Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Stanislaus County Health Services Agency, CA

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Brief Summary Statement

The Stanislaus County Public Health Department (SCPHD) is located in Central California serving approximately 525,000 residents. SCPHD utilized the NACCHO LHD Self-Assessment Tool for Accreditation to address several focused projects as part of a new strategic planning process. The indicators selected were related to the standards of workforce development, PH marketing and media communication, communication of health data availability, and evaluation and improvement of PH programs.

Background

The Stanislaus County Public Health Department (SCPHD) is located in Central California serving 525,000 residents. The SCPHD is a division within the Stanislaus County Health Services Agency, a safety net provider for the county residents with six primary care clinics, Urgent Care, specialty services, pharmacy and ancillary services and a Residency Program. The Agency employs a staff of 800, of which 225 constitute the Public Health workforce.

As a rural/urban mix county, the SCPHD pride's itself on the strength of its partnerships with Local Public Health System Stakeholders. SCPHD has been positioning itself for accreditation through involvement in processes such as APEX-PH, Mobilizing for Action through Planning and Partnership, and Public Health Ready. Lessons learned from these processes include:

- APEX-PH (Assessment Protocol for Excellence in Public Health)- the importance of participation from representatives from the various disciplines in public health, as individuals and as part of the group discussions rather than trying to include all staff; the importance of and challenge in sharing information and the value in including community partners in the process of evaluating the department's performance and community presence. APEXH process focused specifically on the strength or weakness of the local public health department, but left the department questioning next steps.

- MAPP(Mobilizing for Action Though Planning and Partnerships): The lesson in terms of community involvement was carried over to this process, however, this process provided an opportunity to broaden the partners to include and justify the inclusion of many departments, community organizations, and other non-traditional participants in the public health discussions as recognized public health system partners, i.e., public works, city parks and recreation, police, fire, non-profit organizations, Philanthropy, etc. MAPP process helped move from the focus of the local public health department to that of the public health system which helped free public health of some feeling of inadequacy, validated the involvement of others in the broader system, and their role in improving the health (broad sense) of the community; assisted in identifying "forces of change" that greatly impact the ability to make improvement; highlighted the importance of Community Health Assessment in identifying needs within the community and provided a strength based approach for all stakeholders to work together in improving the community's health. The simple beauty of MAPP is that it serves as the foundation for addressing short and long term health concerns, through the strengthening of partnerships and a ready made forum that galvanizes stakeholders.

- Public Health Ready: Public Health Ready is a partnership program developed by the National Association of County and City Health Officials (NACCHO), the Centers for Disease Control and Prevention, and the Columbia University Center for Health Policy. The processes learned through engagement in the previously discussed

processes were applied to this project as well. This strengthened the involvement of specific areas within Hospitals, (i.e., the infection control department staff, emergency responders, environmental control staff, law enforcement, and laboratories). The strength of these already established partnerships along with involvement in Public Health Ready greatly enhanced the public health's capacity to respond and receive designation as a county department that is ready to respond in disaster.

The critical lesson in all of these is inclusiveness and trust. The process can be cumbersome and frustrating when trying to implement when there is time sensitive deliverables, but what has been learned is trust the process, trust the partners to understand the time-lines and importance of the project and timely completion, keep them included in the dialogue through e-mail and phone when they cannot physically be present and trust that the outcome will be far better and more valuable than if they had not been part of the process. The other lesson that has been important throughout all of the processes is having an internal team and yet establishing the designation of ONE Lead Person to maintain contact with all stakeholders and keep the project on track.

In the early months of 2008, the SCPHD management team began to develop a new strategic plan which included a new mission, vision and core values.

Vision: Healthy People in a Healthy Stanislaus

Mission: To promote, protect, and improve the health of the community through leadership, partnership, and innovation

Values: Ethics, Evidence based information and practices, Respect, Responsive, Adaptive, Inclusive, Teamwork, Committed, Flexible, Competent, Credible.

As a result of this strategic planning process, four (4) management teams were created to further carry out established priorities aligning with the Vision, Mission, and Core values:

1. Organizational Business Development Team
2. Marketing/Communications Plan Team
3. Community Assessment Planning and Evaluation Unit (CAPE) Development Team
4. Staff Development Team: Workforce Preparation and Development

The opportunity to participate as a Quality Improvement (QI) demonstration site occurred at a fitting time as the management team embarked on developing a new LHD strategic plan. As a result of this built infrastructure and the help of the QI Consultant Grace Duffy, SCPHD chose to focus on one indicator for each team. The indicators were related to the standards of Workforce development, PH Marketing and Media Communication policy and procedures, communication of health data availability, and evaluation and improvement of PH programs. Each team was assigned a relevant project for application of the Plan-Do-Check-Act cycle.

The ultimate outcome of participation as an accreditation demonstration site is gaining the knowledge and skills to successfully improve the quality of one Public Health area and being able then to apply those skills to other areas of need. Institutionalizing quality improvement processes would support proactive measures versus reactionary approaches that have been so common in Local Health Departments (LHD's) throughout the nation. By improving the provision of the 10 essential services, SCPHD will further align with its mission and further position the PHD for future accreditation. As an accredited LHD, SCPHD would strengthen its ability to be proactive, innovative, and forward thinking.

Goals and Objectives

After the LHD Self-Assessment was completed, the initial goal of the project was solely to focus on Essential Service VIII- Maintain a competent public health workforce. However, after thorough discussions with QI Consultant, Grace Duffy, the QI project team wanted to expand the project scope to align with its new mission and strategic planning process. By hiring Grace, the project team was able to organize a two-day QI training for twenty-six (26) PH leadership staff that facilitated the institution of QI as a core competency.

To coordinate the two-day QI training, the QI project team worked closely with Grace to maximize the benefits and outcomes of this QI demo project. This was done by integrating the self-assessment results, staff feedback, and the strategic planning process. It was then decided to assign relevant essential services needing improvement to each of four strategic planning teams.

Self-Assessment

The SCPHD QI project coordinators consisted of the PH Director, PH Organizational Business Manager, and the CAPE Program Coordinator. The QI project coordinators wanted to ensure that all Public Health staff classifications were represented in the self-assessment. Out of the 220 PH employees, the SCHD QI team selected 1-2 staff members from each classification that had been employed with Stanislaus County for a minimum of 1 year.

A scan-able survey was developed to help facilitate collecting and compiling the results. Forty-two staff members (approx 20% of the PH workforce) were invited to participate through an email sent by the Public Health Director. The next day each invited staff member received a packet that contained a project description fact sheet, a copy of the LHD Self-Assessment tool, and an answer sheet. Two well attended orientations were held to explain how to complete the assessment and to further describe the project timeline. Within two weeks, 38 surveys were received and analyzed for average score, range, and mode. The process was incredibly smooth. Quality assurance was implemented by cross checking the collected surveys with the answer pattern in the scanned database spreadsheet. At least one staff member in the following position classifications completed a survey:

Position	# Staff
Administrative Clerk II	2
Administrative Analyst	1
Assistant Director	2
Associate Director	1
CHW II	2
Clinical Lab Scientist	1
Epidemiologist	2
Health Educator	3
Manager II	4
Manager II – PHN	1
Manager III	1

Position	# Staff
Medical Investigator	1
Nutritionist	1
PHN	3
PHN II	2
PHN III	3
Program Coordinator	1
Program Manager	1
Public Health Nurse	1
Research Analyst	1
Staff Nurse III	3
Total	**38**

Two weeks after the 38 surveys were collected and analyzed, a scoring consensus meeting was held to discuss the results. The meeting focused on major assessment findings specifically the 20 standards/indicators that scored below a 2.5 average (on a scale of 0 to 4). Participants were asked for input when they didn't agree with the average score of a

particular indicator until a consensus was reached. For those indicators scoring below a 2.5, staff was asked to give reasoning for the low score and to offer improvement suggestions. At the end of the meeting, staff voted on their top five indicators for the quality improvement project. The standard area with the most votes was *VIII-B Evaluate LHD Staff members' PH competencies and address deficiencies through continuing education, training, and leadership development activities.* This was the initial standard selected for the QI process. However, after utilizing the QI tools provided by Grace Duffy, it was determined to assign a specific indicator to each of the four management teams:

1. Organizational Business Development Team→ improving the operations of the PH clinic.
2. Marketing/Communications Plan Team → Develop a proactive media strategy
3. CAPE Unit Development Team → Community Health Data availability and accessibility
4. Staff/Workforce Development Team →Institute a New PH employee orientation

Highlights from Self-Assessment Results

Standard/ Indicator #	**Standard and Significance**
III. A. 4	*LHD has a media strategy that includes formal (press releases) and informal opportunities for communicating with the media and responding to media requests, along with routine communication to raise awareness of PH issues.* This indicator scored high with an average score of 3, however through discussion, the consensus was that media releases were very reactionary. It was seen as necessary to develop policies and procedures that would facilitate becoming more proactive for prevention and health promotion messages.
III-B. 5	*The public knows how to obtain health data and information from the LHD.* This indicator received an average score of 2. Strong partnerships amongst community stakeholders exist. One of the common requests is an urgent need for data. The Community Assessment Planning and Evaluation (CAPE) unit frequently received random and sporadic walk-ins and calls from both internal and external stakeholders. This caused frequent disruptions and inefficiency for both the requestors and for CAPE.
VIII-A. 7	*LHD provides new employee orientation, employee in service and continuing education experiences where appropriate.* Although identified as an area of strength scoring an average of 3; this was also an area of weakness for SCPHD. The orientation provided to new PH employees was not specific to PH but broad to services provided through the Health Services Agency. Through a variety of tools, it was determined that a solid employee orientation specific to Public Health would be the best foundation to begin competencies for PH employees. After discussion, SCHD selected this indicator as a priority for the QI process.
VIII-B. *7*	*Evaluate LHD staff members' PH competencies, and address deficiencies through continuing education, training, and leadership development activities* With an average score of 2, the LHD self-assessment participants selected this indicator as their number one priority to address. In light of the revisions of PH competencies through the Council for Linkages, SCHD chose to focus on new employee foundational competencies in understanding the variety of PH programs within our LHD.
IX-B 2	*LHD periodically evaluates its key processes of service delivery for efficiency and effectiveness using established criteria (e.g., from research or management literature)* Scoring a low average of 2, this reflected an immediate need to evaluate service delivery within the PH Immunization Clinic.

Although SCPHD chose to implement four QI projects, the Data Availability and Accessibility project demonstrates the PDCA cycle process that was utilized in all four projects.

Quality Improvement Process

AIM Statement: To understand data needs of internal program staff and develop a mechanism to make data available and usable.

PLAN: In developing the Team charter, the problem was identified as inefficient availability and use of data. A fishbone analysis was used to identify the root causes. The Team decided to focus on reducing the burden of data requests by proactively providing the data that was needed. Members of the Team assessed PH staff to determine how this could most easily be accomplished. After much brainstorming, the team decided to create a data matrix that listed the recurring data needs of internal PH program coordinators. This matrix would then be used to prioritize data analysis proactively by making that data available before it was needed. The Project Team asked staff the best way to make data available and the unanimous decision was to post it on data and publications page of the PH website so that it would also be accessible to the public as well. The current documents available on that website page were 7 health status indicators utilizing outdated data from 2001. In addition, the Team gathered web page use statistics and discovered that it was minimally visited and didn't make the top 50 most frequently visited PH pages. This meant it had less than 154 unique page hits (unduplicated IP addresses) in a one month period.

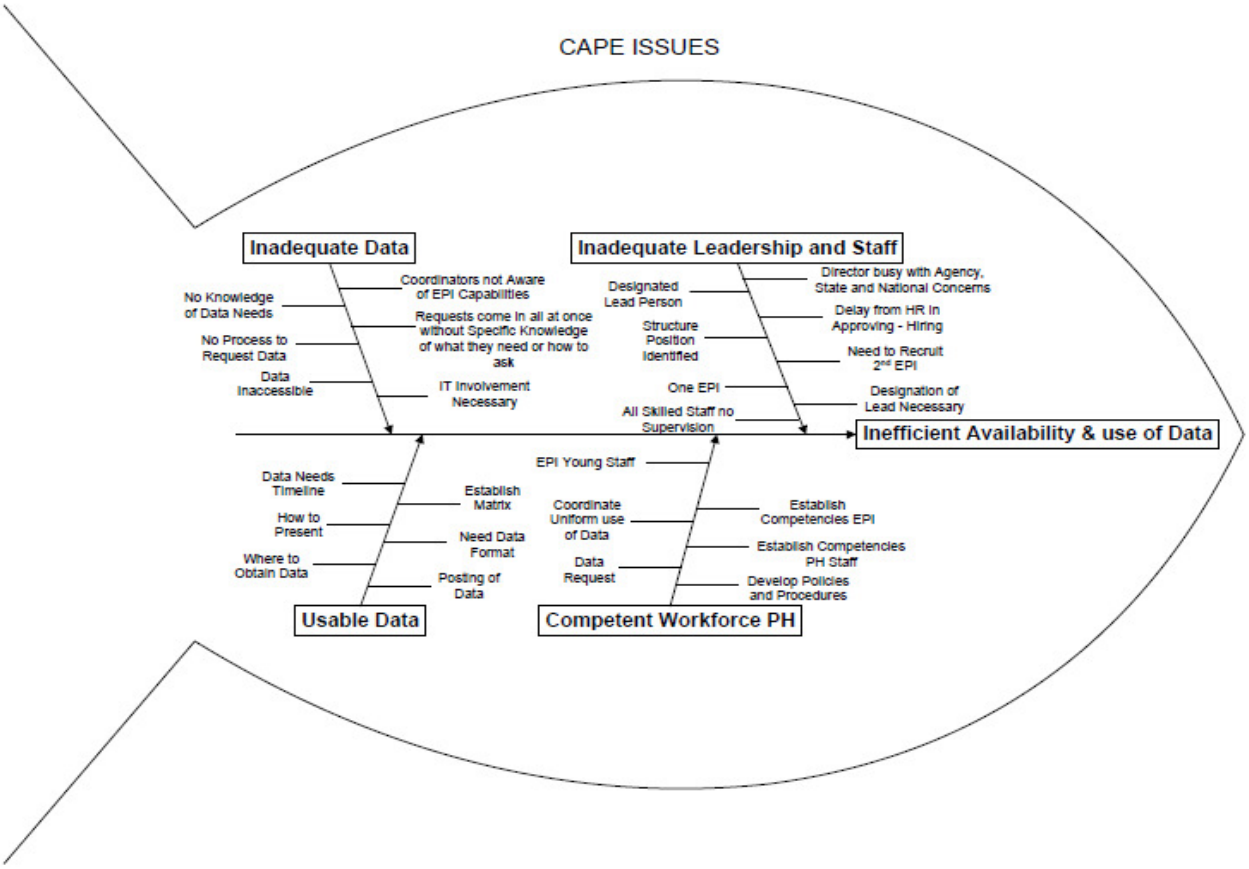
The plan consisted of prioritizing the data needed from the established matrix, posting the data on the website in a usable format, and then communicating that this data was available. Improvement would be measured by increased web hits/downloads demonstrating awareness of data availability for the following month and interviewing a few key staff about the usability of data format.

DO: The team developed a 3-item questionnaire to be filled out by all PH program coordinators and managers that had data needs. Examples were provided for each question as well.

1. Do you need data on a re-current basis? If yes, please specify.
2. Do you have data needs at certain times of the year?
3. Does your program collect your own data/have a separate database? If yes, please specify.

The questionnaire was distributed via email and through an existing PH coordinator meeting. Over 20 completed questionnaires were collected. The matrix was created and the epidemiologists collected and analyzed data for most of the requests listed. A small number of data requests were not within the scope of what the epidemiologists could provide, but most were easily satisfied.

A total of 36 new data files were posted on the PH data and publications web page. As an added plus, the CAPE coordinator worked with the webmaster to create a truncated url for easy recall and direct data access (www.hsahealth.org/data). To communicate the newly available data, the CAPE program coordinator sent out emails through the agency and external stakeholder distribution lists. This new data can be utilized by anyone for activities such as program planning, grant proposals and assessment.



CHECK: Within a one week period of the data being posted, the webpage went from not making the top 50 list to being the 21st most popular page with 197 unique user hits. This was a significant improvement in the access to data.

Several staff provided positive feedback on the use of the data and how easily accessible it was. The results exceeded the expectations.

ACT: The newly developed data matrix will be implemented as a baseline standard of the recurrent data needed. Additional policies and procedures still need to be developed to address the data that is not currently available.

As time permits, additional data will be posted on the webpage and monitored over time for increased access.

Results

There were several successes resulting from this work, some which were exponential. The success exists primarily in the training and continued implementation of QI work with the 36 staff trained by Grace Duffy. Investing in the training of 26 leadership staff will facilitate institutionalizing QI and sustaining the knowledge despite natural attrition.

Strengthening the Management and CAPE teams by providing direction and preventing gridlock with the strategic planning process, due to Grace Duffy's expertise, enthusiasm and commitment was priceless.

This process has laid the basic foundation for the Public Health Department to begin the documentation for the Annual Public Health Report that is presented to the Board of Supervisors every April during Public Health Week. This process supports the Board

Priorities of efficient and effective county government, and provides a compelling demonstration of the Public Health's ability in this area.

Results were documented in every project, but it is recognized that more focused evaluation mechanisms need to be established to determine the full magnitude of improvement. This can be established in new projects or 2nd cycles of improvement projects.

Three new policies and procedures were developed as a result of participation in the NACCHO quality improvement project. Many more are under way. The awareness of all the tools available makes it possible to find a useful tool for any situation.

Lessons Learned

Amongst all the various projects and priorities in public health, there must be commitment to continue implementing quality improvement projects to ultimately improve service delivery to LHD constituents. Complete support from leadership and buy in from all level staff is necessary to make QI successful and sustained.

Reinforcement/Reintroduction of QI tools- Many tools are available and it is difficult to recall all of them if they are not used frequently. Being exposed and trained on a variety of tools in an initial comprehensive training will allow PH staff to select the best tool for a specific project. A reintroduction to tools should be tasked to the QI coordinator on a yearly or bi-yearly basis.

The QI coordinator will need skill in communicating QI value & return-on-investment. The key lies in improved efficiency, reduced effort duplication, and increased ability to improve health outcomes. There may be staff who are resistant to change a process that is not considered "broken", not realizing the benefit of implementing a change that results in a significant improvement for PH staff and PH clients.

Synergies between MAPP & NACCHO QI Project were also identified. Quality improvement could be applied to a Community Health Assessment process, developing partnerships, and designing metrics to evaluate health outcome improvement. The knowledge of QI does not have to remain within Public Health; it should be applied to projects involving multiple stakeholders.

Next Steps

The SCPHD will review those standards and indicators not focused on during this project period, prioritize those that should be addressed during the next cycle of quality improvement efforts until all of those areas of deficiency and/or those areas where greater improvement can be attained have been addressed.
In addition, 2nd and 3rd quality improvement cycles will be implemented until the process is *satisfactory.*

Conclusions

A Local Health Department can gain valuable insight into its department's capabilities and its preparedness for accreditation through participation in the accreditation and quality improvement demonstration sites project. As a demonstration site, a LHD will have access to cutting edge projects and support in preparation for Public Health accreditation.

The benefit of participating in the QI process and in Emergency Preparedness activities are similar, yet more focus is currently put on being able to respond to an emergency that may or may not happen than on preparing Local Health Departments to successfully meet standards for services provided daily. Every LHD can benefit from this limited though highly focused and supported effort in preparing for accreditation and more importantly in being

prepared to improve the health of its community, through partnerships, innovation and proven processes.

Overall, the opportunity afforded this department to identify weaknesses and strengths, to set and accomplish such ambitious goals in such a relatively short period of time and receive the expert assistance in validating and leading our efforts is immeasurable!

Appendices

Appendix A: QI Storyboard
Appendix B: Pre-QI Data Availability and Request Process