

# Public Health Services

## Strategic Plan

### 2017 - 2019



Adopted March 2017



Working together to promote and improve the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement.

**Maryland Department of Health and Mental Hygiene**

# Public Health Services

## Strategic Plan 2017 - 2019



Public Health Services (PHS), a unit of the Maryland Department of Health and Mental Hygiene (DHMH), is committed to improving the health status of individuals, families and communities through prevention, early intervention, surveillance and treatment. The purpose of this Strategic Plan is to clearly articulate the current goals, priorities, strategies and performance measures that will guide the work of PHS over the next two years. The Strategic Plan aligns with Maryland's [State Health Improvement Process](#) (SHIP) and incorporates the major units of PHS.

- Our Vision** Lifelong health and wellness for all Marylanders .
- Our Mission** We work together to promote and improve the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement.
- Who We Serve** PHS oversees vital public services to Maryland's 6 million residents including infectious disease and environmental health concerns, family health services and emergency preparedness and response activities.
- Our Programs & Services** The full public health system in Maryland includes the Department and 24 local health departments – one each in Baltimore City and Maryland's 23 counties. PHS consists of 11 distinct administrations, offices, facilities and boards.
- Strategic Priorities 2017-2019**
- Access to Care:** Improve access to health care across the state, focusing on transformative delivery models and underserved communities.
  - Healthy Beginnings:** Reduce infant mortality through a better understanding of contributing factors and preventive measures within Maryland populations.
  - Healthy Communities:** Reduce fatal and non-fatal opioid overdose in Maryland.
  - Operations:** Ensure a competent and prepared public health workforce.

*Thank you to the employees of Public Health Services for your time and input on the development of the new Public Health Services Strategic Plan. Your dedication and tireless work to provide critical public health services to the residents of Maryland is evident in the health of our state. Even with our success there is still much work to be done. Working towards health equity among our vulnerable populations and ensuring continued access to health care are critical priorities for all of us. I look forward to seeing this Plan grow and adapt as we meet our goals and identify new paths to explore.*

Howard Haft, MD, MMM, CPE, FACPE  
Deputy Secretary, Public Health Services

# PHS Strategic Plan

## *Summary of Priorities*

### **Access to Health Care**

Goal: Improve access to health care in Maryland through innovative care delivery reform and planning, administration of programs and services, and improved access to data. Activities will focus on:

- Diabetes Education at Deer's Head Hospital Center.
- Increasing clinicians in Maryland's underserved areas.
- Implementing Maryland's Primary Care Model.
- Updating Maryland's State Health Improvement Process to better capture clinical health data.

### **Healthy Beginnings**

Goal: Conduct robust data analysis, in conjunction with quality improvement projects, to improve dissemination of best practices and improve operations. Activities will focus on:

- Fetal and Infant Death analysis to understand trends and underlying factors.
- Fetal and Infant Mortality Review program analysis to understand and model best practices across Maryland.
- Pilot and implement electronic newborn screening results with hospitals to reduce testing turnaround time.

### **Healthy Communities**

Goal: Strengthen and streamline cross-unit overdose prevention, treatment, programs, and policies with the goal of further enabling local agency response and harnessing the actions of the Overdose Operational Command Center (OOC). Activities will focus on:

- Data sharing to bolster local opioid response.
- Conduct coordinated provider and community outreach on prescription opioids.

### **Operations**

Goal: Provide frameworks for employee and business success. Activities focus on:

- Achieving and maintaining National Public Health Accreditation.
- Implementing and monitoring Continuity of Operations Planning within PHS.
- Coordination of data analytics within PHS.
- Establishing Quality Improvement capacity within PHS units.
- Improve the culture of learning within PHS through the Workforce Development Learning Collaborative.

# Public Health Services

## Strategic Plan 2017 - 2019



- Strategic Plan Contents**
- Who We Are and What We Do
  - Summary of Priorities
  - Influencing Factors
  - Strengths & Weaknesses
  - Strategic Planning Process & Model
  - Performance Measurement
  - A Culture of Quality Improvement
  - Evaluation & Updates
  - Communications
  - Strategies, Goals, & Objectives
  - Appendices



**Influencing Factors**

Two key factors influence the environment in which the PHS Strategic Plan was created and how it will be implemented: 1) public health capacity at PHS, and 2) innovative health care reform in Maryland as a result of the Patient Protection and Affordable Care Act (ACA).

Public health capacity is the ability of PHS to meet our legislative charges in keeping the water we drink and the food we eat safe, providing preventive health services like tobacco cessation and cancer screenings, and maintaining timely public health laboratory services. Historically PHS has done well in meeting the demands of these services and continues to experience staffing and funding structures that support such efforts.

Capacity also speaks to the ability of PHS to adequately respond to emerging infectious diseases (e.g., Ebola, Zika), provide preventive and responsive solutions to the growing opioid epidemic, and engage communities and populations experiencing adverse health outcomes and disparities to find sustainable solutions. These core public health efforts have not always had access to consistent resources. As a result PHS is exploring enhancement of information management, workforce development, and quality improvement programs to leverage resources and partnerships. This can be seen in the Healthy Beginnings and Operations strategies of this Plan.

Under the ACA Maryland has observed a significant increase in health care coverage through the expansion of Medicaid (291,000 individuals) and the establishment of Qualified Health Plans available through the “Exchange” (142,872 individuals). Since the ACA’s implementation, Maryland has undergone a corresponding decrease in the uninsured rate by more than one-third. Maryland’s uninsured rate declined from 10.1% in 2012 to 6.7% in 2015 and is lower than the national rate (9.4% in 2015).

# Public Health Services

## Strategic Plan 2017 - 2019



### Influencing Factors *Continued*

The ACA also enabled Maryland Medicaid to enhance its benefit package above the minimum standards required under the ACA, increasing access to health services that are not federally required but often crucial to one's well-being. These include mental health services, substance use disorders services, long term care services, and pharmacy services.

While there is uncertainty around the future of the efforts, PHS is proactively working to engage practitioners, payers, and the public around innovative health care transformation models. This speaks to the need for PHS to enhance financial sustainability in our public health efforts. These activities can be seen in the Access to Care priorities of the Strategic Plan.

### SWOT Analysis

In August of 2016 PHS contracted with the University of Baltimore's Schaefer Center for Public Policy to conduct strategic planning efforts, including an analysis of perceived strengths, weaknesses, opportunities and threats (SWOT). PHS leadership from all units completed the assessment in relation to the State Health Improvement Process ([SHIP](#)) focus areas of Healthy Beginnings, Healthy Living, Healthy Communities, Access to Health Care, and Quality Preventive Care.

The findings informed subsequent strategic planning meetings and the approaches seen in the strategies of this document. Key themes from these five focus areas, and where they are reflected in the Strategic Plan, include:

#### Strengths

- Compliance with federal, state, and local regulations and funding requirements.
- Partnerships and collaborations with federal, state, and local organizations.
  - *The Fetal and Infant Mortality Review program work in Healthy Beginnings utilizes partnerships and collaborations to identify and share best practices.*
- Laboratory improvements
- Data and statistical capabilities
  - *The Fetal and Infant Death report in Healthy Beginnings will analyze these deaths by maternal characteristic to better understand trends and factors.*
- Policy and program analysis and development

#### Weaknesses

- Addressing public and community needs
- Institutional and technical support
  - *PHS is forming a health informatics team in Operations to provide technical support for programs while plugging into a department-wide effort to streamline and institutionalize data systems.*
- Workforce development and human resources support
  - *PHS is launching a Workforce Development Plan in Operations to address the culture of learning at DHMH.*

# Public Health Services Strategic Plan 2017 - 2019



## SWOT Analysis Continued

### Opportunities

- Public and provider education
- Coordinate outreach and communication across PHS units and programs
  - *PHS units will be engaging with each other and providers to conduct Opioid outreach in Healthy Communities.*
- Data analytics and health informatics

### Threats

- Social-economic and political factors
- Lack of addiction treatment services
- Infrastructure and growth limitations
- Financial and operational barriers

## Strategic Planning Process

PHS utilized the following resources and organizations in identifying the planning process and the resulting Strategic Plan:

- Association of State and Territorial Health Officials (ASTHO) Strategic Planning Guide
- Public Health Accreditation Board Standards & Measures Version 1.5
- Public Health Foundation Performance Management Self-Assessment



**Model** PHS adopted the ASTHO strategic planning process model to guide the revision of the Plan, focusing on actionable, measurable strategies. See Appendix A for Strategic Planning Participants and Appendix B, Strategic Planning Review, for the timeline for the creation of the Plan.



**Performance Management**

PHS is implementing a systematic process to help meet our mission and organizational goals, and measure progress on the strategies in this Plan. The system is based on the [Public Health Foundation's Performance Management Framework](#). See Appendix C for the PHS Performance Management Update that details the planning, implementation and communication of the new performance management system.

A cloud-based PHS Performance Management Dashboard (dashboard) will measure implementation of the Strategic Plan activities at the PHS Quarterly Directors Meetings. Each PHS unit is responsible for managing the inputs of the dashboard. Quarterly reports will be made available to PHS employees through email.

The dashboard will expand in 2018 to include salient performance measures from the state-mandated Managing for Results (MFR) performance management system. Outcome measures of this Plan were selected to align with MFRs. The end goal is a dashboard that will capture measures that are specific to the Strategic Plan in the context of the overall PHS MFRs.

**A Culture of Quality Improvement**

In an effort to achieve equity and improve the health of communities, PHS is embarking on a roadmap to quality improvement (QI). QI in PHS aims to support continuous public health process improvement through deliberate and defined activities that are responsive to community needs and improve population health. This principle can be seen in the numerous projects within the Strategic Plan.

The establishment of a sustainable QI effort within PHS is reflected in the Operations section of this Plan, while a programmatic alignment of QI efforts is reflected in the Strategic Plan’s Fetal and Infant Mortality Review (FIMR) project. FIMR is one of the first formal QI projects conducted by the QI Council.

The goal is to incorporate one QI project from the Strategic Plan in the QI Council’s work per year. For more information on QI in PHS visit the Office of Population Health Improvement’s [website\\*](#).

**Evaluation & Updates**

The PHS Strategic Plan will be evaluated quarterly at PHS Quarterly Directors Meetings. The PHS Strategic Plan dashboard will be used to report on progress related to activities, and as a tool for PHS units to discuss successes and challenges as they move through implementation.

2017 PHS Quarterly Directors Meetings:

-April 20, 2017

-July 13, 2017

-October 12, 2017

Quarterly reports will be distributed via email to PHS employees. See the *Communications* section below for additional information.

It is the goal of this Plan to be a living document. As activities are implemented and met, PHS will update the Plan accordingly at Quarterly Directors Meetings.

Modifications and updates are noted in Appendix D, referencing the date and page number of the update.

**Communications**

Clarity and consistency in communication with leadership, management, and employees are critical to the success of this effort. As such, information and communications about the PHS Strategic Plan will be posted publicly on the Office of Population Health Improvement [website](#) and distributed via email to PHS employees. This includes quarterly reporting, any changes to the content of the Plan, and linkages to other relevant projects.

Success Stories from the Strategic Plan will also be shared through the State Health Improvement Process newsletters, reaching over 2,000 state and community partners in Maryland.

\* <http://pophealth.dhmmh.maryland.gov/Pages/Quality-Improvement.aspx>



# Access to Care

## Overview

**Focus** To improve access to health care in Maryland through innovative care delivery reform and planning, administration of programs and services, and improved access to data.

**Landscape** Access to quality, affordable health care at the right time and in the right place is a key component of health. According to the Agency for Healthcare Research and Quality ([AHRQ](#)), access to health care consists of being able to enter the health care system, access sites to receive needed services, and find providers and clinicians who meet patient needs.

In Maryland, PHS units and programs have a unique opportunity to influence these access to care drivers through bolstering the clinical workforce for underserved communities, providing data infrastructure to impact programmatic and policy decisions, and serving as a coordinating entity for stakeholders, and partners. Health care access can be measured in various ways, but mostly focuses on having health insurance, assessing ease of patient access, and utilizing health care data.

- Actions**
- Diabetes Education Program at Deer's Head Hospital Center.
  - Increasing clinicians in Maryland's underserved areas.
  - Implementing Maryland's Primary Care Model.
  - Updating Maryland's State Health Improvement Process to better capture clinical health data.



# Access to Care

## *Diabetes Education at Deer's Head Hospital Center*

**Project Description** In Wicomico County the Emergency Department (ED) visit rate due to diabetes (372.7 per 100,000) far exceeds the overall state rate (204 per 100,000). This project will develop a diabetes education and prevention program serving Deer's Head Hospital Center (DHHC) patient and employee populations led by a Certified Diabetes Educator.

The program will focus on obtaining the certification for Registered Dieticians, while building the foundation for a robust diabetes education and prevention program. The end goal is to provide direct access to lifestyle behavior change programs in an effort to help reduce diabetes prevalence and ED visits in Wicomico County.

- Key Outcomes & Applicable Data Points**
- Number of patients with diabetes or at risk for diabetes attending Certified Diabetes Educator Program at Deer's Head Hospital Center (DHHC data collection method to be determined)
  - Wicomico County diabetes prevalence (baseline 11% - CDC diabetes prevalence data 2012 – most recent)
  - Wicomico County ED visit rate due to diabetes (baseline 372.7 per 100,000 - DHMH SHIP data 2014)

<b>Strategic Actions</b>	<b>Process Measures &amp; Dates</b>
1. Identify staff to become Certified Diabetes Educator candidates.	1. Staff identified (by 4/2017)
2. Assist candidates in completing required volunteer hours to meet certification requirements.	2. Volunteer locations identified (by 4/2017)
3. Establish a diabetes support group for DHHC Long Term Care residents.	3. Workgroup established (by 4/2017)
4. Identify knowledge baseline of the group.	4. Baseline knowledge of group identified (by 9/2017)
5. Use knowledge baseline to inform a work plan with short, mid and long-term goals related to educational offerings.	5. Improve knowledge for group members by 10% of the minimum score (by 12/2017)
6. Develop reference resource center for diabetes educator.	6. Reference resource center created (by 12/2017)
7. Continue to implement and monitor diabetes support group.	7. Four educational offerings will be presented to residents, staff or families (by 4/2018)

# Access to Care

## *Increasing Clinicians in Maryland's Underserved Areas*

**Project Description** To expand access to care in underserved communities and ensure an adequate health workforce in the most high need areas, the Office of Population Health Improvement markets and administers health care workforce programs including J-1 Visa, State and Maryland Loan Repayment Program (SLRP, MLARP), National Health Service Corps and the Physician/Nurse Practitioner Preceptorship Tax Credit Program.

This effort uses data and local community engagement to understand workforce needs, manage workforce programs, and integrate workforce programs into clinical care models.

**Key Outcomes & Applicable Data Points** •Effectively utilize existing programs and manage retention data.

*There are currently no SHIP or Public Health MFR measures associated with this topic.*

Strategic Actions	Process Measures & Dates
1. Report on number of Health Professional Shortage Areas (HPSA) analyzed for the year (new, updated, changed).	1. Health Professional Shortage Areas impact analysis finalized (by 10/2017)
2. Analyze school health program staffing and requirements.	2. School health program analysis completed (by 12/2017)
3. Award 100% of available slots for J1 visa.	3. J-1 visa slots filled (by 1/2018)
4. Award 100% of State Loan Repayment (SLRP)/Maryland Loan Assistance Repayment (MLRP) funds.	4. SLRP/MLARP funds awarded (by 1/2018)
5. Award 100% preceptor tax credit awards.	5. Preceptor tax credits awarded (by 2/2018)
6. Conduct quality improvement project on clinical workforce program operations database.	6. Quality Improvement conducted (Standard Operating Procedures and Application procedures by 7/2017, OIT discovery and development by 9/2017)
7. Engage vendor and stakeholders to complete a new Rural Health Plan (last published in 2007).	7. Rural Health Plan published (by 1/2018)
8. Disseminate and implement Rural Health Plan.	8. Rural Health Plan dissemination and communication plan created and implemented (by 1/2018)

# Access to Care

## *Implementing Maryland's Primary Care Model*

**Project Description** Maryland's Comprehensive Primary Care Model (PCM) supports access to primary health care for the Medicare population through financial incentives to providers and care management infrastructure.

This foundational payment and delivery system reform is designed to improve the quality and coordination of care by providing the technical assistance, learning systems, and advanced funding streams to support care delivery transformation. The PCM supports the progression of the hospital-based All-Payer Model. The PCM aims to reduce the total cost of health care over a seven year period.

**Key Outcomes & Applicable Data Points** •Implement the Maryland Comprehensive Primary Care Model in 2018.

*There are currently no SHIP or Public Health MFR measures associated with this topic.*

Strategic Actions	Process Measures & Dates
1. Establish quality metrics for Care Transformation Organizations (CTOs) and Patient Centered Homes (PCHs).	1. Quality metric design (by 6/2017)
2. Negotiate final terms of PCM with Centers for Medicare and Medicaid Innovation (CMMI).	2. Term sheet development (by 6/2017)
3. Release of PCM by CMMI into CMS clearance.	3. Recruitment and identification of existing resources for state regulatory body to project manage PCM (by 7/2017)
4. Release applications for Care Transformation Organizations (CTOs) and Patient-Centered Homes (PCHs).	4. Develop structure of state regulatory body of PCM (by 7/2017)
5. Stand up state regulatory body to project manage PCM.	5. Develop applications for CTOs and PCHs (by 11/2017)
6. Develop, select and negotiate legal agreements for CTOs and PCHs.	6. Negotiate legal agreement for CTOs and PCHs (by 3/2018)
7. Operationalize PCM by CMMI.	7. Support CMMI operationalization of PCM (by 4/2018)
8. Operationalize PCM by Maryland.	8. CMS clearance management (7/2018)

# Access to Care

## Updating Maryland's State Health Improvement Process Data

**Project Description** Maryland's State Health Improvement Process (SHIP) reports on 39 health measures for each Maryland jurisdiction. All 39 measures have a relationship to health care access. SHIP is used by local and state leadership to target programs, policies, and funding to improve health. To continue serving this purpose, the SHIP data points need to be updated in accordance with existing health priorities, data source quality, ability to create actionable interventions, alignment with DHMH health care transformation priorities, and accessibility through an external facing platform.

This project aims to conduct ICD9 to ICD10 conversion on SHIP data, identify new measures, establish data use agreements, and formalize standard operating

**Key Outcomes & Applicable Data Points** •Updated SHIP access to care data.

*There are currently no SHIP or Public Health MFR measures associated with this topic.*

Strategic Actions	Process Measures & Dates
<ol style="list-style-type: none"> <li>1. Identify ICD conversion process/ methodology.</li> <li>2. Test ICD conversion methodology.</li> <li>3. Create work plan and implement rollout of complete ICD conversion.</li> <li>4. Identify type of data use agreement needed for Health Services Cost Review Commission (HSCRC) data for SHIP.</li> <li>5. Collaborate with HSCRC and applicable partners to develop data use agreements that meet OPHI and HSCRC needs.</li> <li>6. Establish data use agreements with HSCRC.</li> <li>7. Develop standard operating procedures (SOP) manual for SHIP data updates to reflect SHIP data update protocols conducted in 2016 for 2008-2014 data.</li> <li>8. Update SHIP measures in alignment with Maryland Comprehensive Primary Care Model population health measure development.</li> </ol>	<ol style="list-style-type: none"> <li>1. Quality metric design (by 6/2017)</li> <li>2. Term sheet development (by 6/2017)</li> <li>3. Recruitment and identification of existing resources for state regulatory body to project manage PCM (by 7/2017)</li> <li>4. Develop structure of state regulatory body of PCM (by 7/2017)</li> <li>5. Develop applications for CTOs and PCHs (by 11/2017)</li> <li>6. Negotiate legal agreement for CTOs and PCHs (by 3/2018)</li> <li>7. Support CMMI operationalization of PCM (by 4/2018)</li> <li>8. CMS clearance management (7/2018)</li> </ol>

# Healthy Beginnings

## Overview

**Focus** PHS will conduct robust data analysis, in conjunction with quality improvement projects, to improve dissemination of best practices and improve operations.

**Landscape** Infant mortality is a sentinel event that serves as a measure of a community's general health status. Although infant mortality rates (IMR) have declined in Maryland by 14% over the past decade, the rates have plateaued over the past five years (IMR of 6.7 infant deaths/1,000 live births in 2010; IMR of 6.7 infant deaths/1,000 live births in 2015).

Racial disparities in infant mortality are unacceptably high in Maryland with a black-to-white IMR ratio of 2.6 to 1 (black IMR of 11.2/1,000; white IMR of 4.3/1,000). Maryland's IMR is 10% higher than the national average and is the 19<sup>th</sup> highest in the U.S. Nationally, a similar number of fetal deaths and infant deaths occur annually. In Maryland, the annual number of fetal deaths is even greater than the number of infant deaths. In 2015, 573 fetal deaths compared with 491 infant deaths were reported among Maryland residents.

- Actions**
- Fetal and Infant Death analysis to understand trends and underlying factors.
  - Fetal and Infant Mortality Review program analysis to understand and model best practices across Maryland.
  - Pilot and implement electronic newborn screening results with hospitals to reduce testing turnaround time.



# Healthy Beginnings

## *Fetal & Infant Death Analysis and Reporting*

**Project Description** In Maryland, limited fetal mortality data is prepared for inclusion in the Vital Statistics Annual Report, and a comprehensive analysis of fetal death data is not routinely conducted.

The purpose of the proposed project is to comprehensively analyze Maryland’s fetal mortality data. In addition, the association of fetal death and infant death with a number of demographic, medical, and pregnancy characteristics will be compared in order to identify similarities and differences associated with the two types of reproductive loss.

**Key Outcomes & Applicable Data Points**

- Fetal Death Report
- The fetal death rate in 2014 was 7.6 per 1,000 total deliveries, compared to a rate of 8.0 in 2013. The rate was 5.3 for whites and 10.8 for blacks. *Source: Vital Statistics Administration*

*The fetal death rate is not a SHIP or MFR measure. The infant death rate is.*

Strategic Actions	Process Measures & Dates
1. Compile and review fetal death data from 1999 to the present to determine completeness of the data.	1. Data compilation and review completed (by 4/2017)
2. Analyze fetal death data by maternal and infant characteristics, pregnancy characteristics, medical characteristics, utilization of care, and cause of death.	2. Fetal death by maternal and infant characteristics analyzed (by 5/2017)
3. Compile comparable infant death data by maternal and infant characteristics listed above and compare similarities and differences associated with the two types of reproductive loss.	3. Comparative analysis completed (by 6/2017)
4. Prepare findings report.	4. Report completed (by 8/2017)
5. Disseminate and discuss report.	5. Dissemination method identified and implemented (by 10/2017)
6. Repeat annually per data availability and incorporate process revisions as needed.	6. Subsequent reports completed (TBD annually)

# Healthy Beginnings

## *Fetal & Infant Mortality Review Program Analysis*

**Project Description** As the financing and delivery of health care services evolve, there is increasing emphasis on population health and health disparities and greater attention given to improving quality and accountability in both the private and public sectors. Faced with these trends, public health professionals must find ways to be more responsive to the needs of women, infants and families throughout the life course.

As Maryland’s progress with infant mortality reduction has stalled, a strategic approach for strengthening evidence-based practices such as the Fetal and Infant Mortality Review (FIMR) process makes sense in order to address systems and community-level factors.

- Key Outcomes & Applicable Data Points**
- Improve FIMR quality across Maryland.
  - Improve public health and health services systems for pregnant women, infants, and their families.
  - Infant mortality rate (6.5 per 1,000 live births in 2014) in Maryland overall and by racial/ethnic group (10.7 for Black Non-Hispanic, 4.4 for White Non-Hispanic and 4.4 for Hispanic). *Source: Vital Statistics Administration.*

*The Infant Mortality Rate is both a SHIP and MFR measure.*

### **Strategic Actions**

### **Process Measures & Dates**

- | <b>Strategic Actions</b>                                                                                                                                                                                                                                                                             | <b>Process Measures &amp; Dates</b>                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 1. Conduct a root cause assessment of Maryland’s current statewide and local FIMR challenges including: 1) Review background information products, conduct key informant interviews, analyze and summarize the current state of FIMR, and 2) Develop a desired state for FIMR via an advisory group. | 1. Root cause assessment completed (by 6/2017)                                                              |
| 2. Identify potential solutions and summary of FIMR best and promising practices via a review of FIMR processes in other states and a literature review of FIMR findings and evaluations.                                                                                                            | 2. Best and promising practices from the literature (by 8/2017)                                             |
| 3. Select and plan a solution or solutions through advisory group, including: 1) Clear metrics, draft recommendations/policy/guidance, and 2) stakeholder feedback                                                                                                                                   | 3. Advisory Group recommendations and associated metrics regarding potential solutions drafted (by 10/2017) |
| 4. Pilot test proposed FIMR policy and/or protocols in elected jurisdictions.                                                                                                                                                                                                                        | 4. Pilot test completed (by 1/2018)                                                                         |
| 5. Determine final disposition for the proposed FIMR recommendations, policy and/or procedures.                                                                                                                                                                                                      | 5. Advisory Group final recommendations and associated metrics determined (by 3/2018)                       |



# Healthy Beginnings

## *Electronic Newborn Testing Results*

**Project Description** The Laboratories Administration screens virtually every baby born in Maryland for 56 hereditary disorders. Newborn Screening (NBS) has been proven to benefit the health outcomes of infants by identifying heritable disorders that when treated greatly reduce morbidity and mortality. For medical interventions to be successful the disorders must be identified by prompt testing immediately after birth.

The goal of this project is to decrease the time frame from when a specimen is collected after birth until the NBS test results are returned to the health care provider through electronic reporting.

**Key Outcomes & Applicable Data Points**

- Established electronic NBS Test HL-7 (Health Level 7) ordering/results platform
- 90% reduction of NBS paper test results by December 2017
- Maintain turn around time for test results (3 days)

*Turn around time for test results is an MFR measure. There are no SHIP measures associated with this project.*

**Strategic Actions**

**Process Measures & Dates**

1. Establish project plan with timeline and goals.	1. Plan completed (by 3/2017)
2. Survey Maryland Hospitals to determine HL-7 implementation concerns/obstacles/challenges.	2. Survey completed/analyzed (by 3/2017)
3. Design Pilot Program to Test HL-7 NBS e-reporting concept.	3. Pilot client selected (by 3/2017)
4. Implement Pilot program for e-reporting.	4. Pilot plan developed (by 4/2017)
5. Complete the upgrade Laboratory Information System.	5. Pilot Program initiated (by 6/2017)
6. Evaluate/Leverage CRISP in NBS Data collection initiative.	6. Starlims v.11 implemented (by 7/2017)
7. Rollout e-reporting to all clients.	7. Progress reports and updates completed (by 12/2017)
8. Design Pilot for HL-7 test ordering/results.	8. Pilot plan developed (by 1/2018)
9. Implement Pilot program NBS HL-7 test ordering/results.	9. Pilot Program for e-test ordering initiated (by 3/2018)
10. Rollout NBS HL-7 test ordering/results to all clients.	10. NBS electronic test ordering available to all clients (by 6/2018)
11. Identify and implement continuous Quality	11. QA identified and implemented (by 6/2018 and ongoing)

# Healthy Communities

## Overview

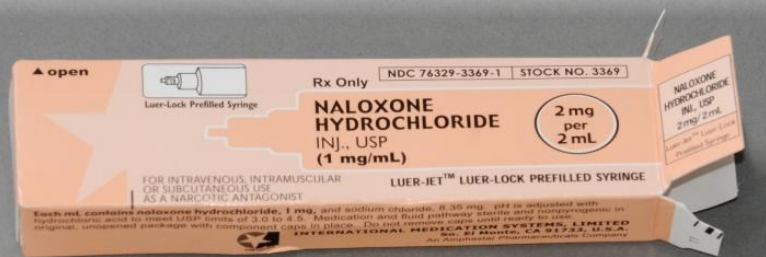
**Landscape** Drug overdoses have become a serious public health challenge in Maryland and across the country. In Maryland, the total number of overdose deaths has risen steadily since 2010, mainly due to the increase in heroin-related deaths. Preliminary analysis shows that Maryland is on track to double fatal opioid related overdoses from calendar year 2015 to 2016.

This epidemic is non-discriminate among race, ethnicity, gender, age, economic status or geographical region.

As it has become more difficult and expensive to obtain prescription opioids, cheaper and more accessible drugs such as heroin and synthetic opioids are becoming more common.

**Focus** Strengthen and streamline cross-unit overdose prevention, treatment, programs, and policies with the goal of further enabling local agency response and harnessing the actions of the Overdose Operational Command Center (OCC).

- Actions**
- Data sharing to bolster local opioid response.
  - Conduct coordinated provider and community outreach on prescription opioids.



# Healthy Communities

## *Data sharing to bolster local opioid response*

**Project Description** Preliminary analysis shows that Maryland is on track to double fatal opioid related overdoses from calendar year 2015 to 2016. To combat this alarming trajectory, in January 2017 Governor Hogan established the Opioid Operational Command Center (OOCC) to work directly with local, state, and federal organizations/agencies to coordinate the needs of local Opioid Intervention Teams and carry out recommendations of the Lt. Governor’s Heroin and Opioid Emergency Task Force.

The goal of this project is for PHS to contribute functional support and subject matter expertise to the OOCC to reduce redundancies and support local health departments in front-line coordination and implementation.

**Key Outcomes & Applicable Data Points**

- Number of opioid overdose related Emergency Department (ED) visits annually and per month (23,391 in 2016 per ESSENCE data).
- Number of fatal opioid overdoses in Maryland, annually and per month (pending release of 2016 data from Vital Statistics Administration)
- Number of opioid related facilitated data shares to local health departments

*Drug-induced death rate and addictions related ED visits are SHIP measures. There are no opioid specific MFRs at this point in time.*

**Strategic Actions**

**Process Measures & Dates**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| <ol style="list-style-type: none"> <li>1. Appropriately staff OOCC as dictated by the Governor’s directive.</li> <li>2. Facilitate data sharing between state agencies and local health departments regarding: 1) Non-fatal opioid overdoses , 2) Fatal opioid overdoses that had a previous non-fatal overdose, 3) Applicable Prescription Drug Monitoring Program data, and 4) Other data as determined by the OOCC and DHMH.</li> <li>3. Set policies to enhance prevention and response, as well as to streamline DHMH overdose programs, policies and procedures.</li> <li>4. Facilitate local application of OOCC activities, including local Opioid Intervention Teams.</li> <li>5. Revisit and welcome the addition of new actions as needed based on changing OOCC objectives and trends.</li> </ol> | <ol style="list-style-type: none"> <li>1. DHMH OOCC contingency fully staffed (by 4/2017 then quarterly)</li> <li>2. State agency data sharing (by 4/2017 then quarterly)<br/>-Local agency data sharing (by 5/2017 then monthly)</li> <li>3. Number of formal (legislative ) and informal (internal protocols) policies per calendar year (by 6/2017 then quarterly)</li> <li>4. Number of OOCC/Local Health Officer conversations facilitated (starting 4/2017 then monthly)</li> <li>5. OOCC objectives and trends added/ modified (by 5/2017 then monthly)</li> </ol> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

# Healthy Communities

## *Coordinated provider and community outreach*

**Project Description** Opioid overdoses have become an epidemic in Maryland. This epidemic is non-discriminate among race, ethnicity, gender, age, economic status or geographical region. The Office of Controlled Substances Administration (OCSA) is placing an increased emphasis on community outreach and education programs targeted to the medical, law enforcement, government, educational and public communities.

The goal of this project is to leverage and coordinate provider and community outreach focusing on opioid abuse, misuse, addiction, overdose and alternatives to opioid prescribing and usage.

- Key Outcomes & Applicable Data Points**
- Improperities and non-compliances discovered during OCSA inspections and documented in OCSA Inspection Reports.
  - Reduction in red-flags revealed during OCSA inspections.

Strategic Actions	Process Measures & Dates
1. Engage partners to identify current/needed educational opportunities around OCSA functions, provider prescribing education, and opioid addiction.	1. Identify Coalition Participants, Establish Coalition Partnership (by 8/2017 then quarterly) -Complete summary report of partnerships (by 8/2017)
2. Identify, adapt and/or create educational materials based on needs of targeted partners and current evidence-based opioid education standards (in consultation with DHMH units). Create schedule and rollout communications with partners.	2. Educational content identified/approved by DHMH subject matter experts, and adapted as needed (by 9/2017)
3. Create and implement a Communications Plan utilizing social media to expand access to educational content (Activity 1) and increase public awareness about role/function of OCSA in the opioid epidemic.	3. Schedule with implementation dates created and updated (by 9/2017 then quarterly)
4. Modify OCSA inspection protocols to include dissemination of educational materials at inspections.	4. Communications plan and quarterly summary of activities (by 9/2017 then quarterly)
5. Establish a regional coalition with the state entities that oversee controlled dangerous substances/opioids to foster cross-state collaboration.	5. OCSA inspection protocols modified (by 11/2017)
	6. Coalition participants identified (by 8/2017) -Coalition framework created (by 9/2017) -Coalition inaugural meeting held (by 12/2017) -Coalition annual work plan created (by 5/2018)

# Operations

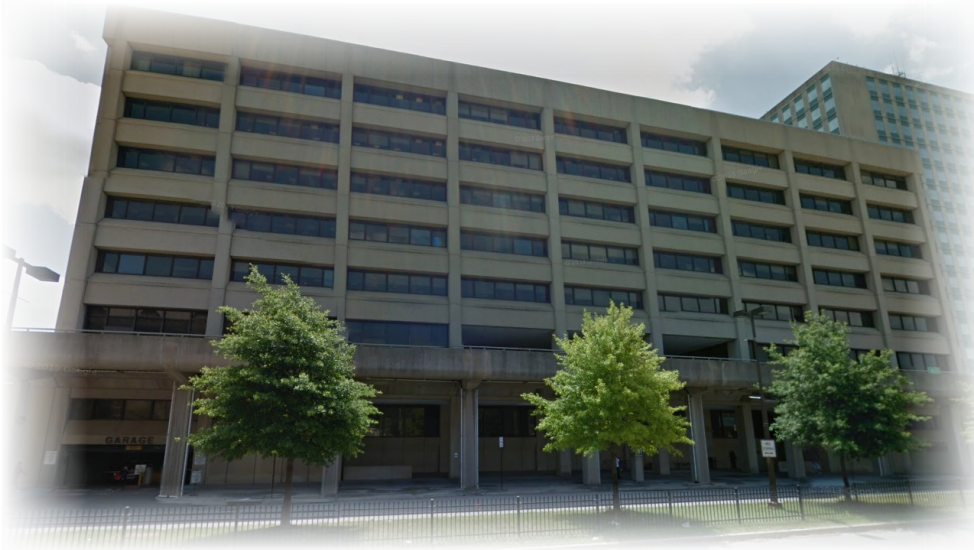
## *Overview*

**Landscape** PHS is committed to improving the health status of individuals, families, and communities through prevention, early intervention, surveillance, and treatment. PHS houses over 1,500 employees across the state who are charged with carrying out essential public health functions, inspections, and services for Maryland.

As a function of state government there are regulations and requirements that govern business functions and human resources operations. At the same time, PHS has the ability and opportunity to work within those systems to improve staff public health competencies and create continuous learning opportunities through health informatics and quality improvement.

**Focus** The training needs and operational capacity to keep PHS functioning are varied and complex. The operations component of the PHS Strategic Plan aims to achieve national public health accreditation, create a prepared workforce, provide needed training and workforce development opportunities, and establish informatics and quality improvement frameworks.

- Actions**
- Achieve and maintain National Public Health Accreditation.
  - Implement and monitor Continuity of Operations Planning within PHS.
  - Centralized management and coordination of data analytics within PHS.
  - Establish and improve the culture of Quality Improvement among PHS units.
  - Improve the culture of learning within PHS through recommendations of the PHS Workforce Development Learning Collaborative.



# Operations

## *Achieve and maintain National Public Health Accreditation*

**Project Description** Public Health Services is pursuing national accreditation through the [Public Health Accreditation Board](#) (PHAB). PHS began the process to achieve accreditation in 2012 and is completing a post-site visit Action Plan due in June 2017. Once accredited, PHS will be responsible for annual reports until reaccreditation in 2020.

The goal of this project is to complete the action plan requirements, meet annual accreditation reporting requirements, and position PHS to meet reaccreditation requirements.

- Key Outcomes & Applicable Data Points**
- Achieve National Public Health Accreditation recognition in 2017
  - Position PHS to achieve reaccreditation in 2020

*National Public Health Accreditation is currently not a SHIP or MFR measure.*

Strategic Actions	Process Measures & Dates
1. Create and implement PHS performance management dashboard.	1. PHS Strategic Plan updated (by 4/2017)
2. Update the PHS Workforce Development Plan and implement Workforce Development component of PHS Strategic Plan.	2. PHS Performance Management dashboard implemented (by 4/2017)
3. Create PHS Quality Improvement (QI) Plan and implement QI component of PHS Strategic Plan.	3. PHS Workforce Development Plan updated and implemented (by 5/2017 then quarterly)
4. Revise PHS environmental health and disease investigation protocols.	4. PHS Quality Improvement Plan created and implemented (by 5/2017 then quarterly)
5. Establish SHIP standard operating procedures.	5. SHIP Protocols revised (by 6/2017)
6. Submit online Action Plan requirements.	6. SHIP SOP created (by 6/2017)
7. Complete and submit annual accreditation reports.	7. Online Action Plan requirement submitted (by 6/2017)
8. Conduct crosswalk exercise of reaccreditation requirements and status of PHS reaccreditation readiness.	8. Accreditation report submitted (TBD based on accreditation date)
9. Develop and implement reaccreditation work plan.	9. Crosswalk completed (by 3/2018)
	10. Reaccreditation work plan created (by 6/2018)

# Operations

## Continuity of Operations Planning (COOP)

**Project Description** Federal agencies define Continuity of Operations Planning (COOP), as an effort within individual executive departments and agencies to ensure that Primary Mission Essential Functions (PMEFs) continue to be performed during a wide range of emergencies, including localized acts of nature, accidents and technological or attack-related emergencies. DHMH does not have a current COOP program and existing COOP plans may not reflect the current state of operations within DHMH. In disasters, there are critical DHMH operations that must continue for the health and safety of Maryland residents.

The goal of this project is to create and implement an updated COOP program for DHMH that will drive the development of associated trainings and exercises to ensure staff preparedness.

**Key Outcomes & Applicable Data Points** •Updated COOP Plan for PHS  
*COOP is currently not a SHIP or MFR measure. A prepared workforce is currently a major project within the PHS Quality Improvement Council.*

Strategic Actions	Process Measures & Dates
1. Office of Preparedness and Response (OP&R) staff will create a COOP template for Office/Administrations.	1. COOP template completed (by 5/2017)
2. OP&R staff will engage PHS Leadership on COOP and essential functions.	2. One meeting with PHS Leadership (by 6/2017, follow up as needed)
3. OP&R staff will create listing of Office/Administration point of contacts (POCs), requested by PHS Leadership.	3. One meeting with POCs (by 7/2017, follow up as needed)
4. OP&R staff will engage POCs with training on template and confirm essential personnel functions.	4. POC list created (by 7/2017)
5. OP&R staff will collate templates and conduct follow up.	-Percent of administrations providing POCs (by 7/2017)
6. OP&R staff will create COOP document and engage POCs in the review process.	5. Percent of templates completed and returned (by 8/2017)
7. PHS COOP Document finalized.	6. Final templates received and approved (by 11/2017)
8. Ongoing periodical review of COOP by POC and OP&R.	7. Final COOP created (by 12/2017)
	8. Review date TBD

# Operations

## *Data analytics capacity within PHS*

**Project Description** Data collection and reporting is a major function of PHS. This function provides state and local partners the means to effectively plan and monitor public health programs and understand the health of their community. Data systems in PHS also meet federal and state guidelines and mandates.

Data analytics at PHS will focus on the creation of a centralized structure to manage data across public health programs to exercise better control over data quality and leverage the information potential of PHS data sources.

**Key Outcomes & Applicable Data Points** •Centralized management of PHS information technology and data  
*Data analytics capacity is currently not a SHIP or MFR measure.*

Strategic Actions	Process Measures & Dates
1. Establish a Public Health IT Director position to coordinate and oversee the full range of information technology services across PHS , including collaboration with the DHMH Office of IT (OIT), the Department of Information Technology (DoIT), and outside IT-related parties.	1. Public Health IT Director position filled (by 6/2017). 2. Public Health Informatics Director position filled (by 6/2017) 3. Position work plans created, implemented and monitored (by 6/2017 then quarterly)
2. Establish a Public Health Informatics Director position responsible for data management, information governance, and data science responsibilities, with the goal of delivering high-value integrated information systems and analyses.	4. Data leads for each administration identified (by 6/2017) 5. Data sharing protocols drafted (by 8/2017) and executed between PHS units (by 10/2017) and other state agencies (by 11/2017).
3. Create and implement actionable plans for the work of the Public Health IT Director and Public Health Informatics Director.	6. PHS GIS system implemented (by 10/2017).
4. Identify data leads for each public health administration.	
5. Engage PHS data leads and administrations to establish internal and external data sharing protocols that comply with larger DHMH and state data sharing standards.	
6. Implement/maintain GIS systems for PHS.	



# Operations

## Quality Improvement

**Project Description** Quality Improvement (QI) is a deliberate and defined improvement process that focuses on activities that are responsive to community needs and improving population health. QI can be applied to general work operations and to public health programs.

The goal of this project is to grow a culture of QI in PHS through the creation of a QI Council and the deployment of a QI Plan.

**Key Outcomes & Applicable Data Points** •Improve the PHS QI culture from beginning (level 1) to moderate (level 3) by 2019 (NACCHO Roadmap to Culture of QI self-assessment).

*Quality Improvement is currently not a SHIP or MFR measure.*

Strategic Actions	Process Measures & Dates
1. Create QI Council based on accreditation guidelines and best practices.	1. QI Council charter, roster and first meeting completed (by 3/2017)
2. Train the QI Council on current evidence-based QI practices in public health.	2. QI Council training conducted (by 6/2017)
3. Develop and update a QI Plan that reflects accreditation requirements and lessons learned from peer state health agencies.	3. QI projects selected (by 4/2017)
4. Cooperatively identify QI Projects with applicable PHS offices and the QI Council.	4. QI Plan published (by 6/2017)
5. Implement and evaluate QI Projects with the QI Council.	5. QI project storyboards completed (starting 6/2017 then quarterly)
6. Spread QI knowledge and lessons learned to PHS staff through new online learning opportunities.	6. Online QI training developed and launched (by 12/2018)
7. Provide technical assistance to PHS units as needed and requested.	7. TA count per quarter
8. Repeat Council QI project work (with new projects) and training as needed.	8. New QI Council projects and applicable training needs identified (by 6/2018)

# Operations

## Workforce Development

**Project Description** Public Health Services is committed to ensuring a competent workforce that supports a culture of learning through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.

To accomplish this PHS will implement and monitor a Workforce Development Plan that addresses the culture of learning at PHS through the training needs of the current and future public health workforce.

- Key Outcomes & Applicable Data Points**
- Percent of front line PHS employees perceive the importance of professional development opportunities (50.4% per 2017 PHS Training Needs Assessment).
  - Percent of management who perceive the importance of providing professional development opportunities for front line PHS staff (49.6% per 2017 PHS Training Needs Assessment).

*Workforce Development is currently not a SHIP or MFR measure.*

Strategic Actions	Process Measures & Dates
1. Maintain the Public Health Services Workforce Development Learning Collaborative (WDLC).	1. Quarterly collaborative meetings occurring (ongoing)
2. Use Training Needs Assessment (TNA) results to identify training plans for PHS and PHS units.	2. Training Needs Assessment Results analyzed and training system procured (by 5/2017)
3. Collaborate with applicable academic institutions and state/community partners to leverage training.	3. Training plans created (by 6/2017)
4. Identify and secure public health training content.	4. List of collaborative training opportunities identified (6/2017)
5. Implement and track public health training content.	5. Training system launched and implemented (by 9/2017 then quarterly)
6. Conduct small studies of change projects identified by the WDLC.	6. Two studies of change per fiscal year conducted (by 10/2017 and 4/2018)
7. Participate in Fall 2017 ASTHO Public Health Workforce Interest and Needs Survey (PHWINS) and disseminate PHWINS results.	7. PHWINS participation (by 11/2017)
8. Update Workforce Development Plan as needed.	8. Plan updated (ongoing)
9. Revise training plans as needed.	9. Training plans revised (ongoing)

# Appendix A

## *Strategic Planning Participants*

Over 50 PHS employees contributed to the PHS Strategic Plan, from reviewing performance measures in the earliest planning stages to detailing strategies and assisting in the final document production.

Alice Bauman	Mike Mannoizzi
Allison Taylor	Nancy Baruch
Alvina Chu	Patricia Tomsko Nay
Ann Walsh	Prince Kassim
Artensie Flowers	Robert Durr
Audrey Clark	Robert Myers
Bernie Wong	Rodney Hargraves
Chad Perman	Russ Montgomery
Cherly DePinto	Ruth Thompson
Clifford Mitchell	Sade Diggs
Colin Flynn	Sandra Yankoski
Dale Rohn	Sharell Myers
David Blythe	Sharien D. Greene
David Fowler	Shawn Cain
Dawn Berkowitz	Sherry Adams
Donna Gugel	Smita Sarkar
Dorothy Sheu	Temi Oshiyoye
Erica Smith	Tina Backe
Genevieve Hugenbruch	Veronica Black
Greg Reed	Wendy Cronin
Howard Haft	
Ilise Marrazzo	
Isabelle Horon	
Jason Linker	
Jeffrey Hitt	
Jennifer Newman Barnhart	
Jim Polek	
Kristi Pier	
Kurt Seetoo	
Lee Hurt	
Mary Beth Waide	
Maura Dwyer	
Michael Reyka	
Michelle Spencer	

# Appendix B

## *PHS Strategic Planning Timeline*



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary*

### **Public Health Services**

### **Strategic Planning Process**

### **State Fiscal Years 2016-2017**

*Updated: July 2017, November 2017, April 2017*

#### **Document Purpose**

The purpose of the Public Health Services (PHS) Strategic Planning Process document is to articulate why PHS is revising their Strategic Plan and outline the revision process that has and will occur between January 2016 and June 2017.

#### **Background**

Three major factors contributed to the decision to revise the PHS Strategic Plan (the Plan). First, in June of 2015 the executive leadership of PHS changed with the appointment of Dr. Howard Haft as Deputy Secretary for Public Health Services. As part of his transition Dr. Haft implemented Organizational Dynamics meetings to improve leadership team cohesiveness and establish clarity around PHS priorities. Second, in December of 2015 Public Health Services hosted their national Public Health Accreditation site visit. The Site Visit Report highlighted the lack of evaluation of the plan. Third, in January 2016 the Governor's Office of Performance Improvement (GOPI) announced major changes to state-mandated performance management systems known as StateStat and Managing for Results (MHF). These factors aligned to create an ideal opportunity to revise the Plan and better integrate performance management and evaluation opportunities into the new Plan.

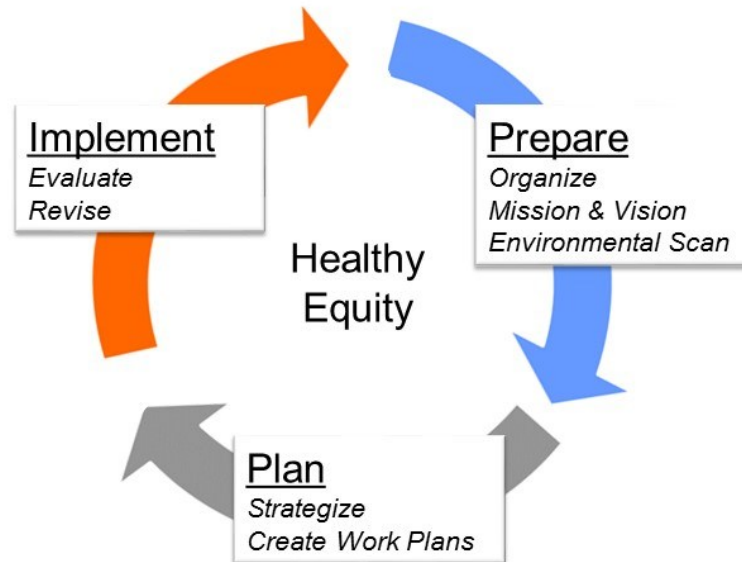
#### **Goal**

The goal of revising the Plan is to create a living document that provides a guiding foundation to set direction for PHS, inform decision making at multiple levels of the organization, and assess performance. The Plan will renew focus on critical operational and health areas with transparent and functional reporting through an Executive Team Dashboard. The Dashboard will include process and outcome reporting that aligns with the above-mentioned GOPI changes as well as the State Health Improvement Process (SHIP).

## Process Outline

To accomplish this PHS will follow the recommendations and seven steps outlined in the ASTHO Strategic Plan Guide. The process will engage Director-level leadership from each major unit of PHS through a series of assessments and in person meetings designed to result in a comprehensive draft that will be shared with all PHS staff through a public comment period in the spring of 2017. This will coincide with performance management trainings within each unit.

### *Public Health Services Strategic Planning Process*



1. Organize: PHS Strategic Planning Team (15)
  - PHS Director
  - PHS Chief of Staff
  - Director of Performance Improvement
  - Director of Minority Health and Health Disparities
  - PHAB Coordinating Office (OPHI)
  - PHS Unit Directors (n = 10)
2. Mission and Vision PHS Visioning Session with PHS Executive Team
3. Strategize Strategic Planning Retreat
4. Work Plans Quarterly Meetings
5. Evaluate PHS Strategic Plan Dashboard
6. Revise Quarterly Meetings

## **Implementation Timeline and Milestones:**

*Note project hiatus January 1 – April 1, 2016 and 2017 due to Maryland's Legislative Session*

<u>Date</u>	<u>Step</u>	<u>Milestone</u>
October 2015	Organize	First Organizational Dynamics meeting to set leadership expectations under Deputy Secretary Haft
December 2015	Mission/Vision	Second Organizational Dynamics meeting to do a facilitated visioning exercise on what the PHS mission and vision mean to participants.
February 2016	Organize	Performance Management meeting to review crosswalk of performance measures and reporting tools.
April 2016	Organize	Post-session reconvening to discuss Strategic Planning process in light of PHAB Action Plan requirements.
July 2016	Organize	Formal decision by the Deputy Secretary to revise the PHS Strategic Plan. Draft work plan and timeline created for revision process.
August 2016	Strategize	PHS Directors complete SWOT analysis tool with the University of Baltimore (UB) Schaefer Center for Public Policy.
September 2016	Strategize	PHS Directors Strategic Planning retreat facilitated by UB.
November 2016	Strategize	PHS Directors complete online Quality Improvement and Performance Management Self-Assessments.
December 2016	Strategize	PHS Quarterly Directors Meeting continued discussion of potential strategies for the Plan. Quality Improvement and Performance Management self-assessment findings presented.
February 2016	Create Workplans	PHS Directors complete Strategic Plan priorities template for their specific units. Quality Improvement and Performance Management training for each PHS unit begins.

March 2016	Implementation	PHS employee public comment period for proposed strategies. Quality Improvement and Performance Management training for each PHS unit continues. <b>PHS units begin implementation of revised PHS Strategic Plan.</b>
April 2016	Evaluate	PHS Strategic Plan reporting dashboard in full use. First round of results discussed at PHS Quarterly Directors Meeting (3 <sup>rd</sup> quarter meeting).

# Appendix C

## *PHS Performance Management Update*



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary*

### **Public Health Services**

### **Performance Management Process Update**

*Drafted July 2016*

*Revised: October 2016, February 2017, April 2017*

### **Overview**

Public Health Services (PHS) within the Department of Health and Mental Hygiene (DHMH) seeks to streamline the performance management system to better align with accreditation requirements of the Public Health Accreditation Board (PHAB), improve reporting efficiencies, and lead to better knowledge and transparency among leadership and staff involved in using the systems. This document outlines the process by which PHS will engage leadership and staff to update and implement the Performance Management process (PM process). The document addresses this through discussions on:

- I. Influencing Factors: What Changed?
- II. Participants
- III. PM Model
- IV. Adopting the Model & Using the System
- V. PM Process & Deliverables
- VI. Communications & Reporting
- VII. Contact Information



## **I. Influencing Factors: What Changed?**

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A number of environmental factors are aligning to better support revising the PHS PM process.

### *Governor's Office of Performance Improvement*

In October 2015 Governor Larry Hogan reorganized the Governor's StateStat program under the Governor's Office of Performance Improvement (GOPI). The Governor disbanded the StateStat performance management system with the intent to utilize Managing for Results (MFR) as the single state agency performance management system. Prior to this both performance management systems were a mandated requirement for all state agencies. This executive action significantly clarified performance management for PHS into one system (MFR).

### *Director of Performance Improvement*

A joint decision between the Secretary of DHMH (Van Mitchell) and the Deputy Secretary of Public Health Services (Dr. Howard Haft) was made in April 2016 to establish a Director of Performance Improvement. The Director of Performance Improvement works across DHMH and PHS units to coordinate MFR reporting, liaison with GOPI and lead strategic planning efforts.

### *Revision of PHS Strategic Plan, Quality Improvement Plan and Workforce Development Plan*

In June 2015 PHS transitioned to a new Deputy Secretary of Public Health Services, Dr. Howard Haft. As part of this transition, and as a result of findings from the PHAB site visit in December 2015, Dr. Haft decided to revise the PHS Strategic Plan, Quality Improvement Plan and Workforce Development Plan in the fall of 2016 and winter/spring of 2017. The decision was made to better align the plans. The Director of Performance Improvement, in conjunction with the Office of Population Health Improvement, is charged with facilitating the revision and alignment process.

## **II. Participants**

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The following PHS offices are participating in the process.

- Office of the Deputy Secretary of Public Health Services: Set leadership expectations and ensure alignment across QI, Strategic Plan and Workforce Development Plan
- Director of Performance Improvement: Facilitate meetings, research and apply best practices, articulate alignment across QI, Strategic, and Workforce Development Plans
- PHS Directors/Deputy Directors (Leadership): Provide content input and recommendations, communicate transparency with staff
- Former PHS StateStat Liaisons (Program Level Staff): Provide operational input
- Office of Minority Health and Health Disparities: Technical Assistance regarding health disparities and health inequities associated with PM
- Office of Population Health Improvement: Manage SHIP and provide technical assistance

### III. PM Model

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PHS is using the Public Health Foundation's Public Health Performance Management Toolkit to inform the methods and process of the project to identify critical elements in creating and implementing a sustainable new performance management system. The model considers the systems, processes and uses of PM standards, PM measurement, using PM to identify opportunities for QI and the mechanisms in place that PHS will use to report progress. For the specific adaptation of the model to PHS refer to section V: Adopting the Model & Using the System.

#### PUBLIC HEALTH PERFORMANCE MANAGEMENT SYSTEM



### IV. Adopting the Model & Using the System

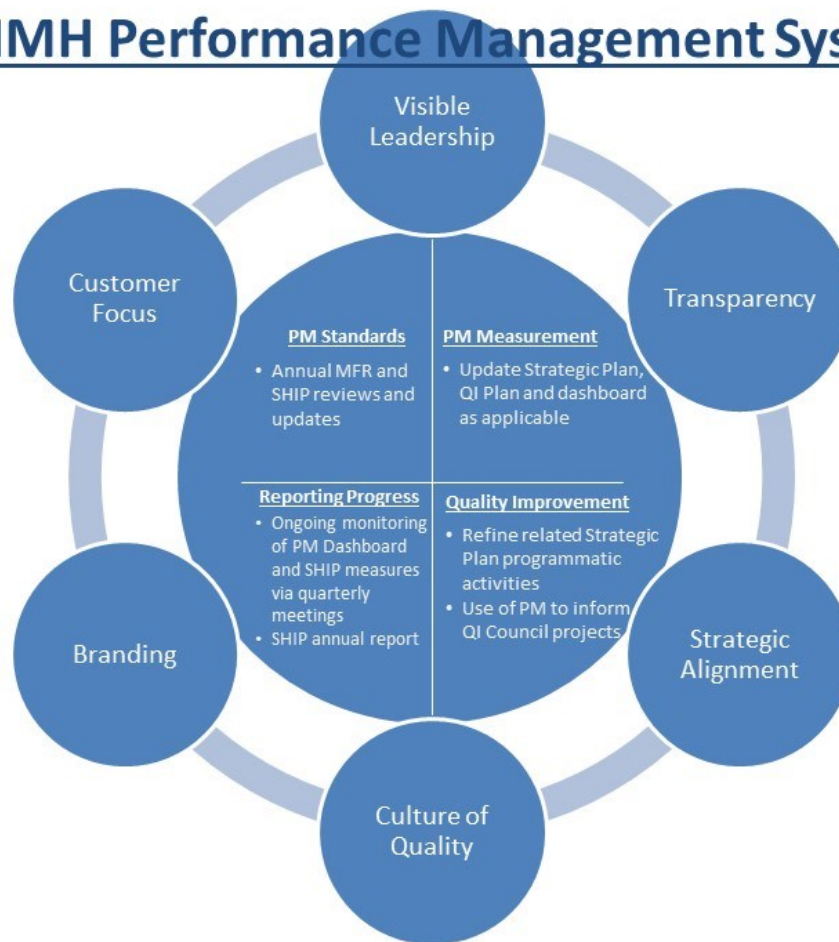
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Performance Management will be implemented in PHS using the model identified in Section III. As part of Activity 3 in Section IV (PM Update & Process Deliverables) staff from the Office of Human Resources, the PHS Workforce Development Learning Collaborative, and the Quality Improvement Council representing different levels of staff (Director, Manager, Coordinator) were tapped to further articulate and propose how the model becomes an active system within the constructs, leadership and activities of PHS. These discussions occurred between May and July 2016 and resulted in the below adaptation of the PHF Performance Management schematic that was presented to PHS leadership on December 12,

2016. Of note, the model was adapted to include branding to articulate the need for reinforced clarity regarding the mission and vision of PHS in performance management.

The central core circle is implemented starting with annual PM standard reviews each summer as part of existing, standard MFR protocols. Additional SHIP reviews occur throughout the year depending on data point submissions. This informs PM measurement updates to applicable plans and dashboards and in turn the refinement of unit programmatic activities and QI projects (and can inform them continuously throughout the year). Progress will be reported to PHS leadership throughout the year (via the PM Dashboard) and annually via the State Health Improvement Process communication mechanisms (annual report, newsletters, etc.). The six constructs of the outer circle will occur in continuous context of the activities of the four elements of the inner circle.

## DHMH Performance Management System



Adapted from the Public Health Foundation and the 2003 Turning Point Performance Management System Framework

## **V. PM Update Process & Deliverables**

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PHS anticipates the project will take a minimum of 12 months to complete. This is based on the need to review current PM system data, conduct a PM self-assessment of PHS leadership, focus alignment with Plans concurrently being developed, and the need to train staff. This timeline also takes into consideration the Maryland legislative session which runs annually from January through the beginning of April. During this time period all PHS leadership and a majority of support staff are detailed to responding to proposed legislation, bill hearings and associated deliverables. The PHS Performance Management Update Timeline is on the following page and contains activities, timeframes, deliverables, owners of the activities, and dates the activities are completed.

### **PHS Performance Management Update Timeline**

*Continued on next page*

Activity	Timeframe	Deliverable	Owner	Completed
1) Review current PM systems with PHS leadership in context of the current landscape and influencing factors.	Winter 2016	Meeting	-Office of Population Health Improvement -Office of the Deputy Secretary for Public Health Services	1/15/2016
2) Cross-walk PM related data points from MFRs, StateStat, SHIP and any other PM related data points.	Winter 2016	Completed cross-walk	-Office of Population Health Improvement	2/29/2016
3) Identify a Performance Management Model that aligns with concurrent updates to Strategic Plan, Workforce Development Plan, and QI Plan.	Spring 2016	PM Model	-Office of Population Health Improvement -Office of the Deputy Secretary for Public Health Services -Workforce Development Learning Collaborative	6/21/2016
4) Conduct PM self-assessment.	Summer 2016	Completed Assessment	-Office of the Deputy Secretary for Public Health Services	11/19/2016
5) Draft potential PM dashboard tool.	Fall 2016	Draft Dashboard	-Office of the Deputy Secretary for Public Health Services -Office of Information Technology	12/6/2016
6) Share PM model, self-assessment findings and draft dashboard tool with PHS senior leadership at Strategic Planning meeting.	Fall 2016	PM Assessment findings and presentation	-Office of Population Health Improvement -Office of the Deputy Secretary for Public Health Services	12/12/2016
7) Align proposed Strategic Planning objectives and goals with MFR and SHIP measures.	Winter 2017	Strategic Plan summary table with identified MFR and SHIP measures.	-Office of the Deputy Secretary for Public Health Services -Applicable PHS Offices	3/29/2017
8) Build out PM dashboard with Strategic Plan objectives and goals	Winter 2017	Revised dashboard	-Office of the Deputy Secretary for Public Health Services	3/29/2017

Activity	Timeframe	Deliverable	Owner	Completed
9) Conduct PM town hall meetings with all PHS units to discuss MFR, SHIP, Strategic Plan, QI Plan and how they come together under the new PM dashboard.	Spring 2017	Sign in sheets and PPT	-Office of the Deputy Secretary for Public Health Services	4/28/2017
10) Conduct PHS leadership training on the PM dashboard as needed	Spring 2017	Training completed	-Office of the Deputy Secretary for Public Health Services	4/28/2017
11) PM Dashboard Deployment	Spring 2017	Live dashboard	-Office of the Deputy Secretary for Public Health Services	3/29/2017

## **VI. Communications & Reporting**

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A major component of launching and implementing the new Performance Management system is communicating the purpose and expectations of the system with leadership and staff, as well as providing clear and ongoing reporting to those same audiences about the status of the projects and goals in the Performance Management System.

As such, activities 9 and 10 in the previous PHS Performance Management Update Timeline address communicating the project and soliciting feedback from both PHS leadership and staff. This is accomplished through town hall meetings with PHS units and one on one training with PHS leadership on the use of the dashboard.

It is the intent of the Office of the Deputy Secretary for Public Health Services to discuss the dashboard as a standing agenda item at the PHS Quarterly Directors Meetings. Subsequent dashboard status reports will be disseminated to staff via PHS leadership on a six-month basis (July and January respectively). The reports will be archived on the Office of Population Health Improvement website.

## **VII. Contact Information**

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The revised Performance Management System is being implemented and monitored on behalf of the Deputy Secretary by the Office of Population Health Improvement. For additional information on the project please contact:

Ann M. Walsh, MHS, CHES  
 Director of Performance Improvement  
 Office of Population Health Improvement  
 410-767-9721  
 ann.walsh@maryland.gov



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