Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Livingston County Department of Health, NY

November 2008
Brief Summary Statement
The Livingston County Department of Health is located in Upstate New York, 30 minutes south of Rochester, 90 minutes southeast of Buffalo. The Department serves a rural population of 65,000, with agriculture as its main industry. The Department completed the LHD Self-Assessment Tool for Accreditation Preparation and selected incorporating Core Competencies in the Performance Appraisal for its Quality Improvement project. The Accreditation Team identified fundamental competencies for all staff, developed a unified performance appraisal process flow chart; the next steps are to identify competencies for each title and communicate the process, progress, and future plans to all staff through a developed Communication Plan.

Background
The Livingston County Department of Health has a staff of 140 providing comprehensive public health services to its residents; according to 2000 Census, 6% of the 65,000 residents are minority. The Department has six Centers: Center for Administration and Fiscal Management, Center for Emergency Medical Services, Center for Environmental Health, Center for Patient Services, and two Centers for Preventive Services (the second Center was created in the fall of 2008 and is yet to be named). The Accreditation Team consisted of the Public Health Director, six Center Directors, eleven Supervisors, one staff member, the Facilitator and the Consultant. The expectation was to prepare for Accreditation as well as improve how the Department conducts business. PDCA #1 and Gantt Chart #1 (Appendix B) is an overview of the Accreditation Preparation Process, describing tasks, time frames, and those responsible for accomplishing it. This depicts the basic history and future of the Department’s Accreditation Process. Beginning in the Year 2000, the Center Directors and Supervisors first began discussing Essential Services, the Operational Definition, and the voluntary Accreditation process. Each year we have talked more about this. We applied the Department’s activities to the Ten Essential Services to determine how what we do related to the Essential Services (2005-2006). This was the indicator that there was still work to do. In 2008 we applied for the NACCHO grant, which we received and completed the QI Process for the Grant (5/15/08 deadline), and now we are continuing with the QI process through the Year 2013 to include applying for Accreditation (2011), celebrating Accreditation, and continuing with the QI process. All staff will share in the celebrating, although this Accreditation Steering Committee will be responsible for most of the work.

PDCA # 2 and Gantt Chart #2 (Appendix B) describes activities from February through May 2008, with the submission of the application to NACCHO in March, and seeking potential facilitators. The Department was awarded the Grant and created the Accreditation Team. The Team went through the orientation process, set their agendas, and completed the matrix, which was entered into the software. The Team completed the Evaluation Survey and selected a Quality Improvement Project.

PDCA # 3 and #4 and Gantt Chart #3 (Appendix B), continues the process from September 2008 through April 2009 with the selection of a Consultant from the Public Health Foundation to guide the Team in the Quality Improvement Process. The Consultant and the Public Health Director spoke several times to establish expectations and determine how he could assist the Team.

The Consultant provided a day long QI Workshop for the Team. During that workshop, the Team learned about the QI process, reviewed the Problem Statement, and completed a Force Field Chart (to identify the strengths that would contribute to the success of the QI
process, as well as barriers that could potentially impact the QI process), High Level Performance Appraisal Flow Chart for the Health Department, Process Decision Program Chart to help error proof the process going forward, and a Radar Chart to help baseline where the Health Department and Centers were starting from in the application of Competencies. In addition, the Team learned how to utilize Gantt Charts. Subsequent meetings included a review of the AIM Statement, identification of fundamental Core Competencies applicable to all staff, Performance Appraisal Flow Charts (one for each Center, and a combination of two Centers, resulting in one flow chart for the Department, Appendix D), development of a Communication Plan to share information about Accreditation, Core Competencies, and Quality Improvement with all staff, and finally how to incorporate Core Competencies into the Performance Appraisal for all titles.

Goals and Objectives
To prepare for Accreditation
- Completion of NACCHO LHD Self-Assessment Tool for Accreditation
- Identify a Quality Improvement Project
- Develop an AIM Statement
- Implement a Quality Improvement Project
- Improve how the Department conducts business

To improve the application of public health competencies in measuring performance throughout the Department
- Develop fundamental competencies applicable to all staff
- Develop a uniform Performance Appraisal process affective for all Centers
- Develop/adopt competencies for all titles in the Department
- Incorporate competencies in the Performance Appraisal form

In retrospect, the Department started with one goal: To prepare for Accreditation. As the Team completed the objectives determined by this project, it became clear that there was additional work to be completed. Incorporating competencies into a performance measurement is not simple, many additional steps (e.g., uniform performance appraisal process, Communication Plan, deciding which titles to apply competencies to, which competencies) needed to be completed. The Accreditation Team, still working toward the ultimate goal of Accreditation, is aware of the many facets still to be addressed.

Self-Assessment
Led by a skilled Facilitator the Accreditation Team diligently worked toward completing the Self-Assessment Tool. The Team agreed at the onset, to use consensus building as a means to score each element. Healthy discussions occurred, which ultimately led to a score decision; also evident was a greater awareness among the entire Team of the services provided by the Department. (The lack of awareness among this level of staff points to the need for improved communications among the Centers and management staff.)

Interesting to note, the Team was intent on scoring as high as it could, often negotiating with each other as to what the score should be. Honesty prevailed, and the Team noted areas that the Department needed to ‘tweak’ in order to score higher. The Team was overall pleased with the results, acknowledging the challenges they faced in the efforts to prepare for Accreditation. The chart below highlights five (5) results from the self-assessment that was noteworthy.
### Highlights from Self-Assessment Results

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<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
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| 5. C. 1-3, 5         | LHD Role in Implementing Community Health Improvement Plan  
  - This was an area of particular strength. The Department has worked with the Community Health Partnership since 1996 to conduct Community Health Assessments, determine community needs, and develop a plan of implementation. MAPP was completed in 2002 and is currently underway again. |
| 5. C. 4              | LHD conducts a formal strategic plan.  
  - This was an area the Team agreed required attention and improvement. The Department has not conducted a departmental strategic plan; although this was identified as a possible QI project, the Team agreed to put the strategic planning process on hold until the next Community Health Assessment was completed. (expected completion date is April 2009) |
| 8. A. 5             | LHD determines needed competencies, composition, and size of workforce.  
  - The Team identified this area, with a low score, as needing improvement and as the QI project. The Department does not have measurable competencies in place for all positions. |
| 2. A. 1-3           | Routine Outbreak Investigations  
  - The Team strongly agreed that staff is very skilled in this Essential Service, and is a strength. |
| 1. B. 3             | LHD uses a quality improvement process  
  - The Team agreed this indicator as well as other indicators (IX. A. 4,5; IX. B. 2.; IX. C. 3.) required improvement through a systematic QI process. After this QI project, these areas undoubtedly will be addressed. |

### Quality Improvement Process

**AIM Statement:** To develop a Department-wide, consistent set of standards against which to measure performance competencies.

**PLAN:** Based upon completing the *LHD Self-Assessment Tool for Accreditation Preparation*, the Accreditation Team identified four potential areas for Quality Improvement (QI). After a detailed discussion, consensus was reached and the Team chose **Core Competencies** for the QI project. The Core Competencies cross-walked several of the Ten Essential Services; the Team believed that by adding Core Competencies to the Performance Appraisal Process, several areas indicating improvement would be addressed. The Department has an adequate Performance Appraisal process and form, however the form lacks specificity with regard to Competencies. The Accreditation Team defined competency as: ability to meet an established standard, ability to do a job successfully, highly knowledgeable of skills and capable of managing a situation, ability to carry out a plan with confidence, attain a desired goal that can be evaluated, able to perform a task within a skill set, and assuring that a skill or action will be performed. The Accreditation Team was asked key questions; their responses are listed:

- Why are adding Core Competencies to the Performance Appraisal Process important?  
  - There is a correlation between competencies, efficiency, and effectiveness  
  - Validation of competency  
  - Increase credibility  
  - Creates a standard-consistency  
  - Learn from history  
  - Determine success factors
What is the cost of not having Core Competencies in the Performance Appraisal Process?
- Loss of productivity
- Loss of time and resources
- Loss of funding
- Loss of customer base

Issues (moving to a new state where Core Competencies are part of the Performance Appraisal Process)
- Time line, how long will it take?
- What steps?
- How detailed, every job, every person, all at once, where to start?

What might change (consequences of not moving to future state) if we do not have Core Competencies in the Performance Appraisal Process?
- Lose efficiency
- Lose market area
- Reliability in public eye
- Lose work force

The Accreditation Team, utilizing the Force Field Analysis, identified the strengths that would contribute to the success of the QI process, as well as barriers that could potentially negatively impact the QI process.

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<th>Minus</th>
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<tr>
<td>Staff is open to change</td>
<td>Time</td>
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<tr>
<td>Administrative support</td>
<td>Staff resistant to Change</td>
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<tr>
<td>Staff is committed to excellence</td>
<td>Uncertainty of change</td>
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<td>Positive community health impacts</td>
<td>High anxiety related to performance</td>
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<td>Some competencies already exist</td>
<td>Current generic nature of performance</td>
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<tr>
<td>Opportunities for advancement</td>
<td>Appraisal</td>
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<td>Objective employee assessment</td>
<td>Money for training</td>
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<td>Enhance competency cross training</td>
<td>Civil Service restraints</td>
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Based upon the above, the Accreditation Team concluded that competencies are fundamental to any practice; therefore the QI project to incorporate Core Competencies into the Performance Appraisal process was chosen. After an in-depth discussion, the Team realized that incorporating Core Competencies into the Performance Appraisal Process was multi-faceted and there were several tasks that required completion before the inclusion could take place.

Task #1-Beginning with the Radar Charts, the Team moved into identifying fundamental core competencies that could be applied across all titles/positions within the Department.

Task #2-The next step was to analyze the Performance Appraisal process (application of process) and develop a singular process understood and implemented consistently by each Center.

Task #3-Once completed, the Accreditation Team’s plan was to develop a plan to explain Accreditation, Core Competencies, and the process, to the entire DOH staff (a Communication Plan).

Task #4-Select certain titles that might be grouped for Core Competencies
Task #5-Incorporate the Core Competencies (developed or adopted) into the Performance Appraisal Process.

Each Task is outlined in the PDCA and is identified below. However, Tasks are at different levels of completion, therefore for the purpose of this report, the focus will be on Tasks #1 and #2.

DO: The Accreditation Team is comprised of the six Center Directors (in the fall, a new Center was created, adding the 6th Center Director), eleven Supervisors and one staff member. Throughout the QI process the Team had the advantage of a Facilitator and Consultant. The Facilitator began working with the Team from the onset, objectively leading the discussions through the LHD Capacity Self-Assessment Tool and determining the QI Project. The experienced Consultant spent a day with the Accreditation Team providing information and training on Quality Improvement, presenting a vast array of tools to be used, and guiding discussions related to the QI process. In addition to the Radar Charts sited above, the Team utilized Process Mapping, a Process Decision Program Chart, Stop-Start-Matrix-Gantt Charts, and the PDCA forms. These tools have proven to be very useful in the QI process, and have been applied and incorporated into the daily work plan.

The Accreditation Team agreed upon an AIM Statement, or goal for the Quality Improvement Project; to develop a Department-wide, consistent set of standards against which to measure performance competencies.

Task #1-The Accreditation Team evaluated how each Center rated (scale of 1-5) utilizing the Eight Core Competencies (developed by the Council on Linkages), and then each Center evaluated how the Department ranked (scale of 1-5). The team approached the project by identifying fundamental core competencies that all staff within the Department would be expected to achieve. These fundamental core competencies will be incorporated into the Performance Appraisal form.

Task #2-Discussion also served to uncover that, although there is a Performance Appraisal process (guidance document) in place, each Center varied somewhat from the process. Flow charts for each Center’s process were developed, consolidated into two flow charts, then into one (Appendix D).

Task #3-The Communication Plan has been developed with an established schedule for presenting the information to staff in January.

CHECK: Task #1-The similarities among the Centers for both analyses were astounding and gave reassurance that the Team (and Department) was on the right track. Using the Eight Core Competencies, the Team identified 1-3 elements for each that all staff, regardless of title, job description, or Center, would be expected to meet. Once these fundamental competencies were identified, there was detailed discussion, with examples as to how they would apply to each staff member. The Team is confident that these fundamental competencies are the first step toward completing the QI project and understanding that the QI project will be ongoing for several years.

Task #2-Currently, staff is tracking the amount of time from commencing the Performance Appraisal process to completion, to determine if the process is too lengthy, if there are barriers, and/or if there are ways to streamline the new process. The estimate was that the process could take from 4-8 weeks (from the first meeting with the staff member to the staff person receiving the final, signed copy). Thus far, based upon one month of analysis, the process is taking less than three weeks.
Task #3-The Accreditation Team developed a Communication Plan (Appendix E) to be implemented that would keep all staff informed and engage them in the process of QI and Accreditation. Three smaller teams are meeting to:

A. Develop common message and talking points;
B. Visual reminders of QI project/task/outcome; and
C. Develop Action Statement to engage staff.

**ACT:** The QI tools have been incorporated into the day-to-day work of the Department. Staff is utilizing several tools to prepare for a project or to plan for a project. It is anticipated that the QI process will have long lasting effects on the Department's program evaluation plan. (This is an added bonus and actually addresses another area, program evaluation, identified in the self-assessment in need of attention.)

Continue with the QI process. This will include, completion of the above, utilizing the tools learned from this project in other QI projects (may be as technical as preparing a report, addressing a performance competency, or as global as implementing a work plan); and incorporating the QI tools into the daily work plans.

Task #1- Incorporation of the fundamental Core Competencies will be incorporated into the Performance Appraisal form, commencing February 2009. (It was decided to implement this once the entire staff has been informed of the QI project).

Task #2- The singular process and time frame for Performance Appraisals will be evaluated after three months (February 2009).

**Results**
The QI project has resulted in several positive outcomes, however the Accreditation Team has acknowledged that their work has 'just begun'. The Team worked in concert to meet the goals, respecting differing views and asking key questions for clarification. The Team developed fundamental competencies applicable to all staff, (Task #1); created a flow chart describing a unified process for Performance Appraisals, (Task #2); and has a work plan established for the next ten months. Two outstanding accomplishments not anticipated were: The Team embraced the QI process and is utilizing QI Tools (especially the Gantt Chart and PDCA form) for work plans. Applying the QI process will address another area in need of improvement, program evaluation. This is a definite added value.

The Team is enthusiastically determined to add Core Competencies to the Performance Appraisal that are relevant, applicable, and not cumbersome. They are willing to give the time and effort to this next Phase. The ultimate goal of achieving Accreditation was described with zeal and stimulated new support for the next Phase.

**Lessons Learned**
There were several lessons learned during the process. The Team is a cohesive group that has worked together on various projects before. The preparation and discussions since 2000 pertaining to the Operational Definition, Ten Essential Services, and voluntary Accreditation were key to the success of this project. Staff had prior knowledge and exposure, which helped them to be prepared for this project. Having an outside Facilitator was especially helpful; the Facilitator was objective, not from the health care world, therefore had no biases, and kept the Team on track (they like to wander). The grant also allowed the Department to contract with an experienced Consultant, which gave the staff the opportunity to learn from an expert about Quality Improvement. They were exposed to several QI tools, which can be and are currently applied to other walks of their public health life.
Next Steps
The Team is ready to move into Phase 2, which captures the next steps for the QI project and preparation for Accreditation. The Team has developed a Communication Plan that will provide information to the entire staff about the Quality Improvement project, Core Competencies, and Accreditation. The Gantt Chart, Appendix E, (Communication Plan) outlines the work expected from January to October 2009. Not only does this QI project address a deficit found in the Self-Assessment matrix with regard to Core Competencies, it also addresses the need to improve on evaluations for programs and services. A recent review of the Self-Assessment results indicate that this QI project has moved the Department closer to Accreditation readiness. The information shared, exposure to the various tools, and applicability to the Ten Essential Services is not only a benefit not anticipated, but enhances the Department’s ability to meet the indicators.

The Accreditation Team has identified the next steps as follows:

Phase 2-Next Steps:
1. Identify the Core Competencies required for each title, incorporate them into the Performance Appraisal Process
2. Identify the order in which titles will be worked on
3. Identify existing competencies that are appropriate/applicable and can be incorporated into the Performance Appraisal process
4. Implement the Communication Plan (Appendix E)

Conclusions
This was a very positive experience for the entire Team. The outcomes surpassed expectations and there was additional value added with the QI in-service that positively impacts the Department in its daily work. The Accreditation Team learned a great deal, they established a plan to meet the ultimate goal of Accreditation and they are enthusiastically energized to move forward. The success of the project can be attributed to several factors; a competent Facilitator and competent Consultant; the Team’s motive to ‘Be the best that we can’, the Team’s desire to improve and of course, the desire to be Accredited. Our sincere thanks to NACCHO for the opportunity to participate in the Self-Assessment Tool and engage in a Quality Improvement Project and to our Facilitator and Consultant for their expertise, patience, and guidance.

Appendices
Appendix A: QI Storyboard
Appendix B: Gantt Chart 1,2,3 and PDCA 1,2,3,4
Appendix C: Radar Charts
Appendix D: Performance Appraisal Flow Chart
Appendix E: Communication Plan