

**Accreditation Preparation &  
Quality Improvement  
Demonstration Sites Project**

**Final Report**

**Prepared for NACCHO by the  
Osceola County Health  
Department, FL**

**November 2008**



## **Brief Summary Statement**

The Osceola County Health Department (OsCHD), located in east central Florida, is one of the 67 county health departments under the State of Florida Department of Health. We serve a combination urban / rural population of approximately 260,000 residents. Through the NACCHO Accreditation Preparation and Quality Improvement Demonstration Site Project, OsCHD conducted a self-assessment using the Operational Definition Prototype Metrics Assessment Tool to identify weaknesses in our capacity to provide essential public health services. From the results, we prioritized our opportunities for improvement and addressed Essential Service VIII, to maintain a competent public health workforce.

## **Background**

While OsCHD is a state governmental office reporting to the centralized Florida Department of Health, we maintain a close contractual relationship with our local Osceola County government. Osceola County, the 6<sup>th</sup> largest county in land mass in Florida, experienced a growth in population of 42% from 2000 to 2006. The county's racial/ethnic background is 48% white, 39% Hispanic / Latino, 9% African American, and 3% Asian. During this time, OsCHD expanded from a Florida Department of Health designation as a medium sized county health department to a large county health department. With 300 staff members and an annual operating budget of \$20 million, OsCHD provides a comprehensive array of traditional public health programmatic services as well as primary care, dental, and prenatal services. We have four service center locations, two of which have classifications as federally qualified health care centers (FQHC). This makes OsCHD one of only five county health departments in Florida to have a county health department and federal Community Health Center designation.

Due to our proximity to Walt Disney World (located across both Osceola and neighboring Orange County), OsCHD is also faced with a daily average of 99,000 overnight visitors, that can swell seasonally to 138,000, in addition to our resident population. These world-wide tourists have the potential to cause a tremendous increase in the number of people that require epidemiological, environmental, and public health preparedness services.

A key strategic challenge for OsCHD is to continue to ensure we are focused on providing quality health care services, based on the needs of our diverse community, while faced with an increasing demand for services and the potential for both decreased state funding and revenue generating capacity during these economic times. Our 2008-2013 Strategic Plan includes objectives addressing financial sustainability as well as integrating a culture of performance excellence throughout the organization. A key performance excellence objective is to achieve national public health accreditation. Having the opportunity to participate in this NACCHO Demonstration Site project, we anticipated that we would gain valuable insight from our self-assessment that would enhance our accreditation preparation efforts.

## **Goals and Objectives**

Project Goals:

- 1) To prepare OsCHD for national public health accreditation in 2011
- 2) To compare OsCHD performance against standards from the NACCHO LHD Self-Assessment Tool for Accreditation Preparation

Project Objectives:

- 1) To determine areas of strength in order to build upon performance
- 2) To determine areas of weakness in order to focus performance improvement efforts
- 3) To develop a plan for sustainability
- 4) To share lessons learned with key stakeholders

**Self-Assessment**

OsCHD selected a project director from the Quality Management department to lead our efforts in completing the NACCHO LHD Self-Assessment Tool for Accreditation Preparation. The first step was to determine various sources of expertise needed to assist in the assessment. These sources included in-house staff with program / sector expertise, community partners with the needed expertise, and Florida Department of Health (DOH) programmatic expertise. The project director held an initial meeting with management level and program lead staff to discuss the reason for the self-assessment, the self-assessment process, and a six-week timeline for completion. Process owners were identified for each of the ten domains included in the Operational Definition of a Functional Local Health Department. The project director worked with the process owners to identify multidisciplinary committees with various levels of management, program / sector experts, and line staff. We wanted to include line staff not only to get their input for their areas of expertise, but also so they would have a sense of ownership in the outcome and future accreditation efforts. A series of weekly roundtable discussions, two hours in length, were scheduled over the next four weeks for the various committees. The project director led each committee through their assigned section, facilitating discussions to ensure scoring consensus continuity throughout the process. There were only a few instances where the committees were not able to meet consensus on scoring an element, and the project director noted those areas for further discussion with senior leadership.

During this timeframe, state-level DOH Office of Performance Improvement (HPI) staff set up a series of weekly conference calls with the four county health departments (CHDs) in Florida that were selected as NACCHO demonstration sites for this project. HPI staff also invited other CHDs that were not part of the project, but had a strong interest in the self-assessment process to participate in the conference calls. HPI staff facilitated discussions on the various standards and operational definition indicators, focusing particularly on what illustrative evidence was available from various existing data sources. HPI staff populated a master self-assessment tool with database links to assist in documenting illustrative evidence and made this available through their sharepoint site for the four demonstration site CHDs and other interested stakeholders. HPI also facilitated discussions on best practices and lessons learned with the demonstration site CHDs.

As the end of the self-assessment timeframe approached, the project director compiled all the information from the data-gathering phase into a completed self-assessment tool. Management staff, process owners, and committee members were invited to a meeting where the assessment tool was projected using the computerized Smart Board so that everyone could see the results to ensure accuracy. Additionally, the team reviewed the groupings of indicators that scored no capacity, minimal, moderate, significant, or optimal capacity.

**Highlights from Self-Assessment Results**

<b>Standard/ Indicator #</b>	<b>Standard and Significance</b>
I-A	Monitor Health Status and Understand Health Issues Facing the Community <ul style="list-style-type: none"><li>• This was an area of strength for OsCHD. As a county health department under the State of Florida Department of Health (DOH), OsCHD has electronic linkage to statewide databases; has appropriate equipment and</li></ul>

	<p>technology; has an electronic disease reporting system; maintains and uses information systems; and contributes to registries of certain events or outbreaks. We monitor population-based health status indicators in our community and compare our results to other county health departments in Florida and Healthy People 2010 through our DOH Osceola County Performance Snapshot. We ensure linkage of these health status indicators to our Strategic Plan so that they continue to receive a priority focus.</p>
VIII.B.9	<p>Maintain a Competent Public Health Workforce -  <i>LHD provides a coordinated program of continuing education for staff which includes attendance at seminars, workshops, conferences, in-service training, and/or formal courses to improve employee skills and knowledge in accordance with their professional needs.</i></p> <ul style="list-style-type: none"> <li>This was an area of weakness for OsCHD, as all indicators scored minimal capacity. This area had also been identified as an area of weakness through an employee SWOT exercise during our strategic planning process. After discussions facilitated by using a prioritization matrix, OsCHD felt this standard would be the best one to address through our QI process, particularly based on the linkage to our 2008-2013 Strategic Plan.</li> </ul>
IX.D.9	<p>Evaluate and Improve Programs – External Evaluation of Other’s Programs</p> <ul style="list-style-type: none"> <li>This was an area that scored at minimal capacity. OsCHD has a strong in-house process for evaluating and improving programs, but does not have this same capacity for external evaluation.</li> </ul>
X.A	<p>Contribute to and Apply the Evidence Base of Public Health – Participate in Research Activities</p> <ul style="list-style-type: none"> <li>This was also an area of lower scoring as OsCHD has not focused resources to make it possible to participate in research nor to propose practice issues to be used by academia to select research agendas. Since the self-assessment, OsCHD has partnered with Florida Hospital’s Center for Health Futures to collaborate on a research-based grant proposal. We also will have greater opportunities to collaborate with local academia as the new University of Central Florida’s College of Medicine is scheduled to open in a couple years along with the Burnham Institute of Medical Research.</li> </ul>

## Quality Improvement Process

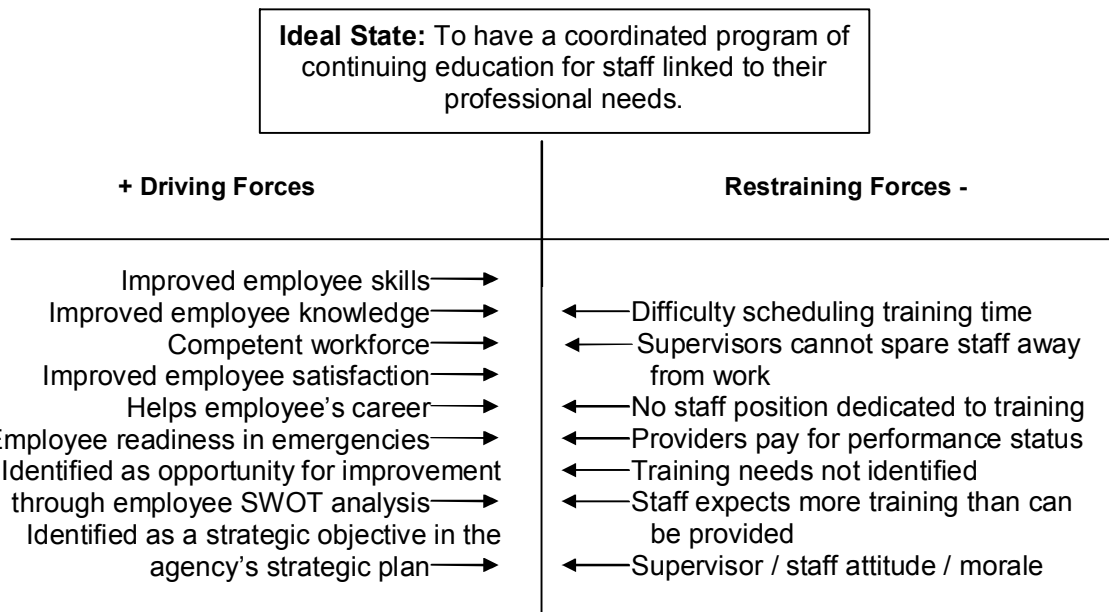
**AIM Statement:** By November 2008, we will improve our program of continuing education for staff to improve their skills and knowledge in order to help them be more effective in their work. We will accomplish this by identifying three overall areas of deficiencies so that in-service training sessions can be developed.

**PLAN:** After we completed our organizational self-assessment, the project director compiled a list of all indicators that scored in the minimal to no capacity range. This list was presented to the senior leadership who then through a prioritization process to evaluate each low scoring standard / indicator against various criteria. These criteria included linkage to our Strategic Plan; importance to our various stakeholders; the weighted chance that a quality improvement effort would actually result in an improvement; and sustainability past the end of the project. Previously during our strategic planning process in February 2008, we had gathered input from staff on their perception of our organization’s strengths and weaknesses. One of the key themes for weaknesses that emerged across all departments was the lack of employee training and education opportunities. From that input, we included a strategic objective to develop an employee training and education program. Based on the results of our prioritization process and input from employees, we chose Essential Service VIII, Operational Definition Indicator VIII-B #9 – *LHD provides a coordinated program of continuing education for staff which includes attendance at seminars, workshops,*

conferences, in-service training, and/or formal courses to improve employee skills and knowledge in accordance with their professional needs – as our key opportunity for improvement.

At this point, we expanded our existing Employee Training Team (ETT) by adding the project director and our contracted QI consultant to the team. The scope of the ETT was enlarged to address our chosen opportunity for improvement using the framework from the Model for Improvement. The ETT wanted to examine the issues surrounding our current employee training approach to determine the driving / positive forces and also what was preventing / restraining progress. Our QI consultant led us through a Force Field Analysis to not only compare the positives and negatives, but also to delve into the real underlying root cause of what was preventing progress.

### Force Field Analysis



**Ideal State:** To have a coordinated program of continuing education for staff linked to their professional needs.

Once we had the drivers and restrainers identified, we decided to focus on the restraining forces in order to remove the barriers that prevented growth in our employee training program. We thought that by removing the barriers we would have a means to break the “change bottleneck” and would be able to accelerate the growth of employee training efforts.

To assist in developing a coordinated program of continuing education for staff that is linked to their professional needs, we first had to know what they felt they needed. The ETT thought it was important that we go directly to the staff to get this information because we wanted them to understand our training focus was linked to what they told us during our strategic planning was a weakness and also linked to the results of our accreditation preparation self-assessment. We decided to use an Individual Development Plan (IDP) to obtain the employee's and their supervisor's input as to what skills and knowledge they saw as deficiencies. We planned to identify the top three areas of commonality and use those to target initial employee education sessions.

#### Improvement Theory

The ETT designed an improvement theory based on identifying the skills and knowledge needed by our non-supervisory / non-managerial workforce in order to improve their public health competencies. We planned to focus on the needs of staff at this level for the duration

of this project due to the fact that managerial and supervisory staff historically has had more opportunities for continuing education. Our prediction is:

- **If** 50% of non-supervisory / non-managerial staff completes Individual Development Plans (IDPs) by September 2008, **then** we will be able to identify three areas of deficiencies common among staff at this level so that we can create a coordinated program of continuing education that would contribute to an improvement in skills and knowledge levels in 50% of the participants.

**DO:** ETT team members researched IDPs samples and brought these to the team meeting for review of the pros and cons of each. We thought several IDPs were too lengthy and unclear as to how they should be filled out. Others IDPs appeared to focus on staff in management positions. We also reviewed the four-page IDP that currently was being used by the health department administrator for senior leadership. We felt this IDP was more involved than what we wanted for non-supervisory / non-managerial staff and that it was focused more on developing managerial staff. We decided to develop for this project a one-page IDP to survey non-supervisory / non-managerial staff to determine what training they needed, their goals to be successful in their current position, and their two- to three-year career goals. As the ETT was in the process of developing the one-page IDP, we learned that the senior leaders already had given the longer IDP to their next level supervisors and some of the supervisors had asked their line staff to complete the IDP as well. The ETT discussed this potential obstacle and decided that since the four-page IDP had already been circulated by some supervisors to their line staff, we would go ahead and use that IDP for the project. We thought this would be less confusing than trying to introduce a completely new IDP.

The ETT team leader attended the next Department Head meeting in August to discuss our progress in implementation of the project, and that we wanted to survey the non-supervisory / non-managerial staff to get their input as to their training needs. Department Heads were asked to ensure their staff completed the IDP and a due date of September 5, 2008 was given.

In the interim, an ETT team member from Human Resources determined the number staff in non-supervisory / non-managerial positions so that we could calculate the percentage of returned IDPs. There was a total of 233 staff in these positions.

As the due date approached, the ETT team realized we were not getting the number of returned IDPs that we had predicted. There were 86 IDPs submitted by the due date, for a return rate of 38%, which was below our goal of 50%. Since time was already blocked for a staff training session in October, the ETT decided we needed to proceed with the limited number of IDPs that had been submitted by the deadline so we would have time to tally the results and identify the three areas of commonality in preparation for training in October.

The ETT reviewed the returned IDPs to try to determine the top three areas of commonality. The results showed many different types of requested training including insurance, eligibility, computer, budget, leadership, HIV, Spanish, laboratory skills, and emergency management. The top three areas were billing / coding, CPR / Basic Life Support, and customer service. As part of our October quarterly Employee Forum, we contracted with a well-known outside training vendor to provide a session entitled How to Handle Difficult People, Reduce Stress and Build Stress Tolerance. The ETT developed a six question pre- and post-training survey that we coordinated with the objectives the trainer had specified for the session. We would focus on one question to measure the staff's perception of their improvement in knowledge pre- and post-training. The post-training question was: *After today's training, my knowledge regarding positive energy, teamwork, and communications increased by: 25%, 50%, 75% or 100%.*

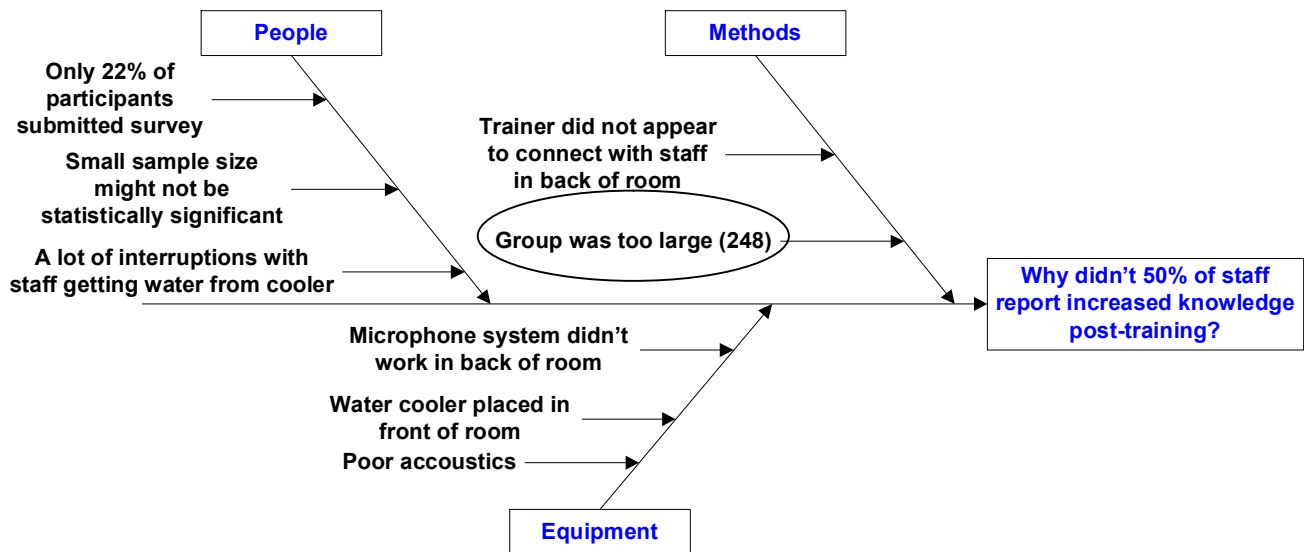
**CHECK:** The results of the post-training survey question:

*After today's training, my knowledge regarding positive energy, teamwork, and communications increased by: 25%, 50%, 75% or 100%.*

Percent Increase	25%	50%	75%	100%	No change
Number responses	15	5	0	0	29

n=49

While the data show that 41% of staff indicated they had an improvement in knowledge after the training, this was below our goal of 50% as indicated in the Aim Statement. Additionally, 59% of the staff said there was no change in their knowledge level pre- and post-training. We used a fishbone diagram with a set of possible causes to facilitate brainstorming in our attempt to identify the root cause of why more staff didn't feel their knowledge level increased.



We learned several key lessons from our brainstorming session:

- 1) Our group (248) was too large to facilitate an interactive session for all staff
- 2) The training vendor's delivery style was probably more adept for a smaller group
- 3) Staff in charge of the meeting didn't realize early enough that staff in the back half of the room could not understand / hear the trainer due to the faulty microphone system and poor acoustics in the room.
- 4) Maintenance staff had delivered a water cooler after the session started and set it in front of the room. This caused a lot of disruption as many staff got up during the session to get water.
- 5) Staff was in a hurry to leave since the session lasted until after 5 PM, so they did not turn in their pre-and post-test survey.

We determined the root cause was that the group was too large to facilitate learning, particularly given that the microphone system was not working in the back of the room.

**ACT:** The ETT decided we needed to test again under different conditions, so we went through a repetitive PDCA cycle to test improvements we implemented from the lessons

learned from the initial PDCA cycle. Since our change did not result in an improvement, we developed a new improvement theory.

Revised Improvement Theory

- **If** we plan our training sessions using the lessons learned from the first PDCA cycle, **then** we will be able to create a coordinated program of continuing education that will contribute to an improvement in skills and knowledge levels in 50% or greater of the participants.

The next training session was scheduled for November and the topic covered was Billing / Coding, which was in the top three areas of commonality identified from the IDPs. There were 77 participants in this session and the trainers were in-house staff billing and coding experts. There were no sound system problems nor were there any artificial distractions such as the water cooler in front of the room. Of the 77 participants, 61% submitted the pre- and post-training survey. This response rate gave us a larger sample size from which to draw more meaningful conclusions.

The results of the post-training survey question:

*After today's training, my knowledge regarding billing and coding increased by: 25%, 50%, 75% or 100%.*

Percent Increase	25%	50%	75%	100%	No change
Number responses	31	7	0	0	9

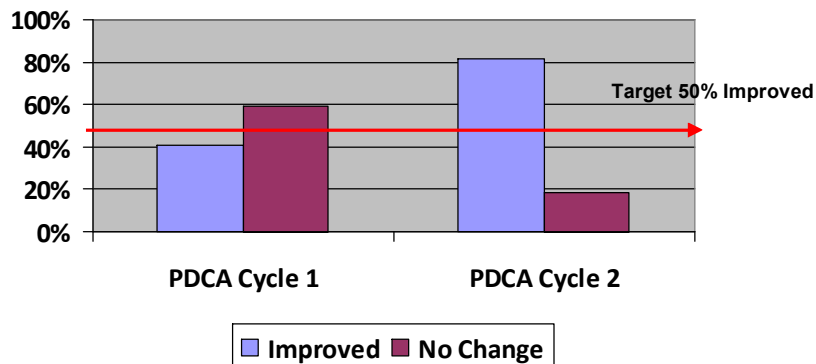
n=47

The data show that 81% of staff indicated they had an improvement in knowledge after the training, which exceeded our goal of 50% as indicated in our improvement theory. Only 19% of staff indicated there was no change in their knowledge level pre- and post-training.

**Results**

End results from the project work showed that while we did not achieve the expected results from our first PDCA cycle, we were able to use a continuous quality improvement process to evaluate that cycle. Then by implementing the lessons learned we were able to test another PDCA cycle that resulted in a more effective learning environment which in turn lead to a greater percentage of staff who indicated their knowledge increased as a result of the training.

**Knowledge Improved after Training**

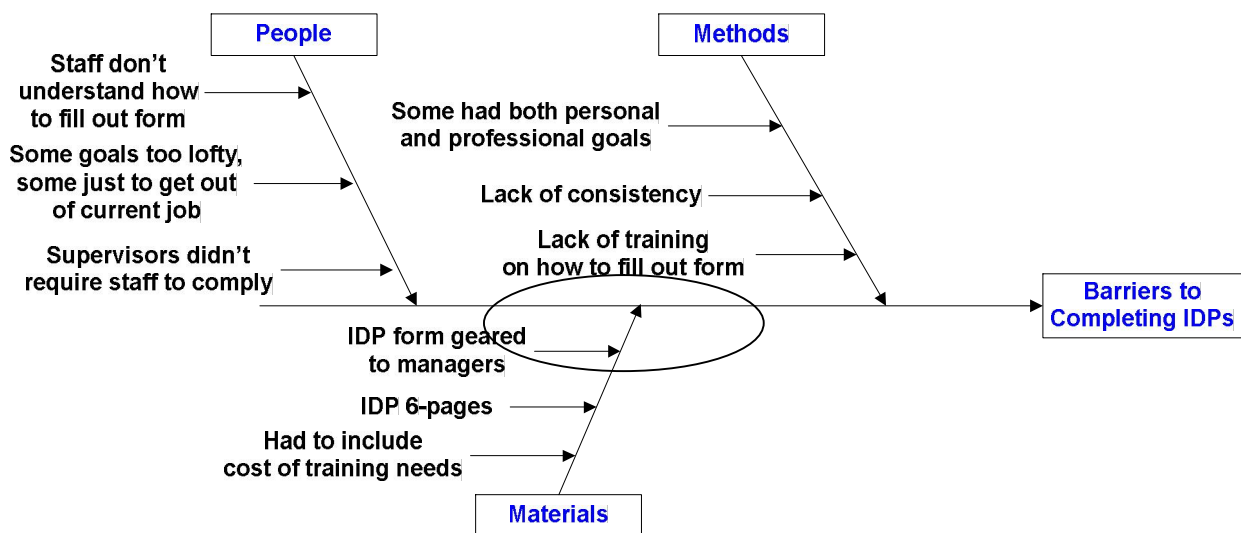


A benefit of having worked through this project is the groundwork we have set in place to develop a coordinated program of continuing education for employees that would contribute to an improvement in their skills and knowledge levels. Also the benefit of having employees realize that based on what they told management was important to them, steps were put into place to address their concerns.

### Next Steps in Improving

We plan to continue developing our IDP process in order to show a cycle of improvement in obtaining more meaningful plans from a great percentage of the staff and that better address their needs. This is a critical step in developing a coordinated continuing education program to ensure a competent public health workforce. In order to achieve a cycle of improvement, the ETT went through a brainstorming session in order to determine the root cause of why our initial IDP process was not more successful.

The following fishbone diagram was completed:



The ETT analyzed the results of the fishbone diagram and decided the root cause in the barriers to completing effective IDPs by non-supervisory / non-managerial staff was a lack of a systematic training process on how to fill out the form. The ETT also decided that the IDP form was too long and seemed more appropriate for managerial staff. A next step in our improvement process will be to consider having a revised IDP form that it is more consistent with the needs of non-supervisory / non-managerial staff, while still keeping the longer IDP for managerial staff.

### **Lessons Learned**

Specific recommendations from our experience in this project work include the following:

- 1) It is critical that performance improvement / accreditation preparation efforts are linked to what the organization determines as its priorities in the strategic planning process. This will help to ensure resources are identified and available to sustain efforts that are started.
- 2) It was helpful for us that we assigned a project director from the beginning of the self-assessment through the quality improvement and evaluation process. This ensured continuity through the entire cycle and kept the process going.

- 3) Input from all levels of staff is an important aspect of the self-assessment process. It ensures that employees are active participants and that they have an understanding of how the work they are doing relates to preparing for accreditation.

### **Next Steps**

The key beneficial end result from the project work is that we have a foundation for a systematic process to follow to continue addressing the opportunities for improvement identified in our self-assessment. Our next steps will be to set up additional multidisciplinary teams focused on replicating the quality improvement steps in the project work we completed in this cycle. The teams will develop action plans based on short-and long-terms goals as we create sustainability of our efforts toward public health accreditation in 2011. We will ensure linkage of accreditation efforts to the goals and objectives established in our annual updates to our 2008-2013 Strategic Plan.

### **Conclusions**

This NACCHO Accreditation Preparation and Quality Improvement Demonstration Sites Project has helped the Osceola County Health Department better understand our strengths and weaknesses through a self-assessment process and be able to implement a systematic quality improvement process to address those weaknesses. From the lessons we learned, we are better prepared to sustain our work past the end of the project with a goal of applying for national public health accreditation in 2011.

### **Appendices**

*Appendix A: QI Storyboard*

*Appendix B: 9-Step Process Management Methodology with PDCA*