Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Summit County Combined General Health District, OH

November 2008
Brief Summary Statement
The Summit County Health District (SCHD) serves approximately 297,000 people in the suburban area around Akron in Northeast Ohio. The QI Planning Team, with members from all areas of the SCHD, used QI techniques to work on a problem that transcended all areas of the agency: Improving the Transfer of Telephone Calls from the Public.

Background
The Hughes-Griswold Act, passed in 1919, created General Health Districts in each of Ohio’s 88 counties. The General Health Districts are the designated public health authority in the townships and villages in Ohio. The Act also provided that any incorporated city could have its own health department apart from the General Health District or it could combine with either the General Health District or with an adjacent city health department.

Summit County is located in northeast Ohio south of Cuyahoga County, the county that includes the city of Cleveland. Summit County’s largest city is Akron, which has its own health department. The cities of Barberton and Norton form a combined city health district. The other ten cities in Summit County (Cuyahoga Falls, Fairlawn, Green, Hudson, Macedonia, Munroe Falls, New Franklin, Stow, Tallmadge, and Twinsburg) have chosen to combine with the Summit County General Health District. The full legal name is the Summit County Combined General Health District, but it is more commonly referred to as the Summit County Health District. The Summit County Health District (SCHD) serves a primarily suburban population of 297,303 according to the July 1, 2007 estimates from the U.S. Census Bureau. Based on the 2000 census, the population served by the SCHD is 94.4% white, 2.0% black, and 1.7% Asian. The Hispanic ethnic group comprises 0.7% of the SCHD’s population.

The SCHD has 110 regular employees, not including 8 intermittent employees. During the summer, the SCHD hires 8-10 college students and adults as temporary employees to operate its mosquito abatement program. Organizationally, the SCHD is composed of four Divisions. These are Nursing, Environmental Health, Policy and Planning, and Administration. In addition, the SCHD provides office space and fiscal management services for the Summit County Family and Children First Council, which has seven full-time employees. The Nursing Division is the largest, with 69 full-time and part-time out of the 110. The Environmental Health Division has 22 full-time employee. The Policy and Planning Division has eight full-time employees and shares one other employee with Environmental Health. Administration consists of 10 full-time employees.

Since 2005, the SCHD has been actively engaged in a strategic planning process. The SCHD’s annual strategic goals target six areas: improved business performance; assuring public health preparedness; promoting healthy lifestyles; access to care and elimination of health disparities; assessing health needs; and assuring a safe and healthy environment. During 2008, the SCHD initiated a special project to develop a strategic plan for the Nursing Division as the first step of a more intense agency-wide review.

The SCHD strongly believes in measuring performance and in the public health accreditation process. In 2006, the SCHD organized and conducted a regional self-assessment using the National Public Health Performance Standards, involving 13 local public health agencies in the process.

The SCHD was pleased to be designated as one of the single local health department demonstration sites in year two (2008) of NACCHO’s Accreditation Preparation and Quality Improvement Demonstration Sites Project. Participating as a demonstration site enabled the SCHD to develop and use Quality Improvement (QI) knowledge and skills that we did not previously have. In order to spread that knowledge and skills among as many people as feasible, the SCHD identified a 9-member planning team to work on the project. The planning team consisted of the following individuals:

1. Rick Davis, Personnel Officer (team leader)
2. Traci Barnett, Nursing Supervisor
3. Tom Edwards, Environmental Health Supervisor
4. Kristi Kato, Community Outreach
5. Kerry Kernen, Emergency Preparedness Administrator
6. Judy McIntyre, Nursing Supervisor
Goals and Objectives
The original goal of SCHD for the demonstration site project was to use the self-assessment to identify an area most needing improvement. Our intent was to use QI techniques to address that area. Working with our QI consultant, Anne Harnish of Health Management Associates, we learned that we needed to narrow our focus to a more manageable issue. Inasmuch as the planning team represented a cross-section of the entire agency, we agreed that our project should involve all areas of the SCHD.

Self-Assessment
To complete the Self-Assessment Tool, the SCHD used a process wherein each administrator completed a hard copy version of the tool on her/his own, and then we met together to reach a consensus response for each item. This process required five two-hour sessions spread over four weeks, ending on April 29, 2008. Different individuals attended each session, depending on availability and on the function being reviewed. A total of seven or eight managers participated, with no session having fewer than three participants. Rick Davis, the Personnel Officer and team leader, participated in every session and was responsible for entering the responses into the online system.

As each indicator was examined, those present indicated how they scored the item. For most indicators, agreement was quickly reached. When differences in scoring appeared, those in the minority explained their thinking. For some items, further discussion ensued before moving on to the next indicator. We found the sample documents and activities particularly helpful in determining the meaning and intent of the indicator in question.

We experienced two significant technical difficulties in completing the tool online. Since we were completing the entire self-assessment, we found using the online software for data entry to be extremely cumbersome and time consuming. Entering our consensus score for each of the 226 items required several clicks and key strokes involving multiple drop-down menus. We asked NACCHO for technical assistance with this. The solution that was developed was a writeable PDF format, which the NACCHO staff would enter into the online tool for us. We were finally able to access our results on May 8, 2009. We are very grateful for this assistance.

When we examined our results, we found low scores on four indicators, which are included in the chart on the next page. Also shown is the indicator that relates to the purpose of our QI project.

Of the 24 topics, our lowest scores were in the following areas:

1. Culturally Appropriate Health Education (2.25 on a scale of 0 to 4)
2. Research (2.67)
3. Evaluation (2.85)
4. Best Practices (2.91)
5. Community Health Assessment (2.93)

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<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
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<td>III-B</td>
<td>General Data and Information Exchange on Issues Affecting Population Health</td>
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<td>- Our score for this indicator was 3.20. Although we do a good job of giving information, we felt that a significant number of calls from the public seeking information were mishandled within the Health Department. Calls sometimes bounced around the building when sent to the wrong place or when the transferee was not there.</td>
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### Quality Improvement Process

**AIM Statement:** The Project Goal was to increase by 10 percentage points telephone calls from the public that are transferred to the proper location.

**PLAN:** Our introduction to QI tools and concepts came from our consultants at Health Management Associates. Along with the two other Ohio LHD Demonstration Projects, we attended a day-long training on June 25, 2008. The trainers were Anne Harnish from Ohio, and Jennifer Edwards from New York. During the training session, we worked to identify and refine our project. The consultants advised us to keep our project small, particularly in light of the short time frame for finishing the project using NACCHO grant funds.

The team discussed various potential projects aiming to select a problem that cut across all parts of the Health District. The issue of transferring telephone calls was selected because it involves every part of the organization, it impedes workflow as some calls are transferred multiple times, and it reflects negatively on customer service. The decision to investigate this issue was subjective. We knew we did not have good data on how widespread or frequent the problem was.

The Planning Team used **Brainstorming** to identify aspects of and possible causes of misdirected phone calls. The brainstorming resulted in 40 ideas. An **Affinity Diagram** was used to group the ideas. Five groupings were identified:

1. Customer service issues
2. Number of available staff
3. System issues
4. Customer/Caller issues
5. Staff issues: Knowledge/Education

The five groupings formed the basis for a **Fishbone Diagram** to enable us to visualize the causes more easily. The Planning Team discussed these various factors and decided to focus first on Customer Service issues. Our theory was that the employees receiving calls from the public sometimes did not know where to transfer the calls based on the information being requested.

**DO:** To test our theory, we decided to survey the 14 personnel who are most likely to receive calls from the public with a list of typical questions and asking them where they would transfer each call. All members of the Planning Team were involved in developing and refining the questions. The final survey consisted of 11 questions; 8 of these were scenarios and the other 3 asked about process.

For consistency, the same non-supervisory member of the Planning Team conducted all of the surveys on June 30, 2008. She collected the data, but the survey was anonymous and individual responses were not identified by name. The Project Leader compiled the responses to the survey. The Planning Team then met on July 2, 2008 to review the responses and to determine which
responses were correct or acceptable. It was determined that two of the questions were either too ambiguous or contained insufficient information so these questions were not considered.

The results of the survey were that 82% of the responses were judged to be correct, so we decided to address how to improve performance in this area. Had the results been more positive, we would have moved on to another factor in the above list.

A Project Team was then selected. The Project Team consisted of four individuals from the reception desk, nursing secretaries, clinic support staff, and environmental health secretaries. The Project Team met with three members of the Planning Team on July 16, 2008. The Planning Team leader explained the project and the survey results. The Planning Team agreed that the best way to improve employee’s knowledge was to give them a one-page guide listing the issues addressed within the various organizational units and which number to use for transferring calls on those issues. After several reviews and revisions, a final version of the Telephone Transfer Guide was pilot tested by the Project Team members for one week from July 24 through July 31, 2008. No problems were found with the guide, so it was distributed to the 14 support staff members on July 31, 2008.

CHECK: Two weeks after distributing the Telephone Transfer Guide, we used the same survey, administered in the same way, as a post-test. The results showed the same rate of 82% correct responses. The percentage of correct responses to some questions went up, but for others it went down. Our goal had been an improvement of 10 percentage points, so the project had clearly not been successful in improving employee knowledge. The results were reviewed using a bar graph comparing the pre-test and post-test results for each survey item. A copy of the bar graph is shown on the next page.

ACT: The Project Team met on August 27, 2008 to discuss next steps. Implementation mistakes were suggested and discussed. One survey item requiring further management agreement was identified and later was resolved. We agreed that the project had not achieved its objective, but it was also agreed that we had learned a lot about the process. Consultant Anne Harnish met with members of the Project Team on October 10, 2008 in an onsite consultation. Together we identified several pertinent observations about how calls are handled, although we still did not have quantitative data. It was agreed that we needed to involve the entire support staff and we needed to inform the entire SCHD management team about the project.

Results
Two of the Project Team members met with the entire support staff group on October 17, 2008 to review the project and to seek their input. The Planning Team leader reviewed the project and the results of the two surveys. The support staff group recommended that each of the program areas meet as a smaller group to identify specific telephone transfer guidelines and to address other
aspects of the project. These meetings are in process and when they have all been completed, the combined group will reconvene. The project will then enter a new cycle based on their input.

**Lessons Learned**
We learned several lessons in our first attempt at using QI. Among these were:

1. Begin with something small. Practice using QI knowledge and skills on a manageable project before moving on to more ambitious efforts.
2. Involve those closest to the process from the beginning. With one exception, our Planning Team was composed of managers who didn’t know as much about the problem as they thought they did!
3. Communicate what you are doing. In a large health department such as ours, it is easy to overlook people who need to know about the project, from upper management to front-line staff.
4. Don’t overestimate your ability to solve the problem. Expect to repeat the PDCA cycle multiple times.

**Next Steps**
We will continue to work on customer service telephone issues based on what we learned in the first PDCA cycle. We will extend the application of QI to other issues as we gain experience and confidence with the process. We have agreed to serve as mentors to another local health department that is just beginning to learn about QI. Along with the other three demonstration sites in Ohio, we will be applying jointly for funds from the Robert Wood Johnson Foundation’s “Public Health Practice: Evaluating the Impact of Quality Improvement” initiative.

**Conclusions**
We now recognize the value of applying QI techniques and processes in a structured way to work on identified problems. With practice, we hope to be able to apply QI to larger issues that will assist us in reaching accreditation status.

**Appendices**
*Appendix A: QI Storyboard*
*Appendix B: Brainstorming Misdirected Phone Calls*
*Appendix C: Customer Satisfaction Quality Improvement Survey*
*Appendix D: Summit County Health District Telephone Transfer Guide*