SHAWANO-MENOMINEE COUNTIES HEALTH DEPARTMENT

2022

PERFORMANCE MANAGEMENT AND QUALITY IMPROVEMENT ANNUAL REPORT

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2022 Summary

In 2022, the Shawano-Menominee Counties Health Department (SMCHD) implemented both a Performance Management (PM) and Quality Improvement (QI) assessment, and developed a Performance Management/Quality Improvement (PM/QI) Plan. This comprehensive plan provides the infrastructure and direction for the department's Performance Management System (PMS).

According to the Public Health Foundation (PHF), performance management "is the practice of actively using performance data to improve the public's health" and "involves the strategic use of performance measures and standards to establish performance targets and goals" (Collaborative, 2003). It is a systematic process which helps the organization achieve its mission and strategic goals by improving effectiveness, empowering employees, and streamlining the decision-making process, and also improves the public's health by strengthening the quality and performance of public health practice.

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

The Performance Management model used by SMCHD was developed by the Turning Point National Excellence Collaborative on Performance Management and updated in 2012. There are four core practices:

- Performance Standards
- Performance Measures
- Reporting of Progress
- Quality Improvement

These are supported by visible leadership to achieve performance excellence with long term benefits. In addition, implementation of the Public Health Performance Management System will help to ensure transparency, strategic alignment, and an evolving a culture of quality for the SMCHD, as well as be customer focused (Performance Management: Turning Point, 2012).

Public Health Performance Management System, Turning Point, 2013

2022 Performance Management Workplan

The 2022 PM/QI Plan also included a performance management workplan, based on the results of the performance management assessment. This workplan serves to guide the department in the implementation and evaluation of its administrative and program area activities.

One of the SMCHD's 2022 PM Workplan **goals** included:
Staff at all levels will be engaged in establishing and using the performance management system.

With an **objective** of:

All lead staff will identify at least 1 program area measure to be incorporated into the department's PMS for 4th quarter monitoring by 9/30/22.

And a **strategy** of:

Include a PM/QI Report in the SMCHD Annual Report.

In October 2022, staff successfully met this objective, and began monitoring select administrative and program area performance measures through the remainder of 2022. The following is a summary of the status of these measures.

Administration

Key Indicator: The Community Health Improvement Plan (CHIP) strategies will be reviewed quarterly by the CHIP Steering Committee- The Assistant Health Officer will be the review facilitator.

Standard: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)

Rationale for Choosing this Indicator: The review of CHIP strategies will support the CHIP evaluation process.

Target: Quarterly Review

Actual: Quarter 4 Review Completed

Analysis: **This measure was met for Quarter 4 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator: The SMCHD Budget status will be reviewed monthly (3 times per quarter).

Standard: Demonstrate accountable financial stewardship (PHAB)

Rationale for Choosing this Indicator: By reviewing the budget on a routine basis, the SMCHD will maintain financial sustainability to support its infrastructure and sustain, enhance, and develop programs and interventions.

Target: 3 (for Quarter 4)

Actual: 3

Analysis: **This measure was met for Quarter 4 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator: One new grant funding opportunity will be identified and reviewed each quarter.

Standard: Demonstrate accountable financial stewardship (PHAB)

Rationale for Choosing this Indicator: Additional funding to support public health processes, programs, and interventions should be sought through a variety of means, including grants.

Target: 1

Actual: 1

Analysis: **This measure was met for Quarter 4 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI project is not needed for this key indicator.

Communicable Disease (CD)

Key Indicator: 100% of Category I suspected or confirmed diseases or confirmatory lab results will have initial follow-up by the CD nurse within one business day. (This excluded COVID-19 cases in quarter 4 2022)

Standard: Wisconsin State Statute 252

Rationale for Choosing this Indicator: The ability to conduct timely investigations of suspected or identified health problems is necessary for the detection of the source of the problem, the description of those affected, and the prevention of further spread of the problem.

Target: 100%

Actual: 100%

Analysis: **This measure was met for Quarter 4 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator: A Wisconsin Electronic Disease Surveillance System (WEDSS) quality assurance (QA) report will be run quarterly to monitor timeliness of CD follow-up.

Standard: Public Health Accreditation Board (PHAB) Domain 2

Rationale for Choosing this Indicator: A component of assuring timely investigations is the monitoring of CD reporting and investigation results.

Target: 1 (for Quarter 4 2022)

Actual: 1 (for Quarter 4 2022)

Analysis: **While this WEDSS QA report was run for 2022 quarter 4, the SMCHD needs to develop a process for analysis.**

Plan: Develop a process for analysis and continue this key indicator for 2023.

Quality Improvement: A QI project MAY be needed for this key indicator.

Emergency Preparedness

Key Indicator: At least one Homeland Security Exercise and Evaluation Program (HSEEP) exercise will be completed annually.

Standard: Wisconsin Public Health Emergency Preparedness (PHEP) Budget Period Contract Objective

Rationale for Choosing this Indicator: A recurring PHEP Contract Objective is to participate in at least one HSEEP consistent exercise and to ensure public health emergency preparedness response competency.

Target: 1

Actual: 1 (Completed in Quarter 4 2022)

Analysis: **This measure was met for Quarter 4 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI project is not needed for this key indicator.

Environmental

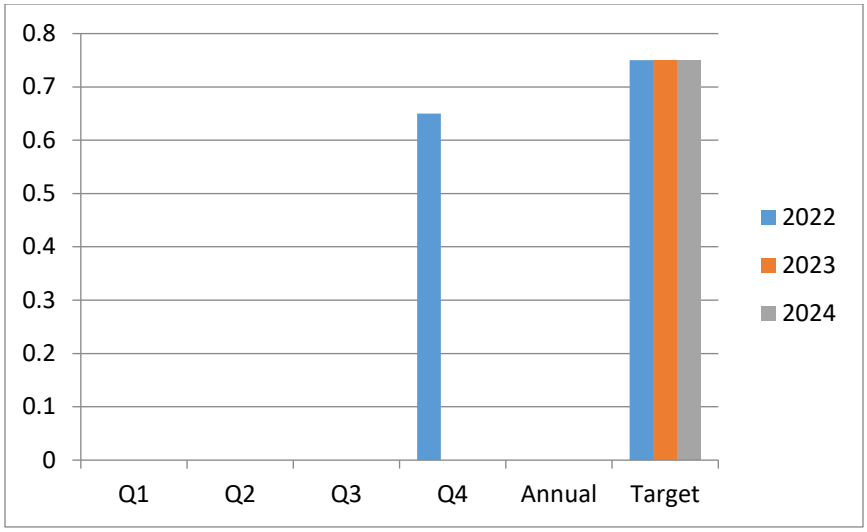
Key Indicator: 75% of domestic animal (dog/cat) bite cases reported to the SMCHD by law enforcement will complete the 10-day quarantine requirements.

Standard: Wisconsin State Statute 95.21

Rationale for Choosing this Indicator: Wisconsin State Statute 95.21 requires that any dog or cat which bites a human complete a 10-day quarantine, to ensure the animal was not infected with rabies at the time of the bite.

Target: 75%

Actual: 65% (Quarter 4 2022)



Analysis: **This measure was not met for Quarter 4 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project MAY be needed for this key indicator.

Key Indicator: 95% of non-vaccinated domestic animals (dog/cat) that bite a human will receive a rabies vaccine prior to their 10-day quarantine release.

Standard: Wisconsin State Statute 95.21

Rationale for Choosing this Indicator: Wisconsin State Statute 95.21 requires all dogs and cats over the age of 6 months to be up to date on rabies vaccine.

Target: 95%

Actual: Unable to measure

Analysis: **This key indicator was unable to be measured in Quarter 4 2022, as the SMCHD did not consistently receive this information from the reporters.**

Plan: Abandon this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

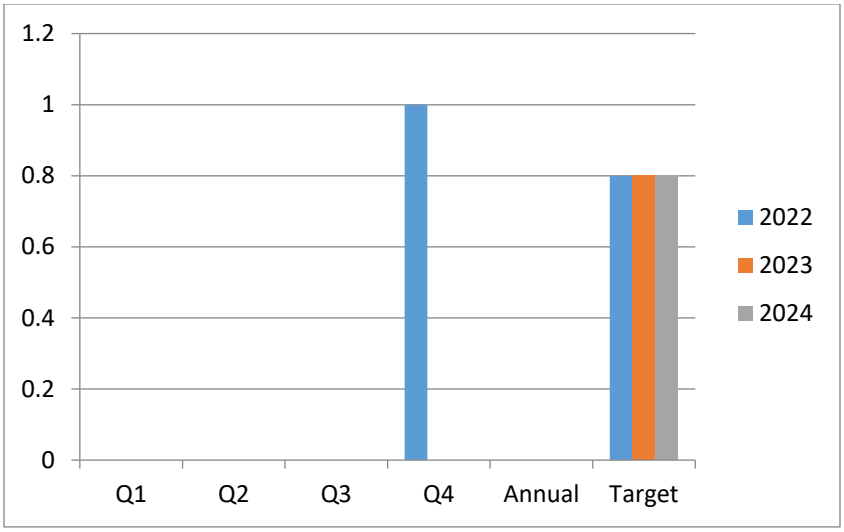
Key Indicator: 80% of fee-exempt water tests kits distributed by the SMCHD will have results returned.

Standard: Implement health communication efforts to encourage actions to promote health (PHAB)

Rationale for Choosing this Indicator: By monitoring the fee-exempt water test return rate, the SMCHD can outreach to families to encourage them to follow through with water testing.

Target: 80%

Actual: 100% (Quarter 4 2022)



Analysis: **This measure was met for Quarter 4 2022**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

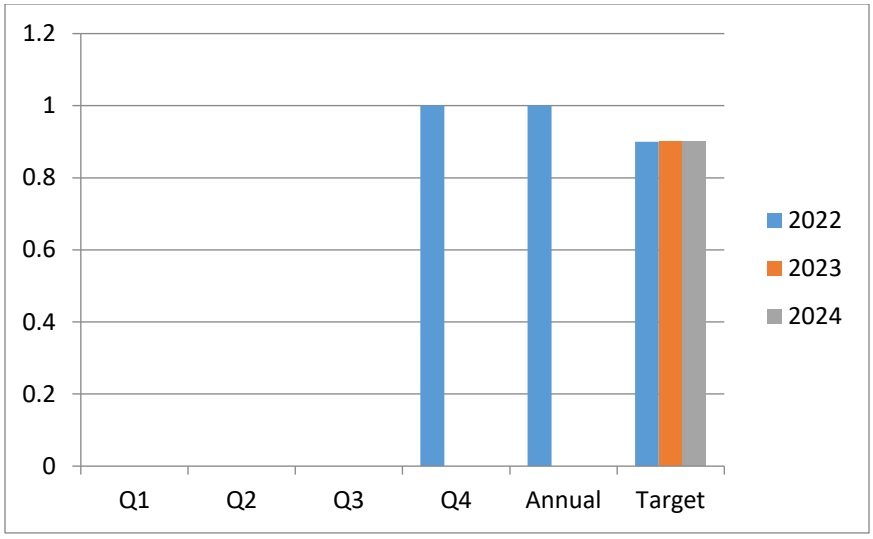
Key Indicator: 90% of environmental complaints will have an investigation started within 7 business days of receipt.

Standard: Wisconsin State Statute 254

Rationale for Choosing this Indicator: Prompt action by the SMCHD will facilitate timely public health interventions, and promote transparency and trust with stakeholders and the community.

Target: 90%

Actual: 100% (Quarter 4 2022)



Analysis: **This measure was met for Quarter 4 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

Immunization

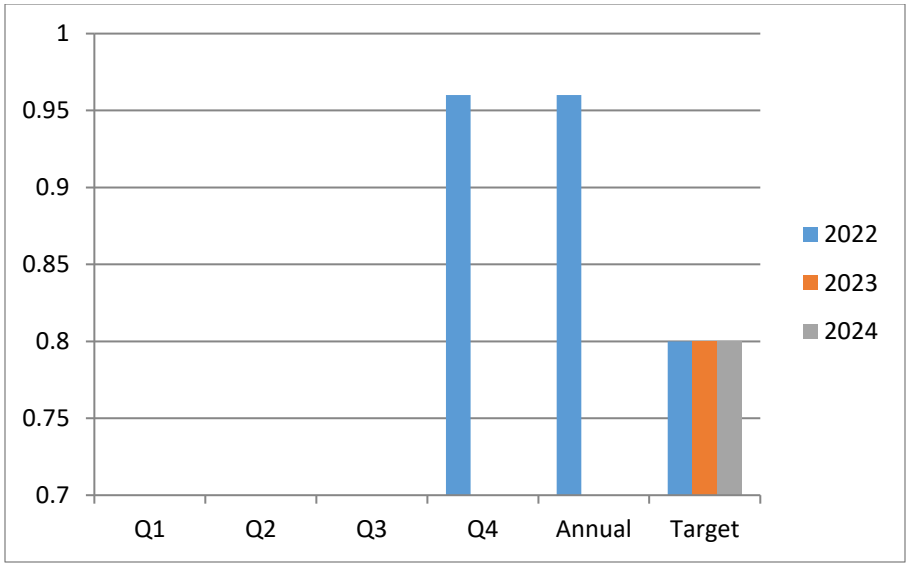
Key Indicator: SMCHD will provide immunization outreach to 80% of Shawano and Menominee County moms with newborns.

Standard: Wisconsin Immunization Consolidate Contract Program Activities

Rationale for Choosing this Indicator: Identifying and providing outreach to new moms has been identified as a QI Project strategy to help improve the 24-month immunization rates in Shawano and Menominee Counties.

Target: 80%

Actual: 95% (Quarter 4 2022)



Analysis: **This measure was met for Quarter 4 2022.**

Plan: Continue this key indicator for an additional 6 months in 2023.

Quality Improvement (QI): This key indicator was identified as a strategy for the 2022 Immunization Program Area QI Project, which was implemented through December 2022.

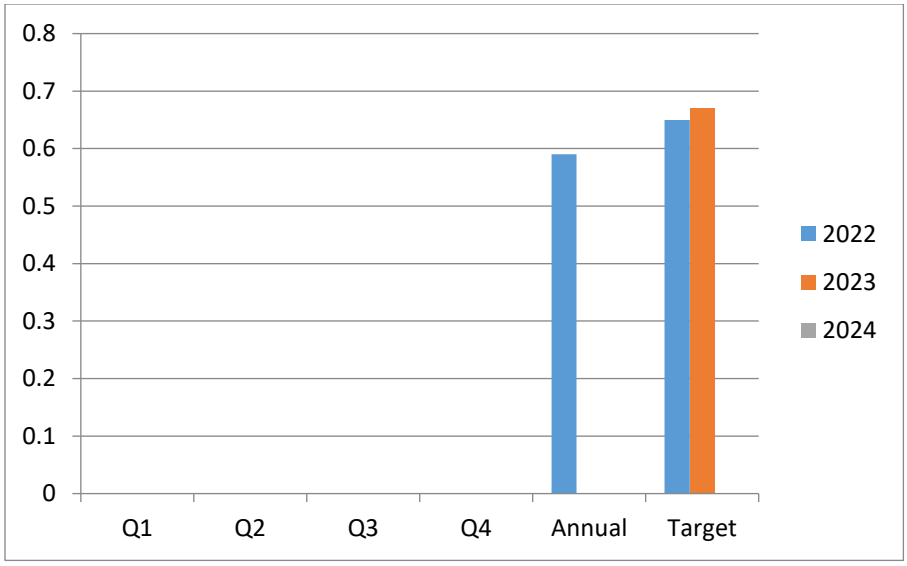
Key Indicator: 65% of children residing in Shawano-Menominee Counties who turn 24 months of age will complete the Advisory Committee on Immunization Practices (ACIP) recommended immunizations.

Standard: Wisconsin Immunization Program Consolidate Contract Deliverable.

Rationale for Choosing this Indicator: SMCHD's Wisconsin Immunization Consolidated Contract Objective is set by the state. It is calculated by the baseline from the prior year, plus 4% increase. (The 2021 goal was 71%).

Target: 65%

Actual: 59%



Analysis: **This measure was not met for 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project had been implemented for this key indicator. One of three strategies had been implemented in 2022. There are two additional strategies that are planned for implementation and evaluation in 2023, with the goal of improving this measure.

Lead

Key Indicator: 75% of children with a capillary blood lead level ≥5mcg/dL will receive a venous confirmation test within 90 days.

Standard: Wisconsin Lead Program Consolidated Contract Objective

Rationale for Choosing this Indicator: A venous blood lead test is more accurate than the capillary, and is needed to provide inspection services.

Target: 75%

Actual: 62.5%

Analysis: **This measure was not met for 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator. The SMCHD will continue to implement the Wisconsin Lead Program Consolidated Contract Activities for 2023 and re-evaluate this measure.

Key Indicator: 100% of children with a venous blood lead level ≥10mcg/dL will be offered a nurse and an environmental home visit.

Standard: Wisconsin Lead Program Consolidated Contract Objective

Rationale for Choosing this Indicator: By offering a nurse and an environmental home visit, education can be provided, and potential lead exposures can be identified.

Target: 100%

Actual: 100% for 2022

Analysis: **This measure was met for 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator: 75% of children with a venous blood lead level ≥10mcg/dL will accept a nurse and environmental home visit.

Standard: Wisconsin Lead Program Consolidated Contract Objective

Rationale for Choosing this Indicator: By performing a nurse and an environmental home visit, education can be provided, and potential lead exposures can be identified.

Target: 75%

Actual: 100%

Analysis: **This measure was met for 2022**.

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Performance Indicators	Q1	Q2	Q3	Q4	2022 YTD	Annual Target
1. 75% of children with a capillary blood lead test ≥ 5 mcg/dL will receive a venous confirmation test within 90 days					**63%**	**75%**
2. 100% of children with a venous blood lead level ≥ 10mcg/dL will be offered a nurse and an environmental home visit					**100%**	**100%**
3. 75% of children with a venous blood lead level ≥ 10 mcg/dL will accept a nurse and environmental home visit					**100%**	**75%**

Maternal Child Health (MCH)

Key Indicator: 75% of MCH clients referred to the SMCHD will receive outreach and resource information.

Standard: Public Health Accreditation Board (PHAB) Domain 7

Rationale for Choosing this Indicator: The SMCHD receives MCH referrals from WIC, hospitals, clinics, DHS and family or close contacts of parents and children. The SMCHD engages in public health activities that assess develop and improve systems to assure higher risk MCH populations have equitable access to services and care that are needed for them to be healthy.

Target: 75%

Actual: 0% for quarter 4.

Analysis: **This measure was not met, but there was only one MCH referral in quarter 4 2022, and the referral did not respond to the MCH nurse's outreach efforts.**

Plan: Revise the Key Indicator to 75% of MCH clients referred to the SMCHD will receive a successful outreach by the MCH nurse to determine needs. Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

School Nursing

Key Indicator: 95% of students who fail the initial vision screening will have a repeat vision screening within 90 days.

Standard: American Academy of Ophthalmology

Rationale for Choosing this Indicator: Vision screening is essential to identify students at risk for vision problems early.

Target: 95%

Actual: 100%

Analysis: **This measure was met for 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator: 95% of students who fail the initial hearing screening will have a repeat hearing screening within 90 days.

Standard: American Speech-Language-Hearing Association

Rationale for Choosing this Indicator: Hearing screening is essential to identify students at risk for hearing problems early.

Target: 95%

Actual: 100%

Analysis: **This measure was met for 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Performance Indicators	Q1	Q2	Q3	Q4	2022 YTD	Annual Target
95% of students who fail the initial vision screening will have a repeat vision screening within 90 days.					**100%**	**95%**
95% of students who fail the initial hearing screening will have a repeat hearing screening within 90 days.					**100%**	**95%**

Woman, Infants and Children (WIC)

Key Indicator: Average WIC participation rate will be at 95% or above assigned caseload each quarter.

Standard: U.S. Department of Agriculture (USDA) Food and Nutrition estimates the number of WIC eligible.

Rationale for Choosing this Indicator: WIC's mission is to safeguard the health of low-income women, infants, and children up to age 5 who are at nutrition risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Target: 95%

Actual: 100%

Analysis: **This measure was met for 2022.**

Plan: Continue this key indicator for 2023.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator: 80% of WIC moms will report they are breastfeeding at 3 months.

Standard: WIC

Rationale for Choosing this Indicator: Breastfeeding is the best source of nutrition for most infants. It can also reduce the risk for certain health conditions for both infants and mothers.

Target: 80%

Actual: Unknown

Analysis: **Complete data was not available for this measure.**

Plan: Modify to include 2 key indicators for 2023:

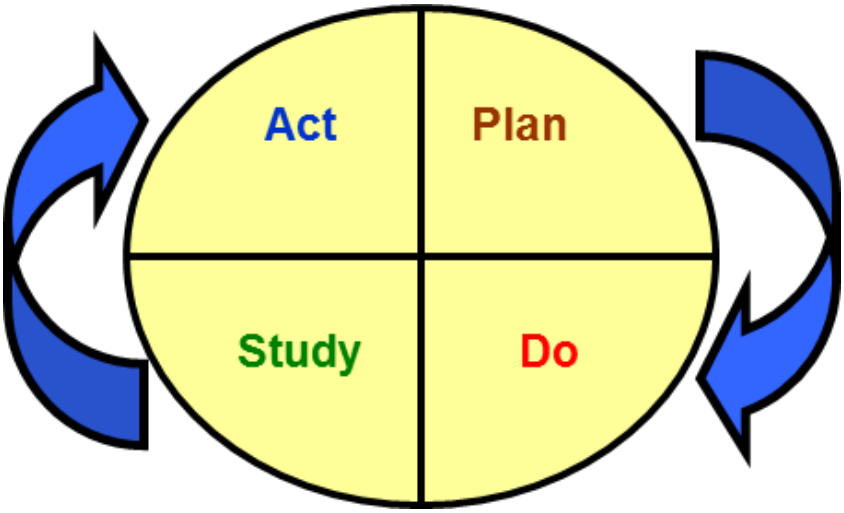
82% of WIC moms will report that they have breastfed at some point (INCIDENCE).

77% of WIC moms will report they are still breastfeeding at 1 month.

Quality Improvement (QI): A QI Project is not needed for this key indicator.

2022 Quality Improvement (QI) Workplan

An important component to the SMCHD's Performance Management System is the implementation of a quality improvement program. SMCHD follows Michigan's Quality Improvement Guidebook Plan- Do-Study-Act (PDSA) Model (Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook, 2011). PDSA is a four-stage problem solving model for improving a process or carrying out change.



PDSA Cycle, Embracing Quality in Public Health: A Practitioner's Quality Improvement Guidebook, 2011

The SMCHD's 2022 PM/QI Plan included a workplan, based on the results of the performance management and quality improvement assessments performed in 2022. This workplan serves to guide the department in the implementation and evaluation of its PM/QI activities.

Evaluation of the 2022 PM/QI Workplan:

PM Goal 1: Leadership will remain engaged in establishing and understanding the performance management system.

Objective 1.1: Communicate status of PMS activities on a bi-annual basis to the Board of Health and Veteran Services (BOHVS) by December 31, 2022

- Strategy 1.1.1 Ensure that PMS is on the BOHVS agenda on a bi-annual basis
- Strategy 1.1.2 Include PMS in the BOHVS orientation packet

- Strategy 1.1.3 Include a PM/QI Report in the SMCHD Annual Report

Responsible party: Health Officer/Assistant Health Officer/PM Coordinator

Evaluation: This objective was met for 2022. Plan: Initiate BOHVS Orientation in 2023. Continue goal, objectives and strategies in 2023.

Objective 1.2: Ensure the performance management system is in alignment with the SMCHD operational plans (Strategic, WFD, PM/QI, others) by December 31, 2022

- Strategy 1.2.1 Include the plan-specific measures in the PMS

Responsible Party: Health Officer/Assistant Health Officer/PM Coordinator

Evaluation: This objective was met for 2022. Plan: Continue goal, objective and strategy in 2023. Align the plan-specific measures with the 2023-2028 Strategic Plan, and appropriate 2023 WFD and 2023 PM/QI Plan updates.

PM Goal 2: Staff at all levels will be engaged in establishing and using the performance management system.

Objective 2.1: All lead staff will identify at least 1 program area measure to be incorporated into the department's PMS for 4th quarter monitoring by 9/30/22

- Strategy 2.1.1 Make PM a routine agenda item and encourage ALL staff to report off on their measures
- Strategy 2.1.2 Develop a basic, more visual tracking system
- Strategy 2.1.3 Identify aspects of core operations and program areas for which performance is already being measured and data is collected or available

Responsible Party: Health Officer, Assist Health Officer, PM Coordinator, Lead Staff

Evaluation: This objective was met for 2022. Plan: Continue goal, expand objective to include additional measures as indicated, and continue strategies for 2023. Implement PM monitoring for all identified measures in 2023.

Objective 2.2: All new SMCHD staff will receive fundamental PM training during their orientation period through December 31, 2022.

- Strategy 2.2.1 Develop PMS training module for new SMCHD staff
- Strategy 2.2.2 Provide PMS training to new SMCHD staff

Responsible Party: Health Officer/Assistant Health Officer/PM Coordinator

Evaluation: This objective was met for 2022. Plan: Continue goal, objective and strategies. Will continue to utilize the PMS training module that was developed. Extend the new SMCHD staff orientation period to a six-month period.

QI Goal 1: The SMCHD will promote a culture of quality and continuous improvement

Objective 1.1 Implement one or more transition strategies as identified in the QI Assessment, to move

SMCHD towards a culture of quality by 12/31/2022

- Strategy 1.1.1 Leadership to assess any sources of staff resistance and develop strategies to counter resistance (effective messaging, training and incentives)
- Strategy 1.1.2 Make QI a routine agenda item, and encourage ALL staff to report out on their QI activities
- Strategy 1.1.3 Encourage QI work: project submissions, ensure resources (time) is available for QI projects, celebrate QI successes

Responsible party: Health Officer/Assistant Health Officer

Evaluation: This objective was partially met for 2022. Additional PM/QI training is needed at both leadership and staff levels. Plan: Continue goal, objective and strategies in 2023.

2022 QI Project

In 2022, the SMCHD implemented a QI Project titled: "Improving 24 Month Immunization Rates." The QI Project Team followed the PDSA Model. The attached QI Storyboard gives an overview of the project.

Shawano-Menominee Counties Health Department (SMCHD) QI Storyboard

Title of Project: Improving 24 Month Immunization Rates
Process Owner: Katie Lemke
Begin Date: 11/2021
End Date: 12/2022
Team Members:

Katie Lemke - Project Owner
Jean Weston - Project Owner
Kayla - BSN Completion Student
Jean Weston - Project Facilitator

Plan

Identify an opportunity and plan for improvement

1. Identify the problem; Determine the data sources and collect necessary data

SMCHD is below the 2021 WI DHS Immunization Consolidated Contract target for 24-month immunization rates:

Data Sources: 2021 Shawano County WIR Report, 2022 Immunization Consolidated Contract Objective

Benchmark: 71%

Current (As of 10/06/2021): 61%

2. Assemble the Team

The team consisted of the VFC Coordinator and Back-up Coordinator and a current student.

Goal Statement:

By December 31, 2022, 65% of children who turn 3 months will be on track to meet the benchmarks as indicated in the 2022 Immunization Consolidated Contract.

3. Examine the Current Approach

Due to the COVID-19 pandemic response, the SMCHD had suspended its routine immunization clinics until late September 2021. In addition, outreach to new parents, tracking, coordination with and outreach to other LTHD and providers, reminder/recall, and collaboration with schools and daycares activities were also suspended. Because of this, the team felt that there was no value to map out the current process, as it had not been implemented since the pandemic response, and all immunization policy and procedures were recently updated. Therefore, the current process was evaluated in coordination with the results of the strategies that were chosen.

4. Identify Potential Solutions

- Identify and provide outreach to new moms.
- Provide education to area providers.
- Work with WIC to identify and vaccinate clients who are behind.

The solutions were ranked to determine which was the easiest to implement and make the most impact.

5. Develop an Improvement Theory

IF we identify new moms and provide outreach and education to them about recommended vaccines THEN moms will facilitate well-baby/child checks for vaccines and our rates will increase.

Do

Test the Theory for Improvement

1. SPHERE access was obtained.
2. A "Welcome Baby" letter was developed.
3. A magnet depicting the recommended childhood vaccines through 18 months was created.

6. Test the Theory

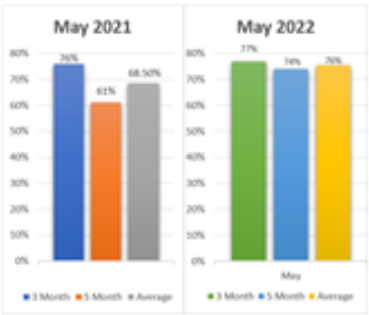
From January 2022 through November 2022 the Office Specialist ran a SHPERE Birth report to obtain data and demographics on county births and mailed the letter and magnet to the new moms listed in the SPHERE Birth Report.

Study

Use Data to Study Results of the

7. Study the Results

The team first reviewed the average Jan-May 2021 "on-track" 3 and 5-month rates as a control (those who had not received a magnet). This rate was 69.4%. The team then compared the Jan-May 2022 "on track" 3 and 5-month rates for those who had received a magnet. This rate was 67% (still lower in 2022). However, the team further analyzed the average 2021 **May** 3 and 5-month "on-track" rate of 68.5% and compared to the average 2022 **May** 3 and 5-month "on-track" rate of 75.5%. This analysis demonstrated that this group that had received a magnet in 2022 had a higher rate of being on track to meet the benchmark.



Act

Standardize the Improvement and Establish Future Plans

8. Standardize the Improvement or Develop New Theory

While there may be confounding factors affecting the above rates due to pandemic effects (national decrease in immunization rates, increased vaccine hesitancy and misinformation), the team felt that this strategy was successful and decided to continue the strategy for another 3 months.

9. Establish Future Plans

A performance measure was added to the SMCHD's tracking system to continue to monitor. In addition, the immunization staff plans to address the additional two strategies that were identified in this QI project:

- Provide education to area providers.
- Work with WIC to identify and vaccinate clients who are behind.

PM/QI Improvements

DATE	ACTIVITY
12/21	Identified Immunization QI Project based off of Immunization Consolidated Contract
1/22	Revised QI Project Templates to better reflect the PDSA process and improve project documentation
1/22	Implemented Immunization QI Project
2/22	Updated PM Coordinator roles and responsibilities and reassigned PM Coordinator position
2/22	Added PM/QI as a routine Health Department Staff Meeting agenda item
3/22	PM Coordinator provided basic PM and QI training to SMCHD staff
4/22	PM Coordinator provided basic PM and QI training to the BOH
4/22	PM Self-assessment conducted
4/22	QI Self-assessment conducted
9/22	Revised PM Tracking Tool
9/22	Program leads and administration identified initial PM measures
	PM/QI Plan approved by HO
10/22	Introduced SMCHD Staff to the PM/QI Plan
10/22	Began monitoring PM measures
10/22	Revised/Improved QI Project Proposal Template
12/22	2022 Performance Management/Quality Improvement Plan approved by BOHVS
1/23	Annual Performance Management/Quality Improvement Progress Report completed to enhance the reporting of progress for both the performance management measures and quality improvement projects initiated.
1/23	QI Storyboard template created and implemented. New Mission, Vision and Values added to Plan. QI Workplan updated for 2023 implementation.
2/23	Performance Management Quarterly Meeting. PM Tracker and select measures revised for 2023 implementation. Added select Strategic Plan Measures. Created “Parking Lot” electronic folder for QI ideas.