EXECUTIVE SUMMARY
The Tooele County Health Department (TCHD) is located in Utah and serves a population of 58,335. Tooele is primarily rural but is located adjacent to Salt Lake City and has a large number of commuters who work in Salt Lake County. Using the Public Health Accreditation Board (PHAB) self assessment and a quality improvement (QI) project, TCHD identified a need to review, update, and train employees on departmental internal policies. As a result, a departmental QI team comprised of employees throughout the department developed a process to review, update, and train employees on internal departmental policies. Application of the developed process resulted in an increase in the percentage of departmental policies reviewed, updated, and presented to appropriate staff within the last three years.

BACKGROUND/INTRODUCTION
Prior to TCHD’s participation in the beta test, the general consensus in Utah among local health departments (LHDs) was against national accreditation. TCHD thought accreditation would assist in evaluating the needs of their community and the effectiveness of the services TCHD provides. TCHD wanted to be a beta test site to meet their objectives and as a demonstration site for the entire state of Utah. TCHD’s intentions were to share experiences with the state health department and the other 11 LHDs. TCHD believed by seeing the accreditation process in action other LHDs in the state would see the benefits of accreditation and would be swayed in their opinions.

BETA TEST SELF ASSESSMENT
An accreditation core team was organized to facilitate the PHAB beta test self assessment. The team comprised the executive management team, division coordinators, and administrative support. The executive management team comprised the health officer, deputy director, family and school health supervisor, and community services supervisor. The deputy director functioned as the accreditation coordinator and project lead. In order to gain staff to buy in and support, top level staff led the way. The core team was comprised of eight people.

The team was organized in November or 2009, and training was conducted for the core team in December of 2009. The accreditation coordinator in consultation with the executive management team assigned standards and measures to each core team member according to who could adequately address the measure. One to two domains were reviewed and assigned every two weeks. The core team met at least once every two weeks to review progress and receive new assignments for standards and measures. As standards and measures were completed, the accreditation coordinator would score the measure and the whole core team would then review the score and comment on consent or consideration for differences.

The self assessment portion of the beta test took two and half months. Approximately 500 staff hours were used to complete the self assessment. When the core team met to review progress on standards and measures, some members expressed difficulty in documenting the measure and often other members would recognize documentation they could use that might meet the standard. Having regular scheduled core team meetings helped keep team members on task, and accountability for deadlines.
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was more readily achieved. On a number of occasions, the team would recognize that a standard and measure was met by the department, but TCHD could not provide adequate documentation to demonstrate the measure.

As the core team worked on documenting standards and measures, the team members became more familiar with the work of other divisions within TCHD. During the process, division supervisors and coordinators would recognize something that could benefit their own division. The process was a positive exercise in unifying staff and creating a team dynamic and facilitated divisions working with each other for a common goal.

### Highlights from Self Assessment Results

<table>
<thead>
<tr>
<th>Standard/Measure</th>
<th>Standard and Significance</th>
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<tbody>
<tr>
<td>A1.1B</td>
<td>Maintain policies and procedures regarding agency operations, review policies regularly, and make them accessible to staff.</td>
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<td>- The self assessment revealed that TCHD had not conducted regular reviews of policies and procedures. Many of the policies were outdated or no longer relevant. In some circumstances, outdated policies can lead to operational inefficiencies and even potential liability. Staff decided to conduct a QI project on outdated policies.</td>
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<tr>
<td>5.2.4B</td>
<td>Review and revise the strategic plan.</td>
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<td>- TCHD did not have a written strategic plan. This has prompted TCHD’s department to evaluate how TCHD conducts community assessments and move the data forward into a community health improvement plan and then a departmental strategic plan.</td>
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<tr>
<td>7.2.1B</td>
<td>Convene and/or participate in a collaborative process to establish strategies to improve access to healthcare services.</td>
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<td>- TCHD received marks and positive feedback on this measure. TCHD organized and facilitated a community oral health coalition that was instrumental in establishing a low income dental clinic to provide services previously unavailable in the community.</td>
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### QUALITY IMPROVEMENT PROCESS (PLAN-DO-CHECK-ACT)

**PLAN**

Because departmental policies and procedures affect all divisions and TCHD employees, a cross-cutting team of divisions and job duties was selected. The team comprised executive management, a line supervisor, and clerical staff. Invitations were given by the deputy director so staff knew the project was supported by executive management.

Because of the unique makeup of the team, the first step was to train team members on basic QI principles. Team members were told why they were selected and why their input to the process was important. Explaining that clerical and line staff’s input was just as valuable as any team member and in many circumstances they had unique perspectives that might be overlooked by management was
critical. The composition of the team remained the same throughout the project; however, a smaller workgroup was formed to accomplish assignments made by the QI team. The work group worked on developing a policy, a checklist, and revised flowchart.

Identifying the problem
The group identified internal policies and procedures as an opportunity for improvement. Many of the internal policies had not been revised, updated, or formally presented to applicable staff in the last three to five years. Other areas identified as opportunities for improvement included community health assessment and community health improvement plans. Both of these were identified as critical issues to improve, but would be difficult to address in a short amount of time.

The methodology used to identify TCHD’s opportunity for improvement was with the Nominal Group Technique. The group was presented with a list of issues that were listed as partially documented or not documented from the self assessment used for accreditation. The group was instructed TCHD wanted to identify an issue that was critical but could be adequately addressed by a December 2010 deadline.

In 2008, TCHD underwent an organizational restructuring. There was some program realignment with the addition of a new division for the department (community services). Team members briefly evaluated the existing internal policies and identified several policies that should have been categorized differently. The team realized that all the policies needed to be reviewed, updated, and presented to appropriate staff for workforce development purposes.

As the workgroup progressed, the aim statement for the QI project was amended.
- July 21, 2010: By Dec. 2, 80 percent of all departmental policies will be reviewed and either updated, abandoned, or approved for no change, and a plan developed to assure policy review every three years.
- July 28, 2010: By December 2, XX percent of all departmental policies will be reviewed and updated and a process implemented to assure 100 percent of all policies are reviewed every three years.
- Aug. 26, 2010: By Dec. 2, the percentage of departmental policies reviewed and updated within the last three years will increase from 9.9 percent to 35 percent, and a process implemented to assure 100 percent of all policies are reviewed every three years.
- Oct. 12, 2010 (final aim statement): By Dec. 2, the percentage of departmental policies reviewed, updated, and presented to appropriate staff within the last three years will increase from 6.6 percent to 35 percent and a process implemented to assure 100 percent of all policies are reviewed, updated, and presented to appropriate staff every three years.

Examine the current approach
After Identifying the problem, TCHD’s QI team discussed the process and flow of how internal policies were developed and presented to staff. Consensus was that most internal policies come about as issues are identified, more commonly known as “putting out fires.” For example, supervisors were concerned about what activities Internet usage on county computers and networks. The administrative staff researched any existing policies at the county level that may address the issue. When it was determined that the county policy at that time did not adequately address the issues of concern, a departmental internal policy was drafted by the administrative staff, presented to the health officer for review, and presented to staff for training upon approval.
The QI team used a fishbone diagram to flush out the cause and effects of the problem. There were four categories identified with several causes listed under each category. Upon discussion and analyses by the team of the listed causes and effects, they determined to first design an intervention addressing “no process for scheduled review.” The team felt by addressing this cause, several of the other listed causes might also be resolved.

**Identify potential improvements**
The team proposed create a draft a policy in which a departmental staff person is assigned the responsibility to develop a review schedule for all internal policies ensuring they are reviewed at least once every three years. The team also drafted a check list of steps the division manager needed to take to complete a review. A staff member was also assigned to track the changes made and staff were trained on any additions to or changes to internal policies.
Policies that have been reviewed updated and presented to staff will be recorded on a spreadsheet and the percentage of policies updated within three years tracked. Using this method, TCHD can compare how internal policies are being reviewed and presented to staff on a timely basis over time. In addition to tracking percentage of internal polices reviewed and presented, TCHD will survey the staff involved in internal policy development and review, asking if the new process is more efficient.

The baseline data indicates that 6.6 percent of the internal policies have been reviewed updated and presented to staff in the last three years. TCHD’s goal is to have 35 percent of the policies reviewed, updated, and presented to staff by Dec. 2, and that by April 1, 2012, all the departments’ internal policies will have been through this process and presented to staff.

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<thead>
<tr>
<th>Policies Reviewed, Updated and Presented to Staff</th>
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<td>Section</td>
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<td>2-General</td>
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<td>3-Administration</td>
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<td>4-Comm. Health</td>
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<td>5-Environ. Health</td>
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<td>6-WIC</td>
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<td>7-HIPPA</td>
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<td>8-Emer. Response</td>
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<td>9-Comm. Services</td>
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<td>TOTAL</td>
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**Develop an improvement theory**

By amending the process and developing a policy on internal policy review, update, and present to staff, internal policies will be more current and relevant to staff and departmental needs. Also, staff involved in policy review will perceive the process to be more efficient.

One month after the new policy is adopted and the new process is implemented data will be collected that will illustrate how many internal policies have been reviewed, updated, and presented to staff. The baseline percentage done over the last three years will be compared to data collected after the intervention is implemented. After the one-month period a survey will be given to staff involved in the review querying their perception of the efficiency of the new process.

**QI Team and Roles**

- Jeff Coombs, QI Team Facilitator, will use the new process to review internal policies and report findings back to team.
- Myron Bateman will use the new process on policies and evaluate efficiency.
- Ericka Jordt logs minutes of meetings, helped design new policy, and process design.
- Sherrie Ahlstrom will use the new process on policies and evaluate efficiency.
- Bucky Whitehouse will use the new process on policies and evaluate efficiency.
- Dennis Richardson will collect and analyze data.
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- Nikki Scow will assign policies to review, will track changes and present and collect data.
- Louise Ekenstam will use the new process on policies and evaluate efficiency.
- Robert Warner will use the new process on policies and evaluate efficiency.

DO
*Run the test/launch the pilot improvement(s)*
The workgroup formulated a procedure for distributing policy and procedures to the appropriate staff, a checklist for actions to consider, and documentation for tracking and recording changes made and training provided.

*Collect the data*
The staff person assigned to tracking policy and procedure amendments and training logged the progress on a spreadsheet. The data was compiled and compared to baseline data to measure progress (see Appendices B and C).

CHECK
*Analyze the data*
The data collected demonstrated an improvement in the number of policies and procedures reviewed, updated, and presented to staff in the last three years. Staff conducting the review reported that the process was efficient and useful. There was no baseline data to measure an increase in efficiency (see Appendices B and C).

While the project demonstrated the intended effect, it will take a couple years to fully evaluate the effectiveness.

*Determine the next step*
Results of the data indicated TCHD should continue with designed improvements and continue to track the data on a regular basis.

ACT
*Institutionalize/standardize the improvement and “hold” the gains*
A staff person was permanently assigned to track policy and procedure update review and training. This responsibility will be added to the employee’s job description and goals.

A policy and procedure tracking database was created to facilitate continued monitoring and improvement.

RESULTS, NEXT STEPS, AND ACCREDITATION

Overall, the QI project and accreditation self assessment was very beneficial. The process of conducting a departmental self assessment for accreditation was illuminating and provided valuable insight into current strengths as an organization and highlighted opportunities for improvement. At the beginning of the beta test for accreditation the agency had no idea of its readiness, now a good base line of plans for improving exists.
While TCHD strived to improve delivery and efficiency of public health services, there was no plan or predefined program for conducting QI. By implementing the plan-do-check-act model of QI the agency began incorporation of a QI culture and made progress in preparing for accreditation.

Staff involved in the project have learned about the QI process and see the benefits of the tools used. Staff have recognized areas within each of their programs were a QI project would be beneficial. TCHD has begun to compile a list of potential QI projects and will begin prioritization of these projects in the near future.

Going into the beta test, TCHD was unsure of its intent to pursue accreditation when it goes live in 2011. Some of the objectives in participating in the beta test were to learn more about accreditation and to participate in the development of the process. After completing the beta test, self assessment, and QI project, TCHD has decided to apply for accreditation at the earliest feasible time.

LESSONS LEARNED
Other Utah LHDs were generally against national accreditation. By participating in the beta test for national accreditation, TCHD was able to convey their findings and experiences to other Utah LHDs. Many barriers and misconceptions have been overcome. As of Dec. 1, 2010, two other LHDs have committed to pursuing national accreditation when it goes live, and several others have shown interest including the state health department. When the three committed LHDs become accredited, The Robert Wood Johnson Foundation’s goal of 60 percent of the population being served by accredited health departments will be achieved in the state of Utah.

As TCHD shares what it has learned with other LHDs about preparing for accreditation, it emphasizes seven key elements:

1. Good community assessments;
2. A community health improvement plan;
3. An agency strategic plan;
4. A plan for continuous QI;
5. Thoroughness in documenting activities;
6. Support and buy-in from executive management and Board of Health; and
7. Inclusion of all staff in the accreditation process.

The TCHD chairperson best described why the agency participated in the beta test and why it intends to pursue full accreditation when she said, “We want to make a difference where we live.” In order for and LHD to go beyond providing services and reacting to impending issues, it has to assess the needs or its community, examine how it delivers health, and plan how it will improve. National accreditation and QI are key elements in being able to achieve these objectives.

APPENDICES

Appendix A: Storyboard

Additional Appendices:
Appendix B: Policies Reviewed and Updated in last three years, before and after intervention
Appendix C: Policies and Procedures Presented to Staff, Before and After Intervention