Accreditation Beta Test Quality Improvement Project: Final Report

PUBLIC HEALTH SOLUTIONS (CRETE, NEBRASKA)

NEW EMPLOYEE ORIENTATION IMPROVEMENT PROJECT

This report was completed by: Kim Buser, Maternal Child Health Project Coordinator, Accreditation Coordinator

---

EXECUTIVE SUMMARY

Public Health Solutions (PHS) serves a five-county region in rural Southeast Nebraska. The service area includes a total population of approximately 58,000 residents. Using the Public Health Accreditation Board (PHAB) self assessment and quality improvement tools provided by NACCHO, a comprehensive new employee orientation process was developed and implemented. By improving the previous new employee orientation, 100 percent of department staff received a perfect score on a knowledge test and employees who have been employed with the agency less than one year received a comprehensive refresher orientation.

BACKGROUND/INTRODUCTION

Being a relatively fledgling agency (formed in 2002), the staff and Board of Health members felt the timing was excellent to begin evaluating the function, structure, and effectiveness of the programs and services offered by PHS. The formation of a new health department naturally presents challenges. The opportunity to focus on capacity development and QI of systems and processes was welcomed by the PHS staff. Although there were initial concerns that the agency would not complete the process with an excellent grade, the benefits of self assessment and outside evaluation far outweighed any apprehension of the process.

BETA TEST SELF ASSESSMENT

The entire staff of 14 was involved in the collection of documentation. One staff person was assigned responsibilities as the point person for the project. The health director knew when beginning the process that many staff did not have a sufficient understanding of LHD responsibilities. While this circumstance put more of a burden on a few staff, it also succeeded in serving as a forum for educating staff, which was the intention. The Board of Health was intent on the participation of the department. Several were present at the meeting with the board leadership and the meeting with community members. Ideally, this process would have had more extensive involvement of board and community such as representatives included on the work team, but the developmental stage of PHS precluded that.

The major difficulty faced was inadvertently made by the department. The filing and record system lies among written and electronic files. The staff did not have enough organization of materials across the department to make organize the necessary documentation. The second major difficulty was that staff did not by practice document processes or decisions and discussions. Unfortunately, if it is not written one cannot say that it exists.

Another unexpected challenge was that there was a perception that the accreditation coordinator (original point person for the project) was primarily concerned with the mechanics of the process more so than the content. As the team worked their way through the process it seemed, at times, as if there was an emphasis on how to put together the information versus what information was available and appropriate. The second and perhaps greatest surprise was the accreditation coordinator's resignation within days of the site visit. Although adjustments were made and a new accreditation coordinator was

assigned to the project, it was a tremendous loss of knowledge and QI savvy when the original trained staff member was gone. PHS continued on with the process. The health director at PHS is quoted as saying, "From a personal perspective, I had thought we would do better than we did so at first it was a surprise to see the reality of the ratings. (I think that comes from my sin of pride.) I like to think that what I do is the best. However, with a second breath I fully embrace the scores and realize my reaction was an emotion and not justified by reality."

The beta test process has allowed all the staff to step back and assess what is being done well, and what is being done well but not documented, and what needs improvement.

Highlights from Self Assessment Results

Standard/ Measure	**Standard and Significance**
Domain 8.2 B	Assess staff competencies and address gaps by enabling organizational and individual training and development opportunities • This would ultimately become the catalyst for the QI project. PHS felt that new employees would benefit from a more comprehensive orientation and training. Training on the principles of public health including the core functions and essential services would provide a solid foundation for which specific roles within PHS could be expanded and refined.
Domain 9	The area in most need of improvement was that of Domain 9: Evaluate and continuously improve processes, programs, and interventions • It was no surprise to PHS staff that much good essential work is being done but the documentation to prove that it is being done was not always available or had not been created. The age-old dilemma of spending your time doing your work vs. spending your time documenting the work you have done continues to pose challenges and opportunities for PHS. The health director is invested in soliciting expertise in the area of policy and procedure development.

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

PLAN

Due to the small number of employees, the decision was made to include all employees on the team, resulting in a team of fourteen. A staff meeting is conducted every Monday morning from 9:30–11:30 AM and staff felt this would be an optimum time to address the QI project and meet as a team. Including all employees also helped to achieve the buy-in needed from each department/staff member. Like all public health departments, staff is stretched thin in their normal daily responsibilities and activities. Asking everyone to devote a good deal of time to the QI process was asking for time that was not available. As the group moved into the project and began to see the possibility of making real and lasting improvements to the organization, staff members were more willing to carve out the necessary time to make this process work.

PUBLIC HEALTH SOLUTIONS (CRETE, NEBRASKA)

The first step in identifying an improvement project was to look at the draft standards and measures developed by PHAB to determine the strengths and areas of improvement in current policies and procedures. The standards and measures are a system of guidelines used by PHAB and the local health department (LHD) in determining if the LHD meets performance criteria for national accreditation. General areas that could use improvement were discussed for several meetings. Team members brainstormed possible areas for discussion and then the coordinator, using the brainstorming information, developed a list of possible project areas. A multi-voting technique was then used to narrow a large list of 22 possible improvement projects down to one. By asking each team member to vote for the top two or three projects of interest, the list was narrowed down by each round of voting. The possible QI areas/projects receiving large amounts of votes in round one included the following:

- Standard 5.1.1B: Monitor public health issues under discussion by governing entities and elected officials;
- Standard 8.2.1B: Complete performance evaluations and improvements/training plans; and
- Standard 5.2.B: Reinforcement of our mission and goals. Develop and implement a health department organizational strategic plan.

After the multi-voting technique was complete, the team had chosen “Orientation of New Staff” as the improvement project. A few of the projects/ideas that were included in the initial voting but not chosen included the following:

- Developing a triage system for nursing in regards to the phone program and home visitation programs;
- Establishing agency policy and capacity to implement a performance management system;
- Getting the department’s name and what it does out to the community ; and
- Developing and distributing community health data profiles to support public health improvement planning processes at the local level.

These top vote-getters would later be voted out and eliminated. As evidenced by the topics addressed, the staff felt strongly that improving employee performance and knowledge was a top priority within the agency. Although all areas of possible improvement were important, the decision was made to focus on staff development and apply QI tools to other projects in the future. The organization had experienced a small amount of staff turnover in the past year. As new employees began their jobs at the agency, the issue of adequate and appropriate orientation became a larger priority. With a relatively new organization (organized in 2002) and most employees having worked at the department for less than five years, it seemed the time was right to improve the existing orientation procedures.

Next, the team worked to determine the root cause of the problem being addressed (insufficient orientation of new staff). Because there was not a comprehensive orientation procedure in place, the team felt that new employees were not receiving adequate basic information to feel comfortable in their jobs. Many employees had come with little or no direct public health experience and to hit the ground running meant spending little time and attention developing a solid knowledge base. As the analysis took shape, it became clear that team members were feeling remorse over not having addressed the problem sooner and a bit of defensiveness on why the orientation of new staff had not been made a priority before now. Newer employees explained how it felt to be the “new kid” in the organization and what things would have made their transition easier. Through the detailed (and time intensive) root cause analysis, it became clear that the organization had done an excellent job of getting programs and services up and running since 2002. Procedures such as the orientation of new staff

members were not an immediate need/priority in order to get the department on its feet nor were the resources available to implement a comprehensive orientation process. Now was definitely the right time to address this issue and (most importantly) it was a natural progression in the development and improvement of the young and growing health department.

While working on the fishbone diagram, a tool used to better visualize the root cause of our problem, the team explored several ideas on orientation and how it could be improved. The current process to orient a new employee included the completion of new employee paperwork (such as the I-9, etc), a brief introduction at a staff meeting, and the opportunity to observe different departments and activities at work. No formal structure or schedule existed to ensure that the employee received information on public health, the history of the department, or the specific programs currently being offered. Although a few employees had taken the initiative to visit with staff members from each department when they were newly hired, this had not happened with everyone. Many ideas were directly related to resources and the cost and time it takes to orient a new employee. Ideally, one person in the department would be responsible for this task and ensuring it is done correctly. PHS does not have the resources, however, to hire a person dedicated to human resources. After looking at all options, the team decided to proceed with improving the current orientation process and making each team member responsible for a piece of the process. The team also felt that this would be a good way for a new employee to get to know their new co-workers.

The team then developed an improvement theory:

If PHS implements the new comprehensive orientation program, then all employees will increase their knowledge of basic public health functions and new employees will begin their new roles in the organization with a basic understanding of public health functions and their specific role within the department.

DO

The team gathered baseline data in the form of a pre test that was administered to all 14 current employees. With feedback from the team, a 10-question survey was developed (see attached copy of the survey) with very basic, general knowledge questions. Staff determined that all employees, after receiving the new orientation procedure, would be able to answer all 10 basic questions. They administered this test before orientation to all current employees, identifying them by length of employment with the department. All five employees who had been with the department less than a year missed one question each. (Please see Pareto chart included in the appendices). The two questions that were missed by one or more employees were related to the three core functions and general health priorities for public health ("Preventing childhood obesity is a high priority for public health departments"). This was the data needed to move forward in testing the new orientation procedure.

The next step was to test the improvement theory by administering the newly developed orientation process to the newer employees who had missed at least one question on the pre-orientation survey. Three members of the employee group that had been with PHS less than one year and were considered new participated in the mock orientation procedure. The newly improved orientation procedure was developed as a result of team meetings and open discussion. The team brainstormed what an ideal new employee would look like when orientation was complete. What knowledge would they have as a result of orientation? Would they feel comfortable and confident in beginning their new job? Would they have a basic understanding of the organization and what services are provided? All ideas for what should be included in a comprehensive orientation process were discussed and the group came to

consensus on the basics that needed to be included in order to provide a solid, comprehensive orientation. The accreditation coordinator, using direction from the team, took the lead in developing the following:

- A welcome letter with specific instructions on when/where to report for the first day of work, who their supervisor would be, what personal identification to bring, etc.
- A master checklist of each department and the supervisor in charge of that department with a scheduled appointment to spend time with that supervisor. Each department head developed their own inner-departmental checklist on content area, based on the core functions and 10 Essential Public Health Services.
- An orientation manual, complete with important information such as use of the phone system, office layout and staff names, department policies and procedures, and general information regarding our district and public health philosophy.
- A pre- and post-survey asking 10 very basic questions on the department and services provided.
- An appointment with each of the department heads and the health director to learn about services, programs, and public health. PHS called this Public Health 101 and the label has stuck and is now widely used within the agency.

Upon the development of the above items, three new employees were given the complete orientation process just as if they were new to their jobs. The entire process only took one afternoon and the three participants were amazed at what they did not know about public health and the great work being done throughout the department.

CHECK

Upon completion of the orientation process, each of the participants was given the post-survey based on the pre-survey that they had taken prior to the orientation. Not only did each participant answer 100 percent of the questions correctly, they were energized and excited to show off their increased knowledge of the agency and public health in the district.

The success of the mock orientation was evident. Comments from the participants included the following:

- “I had no idea that so much diverse work goes on here.”
- “I have a newfound respect for the tremendously talented individuals that work here.”
- “It’s amazing that such a small staff accomplishes so much.”
- “I wish I could have had this information when I started my job. It would have made a world of difference.”

The staff was unanimous in deciding to implement the newly improved orientation procedure.

ACT

It is with a tremendous amount of pride and a bit of relief that the team finalized the newly improved orientation procedure. The agency has taken steps to ensure that the orientation process will be followed and implemented completely with each new employee. Those steps include putting all documents on a shared computer drive, including all forms that would be placed into a new employee manual, assigned responsibility for each step of the process to individuals, and a commitment by the

accreditation coordinator to revisit the process at least twice annually for any needed changes or further work.

The accreditation coordinator feels that all staff members, even those that received a 100 percent on the orientation pre-survey, should participate in a mock orientation. The information and insight gained from this exercise would be useful to everyone in a small staff such as PHS. Completing a major undertaking such as this would take a great deal of time and scheduling. The goal for the coming year will be to have each department head present their orientation at a weekly staff meeting. This will allow each department to practice their orientation presentations and provide a detailed overview of what is currently happening in their work area. Scheduling one departmental presentation per month will allow all employees to hear what is going on within the organization without trying to coordinate a mass orientation event.

RESULTS, NEXT STEPS, AND ACCREDITATION

Although staff knew that developing a more comprehensive orientation procedure would benefit future employees, no one could have guessed the tremendous impact the project had on the newer employees.

The resources made available to the organization regarding quality improvement tools were particularly beneficial. With this knowledge and a bit of excitement, the team can move ahead and apply these principles to other areas of work. The health director is making plans to apply QI and planning tools several programs' development of policies and procedures. The use of these tools and the ability to follow the QI process from beginning to end will allow PHS to better meet accreditation standards. Throughout the entire process, close attention was paid to how the work directly related to the PHAB standards and how the work might help PHS better prepared for national accreditation.

The accreditation coordinator, armed with a tremendous amount of resources and knowledge on QI techniques, will keep the conversation at the forefront of the agency as it moves to the next step in the journey.

LESSONS LEARNED

Below are some thoughts from the PHS health director:

"First, I believe we spent a lot of wasted time pulling together inadequate documentation rather than focusing on meaningful discussions of the assessment measures. Perhaps this was inevitable for beta test sites since many may have gone into the process realizing that they had a lot of work to do to meet accreditation standards. I think it points to the importance of leadership having some idea of the scope of evidence that would be required for accreditation. While we were asked to examine our readiness, I am not sure if that brief statement adequately conveyed this point. Again, the leadership should have some sense of the base of documentation required otherwise the self assessment process is likely to get bogged down in addressing obvious deficiencies, which is not a good use of the time of an accreditation assessment team.

"Second, care should be given to training in the methods used to assemble documentation, a review of the core functions and essential services and the way in which they need to work and make decisions. All should be laid out. Our process could have been much more effective had we organized our records in a more thoughtful manner to better enable retrieval of official records and the documentation of the most recent internal decisions. Regrettably, in our fairly new and small agency that information was in

the minds of people and it was a problem when those people were no longer with the agency. A result of the lack of coherent organization of records, we wasted a lot of time searching rather than using our time as it should have been with meaningful discussions of our work in comparison to standards. Likewise, we were exasperated in our process when we realized how little documentation we had of within agency decision-making. We could not claim adequacy of our performance because we had no written documentation of it. We also realized that we limited our internal opportunities to learn from the past by not documenting what we had decided, how we decided it and the outcome. It would be wonderful if guidelines were developed and made available suggesting an organization of records, rules for record making, and logging of records among multiple staff and functions. QI should be a function and responsibility of all work groups or teams. So it seems to me all those involved in a process or function including any board and community members that might be directly involved ideally should be involved in QI. It should be integral to work teams and management of an organization rather than being something unique.

"Regarding the interactions with other entities through the process, the technical assistance and support from PHAB and partner agencies (NACCHO, ASTHO, NALBOH, NIHB) were invaluable in the process. It became a true team effort as we enjoyed the expertise of these outstanding organizations. Regrettably, the leadership of the state health department is not convinced of the value of the process so was not available to enhance our efforts. Staff at lower levels was as helpful as they could be but were limited in the time they had to give."

The most unexpected challenge for the agency was the untimely loss of the accreditation coordinator two days before the site visit. The team was fortunate that she kept excellent records and had the project documents very well organized but it was certainly a challenge. With a new accreditation coordinator assigned, the staff moved forward and came together in an effort to make sure the project continued to move forward with meaningful, lasting results to the organization. With a small number of employees, it was not practical to assign the project to more than one person. The lesson learned, however, would be to make sure that more than one person attends training, learns the process and acts as assistant and understudy to the accreditation coordinator. Should the accreditation coordinator leave an organization, it would then have an effective backup to step in and move the process forward in a seamless manner.

PHS would like to thank PHAB, NACCHO and all the partners in this Beta Test Project for the outstanding assistance and support they received throughout the test accreditation process. It has truly been a valuable experience for the department.

APPENDICES

Appendix 1: Storyboard

Additional Appendices:

Flow Chart
Pareto Chart
Fishbone Diagram
Sample of Pre-Orientation checklist
Sample of a departmental orientation checklist