Franklin County Health Department
1418 South Main, Suite 1
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Performance Management Plan 2017-2021

The purpose of this plan is to establish a system of continuous assessment and evaluation of progress toward goals and objectives of the department. The system is designed to facilitate improvement in the performance of staff and governing body, the organization and community health outcomes. It is to be reviewed and updated annually by department staff and administrators.

Approved: 5/31/2018
Reviewed:

Mary V Ransom, PhD
Director

Overview

The Performance Management System is used to evaluate performance across the department based upon established objectives and measures and to encourage continuous quality improvement by recognizing progress and identifying problems or issues. Franklin County Health Department system is based upon the four core components of the “Turning Point Performance Management Framework”[1]; Performance Standards, Performance Measurement, Reporting of Progress, and Continuous Quality Improvement. The graphic below illustrates the components and their activities as found at the Public Health Foundation: http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/PM_Toolkit_About_the_Performance_Management_Framework.aspx

Performance Standards

Standards used by the department are guided by national and state performance standards, including Public Health Core Competencies, National Public Health Performance Standards, Healthy People 2020, Public Health Accreditation Board and

[1] Turning Point Performance Management National Excellence Collaborative

general accounting or financial principles. The FCHD vision, mission, values, and strategic plan and Kansas State Goals and Objectives also are used to set expectations for the department.

Performance Measures

FCHD has selected measures to monitor staff performance and workforce development, program goals and objectives, financial and administrative management, service delivery, health promotion and communication, community involvement, and community health outcomes and data collection and information systems. Each staff member reviewed standard reports, project objectives and their job responsibilities to identify issues in need of improvement. Discussion followed with coworkers and the department director as to value and importance of each issue presented to narrow the issues for improvement and tracking. All measures are dated and found in a Performance Management spreadsheet which is reviewed annually.

Reporting Progress

Systematic collection and analysis of data in regards to the measures will be utilized to prepare and present reports both internally and externally. These reports will be used to inform the governing body, the community, and the staff, individually and as a whole. Regular reports include:

- Annual review of the FCHD strategic plan
- Quarterly financial and activity report to Board of County Commissioners/Board of Health
- Annual Community Improvement Plan Progress report
- Healthy Communities Update – semi-annual
- All-Staff meetings quarterly or more frequent

Quality Improvement (QI)

Each staff member reviews quarterly the measures selected against the standard identified for progress toward the objective. The staff as a team selects a QI project based upon objectives not met or sufficient progress made relative to each objective. Sufficient progress toward objective is determined by team prioritization process of all issues presented. The data collected for monitoring the performance measures is used to identify areas for quality improvement. The FCHD staff uses QI tools, including input from management, clients, and stakeholders, to develop the QI plan. The plan addresses department policy, programs, infrastructure and community health status.

Performance Management Team

The FCHD staff comprises the PM Team. The Director is responsible for ensuring integration of performance management across the department. The director is responsible for assuring staff has access to necessary data and training to conduct their duties. No less than quarterly, the FCHD staff will review and record progress toward targets. If targets are not being met or progress not evident, staff will recommend evidence-based initiatives, policy changes, and other actions.

Tracking Progress- The Tools

A combination of electronic systems is used to record data and track progress for the measures and QI plans. Individual program data will be recorded by the program

lead according to individual program standards for timely reporting. The Quality Improvement, Strategic and Community Health Improvement plans are the responsibility of the director. If a specific clinical or program QI plan is being evaluated, the director may appoint another staff member involved in the issue to track data and build reports. An excel spreadsheet is found on the internal staff shared drive for recording progress and accomplishments.

Program/Area	Goal/Objective	Measure	Standard	Tracking System	Staff Lead	Goal Date
Administration						4/1/2018
	Evaluate, monitor and revise as needed the performance management system (PHAB 9.2) annually	Revised/reviewed plan on file	PHAB 9.2	Internal Logs	M Ransom	
	Review and report on strategic plan annually, update every 5 years	Report posted online and presentation to commission	PHAB	Internal Logs	M Ransom	3/1/2018
	Review and update department policies biannually	95% of policy review dates within previous two years.	PHAB	Internal Logs	M Ransom	8/1/2017
Financial						
	Monthly Aging Report is reviewed within 10 days of close of month.	% claims paid within 30 days	90% of claims paid within 30 days	Quarterly Review Log	T Moore	4/1/2019
	All FP/MCH paperwork completed at visit to include demographic, financial, and consents	Title X program requirements requiring 100% accuracy and completeness	100% of individual data entered into system and reportable	Quarterly chart audits – ten random; program data reports	F McCord	4/1/2019
	Complete annual cost analysis on programs	Completion annual date	Fee schedule reflects cost of program service less predetermined grant/county support	Annual review and submission to BOH	RWalker/M Ransom	November 2018
	Maintain timely filing of insurance claims	% of claims filed within running time period of six(6) months	98% of claims filed within two	EMR/Billing claims report	T Moore	April 1, 2019

			weeks of service date			
Clinical						
	Body Mass Index (BMI) screening and follow-up	% of patients aged 2-11 w/ documented BMI during encounter or previous 6 months AND when outside normal parameters, a follow-up plan is documented and referral made	95% MCH children screened on CDC BMI; plotted on growth chart; above the 85 percentile and reveral made as needed	Patagonia QA report	J Garcia	4/1/2019
	Gardasil rates will increase by 20%	65% coverage	CDC/KDHE Immz Program	Patagoinia or WebIZ reports of client immz rates	J Garcia	7/1/2019
	APRN charts reviewed and accepted without error by medical director	# Approved charts/10 charts reviewed	100% of charts reviewed as complete	Patagonia and log	W Ransom	7/1/2019
Individual	Staff performance reviews conducted annually per county policy	# staff performance reviews indicating meets expectations or assigned improvement plan within 10 days of individual review date	100% of staff meet expectations at annual review or within 6 months of improvement plan	Administrative log review	M Ransom	
	Complete Workforce	Completion of required annual	100%	KS-Train	Erin Laurie	April 1,

	training plans as required by grants and core competencies-	trainings, orientation and completion of recommended training per core competencies	completion of required trainings per timeline; 60% of recommended training	reports and internal logs		April 1,2019
Community						
	Key CHA indicators data updated annually and posted on web site	Posted date_	PHAB Minimum one Data indicator posted monthly	Internal Log/ electronic media usage reports	M Ransom	12/2018
	Social media reach is increased annually by 2%	Number of likes and followers	Internal comparison charted	FACEBOOK report/ Webpage report	MA Parkin	4/1/2019
	Social media information is updated weekly to retain interest	Number of posts by general content area	Internal standard to be determined following baseline chart development	Excel Log or Facebook report	MA Parkin	4/1/2019
Disease Investigation and Containment						
	All cases will be completed per state guidelines within established timelines	% completion with data entry in all fields as required by guidelines	KDHE monthly indicators report and semi-annual audit 100% complete	Epitrax; Quarterly report to administration	M Ransom (updates to R Walker – 8/30/2017)	April 1, 2019