

Guide to Organizational Self-Study Process

Overview

Local health departments (LHDs) nationwide are striving to meet a set of nationally recognized performance standards and measures (S/Ms) established by the Public Health Accreditation Board (PHAB), a non-profit formed to serve as the accrediting body for governmental public health agencies. As a part of PHAB's accreditation process, aspiring agencies will undergo an organizational self-study to identify strengths and uncover gaps in agency performance. Over the years, LHDs have undertaken self-assessments through a number of different efforts including the Operational Definition of a Functional Health Department, state based standards or accreditation programs and others. Although this guide to completing an agency self-study is designed to help LHDs organize and prepare for accreditation, it also serves as a valuable tool for those undertaking a self-study outside of the PHAB accreditation process. Whether deciding to apply for accreditation or not, undergoing a self-study is a valuable process providing agencies with the means to assess and understand their own systems and program operations in order to strengthen the services delivered to the community.

Adapted from the Assessment Protocol for Excellence in *Public Health* (APEXPH) framework--a planning tool from the 1990s that was developed to guide LHDs through assessing and improving organizational capacity and working with local communities to improve the health status of their residents--this document provides broad guidance on completing the following four principal steps in conducting an organizational self-study, along with two optional steps on how to act on self-study results to bring forth continuous improvement:

- Step 1:** Initial Preparation
- Step 2:** Gather documentation and score measures
- Step 3:** Identify and analyze strengths and weaknesses
- Step 4:** Prioritize problems
- Step 5 (Optional):** Implement quality improvement (QI)
- Step 6 (Optional):** Institutionalize assessment and QI processes

Upon completion of a self-study (Step 1-4), the LHD will have a list of top priority areas for improvement. Although the self-study process itself is valuable, acting on the results of the process will make certain that improvements are made (Step 5). The self-study serves as a precursor to continuous quality improvement (CQI) efforts as the results of the process can be used to address identified gaps through CQI processes. This guide takes the LHD one step further by providing resources to implement CQI processes. Ideally, self-study and CQI are iterative processes rather than isolated events, and should be embedded as a part of an agency's planning cycle, repeated at regular intervals with demonstrated improvements between cycles (Step 6).

Step 1: Initial Preparation

This step is primarily the responsibility of the Health Director and/or a designated Accreditation Coordinator. It occurs in the following three stages, which will likely overlap:

1. Orienting the staff
2. Forming a team
3. Developing a plan

Orienting the staff

After deciding to undertake the self-study process, the Health Director should first recruit or appoint an Accreditation Coordinator, who can provide leadership as needed while overseeing the self-study and/or accreditation process. For additional guidance on selecting or delegating an Accreditation Coordinator, read PHAB's [Accreditation Coordinator Handbook](#).

At some point during the organizational self-study process, every member of the agency's staff will likely be involved. For the process to be successful, not only must the Health Director visibly and actively support the process, but the health departments' staff at *all* levels must be committed to the work. Listed below are some considerations for orienting and engaging staff in the self-study process:

- **Department-wide orientation** - Staff should be given an overview of the self-study process including information regarding the purpose, necessary time commitment, and steps and activities involved in the process. At this time, the Health Director can also enlist staff support by communicating the potential benefits of the process and instill an appreciation for the role that a self-study plays in cultivating positive change and CQI. The Health Director may also introduce the staff member that will serve as the Accreditation Coordinator, if he/she elects to delegate that responsibility.

If the self-study is done as a part of the PHAB accreditation process, it is important to explain the importance of accreditation and how it will impact the agency. In particular, staff without a public health background will likely be involved in the process and may need more contextual information before contributing. NACCHO has developed 'ready-made' training materials including a PowerPoint presentation and presenter's guide designed to inform LHD staff about accreditation and its importance to the agency. These materials can be accessed on the NACCHO website:

<http://www.naccho.org/topics/infrastructure/accreditation/trainings.cfm>.

- **Ongoing communication** - During the course of the self-study process, regular staff briefings, status reports, or other consistent communication is critical in order to ensure that staff are kept informed of the progress and results.

Forming the team

Because the self-study process takes considerable time and effort, the Accreditation Coordinator should put careful consideration into forming the accreditation preparation team to facilitate an efficient process. An accreditation preparation team is made up of staff throughout

the LHD and is responsible for implementing the self-study process, analyzing the results, and making recommendations regarding program improvements based on the results. The purpose of this process is to conduct a comprehensive assessment of the agency as a whole, and therefore it is often valuable for the team to represent members from all levels of management and staff, and all program areas. This will ensure that the wide range of skills and expertise required to conduct the self-study are available.

Typically, the accreditation preparation team is comprised of any combination of the following: 1) Health Director; 2) Accreditation Coordinator; 3) Senior Management; and 4) Program Staff. The composition and size of the team will vary from one health department to another and it is important for the Health Director and Accreditation Coordinator to take the following points into consideration before recruiting team members:

- Size of LHD
- Organizational structure
- Manner in which responsibilities are assigned to staff
- Workload
- Time it will take to collect evidence and adequately complete the self-assessment
- Subject matter expertise

General guidance on selecting senior management and/or program staff for the accreditation preparation team, including desired characteristics and responsibilities, are summarized in **Table 1** below:

Table 1: Considerations for Selecting the Accreditation Preparation Team Members

Staff Type	Possible Staff	Characteristics	Responsibility
Senior Management	<ul style="list-style-type: none"> • Agency director • Division directors • Senior managers 	<ul style="list-style-type: none"> • Objective/Unbiased • Effective delegators • Effective communicators • Strong leadership skills 	<ul style="list-style-type: none"> • Design and lead the process • Analyze results • Formulate recommendations for CQI efforts • Break ties
Project/Program Staff	<ul style="list-style-type: none"> • Program managers • Program staff 	<ul style="list-style-type: none"> • Objective/Unbiased • Organized • Documentation skills • Subject matter experts 	<ul style="list-style-type: none"> • Provide information and expertise on S/Ms • Collect and organize documentation as evidence for meeting S/Ms • Serve as ambassadors to general staff about the process

Developing a plan

Once the key players in the process have been identified, it is time to establish a deliberate plan of action to ensure efficiency and effectiveness among team members by appropriately delegating responsibilities, training the team, and developing a timeline. During the initial planning phase of the self-study process, the Accreditation Coordinator should consider developing a team charter which is a written document that clarifies the team mission and how to achieve it. The following resource can assist in team chartering:

- Duffy, G. L., Moran, J.W. (2010). *Team Chartering*. Access: <http://www.phf.org/pmqi/Team-Chartering.pdf>.

Delegate responsibilities

In addition to identifying the right people for the process, it is important to determine the best way to organize the way in which the team will function. There are several ways this can be done and each agency should accommodate its own specific needs. Methods used by other LHDs include:

- **Model 1:** The accreditation preparation team is comprised of the Accreditation Coordinator, senior management and program staff. Senior management, including division directors, assign specific domains or S/Ms to staff in their respective divisions or programs based on area of expertise (e.g. the Health Education Service Unit Senior Manager may be in charge of Domain 3 – *Inform and educate about public health issues and functions* - and delegate the S/Ms under Domain 3 to the LHD’s community health educator). These staff members gather documentation for their assigned S/Ms and score each measure based on their findings. Senior management will then analyze these results and make recommendations. This model is commonly used among large LHDs.
- **Model 2:** The accreditation preparation team is comprised of the Accreditation Coordinator and senior management. Together they divide all the standards and measures amongst themselves and complete the entire process, including gathering documentation, scoring standards, analyzing results, and making recommendations. This model is more typical in mid-sized LHDs.
- **Model 3:** The accreditation preparation team is comprised of the Accreditation Coordinator and the Health Director. The Health Director may also choose to serve as the Accreditation Coordinator and complete the entire process. Typically in very small LHDs, the entire self-study process could be successfully implemented with only these one or two individuals.

Though the suggested team structures have been successful with other LHDs, there is no one ‘right’ way to undertake this process. The Health Director along with the Accreditation Coordinator must put careful consideration into the best method for the agency. **The remainder of this document may seem to refer to larger teams that follow Model 1 but this guidance is intended to accommodate all accreditation preparation teams, regardless of the model that is used. Whether the team is a multi-member team or just comprised of one or two individuals, each step outlined in this guidance document will need to be completed.**

Train team members

Once the team composition has been determined and a plan for delegating responsibilities has been agreed upon, it is important for the Accreditation Coordinator to provide training to team members to ensure consistency. Training content should include the purpose of the self-study and how the results will be used, detailed description of the process, discussion of relevant documents including the [PHAB Standards and Measures Version 1.0](#) and the [National Public Health Department Accreditation Documentation Guidance](#), and assignments for S/Ms. It is also recommended to instruct each team member to thoroughly review the relevant documents prior to the beginning of the self-study process.

Develop timeline

Developing a full timeline for the self-study process, including the initial assessment and acting on its findings, is integral in ensuring that the team has a good understanding of the time and commitment required to stay on track with the process. The time required to complete the self-study process will vary greatly from one LHD to another and will depend on the size of the agency and available staff and resources to devote to the process. **Appendix A** provides a template to set target dates for the outlined steps in the self-study process.

Because this process may require a substantial amount of staff time, it is very important for the Health Director to allow staff to allot time for this process. Leadership support of the process will encourage agency staff to view the time and effort needed to complete the self-study as an important component of their workplans as opposed to extra work.

Step 2: Select and Organize Documentation

This step is the responsibility of the entire accreditation preparation team, and possibly additional staff, and will require the following action:

1. Gathering documentation as evidence of meeting S/Ms

Gathering Documentation

The guidance offered in this section is specific to the PHAB process. If a different self-study or self-assessment tool is being used, the LHD should develop a plan that follows documentation and/or scoring guidance from that tool.

In this step, team members will gather documentation to show conformity to PHAB S/Ms and use this information to score each measure. At this point, all team members should be aware of the S/Ms for which they are responsible for gathering documentation and have had the opportunity to review them in the PHAB Standards and Measures. Available on the PHAB website, www.phaboard.org, are the two primary tools needed to complete this step:

1. [PHAB Standards and Measures Version 1.0](#) – This document serves as the official standards, measures, and required documentation for PHAB national public health accreditation. It provides guidance on the meaning and purpose of a measure and the types and forms of documentation that are appropriate to demonstrate conformity with each measure. The standards are based on the Ten Essential Public Health Services and

- focuses on “what” the health department provides in services and activities, irrespective of “how” they are provided or through what organizational structure.
2. [National Public Health Department Accreditation Documentation Guidance](#) – This document provides general guidance for health departments to consider when selecting the specific documentation that will be submitted to PHAB for each documentation requirement contained in the PHAB Standards and Measures, Version 1.0.

The instructions below (taken from the PHAB documents listed above) summarize how to use and interpret the PHAB Standards and Measures while gathering documentation:

1. **Gather documentation** – The necessary documentation for each measure is listed in the PHAB Standards and Measures. Each measure includes: 1. Purpose Statement describing the public health capacity or activity on which the agency is being assessed; 2). Significance Statement describing the necessity for the capacity or activity that is being assessed; 3). Required Documentation listing the documentation the agency must provide as evidence that it is in conformity with the measure; and 4). Guidance which describes guidance specific to the required documentation. The following bullet points provide guidance for collecting evidence. The following bullet points provide additional tips and guidance on how to select documentation:
 - No draft documents will be accepted for review by PHAB.
 - All documentation must be in effect and in use at the time that they are submitted to PHAB.
 - Documents must be submitted to PHAB electronically.
 - A PDF version of all documentation is preferred. If a document is not a PDF, it should be in a commonly used program such as Word, Excel, or PowerPoint.
 - Documents created using health department-specific software, special graphics, or other program not commonly used, will not be accepted.
 - In many cases, a measure is demonstrated only once, at a central point in the health department. Examples of these types of documentation requirements include department-wide policies (such as human resource policies), procedures, and plans. In these cases the requirement is for a specific, central document, rather than for examples.
 - Where documentation requires examples, health departments must submit two examples, unless otherwise noted in the list of required documentation or the guidance.
 - Health departments are encouraged to provide narrative that describes how the submitted document relates to and meets the requirement.

Visit [NACCHO’s Example Documentation for Accreditation website](#) for a repository of examples of documentation from other local health departments.

2. **Organize the process:** LHDs will be required to upload the required documentation into, *e-PHAB*, PHAB’s on-line system. It is important to also create an internal system to organize the documentation and streamline the process used to gather it. This can be accomplished by creating a document or spreadsheet listing the measures, the person(s)

responsible for each, the corresponding documentation, and the location of that documentation. The [PHAB Documentation Selection Spreadsheet](#) offers a blank template for staff to organize documentation.

Step 3: Identify and Analyze Strengths and Weaknesses

This step is *typically* the responsibility of the Accreditation Coordinator and/or senior management members of the accreditation preparation team and will require the following actions:

1. Identifying strengths and weaknesses in agency functions
2. Analyzing strengths and weaknesses

Identifying Strengths and Weaknesses

At this point, the self-study should be complete, with documentation provided for each measure. It is now time for the Accreditation Coordinator and/or the senior management members of the accreditation preparation team to study, analyze, and process the results in order to identify the major strengths and weaknesses of the agency. To begin this process, the team must first aggregate the results within each domain and each standard and display it in a way that will allow the team to easily identify strengths and weaknesses. Next, the team should collectively examine information and make note of, and record, domains with a large number of standards and measures that have not been met. For example, those with a high number of measures where documentation exists are considered areas of strength, while those with a large number of measures where there is no documentation serve as general areas on which to improve. This process will assist in gaining insight and developing a plan of action.

Analyzing Strengths

It is useful to examine the identified agency strengths because the factors that contribute to the strengths may be applicable to finding solutions to identified weaknesses. Drawing upon strengths from one area and applying them to develop and support new strategies in other areas will support an agency's efforts in CQI. After identifying and reviewing the S/Ms that were identified as being strengths, the team must examine all the S/Ms that seem to demonstrate the same strength and discuss what factors contributed to it. For instance, similar strengths across multiple S/Ms could include emerging themes such as having appropriate policies or procedures in place, having in-house staff expertise, staff development opportunities, fostering partnerships with stakeholders, etc.

This step highlights positive aspects of the self-assessment and provides an opportunity to celebrate the successes of the agency. The Health Director may want to consider sharing these findings with stakeholders including the entire staff, or the community.

Analyzing Areas for Improvement

Analyzing areas for improvement uncovered by the self-study is a stepping stone for developing a quality improvement process that will result in solutions. An agency may choose to do this by first defining the problems at one of the following four levels and identifying areas of analysis for that level:

1. **Individual Measures** – Includes weaknesses on individual measures. The team should prepare a problem statement for each measure scored as a major weakness. *Although this level of analysis requires less discussion about any one problem, it does not provide a good picture of the major problems in an agency.*
2. **Individual Standards** – Includes weaknesses among individual standards. The team should consider each standard and identify one or two problem statements that describe the set of measures that were identified as areas for improvement. *This level of analysis begins to provide surface level insight into the problems in an agency.*
3. **Domains** – Includes weaknesses among multiple standards and measures within domains. The team should consider each domain and brainstorm the fewest problem statements possible to describe the measures that were identified as areas for improvement. *This is a higher level of analysis and provides more insightful information.*
4. **Cross-Domain Clusters** – Includes all weaknesses, across all domains that seem to cluster around a common theme. The team should identify weaknesses in several sections that result from the same general problem. *This level of analysis should result in the broadest and most thoughtful analysis of the agency allowing for insights into systemic problems and offer a platform for improvements that have the potential to solve problems that exist in different forms throughout the agency.*

Step 4: Prioritize Problems

This step is primarily the responsibility of the Accreditation Coordinator and senior management members of the accreditation preparation team although the entire team, staff, and other stakeholders could also provide input. At this point, it is likely that the agency has multiple problem areas that need to be addressed and with limited resources, time, and staff, an agency cannot begin to address all of them at once. This step will require the team to select and implement a prioritization technique.

Employing a defined prioritization technique provides a structured mechanism for objectively ranking issues and choosing a focus area. Prioritization techniques also provide a mechanism for gathering input from the entire team and taking into consideration all facets of the competing issues. Five commonly used prioritization techniques include:

1. Multi-voting Technique
2. Strategy Grids
3. Nominal Group Technique
4. The Hanlon Method
5. Prioritization Matrix

The accreditation preparation team should choose a prioritization technique based on the individual needs of the agency. Each of the techniques listed above are ideal in different settings and have their own unique characteristics. Additional guidance on choosing a prioritization technique and detailed instructions and examples of application of these techniques is provided in [“Guide to Prioritization Techniques.”](#)

Step 5: Implement Quality Improvement

It is quite likely that many, if not all, high-priority focus areas identified through step 4 can be addressed through QI processes. Prior to planning and implementing QI processes, it is important to form a QI Team. While the QI team may comprise members from the accreditation preparation team, it also is customary to include front line personnel and staff that are routinely involved with the chosen focus area as the QI cycle is implemented. Prior to initiating any QI processes, it is recommended to develop a team charter to provide the team with a clear and concise plan of action. The following resource provides guidance on writing a team charter:

- Duffy, G. L., Moran, J.W. (2010). *Team Chartering*. Access: <http://www.phf.org/pmqi/Team-Chartering.pdf>.

The Plan-Do-Check-Act cycle (PDCA) has been embraced as an excellent foundation for, and foray into, QI for public health departments, as it is both simple and powerful. Its simplicity comes from the systematic, straightforward and flexible approach that it offers. Its power is derived from its reliance on the scientific method, i.e., it involves developing, testing, and analyzing hypotheses. This foundation offers a means to become comfortable with a host of quality improvement methods and techniques, and to progressively evolve into addressing more complex problems, employing additional QI tools, and migrating to system-wide approaches to QI. The following resources provide guidance to the PDCA process:

- Gorenflo, G., Moran, J. W. (2010). [*The ABCs of PDCA*](#).
- [*Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook*](#)
- Bialek, R., Duffy, G. L., Moran, J. W. (2009). [*The Public Health Quality Improvement Handbook*](#). Milwaukee, WI: ASQ Quality Press.
- [NACCHO Quality Improvement Website](#)
- [NACCHO Quality Improvement Toolkit](#)

Step 6: Institutionalize Assessment and CQI Processes

Agencies applying for PHAB accreditation will be required to undergo the reaccreditation process every five years, demonstrating improvement from the previous cycle. Accreditation is not simply a 'rubber stamp' but rather, a cyclical process of continuous improvement. As outlined in this guide, the self-study process naturally segues into CQI processes. The first round of an organizational self-study identifies a number of areas in which an agency can improve. The agency then selects the highest priority problems for correction. When the goals of the QI project are met for the first selected priority area the agency moves forward with institutionalizing the change. As a next step, the agency can move on to address the next highest priorities using the PDCA cycle and eventually, undergo another agency self-study process.

**Appendix A
 Organizational Self-Study
 Timeline Worksheet**

Step	Activity	Due Date
Step 1: Prepare for a self-study	Department-wide orientation	
	Identify and recruit senior management and program staff to the accreditation preparation team	
	Delegate responsibilities	
	Train team members	
Step 2: Select and Organize Documentation	Create internal system for organizing documentation	
	Gather documentation to demonstrate compliance to standards	
Step 3: Identify and Analyze Strengths and Weaknesses	Identify and record areas of agency strengths and weaknesses	
	Define strengths and identify contributing factors	
	Define weaknesses and identify contributing factors	
Step 4: Prioritize problems	Choose a prioritization technique	
	Implement a prioritization process	
Step 5: Implement a QI process	Implement a Plan-Do-Check-Act cycle	