Northern Kentucky Independent District Health Department, KY

Accreditation Preparation and Quality Improvement Demonstration Sites Project

Final Report

May 30, 2008
Summary
Northern Kentucky utilized an assessment tool developed prior to the development of the NACCHO Local Health Department Self-Assessment Tool. The Northern Kentucky tool was based on the Assessment Protocol for Excellence in Public Health (APEX PH Part I) model and patterned after the National Public Health Performance Standards Version Two.

Background
The Northern Kentucky Independent District Health Department serves four counties in Northern Kentucky just across the Ohio River from Cincinnati. The district serves more than 370,000 residents in a combination of urban, suburban and rural settings. The population in the northern parts of the district closest to Cincinnati is a mix of urban and suburban. The southern parts of the district are rapidly becoming urbanized, but there are still many areas that retain rural environments. The population is mostly white, with a small African-American population and a small, but growing, Hispanic and Asian influence.

In 2004, the Kentucky legislature passed the Core Public Health Act which provides for all Kentucky local health departments to provide six of the 10 Essential Public Health Services as outlined in NACCHO’s “Operational Definition of a Functional Local Health Department.” This act, however, did not define how these services would be provided and there was no mechanism to identify or assess the level of compliance.

The Northern Kentucky Health Department, with guidance from NACCHO staff, developed a scoring and planning methodology for the “Operational Definition Indicator Development Matrix.” The evaluation included the Essential Services Standards, Indicators and Illustrative Evidence from the matrix. The scoring scheme and format was from the National Public Health Performance Standards Version 2.0. The methodology followed the Assessment Protocol for Excellence in Public Health (APEX PH) Part I Organizational Capacity Assessment. A score summary sheet also copies the APEX PH scoring structure.

Goals and Objectives
The primary goal of the project was to prepare the department for accreditation. The primary objective was to use the assessment tool to provide key management staff the opportunity to connect existing services and programs with the Operational Definition and the Essential Public Health Services in a meaningful way.

A new District Director of Health was installed in the middle of the demonstration site process. This was after the assessments were completed, but prior to developing an action plan. With the leadership of the new District Director of Health and the influence of the consultant provided by NACCHO, the goal became more focused, with an emphasis placed on continuous quality improvement as a means to prepare for accreditation.

Self-Assessment
On September 28, 2007, a brief history of the accreditation movement and announcement of the Health Department’s role as an Operational Definition Demonstration Site was presented at the district’s fall all-staff meeting. This was followed by a more in-depth presentation to the senior management on October 31, 2007. At this meeting, two assessment teams were finalized. The four division directors and Interim District Director of Health served as the Importance Assessment Team. Each director then selected the most knowledgeable staff members from his/her division to serve on the Current Status Assessment Team.
Each division director received a binder with the assessment and instructions for preparation. They were asked to complete the assessment prior to the scheduled assessment meeting date. A hard copy of the assessment was provided in their binders and an electronic version was available on the computer network. They were given the option to use either version. They were asked to bring the completed document to the Importance Assessment Team meeting.

Each Current Status Assessment Team member also received a binder with the assessment, instructions for completing the assessment by either hard copy or electronic version and a request to complete the assessment prior to their meeting.

**Importance Assessment**

On November 30, 2007, the Importance Assessment Team met to complete the assessment. Audience response software was utilized to assist the team in reaching a consensus on the importance of each of the Ten Essential Services and subcategories. The Capacity, Process and Output from the NACCHO matrix were utilized as a discussion box to stimulate dialogue among the directors. Each subcategory was rated as: (1) not important, (2) low importance, (3) moderate importance or (4) high importance for the Health Department to be providing.

It took approximately 90 minutes to complete the first four Essential Services. There was a lot of discussion on each item, after the results of the audience response software was presented, to reach a group consensus on the importance of each subcategory. When consensus was reached, all items were rated as high importance.

The assessment process was interrupted by the question, “If the Essential Services are essential, then aren’t they all highly important?” Discussion related to the difference between “importance” and “priority” evolved. It was explained that the purpose of the Importance Assessment was to provide a methodology for determining priorities among low scoring Current Status Assessment items for developing a performance improvement plan. This raised the question if the Importance Assessment was redundant, given that another meeting would still be required to select priority items to address.

It was decided that the remaining six Essential Services would be rated for priority or perceived importance utilizing the audience response software and the scores would be used to compare with the Current Status Assessment results. This limited discussion and the remaining items were completed in time for lunch, during which time more discussion ensued regarding preparation for accreditation. Following the assessment, an evaluation survey of the process was distributed.

**Importance Assessment Evaluation Results and Analysis**

**Evaluation**

All Importance Assessment Team members returned the evaluation survey. Everyone agreed that lunch was good! Most thought the exercise had some value. Time in preparation varied greatly. Those using the paper version took more time than those using the computer version. Most comments addressed the discussion midway through the assessment process. All agreed it would have been better to have spent more time prior to the assessment to come to an agreement as to what the terms meant before proceeding with the evaluation. There was a split between those who preferred expediency (using average scores without discussion) and those preferred dialogue (reaching consensus through discussion).

**Importance Instrument Recommendations**

Based on discussion during the assessment, two changes in the assessment format were recommended.

1. Change responses from “importance” to “priority”
2. Expand the response scale to allow five levels instead of four
3. Add a comment box for each indicator

**Current Status Assessment**
The Current Status Assessment was conducted on December 12, 2007. Like the Importance Assessment, audience response software was utilized to assist team members to reach a consensus. The Capacity, Process and Output from the NACCHO matrix were again utilized as a discussion box to stimulate dialogue. In addition, the person or persons responsible and the supporting evidence were discussed prior to rating the Essential Services and subcategories as: (1) fully, (2) high partial, (3) low partial, (4) some, or (5) none. The assessment took approximately five hours to complete. Each team member was given an evaluation after the assessment meeting.

**Status Assessment Evaluation Results and Analysis**

**Evaluation**

Again, most everyone agreed that lunch was good; and it provided everyone with the opportunity to further discuss accreditation. Most thought this exercise had value, especially in learning about the Essential Services. Time in preparation varied greatly from 15 to 180 minutes. The average preparation time was an hour and a half. Most used the paper version. All thought the audience response software was very useful. All respondents thought the instrument would be moderate to very useful in preparation for an accreditation process. The pre-assessment instructions could have been better with an explanation of how the results will affect the Health Department. More break time was suggested.

**Current Status Instrument Recommendations**

Process Recommendations

Changed response to reflect the scoring definitions utilized in the revised NPHPS instrument; “Optimal, Significant, Moderate, Minimal and None”

**Scoring**

With good facilitation and the audience response software, the teams were able to reach consensus without much difficulty. However, when the scores were added to the summary score sheet, there was not a clear differentiation among subcategories. Those rated as weaknesses were the areas that were rated of low importance, but high level of implementation. This may be more related to the flawed scoring methodology of the Importance Assessment than the Current Status Assessment results. The initial (pre-consensus) raw scores from the audience response software were used to compare directly with the raw scores from the Importance Assessment.

**Highlights from Self-Assessment Results**

<table>
<thead>
<tr>
<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES # 1d</td>
<td>Integrate data with health assessment and data collection efforts conducted by others in the public health system.</td>
</tr>
<tr>
<td></td>
<td><em>Even though this Essential Service was rated as a strength, it was still rated as a priority area that needed additional improvement. Due to the extensive detail and complexity of the issue, it was not selected as an area of improvement for this project.</em></td>
</tr>
</tbody>
</table>
**ES # 8b**
Evaluate LHD staff members’ public health competencies, and address deficiencies through continuing education, training and leadership development activities. The following supporting evidence was lacking:
- Report on annual reassessment of all staff competency levels and training needs
- LHD tracking system for staff participation in training and education
- Written policy on staff development
- List of LHD staff who have participated in workforce development activities including Webcasts, online trainings, workshops, etc. and list of these events

The Health Department scored high on staff development, but was lacking in a coordinated approach to document and track staff development activities. This activity was chosen as the priority area to develop a plan due to the short timeframe and the magnitude of results that could be achieved with a small, but highly focused project.

**ES # 8c**
Provide practice and competency-based educational experiences for the future public health workforce, and provide expertise in developing and teaching public health curricula, through partnerships with academia.
- This need was not selected as a project for the grant process, but was the basis for the subsequent establishment of the Northern Kentucky Public Health Institute. This institute will coordinate student interns from area colleges and universities and provide for the continued development of the public health workforce.

**ES # 9a**
Develop evaluation efforts to assess health outcomes to the extent possible

9a (1) Develop a plan to measure program outcomes instead of counting services and clients.
9a (2) Develop an evaluation process and reporting system that will reduce the time needed to report activities.
9a (3) Expand the RX drug log from one pilot site to include all clinic sites.

- This group of issues was rated as the most important; however a plan to address these issues would exceed the grant timeframe. This was set aside for future long-term planning efforts.

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**Quality Improvement Process Planning and Implementation**
The quality improvement process was delayed for several months, due to the installment of a new District Director of Health and arranging a date for a site visit by the NACCHO-provided consultant. A day in March was arranged.

All of the participants in the two assessments and the new District Director of Health participated in a one-day quality improvement planning retreat. Dr. Kay Edwards, the NACCHO-provided consultant from the Public Health Foundation, facilitated the planning day. Dr. Steven Katkowsky, the new District Director of Health, used the opportunity to announce a continuing process of quality improvement as a new direction and focus for the Health Department.

The first half of the planning day was used to review the assessment results and to begin to drill down to the most important issues cited above. Small groups were given the task of identifying issues that could be completed in a short timeframe, but also were cross-cutting and important issues. The two weakest Essential Services were #8 Workforce Development and #9 Evaluation. Several votes were taken utilizing
audience response software to select a short-term issue to develop a plan. A modified affinity diagram was utilized to identify the root causes.

The second half of the day was utilized to develop a plan to address the identified issue. The Plan-Do-Check-Act model was used to develop a work plan.

**Short-term Plan**

**Problem Statement:** “There is not a method to track staff training to help achieve core public health competencies.”

**Discussion:**
Currently there are several professions that require Continuing Education Units (CEUs). These include Certified Health Education Specialist, Registered Nurse, Registered Sanitarian, Licensed Social Worker and others.

Different divisions within the Health Department use different methods and databases to track staff training. There is not a unified reporting format, consistent database field names, or coordinated data collection.

In addition, there is not a systematic method for reporting training or tracking training across divisions. Problems include obstacles in sharing information across divisions, difficulty in making training budget decisions, a lack of consistent and uniform use of training for employee performance evaluations for merit and promotion considerations, and a lack of evaluation of training and education sources for efficiency, quality and applicability for performance improvement.

**Project Goal:** To develop a unified database, data entry form, and management reports that will be utilized by all staff to track Health Department-sponsored training, Continuing Education Units, conference attendance, academic credits and other performance improvement education.

**Key Project staff:** Ned Kalapasev, GIS/Database Manager; and Alan Kalos, Health Planning Administrator.

**Key Informants:** Division Directors-- Kathy Gavin, Jennifer Hunter, Steve Divine and George Moore and Office of the District Director of Health staff will inform Ned of file names, file location and/or the key staff contacts within each division who can provide this information. This group of key staff will review the forms and reports developed through this project.

**Activities and Timeline:** Specific activities included:
1. Meeting with key informants, identifying needed information, identifying processes, policies and procedures, identifying forms and other key information
2. Designing a database that gathered all needed information and provided a process for assuring policies were followed with proper approvals obtained.
3. Testing the database for a period of time by encouraging staff and supervisors to utilize the database
4. Surveying staff to identify problems and areas of improvement
5. Redesign the database to accommodate the suggestions identified in the survey
6. Requiring all staff to utilize the database for all future training opportunities
Results
The major result of the process was the development of a database that included approval for training and out-of-state travel, if required. This database combined and eliminated two paper forms by utilizing one online process.

Those who tested the new database reported on the evaluation that it was easier to use and required less time than the previous approval process.

The database will provide individuals with a list of courses, trainings and CEU obtained. Managers and supervisors will be better able to manage training resources and identify training needs. In addition, the Health Department will have a better understanding of the budget and resources utilized for training and workforce development. The database form also includes a hot link to the Public Health Foundation’s T.R.A.I.N. Web site, to allow staff to utilize this training resource more easily.

Lessons Learned
The initial objective when applying to be a demonstration site for the Operational Definition assessment was to test the design of the assessment tool that Northern Kentucky had developed. After the demonstration site project began, other assessment tools were developed. The online survey completed as a part of the grant deliverables was an evaluation of the “Local Health Department Self-Assessment Tool” developed by NACCHO. There were several lessons learned from the comparison of the NACCHO tool and the locally developed self-assessment tool. In general, the NACCHO tool is a better instrument in many ways. The revising and condensing of the matrix by combining the capacity and process indicators both shortened the assessment and provided more detail than the instrument used in Northern Kentucky.

One feature of the Northern Kentucky assessment not included in the NACCHO assessment was a line to indicate the person or division primarily responsible for assuring the provision of the service being assessed. The requirement to name the responsible party or position put a face to the service; and the questions seemed to have a more “real” feeling. This feature was also valuable when developing the quality improvement plan and assigning responsibility for implementation.

The part of the local Self-Assessment that did not work well was using the APEXPH model of identifying the importance or priority and comparing this to the current status. This assessment proved to be redundant and did not provide sufficient information to be worth the time spent.

Next Steps
The most important aspect of this project will be the ability to use the fields and tables from this application as a foundation for appending other independent databases into a unified database system for all data management needs. This eventually will include financial, program planning and personnel functions. The long-term plan is to utilize an Intranet interface to incorporate all shared computerized management functions into the same database infrastructure.

Conclusions
The greatest value gained from the experience was for key staff to begin thinking in terms of essential public health services, instead of thinking in terms of programs and categorical funding, and to seriously begin thinking about future accreditation and how that will affect our Health Department. As long as the federal and state funding sources require local health departments to report according to programs instead of by essential services provided, it will be difficult to accumulate and provide the illustrative evidence that will probably be required by a national accreditation program. In the meantime, however, a
focus on continuous quality improvement will support Northern Kentucky efforts to provide the highest quality services to the community.

Appendixes
1. List: Key Participants
Appendices 1: Key Participants List

Accreditation Preparation and Quality Improvement Project
Planning Day – March 20, 2008

Planning Team Members

Facilitation
Dr. Kathleen (Kay) Edwards
University of Maryland University College Graduate School
Program Director of Health Care Administration

Office of the District Director
Steven R. Katkowsky, MD, District Director of Health
Karen Domaschko, Human Resources Administrator
Emily Gresham Wherle, Public Information Manager
Alan Kalos, Planning Administrator
Louise Kent, Planning Administrator
Ned Kalapasev, GIS/Database Manager

Administration and Accounting
George Moore, Director of Administration and Accounting
Deborah Muench, Accounting Manager
Jill Sinclair Hopkins, Grants Manager

Community Health Promotion
Kathy Gavin, Director of Community Health Promotion
Mary Singler, Health Promotion Manager
Stephanie Vogel, Health Education Manager

Clinical Services
Jennifer Hunter, Director of Clinical Services
Evie Van Herpe, Epidemiology Administrator
Lisa Heck, Quality Assurance Manager
Debbie Wright, Clinic Manager

Environmental Health and Safety
Steve Divine, Director of Environmental Health and Safety
Laura Strevels, Environmental Health Manager
Tony Merkle, Food Program Manager
Scott Bowden, Disaster Preparedness Administrator
## Appendices 2: Agenda

**Northern Kentucky Independent District Health Department**  
Quality and Performance Improvement:  
Making a Measurable Difference in Public Health  

**Planning Day**  
March 20, 2008

### Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>8:30 AM</td>
<td>Welcome and Introductions</td>
<td>Dr. Steven R. Katkowsky</td>
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<tr>
<td></td>
<td>Review of project purpose and timeline</td>
<td>Alan Kalos &amp; Louise Kent</td>
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<tr>
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<td>Review of assessment results</td>
<td>Dr. Kay Edwards</td>
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<td>Links with Best Practices</td>
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<td></td>
<td>Use of QI Tools to help prioritize focus areas</td>
<td>Alan Kalos &amp; Louise Kent</td>
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<td>Long and short term</td>
<td>Dr. Kay Edwards</td>
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<tr>
<td>10:15 AM</td>
<td><strong>BREAK</strong> <em>(10:15 – 10:30)</em></td>
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<tr>
<td></td>
<td>Additional QI management tools</td>
<td>All</td>
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<tr>
<td>12:00 Noon</td>
<td><strong>LUNCH</strong> <em>(12:00 – 12:30)</em></td>
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<td>Narrow down to one or two priority areas; Identify key actors and divisions; Selecting focus area for May 31 timeline and beyond</td>
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<td>Taking the project to the next phase: Team leadership and facilitation Assistance needed to achieve indicator(s)</td>
<td>All</td>
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<td>2:30 PM</td>
<td><strong>BREAK</strong> <em>(2:30 – 2:45)</em></td>
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<td></td>
<td>Plan of action: Designation of focus area champions/leaders</td>
<td>All</td>
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<td>Conclusions and evaluation</td>
<td>All</td>
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<tr>
<td>4:30 PM</td>
<td><strong>ADJOURN</strong></td>
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