Arkansas Department of Health

Performance Management and Quality Improvement Plan

2024-2029

Submitted by
Office of Performance Management, Quality Improvement, and Evaluation
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MISSION, VISION AND VALUES

Mission Statement:
Protect and improve the health and well-being of all Arkansans.
(Arkansas Department of Health)

ADH Vision Statement:
Achieve optimal health for all Arkansans to achieve maximum personal, economic, and social impact.
(Arkansas Department of Health)

Performance Management
Performance management encompasses the ongoing process of measuring, monitoring, and reporting progress toward strategic organization, Division, and program goals and objectives.[1] Performance management is closely linked with quality improvement (QI), as it provides a structured, data-driven approach to identifying and prioritizing opportunities for Improvement. However, performance management is distinct from quality improvement. Performance management is the continuous use of four components: performance standards, performance measures, reporting of progress, and quality improvement (*National Association of County & City Health Officials*).

Continuous Quality Improvement
Continuous Quality Improvement (CQI) is a detailed approach that identifies and addresses opportunities for enhancement within an organization's processes, products, or services.
CQI is rooted in the belief that there is always room for growth and that even the most well-established practices can benefit from it. It encourages organizations to adopt a relentless pursuit of perfection, where complacency is never an option, and the status quo is constantly challenged.
(SixSigma: Continuous Quality Improvement, Driving Organizational Excellence)

KEY TERMS AND DEFINITIONS

Key terms and frequently used acronyms are listed alphabetically in this section.

Continuous Quality Improvement (CQI): A progressive and incremental improvement of processes, services, and outcomes. CQI's goal may include improving operations, systems, processes, programs, work environment, regulatory compliance, or outcomes.

Dashboard: A dashboard is a tool commonly used to display data and other important information in a way that is easy to comprehend and digest.

Evaluation: Program evaluation is a critical function that ADH uses to improve and strengthen activities and programs within the agency. Evaluation can provide insights into many questions, including the strengths of current programs and areas for Improvement throughout a program life cycle, such as the adequacy of program resources, accuracy of program assumptions, quality of program operations, and the intended and unintended effects of a program.

Performance Management: A system integrated into the agency's daily practice at many levels, including 1) setting objectives, 2) identifying indicators to measure progress toward achieving objectives, 3) monitoring progress and reporting, and 4) identifying areas requiring focused QI processes.

Plan, Do, Study, Act (PDSA, also known as Plan-Do-Check-Act PDCA): A four-stage, problem-solving model for improving a process or carrying out change. PDSA stems from the scientific method (hypothesize, experiment, and evaluate). A fundamental principle of PDSA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned.

Project Charter: Documents the purpose of a QI project and defines operating rules and responsibilities.

Public Health Accreditation Board: The only national accrediting body for public health in the U.S. that supports health departments in improving quality, accountability, and performance.

Quality Assurance (QA): A systematic process assures the agency that all the necessary systems are in place and that the processes, products, or services meet quality requirements. QA system provides the agency with training, tools, methods, and metrics to improve the processes, products, and services.

Quality Improvement (QI): A systematic approach for achieving measurable improvements in the efficiency, effectiveness, performance, accountability, and outcomes of the processes or services provided by a program, an agency, or an organization.

Quality Improvement Plan: A plan that identifies specific areas of current operational performance for Improvement within the agency.

Storyboard: Graphic representation of a QI Project and team's quality improvement journey.

TRAIN: This is a national learning network that provides thousands of quality training opportunities to professionals who protect and improve the public's health. Powered by the Public Health Foundation (PHF), the TRAIN Learning Network brings together agencies and organizations in the public health, healthcare, and preparedness sectors to disseminate, track, and share training for the health workforce on a centralized training platform.

ACRONYMS

ADH	Arkansas Department of Health
ALCC	Arkansas Lifeline Call Center
CDC	Centers for Disease Control and Prevention
CQI	Continuous Quality Improvement
KSA	Knowledge, Skills, and Abilities
LHU	Local Health Unit
OHC	Office of Health Communications
OPMQIE	Office of Performance Management, Quality Improvement, and Evaluation
OPHP	Office of Public Health Programs
PA	Performance Area
PDSA	Plan, Do, Study, Act
PH	Public Health
PHAB	Public Health Accreditation Board
PM	Performance Management
PMC	Performance Management Council
PMS	Performance Management System
QA	Quality Assurance
QI	Quality Improvement
QIP	Quality Improvement Plan
SAS	Staff Action Summary

INTRODUCTION

The Arkansas Department of Health (ADH) is an accredited public health agency. It received its initial accreditation by the Public Health Accreditation Board (PHAB) in 2016. It is currently awaiting PHAB reaccreditation for the next five years. PHAB requires all accredited agencies to maintain a thriving Performance Management (PM) and Quality Improvement (QI) system, two of the core foundational capabilities of public health practice. PM and QI are interdependent processes. The most current PHAB Standards & Measures v.2022 provides guidance to public health agencies on achieving PM and QI goals and objectives through continuous measuring and monitoring of the processes and reporting progress.

The 2024-2029 PM and QI Plan of the ADH emphasizes the practice of public health performance by ADH by adhering to PHAB Standards & Measures while improving them by having a strong PM and QI system in place. QI is evidenced by specific improvement projects when performance standards lag or fail.

Sustained leadership buy-in, a sound infrastructure, ongoing training programs, strong communication among ADH stakeholders, continued process monitoring of measures, and regular progress reporting are the salient features of the PM and QI systems. An agency with well-established PM and QI systems enjoys process improvement, program development, and improved service delivery.

In this Plan, PM and QI systems will work synergistically at the agency level to promote the culture of Continuous Quality Improvement (CQI). CQI is a culture that normalizes QI through day-to-day practice. When the PM identifies gaps in specific public health program areas, the QI team develops goals to bridge the gap. ADH is committed to developing a culture of CQI through the support of ADH's senior leadership team, the efforts of the Office of Performance Management, Quality Improvement, and Evaluation (OPMQIE), and most importantly, the participation of PM and QI teams across the agency.

PERFORMANCE MANAGEMENT (PM)

PERFORMANCE MANAGEMENT BACKGROUND

As an accredited public health agency, ADH has made efforts to adhere to PHAB Standards & Measures v.2022 in establishing a viable PM process. At the end of 2021, ADH made changes to its existing PM model using a survey and getting input from key ADH staff members. The model was modified again at the beginning of 2023, and it was reviewed and approved by the ADH leadership team members in 2024. The Performance Areas (PA) and measures of the current PM model are based on the ten PHAB public health domains, as illustrated in the figure below. The ten PA leaders constitute a PM Committee. Table 1 on page 10 provides lists of PAs, measures within each PA, and the name of the PA leaders.

OPMQIE provides oversight and support to the PM Committee members in monitoring activities related to the measures. Numerous meetings occurred in 2024 between OPMQIE, and the PA leads to ascertain PA measures and the steps leading to the associated goals. As a group, the Committee members are scheduled to meet in January 2025 for progress updates and reporting. The PM Manager will prepare and provide an annual report to PHAB and the ADH leadership team at the end of the Fiscal Year (FY). The FY period of this Plan coincides with the FY period of the ADH Strategic Plan and the State Health Improvement Plan, the two other core foundational capabilities of ADH.

Source: Standards & Measures for Reaccreditation, Version 2022, Public Health Accreditation Board: https://phaboard.org/wp-content/uploads/Standard-Measures-Version-2022-Reaccreditation.pdf

PERFORMANCE MANAGEMENT STRUCTURE

PM Infrastructure consists of the following components.

OPMQIE: The office has three essential units responsible for performance management, quality improvement, and program evaluation. They consist of a Director, a Performance Manager, a Quality Improvement Manager, two Public Health Evaluators, and a Quality Assurance Analyst. The two managers monitor the PM and QI activities of the Plan.

ADH Senior Executive Team: ADH's senior leadership team involved in the performance initiatives of ADH are the Secretary of Health, the Director (State Health Officer), the Deputy Director for Public Health Programs, and the Deputy Chief Medical Officer. They provide administrative oversight and guidance to OPMQIE operations.

ADH Division Directors: The Directors of the ADH Divisions listed below stay abreast of the PM activities and support the recruitment of PA leads in collaboration with the Deputy Director of Public Health Programs.

A. Health Advancement
B. Health Protection
C. Health Data and Analytics
D. Local Public Health
E. Public Health Laboratory

Performance Area Leads: The PA leads also constitute the PM Committee members. They are committed to a four-year term with the following responsibilities:

A. Assist in developing and monitoring PM measures at the division/program level.
B. Encourage data-driven decision-making.
C. Meet as a Committee with the OPMQIE team and report progress.
D. Identify opportunities for Improvement.

ADH Staff: In the long run, as ADH's PM process matures, the agency expects all ADH employees to get involved through area leads and participate in the process in a meaningful way.

PERFORMANCE MANAGEMENT COMMITTEE:

The new PM Committee members will begin to meet with OPMQIE every quarter, starting in January, to provide updates on their respective measures. OPMQIE will provide technical help to the Committee members in identifying data sources for the measures, collecting data, and reporting them. The data, quantitative or qualitative, are key to measuring changes occurring over time in programs, processes, and services provided. The measures are often tied to the objectives stated in the work plan. The table below provides a list of measures targeted in this Plan and the respective work units and name of the leads. To enhance data collection, management, and the sharing of outcomes, a PM-QI Scorecard will be developed in 2025 using the services of Clear Impact LLC (contract). The CI consultant will monitor PM Committee members and QI champions' access and use of the scorecard.

PERFORMANCE MANAGEMENT MEASURES:

PA # 1: Work Unit	Performance Measure	Description of Performance Measure	Area Leader
Office of Performance Management Quality Improvement & Evaluation (OPMQIE)	Formalize State Health Improvement Plan (SHA) Committee	(1) Reform SHA Committee (2) Update SHA data by January 2025 (3) Use data for planning, implementation of interventions (4) Diversify data to assess health disparities.	Dr. Ashamsa Aryal, Public Health Evaluator
Quality Improvement note: The absence of an active SHA Committee has interfered with the smooth operations of SHA data updates, indicator updates, and revisions in CI system. Navigation of SHA through a Committee is a PHAB requirement. The lead plans to regroup the committee members in 2025.			
PA # 2: Work Unit	**Performance Measure**	**Description of Performance Area**	**Area Leader**
Office of Preparedness & Emergency Response System (OPERS)	Update ADH Safety and Security Plan	(1) Reorganize the Committee, (2) Train Safety Officers, and (3) Implement essential drills.	Joe Martin, OPERS Director
Quality Improvement note: Bring quarterly fire drill practices to the federally mandated standards.			
PA # 3: Work Unit	**Performance Measure**	**Description of Performance Area**	**Area Leader**
Office of Health Communications (OHC), ADH Administration	Develop and implement a Plain Language Strategy for ADH	(1) Conduct plain language needs Assessment, (2) Analyze survey data, and (3) Develop and implement plain language training for ADH staff.	Meg Mirivel, OHC Director
Quality Improvement note: An assessment is needed to determine the plain language practices and training needs of ADH programs.			
PA # 4: Work Unit	**Measure**	**Description of Performance Area**	**Area Leader**
TBD	TBD	TBD	TBD
Quality Improvement note: TBD			
PA # 5: Work Unit	**Measure**	**Description of Performance Area**	**Area Leader**
Office of Performance Management Quality Improvement & Evaluation (OPMQIE)	Collect input from partners to amend SHIP for 2025	(1) Convene SHIP annual meeting (2) Present on annual progress made (3) Receive partners' input for 2025 (4) Amend SHIP based on the input and share.	Rupa Sharma, OPMQIE Director
Quality Improvement note: Overcome financial contract hurdles for a smooth operation of SHIP meetings and reporting.			

PA # 6: Work Unit	Measure	Description of Performance Area	Area Leader
Office of Chief Counsel, ADH Administration	Tracking and Investigating Mobile Food Units (MFU)	(1) Assess the current tracking system; (2) Assess the frequency of complaints about MFUs; (3) Identify gaps in the tracking system; and (4) Respond to fill the gaps.	Laura Shue, ADH Chief Counsel

Quality Improvement note: Fill in the gaps in the tracking system of the MFU operations.

PA # 7: Work Unit	Measure	Description of Performance Area	Area Leader
Division of Local Public Health	Conduct Needs Assessment of access to care in rural areas	(1) Assess primary care and dental provider shortage areas; (2) Identify pockets of **disparities**; (3) Analyze data; and (4) Develop recommendations and share.	Mandy Thomas

Quality Improvement note: Need for assessing access to/availability of primary care providers and specialists in rural Arkansas.

PA # 8: Work Unit	Measure	Description of Performance Area	Area Leader
Office of Workforce Development (OWFD), ADH Administration	Conduct Competency Assessment of ADH employees	(1) Identify tiers of skills assessment; (2) Develop questionnaire; (3) Analyze data and share results with key staff members; and (4) Address competency issues and barriers.	Dr. Kristy Caldwell, Workforce Director

Quality Improvement note: A comprehensive assessment of the core competencies of ADH employees is needed.

PA # 9: Work Unit	Measure	Description of Performance Area	Area Leader
Office of Performance Management Quality Improvement & Evaluation (OPMQIE)	Revision of the existing ADH Quality Improvement Plan	(1) Assess 2020-2023 QI Plan, (2) Incorporate PM components, (3) Link PM components to generate QI projects, and (4) Share with stakeholders.	Patty Hibbs, OPMQIE Manager

Quality Improvement note: Improve linkages of PM, QI, and Strategic Plan (PHAB requirement).

PA # 10: Work Unit	Measure	Description of Performance Area	Area Leader
Office of Performance Management Quality Improvement & Evaluation (OPMQIE)	Develop and implement a new ADH Strategic Plan	(1) Receive ADH staff input on strategic priorities; (2) Engage leadership and governance; (3) Finalize strategic priorities; and (4) Develop the Plan and share.	Rupa Sharma, OPMQIE Director

Quality Improvement note: Improve linkages of Strategic Plan with PM and QI (PHAB requirement).

PERFORMANCE MANAGEMENT WORKPLAN, 2025:

GOAL: Engage key ADH program area leaders in the ADH Performance Management activities by practicing PHAB-recommended Standards & Measures v.2022

Objective	Activity	Responsible Staff	Progress
1. Enlist PM Committee members for 2024-2025 by Jan 2024.	Obtain the names of PA leads from the ADH leadership team to be the PM Committee members for the period.	OPMQIE Director	Complete
2. Receive Committee members' consent on the forms by May 2024.	Have all Committee members sign and return consent forms.	Performance Manager	Complete
3. Conduct PM Committee Quarterly meetings in 2025 (in-person, virtual, and email updates).	Discuss achievements and barriers in collecting data on the measures. Update progress tracking forms after each quarterly meeting.	Performance Manager	Coming up in Jan 2025
4. Conduct Annual PM Meeting by Jan 2025.	Share annual progress with PM and QI teams and the ADH senior leadership team.	OPMQIE, Team	Planning
5. Report annual results in the Block Grant by Dec 2, 2024.	Complete the block grant's annual progress reporting requirement, 2023-2024.	Performance Manager, Director	The annual report completed
6. Report interim results in the Block Grant by Feb 2025.	Complete the interim progress reporting requirement for the Block Grant, 2024-2025.	Performance Manager, Director	Not started yet
7. Perform an Evaluation of the activities outlined in the PM Plan by Dec 2025.	The Public Health Evaluator will use the CDC framework to evaluate the outcomes of the activities stated in the PM-QI Plan.	OPMQIE Public Health Evaluator	An evaluation plan is being reviewed

DASHBOARD

A dashboard is a tool commonly used to display data and other qualitative information in an easy-to-understand format. OPMQIE is developing a public-facing Dashboard to monitor and inform its stakeholders about the activities and outcomes of each of the five foundational capabilities. The capabilities or components include PM, QI, State Health Assessment, State Health Improvement, and Strategic Plan. The OPMQIE Dashboard will also demonstrate the linkage between PM, QI, and the Strategic Plan. The dashboard is also expected to be a resource for internal and external stakeholders who seek to understand more about the roles of OPMQIE as it works toward achieving the goals and objectives of ADH's foundational initiatives. There will also be an Evaluation Section in the Dashboard.

DASHBOARD WORKPLAN:

GOAL: Inform ADH's internal and external stakeholders who seek to understand the role of OPMQIE as it works toward achieving the goals and objectives of ADH's foundational capabilities.

Objective	Activity	Responsible Staff	Progress
1. Develop the first draft of the Dashboard by 2024.	Develop the first draft of the Dashboard and run it by Informatics for review.	OPMQIE team	Complete
2. Develop the second draft of the Dashboard by the first quarter of 2025.	Based on the review, develop the second draft for the presentation and review of the ADH senior leadership team.	OPMQIE team	Ongoing
3. Respond to the changes after the leadership review, by the first quarter of 2025.	OPMQIE will make changes, if any, and route the final draft for SAS signatures/approval.	OPMQIE Director	TBD
4. Post the Dashboard online by the second quarter of 2025.	Continue to collaborate with Informatics to post the Dashboard online (Data Hub).	ADH Informatics OPMQIE	TBD
5. Inform the partners about the Dashboard by the second quarter of 2025.	Share the Dashboard link with partners, including PM, QI, SHA, SHIP, and SP partners, to inform/educate them about its content and understand ADH's foundational capabilities.	OPMQIE	TBD

QUALITY IMPROVEMENT (QI)

QUALITY IMPROVEMENT IN ADH

ADH's goal is to transition the agency from the state of Improvement (I) to Quality Improvement (QI) to Continuous Quality Improvement (CQI) through agency-wide efforts of OPMQIE and the QI teams. QI is a systematic approach to achieving measurable improvements in the efficiency and performance of the processes, program services, and outcomes. Conversely, CQI is a detailed agency-wide approach that identifies and addresses opportunities for enhancement. It encourages the agency to adopt a mindset of relentless pursuit of perfection, where the status quo is constantly challenged.

QUALITY IMPROVEMENT INFRASTRUCTURE

With its continuous efforts, ADH has made great strides over the years in developing QI Infrastructure, which consists of the following components:

OPMQIE: The office has three essential units responsible for performance management, quality improvement, and program evaluation. They consist of a Director, a Performance Manager, a Quality Improvement Manager, two Public Health Evaluators, and a Quality Assurance Analyst. The two managers monitor the PM and QI activities of the Plan. The QI manager facilitates team meetings, develops training, creates communication materials, and writes an annual QI progress report.

ADH Senior Executive Team: ADH's senior leadership team involved in the performance initiatives of ADH are the Secretary of Health, the Director, the Deputy Director for Public Health Programs, and the Deputy Chief Medical Officer. They provide administrative oversight and guidance to OPMQIE operations.

CQI Council Members: The Council comprises directors from the five (5) ADH Divisions and a few Offices of the Office of Directors (OD). The purpose of the Council is to facilitate, promote, and assess the growth of CQI in ADH. Some responsibilities of the CQI Council members are to:

1. Promote CQI as an institutional priority by spreading CQI culture in ADH.
2. Provide input in the development of a CQI communications strategy.
3. Recruit champions and provide oversight to the development of QI projects.

Below is the list of current Council members who have committed to serve a two-year term.

CQI Council Members 2024-2026	
Name	**Division**
Haley Ortiz	ADH Administration (OD)
Katie Seely	Division of Public Health Laboratory
Cristy Sellers	Division of Health Advancement
Connie Melton	Division of Health Protection
Jeremy Courtney	Division of Health Data and Analytics
Sheridan Kwanisai	Division of Local Public Health

QI Champions: There is at least one participating Champion for each of the five ADH Divisions and the ODs. QI Champions meet quarterly with the QI Manager for updates. The role of a QI Champion is to facilitate QI project activities in the following manner.

1. Select ADH staff to train and certify to become QI Pros.
2. Assist QI Pros in the development and implementation of QI projects.
3. Report the QI project outcomes to their Council routinely.
4. Integrate QI project outcomes into their division/unit.

Each Champion, listed below, is committed to participating in the QI project for two years.

QI Champions 2024-2026	
Name	**Work Unit**
David Vrudny	Stroke & STEMI
Sheryl Alexander	Office of Administration (OD)
Megan McCarthy	Public Health Laboratory
Dr. Rachel Sizemore,	Office of Oral Health
Jacob Smith	Injury Prevention Branch
Alan May	Informatics Section
Ebony Crutchfield, Richard McMullen	Local Public Health

QI Recruits and Pros: The roles and responsibilities of QI Recruits/Pros are to:

1. Select project team members to participate in the QI project.
2. Provide the QI Champion with a list of project team members for approval.
3. Lead the project team in developing and implementing the selected QI project.
4. Facilitate meetings guided by this charter.
5. Communicate progress to QI Champion(s) routinely.
6. Partner with their Champion (s) to integrate QI project outcomes into their work units.

Funding: OPMQIE's funding comes from the central budget of PHIG and PHHS Block Grant.

QUALITY IMPROVEMENT TRAINING

OPMQIE designed QI Training videos to equip ADH staff with practical knowledge and skills to develop and implement QI projects within their work areas. Eleven (11) learning videos (3 modules) were made available on TRAIN for all ADH employees. The series helps guide the development and implementation of QI projects by using proper tools and methods. A total of 111 ADH staff completed the 1st module during 2022-2023.

However, in 2024, the 11 videos were condensed into two, The Introduction to Quality Improvement Initiative and Promoting the Culture of CQI, for the ease of learning. The first 13-minute video (Course ID 112145) was placed on ADH TRAIN in Jun 2024. So far, a total of 178 ADH staff have completed the training. The second video is scheduled to be completed by April 2025.

The Introduction to Quality Improvement Initiative video covers the following concepts:

- The mission of OPMQIE and its role
- Definitions of (I), (QI), and (CQI)

- Six elements of QI and seven principles of CQI
- QI infrastructure at ADH
    - ✓ ADH Leadership
    - ✓ Council Members
    - ✓ Champions, Pros, and Recruits
    - ✓ All ADH Staff
- ADH QI Project
- Methods and tools that can be adopted to conduct QI projects. For example:
    - ✓ Plan, Do, Study, Act (PDSA method)
    - ✓ Brainstorming, Run Charts, and Fishbone Diagrams (tools).

Please refer to the section below for a better understanding of how ADH plans to promote the culture of CQI.

CULTURE OF CONTINUOUS QUALITY IMPROVEMENT

With the support of ADH's senior leadership team and the participation of division directors and the branches within, the OPMQIE will continue to integrate CQI practices into the agency. The agency-wide activities currently being implemented to support the culture of CQI in ADH are below:

1. Practice of PHAB Accreditation and Standards & Measures v.2022
2. Integration of PM and QI Plan
3. OPMQIE team overseeing the work of foundational capabilities, including PM and CQI
4. Buy-in of ADH’s senior leadership team
5. Participation of CQI Council members, representing ADH Divisions and Director’s Offices
6. QI Champions representing all ADH Divisions and a few ODs
7. Training videos available on ADH-TRAIN
8. Agency-wide dissemination of the QI Handbook
9. Dissemination of the QI Encyclopedia to the Council members, Champions, and PROs
10. Continue to develop QI Projects - currently 10 being conducted agency-wide
11. PM Committee in place
12. Funding supported by PHHS Block and the PHIG grants
13. The OPMQIE webpage is prepared to disseminate relevant information to its stakeholders
14. OPMQIE Dashboard is currently in production
15. PM & QI Scorecard to be developed in the Clear Impact system, complementary to the Dashboard
16. Potential PHAB Reaccreditation will lay a strong foundation for the journey.

With the currently available workforce and other resources in ADH, we plan to embark on a transformative journey to achieving excellence in managing our performance and enhancing the quality of the processes, programs, and services with the support of PHHS Block and PHIG grant funds.

INFRASTRUCTURE WORKPLAN, 2025

GOAL: Maintain and Enhance the QI infrastructure of ADH to support the culture of CQI			
Objective	**Activity**	**Responsible Staff**	**Progress**
1. Enlist new CQI Council members and Champions by Jan 2024.	Obtain names of CQI Council Members and QI Champions from the Deputy Director of Public Health Programs.	OPMQIE Director	Completed
2. Provide Project Charters to the Council members and Champions to sign by May 2024.	Have all Council, Champions, and Pros sign and return charter	QI Manager	Completed
3. Facilitate quarterly meetings of the Champions (in-person and virtual with email updates) through 2029.	Update QI project reporting forms after each quarterly meeting	QI Manager	Ongoing
4. Organize the first CQI Quarterly meeting with the Council members (ADH Division Directors) by Jan 2025	Update Executive Leadership on CQI Status updates	OPMQIE Director and QI Manager	TBD
5. Organize a CQI meeting with Senior leadership team members in 2025.	Provide continual CQI updates	OPMQIE Director and QI Manager	TBD

TRAINING AND EDUCATION WORKPLAN, 2025

GOAL: Educate and inform all ADH staff on the concepts of QI and CQI.

Objective	Activity	Responsible staff	Progress
1. Revise the QI Handbook for Champions by April 2024.	Review the QI Handbook, v2022, update, and get approval from the ADH Executive Team.	OPMQIE Director and QI Manager	Completed
2. Print the Handbook by May 2024.	Print 100 copies to be distributed to the QI team members and ADH staff.	QI Manager	Completed
3. Disseminate the QI Handbook to ADH staff by Jun 2024.	Disseminate the Handbook to the Champions, Pros, and Council members. Email the PDF version of the Handbook to all ADH staff through the Office of Health Communications.	QI Manager and Office of Health Communications.	Completed
4. Order and disseminate 100 QI Encyclopedia by Dec 2025.	Order 100 copies of the Public Health QI Encyclopedia and disseminate them to the QI Project Champions, Pros, and Council members.	QI Manager	TBD
5. Develop an introductory QI training video by April 2024.	Review existing video script and update it based on feedback from prior trainees. Utilize plain language as much as possible for better understanding. Get ADH approval.	QI Manager, QA Analyst, and OPMQIE Director	Completed
6. Develop a CQI training video by April 2025.	Review video script of other states; receive feedback from Division Directors; based on that, create the new video script; use plain language for the ease of understanding and learning.	QI Manager, QA Analyst, and OPMQIE Director	Ongoing

CONTINUOUS QUALITY IMPROVEMENT WORKPLAN, 2025

GOAL: Expand the scope and participation of QI Projects in ADH to inspire the culture of CQI.			
Objective	**Activity**	**Responsible staff**	**Progress**
1. Obtain the list of QI Project Champions from the Deputy Director of PHP by Jan 2024	Review QI Projects and contact QI Champions and Leads to discuss QI Projects.	OPMQIE Director	Completed
2. Revise the QI Reporting Template for QI Team Members by April 2024	Provide the QI Reporting Template to CQI Council, QI Champions, and Pros.	QI Manager	Completed
3. Obtain QI Project updates from QI Champions and Pros each quarter of 2024	Document updates in the QI Manager's main reporting form	QI Manager, CQI Council Member, QI Champion, and Pros	Ongoing
4. Obtain all QI Project completions - Storyboard, reports, PowerPoint presentations by Dec 2024	Document and share the completion of QI projects.	QI Manager, CQI Council Member, QI Champion, and Pros	Ongoing
5. Follow up on completed QI projects to ensure continuity of process, program, and service improvements, in 2025.	Document updates in the QI Reporting template.	QI Manager and QA Analyst	Ongoing

SUSTAINABILITY

Sustaining the performance management activities and the improvements made through QI projects are integral to the continuum of PM and QI practice in an organization and critical for the culture of CQI.

Plans for maintaining the gains can be actively considered at the beginning of an improvement project. According to the National Health Service Institute for Innovation and Improvement, the three primary factors impacting sustainability are Process, Staff, and Organization. The chart below identifies the elements of each factor.

Process	Adapt and change	Ensure that the new process can support organizational and staff changes
	Demonstrate benefits	Demonstrate that the changes benefit programs and staff
	Monitor progress	Encourage to have a process to monitor progress, communicate results, and provide evidence of impact
	Gather credible evidence and celebrate	Widely communicate the benefits of change and celebrate success
Staff	Training and Improvement	Train staff on how to implement new changes for Improvement
	Attitudes and behavior	Empower staff to improve their attitudes and behavior toward believing that the change is for the better
	Senior leadership and expertise	Involve senior leadership and visibly demonstrate their support
Organization	Fit with organizational goals and culture.	Have clear goals that are consistent with organizational culture and strategic objectives. Share them widely in the
	Infrastructure and sustainability	Ensure that the staff are trained, standard work practices are adopted, and agency policies and procedures are current

<u>OPMQIE will use this framework to complete a sound Sustainability Plan by February 2025, following the 2025 PM-QI Kick-Off meeting of ADH partners in January 29.</u>

Evaluation

EVALUATION

Evaluation of the Performance Management System (PMS)

The evaluation refers to the assessment of the PMS process, its progress, and the outcomes of meeting its goals. The OPMQIE public health evaluator will utilize the [CDC Framework]() to assess the effectiveness and efficiency of the system.

The framework consists of the following steps (also shown in the figure alongside):

1. Assess Context
2. Describe the program
3. Focus on the evaluation questions and design
4. Gather credible evidence
5. Generate and support conclusions
6. Act on findings

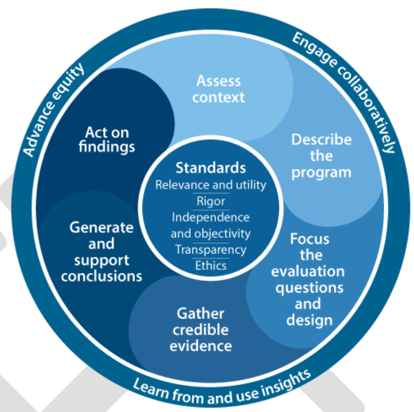


Figure 1: CDC Framework for Program Evaluation

1. **Assess the context**: The ADH delivers a broad range of public health preventive and regulatory services statewide under the leadership of the Secretary of Health. With activities within various programs/departments under the five divisions of the agency, the ADH aims to protect and improve the health and well-being of all Arkansans. The programs will utilize the PM-QI Plan to guide the PM and QI efforts within the ADH.

   The Public Health Evaluator within the OPMQIE will lead the Evaluation of the implementation of the Performance Management and Quality Improvement Plan. The OPMQIE consists of two Public Health Evaluators overseeing the activities across multiple programs/offices, including the Office of Health Disparities Elimination, Substance Misuse and Injury Prevention, and the Public Health Infrastructure Grant (PHIG). The evaluators will extend and maintain partnerships with key interest holders within the agency. The stakeholders, along with their roles, are presented in the table below:

Table 1: List of Interest Holders and Their Roles

Stakeholders	**Roles**
ADH Leadership	Provide guidance for team participation, administration of the system in the ADH, review and approval of the results, and consideration of recommendations based on evidence.
OPMQIE	The director will provide direct guidance in all aspects of the initiatives covered within the System, including PM, QI, SHA, SHIP, and SP. The OPMQIE team will be involved in developing plans, overseeing the implementation of the plans, soliciting progress updates, and evaluating the System.
Performance Area Leads	Guide performances and provide quarterly progress updates.

PMS Committee	Meet quarterly/discuss performances, accomplishments, and challenges
QI Councils	Provide leadership from the Division's perspective and recruit Champions.
QI Champions	Recruit Pros and provide directions in conducting QI project activities.
QI Pros	Fully engage in QI project activities.
QI Recruits	Fully engage in QI project activities.
Strategic Plan (SP)	
• Diabetes Program	Address PHAB recommended linkages between PM-QI and QI
• Heart Health	Address PHAB recommended linkages between PM-QI and QI
• Women/Maternal Health	Address PHAB recommended linkages between PM-QI and QI
• Sexually Transmitted Disease	Address PHAB recommended linkages between PM-QI and QI
• Tobacco use among youth	Address PHAB recommended linkages between PM-QI and QI

2. **Describe the Program**: The OPMQIE provides oversight and support in monitoring core ADH performances associated with the PHAB domains. The core initiatives are the State Health Improvement Plan (SHIP), State Health Assessment (SHA), Strategic Planning (SP), and PM and QI. Together, these components form the ADH's PMS for 2024-2028. Implementing the PM-QI plan will enable the agency to proactively address challenges, innovate, and consistently achieve high standards of performance related to these core initiatives. The implementation of the PM-QI Plan is also necessary for ensuring sustainable growth, operational excellence, and stakeholder confidence. The PM Manager and QI Manager within the OPMQIE will lead the quarterly data reporting on the measures to allow data-driven decision-making to enhance service delivery and efficiency in order to improve compliance and remain accredited by PHAB. The managers will also provide the training and resources on the implementation of the Plan, as needed.
    a. Logic Model: The model will illustrate the System and how the performances are linked to the outcomes (page 26).

3. **Focus on the Evaluation Questions and Design**: Evaluating the PMS will primarily include questions based on the Logic Model. The evaluation questions presented in the table on page 24 will be addressed in the results section:
    - Performance Measures (successful implementation)
    - QI Projects (successful implementation)
    - PM System Dashboard (PM, QI, SHA, SHIP, and SP) – How well it Informed
    - Linkages between PM, QI, and SP - Linkage
    - Whether PHAB standards for inclusiveness, diversity, and disparities were addressed through this Plan

    a. <u>Evaluation questions</u>: Please refer to the table for details.

Table 2: Evaluation Questions:

Process Monitoring	Indicators	Source
Overall		
1. How effective was the Plan in guiding PM and QI activities?	Multiple indicators, TBD	KII
Performance Measures and Quality Improvement		
2. How were the PM and QI measures prioritized for implementation?	# leads consulted, # meetings	KII
3. How effective were PM and QI committees in guiding implementation?	PM & QI Reports	OPMQIE
4. How well did the data collection tools work for collecting PM and QI data?	PM & QI Reports	OPMQIE
5. What methods were used for the reporting of PM and QI outcomes?	Quarterly meetings	Meetings
6. To what extent were ADH staff trained on the CQI concept?	#trained	TRAIN
7. How did OPMQIE communicate data to the interest holders?	Meetings/reports	OPMQIE
PMS Dashboard		
8. What is the current stage of Dashboard development and implementation?	Informatics report/Data Hub	Informatics
9. What metrics were used to update Dashboard data and information?	Meetings	SHA, TS
10. How are the linkages between core initiatives being established?	TBD	TBD
11. How well did the dashboard serve as a learning resource?	#viewed, survey feedback	Informatics
12. How frequently is the dashboard being used for decision-making?	#used	Survey data
PHAB Standards		
13. How well were the PHAB S & M for health disparities addressed?	# S&M addressed	SP Progress
14. How well were PHAB S & M for community engagement addressed?	# S&M addressed	SP Progress
Outcomes (short-term)		
1. To what extent did the PM and QI leaders report within the specified timeframe?	#Reported	PM-QI reports
2. To what extent were the QI projects driven by the PM initiative and vice-versa?	#QIProjects, #PM	PM-QI reports
3. What changes were made to align PM, QI and SP to improve efficiency (linkage)?	Linkage established	SP Progress
Outcomes (long-term)		
4. Have QI projects led to operational efficiency?	#of projects	QI reports
5. To what extent did the dashboard facilitate decision-making?	#decisions made	Survey data
6. To what extent did the dashboard represent office performances?	#views, survey feedback	Informatics
7. How have PM and QI initiatives proven to be sustainable?	#participating PM-QI projects	OPMQIE KII

4. **Gather Credible Evidence**: The annual report will consist of a complete assessment of the implementation of the activities and the immediate results. Long-term results (impact) will only be reported in later years. The annual report will include answers to the evaluation questions, both process and outcomes, to be shared with the stakeholder(s) and to inform System modifications as needed. <u>Data collection & management</u>: Qualitative and quantitative data will be collected to answer the evaluation questions.
    - PM Reports: PM Committee quarterly reports.
    - QI Reports: QI Project quarterly updates.
    - SP Progress: Assessed to identify linkages between PM-QI and SP.
    - Annual KII: A questionnaire may be used to collect qualitative information on achievements, barriers, strategies used to overcome, and lessons learned.
    - Survey: Data will be used to address several outcome evaluation questions.

    <u>Data analysis</u>: Qualitative data obtained from program reports (PM and QI) and KII will be analyzed using thematic and content analysis to identify recurring and relevant themes. Descriptive/inferential analysis will be used to summarize quantitative data, such as frequency tables, percentages, and trends.

5. **Generate and Support Conclusions**: The output/outcome data will be compared with PMS's baseline activities/data. The comparison will be possible only in the later years. The results from the qualitative and quantitative data will be summarized to generate concise and accurate inferences. The conclusions will include the accomplishments related to the performances, barriers faced, strategies used to overcome them, and recommendations on what could be done differently in the future. The conclusion will be shared with the OPMQIE team to ensure a collaborative approach to understanding and interpreting the meanings of the findings.

6. **Act on Findings**: The public health evaluator will submit the annual Evaluation to the OPMQIE director for review. Upon completion of the review and approval at all levels, the report will be submitted to PHAB and CDC. The report will also be shared, upon request, with the stakeholders listed in "Table 1". Evaluation findings will be used to understand the impact of activities in meeting the set goals and objectives. The ways in which the interest holders are planning to utilize the findings will again be discussed in this step to ensure proper communication of the results to the relevant audience.

Logic Model:

INPUT

Funding:
Block Grant
PHIG Grant

Stakeholders:
OPMQIE
ADH Senior Leadership
Division Directors
PM Committee
QI Councils
QI Champions
QI Pros & Recruits
ADH Staff

Technical Assistance:
PHAB Standards & Measures
Centers for Disease Control & Prevention

ACTIVITIES

- Get leadership buy-in for the initiatives.
- Collaborate with ADH Division directors.
- Form PM Committee and QI teams.
- Use the Plan to guide PM & QI efforts.
- Implement the work-plan.
- Train ADH staff on QI.
- Meet with PA leads and QI champions quarterly and discuss facilitators and obstacles.
- Collect data from PM and QI leads.
- Communicate data to the interest holders.
- Assess how the QI-PM Plan is helping address health disparities and community engagement in Arkansas through SP.
- Develop/maintain Dashboard to inform stakeholders on the role of OPMQIE.

OUTPUT

- Leadership buy-in obtained.
- #ADH divisions & programs involved.
- #PA leads and champions involved.
- Plan successfully implemented.
- #ADH staff trained.
- #Meetings occurred.
- #PM measures completed on time
- PM-QI data shared.
- #PAs leading to QI projects.
- #QI projects identifying areas of PM.
- Dashboard developed
- Dashboard published.

OUTCOMES

- Improvement in operational efficiency.
- Sustainability of the PM and QI initiatives.
- Use of dashboard for decision making.
- Continuous Quality Improvements (CQI) throughout the agency.

Acronyms defined: OPMQIE: Office of Performance Management, Quality Improvement, and Evaluation; ADH: Arkansas Department of Health; PM: Performance Management; QI: Quality Improvement; CQI: Continuous Quality Improvement; PHAB: Public Health Accreditation Board; SHA: State Health Assessment; SHIP: State Health Improvement Plan; SP: Strategic Plan.

APPENDICES

APPENDIX 1: Performance Management Measures and Sub Measures

Performance Management Data Reporting Template		
Performance Area 1:		Assess and monitor population health status, factors that influence health, and community needs and assets
Responsible Units:		Office of Performance Management Quality Improvement and Evaluation
Performance Lead:		Dr. Ashamsa Aryal, Public Health Evaluator
Measure:		Formalize State Health Improvement Plan (SHA) Workgroup

Completed Sub Measures Checklist:

☒		1. Revisit SHA partners by April 2024
☒		2. Form a SHA committee by August 2024
☒		3. Meet and discuss PHAB requirements for SHA July 2024
☒		4. Meet for planning SHA updates by July 2024
☒		5. Complete review of SHA indicators by July 2024
☒		6. Complete the first data update by August/September 2024
☒		7. Complete data update and review/approval by September/October 2024
☐		8. Open updated SHA for the public and partners by December 2024
☐		9. Share data as needed
☐		10. Utilize for SHIP and SP as needed, 2024

Performance Management Data Reporting Template		
Performance Area 2:		Investigate, diagnose, and address health problems and hazards affecting the population.
Responsible Units:		Office of Preparedness & Emergency Response System (OPERS)
Performance Lead:		Joe Martin, Director
Measure:		Update ADH Safety and Security Plan (SSP)

Completed Sub Measures Checklist:

☒		1. Form the ADH SSP Committee by March, 2024
☒		2. Review ADH SSP by April 2024
☒		3. Revise ADH SSP by May 2024
☐		4. Train all committee members to quality to be Safety Officers by January 2025
☐		5. Implement essential training and drills/exercises by January 2025
☐		i. Automated external defibrillator (AED) training
☐		ii. Safety & security training against bomb threat
☐		iii. Safety & security training against active shooter
☐		iv. Safety & security training against tornado
☐		v. Emergency evacuation training for the scenarios mentioned above
☐		vi. Complete all the drills (including fire) and exercises by December 2024

Performance Management Data Reporting Template		
Performance Area 3:		Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
Responsible Units:		Office of Health Communications
Performance Lead:		Meg Mirivel, Director (Co-lead: Dr. Chychy Smith)
Measure:		Develop Plain Language (PL) Implementation Strategy for ADH

Completed Sub Measures Checklist:

☒		1. Recruit relevant partners for the PL Implementation Initiative by March 2024.
☒		2. Convene partner meetings by March 2024.
☒		3. Develop a framework for the PL implementation plan by May 2024.
☒		4. Develop and implement a PL needs assessment survey for ADH staff by October 2024.
☐		5. Analyze data and share results with partners by November 2024.
☐		6. Use results to plan for the development of Pl Training by November 2024
☐		7. Develop training (Model after UAMS's Intro to Plain Language Training) by December 2024
☐		8. Place the online training module in ADH TRAIN by Jan 2024
☐		9. Analyze training/evaluation data and share with partners by Jan 2024.
☐		10. Initiate planning of a Small Group Workshop for key ADH staff members for 2025

Performance Management Data Reporting Template		
Performance Area 5:		Create, Champion, and implement policies, plans, and laws that impact health.
Responsible Units:		Office of Performance Management, Quality Improvement, and Evaluation
Performance Lead:		Dr. Bala Simon, Deputy CMO, Arkansas Department of Health
Measure:		Collect input from Stakeholders to revise/implement SHIP (Phase 2)

Completed Sub Measures Checklist:

☒		1. Conduct the 1st SHIP Quarterly meeting by January 2024.
☒		2. Conduct the 2nd SHIP Quarterly meeting by April 2024.
☒		3. Conduct individual meetings with ADH/State partners before July 1, 2024, annual meeting.
☒		4. Conduct/facilitate the SHIP Annual Meeting on July 1 (3rd Q), 2024, to report progress.
☒		5. Collect focus area input from leads and enter the Clear Impact scorecard by August 2024.
☒		6. Share focus area inputs with the ADH leadership team by August 2024.
☐		7. Conduct the 4th Quarterly meeting by December 2024.
☐		8. Revise the Plan based on focus area input by December 2024.
☐		9. Route the revised Plan for approval (SAS) by January 2025.
☐		10. Collect Clear Impact Progress Report for the PHIG year 2025.

Performance Management Data Reporting Template

Performance Area 6:		Utilize legal and regulatory actions designed to improve and protect public health.
Responsible Units:		Office of General Counsel
Performance Lead:		Laura Shue, General Counsel
Measure:		An Assessment of Mobile Food Units (MFU) Tracking System by ADH

Completed Sub Measures Checklist:

☒		1. Identify staff members who will be involved in the Assessment by July 2024
☒		2. Meet and discuss the framework for Assessment by July 2024
☒		3. Develop a report template and complete it to address the following, by December, 2024
☐		a. Current tracking infrastructure of MFUs (background)
☐		b. Description of how MFU permit works
☐		c. Frequency of complaints; nature of most frequently occurring complaints
☐		d. ADH response to the complaints (cite an example); please include an education component, if any.
☐		e. How do other agencies assist with the response?
☐		f. How do our contiguous states track MFUs?
☐		g. What needs and gaps were identified in the Assessment?

Performance Management Data Reporting Template		
Performance Area 7:		Contribute to an effective system that enables equitable access to the individual services and care needed to be healthy.
Responsible Units:		Division of Local Public Health
Performance Lead:		Dr. Richard McMullen, ADH Senior Scientist (Co-lead: Mandy Thomas Division Support)
Measure:		Provider Needs Assessment, Rural Health

Completed Sub Measures Checklist:

☒		1. Contact ADH Rural Health & Primary Care Program by July 2024.
☒		2. Meet RHPC staff and review the latest Needs Assessment Report by August 2024.
☒		3. Identify the focus area and key staff who would participate in the PM Project by August 2024.
☐		4. Develop an action plan based on the Needs Assessment Report by September 2024.
☐		5. Include the following topics in the action plan and complete the report by December 2024.
☐		a. Background - access to Primary Care Providers Dental Care Providers in AR
☐		h. Show trends of PCP and DCP shortage areas. County Map
☐		i. Design strategies to address the shortages (please simplify as you see fit)
☐		j. Implement the strategy (please simplify as you see fit)
☐		k. Analyze data/information collected from partners/stakeholders.

Performance Management Data Reporting Template		
Performance Area 8:		Build and support a diverse and skilled public health workforce
Responsible Units:		Workforce Development
Performance Lead:		Dr. Kristy Caldwell, Director (Co-lead: PH Evaluator Clara Canter)
Measure:		Update and Implement Competency (CC) Assessment of ADH Employees

Completed Sub Measures Checklist:

☒		1. Contact the ADH TRAIN Coordinator to discuss CC Tiers by March 2024.
☒		2. Identify stakeholders and meet by April 2024.
☒		3. Revise and update CC Assessment tiers as needed by May 2024.
☐		4. Complete the questionnaires and get approval by January 2025.
☐		5. Implement CC Assessment to all ADH staff by January 2025.
☐		6. Collect data from TRAIN by February 2025.
☐		7. Analyze data by March 2025.
☐		8. Share results with the ADH Executive team by April 2025.
☐		9. Receive input and develop an action plan accordingly by June 2025.
☐		10. Share with the rest of ADH by July 2025.

Performance Management Data Reporting Template		
Performance Area 9:		Improve and innovate public health functions through ongoing Evaluation, research, and CQI.
Responsible Units:		OPMQIE
Performance Lead:		Patty Hibbs, OI Manager
Measure:		Revise ADH CQI Plan

Completed Sub Measures Checklist:

☒		1. Regroup the OPMQIE team for a review of the QI plan by May 2024.
☒		2. Organize a planning meeting by June 2024.
☒		3. Review the entire Plan and ascertain areas for revision by July 2024.
☒		4. Ensure completion of the Introductory QI training video by July 2024.
☒		5. Begin the revision and conduct follow-up meetings for updates by August 2024.
☒		6. Ensure that descriptions of the latest QI training videos are included in the revised QI Plan by September 2024.
☐		7. Complete revision of the Plan by November 2024.
☐		8. Complete the approval process by December 2024.
☐		9. Share the Plan with stakeholders by December 2024.
☐		10. Post the Plan on the OPMQIE website by January 2025.

Performance Management Data Reporting Template		
Performance Area 10:		Build and maintain a strong organizational infrastructure for public health.
Responsible Units:		Office of Performance Management Quality Improvement and Evaluation
Performance Lead:		Rupa Sharma, Director
Measure:		Develop and Implement the ADH Strategic Plan (SP)

Completed Sub Measures Checklist:

☒		1. Recruit ADH partners by March 15, 2024
☒		2. Organize a planning meeting by April 2024
☒		3. Select SP focus areas and form respective workgroups by May 17, 2024
☒		4. Convene planning meeting by May 17, 2024
☒		5. Complete planning of strategies by May 17, 2024
☒		6. Schedule virtual meetings following the initial meeting by June 20, 2024
☒		7. Develop activities to meet the strategies by June 2024
☒		8. Complete the planning process by June 30, 2024.
☒		9. Begin Phase 1 implementation of the Plan by August, 2024
☐		10. Develop a reporting framework by the end of December 2024

APPENDIX 2: Quality Improvement Project Framework

Primary Changes

- Concentrate more on Division-level QI strategy than specific QI projects.
- Create a team of trained QI Pros who can initiate a QI project at any time.
- Have trained QI Recruits support Champions.

Objectives

- Simplify the QI project initiation process.
- Enhance the engagement of ‘front-line staff in QI activities.
- Facilitate QI capacity-building by creating user-friendly, easily accessible training on TRAIN.
- Increase the number of staff trained in QI.
- Facilitate the incorporation of QI into Division level plans, policies, and initiatives.
- Enhance the spread of the culture of CQI throughout the Division

Process Highlights

- Capacity building
- Encourage ADH staff to complete QI training on TRAIN.
- Maintain a database of all staff who complete the training.
- Provide TRAIN-generated certificates to Champions, Pros, and Recruits and recognize them on the ADH intranet webpage.
- Recruits can become Pros and lead a QI project after completing all QI videos.
- QI Pros will be recognized on our webpage.

QI Projects

- CQI Council Members, QI Champions, or Pros can identify QI projects.
- When more staff are certified as Pros/Recruits and other ADH staff complete the training, a more deliberate way of soliciting project ideas can be established.
- QI Pros, in collaboration with QI Champions, must get approval from the appropriate division manager to start a QI project.
- QI Pro can serve as project lead and begin the project.
- QI Pros are supported on their teams by QI Recruits.
- QI Champion or Pro periodically submits a QI Project report to the QI Manager.
- When the project is completed, the QI Champion/Pro submits the final report to the QI Manager.
- The CQI Council Member, QI Champion, or Pro will create a storyboard or PowerPoint presentation that covers the QI Project.
- The storyboard or PowerPoint presentation must cover the following concepts:
    - ✓ Opportunity for the QI Project
    - ✓ Project Objectives
    - ✓ QI Method and Tools Used
    - ✓ Root Causes
    - ✓ Possible Solutions
    - ✓ Prioritization of Solutions
    - ✓ Project Outcomes
    - ✓ Next Steps
    - ✓ QI Team Members
- Information on the project is included in the OPMQIE Database, and the storyboard/presentation will be placed on the Intranet on the QI webpage.

APPENDIX 3: Continuous Quality Improvement Council Charter

Continuous Quality Improvement
ADH
Improving Processes to Empower People

Arkansas Department of Health

I. Purpose

Members of the Continuous Quality Improvement (CQI) Council facilitate, promote, and assess the growth of a CQI culture in the Arkansas Department of Health (ADH).

II. Responsibilities

1. Promote CQI as an institutional priority by spreading CQI culture in the ADH.
2. Provide input in the development of a CQI communications strategy.
3. Provide oversight to the development of CQI projects via CQI Champions.
4. Oversee the biennial CQI Culture assessment (reports).

III. Membership

The Council is composed of one CQI member from each ADH Division and the QI Manager. A member also represents the ADH administration. Each Council member will appoint two (2) representatives from each Division, known as QI Champions.

IV. Meetings

The Council will meet quarterly, virtually, or in person. The meetings will be organized by the Office of Performance Management, Quality Improvement, and Evaluation (OPMQIE).

V. Training

Every Council member will participate in QI training as needed.

VI. Terms

Council members agree to serve a minimum of two (2) years.

Updated February 2024

APPENDIX 4: Continuous Quality Improvement Champions Charter

Arkansas Department of Health

I. Purpose

Quality Improvement Champions facilitate the incorporation of Continuous Quality Improvement (CQI) and Quality Improvement (QI) into the culture of their division policies, plans, and activities at the Arkansas Department of Health (ADH).

II. Responsibilities

1. Select ADH staff to train and certify to become QI Pros.
2. Assist QI Pros in the development and implementation of QI projects.
3. Report the QI project outcomes to their Council routinely.
4. Integrate QI project outcomes into their division/unit.

III. Training

Every QI Champion commits to participation in QI training. The specific training needs for each QI Champion will be jointly agreed upon between the Champion and the Quality Improvement Manager.

IV. Meetings

QI Champions will meet routinely, virtually or in person. The meetings will be organized by the Office of Performance Management, Quality Improvement, and Evaluation (OPMQIE).

V. Terms

QI Champions agree to serve a minimum of two (2) years.

Updated February 2024

APPENDIX 5: Continuous Quality Improvement Pros Charter

Arkansas Department of Health

I. Purpose

Quality Improvement Pros facilitate the development, implementation, and Evaluation of Continuous Quality Improvement (CQI) and Quality Improvement (QI) into the culture of their division policies, plans, and activities within their Region or Local Health Unit (LHU) at the Arkansas Department of Health (ADH).

II. Responsibilities

1. Select project team members to participate in the QI project.
2. Provide a list of project team members to the QI Champion for approval.
3. Lead the project team in the development and implementation of the selected QI project.
4. Facilitates meetings by this charter.
5. Communicate progress to QI Champion(s) routinely.
6. Partner with Division QI Champion(s) to integrate QI project outcomes into their Division/Region/LHU.

III. Training

Every QI Pro commits to participation in QI training. The training needs for each QI Pro will be determined by the QI Champion(s) and Quality Improvement Manager.

IV. Meetings

QI Pros will routinely meet with the project team, virtually or in person. The QI Pros and project team members will organize the meetings.

1. Meetings will start and end on time.
2. Timekeeper and Scribe roles will be identified.
3. The scribe will maintain minutes.

V. Terms

QI Pros agree to serve continuously during employment.

Updated February 2024

APPENDIX 6: Quality Improvement Project Handbook Cover

APPENDIX 7: Public Health Quality Improvement Encyclopedia

Overview

Quality improvement (QI) in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It is essential for health departments to use QI tools to fulfill their missions, apply for accreditation, improve the health of their communities, and become more efficient and effective. To support these efforts, the Public Health Foundation (PHF) developed and published the. This comprehensive encyclopedia includes 75 QI tools and an extensive glossary.

In this resource, PHF Senior Quality Advisor John W. Moran and co-author Grace L. Duffy define the purpose of each tool and provide guidance on when and how they should be used. They also explain what should be done after implementing each tool and provide examples specific to public health settings. This encyclopedia includes basic and advanced QI tools—many that aren't available elsewhere in print, including:

- Continuum of Quality
- Five Whys
- Gantt Chart
- Purpose Principle
- Stakeholder Analysis
- SWOT Analysis

https://www.phf.org/resourcestools/Pages/Public_Health_Quality_Improvement_Encyclopedia.aspx

APPENDIX 8: Quality Improvement Projects & Performance Notes, 2024-2025

Performance note: Staff Action Summary (SAS) used to be conducted manually. To improve the proper selection of reviewers and minimize the time it took to complete the process, a QI project was conducted in 2023. Review time was reduced, and the reviewers' list was modified based on the type of document. Changes were documented in a policy/procedure manual and placed on the ADH website. However, the agency felt the need to streamline other aspects of the SAS review process by adopting the DocuSign system, using digital files for review, giving access to only designating program staff and reviewers to the system, and further improving the efficiency. This led to the current QI project.

Work Unit	Aim Statement	SMART objective	Tools used	Data used	Solutions
Office of Health Communications Champion: Sheryl Alexander	Digitize the ADH Staff Action Summary (SAS) process using Docu Sign.	By August 1st, 2024, DocuSign will go live with an electronic SAS form. The project completion is scheduled for 12/31/2024.	A modified Gemba Walk, brainstorm—input from staff to complete SAS.	Review of 2000 SAS documents completed in 2023	Prioritized: Use DocuSign to enhance the flow of document review and approval process in ADH.

Performance note: Three-quarters of facility performance data were reviewed, and it was determined that trending performance is essential for measuring actions used to meet QI goals. A QI project was implemented to see trends in the data and provide stakeholders with recommendations to improve public health outcomes.

Work Unit	Aim Statement	SMART objective	Tools used	Data used	Solutions
Office of Preparedness & Emergency Response Systems Champion: David Vrudny, Jon Weigt	The quarterly quality stroke metrics report should display four consecutive quarters of regional and facility stroke performance.	The goal is to provide data to increase 75% adherence to 4 stroke measures, including hospital prenotification, stroke band placement, door to CT < 25 minutes, and defect-free care. We hope to produce this report and have it ready for sharing before Dec 31, 2024.	Brainstorming	Three-quarters of facility performance data were reviewed.	Creation of quarterly report by ADH program epidemiologist and presented by ADH stroke Section representative(s)

Performance note: The Division did not have a system in place to track expenditures or monitor the use of grant funds. As a result, funds were left unspent, and there was no record of how they were used. A Quality Improvement (QI) project was implemented to address this issue and track spending trends.

Work Unit	Aim Statement	SMART objective	Tools used	Data used	Solutions
Office of Preparedness & Emergency Response Systems Champion: Jasmin Gilmore	To place a purchase order tracker for the Stroke and STEMI Section.	The goal is to have an accurate record of all monies spent within our section. This, in turn, will allow us to quickly catch any risk of overspending or future underspending by June 30th, 2025.	Brainstorming	Current contracts and purchase orders were used.	A purchase order tracker will accurately account for funds at the beginning of FY26.

Performance note: In June 2024, the EMS stroke scorecard was created and presented to Central EMS. The service provides recommendations for updating the document in specific areas, which was done. The following scorecard is being prepared for MEMS and will be presented in 2Q FY 2025. A QI project was implemented to track trends and provide recommendations.

Work Unit	Aim Statement	SMART objective	Tools used	Data used	Solutions
Office of Preparedness & Emergency Response Systems Champion: David Vrudny, Christina Joshua, Shallon Holloway	To pilot an EMS stroke scorecard process followed by a rollout to services operating in the most vulnerable counties	The goal is to increase the number of Arkansas ambulance services receiving feedback on stroke care performance in FY 2025. First, this will be accomplished by developing and presenting color-coded benchmarking reports to EMS agencies in FY 2024. Assisting pre-hospital providers in finding and closing gaps in care will ultimately improve patient outcomes.	Brainstorming	EMS Registry	Creation of EMS scorecard by ADH program epidemiologist and presented by ADH EMS Section representative

Performance note: The Arkansas PHL became one of 39 states to participate in a state-wide laboratory system improvement assessment sponsored by the Association of Public Health Laboratories (APHL). The PHL noted a need for increased laboratory system partner communication and collaboration, which led to the coordination of this one-day assessment event.					
Work Unit	**Aim Statement**	**SMART objective**	**Tools used**	**Data used**	**Solutions**
Division of Public Health Laboratory Champion Megan McCarthy	Gather key Arkansas State PHL System partners to participate in a one-day collaborative assessment to evaluate and improve state laboratory system performances.	Discussion themes, votes, and essential service performance measurement tool scores. To coordinate a successful and informative one-day state Laboratory System Improvement Program (L-SIP) assessment on April 25, 2024, for the Arkansas Public Health Laboratory (AR PHL)	Brainstorming (facilitated discussion) Affinity Diagram/Fishbone Diagram	Discussion themes, votes, and essential service performance measurement tool scores.	Update contact lists; improve website visibility, communications, and outreach; increase in-person meetings, collaborations, and staff training opportunities; improve state employee compensations and remain informed on state legislation changes and grant funding opportunities.

Performance note: The Division of Health Advancement has been identifying shareable supplies for the programs to use within the Division. Using the field 'visit type' in Greenway, the Division is sorting the percentage of cost that each program should be charged. This process is time-consuming because each supply needs to be reviewed to determine the % of the cost to be charged to the programs. A QI Project was implemented to do just that.

Work Unit	Aim Statement	SMART Objective	Tools used	Data used	Solutions
Division of Health Advancement Council Member: Cristy Sellers	Revise the cross-agency cost-sharing of clinical supplies, thereby lowering the cost of supplies incurred by each program.	By 2025, utilizing the Greenway system, identify which supplies could be cost-shared for the use of specific programs within the Division.	Greenway Data Management System.	'Visit type,' representing program type, data in the Greenway Management System	Reorganize the cost-sharing of clinical supplies in the Greenway system to improve costs incurred by the programs.

Performance note: Data indicated that only a small percentage of LHU clients aged ≤18 eligible to receive Topical Fluoride Varnish (TFV) received the treatment. A QI project was implemented to improve the number of eligible clients receiving TFV by informing them about its benefits.

Work Unit	Aim Statement	SMART objective	Tools used	Data used	Solutions
Division of Health Advancement Champion: Dr. Rachel Sizemore	Increase compliance with TFV Application policy in LHUs statewide.	1. By April 30, 2024, OOH will create a TFV best practice infographic/toolkit and distribute it to all LHU leadership. 2. By September 30, 2024, the statewide monthly average of TFV applications will increase by 5% over the baseline (baseline: 2023 monthly average).	PDSA, Brainstorming, and Affinity Diagram	Monthly Fluoride Varnish reports from the Greenway system, and qualitative interviews were conducted at high performance.	Use of highly impactful information to increase rates of eligible clients receiving TFV applications.

Performance note: The Division noted that the desk reference guide needed to be updated, and some areas also needed desk reference guides. To improve its use and share crucial information, a QI project was implemented to update or create new desk reference guides.

Work Unit	Aim Statement	SMART Objective	Tools used	Data used	Solutions
Division of Health Protection Council Member: Connie Melton	All sections within the Division update their desk reference Guide and develop one if it's a new program. This is to facilitate the training of new staff and cross-learning.	1. By May 2024, all sections within the Division will update the existing Desk Reference Guides and create new guides for those that still need them. 2. Conduct annual updates of the Reference Guide.	Brainstorming and Fishbone Diagram	1. Meeting notes 2. Existing Desk Reference Guides 3. Reports from Branch Chiefs about the lack of a Desk Reference Guide.	Update/create Desk Reference Guides to help train new and cross-train existing employees.

Performance notes: The Division noted that the content of the supervisory training manual was too in-depth. To share the crucial information contained in the original manual with the new and existing supervisors, a QI project was developed to (1) review the supervisory training manual and, based on that, (2) create new content for a smaller companion manual for efficient learning of supervisory roles and responsibilities.

Work Unit	Aim Statement	SMART objective	Tools used	Data used	Solutions
Division of Health Protection Champion: Jacob Smith	Review and create new content for supervisory training - 101 plus staff supervision.	By November 30th, 2024, complete and disseminate the supervisory companion manual to DHP staff.	Brainstorming and Affinity Diagram	(1) Existing Supervisory Training Manual (2) Notes from brainstorming sessions of supervisors	The newly created companion manual will increase staff knowledge and skills.

Performance note: Link data to enhance completeness of the Hepatitis A and B vaccination records for Ryan White clients. Key stakeholders in this QI Project include Immunizations, Infectious Diseases, Epidemiology, and Informatics. Data systems identified for linkage are – Ryan White CAREWare 6 and WebIZ (immunization records). An existing Ryan White quality measure (https://ryanwhite.hrsa.gov/grants/performance-measure-portfolio/adolescent-adult-measures/hepatitis-b-vaccination) helps guide the reporting of the linkage process.

Work Unit	Aim Statement	SMART objective	Tools used	Data used	Solutions
Division of Health Data and Analytics Champion: Alan May	(1) measure the percentage of Ryan White clients who are up to date on hepatitis A and B vaccines, (2) make current hepatitis A and B vaccine information available to Ryan White program staff, and (3) improve uptake of these vaccines among Ryan White clients.	1) By July 2024, using HIV CAREWare, measure the proportion of Ryan White clients who are up to date on hepatitis A and B vaccines (2) By October 2024, update hepatitis A and B vaccine rate by linking data with WebIZ and share the information with Ryan White program staff. (3) By January 2025, identify and implement strategies to work with Ryan White case managers and medical providers to increase vaccine uptake among those who are not up to date.	(1) Meetings with staff from Ryan White and Immunizations (2) Key informant interviews with Ryan White's clients	(1) Meeting notes from Ryan White staff and results from KII of Ryan White clients. (2) CAREWare data will be used to assess the vaccine uptake rate among Ryan White clients. (3) Linkage with WebIZ data will increase—completeness of vaccine uptake information.	Increase the rate of Ryan White clients who are up to date on Hepatitis A and B vaccines by linking relevant databases.

Performance note: The Division for Local Public Health (DLPH) has identified essential modifications in the Nurse Training Program. The needs were identified through employee exit surveys and the 2020-2023 ADH Training Needs Surveys. A QI Project was implemented to conduct a pre-course evaluation, modify the training program, and conduct a post-course evaluation to assess Improvement.

Work Unit	Aim Statement	SMART Objective	Tools used	Data used	Solutions
Division of Local Public Health Champions: Dr. Richard McMullen and Ebony Crutchfield	Collaborate with all concerned programs to establish a post-course evaluation question for each Nursing Training Program module, to be completed by March 2024.	By March 2024: 1. Use KII to obtain nurses' perceptions and satisfaction levels with the training process and materials. Use the results to plan the changes. 2. Change training modules and the materials accordingly and implement them. 3. Conduct post-course Evaluation.	Key informant Interviews and Brainstorming	Qualitative data from nurses' Key Informant Interviews (KII) and barnstorming notes from meetings with program staff.	Create appropriate evaluation questions to overcome any possible limitations in the Nurse Training Program.

APPENDIX 9: Quality Improvement Projects Storyboard, 2024-2025

Desk Reference Guide Quality Improvement Project, 2024

Division of Health Protection (DHA), Arkansas Department of Health (ADH)

Opportunity for Quality Improvement (QI):

Long-term managers, having gone through procedural and informational changes, recognized the need for an electronic Desk Reference Guide and periodic updates.

Project Objective:

By May 2024, All sections within DHA will update the existing Desk Reference Guide and create new for those Sections that are lacking one.

QI Method Used:

- **PLAN**: Project goal was selected. Desk Reference Guide update and expected completion date were explained.
- **DO**: After initiating the project, periodic reminders of completion due date, answers to frequently asked questions, and examples were shared. Updates of existing Desk Reference Guide and creation of new for some Sections were completed.
- **STUDY**: Periodic checks were conducted to ensure that new staff were aware of the Desk Reference Guide.
- **ACT**: Annual updates of the Guide was determined.

QI Tool(s) Used for:

i. Current Process

- The DHP QI team conducted a brainstorming session to identify need for updating or creating Desk Reference within each Section.

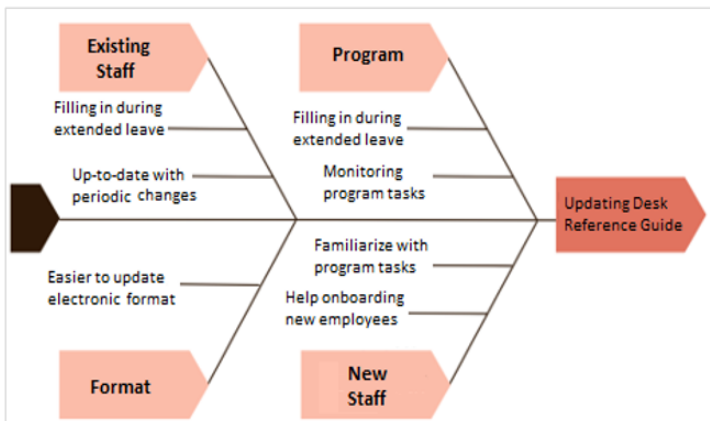
ii. Root Cause(s)

- New managers were unfamiliar with the Desk Reference Guide and its purpose. With easy access to the Guide and orientation would allow them to understand the programs and the work tasks better. It would also support staff who fill in for staff on extended leave.

iii. Possible Solutions

- Update/create Desk Reference Guides
- Assign staff to train new employees on the benefits of the Guide.
- Perform annual updates of the electronic Guide.

iv. Prioritization of solution (Fishbone Diagram)



Notes:

- Updating the desk reference guide in an electronic format was prioritized out of all possible solutions identified by the QI team. Benefits of prioritization to the program, staff, and system is presented on the Fishbone Diagram.

Project Outcome:

- All existing Reference Guides have been updated and new guides were created for the Sections without one.

Next Steps:

- Provide a table of contents or topic list as a guide along with the instructions, when introducing the project to new team members.
- Establishing an annual due date for updating of Desk Reference books will be necessary.

QI Team Members

Council Member (Contact):
Connie Melton: Connie.melton@arkansas.gov

Co-Champion:
Mandy Thomas: Mandy.Thomas@arkansas.gov

Champion:
Jacob Smith: Jacob.Smith@arkansas.gov