

Accreditation Beta Test Quality Improvement Project: Final Report

COMANCHE COUNTY HEALTH DEPARTMENT

IMPROVING COMMUNITY ENGAGEMENT

This report was completed by: Keith Reed, RN, MPH, CPH, Administrative Director, Accreditation Coordinator & Brandie O'Connor, MPH, Assistant Accreditation Coordinator

EXECUTIVE SUMMARY

The Comanche County Health Department (CCHD) is located in Southwest Oklahoma and serves approximately 112,000 residents. Using the Public Health Accreditation Board (PHAB) self assessment and a quality improvement project, the CCHD assessed community engagement in an effort to improve community sector participation in the community health assessment process. As a result, sector participation improved as did overall meeting effectiveness. Both these improved outcomes have resulted in an enhanced community health assessment process.

BACKGROUND/INTRODUCTION

The CCHD serves thousands of clients each year, both inside and outside the county health department facility. Program audits, internal reviews, and laboratory inspections reassure staff that the department is performing at the highest standards, but, more information is desired to satisfy the department's desire to understand the community's thoughts. CCHD recognizes that modern public health is about more than the traditional services offered in clinics, through consumer health endeavors, and even through health education. With that in mind, they have often wondered how they are doing as a local public health agency when compared to national standards, whether they are meeting those standards, and if not, what are they prepared to do about it. In other words, are they truly committed to be the local public health agency Comanche County residents and our community partners deserve?

It was the search for those answers that prompted CCHD to apply to be a PHAB beta test site. This was recognized as an important opportunity to provide what they considered to be critical input into the complex issue of developing national standards that would apply to numerous unique systems. Specifically, as a part of a centralized public health system, CCHD recognized this as an opportunity to ensure the unique organization and operation of a centralized system would be adequately considered in the development of the final accreditation product.

The goal was not just to help PHAB, but also to seize this opportunity to complete a comprehensive self assessment of where CCHD stands as a local public health agency. This process has been very revealing because it has encouraged the celebration of successes and forced CCHD to face deficiencies. While it would be impressive to say no deficiencies were found, that was simply not the case. According to their own self assessment using the PHAB standards and measures, they lag in some key essential service areas. That realization was perhaps the most beneficial of this endeavor. Recognizing deficiencies has opened CCHD's eyes to the opportunity for true quality improvement. The entire beta test process, as they hoped, provided CCHD with incredible opportunities to excel. As such, CCHD was eager to proceed with the quality improvement phase of the beta test.

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BETA TEST SELF ASSESSMENT

The local health department (LHD) administrator served as the primary accreditation coordinator for the beta test. A regional turning point coordinator was asked to serve as the secondary coordinator. Additional team members were recruited based on their subject matter expertise, experience, and position within the health department. The primary and secondary accreditation coordinators attended the PHAB beta test opening session in Washington, DC. Upon their return, the beta test team was formed and began meeting twice a month. Members of the team were assigned domains based on their knowledge and experience. The team was responsible for identifying appropriate documentation that would reflect compliance with each measure, and they offered their recommendation in regard to the scoring. The team met regularly with the primary and secondary accreditation coordinators to discuss documentation, troubleshoot possible problem areas, and to review scoring recommendations. The LHD administrator made the final determination of domain scores.

The team quickly realized that while the CCHD has a well trained, competent LHD staff, their specific training in local service delivery did not necessarily equate to a solid foundation in broad public health knowledge, such as how it relates in context to the 10 Essential Public Health Services (EPHS). There was considerable difficulty correlating the PHAB standards and measures into individual work experiences and identifying appropriate documentation of compliance. However, in a more positive outcome, the self assessment offered staff a reverse insight into the relationship between the broad public health system and individual program efforts. The self assessment essentially served as a learning agent for staff as individuals recognized their roles in the greater public health world.

The self assessment encouraged healthy conversations about the 10 EPHS. CCHD is truly changing the culture of its workforce through this experience. While the positive experiences greatly overshadowed the difficulties encountered, there was a fair share of challenges. As a result, most major challenges occurred when the deadline was approaching. The computer system at the LHD crashed for approximately four days during the two weeks before the deadline. This crisis might have been less serious if there were dedicated staff working solely on the self assessment process, but CCHD did not have that luxury. Instead, everyone involved in the self assessment process had multiple other responsibilities, including work in multiple geographic locations. Needless to say, four days without computer access became a very serious threat to their ability to complete the assessment before the deadline. Compounding the computer malfunctions was the fact that they did not anticipate the excessive amount of time it would take to upload the documents.

Highlights from Self Assessment Results

Standard/ Measure	Standard and Significance
Domain 1 B	Conduct and disseminate assessments focused on population health status and public health issues facing the community <ul style="list-style-type: none">CCHD was pleased that the site visit team recognized the benefits of centralized system in that many of the data functions are within the state health department. Therefore regardless of the size of a LHD, they have access to the same skilled data professionals and reports.
Domain 2.2.2B	Demonstrate that protocols include decision criteria for determining when a public health event triggers the all-hazards plan or the public health emergency response plan

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	<ul style="list-style-type: none">Meeting the requirement for “public health event triggers” would require a fundamental shift in the state’s approach to public health event response.
Domain 3.1B	Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness <ul style="list-style-type: none">The LHD was pleased to learn that they are proficient communicating public health messages using many forms of media, including television, video, newspapers, the Web, brochures, community meetings, and at individual visits with clients.
Domain 5.3.1L	Conduct a community health improvement process that includes broad participation from the community <ul style="list-style-type: none">This was a gap that was anticipated. Therefore this standard was identified as part of the QI project. CCHD is currently taking the opportunity to improve conformance by directly engaging community sectors in the Mobilizing for Action through Planning and Partnerships (MAPP) process. They have actively engaged community sectors in the assessment phases and plan to have active participation of local partners in the development of a Community Healthy Improvement Plan (CHIP).
Domain 6.1.2B	Evaluate the need for changes in laws <ul style="list-style-type: none">CCHD has learned through this process that they can be more involved in local policy evaluation and development and are working to implement new this policy strategies in the LHD strategic plan.

QUALITY IMPROVEMENT PROCESS (PLAN-DO-CHECK-ACT)

PLAN

The LHD administrator recruited quality improvement team members based on the subject matter of the project, interest in quality improvement, and their current involvement in community-based initiatives.

The selected staff members were already working at near full capacity with their current work schedule. As such, competing priorities and scheduling meeting times became an immediate barrier. In addition to routine individual job duties, the LHD was in the midst of planning for a large-scale, statewide preparedness event in a few short months. To overcome these barriers, the LHD administrator and QI team members met to establish priorities and to develop a time table of activities. Whenever possible, ongoing community efforts and projects were shifted to other LHD staff and/or community partners.

While the quality improvement team members have remained consistent throughout the project, CCHD recognized a potential value in including additional disciplines. This addition would not necessarily add to the direct success of this project, but would add to the organizational experience gained through its success. Specifically, the wealth of knowledge gained through the QI training and guidance provided by NACCHO and the state health department (SHD) would easily translate to any area of public health service, and as such, additional disciplines would greatly benefit from the experience. Fortunately, as a centralized system there is the ability to continually look to SHD for training and guidance on future QI projects.

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As the team began discussing potential QI projects, they worked collaboratively with the SHD, focusing on recent PHAB efforts to narrow down the search for an appropriate project. As a result of the PHAB beta test self assessment, CCHD identified several areas in need of improvement, while other areas were in need of development. As prerequisites for accreditation, the team focused heavily on the need for a community health assessment (CHA) and CHIP. CCHD was aware of these missing elements before the self assessment and planned the development of each. However, the self assessment made it clear that the process of development was just as critical as the final product. As a result, the project focus began to shift from the need for an end product to the quality of the process required to produce a CHA or CHIP.

While CCHD is involved in an active community coalition, the coalition partners have not taken the time or effort to stop and develop a CHIP. Through brainstorming and collaboration with the SHD, CCHD began to look at the essential prerequisites to developing a CHIP: broad community engagement, assessments at multiple levels, and community health data. Following a brainstorming session, the team met and determined that a prioritization matrix (Appendix B) would help narrow the identified problem areas that were inhibiting development of a CHIP. The QI team identified improvement in available data, improving community engagement, and community assessment as areas of need. Each team member scored each area of need against the others. The team could rate each need as equally Important (1), more important (5), much more important (10), less important (1/5), or much less important (1/10). The area with the highest score was the area the team would focus on. The team easily identified Improving community engagement with a score of 15 as the area to direct project focus.

The final aim statement was revised on Sept. 10, 2010,:

By December 2010, the Comanche County Health Department will improve community engagement as evidenced by 60 percent of community sectors being represented at meetings, with an average score of 4 on the meeting effectiveness survey.

Community health sectors were defined as the following:

1. Health
2. Schools/education
3. Law Enforcement/fire
4. Government
5. Business
6. Youth
7. Parents
8. Faith
9. Civic
10. Media

Initial aim statement:

By December 2010, the Comanche County Health Department will improve community engagement as evidenced by 60 percent of invited partners attending meetings; an average score of 4 on the meeting effectiveness survey; completion of all four assessments of the MAPP process demonstrating progress toward a CHIP; and completion of a local strategic plan.

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The QI team met and documented the actual sequence of events that takes place when planning for a community meeting. The sequence of events was depicted in a flowchart (see Appendix C). The flowchart showed that the process for engaging community partners was limiting and not engaging. CCHD staff would set a meeting date, sent it out and hoped community partners were motivated enough to attend. Through a fishbone analysis (see Appendix D), the team began to take a closer look at possible reasons that their community partners were not engaged often enough. The reasons fell into four categories: conflicting agendas/priorities, time, apathy, and communication. These four categories led the team to develop strategies to counter the reasons identified for poor community engagement. The improvement theory reasoned that if the LHD demonstrated respect for partner's time and participation, the number of community sectors represented at meetings and meeting effectiveness would be increased.

A tree diagram (see Appendix E) was developed to break the theory down into greater detail, including realistic action steps. CCHD believed that they could improve community engagement by implementing the following strategies:

- In order to show proper respect for community partner schedules, every effort will be made to ensure clear and concise meeting agendas are prepared with relevant objectives.
- An RSVP will be added to all meeting invitations. This will allow the team to see the level of engagement and to identify missing partners/sectors.
- In response to the RSVP, the team will make a concerted effort to engage missing and key partners/sectors through personal contact via a phone call or face to face visit.
- Draft agendas will be sent out at least four weeks in advance providing partners/sectors an opportunity to provide input.
- Meeting requests will have a clear concise goal with beginning and end time.
- Each meeting will conclude with a meeting effectiveness survey.
- Meeting minutes will be taken and circulated in a timely manner.
- Adjustments will be made based on survey results and partner input.

The QI team included the following team members and responsibilities:

Johnetta Miller collected data and administers surveys; prepared meeting materials; and participated in SHD sponsored QI and MAPP training.

Janette New was the primary point of contact for law enforcement, civic, and government. She followed up calls to ensure sector participation and participated in SHD sponsored QI and MAPP training.

Kyle Rogers was the primary point of contact for business, youth, faith, and schools. He followed up calls to ensure sector participation and participated in SHD sponsored QI and MAPP training.

Brandie O'Connor was the primary point of contact for health and parents. She also developed meeting goals, responded to reporting requirements, participated in SHD sponsored QI and MAPP training, and participate in NACCHO webinars.

Keith Reed was the team lead and primary point of contact for civic and media. He coordinated team meetings, established timelines, participated in SHD sponsored QI and MAPP training, participated in NACCHO webinars, and responded to reporting requirements.

To a degree, the perception and approach to community engagement changed as CCHD realized the importance of focusing on proper planning instead of focusing on the planned outcomes of the

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engagement. CCHD has come to realize the value of investing more effort in the planning as opposed to strictly focusing on the goals they want to achieve.

DO

For the most part, the improvement process proceeded as planned. Specific issues became clear during the root cause analysis, and they accurately reflected the areas that needed the focus of interventions. The process yielded the results CCHD had hoped and planned for.

Data included community sector representation and the meeting effectiveness from each of two meetings. The data is reflected in a radar and bar graph (see Appendices F and G). Whether attendance for each meeting was measured or sector representation caused an issue. Initially, the number of attendees invited to the meetings was being measured, but the team realized that the number that attended was of secondary importance to the community sector representation that was needed to participate in the meetings. Once the team reconciled the intent to identify sectors, it became clear that the data they were collecting was more relevant to their goals of community engagement. Having resolved this issue, further data collection was accomplished without difficulty.

The results of the interventions were in line with CCHD expectations. Once the appropriate effort went into planning the meeting, the results yielded were more positive, with greater sector participation and more effective meetings.

CHECK

The improvement theory reasoned that if the LHD demonstrated respect for partners' time and participation by providing draft agendas in advance, offering clear and concise goals with beginning and ending meeting times, requesting RSVPs for meeting participation, and offering feedback via meeting minutes, CCHD will increase the number of community sectors represented at meetings and increase meeting effectiveness as evidenced by an increased score on the meeting effectiveness survey.

The LHD QI team collected and analyzed data over the past two meetings looking for increased sector representation and improvement of meeting effectiveness. The QI team collected information from the invitation list versus actual attendance. The team evaluated the sectors input on the meeting effectiveness survey to gauge meeting quality with the anticipation that if partners are satisfied with the effectiveness of the meetings, they will continue to be engaged. The results of the meeting effectiveness survey went from an average of 3.4 to 4.6 as demonstrated on a radar chart (see Appendix F). A simple bar graph shows an increase in sector representation from 40 to 70 percent with the goal being 60 percent (see Appendix G).

The data clearly indicated that the improvement was effective. The team had set a goal of achieving a 4 on the meeting effectiveness survey and ended up with a 4.6. Additionally, the team had set a goal for six out of 10 sectors to participate, and seven were represented. No unexpected data was revealed.

Considering the success that the data identified, CCHD decided to adopt the improvement. Having exceeded their original goals, the improvement efforts were successful. CCHD must follow the course the data indicates is most effective.

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ACT

For purposes of the quality improvement project, the improvements were focused on one particular area of community engagement: the team's efforts to improve engagement in pursuit of a CHA and ultimately a CHIP. The success CCHD has experienced in this endeavor will be applied in all areas of community engagement. As such, community meetings will be planned in such a way as to incorporate these lessons. CCHD will plan meetings keeping their partners' needs in mind as opposed to planning meetings to meet their own needs.

Members within the organization were very accepting of the improvements for this project. CCHD is interested in seeing how these improvements are carried forward in all community engagements. CCHD is committed to taking more time and effort in the planning phases of community interactions, which requires a consistent commitment from staff. Busy schedules and competing priorities will be a constant obstacle to maintaining these improvements.

CCHD will continue to track sector participation for each meeting through sign-in sheets with organizational/demographic data incorporated. Additionally, CCHD will track our meeting effectiveness using meeting effectiveness surveys for all subsequent meetings. CCHD will also periodically review data comparing it their baseline and the successes they have achieved through this process. During the process, no unexpected results occurred, but CCHD will continue to track the data.

RESULTS, NEXT STEPS, AND ACCREDITATION

As the QI team proceeded through this project, they engaged in formal quality improvement training provided by the Oklahoma State Department of Health. This training process has revealed distinct deficiencies in what CCHD perceived to be a robust QI program. In reality, they had successfully engaged in quality evaluation and control but lacked the continuous and organized process that leads to lasting improvement. Additionally, CCHD has learned to apply QI principles to all areas of their public health practice, including the most vulnerable areas of our practice where they engage community partners.

Using their new found skills in QI, CCHD is more effectively engaging their community partners to complete a CHA, CHIP, and strategic plan, all prerequisite items for accreditation. CCHD has an efficient plan to complete these items, which will position their health department for national voluntary accreditation. In addition, CCHD plans to build a culture of QI by exposing additional staff to a formal QI plan and organize their efforts into a comprehensive program that will cut across all essential public health services.

LESSONS LEARNED

A chronological reflection of CCHD's lessons learned requires an evaluation of their self assessment team. CCHD had difficulty identifying individuals with the broad expertise needed for each domain because they are an LHD operating in a centralized state. Because CCHD's role in the centralized system is mostly delegated to program implementation as opposed to program development, the team struggled to find programs with the broad perspective necessary to assess each domain. As a result, CCHD partnered with their SHD to combine their program development perspective with CCHD's implementation perspective, culminating in an effective comprehensive self assessment.

In addition, the team quickly learned that they frequently failed to document their public health services efforts, especially in those involving community partners. Meeting minutes, sign-in sheets, agendas, and

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presentation materials are all invaluable in documenting these efforts. CCHD also learned to value their partners' efforts and recognize their role in the public health system.

The site visit required particular efforts to educate the site visit team on CCHD's public health system. Training a site visit team to fully understand the qualities of each particular public health system is a difficult task. CCHD realized it was paramount that they fully accept their responsibility to adequately explain their own system. CCHD learned that in order to keep the site visit team focused on their task, they needed to remove the distractions of an unfamiliar system, which can create a time issue. The CCHD site visit agenda was packed tight over two days, and CCHD had limited time to educate the visitors on their centralized system. For future site visits, CCHD will plan better to provide more concise, timely education.

The first QI lesson CCHD learned was to adjust our perceptions of what QI is. Lacking formal QI training, CCHD staff developed their own QI ideals. These efforts did not lack a desire to improve or excel at quality. Instead, staff lacked the necessary theoretical knowledge to achieve the desired results. In order to learn, staff had to recognize the gaps in their knowledge and take advantage of the training and other educational opportunities to fully understanding QI. Staff benefited from NACCHO's technical assistance and additional staff training through their SHD.

Overall, CCHD learned many lessons from this process. The most valuable of all the lessons was also the most basic lesson. The team learned that organizational self awareness is vital when developing a quality public health organization. Organizational self awareness gained by this experience has stirred an awakening in CCHD. They went into the process hoping to see many successes but prepared to accept their deficiencies. That acceptance has provided a framework for comprehensive improvement and will undoubtedly result in local public health excellence.

APPENDICES

[Appendix A: Storyboard](#)

[Additional Appendices:](#)

Appendix B: Prioritization Matrix
Appendix C: Flowchart
Appendix D: Fishbone
Appendix E: Tree Diagram
Appendix F: Radar Chart
Appendix G: Bar Graph