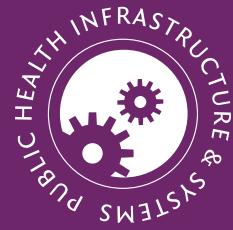


Kane County Health Department: Surviving Layoffs and Embracing Quality and Accreditation



Background

Kane County, IL, is located in the Chicago metropolitan area and is home to 515,000 people. The county contains urban, suburban, and rural communities, and its minority and youth populations have grown significantly in the past 20 years. The Kane County Board, acting as the board of health, and a seven-member Public Health Committee provide policy direction and guidance to Kane County Health Department (KCHD). Additionally, per Illinois state statute, a nine-member Health Advisory Committee (HAC) of community members advises KCHD in decision-making.

As with many American communities, Kane County and its local health department (LHD) saw drastic revenue declines between 2008 and 2010. In addition to the reduced tax revenues and limited client payments seen around the nation, LHDs in Illinois experienced drastic cuts in the funding they received from the state. Illinois, faced with its own budget shortfalls, severely cut grants and set a policy to allow late payment to vendors, including local governments. Overall, at the beginning of FY2011, KCHD had lost \$1 million in state grant revenue and experienced payment delays of 200 days from the state. Because of this situation, KCHD had a negative cash balance, and Executive Director Paul Kuehnert saw the LHD at a crossroads—he had to decide whether to keep “business as usual” or try a new system of thinking about KCHD’s revenue and expenses.

Transformation

Kuehnert’s decision was as visionary as it was drastic: based on extensive research into management theories and analysis,¹ he decided to transform KCHD to focus on population health. This would include a transfer of KCHD direct client services to federally qualified health centers (FQHCs) in the area, a 50-percent reduction in the workforce, and a complete agency reorganization using the Public Health Accreditation Board (PHAB) standards as a framework.² Kuehnert made his proposal to the Kane County Board, which approved the recommendation after six weeks of deliberation. Despite KCHD’s plans to ensure that residents did not lose services and employees had the chance to find work elsewhere, the decision was met with significant resistance from staff, local and national labor union groups, and some community members. Three months after the decision was approved, in November 2010, KCHD transferred its direct-client services and laid off 62 staff. Figure 1 shows the new organizational structure, and Figure 2 shows the transition’s guiding principles.

Strategic Planning

Kuehnert has always involved the board in strategic planning efforts. The LHD’s last strategic plan was published in 2009; the board had participated heavily in its development. Before initiating the transition within KCHD, Kuehnert had laid the groundwork for support for the new structure by involving the board in the strategic planning process. He focused on the notion that KCHD could not afford to be just a good LHD; it needed to be a great LHD. In order to achieve this level of excellence, Kuehnert reasoned, KCHD would need benchmarks and measures to follow; the board agreed. Thus, KCHD was organized around the national accreditation standards and developing a culture of quality improvement (QI). This process laid the groundwork for revising KCHD’s strategic plan, which will be released by the end of 2011.

After the transition, the LHD focused entirely on population health. KCHD wanted to ensure it was performing the functions described in NACCHO’s *Operational Definition of a Functional Local Health Department*³ and in PHAB’s *Standards and Measures Version 1.0*.⁴ Instead of providing direct medical services and state-led health education programs, KCHD worked to determine the programs and services that would be required for meeting federal, state, and local laws and mandates or for receiving different essential funding streams and public health functions (see Figure 1). Additionally, the state of Illinois has required community health improvement plans since 1994 as part of its certification process called IPLAN. Since 2008, KCHD has reported annually on measures that track progress on addressing the community health priorities outlined. Along with community health assessment (CHA) and improvement plan (CHIP), KCHD also has an agency strategic plan, which is currently being updated to relate to the CHA and CHIP.

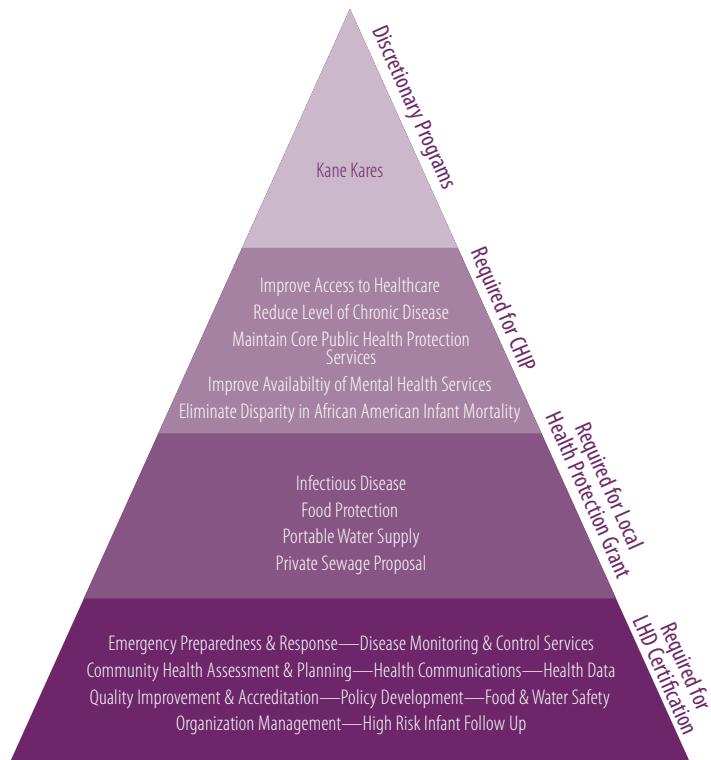
Implementation

Because PHAB’s accreditation program is grounded in QI, KCHD adopted a rapid-cycle improvement process to drive change. From the beginning of the restructuring, Kuehnert understood the necessity of developing a QI culture at KCHD. As part of the transition, Kuehnert created a crosscutting group of positions to support collaboration across the LHD and other city agencies. This division included a health planner, public information officer, emergency response coordinator, epidemiologist, and health data and quality coordinator (HDQC). Kuehnert created the HDQC position knowing that having someone dedicated to

improving processes and programs would be crucial. The HDQC is responsible for QI training, QI technical assistance, strategic planning, informatics, and accreditation preparation.

The HDQC, Julie Sharp, a 10-year KCHD veteran, created a nine-member QI Committee by soliciting interest through an employee survey. During the first six months of 2011, this group focused on fostering a QI culture among all staff by creating a QI policy, a QI plan, and a QI committee charter⁵ that developed a framework of QI activities and set specific goals for implementation and evaluation. The QI Committee also organized training on, and practice of, QI tools through monthly meetings and implemented eight QI initiatives. KCHD had a QI policy prior to the restructuring, but the policy was updated in April 2011 to reflect the new structure. Additionally, staff identified QI training needs in a January 2011 survey, and the QI Committee responded by training staff on common QI tools (Plan-Do-Check-Act, aim statements, flowcharts, cause and effect diagrams, force field analysis, storyboards, Pareto charts, pie/bar/run charts, and check sheets). Training materials were developed using the resources of the *Public Health Memory Jogger*,⁶ *Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook*,⁷ and the American Society for Quality's *Public Health Quality Improvement Handbook*.⁸ KCHD also set time aside at regular staff meetings to review and practice QI tool usage.

FIGURE 1. MANDATED PUBLIC HEALTH SERVICES FOR CERTIFIED HEALTH DEPARTMENTS IN ILLINOIS, 2010



QI Initiatives

Beginning in January 2011, each staff division used a brainstorming process to select an improvement project. Each project developed aim statements, collected baseline data, and completed root cause analyses. Of the eight teams starting projects in January, the Emergency Response and Disease Prevention divisions completed their efforts by July 2011, and the remaining six were underway as of October 2011.

The Emergency Response project focused on increasing staff acknowledgment of "Code Red" calls and improving staff response to these calls. "Code Red" calls are telephone communications with staff regarding their roles and duties during disasters. At the end of the initiative, both indicators had increased but fell short of the aim statement. Therefore, the team is further refining the intervention to improve the levels. A complete description of this initiative is available online.⁹

The Disease Prevention division focused its QI project on eliminating data duplication in the Immunization Program data. A root cause analysis indicated that duplicate systems existed, a result of lack of knowledge of the available computer system and inaccuracies in the automated computer system. The team developed a new spreadsheet and collaborated with a software expert to develop an online database for the data. The team was able to eliminate manual collection of data, teach staff to use the software efficiently, eliminate the time needed for double-checking, reduce time for completing monthly reports, and rely on fewer staff to get through the statistical analysis because of software capabilities. The results exceeded the aim statement's projects and reached 100 percent elimination of data duplication and a reduction in staff time and resource usage. A complete description of this initiative is available online.¹⁰

These efforts, while successful, were not without challenges. During the first weeks of the QI initiatives, some staff were skeptical. Many employees were unsure about sustainability of the QI activities—staff saw them as important only for accreditation and thought they would not last as part of KCHD's culture. Kuehnert's leadership and vision helped staff to see past this view because he supported the efforts and showed interest and investment in their success. In addition, Sharp found ways to make the activities fun. For example, she used a polling system and electronic "clickers" to solicit staff input at meetings and events, and staff enjoyed the anonymity and interaction of such devices. Sharp also introduced QI tools with "fun" examples like creating a Pareto Chart showing reasons why some staff are late.

The teams set their own timelines and saw the project-selection activities as a learning experience. While some started out with large-scale aim statements, most were able to narrow their scope to focus on manageable initiatives. Sharp and her team are happy about the QI successes, and she views the learning process as the best part of the initiative. The effort brought people together during the transition and prevented them from being driven apart due to insecurity and decreased morale.

Being able to work as a team and see improvements helped staff to see the value of their new approach to the agency.

Accreditation

Since KCHD's transition in November 2010, the LHD has worked hard not only to implement a QI culture but also to engage staff around the concept of accreditation. Communication was a key aspect of KCHD's strategy, and because of the executive director's support, Sharp and her team were able to share information about QI and accreditation at each staff meeting and other staff functions. The QI Committee completed a gap analysis of domain 9 of PHAB's Standards and Measures Version 1.0¹¹ (evaluate and continuously improved processes, programs, and interventions) and created a plan to address the missing documentation. Other divisions in the LHD also began to examine the standards in order to prepare for documentation selection and compilation. KCHD plans to apply for accreditation in late 2012 and has already begun collecting documentation to support its application. KCHD's current goal relating to accreditation includes updating prerequisites. KCHD will update its CHIP in fall 2011 and connect it with the agency strategic plan, which is also being updated. KCHD will also implement an agency-level performance management system using the Turning Point¹² model as a framework.

FIGURE 2. GUIDING PRINCIPLES USED DURING TRANSITION

RESTRUCTURING PRINCIPLES
<ul style="list-style-type: none">• Ensure ability to efficiently provide essential and mandated public health services• Effectively address the identified community health priorities• Protect the most vulnerable populations• Maintain a long-term, strategic focus
CORE PUBLIC HEALTH SERVICES
<ul style="list-style-type: none">• Emergency preparedness and response• Communicable disease monitoring, analysis, and response• Evidence-based interventions to improve maternal and child health and prevent chronic disease• Environmental health protection: food, water, toxins such as lead• Community health assessment, planning and evaluation/quality improvement• Health communication and education• Public policy development

Lessons Learned

Sharp found her experiences throughout the transition remarkable and exciting. She was thrilled with KCHD's work and with the impact improvements could have on population health in the county. Her advice to others working to instill a culture of QI is to rely on networks and take advantage of existing guidance, resources, and practices. Because of her

role at the LHD, Sharp was able to join NACCHO's QI Leaders Learning Community.¹³ This networking opportunity allowed her to discuss ideas with other QI coordinators and adapt their documents/processes for KCHD. Few LHDs in Sharp's area are working on QI or thinking about accreditation, so having access to other professionals doing the same work was beneficial.

Kuehnert's words of wisdom center on the importance of planning. Kuehnert and the board chairperson believe that having a strategy with a goal in mind is very important. Five years ago, they developed a strategic plan and linked it to their community health assessment. Many issues arose in that assessment, making it important for them to focus and prioritize. As an agency, KCHD decided not to move from one "hot funding topic" to another. KCHD's job was to focus on the issues in the strategic plan and not pursue funding just because it was available. Kuehnert's acknowledges that "in public health there are currently many challenges, but also new opportunities." He encourages LHDs considering restructuring to "think long and hard and have a dialog with the community as they develop their plans for their agencies."

Acknowledgments

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Notes

1. For information about the theories used in Kuehnert's decisions, watch the webinar he headlined for NACCHO at <http://cc.readytalk.com/play?id=g7resv>.
2. Visit PHAB's website at www.phaboard.org.
3. National Association of County and City Health Officials. (2005). *Operational Definition of a Functional Local Health Department*. Available at <http://www.naccho.org/topics/infrastructure/accreditation/opdef.cfm>.
4. When KCHD restructured, PHAB's Standards and Measures Version 1.0 document was not finalized. However, Kuehnert worked with the draft version to plan his reorganization.
5. These documents are available in NACCHO's QI Toolkit (http://www.naccho.org/toolbox/program.cfm?id=25&display_name=quality%20improvement%20toolkit).
6. The Public Health Foundation's *Public Health Memory Jogger* can be found by searching www.phf.org.



October 2011

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11. Public Health Accreditation Board. (2011). Standards and measures version 1.0. Retrieved Oct. 12, 2011, from http://www.phaboard.org/wp-content/uploads/phab-standards-and-measures-version-1_0.pdf .
12. Turning Point Performance Management: <http://www.turningpointprogram.org>
13. LHD QI coordinators interested in joining this network of QI leaders may contact Pooja Verma at pverma@naccho.org.

FOR MORE INFORMATION:

Please contact accreditprep@naccho.org.



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