Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Genesee County Health Department, MI

November 2008

Summary

The Genesee County Health Department GCHD) is located in south-eastern Michigan and serves a diverse urban and rural population of approximately 439,000 residents. After reviewing the results from the NACCHO LHD Self-Assessment Tool for Accreditation Preparation, GCHD chose to focus on improving capacity in Standard 8B: *Evaluate LHD staff members' public health competencies, and address deficiencies through continuing education, training, and leadership development activities*, under Essential Service 8: *Maintain a competent public health workforce*. For the purpose of this grant project, the CQI project team chose a CQI project that focused on reviewing and improving our training documentation process.

Background

Established in 1929 to protect and promote the public's health, the Genesee County Health Department (GCHD) assesses health processes and health outcomes for Genesee County, recommends policies to its governing board and others to improve the public's health, and performs its assurance role through its own internal resources as well as through its collaboration with other individuals and organizations. Over 40 service programs are directly administered in the areas of clinical and community services, personal health services, and environmental health. The GCHD has a staff of approximately 140 individuals at three different locations in Genesee County and serves a diverse urban and rural population of approximately 439,000 residents.

During the past several years, the Genesee County Health Department has been involved in several projects applying principles of CQI to public health, including the Prepare for PI project and the Michigan Accreditation Continuous Quality Improvement Collaborative (MACQIC) – Michigan's MLC-2 project. In these various projects, the GCHD has been introducing CQI principles and tools to an ever widening circle of staff. In participating in the Accreditation Preparation Demonstration Sites Project the GCHD had two primary goals. The first was to use the LHD self-assessment tool to assess the capacity of the department to meet the indicators laid out in the tool. The second goal was begin to apply several of the organizational strategies in our 2008-2012 strategic plan to our work. In addition to improving quality continuously, the department as also committed itself to fostering a learning organization and coordinating across disciplines as organizational strategies to achieve our desired outcomes.

Goals and Objectives

After selecting the focus area for the project, the initial goals of the project team were to create a central database for training documentation, increase the amount of training notifications to staff, and link all trainings to public health core competencies. As the team began its analysis, it became clear that our initial goals were both too broad for this project and did not necessarily address the real problem.

After conducting a root cause analysis of the overall problem, creating a process map, and gathering some baseline data about the issue, the project team developed a list of goals, broken down into short, medium, and long term. For the purposes of the Accreditation Preparation Demonstration Sites Project, the team focused on the short term objectives.

<u>Short term objectives (our project aim statement)</u>
By November 30, 2008

- Increase the number of trainings documented in a central database by 50%
- Ensure that 100% of all trainings documented have 100% of fields completed in the central database

By April 1, 2009

- Accurately and completely document 100% of future trainings in a central database.

<u>Medium Term Objectives/Outcomes</u>

- Consolidate/Document 100% of trainings from 2005-2008 in common/central database.
- Document 100% of trainings/presentations given by staff in a common/central database.

- Link 50% of all trainings attended to public health core competencies
- Perform annual review of employee training/training needs
- Introduce public health core competencies to staff

Long Term Objectives/Outcomes
- Link 100% of all trainings attended to public health core competencies
- Breakdown GCHD silos
- Increase all staff public health competencies
- Create staff training plan.
- Supervisors perform evaluation of staff PH competencies for 100% of staff.
- Link staff training to strategic plan

Self-Assessment

The Genesee County Health Department's programs are divided into three divisions: Environmental Health, Personal Health, and Community Health. Additionally, staff whose core function is to provide program and staff support across the health department are classified as central services. In April, 2008, each division and central services staff completed self-assessments of their divisions or program areas using the Operational Definition Prototype Metrics Assessment Tool. The GCHD Accreditation Coordinator then worked with the department's Administrative Team during several meetings to create a composite self-assessment for the entire department that was based on the results of the individual self-assessments. This approach was useful because it allowed us to determine which programs/divisions of the GCHD had the capacity to meet each indicator. It also underscored the degree to which GCHD staff function in silos.

Highlights from Self-Assessment Results

Standard/ Indicator #	Standard and Significance
8. B. 2 8. B. 3 8. B. 5	Training and leadership opportunities are available. LHD assesses its staff members to identify deficiencies in knowledge, skills and authority; and remedial action is taken when required. LHD provides opportunities for continuing education, training • These indicators were the focus of this project and work that will continue when this project is finished. Staff training had been identified as an issue in the self-assessment, as well as in a Dimensions of a Learning Organization staff survey the previous year.
3. C. 1-6	Provide targeted, culturally appropriate information to help individuals understand what decisions they can make to be healthy. • This focus area was one of our lower scoring focus areas and actually scored lower than target area for this project. This particular set of indicators is included in a separate grant project that has been funded and will begin in 2009.
5. C. 1-8	Engage in LHD strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs. • This was an area in which the GCHD scored particularly well. The GCHD has recently adopted its 2008-1012 strategic plan. The GCHD will be using CQI as part of the process for implementing and monitoring our strategic plan work.

Quality Improvement Process

1. PLAN

What was the state of affairs when you began?
The area for improvement was identified during the self-assessment process. The results of the assessment were reviewed and several of the lowest scoring standards were considered for possible projects. Standard 8B was chosen as the project's focus area. Staff issues with continuing education, training, and leadership development activities had previously been identified by a Dimensions of the Learning Organization (DLOQ) survey. Additionally, anecdotal data told us that there were problems with documenting staff training and to some extent, much of the data collected was incomplete and there was a significant amount of data that was not even being entered into the current system

Once the focus area was identified, an e-mail was sent out soliciting volunteers for the project team. Project team members were chosen so that the team would have representatives from each division in the Health Department.

The team met and considered the various indicators in the chosen focus area. By consensus, indicator #2 - "Training and leadership opportunities are available" – was chosen as the primary focus of the project. The team then developed an initial aim statement for the project:

> *We will maintain a competent public health workforce by evaluating LHD staff members' public health competencies, and address deficiencies through continuing education, training, and leadership development activities. This will be done by documenting 100% of future trainings in a central/common database, increasing the number of notifications across divisions of appropriate training to staff by 50%, and linking 100% of all trainings attended to public health core competencies by November 30, 2008.*

The team also developed mid- and long-term objectives that will continue to work towards addressing the root cause of the problem.

The team discussed the current process and could not reach consensus about what the process looked like or what was happening with how training was being documented. A report form was supposed to be the primary trigger for information being entered into the training documentation database. The report form was not being filled out for a large number of trainings. We also learned from staff reports that in some instances, a report form had been filled out, but was not being entered into the system. Of the report forms that were being filled out and entered, some of them contained incomplete information.

Because of the lack of existing data about what was going on, the team first set a plan to determine the cause of the problems, which would then lead us to theories on how to achieve the aim. The plan included:

- Interviewing the Department's management team to gather information about what training was being documented and how the training was being documented in each division.
- Creating a composite process map that documented what the overall process for documenting training across the department looks like.
- Reviewing training documentation in the current training documentation database for a six month prior period.
- Using a check sheet to count specific observations of documentation in the training documentation database.
- Surveying staff to try to set a baseline for how much training was taking place.

Following the survey of the Department's Management Team, we learned that there was no clear consensus from among the Management staff on what training was, what training needed to be documented, and how to best document that training.

What change could be made that would result in improvement?
After reviewing data that we gathered, it was determined that there was a large gap between what was being documented and what was not being documented in our current employee training documentation system. Data from a check sheet was graphed to reflect the number of entries for each month during a 12 month period (August 2007 – July 2008). Data was also collected on a staff survey to determine staff participation in training and where staff were documenting their training information. After comparing the check sheet data with the staff survey data and weighting it appropriately (to prevent over representation of positions that may require more training), it was determined that prior

to any intervention, the average number of trainings that should have been documented in the central database per month was 25. It was also determined that 85.5% of the trainings documented in the central database were incomplete. From data collected from the staff survey, we learned that at least 31% of staff trainings were not being documented in a central location. The aim statement was revised to narrow the scope of the project and to reflect the goal increasing complete documentation in a central location. The current aim statement is:

> *By November 30, 2008, to begin the development of and maintenance for a competent public health workforce, the Genesee County Health Department (GCHD) will focus on continuing education, training, and leadership development activities. GCHD staff will increase the number of trainings documented by 50% and ensure that 100% of all trainings documented have 100% of fields completed in the central training database. By April 1, 2009, the GCHD staff will accurately and completely document 100% of future trainings in a central/common database.*

The team used the "5 whys" to isolate the root cause of the problem and to learn more about the issues surrounding the use of a central database, made a chart documenting what was known about the problem and what was not known about the problem, and completed a composite process map to guide the development of theories for improvement. The team also charted data from the check sheet on pareto charts to determine what the biggest areas of incomplete information were.

An "if then…than…." approach was used to describe our theories.

- If we define what training should be documented, the number of report forms completed will increase.
- If we educate staff about the need for documenting training in a central location, the number of report forms completed will increase and the completeness of documentation will increase.
- If we educate staff about the need for documenting training, the completeness of documentation will increase.
- If we simplify the report form, the number of report forms completed will increase.

2. DO

How was the test implemented?

Activities to test the theories for improvement included:

- Development of an "official" definition of what is training and what needs to be documented.
- E-mails went out to the Department's management team educating them about what is considered training and the long term goals of documenting training.
- Weekly screensavers were created to remind staff to document their training.
- Information about documenting training was included in the staff newsletter – the Extra Mile.

Team members developed, reviewed, and approved the official definition of what is considered training and what staff need to document with a training report form. The definition was based on the information collected from the Management Team survey.

Starting September 24, 2008, a total of 3 e-mails went out to Management Staff requesting that all staff document all training (see below).

> *The CQI Team has developed the following AIM statement in order to improve capturing of training and education data:*
>
> > *By November 30, 2008, in order to develop and maintain a competent public health workforce by addressing deficiencies through continuing education, training, and leadership development activities, Genesee County Health Department staff will increase the number of trainings documented by 50% and ensure that 100% of all trainings documented have 100% of fields completed in the central training database. By April 1, 2009, the GCHD staff will accurately and completely document 100% of future trainings in a central/common database.*
>
> *The first step is to collect as much data as possible about the amount of training actually taking place. The CQI Team is using the following as the definition for the data to be collected:*
>
> > *Any conference, seminar, web cast/satellite program, on-line training, instructor led training, or mandatory education which imparts knowledge and is not part of a regularly scheduled*

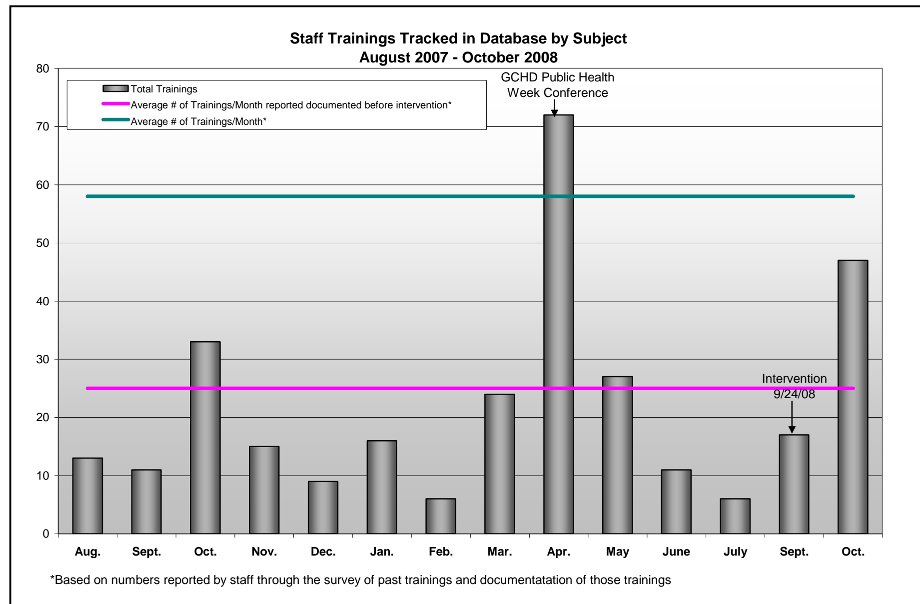
program meeting (i.e. speakers at scheduled staff or department meetings do not need to be tracked).

Please have all staff completely fill out the training report form, "Report Regarding Workshop, Conference, Convention, or Seminar Attended" for each training attended from this point on. *Also, please ensure that those forms are forwarded to the person in your division responsible for entering the training data into the current database.*

The team recognized that not all management staff were sharing this information with their staff. So, in addition to the Management Team e-mails, a screensaver was created by the CQI team that was displayed for two weeks to remind staff to document their training. The team also drafted an article about training documentation for the monthly staff newsletter.

3. CHECK

Did it work?
Following the initial e-mails to Management Team, a check sheet was again employed to collect data to monitor for improvement. Data for the months of September, October, and early November were collected. Based on the weighted staff survey data, it was determined that if every training that staff participated in were being recorded appropriately, there should be approximately 57.9 trainings recorded every month in the central database. The preliminary data collected leaves the team cautiously optimistic. For the month of October, there have been 47 training entries into the documentation system, which is an increase from the previous October. October is a month where there are traditionally more trainings taking place. Additionally, the number of incomplete entries was 0. While we have not yet reached the average of 57.9 trainings, we have surpassed both what should have been being entered before the intervention and what was actually being entered before the intervention.



Further monitoring and testing will be taking place in the coming months. It may take the team several months to have complete post-intervention data and to be able to determine if our interventions did work. Given the current system for entering the report form data, there is some lag time from the time a form is completed until it gets entered into the system.

It was also noted in the raw check sheet data that training entries for mandatory and in-house trainings are beginning to show up in the documentation database. These trainings had not previously been entered into the central training documentation database.

4. ACT

What are the next steps?
For the first time, the types of training that needed to be documented were clearly defined and the process for documenting all training was clearly defined. If future tests continue to show improvement in documentation rates, then this definition and process will likely be institutionalized in a policy revision.

Staff will continue to be expected to submit a report form for each training attended. The CQI team will continue to monitor the monthly entries for completeness and total number submitted. In response to questions regarding the form used to document training, the team has received permission to begin simplifying the reporting form used to document training. An e-mail has already gone out to Management Staff regarding this process. We are hoping that by simplifying and improving the reporting form will help to further increase staff willingness to document training.

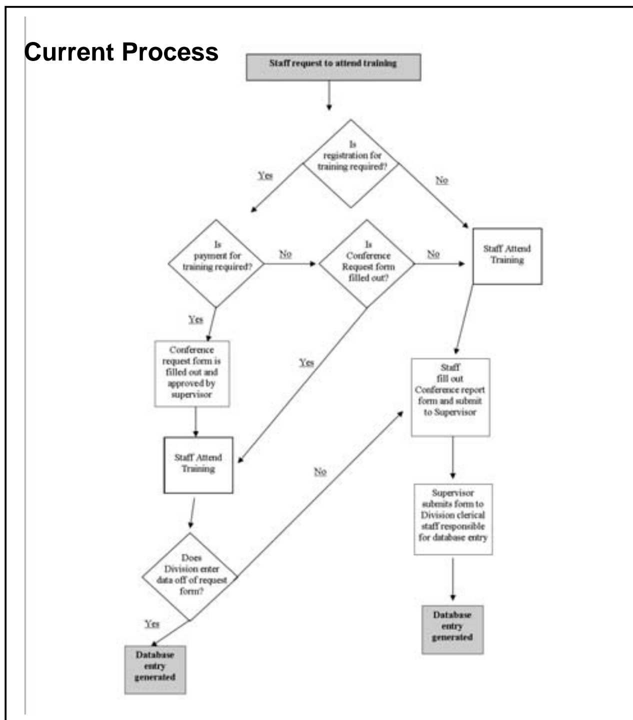
In addition to continuing the data collection from the training database, the team is planning a follow-up staff training survey in six months time. We hope to see what staff are reporting is reflected by the central training database.

The next steps for improving include:

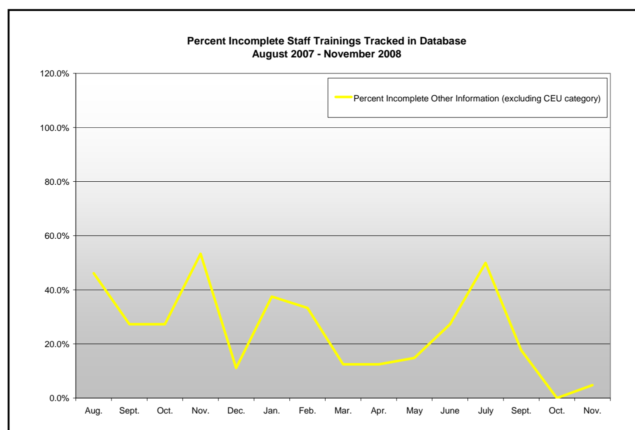
- Revising process map and policy to reflect changes to documentation process.
- Decreasing/Improving the time from the completion of a training report form to the entry of the data into the training database.
- Improving staff satisfaction with the report form.
- Improving the data collected so that only the data that is needed is collected.
- Linking the staff training information collected with public health competencies.
- Improving the feedback to staff about their training documentation, so staff recognize training as a priority.

Results

The process for documenting staff training has been refined to increase the number of trainings being documented and to increase the completeness and accuracy of the information being documented. The original process had several instances where no training documentation was generated. The new process (see current process) has eliminated the dead-end situations. The project team is currently gathering data on this process to evaluate how effective it is. We are cautiously optimistic that the number of trainings being documented is increasing. Following the intervention, the number of trainings being documented increased to well above the average post intervention documentation. We are also satisfied that the completeness and accuracy of the trainings being documented has increased (see below). Since the intervention began, all entries into the database have been complete and accurate. Additionally, certain types of trainings that were not being documented prior to the intervention are now being documented.



One unexpected result of the project was to expose other deficiencies in the system that had not been previously recognized. While documentation appears to be increasing, we are having difficulty documenting this because of the delay in both staff completing the report forms and in the report forms being entered into the system.



Awareness among staff about the importance of correctly documenting staff training has increased. Prior to this project 91% of staff were documenting their training. However, only 43% of their trainings were documented correctly. The process for documenting staff training has now been clearly defined. Preliminary data suggests that staff are correctly and accurately documenting more of their

trainings. Supervisors are more aware of training that staff are attending.

The team has been conducting a campaign to raise awareness. In addition to providing monthly updates at the Management Team meetings, screensaver slides and articles in the staff newsletter regarding training documentation, the project team has been sending e-mail updates to staff. For example, the following was sent to staff to communicate data from the project along with the corresponding actions to that need to be taken:

Examples of the results and how we have used or will use the data:

- *Evaluating the process from submission of request/report form to documentation in the database*
  - *Data collected*: Approximately 20% of trainings documented correctly were still not making it into the database
  - *Recommendation*: The CQI team asks that supervisors ensure that forms are given to the staff responsible for entering the data
- *Defining what trainings should go into the database*
  - *Data Collected*: Request/report forms were more likely to be filled out for conferences than other trainings (85.5% vs. 24.8%)
  - *Recommendation*: The CQI team reminds staff to submit a request or report form for every conference; seminar; webcast, satellite, or on-line training program; instructor led training; and any other mandatory education no matter the cost
- *Establishing a baseline number of trainings that GCHD staff*
  - *Data Collected*: On average, GCHD staff attend a total of 58 trainings per month.
  - *Recommendation*: The CQI team will work with staff to link trainings to public health core competencies and direct trainings to build staff skills

Lessons Learned

Completion of the Local Health Department Self-Assessment tool came at an opportune time for the GCHD. The Health Department was beginning to implement its 2008-2012 strategic plan and was exploring how reorganizing staff, programs, and resources might enhance our ability to meet our strategic plan goals. Completing this tool was a useful exercise, allowing us to document where and how our resources were currently being utilized. It also spurred discussion on current resource allocation and the effectiveness of that allocation.

Consensus is an important element of any self-assessment or quality improvement project. During the self-assessment stage of the project, the GCHD's Administrative Team spent quite a bit of time discussing how the Department, as a whole, should be scored for each indicator. Given that each person had already scored the indicator based on his or her division or program area, it was a very useful discussion and led to awareness among upper management just how much the Department is broken up into silos and discussion about how the silos can be dismantled.

Consensus among the team members on any CQI project is also very important. Unlike past CQI projects, the team had a difficult time reaching consensus on what we were trying to achieve and what the process we were improving looked like. As it turns out, the process we were dealing with was not uniform or stable across the Department. This was a new idea for us and one that we had not dealt with before on previous projects. Addressing this issue of stability and predictability took more time than we had anticipated, but it was an issue that needed to be addressed before we could move forward. If we hadn't addressed the issue of stability on our current process, we would not be able to draw any conclusions as to the success of our project.

Next Steps

The project team will continue to work towards both the short term and longer term objectives of this project. We are continuing to gather data to monitor for improvement in the number of trainings being documented in the central database. Additionally, several other issues involving training documentation have been identified, including the amount of time from completion of training until the staff person completes the required report form and the amount of time from submission of the training report form until the information is entered into the training documentation system.

The next steps for improvement include:

- Decreasing/Improving the time from the completion of a training report form to the entry of the data into the training database.

- Improving staff satisfaction with the report form.
- Improving the data collected so that only the data that is needed is collected.
- Creating a staff training plan.
- Linking the staff training information collected with public health competencies.
- Improving the feedback to staff about their training documentation, so staff begin to recognize training as a priority.

Michigan already has a nationally known accreditation process. In both that process and the national accreditation process, the need to maintain a competent public health workforce is reflected in the indicators. In addition, Michigan is adding a CQI component to its accreditation process.

Conclusions

The self-assessment activities and continuous quality improvement work associated with this project are highly time intensive work for all staff involved. There were issues with getting project staff complete project assignments, especially given budget constraints and staff changes in the organization. Whether or not staff will remain committed long term to adhering to the project teams recommendations remains to be seen.

However, both activities were also extremely valuable to our organization. The self-assessment activities allowed for us view our organization through a different set of lenses and assess not only whether or not we were aptly organized to meet not only the national accreditation standards, but also to implement our strategic plan. The CQI work offered staff additional opportunities to apply our strategic plan internal strategies and to begin work on meeting the Michigan accreditation section on continuous quality improvement.

Appendices

Appendix A: QI Storyboard
Appendix B: Staff Survey
Appendix C: Tools, Diagrams or Processes Used