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EVALUATIONS PHASE I (2024)

Team Name

Quality Improvement Storyboard

Team Lead: Julianne Nesbit
Team Members: Amanda Myers - Timekeeper, Jessica Johnson, - Scribe, Katrina Stapleton, - Data Manager, Maalinii Vijayan - Facilitator, Tara Jimison - Document Manager
Target Population: Supervisors and non-supervisors

Plan

Problem Statement

Through routine evaluations and staff feedback surveys, leadership staff have identified a disparity within the current evaluation process, as it fails to adequately accommodate the diverse roles and responsibilities of supervisors and non-supervisors. This deficiency leads to generic assessments that overlook specific skill sets, thereby diminishing the effectiveness of feedback and impeding individual growth.

AIM Statement

By August 1, 2024, the Quality Quest Patrol team will revamp the staff evaluation process to ensure equity across all roles. The goal is to increase the percentage of supervisory staff who positively or neutrally rate the current evaluation template as meeting the needs of supervisors from 36.36% (4/11) to at least 75% (8/11) by December 2024.

Process Outline and Relevent Data

Employee evaluations use the same criteria for all, making it hard to assess supervisors, non-supervisors, and probationary staff. A survey of supervisors gathered feedback on the tool, with only 63.3% (4/11) responding positively or neutrally. A separate survey collected input from all staff on the evaluation process. Qualitative feedback was also gathered.

Potential Cause

The QI team conducted a brainstorming session, reviewing both qualitative and quantitative feedback from staff and supervisors, and compiled a list of identified issues, and discussed potential causes.

Potential Solution

The QI team created a Problem Selection Grid and Process Decision Chart to identify issues, assess process changes, and brainstorm solutions. Key improvements included updating evaluation competencies, adding leadership criteria for supervisors, revising the rating scale, reducing and clarifying pre-evaluation survey questions, and aligning supervisor survey questions with the new leadership criteria while making responses optional. The pre-survey also highlighted the need for a specific evaluation tool for probationary staff to assess their true performance during their short time with the agency.

Prioritization/Selection of Solutions for Implementation

Potential solutions were prioritized using a process that considered factors such as time frame for completion and potential impact on equity. Solutions were ranked on a scale of 1 to 3 based on how quickly they could be implemented. The QI team focused on high-priority activities ranked 1 and 2, while those ranked 3 were set aside for the next project phase. This structured approach ensured that the most impactful and feasible solutions were addressed first, while minimizing delays and promoting equity.

Do

Test of Possible Solution

The QI team conducted a brainstorming session, reviewing both qualitative and quantitative feedback from staff and supervisors, and compiled a list of identified issues, and discussed potential causes.

Check

Study of Results

The updated pre-evaluation and evaluation process was implemented during the 2024 evaluation period. Following its implementation, a post-survey was conducted among the supervisors. The results indicated a significant improvement, with satisfaction in the evaluation process increasing from 36.36% (4 out of 11 supervisors) to 100% (11 out of 11 supervisors).

Act

Standardize Improvement Theory

A Standard Operating Guideline (SOG) was developed to outline evaluation timing, steps in Employee Self-Service, and competency guidelines. Handouts and a PowerPoint were also created to clarify the process and expectations.

Performance Metrics

Increase the percentage of supervisory staff who positively or neutrally rate the current evaluation template as meeting the needs of supervisors from 36.36% (4/11) to at least 75% (8/11)

GRANTS GUIDE (2023 - 2024)

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Team Name

Quality Improvement Storyboard

Team Lead: Maalinii Vijayan, Katrina Stapleton, Tara Jimison
Team Members: Tim Kelly, Tyler Braasch, Robert Wildey, Katherine Schneider
Target Population: CCPH staff who manage and implement grant activities

Plan

Problem Statement

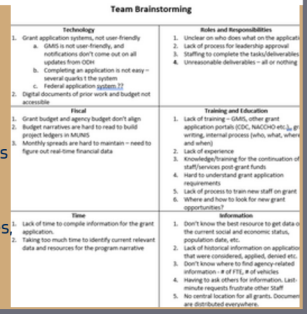
CCPH lacks a standardized process or centralized resources for grant application development, leading to inefficiencies. Grant work is often saved in personal or unknown locations, making it difficult to access and assemble required sections. This results in wasted time, duplicated efforts, and lower staff satisfaction with the grant management process. Staff spend an average of 90.75 hours per year on grant applications, often unaware of internal resources available to assist.

AIM Statement

By September 2024, improve the internal CCPH resources for the grant application and management process. The goal is to reduce the percentage of grant managers unaware of internal resources for developing a grant budget from 55% to 0%. Additionally, decrease the percentage of grant managers uncomfortable with writing a program narrative from 44% to 20% by 2024, and further reduce this to 10% by 2025.

Process Outline and Relevent Data

The QI team created a flowchart to map the current grant application process, including both new grants and continuous solicitations. An observational walk was conducted to identify areas of concern or areas needing improvement, which were then categorized into technology, fiscal, time, roles and responsibilities, training and education, and availability of information.



Potential Cause

A brainstorming session was conducted to identify the potential causes behind the areas needing improvement. These causes were then further analyzed using a control and knowledge matrix. The team chose to focus on concerns within their control, where they had the internal knowledge and resources to address them. Areas outside their control were either tabled for long-term goals or identified as opportunities to influence externally.

	Control	No Control
Expert	**Areas we should focus on** 1. Digital documents of prior work and budget are not accessible. 2. Grant budget and agency budget don't align. 3. Budget narratives are hard to read to build project ledgers in MUNIS. 4. Taking too much time to identify current relevant data and resources for the program narrative. 5. Unclear on who does what on the application 6. Lack of process for leadership approval 7. Lack of process to train new staff on grant 8. Don't know the best resource to get data on the current social and economic status, population date, etc. 9. Lack of historical information on applications that were considered, applied, denied etc. 10. Don't know where to find agency-related information - # of FTE, # of vehicles 11. Having to ask others for information. Last-minute requests frustrate other Staff 12. No central location for all grants. Documents are distributed everywhere 13. Inconsistent coding for grant writing/ management.	**Areas we can provide knowledge about and possibly expand control into** 1. Lack of training – GMIS, other grant application portals (CDC, NACCHO etc.), grant writing, internal process (who, what, where, and when) 2. Lack of experience
on-expert	**Areas the team may focus on with expert assistance** 1. Monthly spreads are hard to maintain – need to figure out real-time financial data 2. Hard to understand grant application requirements	**Areas the team should not initially address** 1. Staffing to complete the tasks/deliverables 2. Unreasonable deliverables – all or nothing

Potential Solution

The team brainstormed several potential solutions, including developing a grants guide, creating a centralized folder for current and past grants, and offering training resources.

Prioritization/Selection of Solutions for Implementation

After evaluating potential solutions using an impact and feasibility matrix, the teamprioritized building a centralized folder and creating a grants guide to address key concerns within their control and expertise. While training resources were considered, the team acknowledged that training without hands-on involvement in the grant application process—particularly grant writing—would be ineffective. As a result, they focused on enhancing internal resources by gathering materials from grant writing and management sessions and saving them to the staff training folder for future reference

Do

Test of Possible Solution

The grants guide with its attachments were tested on a continuation solicitaion application and the accessability of centrlized fodler and trainign resources were tested by team members who would potentially be inlvoved in the grant application process.

Check

Study of Results

Qualitative feedback from the small-scale review highlighted the need for password protection on documents containing personnel information, as well as identifying key staff members who require access to this information. Additonal improvements were made and leadership staff invloved in managing the grants were informed the avaibility of the new resources. A post test was administered to gain feedback on the staff invloved in applying and managing grants.

Act

Standardize Improvement Theory

The grants guide document was developed and shared with the leadership team. A post-survey indicated that the percentage of grant managers unaware of internal resources for developing a grant budget went from 55% to 0%. Aditionally, the percentage of grant managers uncomfortable with writing a program narrative decreased from 44% to 0% by January 2025.

Performance Metrics

Decrease the percentage of hours per grant spent on grant writing and grant management from 90.75 Hours, 4.4% FTE per grant (baseline excludes COVID grants) to 73 Hours 3.5% FTE per grant.

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STAFF RETENTION (2024)

Quality Improvement Storyboard

Team Lead: Katrina Stapleton, + Jessica Johnson
Team Members: Claudia Kadon, Claire Kinner, Carly Lansley, John Mentzel, Rachel Moore, Naycalie Rodriguez
Target Population: Current CCPH staff

Plan

Problem Statement

The 2017 Staff Retention project did not have the desired outcome. In 2023, eighteen staff members resigned for a 34% turnover rate. The 2017 goal to limit resignations to four per year was only met in 2018.

AIM Statement

Limit resignations to four per year.

Process Outline and Relevent Data

The QI team reviewed the work and output of the 2017 team to orient themselves. Turnover data and exit interview results since implementation of the 2017 strategies were analyzed.

The effectiveness of the Onboarding Buddy Program as a retention tool was discussed.

The Leadership Team requested a process for Stay Interviews be developed.

AOHC 2024 salary survey data for like sized LHDs in the SW district was reviewed. Only three positions had the lowest starting pay; however, the actual current pay for those position was in line. It was noted that the responsibilities for the third position were not like for like . It was noted that substantial pay scale and salary adjustments were made in late 2023.

Potential Cause

Exit interview data from 2017-2023 showed that pay and compensation for entry-level and professional positions, advancement opportunities, and morale for entry-level positions continued to be contributing factors of turnover. Wish list items fell into the categories of Compensation and Benefits, Working Hours, Staffing, Leadership, and Things.

Potential Solution

A confidential Stay Interview process was developed which would target staff near their three year anniversary as that was the highest instance of turnover.

Items from the staff wish list should be addressed.

Prioritization/Selection of Solutions for Implementation

Several wish list items were already addressed in current policies. The team eliminated those items from their focus and requested they be discussed during the monthly Leadership meeting to ensure consistent enforcement and implementation. The remaining wish list items were sent to all staff for prioritization. The prioritized list was sent to the Health Commissioner for feedback before selecting items to address. Many items were dependent on the budget. and may not be consistently feasible.

The number one item in the highest ranked category was raised that match inflation at minimum. When the inflation rates for the last ten years were compared to the raise pools for those years, the raise pool exceeded inflation in all but the two years of the pandemic. However, the combined raise pools for those ten years was still greater the the combined inflation rates.

An equipment reimbursement policy would require the reimbursable items to be required. The group did not want to add restrictions to the dress code. Instead staff would be encouraged to use their CCPH bucks to purchase items.

Staffing items should be addressed in the Workforce Development or Strategic Plan. The "Things" category was the lowest priority for staff. The QI team felt that items that were financially feasible would not be successful. Expanding the pathways to promotion plan was proposed as a 2025 quality improvement project. Items presented to Leadership were: anniversary bonuses, increased vacation accrual, a flexible 4/10 schedule, hour lunch option, and increased parental leave.

Do

Test of Possible Solution

The updated parental leave, anniversary bonus and updated vacation policies were approved by the Board of Health, and the Stay Interview process was implemented in January 2025.

Check

Study of Results

The number of resignations in 2024 was two. Turnover, exit interview, and stay interview data would be monitored and reviewed with leadership annually.

Act

Standardize Improvement Theory

The vacation, parental leave, and anniversary bonus policies were approved by the Board of Health and the Stay Interview process was implemented in January 2025.

Performance Metrics

Limit resignations to four per year.