SHAWANO-MENOMINEE COUNTIES HEALTH DEPARTMENT

"The Shawano-Menominee Counties Health Department will be an engaged leader in inclusive communities which support optimal health for all."

PERFORMANCE MANAGEMENT AND QUALITY IMPROVEMENT ANNUAL REPORT

2024

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Introduction

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).

Performance management practices have been shown to measurably improve public health outcomes, and can also be used to allocate resources, prioritize programs, and change policies to meet goals.

The Performance Management model used by the Shawano-Menominee Counties Health Department (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 Measurement**
- **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 an organization, as well as be customer focused (Performance Management: Turning Point, 2012).

Public Health Performance Management System, Turning Point, 2013

The SMCHD Performance Management (PM)/Quality Improvement (QI) Plan provides the infrastructure and direction for the department's Performance Management System (PMS), and reflects the 2023-2028 SMCHD Strategic Plan goals.

Performance Measure Summary/Evaluation

The department actively implemented performance measurement throughout 2024, adding 7 new administrative and program area key indicators to track and analyze, and answer the question: "How are we performing relative to our goals?"

Administration

The SMCHD added 5 new administrative PM indicators (designated with a *) to its PMS in 2024.

Key Indicator #1: The SMCHD Workforce Development (WFD) Plan will be reviewed and updated annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: By reviewing the outcomes and impacts of the WFD Plan, changes in workforce or training needs will be identified. The Plan will be reviewed at the completion of the calendar year, with a new or revised plan of action developed for implementation in the next year.
- Target: Annual Review
- Actual: The 2024 WFD Plan was reviewed and updated for 2025 implementation.
- Analysis: **This indicator was met for 2024**
- Plan: Abandon this indicator for 2025, as it is routinely monitored through the SMCHD Strategic Plan Tracker.

Key Indicator #2: One Public Health (PH) Core Competency will be assessed annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: In order to objectively asses the competency and training needs of staff, the SMCHD will need to use a standardized set of core competencies.
- Target: 1
- Actual: 1. The SMCHD assessed "Data Analytics and Assessment Skills" in 2024
- Analysis: **This indicator was met for 2024.**
- Plan: Modify this indicator for 2025 to read: Two PH Core Competencies will be assessed annually.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator #3: One Employee Recognition activity will be implemented annually.

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

- Rationale for Choosing this Indicator: It is important to create an organizational culture and work environment that is supportive of the staff, and to recognize staff accomplishments and achievements.
- Target: 1
- Actual: 3
- Analysis: **This indicator was met for 2024. (Over the target).**
- Plan: Modify this indicator for 2025 to read: One Supportive workplace environment will be implemented quarterly. (Will continue to monitor employee recognition through the Strategic Plan Tracker.)
- Quality Improvement (QI): A QI project is not needed for this key indicator.

STRENGTHEN AND MAINTAIN PARTNERSHIPS

Key Indicator #4: The Community Health Improvement Plan (CHIP) strategies will be reviewed quarterly by the CHIP Steering Committee.

- Standard/Benchmark: 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: 4
- Actual: 4
- Analysis: **This indicator was met for 2024.**
- Plan: Continue this key indicator for 2025, then modify to include specific indicators from 2025 CHIP.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator #5: Applicable Community Health Assessment (CHA) data will be collected/analyzed/reported annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: The review of applicable CHA data will support the Community Health Improvement Plan (CHIP) evaluation process. The SMCHD Surveillance Plan will support this action.
- Target: Annual data collection/analysis/reporting
- Actual: The SMCHD collected/analyzed/reported CHA data during the new CHA cycle in 2024
- Analysis: **This indicator was met for 2024.**
- Plan: Abandon this indicator for 2025. The Surveillance Plan was updated to include this process, and updated CHA data will be reported in subsequent annual reports.

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

Key Indicator #6: One data-set from Menominee County CHA and/or other surveillance will be identified and evaluated annually to drive program activities.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: The SMCHD is a multi-county health department that serves the geographical jurisdictions of Shawano and Menominee Counties, excluding tribal lands. It is important that the SMCHD maintains partnerships with organizations within Menominee County, and that services are accessible to, and in alignment with the needs of the residents.
- Target: 1 data-set identified and evaluated annually
- Actual: The SMCHD collected/analyzed/reported Menominee County CHA and surveillance data in 2024 as part of the new CHA cycle. A subset of this data will continue to be monitored annually as part of the 5-year Population Health Outcomes reporting for PHAB.
- Analysis: **This indicator was met in 2024 with the new CHA cycle.**
- Plan: Abandon this key indicator for 2025, as it is routinely monitored through the SMCHD Strategic Plan.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator #7: Customer Feedback/Satisfaction information will be collected from two partners annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: Customer feedback is a method to "listen to the voice" of the customer, community, partners and stakeholders to build relationships, determine the level of satisfaction with the department, and indicate whether a SMCHD public health activity is successful or needs improvement. Customer feedback supports reaccreditation. A 2024 follow-up PM assessment indicated that 67% of staff only somewhat think that performance is actively monitored in Customer Focus and Satisfaction. Staff received additional training on the current process.
- Target: 2
- Actual: 1
- Analysis: **This indicator was not met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI project may be considered for this key indicator.

DEMONSTRATE DEPARTMENTAL EXCELLENCE

Key Indicator #8: The SMCHD Performance Management (PM)/Quality Improvement (QI) Plan/Work Plan will be reviewed and updated annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: By reviewing the outcomes and impacts of the PMQI Plan, the SMCHD can continuously assess its culture of quality. The Plan will be reviewed at the completion of the calendar year, with a new or revised plan of action developed for implementation in the next year.
- Target: Annual Review
- Actual: The 2024 PM/QI Plan was reviewed and updated for implementation in 2025.
- Analysis: **This indicator was met for 2024.**
- Plan: Abandon this key indicator for 2025, as it is routinely monitored through the SMCHD Strategic Plan.

Key Indicator #9: One Program Area QI project will be implemented annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: By implementing a program area QI project the SMCHD will ensure that it uses data for decision-making, manage change, and create a learning organization.
- Target: 1
- Actual: 1. An Emergency Preparedness QI Project was implemented in 2023 but was discontinued in 2024 due to lack of data.
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator #10: One Administrative QI Project will be implemented annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: By implementing an administrative area QI project the SMCHD will ensure that it uses data for decision-making, manage change, and create a learning organization.
- Target: 1
- Actual: 0. No Administrative QI projects were implemented in 2024.
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator #11: Progress towards the objectives and strategies of the SMCHD Strategic Plan will be reviewed and updated quarterly.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: The Strategic Plan provides a roadmap to foster a shared understanding among staff to align towards contributing to what the SMCHD plans to achieve, how it will achieve it, and how it will know whether efforts are successful.
- Target: 4
- Actual: 4
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator #12: 100% of the SMCHD Policies and Procedures will be reviewed annually.

- Standard/Benchmark: Wisconsin Administrative Code 140, Public Health Accreditation Board (PHAB)
- Rationale for Choosing this Indicator: Written policies and procedures serve as tools to guide the SMCHD's work, and bring structure and organization to the department and must be reviewed, revised and remain in alignment with administrative and human resource changes or new directives, be based on the best available evidence and be available to all staff, to ensure the effectiveness of processes, programs and interventions.
- Target: 100%
- Actual: 97%.
- Analysis: **This measure was not met for 2024.** The SMCHD developed a procedure and tracking system to facilitate this activity in 2023, and will further implement the process for 2025. Several administrative and program area policies and procedures were created to ensure that the department was following best practices in its operations.
- Plan: Abandon this key indicator for 2025, as it is routinely monitored through the SMCHD Strategic Plan.

DEMONSTRATE GOOD STEWARDSHIP AND SUPPORT FOR PUBLIC HEALTH RESOURCES

Key Indicator # 13: The SMCHD Budget status will be reviewed and evaluated monthly (3 times per quarter).

- Standard/Benchmark: 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: 12
- Actual: 12
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Key Indicator #14: Four new grant funding opportunities will be identified and reviewed annually.

Standard/Benchmark: 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: 4

Actual: 3

Analysis: **This measure was not met for 2023.**

Plan: Continue this key indicator for 2025.

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

The SMCHD will be removing 5 Administrative Key Indicators for 2025 as these are monitored through the Strategic Plan Tracker and were all met for 2024:

***Key Indicator #15:** The Public Health Emergency Response Plan (PHERP) will be reviewed annually and revised as necessary.

***Key Indicator #16:** The Communication Plan will be reviewed annually and revised as necessary.

***Key Indicator #17:** The Branding Strategy Plan will be reviewed annually and revised as necessary.

***Key Indicator #18:** One innovation strategy will be identified and implemented annually.

- Standard/Benchmark: Foster innovation: (PHAB)
- Rationale for Choosing this Indicator: As public health continues to address complex and rapidly changing problems, the need for innovation is urgent.
- Target: 1
- Actual: 0
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

***Key Indicator #19:** Interaction Data (likes, comments, shares) on four original face book posts will be collected monthly.

- Standard/Benchmark: Maintain procedures to provide on-going communication outside the health department (PHAB)

- Rationale for Choosing this Indicator: The SMCHD must ensure that information is in an appropriate format to reach priority audiences.
- Target: No data available
- Actual: An average of 66 content interactions per month
- Analysis: **This measure was not met for 2024.**
- Plan: Modify this key indicator to read: *The SMCHD will receive at least an average of 70 content interactions per month on Facebook posts for 2025.*
- Quality Improvement (QI): A QI project is not needed for this key indicator.

The SMCHD will be adding 3 new Administrative Key Indicators for 2025:

Key Indicator #8: All SMCHD staff will participate in at least one QI project annually.

Key Indicator #16: Two communication campaigns will be implemented and evaluated annually.

Key Indicator #20: 100% of SMCHD staff will complete at least one Health Equity training annually.

Communicable Disease (CD)

The SMCHD added 1 new CD PM measure (designated with a *) to its PMS in 2025.

DEMONSTRATE DEPARTMENTAL EXCELLENCE

Key Indicator #1: 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 ongoing community pertussis cases in 2024).

- Standard/Benchmark: 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 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #2: A Wisconsin Electronic Disease Surveillance System (WEDSS) quality assurance (QA) report will be run and evaluated quarterly to monitor timeliness of CD follow-up.

- Standard/Benchmark: 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: 4

- Actual: 4
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement: A QI project is not needed for this key indicator.

Key Indicator #3: The annual Shawano County STI rate will be below the Northeast WI STI rate.

- Standard/Benchmark: Wisconsin 2022 rates per 100,000- Chlamydia- 439/Gonorrhea-150/Syphilis-33
- Rationale for Choosing this Indicator: It can be beneficial to compare local data to state reported data to help identify patterns and trends, and to identify, implement and evaluate public health interventions.
- Target: Rates per 100,000 below- Chlamydia- 439/Gonorrhea-150/Syphilis-33
- Actual: No real-time data available
- Analysis: No real-time data available
- Plan: Abandon this key indicator for 2025
- Quality Improvement (QI): A QI project is not needed for this key indicator.

***Key Indicator #4:** One enteric audit will be completed quarterly.

- Standard/Benchmark: Wisconsin State Statute 252
- Rationale for Choosing this Indicator: Routine review of case investigations will ensure standardization of process and help to identify improvement opportunities.
- Target: 4
- Actual: 4
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Emergency Preparedness

- **STRENGTHEN AND MAINTAIN PARTNERSHIPS**
- **DEMONSTRATE DEPARTMENTAL EXCELLENCE**

Key Indicator #1: At least one Homeland Security Exercise and Evaluation Program (HSEEP) exercise will be completed annually.

- Standard/Benchmark: 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
- Analysis: **This measure was met for 2024.**
- Plan: Abandon this key indicator for 2024 as the emergency preparedness deliverables are tracked through RedCap.
- Quality Improvement (QI): A QI project is not needed for this key indicator.

Environmental

Strategic Plan Goals

- **STRENGTHEN AND MAINTAIN PARTNERSHIPS**
- **DEMONSTRATE DEPARTMENTAL EXCELLENCE**

Key Indicator #1: Domestic animal (dog/cat) bite cases reported to the SMCHD by law enforcement will be reviewed quarterly to determine if 75% completed the 10-day quarantine requirements.

- Standard/Benchmark: 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: 77% (average)
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025. Will look at data collection and excel tracker to improve data analysis.

Key Indicator #3: Environmental complaints will be reviewed quarterly to determine if 90% of the investigations were started within 7 business days of receipt.

- Standard/Benchmark: 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: 95%
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #4: 100% of environmental complaints referred to partners will have follow-up within 30 days of referral to obtain information on partner enforcement or other actions.

- Standard/Benchmark: 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: 100%
- Actual: 38%
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is needed for this key indicator.

Immunization

Key Indicator #2: SMCHD will implement one immunization outreach activity per quarter.

- Standard/Benchmark: Wisconsin Immunization Consolidate Contract Program Activities
- Rationale for Choosing this Indicator: Sharing immunization information with area physicians, other stakeholders and the community can help to improve immunization rates in Shawano and Menominee Counties.
- Target: 4
- Actual: 5
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #3: 67% 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/Benchmark: Wisconsin (WI) 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.
- Target: 67%
- Actual: 60%
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025. Target will be 69%. (Set by WI DHS Immunization Program)
- Quality Improvement (QI): A QI project is not needed for this indicator at this time.

The SMCHD will be adding 1 new Immunization Key Indicator for 2025:

Key Indicator #4: 100% of Medicaid eligible children who receive a vaccination from the SMCHD will have the service billed through the Forward Health Portal.

Lead

The SMCHD added 1 new Lead PM measure (designated with a *) to its PMS in 2024.

Key Indicator #2: 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%
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #3: 75% of children with a venous blood lead level ≥10mcg/dL will accept a nurse and environmental home visit within four weeks.

- 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 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

***Key Indicator #4:** 80% of parents of children with a venous blood lead level ≥5mcg/dL will receive a successful outreach (phone call, text, letter, face-to-face) from the PHN within 2 weeks of the venous blood lead level report date.

- Standard: Wisconsin Lead Program Consolidated Contract Objective
- Rationale for Choosing this Indicator: Outreach facilitates educational opportunities for parents, allowing them to express questions and/or concerns.
- Target: 80%
- Actual: 100%
- Analysis: **This measure was met for 2024.**

- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

The SMCHD will be adding 2 new Lead Key Indicators for 2025:

Key Indicator #5: 100% of Medicaid eligible children requiring follow-up by the SMCHD will have the service(s) billed through the Forward Health Portal.

Key Indicator #6: SMCHD will implement one lead outreach activity per quarter.

Maternal Child Health (MCH)

Strategic Plan Goals

- **STRENGTHEN AND MAINTAIN PARTNERSHIPS**
- **DEMONSTRATE DEPARTMENTAL EXCELLENCE**

Key Indicator #1: 75% of MCH clients referred to the SMCHD will receive a successful outreach (phone call, text, letter, face-to-face) by the MCH nurse to determine needs within 2 weeks of referral.

- 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: 79%
- Analysis: **This measure was met for 2024.**
- Plan: Continue this indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

The SMCHD will be adding 1 new MCH Key Indicator for 2025:

Key Indicator #4: The SMCHD will participate in 50% of the SAECP events annually.

School Nursing

Strategic Plan Goals

- **STRENGTHEN AND MAINTAIN PARTNERSHIPS**
- **DEMONSTRATE DEPARTMENTAL EXCELLENCE**

Key Indicator #1: 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 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #2: 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 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Woman, Infants and Children (WIC)

- **DEMONSTRATE DEPARTMENTAL EXCELLENCE**
- **ASSURE EQUITABLE ACCESS TO SERVICES AND HEALTH CARE**

Key Indicator #1: 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% (Average)
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #2: 82% of WIC moms will report they have breastfed at some point (incidence).

- Standard: WIC (82%)
- 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: 82%
- Actual: 75% (Average)
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #3: 77 % of WIC moms will report they are still breastfeeding at 1 month

- Standard: WIC (77%)
- 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: 77%
- Actual: 80% (Average)
- Analysis: **This measure was met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #4: 60% of WIC moms will report they are breastfeeding at 6 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: 60%
- Actual: 45%
- Analysis: **This measure was not met for 2024.**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #5: Reasons why WIC Breastfeeding moms stop breastfeeding will be reviewed quarterly.

- 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: 4
- Actual: 4
- Analysis: **This measure was met for 2024**
- Plan: Continue this key indicator for 2025.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Chronic Disease: Tobacco Prevention

Key Indicator #1: Two tobacco prevention social media messages will be developed and posted each month.

- Standard/Benchmark: Public Health Foundational Area (Chronic Disease)
- Rationale for Choosing this Indicator: The SMCHD will communicate effectively to inform and education people about health, factors that influence it, and how to improve it.
- Target: 24
- Actual: 14
- Analysis: **This measure was not met for 2024.** The SMCHD has updated its Communication Plan for 2025 and identified a Communication Specialist, who will be responsible for social media.
- Plan: Modify this key indicator to read: Two tobacco prevention Facebook messages will be posted each quarter.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

Key Indicator #2- The SMCHD will initiate one partnership with a local tobacco prevention alliance in 2024.

- Standard/Benchmark: Participate actively in a community health coalition (PHAB)
- Rationale for Choosing this Indicator: Community partnerships and coalitions facilitate public health goals being accomplished, promotes community resilience, and advances the improvement of the public's health.
- Target: Membership into one tobacco alliance
- Actual: 0
- Analysis: **This measure was not met for 2024.**
- Plan: Abandon this indicator as the SMCHD has been unable to join a regional tobacco coalition.
- Quality Improvement (QI): A QI Project is not needed for this key indicator.

2024 Performance Management Workplan Evaluation

The PM reassessment, implemented in Jan 2024, and based off of the Public Health Foundation (PHF) Performance Management Self-Assessment, identified both strengths and areas in need of improvement. Based on this assessment, as well as to ensure the SMCHD continues to implement a PMS in alignment with PHAB requirements, goals, objectives and strategies were developed (guided by the transition strategies) to address identified gaps:

PM Goal 1: Governing Bodies and 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 by December 31, 2024

- Strategy 1.1.1 Ensure that PMS is on the BOH agenda on a bi-annual basis (FEB, AUG) - **This strategy was not fully met due to turnover in the HO position.**
- Strategy 1.1.2 Utilize the BOHVS Orientation Packet to provide PM/QI training for any new members - **This strategy was not implemented in 2024 as there were no new BOHVS members.**
- Strategy 1.1.3 Include a PM/QI Section in the SMCHD Annual Report - **This strategy was met for 2024 and will be an ongoing section in future SMCHD Annual Reports**

PLAN: Will continue Strategy 1.1.1 and 1.1.2 for 2025.

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

Objective 1.2: Ensure the performance management system is in alignment with the SMCHD operational plans (2023-2028 Strategic, WFD, PM/QI, PHERP, Communication and Branding Strategy Plans) by December 31, 2024

- Strategy 1.2.1 Include the plan-specific measures in the PMS - **This strategy was not completely met and plan strategies will be included in the PMS.**
- Strategy 1.2.2 Include CHA/CHIP measures in the PMS (NEW) This strategy was not met.

PLAN: Will continue with Strategy 1.2.1 and 1.2.2 for 2025.

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

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 continue to identify additional program area measures to be incorporated into the department's PMS by December 31, 2024

- Strategy 2.1.1 Make PM a routine agenda item and encourage ALL staff to report off on their measures - **This strategy was met and PM will continue to be a routine agenda item.**
- Strategy 2.1.2 Identify opportunities to enhance the tracking system - **This strategy was met through the assistance of an AHEC intern.**
- Strategy 2.1.3 Continue to Identify aspects of core operations and program areas for which performance is already being measured and data is collected or available (Emphasis on Customer Focus and Satisfaction and Financial Systems) - **This strategy was not met.**

PLAN: Will continue with Strategy 2.1.3 for 2025.

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

Objective 2.2: All new SMCHD staff will receive fundamental PM training within six months of hire through December 31, 2024.

- Strategy 2.2.1 Provide PMS training to new SMCHD staff within six months of hire- **This strategy was met and was added to the New Hire Orientation Checklist.**

Objective 2.3: All SMCHD staff will receive PM training based on the 2024 PM Reassessment by December 31, 2024

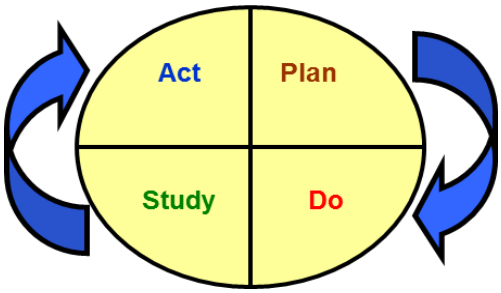
- Strategy 2.3.1 Conduct PM Reassessment - Completed 1/2024 - **This strategy was met.**
- Strategy 2.3.2 Identify training needs based on reassessment (NEW- Completed 2/2024)- **This strategy was met.**
- Strategy 2.3.3 Conduct training based on reassessment (NEW-Specific to performance measure criteria and selection) - **This strategy was met.**
- Strategy 2.3.4 Evaluate training - **This strategy was not met.**

PLAN: Develop training evaluation process.

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

2024 Quality Improvement Workplan Evaluation

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 QI reassessment, implemented in January 2024, and based off of NACCHO's Roadmap to a Culture of Quality, identified both strengths and areas in need of improvement. Based on this assessment, as well as to ensure the SMCHD continues to implement a PMS in alignment with PHAB requirements, goals, objectives and strategies were developed (guided by the transition strategies) to address identified gaps:

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 Reassessment, to move SMCHD towards a culture of quality by 12/31/2024

- Strategy 1.1.1 Administration to seek out additional PM/QI trainings for both leadership and staff - **This strategy was not met.**
- Strategy 1.1.2 Conduct QI Reassessment (NEW- Completed 1/2024) - **This strategy was met.**
- Strategy 1.1.3 Identify training needs based on reassessment (NEW- Completed 2/2024) - **This strategy was met.**
- Strategy 1.1.4 Conduct training based on reassessment (NEW-Specific to the formal steps of a QI Project) - **This strategy was met.**
- Strategy 1.1.5 Evaluate training - **This strategy was not met.**

PLAN: Continue strategy 1.1.1. Develop training evaluation process.

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

Objective 1.2 All staff will participate in at least one QI Project annually by 12/31/2024

- Strategy 1.2.1 Continue to include PM/QI a routine agenda item, and encourage ALL staff to report out on their QI activities - **This strategy was met.**
- Strategy 1.2.2 Encourage QI work: project submissions, ensure resources (time) is available for QI projects, celebrate QI successes - **This strategy was not met. No QI projects were submitted in 2024.**

PLAN: Continue strategy 1.2.2

Responsible party: All SMCHD Staff

2024 QI Projects

In 2024, the SMCHD initiated a program area QI Project for Emergency Preparedness entitled "EP Partner Notification" as part of an After-Action Report/Improvement Plan on an EP Reception Center Tabletop Exercise completed in 2023. However, this QI Project was abandoned in April 2024 as there was no additional data available to proceed and the department was unable to implement the chosen solution. Unfortunately, due to staff turnover and capacity, no additional QI Projects were implemented.

2024 PM/QI Improvements

DATE	ACTIVITY
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.
4/23	Performance Management Quarterly Meeting. PM Tracker updated with Population Health Outcomes and additional program area measures.
7/23	Performance Management Quarterly Meeting. PM Tracker updated with modified measures.
11/23	PM data entry process clarified. SP Goals added to PM Tracker
12/23	Added Brainstorming Appendix. PM Tracker modified for 2024 implementation.
4/30/2024	QI Project abandoned due to lack of additional data and inability to implement RAVE.
6/12/2024	Staff received QI Training based on 2024 QI Reassessment
7/30/2024	Staff received PM Training based on 2024 PM Reassessment. Staff received Customer Focus/Service Trainings.