedia, 2012)*

**Lean Wastes**
The Lean philosophy is defined as a systematic approach to identifying and eliminating waste (non-value-added activities) through continuous improvement.  Lean focuses on expending resources only for activities that the customer will value.  It can also be described as giving customers what they want, when they want it, where they want it, and in the quantity/variety that they want.  Lean Wastes are any actions that ineffectively use resources or fail to add value to either internal or external customers.  There are 8 Lean Wastes: overproduction, waiting, unnecessary motion, transportation handling, over-processing, unnecessary inventory, defects, and intellect.  *(Public Health Quality Improvement Encyclopedia, 2012)*

**Modernization**
The 2013 Oregon Legislature passed a bill to "modernize" the governmental public health system.  Every health department in the state will be required to provide at least a core set of services, called "foundational programs," in topic- and disease-specific work.  They will also require departments to have staff with certain knowledge, skills, and abilities – "foundational capabilities" – to implement the services. The 2016 Public Health Modernization Manual provides a conceptual framework, roadmap, and detailed description of these efforts.

**PDSA Cycle**
The Plan-Do-Study-Act (PDSA) Cycle is W. Edwards Deming's version of a four-step model for creating and implementing change.  It is an iterative process that is repeated for continuous improvement.  Deming stressed emphasis on studying the effect of change before full implementation.  *(Public Health Quality Improvement Encyclopedia, 2012)*

**Performance Management:**
The use of performance measurement information to help set agreed-upon performance goals, allocate and prioritize resources, inform managers to either confirm or change current policy or program directions to meet those goals, and report on the success in meeting those goals.  *(Turning Point Guidebook for Performance Management, 2010)*

**Performance Measures:**
The specific, quantitative representations of a capacity, process, or outcome deemed relevant to assessing performance  *(Turning Point Guidebook for Performance Management, 2010)*

**Performance Standards:**
Generally accepted, objective standards of measurement such as rules or guidelines against which an organization's level of performance can be compared.  *(Turning Point Guidebook for Performance Management, 2010)*

**Quality Improvement**
In Public Health, the use of a deliberate and defined improvement process, such as Plan-Do-Study-Act, which focuses 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. *(Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook, 2013)*

**Radar Chart**
A tool used to display a baseline picture of a problem or issue on a defined measurement criteria. It identifies both the current state and the future state of team abilities by showing improvement goals and performance gaps on the same diagram. This tool identifies areas that need improvement and areas of excellence that should be replicated and leveraged. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Reliability**
The probability of a product or process performing its intended function under stated conditions without failure for a given period of time. Reliability is most improved through variation reduction. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Root Cause**
The true underlying reason that resultsin a non-conformance. Only when the root cause is corrected will the recurrence of the same or similar non-conformance be prevented. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Swimlane Process Map**
This is a Flowchart organized according to the individual performing each step. The term "swimlane" comes from the visual representation of tasks residing in individual lanes. This tool can be created with horizontal swim lanes, as shown in the example, or vertical swim lanes (not displayed here). *(Public Health Quality Improvement Encyclopedia, 2012)*

**SWOT analysis**
This analysis provides a systematic assessment of an organization's internal and external environment; it identifies elements that affect the organization's ability to achieve its vision. The letters S, W, O, and T stand for Strengths, Weaknesses, Opportunities, and Threats. Strengths are the internal characteristics of the organization that allow it to meet customer needs. Weaknesses are internal challenges that detract from the ability of the organization to perform effectively. Opportunities are external events that the organization can take advantage of to become a leader in the field. Threats are external events that may negatively impact the organization's ability to perform effectively. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Storyboard**
A technique used to display the thoughts and ideas of a group in some logical grouping or sequence. It may also be used to communicate the activities of a team as it progresses toward an improvement. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Waste**
Any activity that consumes resources and produces no value added to the product or service a customer receives. *(Public Health Quality Improvement Encyclopedia, 2012)*

**Modernization of Oregon Public Health System**
**Lane County Public Health Assessment Findings**

**Responding To:**
- Limited State Funding
- Dependence on Federal Categorical Grants
- Health Care Transformation
- Changing PH Practice
- Emerging and Changing Community Health Issues
- Variations in Local Investments resulting in inconsistencies in LHD service and activities

### *Key Components of Oregon's Modernization Process*
- Legislative adoption of Framework for Oregon Public Health Services as recommended by the 2014 Task Force on the Future of Oregon's PH System

- Development of Modernization Manual (Completed in 2015)
    - Collaborative state & local process - including public input
    - Manual defines State and LHD roles
    - Defines deliverables and tools needed for implementation of Oregon PH Modernization model
    - Linked to PH accreditation standards
    - Will be made official thru OAR after legislative review

- PH System Assessment
    - Completed by all LHDs and the State in early 2016
    - Assess degree of current implementation at state and local health departments
    - Document current spending
    - Identify additional resources needed to fully implement foundational capabilities and programs

- Creation of new State Advisory Committee (PHAB - State PH Advisory Board)

- Development of Funding and Metrics Structure (function of the State PH Advisory Board)

- Implementation plans for all LHDs implemented by 2023

## Statewide Financial Findings of the 2016 Assessment
- Cost of Full Implementation $105M (annually)
- Approximate needs = 25% State and 75% Local
- Foundational Programs Represent 2/3 of Total Costs
- Three Capabilities Would Require Doubling Current Spending
  - Communication
  - Health Equity and Cultural Responsiveness
  - Policy and Planning

## Statewide Programmatic Findings of the 2016 Assessment

- Meaningful gaps across system in all Capabilities and Programs
- Gaps are not uniform across the system
- Significant interdependencies between state and local many capabilities and programs support each other resources may be needed in one to fully implement another
- Implementation should be undertaken in a phased approach
- Shared resources approaches need further development

## Development of Modernization Funding Structures

- Funding Structure Includes Three Components
  - Base Funding Metrics
    - County population
    - Burden of disease
    - Health status
    - Racial/ethnic diversity
    - Population impacted by poverty
  - LPH investments
    - Need to develop a uniform methodology for calculations
  - LPH incentives
    - Based on achievement of accountability metrics

## Development of Modernization Metrics Structures

- Metrics Framework Under Development
  - Possible required components
    - Promotes health equity
    - Respectful of local health priorities
    - Transformative potential
    - Consistent with state and national metrics

- Feasibility of measurement
- Metrics Framework Modeled off  Work with OHA/CCO's

## **PHAB (Advisory) Recommended Funding Priorities for 2017-2019**

- Foundational Programs:
  - Communicable Disease
  - Environmental Health
- Foundational Capabilities:
  - Emergency Preparedness
  - Health Equity
  - Assessment & Epidemiology (Population Health Data)
  - Leadership & Organizational Competencies (Ongoing Modernization Planning)

## Ongoing Work In Progress

### Modernization Funding Formula
Draft models include the following variables:
- Population size
- Disease burden
- Health status
- Racial & Ethnic diversity
- Poverty
- Limited English Proficiency
  - Draft formula also includes matching funds for local investment and a quality pool

### Accountability Metrics
HB 3100 requires the use of "incentives" to encourage effective provision of PH services
PHAB (advisory) recommends that - to the extent feasible - the final quality measures will align with:
- Statewide PH initiatives (SHIP)
- National PH initiatives (CDC Winnable Battles)
- Oregon Health Transformation (CCO's)
- Oregon Early Learning (EL Hubs)

# 2016 Oregon PH Modernization Assessment
## Percentage of current capacity vs "modernized" capacity

|  | FTE% | FUNDING % |
|---|---|---|
| **LANE COUNTY OVERALL** | **40.90%** | **38.19%** |
| *Lane Co. Foundational Programs* | *28 %* | *28.72%* |

| **Communicable Disease** | **21.36 %** | **21.89 %** |
|---|---|---|
|  | Capacity | Expertise |
| CD Surveillance | 4/10 | 8/10 |
| CD Investigation | 5/10 | 9/10 |
| CD Intervention & Control | 3/10 | 8/10 |
| CD Response Evaluation | 2/10 | 8/10 |
| **CD Overall** | **3/10** | **8/10** |

| **Environmental Health** | **41.18 %** | **40.32 %** |
|---|---|---|
|  | Capacity | Expertise |
| Identify & Prevent EH Hazards | 3/10 | 7/10 |
| Conduct Mandated Inspections | 9/10 | 10/10 |
| Promote Land Use Planning | 3/10 | 5/10 |
| **EH Overall** | **6/10** | **8/10** |

| **Prevention & Health Promotion** | **30.23 %** | **34.03 %** |
|---|---|---|
|  | Capacity | Expertise |
| Prevention of Tobacco Use | 3/10 | 9/10 |
| Improving Nutrition & Increasing Physical Activity | 3/10 | 9/10 |
| Improving Oral Health | 2/10 | 6/10 |
| Improving Maternal & Child Health | 7/10 | 9/10 |
| Reducing Accident Rates | 3/10 | 9/10 |
| **Prev & Health Promotion Overall** | **4/10** | **8/10** |

| **Clinical Prevention Services** | **15.64%** | **14.34 %** |
|---|---|---|
|  | Capacity | Expertise |
| Access to Vaccination Services | 5/10 | 8/10 |
| Access to Preventable Disease Screening | 4/10 | 6/10 |
| Access to STI Screening | 7/10 | 10/10 |
| Access to TB Treatment | 7/10 | 10/10 |
| Access to Clinical Care | 5/10 | 9/10 |
| **Clinical Prevention Serv Overall** | **5/10** | **8/10** |

|  | FTE % | FUNDING % |
|---|---|---|
| *Lane Co. Foundational Capabilities* | *57.75 %* | *48.50 %* |

### Assessment & Epidemiology — 55.51% / 45.28 %

|  | Capacity | Expertise |
|---|---|---|
| Data Collection & Electronic Information Services | 4/10 | 8/10 |
| Data Access Analysis & Use | 4/10 | 9/10 |
| Respond to Data Requests & Translate Data | 4/10 | 8/10 |
| Conduct / Use Comm & State Health Assessments | 8/10 | 10/10 |
| Infectious Disease-Related Assessment | 5/10 | 9/10 |
| **Assessment & Epidemiology Overall** | **4/10** | **9/10** |

### Emergency Preparedness & Response — 56.58 % / 56.81 %

|  | Capacity | Expertise |
|---|---|---|
| Prepare For Emergencies | 4/10 | 9/10 |
| Respond To Emergencies | 5/10 | 8/10 |
| Coord/Communicate Before/During Emergencies | 6/10 | 8/10 |
| **Emergency Prep & Response Overall** | **4/10** | **8/10** |

### Communications — 57.33 % / 34.49 %

|  | Capacity | Expertise |
|---|---|---|
| Regular Communication | 3/10 | 8/10 |
| Emergency Communication | 7/10 | 8/10 |
| Educational Communication | 5/10 | 9/10 |
| **Communications Overall** | **4/10** | **8/10** |

### Policy & Planning — 74.21 % / 73.86 %

|  | Capacity | Expertise |
|---|---|---|
| Develop & Implement Policy | 6/10 | 9/10 |
| Improve Policy with Evidence-Based Practice | 6/10 | 9/10 |
| Understand Policy Results | 5/10 | 8/10 |
| **Policy & Planning Overall** | **6/10** | **10/10** |

### Health Equity & Cultural Responsiveness — 36.50 % / 36.50 %

|  | Capacity | Expertise |
|---|---|---|
| Foster Health Equity | 4/10 | 8/10 |
| Communicate & Engage Inclusivity | 5/10 | 9/10 |
| **Equity & Cultural Responsiveness Overall** | **4/10** | **8/10** |

### Community Partnership Development — 81.56 % / 81.65 %

|  | Capacity | Expertise |
|---|---|---|
| Identify & Develop Partnerships | 3/10 | 9/10 |
| Engage Partners in Policy | 3/10 | 7/10 |
| **Community Partnership Dev Overall** | **3/10** | **8/10** |

|  | FTE % | FUNDING % |
|---|---|---|
| **Lane Co. Leadership & Org Competencies** | **45.57%** | **48.12%** |

|  | Capacity | Expertise |
|---|---|---|
| Leadership & Governance | 6/10 | 8/10 |
| Performance Mgmt / QI / Accountability | 2/10 | 4/10 |
| Human Resources | 4/10 | 4/10 |
| Information Technology | 2/10 | 3/10 |
| Financial Mgmt / Contracts / Procurement / Facility | 7/10 | 9/10 |
| **Leadership & Org Overall** | **4/10** | **6/10** |

---

## LANE CO. PH FUNDING ASSESSMENT          38.19%

**Current Annual PH Funding (per 2016 assessment) = $6.13 m**

**61.81% assessment-identified gap       = $9.93 m**

**Total Funding Needed for Full Modernization = $16.06 m**


Foundational programs ~ approx. **60%** of total LCPH gap = **$5,951,000**
- CD
- EH

Foundational capabilities ~ approx. **33%** of total LCPH gap = **$3,291,000**
- Preparedness
- Population data

Leadership and Competencies ~ approx. **7%** of total LCPH gap = **$684,000**
- Health Equity
- Modernization Planning, Admin/Mgmt

# Lane County Public Health Division
# Performance Management & Quality Improvement Council

| TITLE | Performance Management and Quality Improvement Council Charter |
|---|---|
| **CHARTER DATE** | Authorizing Charter Date:  _____December 2015_<br>Charter Revision Date:  _____June 2016_____<br>Charter Revision Date:  _____ |
| **TIMELINE** | This is a standing/ongoing committee. The Charter will be reviewed and confirmed at least annually by the Council members. |
| **MEETING FREQUENCY** | The committee will meet for 90 minutes on the 3<sup>rd</sup> Monday of each month.  Ad hoc work groups will meet as needed. |
| **SPONSORS** | Lane County Public Health Administration and all Public Health Sections |
| **PURPOSE** | To develop a fully functioning performance management system for Lane County Public Health that meets all PHAB requirements and is completely integrated into daily practice at all levels.  Including:<br>1.) Setting organizational objectives across all levels of the Public Health Division in alignment with the Community Health Assessment and Community Health Improvement Plan;<br>2.) Identifying indicators to measure progress toward achieving objectives on a regular basis in alignment with the Community Health Assessment and Community Health Improvement Plan;<br>3.) Identifying responsibility for monitoring progress and reporting;<br>4.) Identifying areas where achieving objectives requires focused quality improvement processes;<br>5.) Developing and implementing a quality improvement plan and improvement processes;<br>6.) Providing visible leadership for ongoing performance management; and<br>7.) Applying an equity lens in all quality improvement efforts to help all Sections of Public Health ensure that interventions are focused on improving health equity in Lane County. |
| **ROLES & RESPONSIBILITIES** | • **Chairperson/facilitator:** generates agenda with committee members, facilitates meeting discussion and ensures tasks are assigned<br>• **Minutes taker:** The Administrative Assistant for the Public Health Division is responsible for taking minutes.<br>• **All Council Members:** participate in developing meeting agendas, actively participate in each of the 7 committee purpose areas |
| **OPERATING PRINCIPLES** | The Council will operate using the following principles:<br><br>• It will ground its work on fostering a culture of continuous quality improvement (CQI) and promoting the use of QI methods and tools.<br>• Its decisions will be data-driven and evidence-based, but it will also use and respect people's knowledge and experience.<br>• It will make the internal and external customer perspective central to its decision-making and strive to consistently meet or exceed customer |

| | |
|---|---|
| | expectations. |
| | • Its processes will be transparent, collaborative and inclusive. |
| | • It will foster engagement and accountability with all persons involved in the CQI effort. |
| | • It will focus on learning and improvement rather than judgment and blame, and value prevention and problem solving over correction. |
| **TEAM NORMS** | All members adhere to the following established team norms/ground rules: <br><br> • Behave with compassion and forgiveness for one another. <br><br> • To ensure that differences produce more creative decisions, we will focus on issues, not on personalities. <br><br> • We will have equal opportunity to participate, and accept equal responsibility for the success of the meetings. <br><br> • Assume the best intentions of others. If you find yourself making an assumption about someone's position, share it and ask if it is right. <br><br> • Be a good listener as well as an effective advocate. <br><br> • If the agenda or facilitation is not working, speak up and say so. |
| **DECISION PATH & AUTHORITY** | The committee will operate with the participation and guidance of the Public Health Manager and the Public Health Leadership team. The Chair will be the point of contact for the committee. <br><br> We will use consensus – agreement of everyone – to make decisions. <br><br> The committee will utilize the 'thumbs' model: thumbs up=support, thumbs to the center=okay, will not block, thumbs down=cannot support <br><br> If you cannot support the emerging consensus of the group, you are obligated to offer an alternative that you believe the others can support. Or you can inform the group that you can't live with the emerging consensus, and ask that everyone help develop another option that all support. |
| **MEMBERSHIP** | a. A minimum of two staff from outside leadership and Administration <br> b. All members of the Public Health Leadership team <br> c. The Public Health Division's Performance Improvement Lead |
| **MEMBER ACCOUNTABILITY** | Each committee member is responsible for fully and actively participating on the Council in order to achieve the goals as described in this Charter—accepting his/her responsibilities diligently and carrying his/her share of the work. <br><br> • The members should act as a liaison to their Sections, providing regular updates regarding the Council's work at team meetings, seeking their reactions, and building support for committee decisions as appropriate to their position within their teams. <br> • The members are responsible for reviewing minutes, coming prepared to meetings, and carrying out assigned tasks. |

| | |
|---|---|
| **SELECTION PROCESS** | The Public Health Manager will assure appropriate staffing of the committee and fill vacancies as they occur. The committee may recruit additional members for ad hoc work groups based on the skill set needed to complete the work. |
| **TERMS** | Members of the Public Health Division's Leadership Team and the Performance Improvement Lead are permanent members of the Council.  Other staff participating on this Council commit to 2-year terms. A roster of current and past members will be maintained by the minutes-taker. |
| **MONITORING EFFECTIVENESS** | The Council will complete the Public Health Foundation's "Public Health Performance Management Self-Assessment Tool" each July to assess progress in developing organizational support for continual performance improvement. |

**Lane County Public Health**
**Performance Management and Quality Improvement (PMQI) Council**
**2017 Roster of Members**

**Nick Alviani**, Environmental Health Specialist 1
Staff representative, term ending January 2018

**C.A. Baskerville**, Prevention Supervisor
Leadership Team

**Elizabeth Edwards**, WIC Certifier
Staff representative, term ending February 2019

**Brian Johnson**, Epidemiologist/ Supervisor
Leadership Team

**Jeff Lang**, Environmental Health Supervisor
Leadership Team

**Pat Luedtke**, Health Officer
Leadership Team

**Cindy Morgan**, Communicable Disease Nursing Supervisor
Leadership Team

**Kalle Pierce**, Administrative Assistant
*Minutes Taker*

**Amber Roche**, Senior Administrative Analyst
Accreditation Coordinator

**Jill Rodolf**, Maternal and Child Health Community Health Nurse 2
Staff representative, term ending October 2018

**Connie Sullivan**, WIC Supervisor
Leadership Team

**Jocelyn Warren**, Public Health Manager
Leadership Team

**Chelsea Whitney**, Maternal and Child Health Nursing Supervisor
Leadership Team
*Council Chair*

# Appendix E

## Performance Measure Proposal Form *(updated Dec 2016)*

For each section-proposed performance measure, complete the below table and line-of-sight sheet indicating alignment with an LCPH Division-wide performance measure.  The gray-filled first row is an example template.

| # | Which Division Measure Line of Sight? | Performance Measure | Baseline | Target | Data Source | Which staff member responsible for updateing? |
|---|---|---|---|---|---|---|
| *Sample* | *Tobacco: connection to referrals* | *Percentage of NFP parents who reported using tobacco at enrollment AND who were referred to tobacco cessation counseling services with three months of program enrollment.* | *Measure changed October 1st, 2016; first quarter data report available January, 2017* | *85%* | *MIECHV Quarterly Reports* | *Chelsea* |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

Line of Sight (complete one for each proposed measure):

Measure #:_____

**Individual or Team Measure (if applicable):**



## So That ↓

**Section Level:**



## So That ↓

**Division Measure:**



## So That ↓

**Community Health Outcome/CHIP Measure:**

# Lane County Public Health
## 2017-2018 Performance Measures

| **Community/Department Goal:** Reduce the rate of youth and adult smoking in Lane County | | | | | | |
|---|---|---|---|---|---|---|
| **Division Objective 1:** Implement a brief tobacco intervention during in-person interactions with LCPH clients who use tobacco | | | | | | |
| **Program** | **Measure** | **Baseline** | **Target** | **Data Source** | **Update Frequency** | **Responsible Staff** |
| PH Division | 1A. Percentage of MCH and CD direct service clients who are screened for tobacco use | TBD, to be calculated with Jan 1-Dec 31 2016 data. | Assure 90% of MCH & CD clients are screened for tobacco use | NextGen, MIECHV Quarterly Reports, CD charts (STD & TB clients | Twice per year | Chelsea Whitney, Cindy Morgan |
| Communicable Disease | 1A-CD. Develop and implement a system to track tobacco use and cessation referrals amongst CD STD & TB clients | No tracking system | Tracking system for CD clients established by July 1, 2017 | STD & TB charts | Quarterly | Cindy Morgan |
| WIC | 1A-WIC.  Percentage of pregnant WIC clients referred to QTIP who participated in smoking cessation interventions | 50% | Increase enrollment by 2% | QTIP records | Quarterly | Janet Winter |
| WIC | 1B-WIC.  Percentage of pregnant WIC clients enrolled in QTIP who maintained quit status through their prenatal QTIP visits | 30% | Assure maintenance of 30% | QTIP records | Quarterly | Janet Winter |
| MCH | 1A-MCH. Percentage of NFP parents who reported using tobacco at enrollment AND who were referred to tobacco cessation counseling services with three months or program enrollment | Measure changed on Oct 1, 2016 – first quarter data report available Jan 2017 | 75% | MIECHV Quarterly Reports | Quarterly | Chelsea Whitney |
| MCH | 1B-MCH. Percentage of | 63% | Increase by 2% | Nightingale Notes | Twice per | Chelsea |

| | MCM/NFP pregnancy clients who received the 5As/2As&R Smoking Cessation Intervention during pregnancy | | per year to level of assuring 90% of clients receive intervention | chart audit (baseline); NextGen reports ongoing | Year | Whitney |

| **Community/Department Goal:** Reduce the rate of youth and adult smoking in Lane County |
| **Division Objective 2:** Assure tobacco retail licensing |

| Program | Measure | Baseline | Target | Data Source | Update Frequency | Responsible Staff |
|---|---|---|---|---|---|---|
| PH Division | 2A. Percentage of tobacco retail facilities in Lane County covered by a licensing law that aligns with the County tobacco retail license law | 24.6% | Increase by 2% per biennium | Prevention records | Twice per year | Christy Inskip |
| Prevention | 2A-Prev. Written procedures created by Dec 31, 2018 to address retailer non-compliance | 0 Corrective action procedures for any of the 10 requirements for Lane County licenses | 10 Corrective action procedures written, one for each license requirement | EH and Prevention procedure guides | Twice per year | Christy Inskip |
| Environmental Health | 2A-EH. Number of retailers licensed and inspections completed per year | 57 licensed retail facilities | 1 inspection of each retailer per year (57) | EH inspection records | Twice per year | Annette Brinton-Krecklow |
| Environmental Health | 2B-EH. Written procedures created by Dec 31, 2018 to address retailer non-compliance | 0 Corrective action procedures for any of the 10 requirements for Lane County licenses | 10 Corrective action procedures written, one for each license requirement | EH and Prevention procedure guides | Twice per year | Nick Alviani |

Updated June 26, 2017

| | | | | | | Update | Responsible |
|---|---|---|---|---|---|---|---|

**Community/Department Goal:** Reduce health disparities in Lane County

**Division Objective 3:** Lane County Public Health will adopt and implement the CLAS standards so that LCPH provides "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."

| Program | Measure | Baseline | Target | Data Source | Update Frequency | Responsible Staff |
|---|---|---|---|---|---|---|
| PH Division | 3A. Percentage of print and multimedia materials utilized by LCPH that are available in English and Spanish. Addresses CLAS Standard #8 | TBD | Increase by 2% per biennium to assure 90% of print and multimedia materials are available in Spanish. | Survey of LCPH print and online materials: administrative and legal documents; clinical information; education, health prevention and promotion, and outreach materials; and, building signage and wayfaring information. | Annually | Jocelyn Warren |

Updated June 26, 2017

| | | | | | Update | Responsible |
|---|---|---|---|---|---|---|

**Community/Department Goal:** Help children and families heal from adverse or traumatic events and work to prevent cycles of trauma in our communities

**Division Objective 4:** Lane County Public Health will work to become a trauma informed care organization.

| Program | Measure | Baseline | Target | Data Source | Update Frequency | Responsible Staff |
|---|---|---|---|---|---|---|
| PH Division | 4A. Percentage of LCPH Staff who have received training in Trauma Informed Care | Obtain from LEAP training records | Assure 90% of LCPH staff have completed introductory TIC training. | LEAP Training Records | Annually | Amber Roche |
| PH Division | 4B. LCPH Will complete the standards of practice for Trauma Informed Care Survey once by December 31st, 2019 | Not yet begun | 1 completed survey | Admin records for Public Health | Annually | Jocelyn Warren |
| MCH | 4A-MCH. Percentage of MCH clients (BF!, CC, MCM, NFP) who have received a NEAR focused home visit within 6 months of enrollment | 5% | Increase by 2% per year to assure 75% rate of completion | Nightingale Notes Chart Audits (baseline); NextGen reports ongoing | Quarterly | Chelsea Whitney |
| MCH | 4B-MCH. Percentage of NFP primary caregivers who receive an observation of caregiver-child interaction by the NFP RN using a validated tool (DANCE). | Measure changed October 1st, 2016; first quarter data report available January, 2017 | 85% | MIECHV Quarterly Reports | Quarterly | Chelsea Whitney |

Updated June 26, 2017

| | | | | | Update | Responsible |
|---|---|---|---|---|---|---|
| **Program** | **Measure** | **Baseline** | **Target** | **Data Source** | **Frequency** | **Staff** |

**Community/Department Goal:** Help children and families heal from adverse or traumatic events and work to prevent cycles of trauma in our communities

**Division Objective 5:** Lane County Public Health will promote and increase opportunities for staff to be become better informed and aware of risks for suicide.

| **Program** | **Measure** | **Baseline** | **Target** | **Data Source** | **Update Frequency** | **Responsible Staff** |
|---|---|---|---|---|---|---|
| PH Division | 5A. Percentage of LCPH staff who have received training in suicide awareness by December 31st, 2017. | Unknown | Assure 90% of LCPH staff have completed suicide awareness training. | LEAP Training Records | Annually | Amber Roche |
| Prevention | 5A-Prev. Training created for Public Health staff about awareness of suicide risks. | No training for suicide awareness that is specific to the needs of Public Health staff | New training created by 6/30/2017 | Sandy Moses | Quarterly | Sandy Moses |

Updated June 26, 2017

| **Community/Department Goal:** Reduce the rate of food insecurity and improve the nutrition of people in Lane County | | | | | | |
|---|---|---|---|---|---|---|
| **Division Objective 6:** Implement the "Screen and Intervene" questionnaire during in-person interactions with LCPH clients, and provide food resource information to all clients who screen positive. | | | | | | |
| **Program** | **Measure** | **Baseline** | **Target** | **Data Source** | **Update Frequency** | **Responsible Staff** |
| PH Division | 6A. Percentage of MCH and TB clients who are screened for food resources | TBD, to be calculated with Jan 1-Dec 31 2016 data. | Assure 50% of LCPH clients are screened for food insecurity. | NextGen, MIECHV Quarterly Reports, and TB charts | Twice per year | Kevin Burns; Cindy Morgan |
| Communicable Disease | 6A-CD.  Percentage of TB clients who are screened for food resources | TBD | Assure 50% of TB clients are screened for food insecurity. | CD TB charts | Twice per year | Cindy Morgan |
| MCH | 6A-MCH. MCH-A Percentage of MCH clients (BF!, CC, MCM, NFP) who have been screened for food insecurity using the screen and intervene tool within 3 months of program enrollment | Implemented January 2017. Baseline to be assessed by July 1, 2017 | Increase by 2% per year to level of assuring 90% of clients receive intervention | Nightingale Notes Chart Audits (baseline); NextGen Reports Ongoing | Twice per year | Kevin Burns |

| **Community/Department Goal:** Improve the performance of the local public health system in delivering the 10 Essential Public Health services (CHIP objective) | | | | | | |
|---|---|---|---|---|---|---|
| **Division Objective 7:** Improve the quality of community partnerships | | | | | | |
| **Program** | **Measure** | **Baseline** | **Target** | **Data Source** | **Update Frequency** | **Responsible Staff** |
| PH Admin | 7A. Essential Public Health Services (EPHS) and Model Standards scores | 50.3% (2015) overall; 55.5% #4 Mobilizing Community Partnerships | 57.3% (average score); 65.5% #4 | National Public Health Performance Standards Program: Local Public Health Systems Assessment | Every 3 years | Jocelyn Warren |

Updated June 26, 2017

| Community/Department Goal: Improve the performance of the local public health system in delivering the 10 Essential Public Health services (CHIP objective) | | | | | | |
|---|---|---|---|---|---|---|
| Division Objective 8: Improve customer satisfaction with Public Health Services | | | | | | |
| Program | Measure | Baseline | Target | Data Source | Update Frequency | Responsible Staff |
| PH Admin | 8A. Customer satisfaction with service from Lane County Vital Records, on scale of 1 to 10. | Need to establish | TBD | Vital Records survey | Every 2 years | Jocelyn Warren |

Updated June 26, 2017
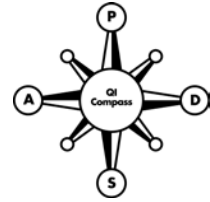
**LCPH QI Project Proposal Form:** *(updated June 2017)*


Who Submitting (Name, email, phone extension):

Section(s) Involved:

- ☐ PH Admin
- ☐ MCH
- ☐ WIC
- ☐ EH
- ☐ CD
- ☐ Prevention
- ☐ Other H&HS Divisions/Programs: _____
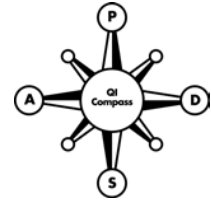- ☐ Other Outside Agencies: _____


What is the problem?:



What do you want to accomplish?



Who do you think needs to be involved in finding a solution?:



Have you tried finding a solution in the past? If so what did you try?



Email completed form to: 1. Your Section PMQI rep 2. Chelsea Whitney 3. Amber Roche
You will hear next steps from Chelsea or Amber within 10 days

# Lane County Public Health Continuous Quality Improvement Report Template
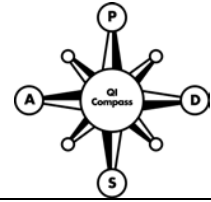
**Date:**
**Author:**

**1 - Team**  (See more detailed guidance for each section at the end of the document)

| | | |
|---|---|---|
| **1.1** | Team Members | |
| **1.2** | Team Meeting Frequency | |
| **1.3** | Was a Member of PMQI a liaison to this project? | |
| **1.4** | Scope of this project? Section, Multi-Section, Division, etc. | |

**2 - Plan**

| | | |
|---|---|---|
| **2.1** | Focus Area of This QI Initiative | |
| **2.2** | How was Focus Area Above chosen? | |
| **2.3** | Problem Statement | |
| **2.4** | Current Process | |
| **2.5.1** | Root causes | |
| **2.5.2** | Process of deciding Root Causes | |

| | | |
|---|---|---|
| **2.6** | Solution to test, test steps, data to collect | |
| **2.7** | Aim statement | |
| **2.8** | Success measures (SMART) | |

## 3 - Do

| | | |
|---|---|---|
| **3.1** | Describe the specific actions taken to implement the solution: | |
| **3.2** | Key Dates | |

## 4 - Study

| | | |
|---|---|---|
| **4.1** | Describe the results or outcomes of the action taken | |
| **4.2** | Key Dates | |

## 5 - Act

| | | |
|---|---|---|
| **5.1** | Describe the plan to build on your learning, e.g. plan for further changes: | |
| **5.2** | Key Dates | |
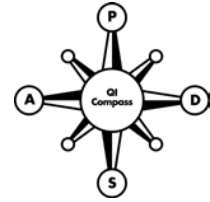
**6 - Support**

**7 - Attachments**

**Continuous Quality Improvement (CQI) Report Template Guidance**

<u>Team</u>
**1.1** List the members of your CQI team.

**1.2** Identify how often the CQI team is meeting. In example, do you meet weekly, monthly or as needed?
**1.3** List if there was a liaison providing support or consultation from the Public Health Performance Management and Quality Improvement Council to this project?
**1.4** Is this a project focused on one section, multiple sections, division wide or other scope? If beyond one section a liaison to PMQI and cross section team members should be identified in 3.1.1 and 3.1.3 (scope of project may change as root causes/possible solutions are identified—if so indicate revisions and date to scope/team members).

<u>Plan</u>
**2.1** What is the initial focus area of the CQI project? Broadly, what are you trying to address?
**2.2** How did you decide on the focus area in 2.1? Data reviewed, staff discussions, consultation with PMQI council, etc.?
**2.3** Provide a statement that identifies the current understanding about the problem. It should be concise yet describe the current state that adversely affects the organization. Include baseline data about the current state and specify project goals.

**2.4** Briefly describe the process that is currently used and attach a process map as applicable.

**2.5.1** Identify one to three true underlying reasons that contribute to non-conformance.
**2.5.2** Identify the process used to determine root causes and as applicable and attach a document that demonstrates a root-cause analysis process (for example, fishbone diagram). See the Public Health Quality Improvement Encyclopedia for assistance in selecting processes to use.

**2.6** Describe the solution you will test, the steps the team will take to test it, and the team member responsible for each step. Include what data you will collect.

**2.7** In broad terms, describe what you are working to achieve through your solution to test.

**2.8** Using SMART objectives, identify how you will know if you succeeded.
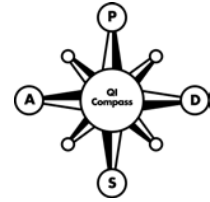
## DO
 **3.1** Identify and list each specific action taken to test each solution.
**3.2**  Assign a date to each specific action.


## Study

**4.1** Describe the results and/or findings of the actions you took.  Compare data to predictions – any surprises?
**4.2**  Assign a date to each specific action.

## Act

**5.1** Outline how you intend to incorporate your learning into improvements in your processes and additional opportunities for CQI.
**5.2** Assign a date to each specific action.

## Support Needed
What support do you need from the PMQI council, other staff in Public Health/H&HS, and/or OHA?

## Attachments
List any accompanying relevant documents such as meeting notes, flow charts of processes, etc.

# PMQI Trainings

**CQI in Public Health, the Fundamentals**
Center for Public Health Practice, College of Public Health at the Ohio State University
https://osupublichealth.catalog.instructure.com/courses/phqi-0001

**Module 1: required for all staff**
**Modules 2-3: required for PMQI Council**

Module 1: CQI Intro & Principles
Define quality improvement
Identify the benefits of CQI
Identify key CQI concepts and principles
Distinguish a quality culture
Recognize that change is essential to improvement

Module 2: CQI Training Problem-solving/ PDSA Tools & Case Study
Identify problem-solving strategies
Explain the CQI process
Identify the current and desired states
Recognize the basic tools of CQI and how they are applied

Module 3: CQI Training: Project Selection & Successful Teams
Be able to select a QI project
Define a CQI mission statement
Define CQI team composition
Identify team success factors
Recognize the team development process

**Embracing Quality In Public Health: Performance Management Primer**
Michigan Public Health Institute Office of Accreditation and Quality Improvement
https://www.mphiaccredandqi.org/PMQITraining/Login.aspx

**Required for all staff**

Define performance management
Reasons for performance management
Turning Point Public Health Performance Management System
- Identify and use performance standards
- Create performance measures
- Develop an ongoing process and timeline for reporting progress
- Use a quality improvement process to respond to identified needs
Performance Management Example
Getting started with performance management
Quality Improvement Primer
- Plan-Do-Study-Act Cycle

**Quality Improvement 101: The Fundamentals of Real Change**
National Institute for Children's Health Quality (NICHQ)
http://www.nichq.org/QI_101/story.html

**Optional**

Model For Improvement (MFI) framework
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?
- Use the Plan-Do-Study-Act cycle to test changes

Course Objectives:
Describe the necessary ingredients for improvement
Identify the components of an aim statement
Write an aim statement
Describe the three types of improvement measures
Describe the use of run charts in improvement
Understand the components of a run chart and the information it provides
Describe the types of changes that result in improvement
Follow the steps in a Plan-Do-Study-act cycle to test a change
Describe the key components of an implementation strategy
Describe the Breakthrough Series learning collaborative framework for spread

# Quality Culture Survey
October 28, 2016

Instructions: Quality Improvement (QI) is a management philosophy adopted by organizations to improve organizational performance. Please check the box that best indicates the extent to which you believe Lane County Public Health has implemented the activities listed, below.

**Key**:

**0** = No awareness or activity in this area
**1** = Awareness and discussion
**2** = Implementation in some programs or sections
**3** = Implementation across the Division
**4** = Implementation and ongoing evaluation across the Division

|  | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| Quality improvement is part of the Division's strategic plan. |  |  |  |  |  |
| Education on quality improvement is provided to all staff. |  |  |  |  |  |
| Quality improvement tools are used by staff. |  |  |  |  |  |
| The division manager/supervisors are supportive of quality improvement activities. |  |  |  |  |  |
| Quality is part of the routine agenda in staff meetings. |  |  |  |  |  |
| Supervisors use quality improvement tools to improve processes. |  |  |  |  |  |
| Staff is involved with quality improvement and initiatives related to the Community Health Improvement Plan (CHIP) and strategic plan. |  |  |  |  |  |
| Routine processes are in place for the collection and reporting of data (*such as counting/tracking daily work processes, # inspections/visits, # shots, # calls, etc.).* |  |  |  |  |  |
| Systems are in place for regular review of performance against standards, targets or benchmarks. |  |  |  |  |  |
| There are cross-sectional forums for sharing and discussion of audit and quality outcomes (*such as All-Staff meetings, Lunch & Learn, brainstorming sessions, Quality Improvement meetings, regular newsletter content).* |  |  |  |  |  |
| Systems of accountability (Quality Improvement Plan and Performance Management System) are in place for the implementation of quality improvement recommendations from audits, customer satisfaction surveys, data analysis, self-assessments, etc. |  |  |  |  |  |
| A variety of methods for sharing and collaboration about Quality Improvement activities (*such as QI project storyboards, visual displays of work processes, topical Lunch & Learn sessions*) are used among employees. |  |  |  |  |  |
| The sharing of information, improvements, ideas, problems and experiences is encouraged and expected. |  |  |  |  |  |
| There are appointed staff responsible for directing quality improvement/performance management activities. |  |  |  |  |  |
| There are effective systems for receiving, resolving and identifying root causes to customer problems. |  |  |  |  |  |
| Customer satisfaction is a central part of the Division's quality policies and quality system. |  |  |  |  |  |
| Employees are empowered to take appropriate corrective action on customer issues. |  |  |  |  |  |