ALABAMA DEPARTMENT OF PUBLIC HEALTH

Performance Management/Quality Improvement Plan

2022–2025

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Scott Harris, M.D., M.P.H.
STATE HEALTH OFFICER

May 15, 2022

I am pleased to present the Alabama Department of Public Health's (ADPH) plan for growing and enhancing performance management (PM) and quality improvement (QI) within the agency. In the 2019 Strategic Plan, PM and QI were core concepts in the strategic priorities of data-driven decision making and organizational adaptability. With the adoption of Results Based Accountability (RBA) in 2019, ADPH has worked to shift how program success is defined so leadership can make informed decisions to drive resource allocation.

RBA is a commonsense model for using performance measures, root causes, evidence-based practices, innovation, and a collaborative approach to impact population health more effectively. It is my belief that implementation of RBA and quality improvement will encourage public health programs to be more impactful and to make better business decisions throughout its life cycle. I encourage programs to work with the Office of Performance Management to increase their understanding and ability to implement RBA so we can start to turn curves in Alabama.

Sincerely,

Scott Harris, MD

Scott Harris, M.D., M.P.H.
State Health Officer

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Alabama Department of Public Health's Journey Through Performance Management and Quality Improvement

ADPH began their journey with formalizing Performance Management (PM) and Quality Improvement (QI) in 2015 with the establishment of the QI Council that led the development of the QI Plan, monitoring implementation of QI and PM, and providing resources to staff. Through this process, ADPH greatly strengthened the resources available to staff that included development of a QI Training Team that offered courses on a variety of QI tools, staff who were specially trained to assist with QI efforts across the department, customized coaching for teams or individuals working on a QI effort, and development and sharing of storyboards from completed projects.

In 2019, ADPH shifted the focus toward strengthening the formal implementation of PM concepts and establishing departmental measures. Through this work, the Office of PM staff realized there was limited information and guidance on how to implement the PM model selected in 2015 (Turning Point Model) outside of hiring a consultant to lead the implementation, which was not cost efficient or sustainable. ADPH began researching PM models again in 2019, and found that Results Based Accountability (RBA) had several benefits including:

- It is a common sense model.
- Responsibility is not placed on the individual employee to change health indicators.
- There are specific and ready-to-use implementation tools provided.
- There is training available online for free.
- It focuses on getting from talk to action quickly.
- It prioritizes data-driven decision making, which is important to ADPH leadership.
- It was established in the 1990s and is proven to be effective in public health efforts.

ADPH adopted RBA as the PM model and began the work of shifting to implement in early 2020. Due to Coronavirus Disease 2019 (COVID-19) and the broad activation of staff to assist with response efforts, this was delayed until 2021. In January 2021, the PM/QI Council was established and charged with guiding the development and implementation of PM and QI for the department. During the shift to RBA, the PM/QI Plan is intended to be a living document that will be enhanced as the implementation of PM develops. Feedback from staff will be incorporated as ADPH learns how to best implement this model.

Office of Performance Management

The Office of PM has staff trained specifically for the implementation of PM and QI concepts, with guidance and assistance from the PM/QI Council and QI Training Team members. These staff consult with the Council and individuals across ADPH and at varying levels to test training, tools, and guidance developed to ensure it is clear and communicates what was intended by the Council.

Funding for the Office of PM comes from the Preventive Health and Health Services Block Grant. These dollars are used to support the staff, software needs, and implementation of QI projects where funds are needed for the agency. This office assists ADPH by spearheading several major initiatives including PM, QI, Strategic Plan, State Health Improvement Plan, and State Health Assessment. This centralization of major initiatives enables ADPH to ensure these efforts functionally align with each other and are leveraged to the benefit of ADPH.

In addition to leading training, facilitating teams, coaching individuals, and providing customized assistance to programs as needed for PM and QI, the Office of PM also ensures ADPH staff are aware of ongoing and past activities.

This is accomplished through presenting at staff meetings for specialty groups (social workers, nurses, etc.), bureau staff meetings, and Central Office staff meetings where ADPH leadership convenes. The Office of PM also ensures ADPH leadership is kept abreast of ongoing developments and is equipped to share the information with the State Committee of Public Health.

Performance Management/Quality Improvement Council Structure and Roles

The PM/QI Council is tasked with overseeing the development, implementation, and maintenance of PM on a departmental scale. The purpose of the PM/QI Council is to:

- Guide development of the PM/QI Plan.
- Guide development of resources for ADPH staff.
- Monitor performance at the program level for select performance measures.
- Encourage data-driven decision making.
- Provide a platform to discuss improvement opportunities.
- Ensure there is a clear understanding of goals compared to actual performance.
- Increase transparency with external customers, partners in the communities, and within ADPH.
- Encourage staff to partner input when combined with a framework that establishes these conversations as a norm.

The Council is comprised of 10 members from across ADPH with varying degrees of experience and influence. Members must be actively attending meetings in order to maintain their place on the Council. After missing 6 meetings in a calendar year, Council members are automatically removed from the membership and replaced.

The PM/QI Council is charged with the following roles:

- Maintain the PM/QI Plan.
- Guide the development and maintenance of training, guidance, and resources for staff to use.
- Ensure leadership engagement and staff engagement in PM/QI implementation:
    - Identify and support early adopters.
    - Identify and support future adopters.
    - Identify potential QI projects.
- Establish and update the process for developing reports:
    - Develop templates for reporting.
    - Include linkage to other major departmental efforts.
- Monitor reports:
    - Review performance measure data.
    - Make recommendations to improve performance, including potential QI projects.
    - Establish and maintain standard processes for maintaining performance data.
    - Elevate PM data insights to leadership as needed for decision making.
- Meet monthly with a standard monthly meeting agenda:

- Discuss and address issues from reports.
- Send updates to ADPH administration.
- Review consistency of programs updating data.
- Discuss any new performance measures or teams.
- Discuss any process challenges with implementation of PM/QI and the effectiveness of the PM/QI Plan.
- Discuss any recommended or requested tools and training.
- Receive updates on ongoing QI activities.

Revision of Performance Management/Quality Improvement Plan in 2021 – 2023

It is anticipated that the PM/QI Council will be learning about RBA and how to best implement it for the first 2 years. This means the revision process needs to be more flexible and rapid than in past years. During this time, the PM/QI Council will release new information as it is developed by publishing addendums and tools to the PM/QI Plan via the ADPH website.

In 2023, ADPH plans to conduct a final review and shift to a long-term strategy for the revision process. The proposed process is to have the Office of PM review the plan annually to assess if the current plan aligns with the implementation efforts being led by this division. The PM/QI Council members will also review the plan to help identify any updates or clarifications needed based on what has been learned since the last update. Any suggested changes will be reviewed and approved by the PM/QI Council before release.

Performance Management Overview

Results Based Accountability Model for Performance Management

In 2019, ADPH adopted the RBA Model for PM, based on *Trying Hard Isn't Good Enough* by Mark Friedman. This model has been used for over 30 years in public health and is shown to be effective with extensive actionable guidance available for free. The transition to RBA started in 2021 with the establishment of the PM/QI Council and development of the PM/QI Plan to guide implementation and monitoring of performance measures. Core concepts that will start the development of RBA within ADPH are performance accountability and population accountability.

Performance Accountability

In RBA, performance accountability is the ongoing monitoring and review of program performance and effectiveness. The focus of performance accountability is to ensure the program is "doing the right things" and "things are being done the right way." If the program is doing a lot of activities but these activities are not contributing to the intended impact on the target population, there is a justifiable need to change so that the program can begin to have an impact.

Performance accountability focuses on services provided by a particular program, whether this is a support function of the agency or a program directly addressing a public health issue. Groups focusing on performance accountability are typically internal to ADPH and focus on the effectiveness of the services provided by ADPH This framework can also be used with vendors who are providing services on behalf of ADPH.

Because of the focus on providing meaningful services, it is important for performance accountability to include customer service data so that the collective customers' opinions can influence decision making. This should be done in a formal way but can be as simple as a 2 to 4 question survey:

1. Did we treat you well? (likert scale)
2. Did we help you with your problems? (likert scale)
3. Why did you rate us this way? (open narrative)
4. How can we do better? (open narrative)

Reference: Chapter 4 of Trying Hard is Not Good Enough
ADPH Specific Tools: Perf Acc Meeting Packet

Population Accountability

In RBA, population accountability is the ongoing monitoring and reviewing of the population well-being in a geographic area where a group of partners are working toward a collective impact. The focus is on a specific population group, their behaviors, and the collective impact on the population. The work of population accountability is done with many partners at the table and it may not have a single cause-and-effect relationship because partners can pursue very different approaches to the same problem. The importance is placed on the collective impact rather than political alignment among partners.

Reference: Chapter 3 of Trying Hard is Not Good Enough
ADPH Specific Tools: Pop Acc Meeting Packet

Implementing RBA

Program staff and other teams can begin implementation by using the five question framework to guide meeting discussion using a turn-the-curve mindset. This is currently being used for Annual Planning Teams, which are doing the work of implementing the Strategic Plan. The five questions are:

1. How are we doing?
2. What's the story behind the curve?
3. Who are the partners that have a role to play?
4. What strategies do we know that work?
5. What is our plan to turn the curve?

The five question framework is outlined in the meeting templates for performance and population accountability, along with guidance on each agenda item for facilitators.

The PM/QI Council provides resources for programs to utilize to implement RBA. This includes:

- Meeting agendas and reports based on the five question framework.
- Selecting performance measures guidance.
- Copies of *Trying Hard is Not Good Enough* are available upon request from the Office of PM.

Several resources are under development:

- Introductory RBA training.
- Performance Measure Selection training.

Departmental implementation will be accomplished through the ongoing monitoring of multi-level performance measures that will be established through a collaborative effort including program staff, bureau directors, and administration. How these will be developed is defined in the Selecting Departmental Performance Measures section.

Monitoring Implementation

The PM/QI Council conducted the first assessment of implementation using the RBA Implementation Self-Assessment for Government and Nonprofit Organizations (Appendix G of Turning Curves, An Accountability Companion Reader by Mark Friedman). This assessment was conducted on March 30, 2021, and resulted in a score of 8.5 out of 110 possible points. This is prior to developing a plan or significant work toward implementation. This assessment will be conducted annually by the PM/QI Council.

Additional information will be gleaned from training participation surveys to measure the meaningfulness and impact of the training content and identify new training content needed. The assessment results, performance data, and other knowledge gained through doing this work will be used to inform the PM/QI Council, while furthering the implementation of RBA.

Data-Driven Decision Making

The PM/QI Council will receive a plethora of information throughout implementation, including updates from units implementing RBA, performance reports, and feedback from training participants. All this information will be used together to make recommendations to ADPH Administration regarding potential QI projects, gaps in services, major barriers that hinder performance, and resource allocation. ADPH Administration will use the recommendation and related data to determine how to address the situation on a case-by-case basis. If requested, the PM/QI Council will continue to monitor the situation and provide ongoing updates to ADPH Administration.

Performance Management Training and Coaching

The Office of PM will coordinate, develop training, and provide coaching to all ADPH staff and programs upon request at no charge.

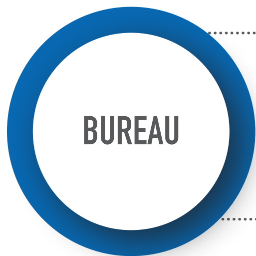
An introduction to RBA will be recorded and made available via Healthicity to all staff. This will be limited to 30 minutes and cover the main points of RBA and how to use the five question framework during a meeting. An additional training will be developed on performance measure identification and selection that will target staff with less experience defining measures. This need has been identified through QI training and informal feedback during training when discussing performance measure selection as part of goal statement development.

As teams begin using RBA, the Director of the Office of PM will provide individual and team-based coaching at the level requested. This varies from providing meeting documentation and facilitation to quick phone calls or emails. This applies to any part of the RBA process and will supply information to help identify training needs for future development.

Selecting Departmental Performance Measures

The PM/QI Council will establish a standard report to include standard performance measures for the agency to report on a routine basis. The Office of PM will coordinate this effort following the process outlined below:

- Work with each Bureau Director and program staff to determine 3 to 5 performance measures per division.
- Focus on measures related to Quality of Effort or Quality of Effect.



- Using the Division Level measures, work with the Bureau Director to identify 3 to 5 Bureau Level measurements that communicate their collective effort.
- Focus on measures related to Quality of Effort or Quality of Effect.

- Using the Bureau Level measures, identify 3 to 5 measures per leader to monitor their chain of command and communicate their impact.
- Establish a standard report for each leader to use as their "Charts on a Wall"
- Establish a health outcomes report based on the priority areas in the SHA to include in their "Charts on a Wall."

- Establish progress reporting procedures for each Bureau to use to collect new data for their Division and Bureau Level performance measures.
- Release quarterly reports shared with the PM/QI Council, Bureau Directors, and Administration.
- Release annual reports shared with the State Committee of Public Health, Administration, Bureau Directors, program staff, and general public.

Monitoring Performance Measure Data

Departmental performance measures will be reported to the PM/QI Council on a quarterly basis. This report will start in a simplified Excel template that will require minimal expertise or knowledge of RBA to complete. The template will include the following elements at a minimum:

- Health outcome(s) this work contributes to (if applicable).
- Contact information (bureau, division, name).
- Measure title.
- What question does this answer (What difference did it make? How well did we do it)?
- Calculation for this measure.
- Data source.
- Frequency new data is available (If annual, in which month is it normally released?).
- Data, including historical data, to establish a trend line.
- Target or goal.

After the initial data collection is completed, programs will be provided the template as previously completed so that new data can be added. Because health outcomes data is collected as part of the SHA process, this will be leveraged to minimize time spent on data collection. This will ensure less time is spent on reporting so that programs will be more likely to respond quickly to requests for updated data. Using this pre-filled template, data will be collected quarterly, prompting those with annual reporting frequencies during the quarter when new data should have been made available.

Once data reports have been submitted, the information will be compiled into an internal, quarterly report available to leadership and the PM/QI Council. A formal publication will be created annually with the latest data included. This formal publication will be made available on the ADPH website for programs and partners to access. A printed copy of the report will be made available to the State Committee of Public Health, ADPH leadership, and any others upon request.

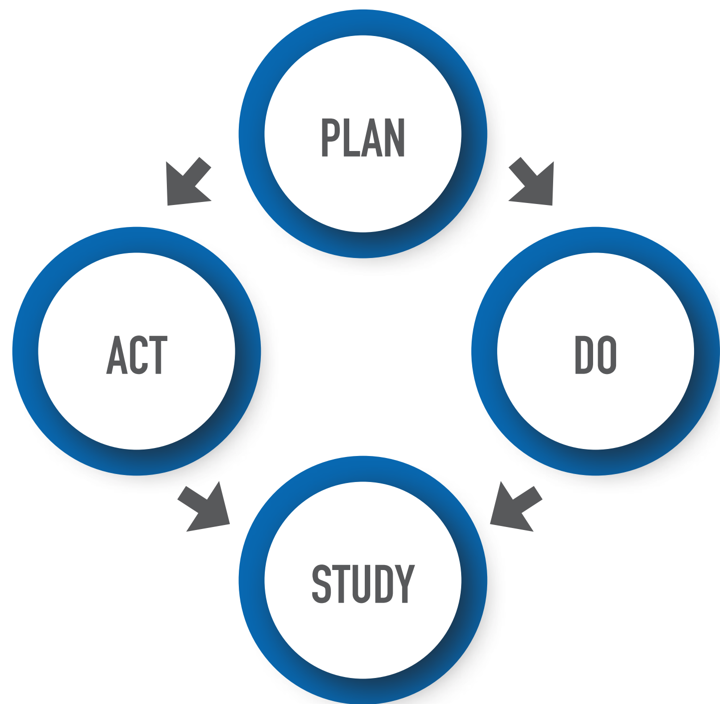
Quality Improvement Overview

PLAN, DO, STUDY, ACT MODEL FOR QUALITY IMPROVEMENT

ADPH utilizes the Plan, Do, Study, Act (PDSA) cycle for all QI initiatives. This is meant to be a continuous cycle that is utilized to mindfully assess processes and work toward improving efficiency and effectiveness.

PLAN – Gather information about the current process:

- Understand the problem.
- Identify root causes.
- Identify effective and efficient solutions.
- Set goal and measures.
- Collect information and data.
- Analyze and identify potential solutions.



DO – Pilot or test potential solutions:

- Perform tasks to test potential solutions.
- Test job aids or tools developed.
- Measure results of the pilot.

STUDY – Review and reflect on the pilot results and data:

- Identify whether goal has been reached.
- Learn why and what further actions are required.
- Analyze results and determine impact.
- Extract learning.

ACT – Effectively implement the new process or outcome for everyone:

- Create a reliable process and standardized work.
- Teach the reliable process and establish accountability for use.
- Continue monitoring performance measures.
- Provide mechanism for addressing questions and receiving ideas.
- Provide feedback and consequences for use.

Implementing Quality Improvement

While the Office of PM is tasked with guiding the implementation of QI, this is ultimately accomplished by programs and staff across ADPH through projects and ad hoc QI activities. The QI Coordinator is tasked with ensuring the plan established here is implemented, monitored, and updated with guidance from the PM/QI Council. The QI Coordinator serves as a conduit for ADPH programs to seek guidance as they navigate the QI process.

The QI Training Team serves as a resource to all divisions within the department to aid in the implementation of QI through practice. These staff are highly trained in QI and are engaged in providing training and coaching teams through QI projects. The QI Training Team report activities back to the PM/QI Council so that all known activities are monitored. The ongoing development to master new skills is provided based on the content needed by ADPH staff.

Monitoring Implementation

Implementation of QI throughout ADPH will be measured through a QI Maturity Score Survey marketed to all staff. This survey tool is based on a survey developed by Minnesota Public Health practice-based research network (PBRN). PBRN used methods to identify a select number of items from a larger QI maturity tool as a basis for calculating organizational and system level QI maturity scores. These survey questions collectively span the key domains of QI maturity which include organizational culture, capacity/competency, and alignment/spread. Scoring is measured on a scale of 1.0 to 5.0 as shown below:

CATEGORY	DESCRIPTION	SCORE
Low QI Maturity	No knowledge of QI or lack of involvement with QI	1.0-2.9
Medium QI Maturity	Informal or ad hoc QI	3.0-3.9
High QI Maturity	Formalized QI throughout the entitty	4.0-5.0

ADPH began using this survey process in 2015 with a score of 3.30 across all respondents. In 2019, the survey results showed an increase to 3.56. This increase is attributed to the increased consistency of in-house training and the availability of the QI Training Team to coach staff. The QI Maturity Score will be assessed again in 2021, which will help the PM/QI Council reposition after public health programs have been re-established.

Additional monitoring of implementation will occur on a more frequent basis through the monthly PM/QI Council meetings. Part of the standard agenda is an update on ongoing QI activities. These will also be included in the annual PM/QI Report that aims to share progress with ADPH staff.

Data-Driven Decision Making

Because the State Health Officer has emphasized the need for data-driven decision making through the Strategic Plan, the PM/QI Council will actively support this by making recommendations to ADPH administration for potential QI projects based on the PM data reported to them on a routine basis. This will ensure QI is considered even if the unit is unaware of the QI process or how to proceed with a QI project.

Quality Improvement Training and Coaching

The QI Training Team provides virtual training on a routine basis that includes four tools:

- Goal statement writing.
- Process mapping using swim lanes.
- Root cause analysis using the "5 Why" method.
- Practicing Coaching Quality Improvement (CQI) with team huddles.

Attendance to these classes is free and available to all ADPH staff. Nurses and Social Workers will receive Continuing Education Units (CEU) credits for attending. These are currently offered virtually but will also be available in-person once social distancing restrictions allow.

Individualized coaching is available for one-on-one work or with teams upon request. The QI Training Team will customize the level of support to meet the needs of the ADPH staff requesting assistance and at a frequency level that considers their capacity.

While in-person classes were in place in early 2020, social distancing has restricted the provision of these classes. There is a need to transition some trainings to virtual format and develop other training content. Plans for training development in 2021 and 2022 include:

- Introduction to QI (transition to virtual format).
- Introduction to QI for New Employees (recorded to incorporate into the New Employee Orientation owned by Human Resources).

A conscientious effort to ensure programs are collecting customer service data is being incorporated into the new QI projects. This includes assisting the QI Team in developing meaningful survey questions, data collection process, and targets. The intent is to align the customer service data with the RBA model which helps staff incorporate PM into the QI process.

Monitoring Quality Imrpovement Efforts

The PM/QI Council will receive monthly updates on active QI Teams, updates to training content, QI Pods, and any other relevant updates on QI efforts. They will be given an opportunity to ask questions and provide input as the program is being modified to meet the ever-changing needs of ADPH.

Training needs are monitored through training evaluation feedback and used to inform changes to existing classes and the development of new content. Additional feedback is gathered through the annual Workforce Development Needs Assessment which includes questions specific to QI.

CEUs are available for Social Workers and Nurses, which adds a limitation to how much the training can be changed after CEUs are approved. Major revisions that would affect CEUs are released when the CEUs are updated every 2 years.

Terms and Definitions

PM SPECIFIC TERMS

- Performance Management (PM) - The use of established performance measures to monitor the meaningfulness of programs, activities, and services provided by ADPH so that action can be taken when the measures are not trending in the direction needed to positively influence population health outcomes.

- Results Based Accountability (RBA) - Based on the book from Mark Friedman, *Trying Hard is Not Good Enough*, this model uses a common sense approach to PM that includes defined approaches to selecting performance measures, engaging partners, and assessing the meaningfulness of the program work without placing blame on individuals for ineffective activities.

- Performance Accountability - The ongoing monitoring and review of *program performance* and effectiveness. The focus of performance accountability is to ensure the program is doing the right things and that things are being done the right way.

- Population Accountability - The ongoing monitoring and review of *population well-being* in a geographic area where a group of partners are working toward a collective impact. The focus is on a specific population group, their behaviors, and the collective impact on the population.

- Performance Measure - Mindfully selected measurable data elements that are meaningful and measure a program's Quality of Effect or Quality of Effort. This is a shift from measuring Quantity of Effort which is often required for grant reporting purposes but, in itself, is the least meaningful type of measure.

	QUANTITY	QUALITY
EFFORT	# How Much Did We Do?	% or Ratio How Did We Do It?
EFFECT	Is Anyone Better Off? # Integer Decimal	% Or Rate

- Customer Service Data – Any formal data where customers, partners, or recipients of services provided feedback on their experience with ADPH's work. This could be collected through survey cards, electronic survey, focus groups, cold calls, etc.

- Trend Line – The graphical representation of a variable's tendency, over time, to increase, decrease, or remain unchanged.

- Baseline – The beginning point, based on an evaluation of output over a period of time, used to determine the process parameters prior to any improvement effort; the basis against which change is measured.

- Forecast – Using the trend line and baseline data, the forecast projects what the trend line is likely to look like if no improvements or changes in strategies occur.

- Benchmark – A technique in which an organization measures its performance against that of best-in-class organizations, determines how those organizations achieved their performance levels and uses the information to improve its own performance. Subjects that can be benchmarked include strategies, operations, and processes.

- Target – The ideal or goal measurement that the program is working toward meeting.

QI SPECIFIC TERMS

- Cause and Effect Diagram - A tool for analyzing process dispersion. It is also referred to as the "Ishikawa diagram," because Kaoru Ishikawa developed it, and the "fishbone diagram," because the complete diagram resembles a fish skeleton. The diagram illustrates the main causes and subcauses leading to an effect (symptom).

- Root Cause - A factor that caused a nonconformance and should be addressed with corrective action.

- Root Cause Analysis - The method of identifying the cause of a problem, solving it and preventing it from occurring again. Uncovering the correct and accurate reason(s) why something is happening or has already occurred.

- Goal Statement - A broad statement describing a desired future condition or achievement without being specific about how much and when.

- Process Map - A type of flowchart visually depicting the steps in a process. This can be accomplished using a flowchart, spaghetti map, or swim lane.

- Brainstorming - A technique teams use to generate ideas on a particular subject. Each person on the team is asked to think creatively and write down as many ideas as possible. The ideas are not discussed or reviewed until after the brainstorming session.

- Quality Improvement Cycle - The QI Cycle is a nonliner cycle consisting of four phases that take place when QI is performed at any scale. It is fully defined under the section "PDSA Model for QI" in the PM/QI Plan.

- Continuous Quality Improvement (CQI) - The practice of using the QI Cycle in a nonlinear fashion for an extended period of time which includes continuously reviewing and working to improve the process.

- Storyboard - A visual representation of significant progress made in a QI project that serves to "tell the story" of a project.

- Quality Improvement Pod - A QI Pod is used within ADPH to bring together representatives from up to 5 projects who work through using the QI tools and templates on their respective QI projects. These pods offer teams one-on-one assistance with a QI Training Team Member and a QI Pod Facilitator that provides support and encouragement throughout the process.

Sources for Terms and Definitions:

- *American Society for Quality (ASQ.org)*
- *Trying Hard is Not Good Enough – Mark Friedman*

Selecting Performance Measures

Population Accountability vs Performance Accountability

Population accountability relates to the population that is being targeted and a general state of well-being that we desire. An example of this is: All children receive high quality pediatric care. This is called a result and we cannot necessarily reach this entirely. It is not meant to be measurable, but we can use indicators to tell us how well we are doing in this general area. Both results and indicators are specific to population accountability and can only be impacted through a collective effort by government, partners, and the community. We cannot take responsibility or measure our own performance by these results or indicators. This responsibility for an agency's success is captured as performance accountability or how much of a difference our program makes on the customers.

Identifying Meaningful Measures

In performance accountability, we have four types of measures we prefer to look at to measure the success of a program, division, bureau, or agency. The measures are broken down in the chart below to help understand what types of measures should be used and their level of importance:

	QUANTITY	QUALITY
EFFORT	How Much Did We Do? LEAST IMPORTANT	How Well Did We Do It? 2nd MOST IMPORTANT
EFFECT	Is Anyone Better Off? 3nd MOST IMPORTANT	MOST IMPORTANT

We are very comfortable with measuring how much we did and, in some programs, how well we did it. We are not as comfortable measuring if anyone is better off because of our program. This is the most important way to measure our performance and ensure we are assessing the benefit of the program to the customer. It is also where we have the least amount of control. This will require stepping outside of your comfort zone.

How much did we do?	How well did we do it?
# Customers Served (by customer characteristic) # Activities Completed (by type of activity)	*Measures that answer: How well did we treat you?* customer satisfaction, workload ratio, staff turnover, percent of staff fully trained *Measures that answer: How well did we do the activity?* Percent of actions completed timely and correct, percent of clients completing the activity, percent of actions meeting standards
Is anyone better off? (#)	**Is anyone better off? (%)**
# Skills/Knowledge # Behavior # Circumstance	% Skills/Knowledge % Behavior % Circumstance % Improvement in health outcome (long term measure)

For examples of measures, reference Chapter 4 of Trying Hard is Not Good Enough or visit: https://clearimpact.com/results-based-accountability/example-performance-measures-can-use-program-service/

Applying a Health Equity Lens

Before moving on to prioritizing and selecting final measures, reflect on the measures to determine if considerations were made for populations that are vulnerable. Here are a few considerations to keep in mind through this process:

1. Are the groups affected by these measures represented at the table?
2. How will this measure affect vulnerable populations differently?
3. How will these measures be perceived by vulnerable groups?
4. Will this measure ignore or worsen existing disparities?
    a. If yes, reconsider the measure.
5. Do we have measures that will allow for monitoring of vulnerable populations in addition to general population?
    a. If yes, can we specifically use this measure to address disparities and gauge impact on disparities in the short-term and midterm?

It is best to identify measures that allow the group to monitor impact on vulnerable populations. This will enable the group to adjust strategies if there is no impact or a negative impact. It may be beneficial to have these measures in a separate data report specific to monitoring the impact of strategies on vulnerable populations.

Prioritizing Measures

After you have identified meaningful measures, you may need to narrow down the list so that you only have 3-5 headliner measures. There are three criteria to consider here and chart below to simplify the prioritization process.

Communication Power: Does the measure communicate to a broad and diverse audience? If you tried to use this measure to explain the performance of your program to your neighbor, would they be able to understand? Measures that rate high here will be common sense and compelling to broad audiences. For example, most people would be able to reasonably understand what "percent of children in public schools immunized" means.

Proxy Power: Does this measure share something of central importance about the program or division? Consider that data tends to run in herds. You would not want 20 measures to tell the same thing when one can represent all of them as a headliner measure and still tell the story. Using a measure that shares something of central importance and runs with the herd will be a stronger measure.

Data Power: Do we have quality data on a timely basis? Is the data reliable and consistent? If the answers to these questions are "no" this will rank low in data power and be a candidate for the data development agenda.

Prioritizing Performance Measures			
	Communication Power	Proxy Power	Data Power
	Common sense and compelling	Central importance and representative of trends	Quality data is available, reliable, and consistent
Measure 1	H M L	H M L	H M L
Measure 2	H M L	H M L	H M L

RBA Implementation Self-Assessment

For Government and Nonprofit Organizations

Source: http://resultsaccountability.com/wp-content/uploads/2014/03/RBA-Implementation-Self-Assessment-v2.pdf

1. LANGUAGE DISCIPLINE (10)

a. Has your group or organization adopted a common language using the Tool for Choosing a Common Language or some other method? Does this common language allow you to clearly distinguish population and performance accountability? (7)

b. Can you crosswalk your language usage to that of your funders and other partners? (3)

2. POPULATION ACCOUNTABILITY (30)

a. Has your organization identified one or more population level results or conditions of well-being stated in plain language to which your work contributes? (5)

b. Have you identified the 3 to 5 most important indicators for each of these results? (5)

c. Have you created a baseline with history and a forecast for each of these measures? (5)

d. Have you analyzed the story behind these baselines? (5)

e. Do you have a written analysis of what it would take to turn these conditions around at the national, state, county, city, or community level? (5)

f. Have you articulated the role your organization plays in such a strategy? (5)

3. PERFORMANCE ACCOUNTABILITY (45)

a. Has your organization established the 3 to 5 most important performance measures for what you do, using the performance accountability categories? (How much did we do? How well did we do it? Is anyone better off?) (5)

b. Have you created a baseline with history and a forecast for each of these measures? (5)

c. Do you track these measures on a daily, weekly, monthly, or quarterly basis? (5)

d. Do you periodically review how you are doing on these measures and develop action plans to do better using the performance accountability 7 questions? (5)

e. Have you adapted your management, budget, strategic planning, grant application, and progress reporting forms and formats to reflect systematic thinking about your contribution to population conditions and your organization's performance? (5)

f. Are the population and performance baseline curves you are trying to turn displayed prominently as one or more charts on the wall? (5)

g. Have you identified an in-house expert to train and coach other staff in this work? (5)

4. BOTTOM LINE QUALITY OF SERVICE (15)

a. Considering case mix difficulty, are you doing well or poorly on the most important Is Anyone Better off? measures compared to others? (Others = comparable providers, industry benchmarks, or reasonable targets or standards) (5)

b. How are you doing on the most important How well did we do it? measures compared to others? (Others = comparable providers, industry benchmarks, or reasonable targets or standards) (5)

c. Have you turned any curves? (5)

5. BONUSES AND PENALTIES (-20 TO +10)

a. Research and Evaluation Bonus: Do you have (recent i.e. less than 3 to 5 yrs. old) research or evaluation evidence that shows your services cause improvement in customers' lives as shown by Is Anyone Better off? measures? Yes = plus 10 No = 0

b. Skimming Penalty: Is there any evidence that you are skimming easy customers in order to increase success rates on Is Anyone Better off? measures? Yes = 0 No = minus 10

c. Unit Cost Penalty: Given the intensity of your services are your unit costs per customer in line with other providers in the field? Yes = 0 No = minus 10

Total Score:

Date of Assessment:

When I answered these questions, I was thinking of:

- ADPH as a whole
- My bureau
- My division
- My program

Learning Survey: CQI – Goal Statement Workshop

Name (optional): **Date:**

Instructions: For each element, place a "B" (Before training) in box that indicates your level before training. For each element, place an "A" (After training) in the box that indicates your level after training.

Level / Element	1 I have no knowledge	2 I have heard about this	3 I have an understanding	4 I can see where to apply this in the workplace	5 I can see it and help explain it to others
Understanding of improvement cycle					
Ability to write a goal statement to address the problem					
Ability to establish how progress will be measured					
Ability to use a goal statement to create focus for your team					

What in the training will you most likely use in your job and make you more effective in your role?

Which topic(s) did you wish there was additional or follow-up training on?

Where can we make improvements? (Did you like the format of the course? Do we need to spend more/less time on a particular area? Is there something we did not cover that we should?)

Do you have suggestions for future course topics?

Overall, how much benefit do you feel you received from this course? Circle the number that best shows your reaction.

Not benefited at all	Somewhat benefited	Benefited	Greatly benefited
0	1 2 3	4 5 6	7 8 9

Office of Performance Management

Office of Performance Management (OPM) is a division of the Alabama Department of Public Health with the following functions:

- Performance Management.
- Quality Improvement.
- State Health Assessment.
- State Health Improvement Planning.
- Strategic Planning.
- Public Health Accredidation Board Accreditation.

OPM is fully funded by the Preventive Health and Health Services Block Grant, which covers the cost of staff, travel, software, and other resources needed to conduct these functions. These funds are also used to aid QI projects that are without funding and would otherwise not be possible.

OPM staff include:

- Carrie Allison, Director:
  - Performance Improvement Manager.
  - Strategic Plan lead.
  - PHAB Accreditation Coordinator.
  - Domain 9 Co-Lead for PHAB Accreditation.
- Catrece Hoult, State Health Improvement Planning Coordinator:
  - Incorporates Results Based Accountability into the State Health Improvement Plan.
  - Domain 5 Lead for PHAB Accreditation.
- Vacant, QI Coordinator:
  - Leads QI projects.
  - Coordinates the QI Training Team.
  - Guides the provision of QI Training.
  - Incorporates Results Based Accountability into QI.
  - Domain 9 Co-Lead for PHAB Accreditation.
- Vacant, Administration Support:
  - Schedules meetings for OPM staff.
  - Maintains appropriate documentation of meetings.

Other ADPH staff and external partners support these efforts through a variety of teams:

- Performance Management Council:
  - 10 Members.
- QI Focus Groups;
  - 3 QI Training Team members.
  - 15 members to be selected in February 2021.
- State Health Assessment Development:
  - 5 Core Team members.
  - 30 contributors.
- Strategic Plan Teams:
  - 5 team leads.
  - 5 executive sponsors.
  - Approximately 50 team members.
- Accreditation Teams:
  - 24 Domain leads.
  - 8 Document Review Panel members.

Storyboard Introduction

Storyboards are a mechanism for sharing a QI project with staff and partners who were not necessarily part of the QI project. A storyboard incorporates key components of a QI project to create a visual display of the project progression through the QI process as defined in the ADPH PM/QI Plan. Storyboards are meant to include the key elements but also be flexible enough to showcase each project using the information and visuals available and relevant.

KEY ELEMENTS

The key elements of a storyboard were adapted from the PHAB Standards, ideas gathered from other health departments, and lessons learned by ADPH. In 2020, PHAB gave feedback on a specific storyboard developed by ADPH that further enhanced the key elements.

- A goal statement that includes measurable outcomes with targets. This should be completed using the goal statement template taught as part of ADPH's QI training.
- A description of the existing gap that drove the project.
- How the project was selected or prioritized.
- The QI tools and templates used in the project. Examples include:
  - Process mapping.
  - Root cause analysis.
  - Prioritization of issues.
  - Prioritization of solutions.
  - Return on investment or impact analysis.
  - Action plan or action item list.
- A description of how implementation was accomplished.
- The outcome or progress of the project.
- How the team or team lead reviewed and evaluated the result of solutions implemented.
- How the team or team lead continued monitoring the progress of the project.
- Dates throughout showing the progress through the project.
- A version date for the storyboard (when it was last updated).
- Evidence of authenticity (ADPH circle logo).
- Staff members who were included in the team, identifying the team lead.
- A meaningful, descriptive title.

FORMAT

ADPH uses a simplified format to make the progress through the project easy to understand and correlate with the QI cycle. The image below shows this format:

Specialty Clinic QI Storyboard • Montgomery County Health Department

ALABAMA PUBLIC HEALTH

Plan

The mission of the Montgomery Health Department is to work with the people of Montgomery County for a healthy life. The Specialty Clinic provides confidential investigation, examination, counseling, and treatment of sexually transmitted diseases for anyone 12 years of age or older.

Major concerns with walk-in model:

- Limited to 18 patients
  - Up to 12 patients at 8 am
  - Up to 6 additional patients at 11 am
- Not flexible enough to allow patients arriving outside of designated times
- Unable to see all patients requesting services
- Staff unable to plan ahead
- Excessive movement of staff and patient
- Unable to schedule follow-up visits for established patients
- Decreased morale for staff due to having to turn away patients in need

Prior to Changes

Number of patients per day	18 maximum
Appointment process	Walk-in only
Continuum of care provided	Based on patient obtaining a walk-in appointment
Wait time per patient	Depending on where the patient is in the queue #1 – Avg 1.5-2 hours #12 – 4 hours minimum
Estimated salary cost per patient	$48.42 (does not include fringe or indirect)

Spaghetti Chart – Before Changes

Key:
- Patient
- Lab Technician
- Disease Intervention Specialist (DIS)
- Nurse

Process:

1. Patient enters clinic and gets one of 12 clipboards.
2. Patient fills out clipboard.
3. Patient completes intake process with clerk.
4. Patient waits to be called back.
5. DIS gets patient, takes to room, and conducts interview.
6. Patient returns to waiting room.
7. Lab Tech takes patient to collect specimens.
8. Patient returns to waiting room.
9. Nurse takes patient to an exam room to conduct exams and consultation.
10. Patient leaves clinic.

Do

Summary of Major Changes:

- Formed a QI Team to address this problem
- Moved to appointment scheduling
  - Initial visits scheduled every at 0:00 and 0:30
  - Treatment only visits schedule at 0:15 and 0:45
  - Posted banners to announce change
- Patients no longer return to main waiting room (a sub waiting room is used if needed)
- DIS works with Lab to keep patients moving through lunch hour by alternating lunch schedules
- Started reminder calls to prevent no-shows
- Staff kept three open appointment slots per day for walk-ins
- Patients who call or walk-in were given an appointment time for that day or next day and returned at that time
- Patient needing follow-up or regular visits started scheduling follow-up visits

Go-Live Date: June 12, 2017

Spaghetti Chart – With Changes

Key:
- Patient
- Lab Technician
- Disease Intervention Specialist (DIS)
- Nurse

Process:

1. Patient checks in at desk and sits.
2. Patient completes intake process with clerk.
3. Patient waits to be called back.
4. DIS gets patient, takes to room, and conducts interview.
5. Patient goes directly to lab. (DIS escorts on the way to pick up the next patient.)
6. Lab Tech collects specimens.
7. Lab Tech takes patient directly to exam room.
8. Nurse reviews chart and slides and goes to patient.
9. Nurse conducts exams and consultation.
10. Patient leaves clinic.

Study

Major concerns with walk-in model:	Were the major concerns addressed?
• Limited to 18 patients ○ Up to 12 patients at 8 am ○ Up to 6 additional patients at 11 am	• Schedule can accommodate up to 28 patients per day, including a few walk-ins
• Not flexible enough to allow patients arriving outside of designated times	• Schedule allows walk-ins to leave and return at a designated time
• Unable to see all patients requesting services	• All patients are seen within a reasonable time
• Staff unable to plan ahead	• Staff can plan for patients coming in later
• Excessive movement of staff and patient	• Patient does not return to main waiting area. Patient might use the secondary waiting area if necessary.
• Unable to schedule follow-up visits for established patients	• Follow-up visits can be scheduled as far out as the patient requests.
• Decreased morale for staff due to having to turn away patients in need	• Staff are happier with the work environment

Comments from patients:

The clinic is much more organized.

I'm getting out of the clinic so much faster!

I can plan my visit instead of taking a chance on being seen.

Three Months After to Changes

Number of patients per day	28 patients per day | **55% increase**
Appointment process	Primarily appointments; Walk-ins assigned an appointment time
Continuum of care provided	Follow-up appointments available for all STD patients
Wait time per patient	Wait time is the same for all patients TBD
Salary cost per patient	$31.16 (does not include fringe or indirect) | **$17.26 Less per patient without changing staffing levels!**

Act

Progress was reviewed three months after the implementation date and adaptations to the process were discussed, specific implementation plans were set, and a group meeting was planned.

What do we do next?

Further changes to make to the process:

- **Leave DIS open spots to address treatment needs.**
  - Tuesday and Thursday only.
  - Specifically for symptomatic, urgent treatment needs (not routine testing).
  - 2 in the morning (only 1 can be an initial; both can be treatment) (8:15, 9:15).
  - 2 in the afternoon (only 1 can be an initial; both can be treatment) (1:15, 2:15).
  - Hold standard time for those appointments each day (8:15, 9:15, 1:15, 2:15).
  - Start testing this change on October 24, 2017.
- **Designated DIS for daily lunch schedule based on nursing needs.**
  - DIS to rotate duties across staff so that all DIS staff members are familiar with process and to maintain proficiency.
  - Lead DIS to write schedule for DIS staff to assist in lab during lunch.
  - Start testing this change on October 23, 2017.
  - Allow adjustments day to day based on nursing needs in lab.
- **Try to schedule appointments that are non-urgent later to allow for more urgent, last-minute scheduling. Can schedule for the following open clinic date.**
  - Clerical supervisor (also the Nurse Supervisor) to meet with clerks and try to guide this change.
- **Hold a group meeting for all clinic staff.**
  - Close clinic for a couple of hours.
  - Brief staff on changes and new process.
  - Collect feedback from all staff on changes in process and any additional input.
  - Schedule for week of November 6, 2017, in the afternoon (3:00-3:30). May be the following week depending on scheduling.
  - No appointments made after 2:00 to ensure all patients are out of clinic before meeting.
  - Ona Jean will follow-up with a date, time, and location of the meeting.

As of October 19, 2017

This format is created using a Word document with each phase of the QI cycle appearing on a single page in landscape view. Data tables, charts, and images should be used to tell the story and make the storyboard more appealing. The ADPH Health Media and Communications Division takes this information and creates a poster that displays all four pages on one large poster.

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