Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Municipality of Anchorage Department of Health and Human Services, AK

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Brief Summary Statement

The Municipality of Anchorage Department of Health and Human Services (DHHS) is located in Alaska's largest urban center. Located in the South central region of the state, Anchorage has a population of approximately 280,000, and is one of only two communities in the state with local health powers. The DHHS QI Demonstration project included a comprehensive self-assessment process that identified evaluation and data capacity as an important priority for our department. With this information we selected our Reproductive Health clinic and HIV opt-out testing program to apply a QI model and demonstration project. Results from this effort will improve HIV testing rates and the long-term goal to reduce HIV infection rates.

Background

The Municipality of Anchorage Department of Health and Human Services (DHHS) has been providing core public health services in one fashion or another since as early as 1926. Since that time of course, the department has seen much growth and change to meet the health and human services needs for the Anchorage community. Anchorage assumed "local health powers" in 1964, and DHHS has been a vital component of our local municipal government since that time. DHHS operates with five core Divisions, including: Environmental Services, Human Services, Community Health Services, Health Planning and Preparedness, and Administration. Administrative operations include Animal Care & Control (Municipal Animal Shelter), and the Anchorage Memorial Park Cemetery. DHHS employs approximately 160 staff members, with an annual budget of approximately $26.3 million (including tax-supported, fees, and grant revenue).

DHHS is managed under Municipal charter and code. The DHSS Director is a direct-report to the Municipal Manager, and does not operate under a local health "authority", such as a "Board of Health." DHHS does provide staffing for several "Advisory" Boards & Commissions that provide input to the Mayor and Anchorage Assembly regarding health and related matters. These include: Health & Human Services Commission; Military & Veteran's Affairs Commission; Women's Commission; ADA (Disabilities) Commission; Senior Commission; Animal Care & Control Advisory Board; and, Cemetery Advisory Board.

Quality improvement has long been identified as a priority for our department. Developing a quality improvement "initiative" for the department was identify as a primary objective of the department's five-year strategic plan in 2006. In addition, as the work of the Public Health Accreditation Board and the national effort surrounding accreditation of local health department's has evolved, our department has established it's commitment to prepare for an accreditation process through quality improvement strategies.

When NACCHO announced this funding opportunity to develop an QI/accreditation "demonstration project" earlier in 2008, we saw this as a perfect opportunity to ramp up our efforts for QI implementation department-wide.

This QI demonstration project targeted clients who we serve through the department's Reproductive Health Clinic (RHC). RHC is located in our department's central location in Downtown Anchorage, and serves approximately 7,000 clients annually. Reproductive Health Services include: STI evaluation and treatment; exams; contraception, pregnancy testing; referrals, and partner notification. RHC's HIV Opt-Out Testing Program was identified as an ideal "direct service" program that could yield data and information to test the use of a QI model within a relative short timeframe. The goal of the HIV testing program is to reach 100% of RHC clients by providing an opportunity to test for HIV. The testing program has incorporated a client survey to determine attitudes and general understanding of HIV infection.

Through this QI project we were able to capture survey data to determine if attitudes and knowledge regarding HIV infection would change overtime, and determine if HIV testing rates will improve.

Of the many health measures that our department evaluates for the Anchorage community, HIV infection rates are an important indicator. Our department has improved efforts to increase awareness and knowledge of HIV infection and will continue to use the opt-out testing program to expand these efforts.

Goals and Objectives

Goal #1: (Completed)
Complete the LHD Self-Assessment Tool for Accreditation Preparation for the department and provide feedback on the metrics.

Partnering with United Way of Anchorage, we plan to engage a consultant to assist us in establishing a Quality Improvement "Team" (to include both internal and external stakeholders) for the department. This team will convene to review and conduct the self-assessment process. Several raters (3-5) will be identified and will use the LHD Capacity Assessment Tool. The responses will be "compiled" to provide one final self-assessment report. Feedback to NACCHO on the metrics will be provided within the two-week timeline following self-assessment as requested.

Timeline: Self-Assessment Due by May 9th, 2008

Goal #2: (Completed)
Complete analysis and scoring of self-assessment results and develop goal statements and priority areas for QI process.

Our department will prepare a comprehensive report on self-assessment results to submit to NACCHO. This report will include: a) goal statements for areas of improvement as identified in the assessment, and b) at least one priority focus area to be targeted for a quality improvement process at the department.

Timeline: Report due to NACCHO by May 23rd, 2008

Goal #3: (Completed)
Implement a QI process at the department using the priority focus area identified through the self-assessment process.

Through this project we will request assistance from a QI consultant that has been identified by NACCHO and develop a QI process using the "Plan-Do-Check-Act" (PDCA) model. It is our goal that we have at least one opportunity to assess the QI process and impact upon program-level outcomes, prior to the conclusion of this project.

Timeline: QI Process initiated at the program level by July 1st, 2008

Goal #4: (Completed)
Submit a Model Practices Application to NACCHO that outlines our self-assessment and QI process.

Following our QI process implementation and review of program-level outcomes, we will submit an application to NACCHO's Model Practices program to inform NACCHO members and the public of our self-assessment process, and the QI plan we developed as a result of the assessment.

Timeline: Submit application by September 30th, 2008

Goal #5: (Completed)
Provide a final project report to NACCHO

Using NACCHO's reporting template for this project, we will send a final report by the requested deadline.

Timeline: Final report due by project end-date: November 30th, 2008

Self-Assessment

The self-assessment process for our department was undertaken with our QI "Team" that consisted of internal stakeholders, including the Department's Management Team and the QI Implementation Committee. A total of 11 staff members were involved in this process.

At the beginning of this project we identified a QI consulting firm that could assist with the self-assessment process, QI implementation planning, and coordination with community partners on broader community efforts regarding health indicators and community assessment. The consultant was asked to meet with our QI Team to provide an "orientation" to the self-assessment tool and

Operational Definition of a Functional Local Health Department. The QI team was introduced to the tool, discussed the scoring methodology and made a plan to collect responses from each individual team member.
The QI Team as asked to complete the survey metrics within two weeks following the orientation meeting. Each participant was asked to submit an excel spreadsheet that included every survey metric and all responses were consolidated into a single spreadsheet.

The QI Team met with the project consultant in a half-day meeting to review the summary of self-assessment responses. The group identified those responses that had the greatest range in scoring and collectively decided what the "group" score would be for each metric. From the consolidated scoring, the group determined which metrics received the lowest and highest scores. Those metrics with the lowest scores were discussed to determine what "priority" metric would be selected to develop the QI demonstration project for the department.

The metric selected by the QI Team included Essential Service IX: *Evaluate and Improve Programs*. Metric # IX-A:5; *LHD has evaluations with analysis of local data with goals, objectives, and performance measures* was selected as the specific focus for our demonstration project.

Highlights from Self-Assessment Results

Standard/ Indicator #	Standard and Significance
IX.A:5	*LHD has evaluations with analysis of local data with goals, objectives, and performance measures* - *With an overall average score of "1" for this standard, the QI Team selected this as the "priority" issue for our project. The team views evaluation and data analysis capacity as crucial to the long-term success and effectiveness of the department.*
VI-E:4	*LDH promptly conducts enforcement in response to emergencies.* • *Standard VI E: Competent and Fair enforcement actions was identified as a major strength of the department, resulting in some of the highest scores in the self-assessment. Enforcement capacity is a strong asset of the department.*
IV-A: 1-11	*Community planning process engaging systems partners* • *This standard/focus was discussed by our QI Team as an area of strong interest with respect to QI. In the end, our team selected the above-mentioned standard recognizing the short project timeline and goals we had in mind.*

Quality Improvement Process

AIM Statement: Increase the number of clients at our department Reproductive Health Clinic receiving HIV testing, with a goal of reaching 100% of all RHC clients (getting testing, or have received testing in the preceding 12 months) by December, 2008.

PLAN: Following the "self-assessment" process we completed in the early phases of this project, our QI Team identified the priority "focus areas" to initiate a QI process within our department. The priority focus-area considered most important to the department for the short-term (and long-term too) was the Essential Function #9*: Evaluate and Improve Programs.* The specific standard and indicator targeted by this project was IX-A:5: *LHD has evaluation with analysis of local data with goals, objectives and performance measures.*

Once we had this priority identified, the QI Team reviewed program areas on the department that could most immediately benefit from an application of QI principles, and yield relatively short-term measurable outcomes. The Team selected our Reproductive Health Clinic (RHC) and HIV "Opt-Out" testing program as fertile ground for a QI Demonstration Project. RHC received grant funding in the Fall of 2007 to focus on HIV testing, which provided additional staff and administrative resources to enhance the department's testing program. This funding opportunity coincided conveniently with the objectives we wanted to achieve through our QI demonstration project. RHC clinic staff were eager to apply QI principles to this program. The HIV testing program is administered by asking every visitor to our Reproductive Health Clinic to participate in HIV testing (if not recently tested) and to complete a brief survey regarding HIV status, perception of risk associated with contracting HIV, and general knowledge of HIV and sexually transmitted diseases.

The QI Team identified “increased HIV/STD survey participation” and “increased HIV testing rates among RHC clients” as indicators of “improvement” for this project. Prior to the implementation of this testing program, RHC’s data regarding HIV testing rates among clients was inconsistent and showed that improvement was needed. In calendar-year 2007, a total of 36.5% of RHC clients were tested for HIV in our clinic. This coincides with national efforts through Title X programs to increase rates of testing and proactive intervention with those contracting HIV.

DO: Once the PDCA model was developed for the HIV testing program, our QI Team had little direct involvement in administering testing and survey activity. That has been handled by our RHC clinic staff, with evaluation support by our internal Data Analyst.

The “Do” steps for this project as outlined in our PDCA cycle summary include the following:

- Begin offering HIV tests to Initial & Annual exam RHC clients
- Begin offering HIV tests to clients seen as contacts to sexually transmitted infections (STI) and clients seeking STI screening.
- Begin offering the test to all eligible clients seen in the Reproductive Health Clinic (RHC)
- Offer Pre/post Surveys to all eligible clients

Detailed steps of this process are provided in flow-chart form in Appendix B of this report.

CHECK: Preliminary analysis of survey results in August of this year indicated that the program was not meeting the goals established for survey participation and testing. Clinic staff convened at that time to review administrative processes and other factors to determine if survey participation and testing activity can be increased. New procedures were implemented as a result of this review and final data analysis is expected to reveal improvement in program participation and HIV testing.

The “check” steps for this project as outlined in our PDCA cycle summary include the following:

1. Completed Beta analysis of initial survey results.in August, 2008.
   a) For those patients who did NOT complete surveys, it was NOT possible to determine if: 1) They were offered pre-post surveys but declined to participate; 2) Their survey was among 66 records omitted from the survey population due to documentation errors; 3) They were simply not offered a survey
   b) 98% of survey participants answered all questions of the survey
   c) Age & gender were found to be variables that affected willingness to participate in survey. Younger female clients were more likely to participate (p-value >= .05) then older, or male clients.
2. RHC staff convened during a planning retreat to review progress of the HIV testing program, and obtain staff feedback & recommendations for project improvements:
   a) Staff identified records not being coded correctly to match testing activity with survey administration
   b) Clarification on “definition” of “abstinence” with survey participants needed to get better validity on survey responses

ACT: Please see attached (in appendices) for a *process flow chart* of the RHC survey and HIV testing administration. The flow chart shows the steps involved in determining if an HIV test will be administered in the clinic (assuming a same-day visit). This process was reviewed during a RHC staff retreat and strategies were identified to improve this overall process for clients. Those changes were implemented in September of this year.

The following steps were taken as a result of data analysis and “Check” process with program staff:

1. During the staff planning retreat in August, the department data analyst provided a project-to-date review of survey and testing data results. Data to all survey responses were reviewed by staff, which serves as baseline data for the overall project. The following questions were discussed with staff during the retreat to determine what, if any changes could be made to the project to find improvement:

a) Does the data you've seen today make sense with what you see on a day to day basis?
b) Is everyone who is eligible being offered a survey?
c) If not, how can we make sure that they do?
d) What would you improve about the survey or the process?

2. The discussion using the above questions yielded two important changes:
    a) The pre/post survey instrument was amended to add two questions regarding the "understanding" of abstinence:
        I. "How do you define abstinence" (open-ended question)
        II. "Do you think abstinence includes abstaining from…" list includes six different sexual activities with an option of answering of "yes," "no," "don't know."

        Staff believed that further clarification regarding the meaning of abstinence would result in more reliable responses related to that question.
    b) The process for handing out pre-post surveys with clients was changed to try and capture 100% of clients visiting the clinic. This involved clerical staff in the survey administration process and documentation for medical records.

These changes were implemented by September, 2008. The RHC program will complete a comprehensive analysis of survey and testing data by March, 2009 to determine the outcomes of these quality improvement measures, and the success of the program.

Results

Complete data analysis for our HIV Opt-out Testing program is expected in early 2009. At that time we will have a better understanding of the impact of our QI process upon this program. Our preliminary review of data and anecdotal evidence from program staff indicate that these efforts were successful in getting improved participation in HIV testing, and participation in the pre/post survey for this program.

In calendar-year 2008, total RHC clients tested for HIV increased from the previous year from 36.5% to 51.4%, which is a 31% increase in percentage of clients tested at our RHC clinic. These results look promising and can be attributed primarily to the increased focus on obtaining HIV tests for clients, and improving the process for testing and gathering of survey data.

This information will be used to track the progress we are making at our department to improve access to HIV testing and counselling for RHC clients, and determine if long-term HIV infection rates will be reduced through these efforts.

Lessons Learned

Undertaking quality improvement in a local health department can be a "mixed blessing" of finding both the opportunities for improvement that already exist, and confronting major administrative challenges to accomplish long-term QI goals. It is our perspective that our department must find ways to continuously assess and review the impact and outcomes that result from day-to-day work within our community. In fact, the principles of QI can and should be applied to practically every organization that works with people and provides products or services that are demanded by the public.

This project has allowed us to tap into expertise and a collective knowledge base that has significantly influenced our department's capacity and interest in adopting QI principles into our daily practice.

As a part of this project we conducted several activities to introduce the concepts of QI to our department staff. This included providing a Quality Improvement "overview" at a department-wide staff meeting in June, 2008. Since then, the department QI Team has developed a comprehensive QI "Implementation Plan" that includes the various internal and external resources required to achieve quality improvement strategies across the entire department. This implementation plan includes assessing staff perceptions and a general understanding of quality improvement, so we can be better informed about obstacles that may exist in gaining full staff buy-in with adopting QI at our department.

Following the staff overview that we conducted in June, our QI Team sent out a department-wide electronic survey to obtain baseline measures in staff knowledge and attitudes toward QI. A summary of these responses is provided in the appendices to this report.

The results from this survey, and the ongoing input we hear from staff about using QI, tells us that we need to carefully plan how we provide information to staff about quality improvement, and determine what strategies will help staff to succeed with incorporating QI into daily practice. We are presently developing a comprehensive “QI Training plan” to implement department-wide in early 2009. This will include using a local QI consultant to assist in training, and plan implementation.

Next Steps

Our Department Management Team has identified Quality Improvement as a priority issue. Implementing QI department-wide has been identified as a major objective in the department strategic plan developed in 2006.

As mentioned in other sections of this report, we are developing a comprehensive QI implementation plan for the department (see appendices plan summary), with major steps taking place in early 2009.

We have just completed the “pre-application” for the RWJF Call for Proposals for Public Health Practice: Evaluating the impact of Quality Improvement. We hope to be invited to submit a full proposal in early Spring, 2009.

With or without additional funding support for QI activities, it is in our long range management plan to pursue national accreditation through the PHAB when the process is initiated. We hope these preliminary steps that we have taken to develop quality improvement principles and practice at our department will help lay the foundation for successful national accreditation.

Conclusions

We have seen that participating in this project with NACCHO has been a great benefit for our department. This project has provided us the opportunity to utilize core QI principles to “experiment” with the introduction of QI into the department in a comprehensive fashion. Having the ability to conduct a comprehensive self-assessment based upon national PH practice standards and using that information to identify performance priorities for the department will give us a great advantage in developing the capacity to meet long-term practice standards through national accreditation.

Regardless of our long-term outcomes regarding accreditation, we believe our department, and the public we serve will benefit from using quality improvement as a core part of our business activities and services we provide.

Another substantial benefit of this project is being a part of the “cohort” that worked together to accomplish the objectives of this program through NACCHO. We now know of at least 40 other local health departments that have similar objectives regarding the improvement of services, and meeting national accreditation standards. This will be an invaluable resource for us.