The Quest for Exceptional Performance:
A Crosswalk Between the
Baldrige Performance Excellence Program and the Public Health Accreditation Board

Increasingly, health departments are becoming involved in various performance initiatives. Both the Malcolm Baldrige Award for Excellence (Baldrige) and the Public Health Accreditation Board (PHAB) programs offer nationally-recognized programs to support and promote performance and quality improvement. This crosswalk tool describes the similarities, differences, and complementary nature of the Baldrige and PHAB programs, and is intended to facilitate the application process for health departments interested in pursuing either or both initiatives.

The first portion of the tool is a narrative description of each program's mission and history, and an overview of the basic elements of each, culminating in a chart that compares the evaluation system, required documentation, site visit, results, use of results and periodicity. Seven appendices provide more detailed information about the Baldrige process, in addition to sample Baldrige applications from state and local health departments. Two crosswalks that illustrate how the Baldrige criteria and PHAB measures align with one another complete the tool. The first crosswalk lists the Baldrige criteria in order, and the second crosswalk is in the numerical order of the PHAB standards and measures.

It is important to note that there are some significant differences in the emphasis as well as the presentation of the Baldrige criteria and PHAB standards and measures. One fundamental difference between the two programs is the type of information that is requested. The Baldrige program requires the applicant to describe various processes and the results of those processes, while PHAB requests specific pieces of documentation. Additionally, terminology varies between the two programs. Familiarity with the Baldrige Glossary of Key Terms (page 55) and the PHAB's Acronyms and Glossary of Terms will greatly assist new program users in understanding the terminology specific to each. Finally, the degree of alignment provided in the crosswalks reflects a very high-level comparison. A full understanding of the relevance and intent of a PHAB measure is only possible within the context of its accompanying domain and standard and their written descriptions and explanations, in addition to the purpose, significance statements, and required documentation and guidance of the measure.

Overview of Baldrige

In the mid-1980s, U.S. leaders realized that American companies needed to focus on quality in order to compete in an ever-expanding, demanding global market. Then-Secretary of Commerce, Malcolm Baldrige was an advocate of quality management as a key to U.S. prosperity and sustainability. After he died in 1987, Congress named the Award in recognition of his contributions. While the original goal of the Malcolm Baldrige National Quality Award was to enhance the competitiveness of U.S. businesses, its scope has since been expanded to health care and education organizations (in 1999) and to nonprofit/government organizations (in 2005).

The Baldrige Performance Excellence Program is part of the National Institute of Standards and Technology (NIST) in the U.S. Department of Commerce. It has evolved to become a public/private partnership that enhances the competitiveness, quality, and productivity of U.S. organizations for the benefit of all citizens. The first Malcolm Baldrige National Quality Awards were given in 1988 to three manufacturing companies, Globe Metallurgical Inc., Westinghouse Electric Corporation, and Motorola Inc. Over the past 24 years a total of 91 US-based organizations have received the Baldrige Award. These recipients have come from the world of manufacturing, service companies, small business, education, health care, and nonprofit/government.

There are also approximately 40 state-based "Baldrige" organizations with programs similar to the national Baldrige Program. In addition to providing statewide award processes, many of the state programs offer various training and consultation based on the national program and in various other performance improvement tools. An entity in a state with one of these programs must first win its recognition before it is eligible to pursue recognition from the national program. While the state-based programs are similar in nature to the Baldrige program, there are some considerable differences, and there is significant variation among them. This tool only covers the elements of the national program. More information about state programs is available on http://www.baldrigepe.org/alliance/.

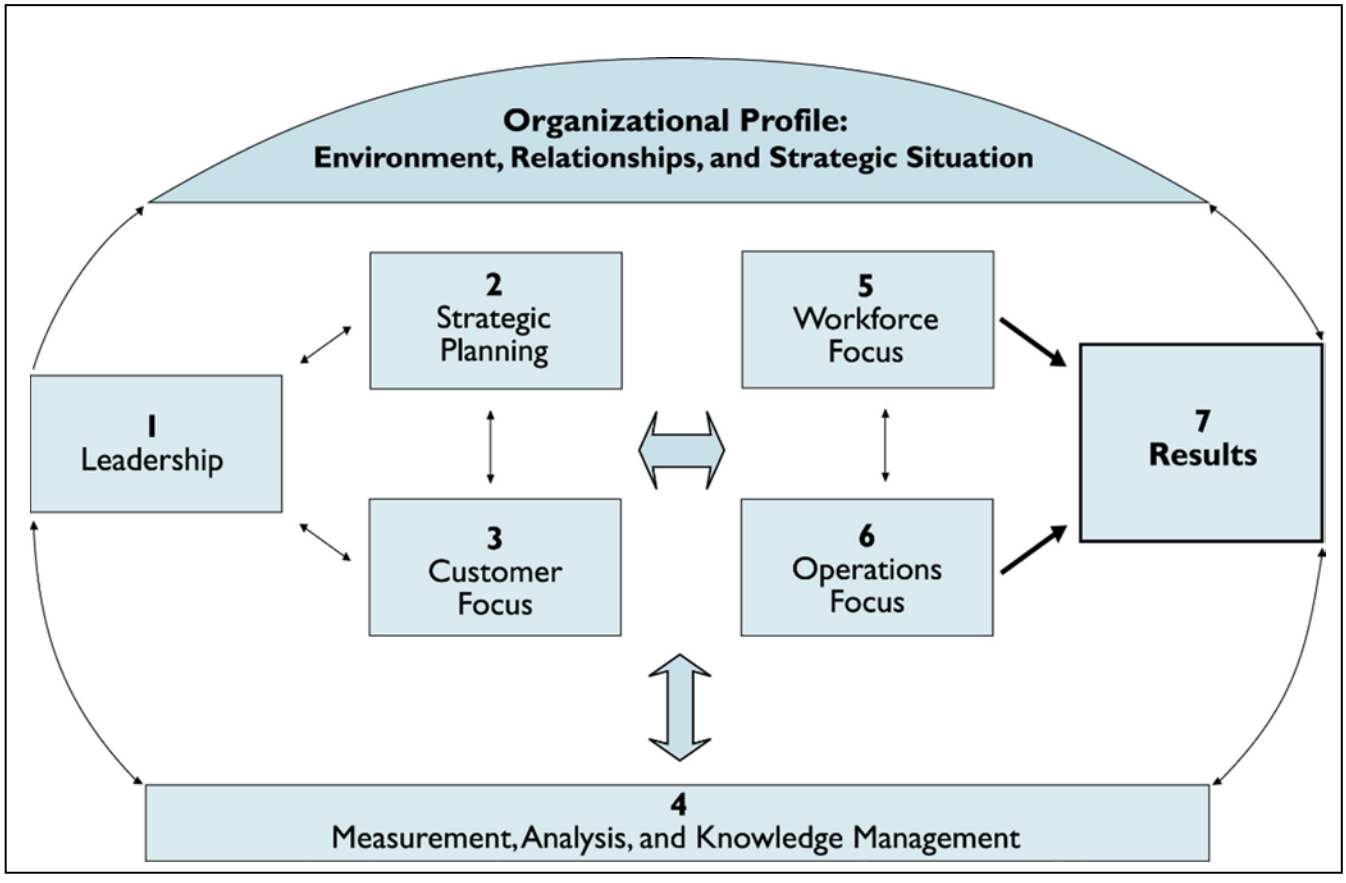
Although no public health department has received the Baldrige Award at this time, at least three have received Baldrige-based awards by their respective state programs. The first was Miami-Dade County (Florida) that as of May 2012 has won the Florida Governor's Sterling Award three times. St. Johns County Health Department (Florida) and Sullivan County (Tennessee) received state-level recognition in 2009 and 2011, respectively. Other state and local health departments have used Baldrige for internal organizational assessments.

Performance Assessment Framework

The Baldrige Performance Excellence Program is based on the *Baldrige Criteria for Performance Excellence*. No matter the size or nature of the organization, the *Criteria* serve as a guide in the journey toward performance excellence. They can help an organization align resources; improve communication, productivity, and effectiveness; and achieve strategic goals.

The *Criteria* are simply a set of questions focusing on critical aspects of management that contribute to performance excellence: leadership; strategic planning; customer focus; measurement, analysis, and knowledge management; workforce focus; operations focus; and results. The *Criteria* work as an integrated framework for managing an organization, as shown in Figure 1.

FIGURE 1: BALDRIGE PERFORMANCE EXCELLENCE CRITERIA FRAMEWORK



The seven Baldrige categories in the center of Figure 1 define an organization's processes and results achieved.

Leadership (category 1), Strategic Planning (category 2), and Customer Focus (category 3) represent the leadership triad. These categories are placed together to emphasize the importance of a leadership focus on strategy and customers. Senior leaders set organizational direction and seek future opportunities for the organization.

Workforce Focus (category 5), Operations Focus (category 6), and Results (category 7) represent the results triad. The organization's workforce and key operational processes accomplish the work of the organization that yields your overall performance results. Measurement, Analysis, and Knowledge Management (category 4) are critical to the effective management of your organization and to a fact-based, knowledge-driven system for improving performance. Measurement, analysis, and knowledge management serve as a foundation for the performance management system.

All actions point toward Results, which is a composite of product and process outcomes, customer-focused outcomes, workforce-focused outcomes, leadership and governance outcomes, and financial and market outcomes.

The horizontal arrow in the center of the framework links the leadership triad to the results triad, a linkage critical to organizational success. Furthermore, the arrow indicates the central relationship between Leadership (category 1) and Results (category 7). The two-headed arrows indicate the importance of feedback in an effective performance management system.

There are three versions of the *Criteria for Performance Excellence*: Business/Nonprofit (which specifically includes government agencies), Education, and Health Care. The three criteria are nearly identical but use language that is friendly to the particular industry to which it applies. For example, the Business/Nonprofit Criteria speaks of customers, while the Health Care Criteria speaks of patients, and the Education criteria speaks of students.

The Baldrige Management model is a generic non-industry specific model that is designed to be applied to any organization that is focused on using evidence-based management and performance improvement practices. It works in conjunction with any industry specific standards that apply to an entity, such as PHAB or the Joint Commission. Whether using Baldrige as a self-assessment process (as many do) or in applying for an award, the process begins with the completion of an Organizational Profile, that asks each organization specific questions about their purpose, the nature of their business, their specific customers and employees, and what are their challenges. This sets the stage for an assessment that uses the specific *Criteria* questions.

In order to use the *Criteria* for Public Health, it is important to define the public health customer being served (primarily the general public, but often others as well), what the organization and the community are seeking to accomplish (Strategic and Community Plans), and how performance will be measured. The *Baldrige Criteria* questions should be answered within the context of the public health services that you provide. Either the Business/Nonprofit Criteria or the Health Care Criteria may be used. If your health department has a strong focus on the provision of clinical services, the Health Care Criteria may be more appropriate.

Some questions and concepts within the Baldrige Criteria may not seem to apply to government-based public health agencies. It is important to realize that some questions are more relevant and important to your organization than others and in some cases you will find that if you tweak the question just a little it may apply very well to your organization. For example, in Category 3, the *Criteria* ask about customer satisfaction relative

to competitors. Government agencies may not have direct competitors for public health services; however, they do compete with other agencies for funding, for staffing, and there may be some overlap in service offerings. These other agencies, therefore, may be identified as your competitors/ comparators. Moreover, hHealth department customers are entire communities, and this distinction changes the complexion of some of the crosswalk and the relevance of some of the customer focus to a focus on community partnerships and population based efforts.

The purpose of the Baldrige process is to push an organization to continuous improvement. No matter how mature the organization, questions will always emerge for which there is no adequate response. These are "opportunities for improvement" and provide the next steps in the journey of continuous improvement.

Overview of Public Health Accreditation Board (PHAB)

PHAB is the national accrediting organization for public health departments. A nonprofit organization, PHAB is dedicated to advancing the continuous quality improvement of state, local, tribal, and territorial public health departments. PHAB is working to promote and protect the health of the public by advancing the quality and performance of all public health departments in the United States through national accreditation. Its vision is a high-performing governmental public health system that will make us a healthier nation.

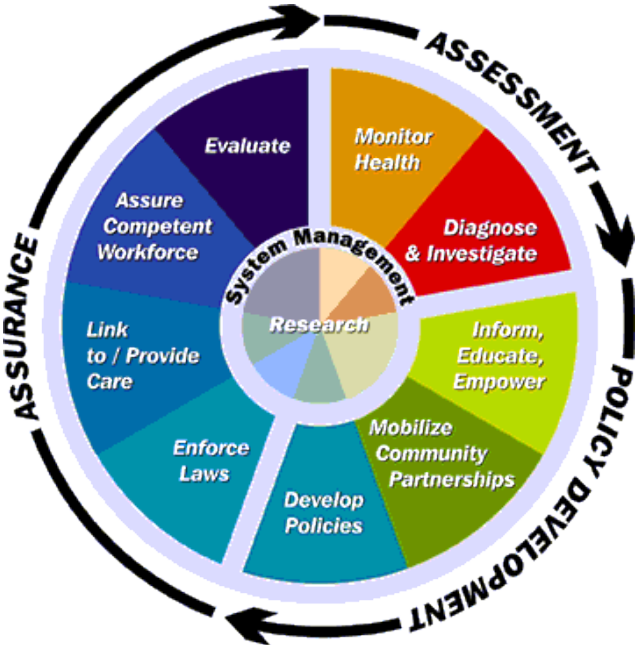
Incorporated in May 2007, and with support from the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation, PHAB works closely with several organizations that represent the wide variety of public health departments and structures across the country. These partners include: the American Public Health Association, the Association of State and Territorial Health Officials, National Association of County and City Health Officials, the National Association of Local Boards of Health, the National Indian Health Board, the National Network of Public Health Institutes, and the Public Health Foundation. All these partner organizations share the common objective of assuring that health departments meet a set of standards and measures to continuously improve their performance.

PHAB standards were developed with input from a comprehensive group of public health practitioners, including: a Standards Development Workgroup made up of representatives of state and local health departments; a Tribal Standards Workgroup made up of representatives of Tribal, state, and local health departments; various Think Tanks; and expert panels on such topics as governance and community health assessments. The standards, measures, and required documentation were tested through an alpha test (desk review by eight state and local health departments), vetting (three months of public comment), and a beta test where feedback was collected from 30 beta site health departments and 97 beta test site visitors. Finally, Version 1.0 of the standards, measures, and required documentation was adopted by the PHAB Board of Directors in May, 2011. PHAB conferred the first accreditation of state, local and tribal health departments in June 2012.

Accreditation demonstrates the capacity of the public health department to deliver the three core functions and the ten essential services of public health as represented in Figure 2. The accreditation process and standards are intended to be flexible and inclusive, accommodating many different configurations of governmental public health departments at all levels – Tribal, state, local, and territorial. Participants may include: centralized and decentralized state health departments; health departments that are part of a larger governmental agency; health departments that may have environmental public health responsibility; regional and district health departments; and health departments that share resources to fulfill particular functions. Public health department accreditation standards address the range of core public health functions and services that support all programs and activities including, for example, environmental public health, health education, health

promotion, community health, chronic disease prevention and control, communicable disease, injury prevention, maternal and child health, public health emergency preparedness, access to clinical services, public health laboratory services, management /administration, and governance. Thus, public health department accreditation gives reasonable assurance that a health department has the capacity to fulfill its roles and responsibilities.

FIGURE 2: PUBLIC HEALTH CORE FUNCTIONS AND TEN ESSENTIAL SERVICES[1]



Despite public health's critical roles, there has previously not been a national accreditation program to ensure public health departments' quality of service. Accreditation is based on standards that health departments can put into practice to ensure that they are continuously improving services to keep their communities healthy. Accreditation will drive public health departments to continuously improve the quality of their services and their performance.

<u>Relevance/Benefits – Why do this?</u>

Baldrige

Many organizations ask, why would we want to do this? There is a lot of work involved over a number of years to deploy and improve a Baldrige-based management system. You may rightly feel that you already run a good organization, so why make the additional effort? Mr. Rulon Stacey, President of Poudre Valley Health System, 2008 Baldrige Award Recipient, states "I honestly in *m*y heart believe that because we participated in the Baldrige program and because it gave us that consistent feedback, there are people who are alive today who wouldn't have been had we not been so committed to the Baldrige process."

[1] www.cdc.gov/nphpsp

Organizations that effectively implement Baldrige outperform those who do not. For example, a 2011 report found that health care organizations that have won *Baldrige National Quality Awards* or been considered for a Baldrige Award site visit, outperform other hospitals in nearly every metric used to determine the 100 Top Hospitals, a national recognition given by Thomson Reuters. Commissioned by the Foundation for the Malcolm Baldrige National Quality Award, and conducted by Thomson Reuters, the report found that Baldrige hospitals were six times more likely to be counted among the "100 Top Hospitals", which represent the top 3 percent of hospitals in the United States, and that they statistically outperform the "100 Top Hospitals" on core measures established by the U.S. Centers for Medicare & Medicaid Services. There have been numerous other studies with similar results.[2]

PHAB

PHAB has identified the following as the benefits of achieving accreditation status:

High Performance and Quality Improvement

The accreditation process will highlight strengths and also allow health departments to identify and address areas for quality and performance improvement. Improvements to achieve and maintain public health department accreditation will lay the groundwork for improved health outcomes for the jurisdiction that the health department serves. Once a health department has begun the process of preparing for accreditation, it will gain immediate benefits in the form of identified strengths and weaknesses and opportunities for quality improvement.

Recognition, Validation, and Accountability

Accreditation verifies the meeting of nationally adopted standards that are recognized as validating the services provided by health departments. Public health department accreditation raises the visibility of public health to the citizens who are served by the health department. It also provides accountability to the public, funders, and governing entities at all levels.

Improved Communication and Collaboration

Within a health department, accreditation improves the understanding of the functions and roles of health department staff. It promotes staff understanding of how their job contributes to the health department's mission and the delivery of essential services. It encourages better communication and collaboration among staff, governing entities, partners, community members, and other external stakeholders.

Potential Increased Access to Resources

Accreditation highlights the capacity and capability of the health department. This may result in increased opportunities for resources. These resources might include:

- Access to funding to support quality and performance improvement;
- Funding to address infrastructure gaps identified in the accreditation process;
- Opportunities to pilot new programs and processes;
- Streamlined application processes for grants and programs; and
- Acceptance of accreditation in lieu of other accountability processes.

As the public health department accreditation movement grows and as PHAB's accreditation system develops, other benefits may also emerge.

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[2] http://www.nist.gov/baldrige/baldrige-102511.cfm

Performance Assessment Review

Baldrige

Performance Indicators
The evaluation system is based on the applicant's responses to the detailed *Criteria* questions. In responding to the questions, applicants speak to four different evaluation factors. For the six categories that address process (1-6 in Figure 1), the factors are Approach, Deployment, Learning and Integration (ADLI). As a results-based system, Baldrige seeks to validate improved outcomes. Therefore, the Baldrige "Results" section (Category 7, Figure 1) is evaluated according to Performance Levels, Trends, Comparisons and Integration (LeTCI). Appendix A contains a detailed explanation of ADLI and LeTCI.

Documentation
Organizations that apply for the Baldrige Award must submit an Eligibility Application as well as a 50 page Application plus a five page Organizational Profile. To be eligible to apply for the national award, an organization must first win its own state award (if available). These application documents provide the organization's response to the *Criteria* questions regarding the seven categories. It is expected that the answers to the *Criteria* questions will reflect how the organization applies the evaluation factors (ADLI and LeTCI) as well. There is no requirement for submitting any specific documentation other than the 55 page Application referenced above. While supplemental documents may be included as part of the 55 pages, most organizations discuss available documentation in their application but do not choose to include it. It is more important to describe systematic processes and systems in the allotted pages.

Documentation Review Process
Upon receipt, each Award Application is assigned to a team of six to eight volunteer Baldrige Examiners. Baldrige Examiners come from a broad range of Industries and every state in the union. They tend to be mid- to upper-level executives and many of them are considered to be high potential employees by their sponsoring employers. Baldrige Examiners must undergo a rigorous selection process and they are required to complete an annual three day training program that requires extensive upfront preparation.

The Baldrige Examination team spends an average of 60 to 80 hours per examiner evaluating the Application and coming to consensus on a list of Organizational Strengths, Opportunities for Improvement and scores (see section entitled Baldrige Scoring). After reaching consensus the team's "Scorebook" is submitted to the Baldrige Panel of Judges for site visit selection. Approximately twenty percent of Baldrige Applications are selected for site visits. Those organizations who do not get Site Visits receive Feedback Reports based on this review.

Site Visit
The Baldrige Site Visit is a very intensive validation of the organization's response to the *Criteria* questions and to what degree it has deployed the processes cited in the application. It also examines whether the organization has undergone systematic cycles of improvement and whether processes are aligned with what is most important to the organization. In other words, the team uses ADLI as their review tool. A similar process is used by the team to analyze results using LeTCI.

The Baldrige Site Visit team again consists of six to eight volunteer examiners. Generally Site Visit teams are staffed with very experienced examiners, who are able to provide accurate and actionable feedback both to the Applicant Organization and the Baldrige Judges. The Site Visit is a full week process for the Examination Team. The usual process is for the team to arrive on a Sunday and complete their report the following Saturday. The team will generally be on site for three full work days and will visit any major work locations and both day and

night shift employees (if applicable). Two very important aspects of the Site Visit are interviews with organizational leaders and selected staff and a review of documents requested by the Examination Team to help examiners better understand processes and whether they are fully deployed. Examiners also perform "Walk Around" interviews with front line staff in order to better understand the culture of the organization and the depth and breadth of process deployment and improvements. The Examination Team will not interview any customers or partners but will ask about them as they interview staff.

Baldrige Examiners conclude their very exhaustive week by rescoring based on Site Visit findings and writing an in-depth Feedback Report that provides a numerical score for each category, and more importantly an extensive discussion of strengths and opportunities for improvement.

Scoring

Each of 7 Baldrige Categories are assigned a maximum number of points ranging from 85 points to 450 points as follows:

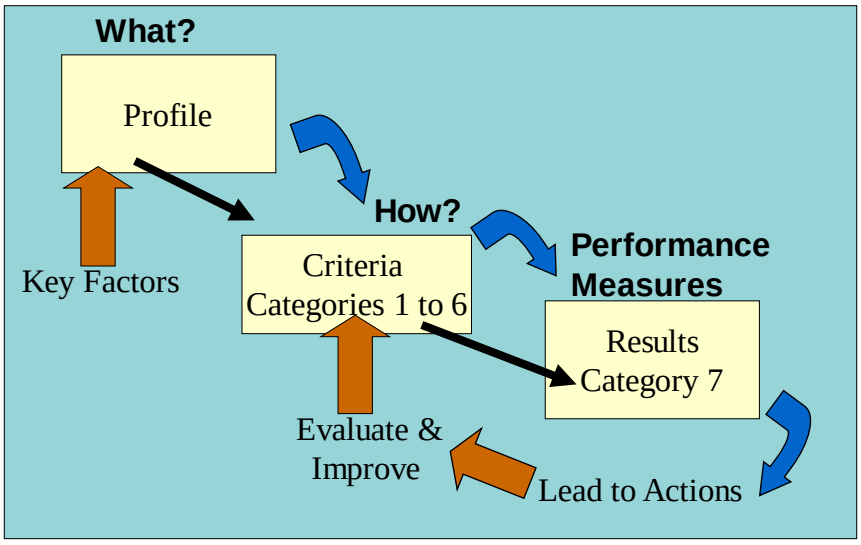
Leadership	120 points
Strategic planning	85 points
Customer focus	85 points
Measurement, analysis, and knowledge management	90 points
Workforce focus	85 points
Operations focus	85 points
Results	450 points
Total possible	1000 points

The Baldrige scoring system is intentionally harsh with scores above 70% of the possible points being rare. Baldrige Award recipients typically score about 700 of 1000 possible points. A good organization that is largely responsive to the Baldrige Criteria will score about 500 points. See Appendix B for more detailed information about the scoring system.

Using Results for Continuous Improvement

The Baldrige Performance Excellence Model facilitates using both a process improvement focus and an overall organizational improvement focus through a type of Plan-Do-Check-Act model illustrated in Figure 3.

FIGURE 3: BALDRIGE PERFORMANCE EXCELLENCE MODEL



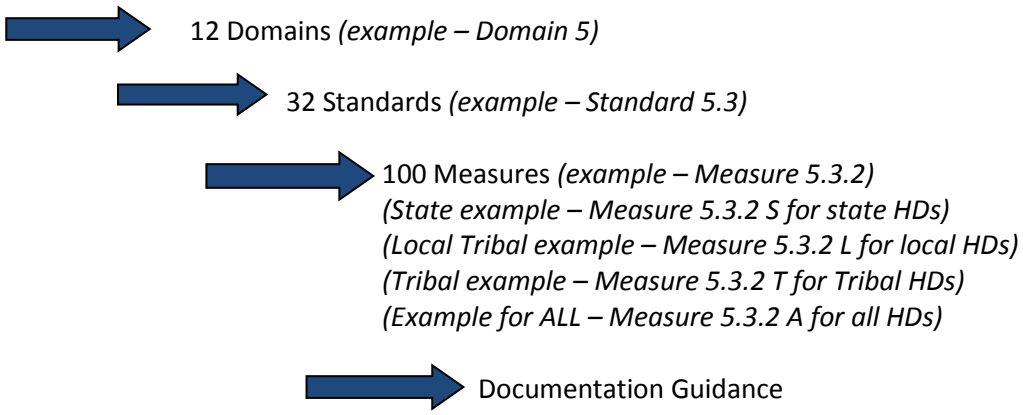
The Organizational Profile describes what is most important to the organization and what challenges must be addressed to ensure sustainability. The answers to the *Criteria* questions (Categories one through six) describe how the organization systematically develops and deploys processes that address these challenges. The *Criteria* also ask how the organization measures the performance of these processes. The results in Category 7 consist of the performance results. If an organization is not satisfied with the results, this should lead to process refinements that ultimately lead to improved results. The cycle continues until the organization is satisfied with the results and is then able to make improvements in other areas.

Periodicity
The Baldrige Award Program is on an annual cycle with Eligibility Applications due each year in April and full Applications due in May.

PHAB

Performance Indicators
Domains are groups of standards that pertain to a broad group of public health services. There are 12 domains; the first ten domains address the ten Essential Public Health Services. Domain 11 addresses management and administration, and Domain 12 addresses governance. Standards are the required level of achievement that a health department is expected to meet. Measures provide a way of evaluating if the standard is met. Required documentation is the documentation that is necessary to demonstrate that a health department conforms to a measure.

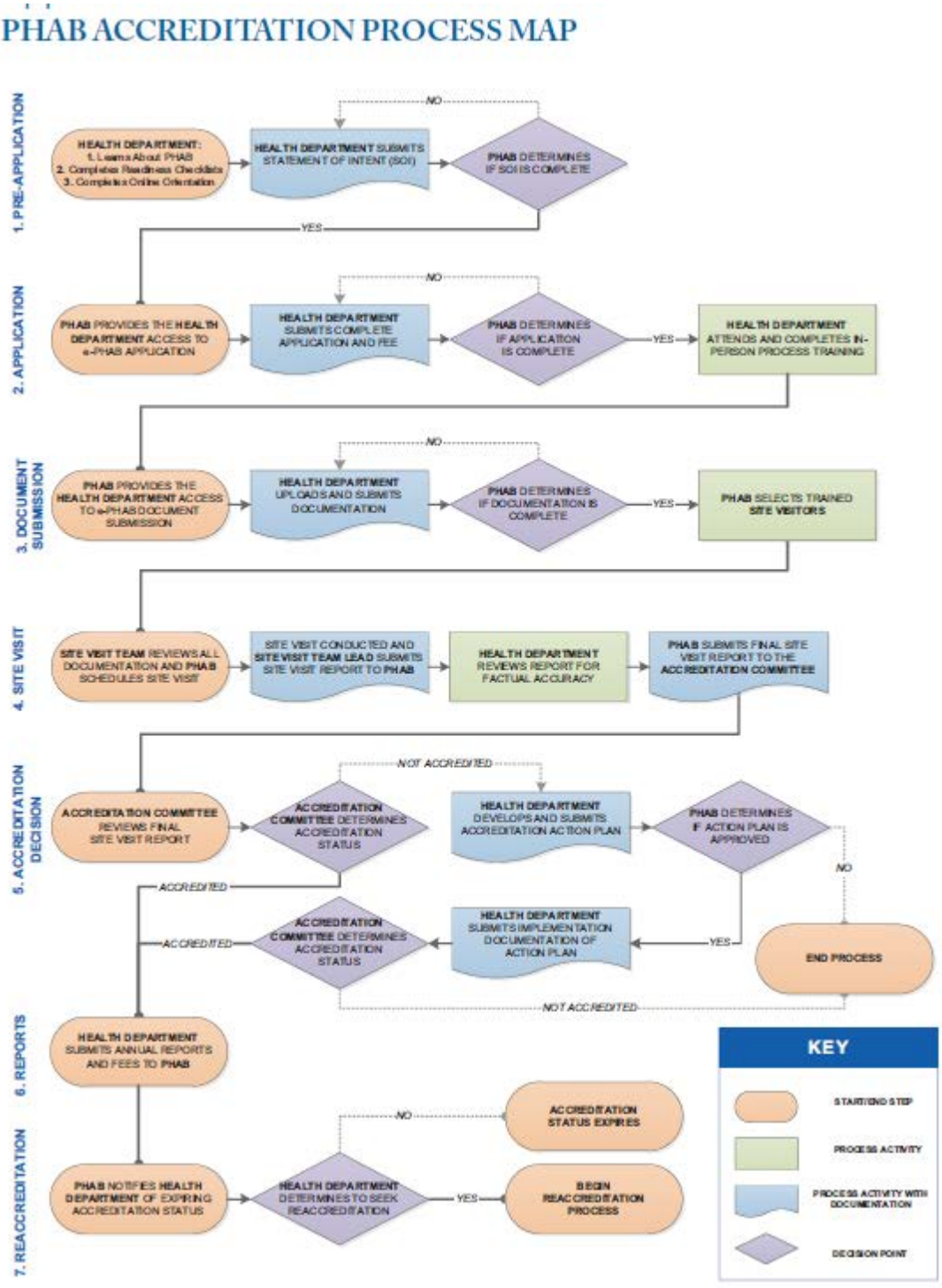
The structural framework for the PHAB domains, standards, and measures uses the following taxonomy:



All of the standards are the same for Tribal, state and local health departments. The majority of the measures are the same for Tribal, state and local health departments and these are designated with an "A" for "all." Where the measure is specific to Tribal, state, and/or local health departments, the measure addresses similar topics but has slight differences in wording or guidance and will be designated with a "T" for Tribal health departments, "S" for state health departments, and "L" for local health departments. Some measures are designated T/S, some are T/L, and some are S/L.

PHAB Accreditation Process
The PHAB accreditation process consists of seven steps as illustrated in Figure 4: (1) Pre-application, (2) Application, (3) Documentation Selection and Submission, (4) Site Visit, (5) Accreditation Decision, (6) Reports, and (7) Reaccreditation.

FIGURE 4: PHAB ACCREDITATION PROCESS MAP



Documentation
The applicant submits extensive documentation to provide evidence of performance against the standards and measures. All documentation is submitted by health departments to PHAB through e-PHAB, PHAB's online information system. The Documentation Guidance provides guidance concerning the selection of documentation to meet the PHAB standards and measures. PHAB site visitors review the documentation that is submitted to determine the adequacy of it as evidence that the health department is in conformity with each measure. Go to the PHAB website at www.phaboard.org for a copy of the Documentation Guidance publication.

Documentation Review
A team of peer reviewers, selected and trained by PHAB, evaluates performance against a set of standards and measures by conducting offsite review of documentation submitted by the health department for each PHAB measure. The review team then reaches consensus on the scoring and conducts additional review of documentation by observation and interviews during the several-day site visit.

Site Visit
The visit serves several purposes: verify the accuracy of documentation submitted by the health department, seek answers to questions regarding conformity with the standards and measures, and provide opportunity for discussion and further explanation. The team asks questions about the documentation and operation of the health department. Further documentation or examples from other program areas may be requested by the site visitors before the site visit or, at their discretion, during the site visit. The health department has an opportunity to describe its operations, its relationship with the community, and the role of its governing entity, and also to provide other qualitative information.

Scoring
The site visit team makes the final determination as to whether any given measure is fully demonstrated, largely demonstrated, slightly demonstrated, or not demonstrated, based on the submitted documentation and the site visit. The PHAB-appointed Accreditation Committee makes the final decision on the accreditation status based on the site visit report prepared by the peer review team. There are two accreditation status decision categories: either "Accredited" (for 5 years) or "Not Accredited."

All applicants receive a written report with scoring by standard and recommendations for improvement.

Using Results for Continuous Improvement
If the health department receives a status of "accredited," the Accreditation Committee provides the health department with a list of opportunities for improvement, intended to serve as the basis for the department's continuous quality improvement efforts and the annual reports required by PHAB to maintain accreditation status for five years.

Summary Chart

The chart below summarizes the performance assessment processes for the Baldrige Award and PHAB accreditation.

	Baldrige Award	*PHAB Accreditation*
Documentation	Applicant submits a 50 page Application plus a five page Organizational Profile. These documents provide the organization's response to the seven *Criteria* categories.	Applicant submits extensive documentation to provide evidence of performance against the standards and measures.
Documentation Review	Team of examiners reaches consensus on performance against a set of established criteria by evaluating narrative description for Baldrige "Process" Categories (1-6, see Figure 1) and by evaluating numeric results presented in Category Seven. After reaching consensus the team's "Scorebook" is submitted to the Baldrige Panel of Judges for site visit selection. Approximately twenty percent of Baldrige Applications are selected for site visits.	Team of peer reviewers evaluate performance against a set of standards and measures by conducting offsite review of documentation submitted by the health department for each PHAB measure. The review team then reaches consensus on the scoring and conducts additional review of documentation by observation and interviews during the several-day site visit.
Site Visits	The Baldrige Site Visit is a very intensive validation of the organization's response to the *Criteria* questions and to what degree it has deployed the processes cited in the application. It also examines whether the organization has undergone systematic cycles of improvement and whether processes are aligned with what is most important to the organization. The Site Visit is a full week process for the six to eight member Examination Team. Two very important aspects of the Site Visit are interviews with organizational leaders and selected staff and a review of documents requested by the Examination Team to help examiners better understand processes and whether they are fully deployed. Examiners also perform "Walk Around" interviews with front line staff in order to better understand the culture of the organization and the depth and breadth of process deployment and improvements.	The visit serves several purposes: verify the accuracy of documentation submitted by the health department, seek answers to questions regarding conformity with the standards and measures, and provide opportunity for discussion and further explanation. The review team asks questions about the documentation and operation of the health department. Further documentation or examples from other program areas may be requested by the site visitors before the site visit or, at their discretion, during the site visit. The health department has an opportunity to describe its operations, its relationship with the community, the role of its governing entity, and provide other qualitative information.
Scoring	Each of the seven Baldrige Categories are assigned a maximum number of points ranging from 85 points to 450 points as	The site visit team will make the final determination as to whether any given measure is fully demonstrated, largely

	Baldrige Award	*PHAB Accreditation*
	follows: • Leadership (120 points) • Strategic planning (85 points) • Customer focus (85 points) • Measurement, analysis, and knowledge management (90 points) • Workforce focus (85 points) • Operations focus (85 points) • Results (450 points) Total - 1000 possible points	demonstrated, slightly demonstrated, or not demonstrated, based on the submitted documentation and the site visit.
Recognition Determination	Only organizations that achieve a very high level of performance receive the Baldrige Award, as determined through a somewhat subjective process. Although scores are provided, Baldrige Judges carefully discuss all aspects of the application to ensure that there are no issues or circumstances that would interfere with an applicant's being recognized as a Baldrige Role Model. All applicants receive a written report detailing strengths and opportunities for improvement.	The PHAB appointed Accreditation Committee makes the final decision on the accreditation status based on the site visit report prepared by the peer review team. There are two accreditation status decision categories: • Accredited (5 years) • Not Accredited All applicants receive a written report with scoring by standard and recommendations for improvement.
Uses of results	The Baldrige Performance Excellence Model facilitates using both a process improvement focus and an overall organizational improvement focus through a type of PDCA model	If the health department receives a status of "accredited," the Accreditation Committee will provide the health department with a list of opportunities for improvement. This will support the department's continuous quality improvement efforts and will be the basis for annual reports to be submitted by the accredited health department to PHAB.
Periodicity	The Baldrige Award Program is on an annual cycle with Eligibility Applications due each year in April and full Applications due in May.	PHAB accepts applications on an ongoing basis throughout the year.

Summary Comments

These nationally-recognized performance improvement programs have several striking similarities. The application itself, is similar, as is the use of teams to undertake the assessment process, site visit, and report development. Most importantly, both processes generate a description of opportunities for improvement to drive further improvement efforts. This is true regardless of whether recognition or accreditation status is achieved by an applicant organization.

In addition to the programs' similarities, it is also interesting to note their differences. An organization seeking Baldrige recognition selects which set of criteria to use; while the criteria are generic, there are different tools with language tailored to Healthcare, Education, and Business/Nonprofit. PHAB's Standards are specific to public health agencies, with specific eligibility requirements for each set of standards (state/territorial, tribal and local). While only a few organizations ever receive Baldrige Award recognition, it is anticipated that many public health agencies will attain PHAB accreditation. A number of states have Baldrige-based programs that provide various recognition and learning opportunities, and PHAB is a national level program only at this time (although a few states do have their own public health agency accreditation programs). Finally, two concepts within the Baldrige Criteria are not fully captured within the scope of the PHAB standards: Organizational Leadership, with an emphasis on guiding innovation; and performance comparisons and benchmarking with high performing organizations, both within and outside of public health to identify best practices and help set performance improvement targets.

Regardless of which program is the chosen path, an organization that receives recognition or accreditation status signals a desire to demonstrate accountability and engage in an ongoing quest for exceptional performance.

Independent consultants Dave Klater, Marni Mason and Grace Gorenflo developed this tool with support from the Robert Wood Johnson Foundation. The tool was vetted through a workgroup comprising Gary Mayes, Sullivan County Health Department (TN); Susan Ramsey, Washington State Health Department; Lillian Riviera, Miami-Dade County Health Department (FL); Kaye Bender, Public Health Accreditation Board; Jessica Solomon-Fisher, National Association of County and City Health Officials and Jim Pearsol, Association of State and Territorial Health Officials. Special thanks to the health departments that graciously shared their applications: Miami-Dade County Health Department and St. John's County Health Department (FL); Sullivan County Health Department (TN); and Washington State Health Department.

Appendix A

Baldrige Evaluation Factors: ADLI and LeTCI

For Baldrige "process" categories (i.e., categories 1 through 6), applicants respond to the detailed criteria questions along with an explanation of how four evaluation factors -- Approach, Deployment, Learning and Integration (ADLI) -- are addressed by your organization. See Figure 5, below, for an explanation of ADLI.

FIGURE 5: BALDRIGE PROCESS (CATEGORIES 1 THROUGH 6) EVALUATION ELEMENTS[3]

Evaluation Factor	Description
Approach (A)	▪ the methods used to accomplish the process ▪ the appropriateness of the methods to the *Criteria* item requirements and the organization's operating environment ▪ the effectiveness of your use of the methods ▪ the degree to which the approach is repeatable and based on reliable data and information (i.e., systematic)
Deployment (D)	▪ your approach is applied in addressing *Criteria* item requirements relevant and important to your organization ▪ your approach is applied consistently ▪ your approach is used (executed) by all appropriate work units
Leaning (L)	▪ refining your approach through cycles of evaluation and improvement ▪ encouraging breakthrough change to your approach through innovation ▪ sharing refinements and innovations with other relevant work units and processes in your organization
Integration (I)	▪ your approach is aligned with your organizational needs identified in the Organizational Profile and other process items ▪ your measures, information, and improvement systems are complementary across processes and work units ▪ your plans, processes, results, analyses, learning, and actions are harmonized across processes and work units to support organization-wide goals

[3] *2011–2012 Criteria for Performance Excellence*, the Baldrige Performance Excellence Program at the National Institute of Standards and Technology in Gaithersburg, MD

For the Baldrige "results" category (i.e., category 7), applicants respond to the detailed criteria questions along with four different evaluation factors, Performance Levels, Trends, Comparisons and Integration (LeTCI). See Figure 6, below, for an explanation of LeTCI.

FIGURE 6: BALDRIGE RESULTS (CATEGORY 7) EVALUATION ELEMENTS[4]

Evaluation Factor	Description
Levels (Le)	▪ your current level of performance
Trends (T)	▪ the rate of your performance improvements or the sustainability of good performance (i.e., the slope of trend data) ▪ the breadth (i.e., the extent of deployment) of your performance results
Comparisons (C)	▪ your performance relative to appropriate comparisons, such as competitors or organizations similar to yours ▪ your performance relative to benchmarks or industry leaders
Integration (I)	▪ your results measures (often through segmentation) address important customer, product, market, process, and action plan performance requirements identified in your Organizational Profile and in process items ▪ your results include valid indicators of future performance ▪ your results are harmonized across processes and work units to support organization-wide goals

APPENDIX B

Baldrige Scoring Methodology

Baldrige Examiners use a scoring method that is based on the ADLI and LeTCI evaluation elements (see Appendix A). Each of 7 Baldrige Categories are assigned a maximum number of points ranging from 85 points to 450 points as follows:

- Leadership (120 points)
- Strategic planning (85 points)
- Customer focus (85 points)
- Measurement, analysis, and knowledge management (90 points)
- Workforce focus (85 points)
- Operations focus (85 points)
- Results (450 points)
- Total - 1000 possible points

Examiners use a set of Scoring Guidelines based on ADLI (Figure 7) for process categories and LeTCI (Figure 8) for results. Based on the Strengths and Opportunities for Improvement identified for each of the seven Baldrige Categories and 18 scoring items, Examiners first assign a scoring range and then an exact score ranging from 0% to 100% for each of the 18 items. The percentage score is then multiplied by the possible points available for the scoring item. The Baldrige scoring system is intentionally harsh with scores above the 70-85% scoring range being extremely rare. Organizations that attain Baldrige recognitions typically score about 700 of 1000 possible points. A good organization that is largely responsive to the Baldrige Criteria will score about 500 points.

FIGURE 7 BALDRIGE SCORING GUIDELINES - PROCESS CATEGORIES[4]

SCORING RANGE	PROCESS (for use with categories 1–6)
0% or 5%	▪ No systematic approach to item requirements is evident; information is anecdotal. (A) ▪ Little or no deployment of any systematic approach is evident. (D) ▪ An improvement orientation is not evident; improvement is achieved through reacting to problems. (L) ▪ No organizational alignment is evident; individual areas or work units operate independently. (I)
10%, 15%, 20%, or 25%	▪ The beginning of a systematic approach to the basic requirements of the item is evident. (A) ▪ The approach is in the early stages of deployment in most areas or work units, inhibiting progress in achieving the basic requirements of the item. (D) ▪ Early stages of a transition from reacting to problems to a general improvement orientation are evident. (L) ▪ The approach is aligned with other areas or work units largely through joint problem solving. (I)
30%, 35%, 40%, or 45%	▪ An effective, systematic approach, responsive to the basic requirements of the item, is evident. (A) ▪ The approach is deployed, although some areas or work units are in early stages of deployment. (D) ▪ The beginning of a systematic approach to evaluation and improvement of key processes is evident. (L) ▪ The approach is in the early stages of alignment with your basic organizational needs identified in response to the Organizational Profile and other process items. (I)
50%, 55%, 60%, or 65%	▪ An effective, systematic approach, responsive to the overall requirements of the item, is evident. (A) ▪ The approach is well deployed, although deployment may vary in some areas or work units. (D) ▪ A fact-based, systematic evaluation and improvement process and some organizational learning, including innovation, are in place for improving the efficiency and effectiveness of key processes. (L) ▪ The approach is aligned with your overall organizational needs identified in response to the Organizational Profile and other process items. (I)
70%, 75%, 80%, or 85%	▪ An effective, systematic approach, responsive to the multiple requirements of the item, is evident. (A) ▪ The approach is well deployed, with no significant gaps. (D) ▪ Fact-based, systematic evaluation and improvement and organizational learning, including innovation, are key management tools; there is clear evidence of refinement as a result of organizational-level analysis and sharing. (L) ▪ The approach is integrated with your current and future organizational needs identified in response to the Organizational Profile and other process items. (I)
90%, 95%, or 100%	▪ An effective, systematic approach, fully responsive to the multiple requirements of the item, is evident. (A) ▪ The approach is fully deployed without significant weaknesses or gaps in any areas or work units. (D) ▪ Fact-based, systematic evaluation and improvement and organizational learning through innovation are key organization-wide tools; refinement and innovation, backed by analysis and sharing, are evident throughout the organization. (L) ▪ The approach is well integrated with your current and future organizational needs identified in response to the Organizational Profile and other process items. (I)

[4] *2011–2012 Criteria for Performance Excellence*, the Baldrige Performance Excellence Program at the National Institute of Standards and Technology in Gaithersburg, MD

FIGURE 8 BALDRIGE SCORING GUIDELINES - RESULTS CATEGORY 7[5]

SCORING RANGE	RESULTS (for use with category 7)
0% or 5%	▪ There are no organizational performance results and/or poor results in areas reported. (Le) ▪ Trend data either are not reported or show mainly adverse trends. (T) ▪ Comparative information is not reported. (C) ▪ Results are not reported for any areas of importance to the accomplishment of your organization's mission. (I)
10%, 15%, 20%, or 25%	▪ A few organizational performance results are reported, responsive to the basic requirements of the item, and early good performance levels are evident. (Le) ▪ Some trend data are reported, with some adverse trends evident. (T) ▪ Little or no comparative information is reported. (C) ▪ Results are reported for a few areas of importance to the accomplishment of your organization's mission. (I)
30%, 35%, 40%, or 45%	▪ Good organizational performance levels are reported, responsive to the basic requirements of the item. (Le) ▪ Some trend data are reported, and a majority of the trends presented are beneficial. (T) ▪ Early stages of obtaining comparative information are evident. (C) ▪ Results are reported for many areas of importance to the accomplishment of your organization's mission. (I)
50%, 55%, 60%, or 65%	▪ Good organizational performance levels are reported, responsive to the overall requirements of the item. (Le) ▪ Beneficial trends are evident in areas of importance to the accomplishment of your organization's mission. (T) ▪ Some current performance levels have been evaluated against relevant comparisons and/or benchmarks and show areas of good relative performance. (C) ▪ Organizational performance results are reported for most key customer, market, and process requirements. (I)
70%, 75%, 80%, or 85%	▪ Good to excellent organizational performance levels are reported, responsive to the multiple requirements of the item. (Le) ▪ Beneficial trends have been sustained over time in most areas of importance to the accomplishment of your organization's mission. (T) ▪ Many to most trends and current performance levels have been evaluated against relevant comparisons and/or benchmarks and show areas of leadership and very good relative performance. (C) ▪ Organizational performance results are reported for most key customer, market, process, and action plan requirements. (I)
90%, 95%, or 100%	▪ Excellent organizational performance levels are reported that are fully responsive to the multiple requirements of the item. (Le) ▪ Beneficial trends have been sustained over time in all areas of importance to the accomplishment of your organization's mission. (T) ▪ Evidence of industry and benchmark leadership is demonstrated in many areas. (C) ▪ Organizational performance results and projections are reported for most key customer, market, process, and action plan requirements. (I)

[5] *2011–2012 Criteria for Performance Excellence*, the Baldrige Performance Excellence Program at the National Institute of Standards and Technology in Gaithersburg, MD

Appendix C

Miami-Dade County, FL
Sterling Award Application

This application is for the Governor's Sterling Award, given by the Florida Sterling Council. The Governor's Sterling Award is based on the National Malcolm Baldrige Criteria for Performance Excellence.

Miami-Dade County Health Department

FLORIDA DEPARTMENT OF HEALTH

2012 Governor's Sterling Award Application

TABLE OF CONTENTS

2012 Governor's Sterling Award Application Form

GENERAL INSTRUCTIONS

Please update any information that has changed since the Application of Intent and type or very clearly print all information requested. The Application Form may be duplicated and single-sided pages submitted. Applicants must submit a copy of the Application Form with each copy of the Application. **A total of sixteen (16) complete Applications are required to be submitted.**

ITEM INSTRUCTIONS

Item 1 – Applicant — Provide the official name and mailing address of the organization applying for the Award.

1. Applicant Official Name

Organization Name: Miami-Dade County Health Department

Address: 8323 NW 12 Street, Suite 212, Doral, FL 33126

Item 2 – Official Inquiry Point — As the examination proceeds, the Administrator may need to contact the Applicant for additional information.

Give the name, address, and telephone number of the official with authority to provide additional information or to arrange a Site Visit.

If this official contact point changes during the course of the Application process, please inform the Florida Sterling Council.

2. Official Inquiry Point

Name: Rene Ynestroza, MBA, MSMIS

Title: Senior Public Health Services Manager

Mailing Address: 8323 NW 12 Street, Suite 212

Doral, FL 33126

Overnight Mailing Address: 8323 NW 12 Street, Suite 212

Doral, FL 33126

Telephone Number: 786-336-1255

Fax Number: 786-336-1297 Email Address: rene_ynestroza@doh.state.fl.us

Item 3 – Fees —

Application of Intent Fee	$100 (Submit with Application of Intent)
Small/Med. Org Application Fee	$3,000 (Submit with application)
Large Organization Application Fee	$5,000 (Submit with application)
Site Visit Fee	$2,500 (Due 30 days prior to site visit)
Plus Examiner's Expenses	TBD (Billed after site visit)

3. Fee (see instructions)

Enclosed is $ see memo to cover the Application Fee. Make check or money order payable to:

THE FLORIDA STERLING COUNCIL

Item 4 – Release Statement — Please read this section carefully. A signed Application indicates that the Applicant agrees to the terms and conditions stated therein.

4. Release Statement

We understand this application will be reviewed by members of the Board of Examiners. We agree to host the Site Visit and facilitate an open and unbiased examination. We understand that Site Visit expenses will be determined in accordance with the section: *Application Fees* (page 63, *2012 - 2013 Sterling Criteria for Performance Excellence*).

Item 5 – Authorizing Official — The signature of the Applicant's highest ranking management official or designee is required and indicates the Applicant will comply with the terms and conditions stated in the document.

5. Signature, Authorizing Official: 

Name: Lillian Rivera, RN, MSN, PhD

Title: Administrator

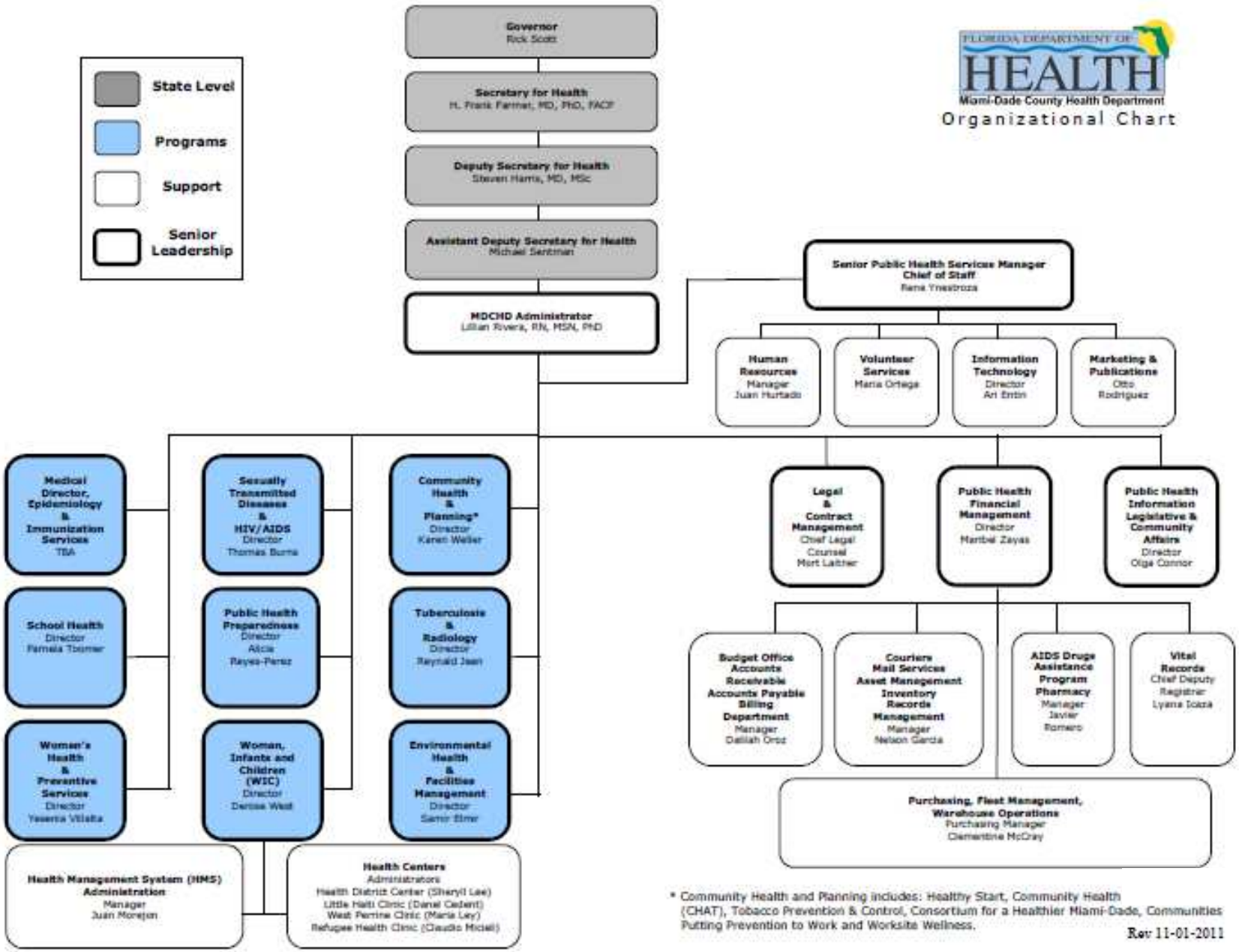
Address: 8323 NW 12 Street, Suite 212

Date: 11/1/11 Telephone Number: 786-336-1259

Site Listing and Descriptors Form A

Address of Site	B. Relative Size – Percent of Applicant's		C. Description of Products, Services, or Programs
	Employees	Sales or Operating Budget	
8323 NW 12 Street, Suites 212/214, Doral, FL 33126	2%		Administration/ Communications and Legislative Affairs/ Human Systems/ Volunteer Services/ Legal/ Contract Management/ IT
8175 NW 12 Street, third Floor, Doral, FL 33126	11%		Financial Management/ Asset Management/ Purchasing/ School Health/ Public Health Preparedness/ Research and Statistics/ Mail Services
8600 NW 17 Street, Second Floor, Doral, FL 33126	10%		Epidemiology, Disease Control & Immunization Services/ HIV/AIDS/ Women's Health/ Dental
1725 NW 167 Street, Miami, FL 33056	8%		Environmental Health
1313 NW 36 Street, Suite 102, Doral, FL 33142	2%		AIDS Drug Assistance Program/ Pharmacy
18255 Homestead Avenue, Miami, FL 33157	8%		Community Health & Planning/ Vital Records/ Healthy Start Data Management/ Clinic Services (Family Planning, Lab, STD, TB, WIC)
1350 NW 14 Street, Miami, FL 33125	27%		Vital Records/ Clinic Services (Sexually Transmitted Diseases/ Tuberculosis/ Hepatitis/ Family Planning/ Laboratory/)
315 NW 27 Avenue, Miami, FL 33125	8%		Refugee Health Assessment
7785 NW 48 Street, H300-325, Doral, FL 33166	21%		Women, Infants and Children (WIC) and Nutrition
300 NE 80 Terrace, Miami, FL 33138	3%		Women's Health/ STD/ TB/ Immunizations

The above is a list of the MDCHD's main facilities. There are several other satellite and mobile units.


State Level
Programs
Support
Senior Leadership
Governor
Rick Scott
Secretary for Health
H. Frank Farmer, MD, PhD, FACP
Deputy Secretary for Health
Steven Harris, MD, MSc
Assistant Deputy Secretary for Health
Michael Sentman
MDCHD Administrator
Lillian Rivera, RN, MSN, PhD
FLORIDA DEPARTMENT OF HEALTH
Miami-Dade County Health Department
Organizational Chart
Senior Public Health Services Manager
Chief of Staff
Rene Ynestroza
Human Resources
Manager
Juan Hurtado
Volunteer Services
Maria Ortega
Information Technology
Director
Ari Entin
Marketing & Publications
Otto Rodriguez
Medical Director, Epidemiology & Immunization Services
TBA
Sexually Transmitted Diseases & HIV/AIDS
Director
Thomas Burns
Community Health & Planning*
Director
Karen Weller
School Health
Director
Pamela Tanner
Public Health Preparedness
Director
Alicia Reyes-Perez
Tuberculosis & Radiology
Director
Reynald Jean
Women's Health & Preventive Services
Director
Yesenia Villalta
Woman, Infants and Children (WIC)
Director
Denise West
Environmental Health & Facilities Management
Director
Samir Elmir
Health Management System (HMS) Administration
Manager
Juan Morejon
Health Centers
Administrators
Health District Center (Sheryll Lee)
Little Haiti Clinic (Danal Cadet)
West Perrine Clinic (Maria Ley)
Refugee Health Clinic (Claudio Miceli)
Legal & Contract Management
Chief Legal Counsel
Mort Leitner
Public Health Financial Management
Director
Maribel Zayas
Public Health Information Legislative & Community Affairs
Director
Olga Connor
Budget Office
Accounts Receivable
Accounts Payable
Billing Department
Manager
Dalilah Ortiz
Couriers
Mail Services
Asset Management
Inventory Records Management
Manager
Nelson Garcia
AIDS Drugs Assistance Program Pharmacy
Manager
Javier Romero
Vital Records
Chief Deputy Registrar
Lyana Icaza
Purchasing, Fleet Management, Warehouse Operations
Purchasing Manager
Clementine McCray
* Community Health and Planning includes: Healthy Start, Community Health (CHAT), Tobacco Prevention & Control, Consortium for a Healthier Miami-Dade, Communities Putting Prevention to Work and Worksite Wellness.
Rev 11-01-2011

ORGANIZATIONAL PROFILE

Public health is a specialized science that focuses on the community as its client with a focus on health promotion/ disease prevention activities. The Miami-Dade County Health Department (MDCHD), under a unit of the Florida Department of Health (DOH), is the county health department located in Miami, Florida. It provides population/ community-based services to the county's 2.5 million residents and over 12.6 million annual visitors, and is responsible for assessing, maintaining and improving health and safety within the county. Although MDCHD dates back to the 1940s, the current organizational structure dates to 1997 when the legislature created the DOH and the Department of Children and Families from the former Department of Health and Rehabilitative Services.

MDCHD is the lead agency providing core public health (PH) functions and essential services in the county as part of a complex PH system that includes hospitals, clinics, planning agencies, community-based organizations and others. PH is a fundamental element of the quality of life available to residents and visitors in Miami-Dade County and focuses on promoting and protecting community health through prevention and preparedness. MDCHD currently employs approximately 900 staff and has an annual budget in excess of $80 million.

P.1a. Organizational Environment

P.1a(1) Product Offerings

In order to best achieve its mission and vision, MDCHD is organized into a number of program areas that focus on the surveillance, prevention, detection and treatment of the most significant health and environmental issues within the county. The major services provided by MDCHD as they align with the essential PH Services as determined by the national Centers for Disease Control and Prevention (CDC) are shown in **Figure P.1-2.**

P.1a(2) Vision and Mission

PH is a modern concept, although it has roots in antiquity. As opposed to the past, when PH focused mostly on communicable diseases and sanitation, modern PH incorporates a variety of general health determinates and focuses on health promotion and preventative actions.

Employees work together in the spirit of public service to prevent and resolve significant and emerging health concerns that may impact the community.

MDCHD's Mission, Vision and Values were developed in 1997 upon the restructuring of the Department and signified a deliberate change of organizational culture. They were reviewed and updated four times as part of the strategic planning process in 2001-02, 2003-04 2004-06 and during the 2010-11 strategic planning cycle the state vision and mission were adopted to provide focus for all county health departments in the state. Core competencies are based on a listing of PH Core Competencies are identified through a self examination process by leadership and reviewed in the Strategic Planning Process. See **Figure P.1-1.**

Figure P.1-1 Organizational Culture
Purpose Prevent disease and improve the health of the Miami-Dade County community
Vision A healthier future for the people of Florida
Mission To protect and promote the health of all residents and visitors in Miami-Dade County Florida.
Core Values Integrity; Customer and Community Focus; Accountability; Teamwork; Excellence; Respect for People; Learning; Continuous Improvement and Innovation
Strategic Priorities 1. Prevention & Preparedness 2. Return on Investment 3. Service Excellence
Core Competencies 1. Collaboration and Partnerships 2. Public Health Emergency Preparedness 3. Epidemiology, Disease Control and Prevention 4. Public Health Environmental Regulation 5. Public Health Promotion and Services

P.1a(3) Workforce Profile

Workforce Profile. The workforce Profile is shown in **Figure P.1-3**.The number of employees fluctuates due to grants and contracts that employ individuals on a short-term basis. Of the approximate 900 employees, 88% are classified are full time positions and 12% are OPS (contract) employees who are in temporary/per diem positions. Employees are highly educated, and representative of the population of the county and possess the language skills needed (English, Spanish and Creole). Collective bargaining organizations include the Florida Nurses Association, the Federation of Physicians and Dentists, and the American Federation of County, State and Municipal Employees.

Workforce benefits include health, dental, vision, life insurance as well as tuition waivers, reimbursement accounts, deferred compensation, Employee Assistance Program, paid time off and holiday pay amongst others.

The organization has special safety needs and requirements as is typical of the health care industry. Safety training is an ongoing part of staff development. Safety inspections of facilities are regularly conducted and Occupational Safety and Health Administration standards are followed as part of the Safety Program. A Safety Committee fosters safety in the workplace through multiple initiatives and exercises.

Staff engagement is cultivated through a team environment embracing collaboration, ongoing leadership and a robust rewards and recognition program.

Figure P.1-2 Miami-Dade County Health Department Services and Delivery Mechanisms			
Public Health Domains (10 Essential Services plus 2 Administrative Services)	**Health Department Core Programs (Domain Alignment)**	**# FTE**	**Delivery Mechanisms**
1. Monitor health status and understand health issues	HIV/AIDS Prevention (1,2,3,4,7,8,10)	**57**	**C,F,P,I**
2. Protect people from health problems and health hazards	Sexually Transmitted Diseases (1,2,3,7,8,10)	**21**	**C, F, P**
3. Give people information they need to make healthy choices	Tuberculosis Control (1,2,3,7,8,10)	**52**	**C, F, P**
4. Engage the community to identify and solve health problems	Epidemiology (1,2,3,5,6,7,9,10)	**34**	**C, O, F, P**
5. Develop PH policies and plans	Chronic Disease and Health Promotion (1,2,3,4,5,7,9,10)		**O, F, P, I**
6. Enforce PH laws and regulations	School Health (1,2,3,7,9,10)	**36**	**C, F**
7. Help people receive health services	WIC (3,7,9,10)	**189**	**C, P**
8. Maintain a competent PH workforce	Refugee Health (1,2,3,7,9,10)	**77**	**C**
9. Use continuous quality improvement tools to evaluate and improve the quality of programs and interventions	Women's Health/Family Planning (1,2,3,5,7,10)	**49**	**C**
10. Contribute to and apply the evidence base of PH	Environmental Health (1,3,5,6,9,10)	**69**	**F, I**
11. Maintain administrative and management capacity	Public Health Preparedness/ Emergency/ Disaster Response (1,2,4,5,8,9 ,10)	**18**	**O, F, I**
12. Maintain capacity to engage the PH governing entity	Vital Records (birth/ death certificates) (9,11)	**22**	**O, I**
	Community Health and Planning (1,2,3,4,5,7,9,10)	**19**	**O, F**
	Administration (1,,2,3,4,5,6,7,8,9,10,11,12)	**51**	**O, P**
Key - Delivery Mechanisms(C)-Clinic (O) Office (F)-Field (P)-Phone (I)-On-line			

P.1a(4) Assets

Major Facilities and Equipment: MDCHD has 42 strategically located facilities operated by 14 community programs and supported by 10 operational programs. Thirty locations comprise clinical settings and more than 60% of our employees are based out of 4 locations within the North, Central and Southern part of the county along with smaller health clinics, shared sites and mobile vans. Field service workers provide outreach to targeted high risk areas. MDCHD has established primary and secondary emergency command centers in the north and southeast of the county to support MDCHD's role as the county's health and medical lead during emergencies. With the growth of our community we continue to renovate and move to strategic locations. We recently built a 64,000 sq. ft. Health Care Clinic (MDCHD Health District Center), renovated a 2,000 sq. ft facility for Women's Health and built a Tobacco Cessation training facility. The facilities are equipped with state of the art medical, life safety and security equipment. The MDCHD operates a March of Dimes MOMmobile prenatal care clinic, born in response to the devastation caused by Hurricane Andrew in South Dade, is designed to operate like a traditional health care provider's office providing prenatal and post partum care, education, screenings, and referrals to ensure healthy birth outcomes.

Technology: We have a full-fiber optic/high-speed backbone leveraging the State of Florida MyFlorida.NET wide area network for a high level of available bandwidth, flexibility and cost-savings enabling video conferencing, web cams, voice-over-IP phones and secure wireless technologies in our service sites as well as reliable access in a variety of environments. We also use various technology tools for Emergency Preparedness including: communications platform, ready-to-deploy technology kits, mobile wireless internet access, VPN, satellite access and telecommunications tools. The Intranet is used for disseminating important organizational and preparedness information to our staff. We use *Footprints*, for submitting and tracking of service related items, and an integrated customer survey component with dashboards and reports for monitoring satisfaction and outcomes.

We also use the state operated Health Management System (HMS), a dedicated public access phone line, and an employee hotline for emergency notification (FDENS). We also maintain 24-hour on call coverage and are linked with hospitals and physicians through data sharing and surveillance systems that provide alerts to PH emergencies.

P.1a(5) Regulatory Requirements

The MDCHD is governed by FS Chapter 154. It operates in a highly regulated and political environment. Functions and funding levels are determined by the state legislature. There are numerous, federal, state and county regulations that affect virtually all aspects of services and employment.

We are also required to adhere to licensing standards for various healthcare professionals, and Medicare and Medicaid regulations. Furthermore, as a provider of healthcare services, MDCHD is subject to the Health Insurance Portability and Accountability Act (HIPAA) and laboratory/healthcare provider licensure requirements.

Although there are no required accreditation or certification requirements, we participated in a Beta Test of a new Local

Health Department Accreditation Process overseen by the Public Health Accreditation Board (PHAB). We intend to pursue voluntary accreditation as soon as it is possible to apply (late 2011) A letter of intent to apply has been submitted.. Accreditation serves as a comprehensive assessment of PH processes that enable compliance with standards regarding the provision of the 10 Essential PH services (See **Figure P.1-2**).

Figure P.1-3 Workforce Profile	
Employees	878 Total (Female 73%, Male 27%)
Age	20-29: 11.39% 50-59: 25.29% 30-39: 19.36% 60-64: 10.14% 40-49: 27.10 % 65+: 6.72%
Workforce Diversity	Hispanic: 48.28%; Black: 34.02%; White: 15.63%; (mirrors the county we serve) 48.41% speak two or more languages Spanish: 39.82% Creole: 11.44% French: 7.55% Other: 1.72%
Job Diversity	Exempt (salaried): 3.5%; Non-exempt (hourly): 96.5%
Education	Doctorate: 6% Associate: 12% Master: 15% Vocational/Tech.: 7% BA/BS: 26%; High School: 34%
Tenure	0-5 Years: 11% 16-20 Yrs: 11% 6-10 Yrs: 28% 21-25 Yrs: 9% 11-15 Yrs: 13% 26+ Yrs: 7%
Employee Categories	Administrative/clerical: 34% Nurses: 11% Physician: 2% Paraprofessionals: 9% Nutrition Educators & Dieticians: 8% Engineers/ Inspectors: 6% Health Service Reps & Technicians: 10% Managers /supervisors 15% Other: 20%

P.1b. Organizational Relationships

P.1b(1) Organizational Structure

The MDCHD primarily falls under the purview of the State Executive Branch (Governor) through the DOH cabinet position (Surgeon General); however, it can also be seen as a hybrid operating with the county but with the state retaining ultimate jurisdiction.

The MDCHD is led by its Administrator who reports to the state Assistant Deputy Secretary, who reports to the Deputy Secretary, then the State Surgeon General and finally the Governor as shown in the Table of Organization. The Administrator is supported by a team of 12 Senior Leaders (SLs) comprised of 9 Program Directors, a Chief of Staff, and 3 Administrative Directors that oversee support functions that cut across the entire organization.. SLs are all responsible for the specific functions and/or programs of the organization. SLT is responsible for developing the long term strategic plans and for optimizing organizational agility and performance. SLs identify and address the key issues that may impact organizational sustainability.

Figure P.1-4 Key Customers and their Requirements		
Customer Groups	**Location**	**Requirements**
DIRECT		Accuracy Confidentiality Culturally sensitive Multi Lingual Timeliness Cost-effective Efficient Accessibility
- Clinical service recipients	N,C,S	
- Outreach Recipients	Countywide	
- WIC	Countywide	
- EH	N,S	
- Refugees	C	
- Vital Records	N,C,S, I	
INDIRECT		
- EH & Epidemiology	Countywide	
- PH Preparedness	Countywide	
Location - N (North), C (Central), S (South), I (Internet)		

P.1b(2) Customers and Stakeholders

Our key customer groups and their requirements are provided in **Figure P.1-4.** MDCHD provides PH services at the local county level as mandated by legislature. Miami-Dade is listed among the nation's largest counties in terms of PH issues. MDC is a gateway to the Caribbean and Latin America and it has become a melting pot of various cultures and ethnic groups, with significant immigrant populations from Central and South America, primarily Cuba and Haiti.

The organization has divided its customers into two distinct groups, the first being direct service recipients (clients) of MDCHD's clinical and preventive services. These include residents and visitors receiving services along with related case management and counseling services. These clients tend to be medically indigent and do not have insurance coverage or means to access private sector health care services. More than 200,000 clients are directly served by MDCHD annually. We also segment customers by service provided, by geography and by demographics.

The second group of customers includes the entire population of residents and visitors to MDC. These customers are often not aware of services being provided for them but benefit from preventative services (such as environmental and disease surveillance). They often become aware of these services only when emergency situations (such as a hurricane), and environmental issues (such as a beach closing), or a disease outbreak in a school makes the headlines. This group of customers constitutes likely future clients of MDCHD's clinical and preventative services.

P.1b(3) Suppliers and Partners

Figure P.1-5 provides a listing of Key suppliers and partners along with communications methods, and supply chain requirements. Suppliers are selected and managed consistent with criteria and guidelines established by FDMS.

Figure P.1-5 Key Partners and Suppliers

Agency/ Group And Role in Work System	Relationship/ Communication	Supply Chain Requirements	Role in Innovation
KEY PARTNERS: Work with us to deliver services.			
BOCC: Approve local funding **CDC: R**egulates disease control and provides funding **Hospitals/ Funeral Homes:** Birth/ death record data **DOH Bureaus:** Regulate internal procedures **State agencies** (DMS, DFS, AHCA) provide administrative services **Local non-profit organizations and local, state, federal agencies:** Provide Program Funding	• Official Memorandums • Two-way communication • Meetings/Conference calls/emails • Customer Service Survey • BOCC Official Meetings • Grant applications	• Satisfaction • Timely delivery of service and information • Accuracy • Legal/Policy Compliance • Team work	• Improvement ideas • Collaboration to address obstacles/ complaints/ suggestions
KEY SUPPLIERS: Businesses we pay to provide Important Services			
Leasing/ management Computers, IT equipment Copy equipment rental Office supplies/furniture Electricity/water/sewer Mail/package delivery Fleet management Security guard services Staffing Services Pharmaceuticals Medical providers, health/ lab services Medical Supplies and vaccines	• Supplier Customer Service Survey • Quotes • Contract Management • Two-way Communication • Meetings/conference calls/emails • RFP/ITB/ITN Process • Counseling • MFMP integration	• Timely delivery of services • Satisfaction • Fair and competitive pricing • Customer Support • Billing accuracy • Contractual compliance • Prompt Payment of Services	• New products/ services • New technology • Participate in action planning • Participate in idea generation

One of our strategic objectives is to increase the promotion of our PH messaging and services, and dissemination of health information to our clients, and our key community collaborators (Miami Matters and the Consortium for a Healthier Miami-Dade). We meet the needs of a large county with limited resources, through collaboration and contracting with providers of services. Our role has been shifting from directly providing services, to contracting with, overseeing and monitoring organizations that provide these services.

MDCHD also partners with many community organizations and individuals who provide both in-kind contributions of services and volunteer labor hours. These enable us to provide services beyond our budgeted capability. The Consortium is our leading disease prevention and health promotion program utilizing a broad range of support from organizations throughout MDC.

P.2a. Competitive Environment

P.2a(1) Competitive Position

MDCHD is the largest county health department in the state in budget and population and second in the number of employees. While there is year to year variation in the number of clients seen per program, there has been a growth rate of about 5% annually in overall clients served.

MDCHD provides statutorily mandated services and certain federally funded programs administered in Florida through CHDs that have no direct competitors. These include epidemiology, disease surveillance, vital statistics, PH preparedness and response, specific EH activities, WIC and Refugee Health.

MDCHD does have competition for funding and clients, particularly those with insurance, from numerous private and publicly funded care providers in the areas of direct patient services: Women's Health, STD, TB, and HIV/AIDS. MDCHD serves many clients without access to medical insurance and is required to provide many services without charge, and regardless of ability/refusal to pay.

Many community organizations serve as partners in the PH system and there is cooperative coordination and limited direct competition with these agencies. Examples include school health services, Healthy Start, and chronic and communicable disease prevention. While MDCHD does not have direct competition for a number of its programs, it must compete with other government and social service agencies for the limited funding available and therefore must provide high quality services at a lower cost than others.

P.2a(2) Competitiveness Changes

Principle factors that determine competitive success:

PH programs measure success by analyzing health outcome measures with comparisons to other CHDs and to statewide and national health indicators, goals and targets. MDCHD must leverage its PH leadership role to develop community partnerships and coalitions to successfully address health priorities and outcomes. In addition, MDCHD must identify and respond to PH emergencies 24/7/365, be able to

communicate information quickly through its media partners and mobilize for rapid community response.

Key changes affecting competitive situation: In 2010 the Legislature passed a bill requiring DOH to evaluate and justify its divisions and programs and provide recommendations for restructuring and reducing programs. This action could significantly impact our priorities and programs. Funding has been reduced by the legislature annually the past 5 years. Since FY 07/08, State funding for MDCHD has decreased 34% and Medicaid cost based reimbursement rates have declined 44%. Federal funding is now following the same trend. Since FY 09/10, MDCHD has experienced a 28% reduction in federal funds. MDCHD must be agile to adjust to these changes.

State imposed limitations on salary and reductions in benefits are impacting the retention and recruitment of professional staff. MDCHD's ability to innovate and seek grants has been curtailed due to DOH and legislative restrictions/directives. For example, social networking tools such as Facebook or Twitter are prohibited although DOH is pilot testing their use on a limited basis. Also, we are sometimes unable to pursue grant funding opportunities or make program changes that may be competing with private businesses. Therefore we must continually find innovative ways to partner in order to impact these health outcomes.

Opportunities for innovation and collaboration:
PH programs will need to be further prioritized and an emphasis placed on outcome measures, productivity, and cost effectiveness. Innovative opportunities for efficiencies and cost containment include implementing electronic health records, telemedicine, video conferencing, web-based training, and using social networking. Community partnerships and collaboration is vital to these efforts. MDCHD is pursuing an Academic partnership with FIU.

P.2a(3) Comparative Data

In Industry: When MDCHD was a GSA recipient in 2006, the available sources of comparative PH data were very limited. Today they are much more robust. There are several major sources of this data including the County Health Ranking report (done for the past two years by the University of Wisconsin and the Robert Wood Johnson Foundation) , the Community Health Status Indicators report by the CDC which provides for comparative results with Florida and National Benchmark counties, the Florida Charts system which provides various health statistics, and the Miami Matters dashboard system which provides a large variety of community data from numerous systems that are consolidated by the dashboard tool. There are many other sources of comparative data for tracking disease data, community assessment data, (PATCH), financial data, employee data, and customer data.

Outside industry*;* We also compare ourselves outside of our industry to high performing organizations who have similar processes. These include other Sterling Award recipients and Malcolm Baldrige Award recipients.

P.2b. Strategic Context

Strategic Challenges and Advantages: Figure P.2-1 lists our key Strategic Advantages and Challenges as determined during our Strategic Planning process.

P.2c. Performance Improvement System

The overall approach to maintaining an organizational focus on performance improvement, and organizational learning, is through strategic planning and systematic evaluation and improvement methods. The strategic planning process described in item 2.1a outlines the ongoing evaluation of organizational objectives and opportunities to develop action plans to close the gaps.

Figure P.2-1: Key Strategic Challenges and Advantages

Type	Challenges	Advantages
Business and Com-munity	-Funding Limitations -Unfunded mandates -Travel Restrictions - Brand awareness -Healthcare Reform -Political changes	-Strong partnerships -Expertise in PH epidemiology, EH, PH preparedness
Opera-tional	-Central Office clearance requirements	-Centralized service requests
Societal	-Many cultures /languages -High number of tourists/ transients	-Medical schools and health training facilities -Media market
Human Resource	-Below market salaries -No means for financial rewards -Training funds limited/ restricted	-Dedicated Staff -Skilled in Core Competencies -Diverse workforce

There is a systematic review of business results on a monthly, quarterly and annual basis. MDCHD uses several systematic approaches to ensure continuous evaluation and improvement of our services, systems and processes. These include our leadership review process (discussed in Category 1), process management (discussed in category 6), employee involvement problem-solving teams/workgroups (discussed throughout the application), and the systematic assessment of our management system through regular Sterling/Baldrige assessments and feedbacks reports. Our approach to systematic knowledge and skill-sharing throughout the organization is accomplished through our team based employee involvement and sharing at all levels, through an annual employee conference/programmatic retreat, regular team reviews, weekly leadership meetings and wide availability of data and information as discussed in P.2a(3).

Figure P.2-2 Performance Excellence Journey

1997 - Continuous Improvement Initiative Begins Sterling/Baldrige model adopted, QIC Teams Begin
2002 & 06 Governor's Sterling Award Recipient
2006 - Selected for Malcolm Baldrige National Quality Award Application Non-profit Pilot
2010 - Beta Test Site for PHAB Accreditation Process
2011 - Problem Solving Teams, Organizational Development Workgroup, Process Management/Quality Improvement Quality Assurance Committee established, QIC Trainings for employees, Great Practice Showcase , Employee Satisfaction Focus Survey, Improved Customer Listening Points, Refinement of Strategic Plan, Refinement of IDPs, Lean Training, Improved Customer Surveys

GLOSSARY

AAR	After Action Report
Action Plan	The individual ideas for improvement that have been extensively detailed with who, what, where, when and how
AERT	Applied Epidemiology and Research Team
BMI	Body Mass Index
BP	Blood Pressure
BRFSS	Behavioral Risk Factor Surveillance Survey
BSTP	Basic Supervisor Training Program
BT	Bioterrorism (Hazardous biological, chemical and radiological agents)
CASS	Clinic Administrative Support Services
CDC	Centers for Disease Control and Prevention
CEMP	Comprehensive Emergency Management Plan
CEU	Continuing Education Units
CHARTS	Community Health Assessment Resource Tool Sets
CHD	County Health Department
CHOP	Community Health Outreach Program
COOP	Continuity of Operations Plan
CPPW	Communities Putting Prevention to Work
CPS	County Performance Snapshot
CRCCP	Colorectal Cancer Control Program
CRI	Cities Readiness Initiative
DMS	Department of Management Services
DOH	Department of Health
DPPL	Disaster Preparedness Personnel Liaison
EAP	Employee Assistance Program
EAR	Employee Activity Record

EDC-IS	Epidemiology, Disease Control and Immunization Services
EEO	Equal Employment Opportunity
EH	Environmental Health
EHD	Environmental Health Database
EOM	Employee of the Month
EOP	Emergency Operations Plan
Epi	Epidemiology
Epidemiology	Communicable Disease Prevention, Surveillance and Control
ESF 8	Emergency Support Function 8 - Health and Medical
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics
FDOH	Florida Department of Health
FDENS	Florida Department of Health Emergency Notification System
FIRS	Financial and Information Reporting System
FLAIR	Florida Accounting Information Resource
FTC	Fast Track Clinic
GIS	Geographic Information System
GSA	Governor’s Sterling Award
Hazmat	Hazardous Materials
HMS	Health Management System-HCMS no longer exists
HCSF	Health Council of South Florida
HDC	Health District Center
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HMS	Health Maintenance System
HR	Human Resources

HSEEP	Homeland Security Exercise and Evaluation Plan
ICS	Incident Command System
ID	Identification
IDP	Individual Development Plan
IT	Information Technology
Key Requirements	The most important needs of a stakeholder that must be met to achieve stakeholder satisfaction
ITB	Invitation to Bid
ITN	Invitation to Negotiate
KSA	Knowledge, Skills and Abilities
LAN	Local Area Network
LT	Leadership Team
MAPP	Mobilizing for Action through Planning and Partnerships
MDC	Miami-Dade County
MDCHD	Miami-Dade County Health Department
MDEAT	Miami-Dade Economic Advocacy Trust
MDHAN	Miami-Dade Health Action Network
MERLIN	Florida's official web-based system for disease reporting, surveillance and analysis activities
MFMP	My Florida Marketplace
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
MSM	Men who have sex with men
MVV	Mission, Vision, Values
NACCHO	National Association of City and County Health Officials
NIMS	National Incident Management System

OPPAGA	Office of Program Policy Analysis and Government Accountability
OPHN	Office of Public Health Nursing
OPS	Other Personnel Services
OSHA	Occupational Safety and Health Administration
PDCA	Plan, Do, Check, Act
People First	State of Florida web-based human resources tool
PH	Public Health
PHAB	Public Health Accreditation Board
PPE	Personal Protective Equipment
PPHR	Project Public Health Ready
QA/QI	Quality Assurance/Quality Improvement
QIC® Story	Quality Improvement and Control Story Problem Solving Methodology
RFP	Request for Proposals
ROI	Return on Investment
RS	Results Scorecard
Florida SHOTS	State Health Online Tracking System
SIP	Special Immunization Program
SL	Senior Leader
SLT	Senior Leadership Team
SNEC	Special Needs Evacuation Shelters
SP	Strategic Priority
SPP	Strategic Planning Process
Stakeholders	Any group or individual that is or might be affected by an organization's actions and success
STD	Sexually Transmitted Disease
Strategic Objectives	Broad statements that communicate what an organization must achieve to remain or become competitive and ensure long-term sustainability

Surveillance	Tracking the Spread of Disease
SWOT	Strengths, Weaknesses, Opportunities and Threats Analysis
TB	Tuberculosis
TFAH	Trust for America's Health
TQM	Total Quality Management
UNC	University of North Carolina
USF	University of South Florida
VPN	Virtual Private Network
WHO	World Health Organization
WIC	Women's Infants and Children's Program
YPLL	Years of Potential Life Loss
YRBS	Youth Risk Behavior Survey

CATEGORY 1: LEADERSHIP

1.1 Senior Leadership

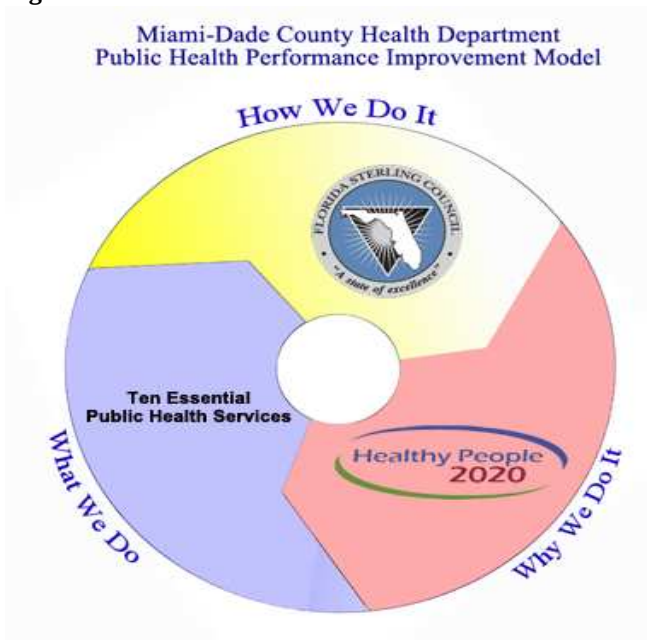
Leadership System: The MDCHD moved from a traditional government bureaucratic organization and evolved into a flattened organization to break down the silos and deliberately create a collaborative culture. The "team collaborative" model provides the key benefits of maximizing resources and reducing silos and was introduced by the Administrator. The model facilitates innovation and teamwork by fostering a culture of shared responsibility, authority and accountability for results. It creates cross-functional integration of programs with a flattened hierarchy, and creates conscious efforts that embed, reinforce and enable a team-based organization. This leadership structure facilitates increased leadership agility. There are two components, the Senior Leadership Team (SLT) and the Leadership Team (LT).

The SLT is the top level of leadership that consists of the Administrator, 9 Program Directors, a Chief of Staff, and 3 Administrative Directors that oversee support functions that cut across the entire organization. It is responsible for setting direction, executing the mission and making high-level policy/operational decisions and overseeing program operations. An important responsibility for the SLT is a monthly Business Review, where SLs focus on performance measures and meeting local and state strategic priorities. (See 1.1B and item 4.1) Program managers/supervisors, who are direct reports to SLs, together make up the LT, which provides the programmatic level of leadership to the organization. The LT is more operational and responsible for day-to-day programmatic direction and decision-making.

1.1a(1) Vision and Values

Setting: A key function of our leadership system is to set and deploy the direction of the organization in regards to the mission, vision, values, strategic priorities and purpose. This top-down and bottom-up process originally started in 1997 with the use of a consultant to facilitate the process of developing shared mission, vision and values (MVV) statements. A series of retreats were held for communication/feedback with the SLT and LT to review DOH's overall mission/vision and develop a set of local values, mission and vision statements for our CHD. A confirmation process incorporates communication/feedback from employees/stakeholders. As part of the Strategic Planning Process (SPP), our values, mission and vision are reviewed at least annually by the SLT and LT during the SWOT Analysis Process. The SWOT is deployed to all levels of the organization to ensure alignment and involvement. Our mission, vision, values and priorities were updated in 2001 and again in 2004 by the LT and with the help of an employee ballot to name the mission. The core competencies were determined as a result of an environmental scan and SWOT analysis conducted in 2010. In 2011 the MDCHD aligned with a state directive and adopted the State DOH vision and mission. A purpose was incorporated and the core values reviewed and expanded. All elements of our Strategic Plan are linked to our MVV and purpose statements.

Figure 1.1-1 MDCHD Performance Excellence Model



Deploying: To make our organization's values "real," the SLT demonstrates and communicates the vision and values and expectations of the organization through direct communication and role modeling. For example, the SLs maintain focus on the mission and vision not only at SL meetings, but also in staff meetings. The SLT conducts programmatic business reviews that reinforce the organization's mission, vision, values, and priorities. In addition, our values are directly deployed to staff, commencing with the recruitment and selection process and new employee orientation whereby the MVV, purpose and expectations are communicated and reinforced. For example, prior to final approval for hire, the Administrator interviews all final applicants for positions during which she reviews the mission, vision, purpose, core values and the role of the organization. A take home packet is given to reinforce this message. An introduction to organizational performance excellence and customer service training is also included as part of the orientation process. Our MVV, strategic priorities and MDCHD Performance Excellence Model (**Figure 1.1-1)** are displayed on posters at key locations for all employees and customers. The new MVV, and purpose were unveiled at the annual employee conference in 2011. The MVV are printed on all employee ID badges and they are prominently displayed on our intranet. Employees' performance standards support our MVV, and priorities.

Our website www.dadehealth.org and Annual Report also communicate the organization's mission, vision, values, purpose, priorities and business results to its customers, suppliers and partners. All contracts for services are based on meeting the MDCHD's mission, vision, values and priorities. **Figure 1.1-2** further illustrates the setting, deploying and communicating processes utilized by the MDCHD.

Communicating: SLs communicate and deploy the MVV, and expectations in a variety of ways throughout the organization. The Administrator drives this process and holds each Senior

Leader responsible and accountable for demonstrating and communicating the department's values and performance expectations. SLs are responsible for creating and maintaining an organizational culture that continually encourages and fosters integrity, customer/community focus, accountability, teamwork, excellence, respect, learning, continuous improvement and innovation. For example, the Administrator and each SL hold individual programmatic retreats that include reinforcement of our MVV and priorities, a review of organizational and programmatic business results, an interactive values session, and employee recognition. Employees also participate in providing feedback with a bi-annual organizational assessment/employee satisfaction survey. The annual performance appraisal/evaluation process and core performance standards also reinforce a commitment to the organization's values. Employees who do not demonstrate or comply with the values of the organization are counseled and may be subject to discipline. **Figure 1.1-2** shows how the leadership system is communicated and reinforced. Our Administrator holds weekly business review meetings with the SLT. In 2010 the Administrator and Chief of Staff researched electronic systems to facilitate monitoring of performance measures. As a result, the LT decided to obtain an electronic results accountability scorecard. Deployment has begun in the organization and will be completed in 2012. One SLT meeting each month is dedicated to business results and review of performance measures. The results accountability scorecard recently deployed provides current performance measures and results. The scorecard provides a tool to the organization to facilitate discussion during business reviews.

An example of MVV deployment is *Healthy Stories*, an innovative publication conceived and driven by SL Mort Laitner. Staff contributions tell real life stories of public health (PH) and therefore reinforces our MVV, and purpose far beyond our immediate stakeholders. It has grown from a small in-house publication to its fifth volume and was nationally recognized as a best practice. The publication has reached a worldwide audience via internet booksellers.

1.1a(2) Promoting Legal and Ethical Behavior

We are a highly regulated and ethical organization. The Administrator has implemented a policy with a "zero tolerance" for noncompliance to any legal and/or ethics requirements and policies. She discusses the importance of legal and ethical behavior as part of the final interview screening of new employee candidates. New employees receive training by the Legal Department at orientation directed at topics such as ethics, confidentiality, information security and sexual harassment. SLs receive reports of any annual mandatory training update delinquencies to follow up with staff. In addition, special topics are often covered during our Leadership meetings such as the purchasing/ contracting process and sexual harassment that touch on legal and ethical issues. In addition, quality assurance/quality improvement processes are in place to ensure compliance of legal and ethical standards. All employees and contracted vendors are required to sign the Confidentiality and Security Statement of Understanding, which are non-negotiable requirements of employment. SLs continually communicate and role model the "zero tolerance" for non-compliance. For example, the Administrator gives real examples of unethical behavior and the outcome. Noncompliance is immediately reported and addressed. The Legal Department handles labor relations and is available for consultation to SL and staff. An updated ethics policy was distributed to all employees in 2011.

1.1a(3) Creating A Sustainable Organization

We promote sustainability through our performance excellence model (**Figure 1.1-1**). Our Performance Excellence Model integrates the Ten Essential Public Health Services (See **Figure P.1-2**) as defined by the CDC with the goals of Healthy People 2020 which establish performance benchmarks for community health to be attained by the year 2020 along with the Sterling Criteria, which is used as a management model for the organization. Our strategic planning and business review processes ensure that the organization continues to grow and prosper. For example, the continued threats of manmade and natural disasters have brought preparedness and response to the forefront. Prevention and Preparedness is one of our SPs and we have aligned our resources to support the multi-faceted activities for this critical priority. The Continuity of Operations Plan (COOP) ensures that essential services will be continued in the event of a natural/manmade disaster. An HSEEP exercise of all MDCHD COOPs was conducted in 2010. In 2011 MDCHD was certified through Project Public Health Ready which is a national preparedness and response standard. We are one of only 198 local health departments so recognized.

Environment for Performance Improvement: We are committed to performance excellence and continuous improvement and consistently strive toward higher levels of performance. Our performance model is built around a shared desire to exceed expectations and to achieve remarkable results. We adopted the Sterling/Baldrige Model for Performance Excellence in 1997 and have consistently operated the organization based on this leadership model. This model has been incorporated to what is known as the MDCHD Performance Excellence Model **(See Figure 1.1-1)**. In their employee orientation, new employees receive training in the Sterling Management model. They are actively engaged in the continuous improvement process through employee teams, councils, workgroups, and committees. The implementation of the MDCHD's Performance Excellence Model, (specifically strategic planning, employee involvement and process management) has been showcased throughout DOH as well as Sterling Conferences. The MDCHD also has been featured in Quality Team Showcases at the regional and state levels, and has assisted other CHD's/organizations in their performance excellence journey. The Administrator is a state leader in promoting the Sterling model through creation of a regional committee and presenting the model to the local Chamber of Commerce and is a former President of the Sterling Council.

Environment for Accomplishment of Strategic Priorities: The SLs set performance expectations through our SPP (described in Category 2), utilizing data and input from a variety of internal and external sources. Strategic Priorities (SP) concentrate efforts and resources on a few critical priority

issues. SLs are responsible for ensuring that the SPs are deployed and targets are set and achieved. The three SPs, 1) Prevention and Preparedness, 2) Return on Investment and 3) Service Excellence, are overarching throughout.

Innovation: We take advantage of any opportunities to use innovative approaches to PH; we recognize innovation internally and pursue recognition externally. Innovation is recognized on a local level through an Employee Recognition Award process that outlines specific criteria for recognition. At a state level, the Davis Productivity Award process recognizes individual employees and employee team/workgroups that have made significant improvements in their work. In 2010 our Applied Epidemiology and Research Team (AERT) received this award and a NACCHO Model Practice Award for creating two automatic surveillance alert systems during the H1N1 outbreak. The MDCHD also received national recognition for its innovative Healthy Stories publication.

Another vehicle to encourage innovation is the organization's commitment to the Baldrige/Sterling Performance Excellence Model. We encourage the SL and LT to become Sterling Examiners and have had an examiner on staff for the past 12 years. In 2011 the MDCHD provided training for five staff to become Lean certified and established a Lean team.

Many of our programs such as STD, HIV, EH, Preparedness, Epi, Women's Health, and WIC have been recognized for their creative and innovative approaches to identify and close gaps. For example, our HIV program spearheaded the Test Miami campaign to encourage physicians to make HIV testing routine.

We submitted a Baldrige application in 2006 as part of the Baldrige Pilot project for non profit organizations. We were a Beta Test site for PH Accreditation in 2010 and have submitted the application of intent to achieve accreditation by 2013.

In order to provide a positive customer experience, SLs role model positive behavior in their interactions with staff. Customer surveys are an integral part of service encounters. Results are segmented by program, site and unit and displayed on the intranet and reviewed by SLs in program meetings. When warranted, survey results undergo a PDCA process and/or additional staff trainings conducted.

Organizational Agility: SLs set the environment for ensuring organizational agility in several ways. These include: the organizational structure, the collaborative team model, preparation through planning; workforce empowerment and training; and employee involvement to quickly resolve key issues. Our SPP (See Item 2.1) is a priority setting process for the organization and results in action plans created to make improvements based on these priorities. Systems are in place to enable MDCHD to respond quickly to situations, including our disease surveillance system, emergency operations system and the organizational chain of command/incident command system (ICS). When the organization must act quickly, we are able to adjust priorities and develop new action plans as required. By empowering our workforce and giving it the skills needed to quickly resolve problems, we can immediately charter new teams, workgroups or individuals to address critical issues. We are considered to be a role model in disaster preparedness and response. In 2005 the ICS was introduced providing a new dimension to our ability to react/respond further improving our organizational agility. We quickly responded to the H1N1 outbreak leading the distribution of medication to hospitals and educating/vaccinating the public. We continue to receive high marks from the CDC for the Cities Readiness Initiative (CRI) in exercising Bioterrorism Preparedness. We have engaged all of our employees and community partners in the development of a comprehensive response plan, facilitated various levels of training, Personal Protection Equipment (PPE) fit testing, and coordinated drilling, evaluating and improving the plan.

Encouragement/Support of Learning: SL support for continuous learning and development is one of the key objectives of the SP Service Excellence. Educational leave, tuition waivers, and paid attendance at local/regional/state conferences/educational programs allow employees the opportunity to meet their personal and professional development goals. We directly provide orientation, basic supervisory and mandatory trainings, and facilitate teleconferences and program-specific staff development opportunities throughout the year that are aimed at all levels of the organization. Teleconferences and web-based online learning offer a cost-effective means for staff to participate in continuing education as well as receive continuing education units and certifications for specialty training. MDCHD facilitates clinical student internships and residencies for medical students, physicians, nutritionists, social workers, and nurses. As a result of a nursing educational assessment, the organization contracted with Nursing Spectrum to provide unlimited access to online CEU courses for its registered nurses. Collaterally, this initiative facilitated improved computer literacy among our nurses.

As part of our quality journey, the department has concentrated additional resources to provide organizational-wide training in performance excellence, Sterling Criteria, strategic planning, process management, leadership and facilitation, teambuilding, and internal quality to staff at all levels. Recently, a Sterling Council trainer conducted a two day training on innovation and another two day training on the Sterling Criteria. We continue to learn from GSA winners by attending their showcases or participating in workshops. For example the City of Coral Springs provided training for SLs on the Sterling Process. We also use consultants in leadership, executive leadership, internal quality, performance excellence, and team building to facilitate individual and collective staff/team development.

Leadership Role in Succession Planning: One of the organization's strategies is to develop current and future leaders. SLs practice the executive leadership skills learned at the Management Academy for PH at UNC. Several SL have attended the USF School of Public Health's Leadership Institute. The Administrator via performance appraisal expects SLs to actively participate in the development of future leaders for the organization. The SL of each program participates directly in the training and transition processes to demonstrate a commitment from the top and to ensure a common understanding that people in lower levels to will be developed to assume higher level positions as anticipated turnover occurs.

In 2010 four of our top managerial positions where appointed from within. As an organization that is in the public sector we recognize the given personnel system constraints. We are intent on creating a pool of future leaders capable of meeting the succession needs of the organization. At their annual performance evaluation, SL meet with the Administrator and employees meet with their supervisor to review the past year's performance and set individual objectives. An Individual Development Plan (IDP) is created to set goals and identify the skills needed to attain the goals for the coming year. This yearly assessment is a personalized tool that guides employees toward personal and professional improvement. To generate promotions from within, the employees are notified when a position is posted on the People First website.

1.1b(1) Communications

SLs use our day-long Annual Employee Education Conference/ Programmatic Retreat (now in its twelfth year) as a primary means of communication, recognition and organizational learning. The retreat is held for all employees to re-communicate the MVV, purpose, SPs and strategic plan. The Administrator gives a "state of the agency" address incorporating historical and future perspectives; agency SWOT analysis and business results; progress of employee involvement, showcasing of best practices and employee recognition at all levels. In addition, several topics of interest are presented at the conference and employees reaching service milestones are recognized. Conferences and retreats are employee driven, and planned and evaluated by an employee committee. Other means of employee communication are provided in **Figure 1.1-2.**

Empowerment and Motivation: In addition to the employee conference, our implementation of the Organizational Performance Excellence Model transformed a historically autocratic reactive culture to one that is proactive and fosters an environment that empowers front-line employees to make decisions. This enables leaders to be more focused on strategic issues and the employees on day-to-day issues. Cross-functional employee team/workgroups are routinely empowered to solve departmental problems and issues. The Employee Education Conference provides another example of SL support of empowerment. This is an employee-driven and planned conference. The conference is evaluated and opportunities for improvement are identified for the next year.

SL share key decisions via email, during staff meetings, individual consultations or the intranet. An open dialogue is

Figure 1.1-2 How the Leaders Set, Communicate and Deploy Leadership System Elements

Leadership System Elements	Setting	How Communicated	How Deployed
• Mission, Vision, Values • Purpose • Fundamental Principles • Strategic Priorities • Legal/Ethical Compliance	• Strategic Planning • Direct Input From Customers, Partners And Stakeholders • Environmental Scan	• Direct Communications • Role Modeling • Mission, Vision On IDs • Quality Plan • Strategic Plan • Leadership Meetings • State of Organization Address	• Employee Orientation • Customer Service Training • Supervisor Training • Newsletter/Website/Intranet • Annual Employee Conference/Retreats
• Performance Expectations	• Strategic Planning • Performance Standards Linked To Objectives • Individual Development Plans • Competency Based Performance Expectation	• Champion For Each Strategic Priority • Performance Measures Tracked • Team Improvement Projects • Results-based Accountability Framework	• Business Results • Performance Appraisals • Annual Employee Conference/Retreats • Newsletters • Business Review Minutes And Action Plans
• Creating Value for Customers & Stakeholders	• Employee Surveys • Customer Surveys • Strategic Priorities • Benchmarking • Legislative Contact	• Annual Employee Conference/Retreat • Strategic Objectives • Survey Results	• Employee Workgroups/Teams • Customer Service Training • Quality Training • Role Modeling
• Establish & Reinforce Environment For Empowerment	• Use Of Sterling Management Model • Cross Organization SWOT • Open Door Policy	• Program Strategic Plans • Employee Opinion Survey • Employee Involvement Showcases	• Team Showcasing • Quality Training At All Levels • SL Accessibility • Programmatic Employee team/workgroups
• Organizational Agility	• Strategic Planning • Employee Empowerment & Training • Employee Involvement Presentations	• Strategic Priorities And Key Objectives • Annual Employee Conference/Retreats • Meeting Summaries	• Business Plans • Action Plans • Business Results • Training

encouraged by maintaining respect of individuals and opinion. Individual discussions of sensitive matters remain confidential. The Administrator delivers certain important messages via email or video on the intranet home page.

Senior Leader Role in Reward and Recognition: Despite the limitations of state law on recognizing employees, SL has empowered a formal Employee Image/Recognition Committee that is employee driven and focuses on employee involvement and recognition. As resources have become more scarce, many SLs donate their personal funds for encouragement and team motivation incentives/activities. The Employee of the Month (EOM) is recognized on the intranet, and in 2011 the EOMs were recognized at the employee conference. For the first time an employee of the year will be named early in 2012. SLs engage in programmatic recognition of staff in creative ways. For example, the WIC Director holds an annual picnic to recognize her staff. The EH division has programmatic EOM recognitions. The Administrator sends a handwritten note and recognition pin to the EOM.

1.1b(2) Focus on Action

Leadership Review of Organizational Performance: The SLT monthly Business Review meeting focuses the organization on attaining our local/state SPs identified in the SPP. The results accountability tool is being implemented to determine if performance measures are met. SL create a focus on the accomplishment of the SPs in several ways, Indicators monitored by SL are brought to the weekly SLT meeting for discussion. Issues may be raised to the Chief of Staff to be placed on the meeting agenda. Presentations are given and the issue discussed. The high level indicators of the Administrative Snapshot are reviewed at the monthly business review. The DOH County Health Department Snapshot is reviewed when received each year. SLs review the results and undertake a PDCA approach to any lagging indicators. This is accomplished by incorporating the intrinsically linked Performance Excellence Model dimensions of employee involvement, SPs, and process management with the fundamental principles of decision by facts, respect for people, and customer satisfaction. A review process similar to the one described here also has been implemented at the program level. For example EH underwent an examination of its billing process. Data from the billing cycle was used to determine performance level and process time. Feedback from the business office and EH staff was incorporated into a revised process with the business office assuming a quality control and assurance role. Collections were monitored to determine improvement.

Through the SPP and the SWOT analysis, review findings are analyzed to identify trends, prioritize improvements, and identify opportunities for innovation. Due to limited resources, a prioritization matrix is used to optimize effectiveness. When a process measure or performance indicator is not meeting target, it is examined in more depth and appropriate countermeasures are taken. When suppliers or service providers are involved in the process, they may be asked to participate in the improvement effort. If further improvement is needed it may be brought forward as part of the SPP and be identified as a strategic objective. If a gap between the current and target measures continues to exist, an employee team/workgroup or workgroup may be identified to proceed through the PDCA process. In 2011 SLs decided to deploy an electronic results accountability scorecard which is currently being deployed.

Creating/ Balancing Value for Customers and Stakeholders: The setting of our three SPs helps to create a balance in focus.

Prevention and Preparedness focuses on the community and external clients. Return on Investment focuses on the legislature and taxpayers. Service Excellence focuses on external customers, internal staff and our various partners. A focus on customers and the community is an important value within the organization. The SPP incorporates value for the customer and stakeholder by prioritizing needs based on their input. For example, prior to our strategic planning sessions, a partners survey was conducted using a professional tool adapted to our needs. The process of gathering data and feedback from customers and other stakeholders is continuously being improved. We have made significant improvements in terms of listening to our customers. Community/public forums, focus groups, and town meetings are utilized as part of the process of gaining community input. Also, results of our External Customer Satisfaction Survey and Client Complaint/Inquiry System are incorporated into the SPP. SPs, goals and objectives have been aligned with the MVV as well as human/fiscal resources. One of our new Governor's priorities is to hold State agencies accountable for spending. He believes that taxpayers have the right to know how their money is being spent and assess the return on that investment, and that taxpayers have a right to know what is taking place in state government. As a result the new website Florida has a Right to Know was developed. The culture of the MDCHD is one that shares the belief that we are accountable and need to be diligent stewards of taxpayers' contributions. We use numerous ways to evaluate and improve the leadership system using the results of performance reviews and employee feedback. The Feedback Reports from the Sterling Challenge in 1997, followed by the GSA Applications in 2001, 2002, 2006 and the Baldrige feedback report in 2006 facilitated critical improvements in our organizational structure and culture, as well as provided inputs towards the strategic planning process that has continually evolved and improved over the years. In 2010 we participated in the Public Health Accreditation Pilot, which again provided an intensive assessment and identified opportunities for improvement. Key Leadership System improvements since adopting the Sterling Process in 1997 are in **Figure 1.1-3.**

1.2 Governance and Social Responsibility

1.2a(1) Governance System:

Accountability for leadership actions, fiscal accountability and protection of stakeholder interest is ensured locally through organizational and programmatic quality assurance and improvement, business review, SL performance indicators and internal/external auditing processes. Operations are streamlined utilizing the PDCA model to minimize costs to the

taxpayer. We are externally audited by DOH Peer Review Team and the Inspector General.

On a State level, the Office of Policy Performance and Government Accountability (OPPAGA) reviews key program and fiscal processes. In addition, our programmatic fiscal reviews are subject to reviews by the State Attorney's Office and Federal Auditing. The organizational structure provides accountability for management's actions with oversight and specific responsibilities as described in the each leader's position description. Accountability starts with the state DOH oversight of the Administrator who in turn holds the SLs accountable. Transparency in operations is guaranteed through the Florida in the Sunshine law, sharing of information with partners, community assessments, a budget review process and a schedule of programmatic and contractual audits. Our daily transactions for fund disbursement are monitored by a local comptroller and an alliance was developed with the State Health office to process our accounts payable and purchases. Oversight for the MDCHD is provided by the DDOH at the programmatic and operational level.

1.2a(2) Performance Evaluation:

SLs use a broad range of reviews and surveys to evaluate and improve their effectiveness. They affect the organization through the quality management process utilizing a comprehensive approach that includes incorporating the Sterling and Baldrige Feedback Reports, SWOT analysis, the Employee Opinion and Customer Satisfaction Survey results, and the SLs Individual Leadership Development Plans (IDPs) to identify opportunities for improvement.

Competency-based performance standards for SLs are incorporated into their performance appraisal process. The Administrator conducts annual performance appraisals that include individual 180 degree reviews with the SLs. A mid-year review is being instituted this year. The Deputy Secretary for Health evaluates the Administrator's performance. The Administrative Snapshot, comparing business performance measures for MDCHD and its peers is an integral tool of the Administrator's performance evaluation.

Figure 1.2-1 illustrates some of the approaches utilized to improve leadership effectiveness. Examples of improvements made to the leadership system since adopting the Sterling Model are shown in **Figure 1.1-3**.

1.2b Legal and Ethical Behavior

1.2b(1) Legal and Regulatory Behavior:

Our key process measures and goals for addressing regulatory and legal requirements for risks associated with services and operations. We set stretch targets that clearly surpass minimum requirements. We anticipate and proactively address public concerns by maintaining ongoing communication with both internal and external customers. As shown in **Figure 1.2-2,** the SLT is involved in numerous activities designed to anticipate, assess and prepare for public concerns. For example, we continually anticipate and evaluate PH needs that could result from a natural or manmade disaster. MDCHD is the county's lead agency for ESF8 health and medical which includes bioterrorism. Emergency response systems are activated and staff alerted to a state of readiness via FDENS. Staff notifies hospitals to report any unusual outbreaks, and staff works with the press and community leaders to minimize potential PH threats through the delivery of appropriate information. MDCHD's response to disasters is debriefed by the SL and lessons learned are used for improvement and future planning.

Environmental stewardship is a shared responsibility for protecting the environment and minimizing the impact of our daily decisions. We are committed to resource conservation and environmental sustainability while meeting the

Figure 1.1-3 Key Leadership System Improvements Since 1997

Year	Improvements To Leadership System	Year	Improvements To Leadership System
1997-2001	• Enlightened Leadership • Flattened Organization • Sterling Challenge Site Visit Leadership/Facilitation Training • Formalized SP Process • First Annual Employee Conference • Charter Employee QIC® Story Teams • Process Management Training • First Annual Nursing Summit • Nursing Leadership Development • Employee team/workgroups	2003-2006	• Leadership Development • Behavioral Event Interviewing • CDC National Public Health Institute • Facilitative Leadership • Collaborative Team Structure • UNC Management Academy • USF Public Health Leadership Institute • Peer Coaching/Executive Leadership Workshop/ 360 Review – SL
2001-2003	• Programmatic SPs • GSA Application • Implementation Of IDPs For SL • 360 Review – Administrator Level • Improvements from GSA Feedback • Establish Public Health Institute • SLT Cross Training - Shadowing Program • Leadership Modules • Development of Indicator Matrix • Internal Quality Workshop • Leadership Development Workshops	2006-2011	• Site Visit to City of Coral Springs (Sterling and Baldrige award winner) • RWJ Executive Nurse Leaders course • QIC® Story training agency wide • Introduction to Lean (SL and Leadership) • Lean team created and trained • 180 review for SL performance appraisals • Targeted readings • Bill Blackwood – Leadership Workshop • Results Accountability Scorecard

requirements of the 2008 FDOH Executive Order "Lean to Green" Initiative. We established a cross-programmatic Green Initiative Team in 2010 which developed a Green Office Policy based on DMS guidelines for energy conservation and reduction. Recycling has been implemented at six locations with environmental sustainable products used for custodial cleaning. We have a three year plan for improvements in recycling, water conservation efforts, and energy savings through energy audits and continuous employee training.

MDCHD has developed unique and innovative methods designed to create a balanced market place with supplies and partners in the community (see 6.2b(2)). We utilize opportunities from our contract vendors to capitalize on our conservation efforts which allow us to purchase recycled printer cartridges yielding a 16% savings. Recycled printer cartridges are currently being used by two offices. The initiative is tracked within the Green Initiative Committee action plan. We purchase 30% recycled paper from our State Term contracted vendor. We ensure use of effective supply chain processes by following State procurement guidelines and implementing PDCA methodology.

1.2b(2) Ensuring Ethical Behavior:

MDCHD must meet state and federal mandates designed to safeguard the well being of our customers and protect the interests of the residents and visitors of Miami-Dade County. Expectations of compliance with ethical practices are conveyed to all employees during the final interview process with the Administrator. The New Employee Orientation, where the Employee Handbook is distributed, reviewed and signed by each employee. Code of Ethics is presented on the first day and mandatory training compliance is monitored in the Trak-It system. Policies are readily available on the intranet. Compliance is assessed by quality audits and peer reviews. Preventive and corrective actions are taken as necessary. Our Legal Department conducts supplemental ethics training for employees that includes role playing and examples of the policy's application to MDCHD. Employees are encouraged to utilize their chain of command when in doubt. Employee concerns may be communicated to their manager/supervisor, our Legal/Labor Relations staff, the Inspector General, EEO Office and/or the Comptroller.

MDCHD's key compliance processes include monitoring mandatory training records, contracts, incident reporting, and individual employee behavior. We have 7 certified contract mangers on staff. Also, our internal and external audits and monitoring ensure compliance with ethical standards.

1.2c Supporting Key Communities:

1.2c(1) Societal Well-Being

Societal Well-Being is a factor considered during our strategic planning process and especially during the development of our community health improvement plan. Our mission is based on societal well-being and is a unique driver for our organization. Across all daily operations we serve the community through, health fairs, media campaigns, health education, advocacy and being a convener to foster new initiatives. Examples include continuation of the Healthy Beaches water testing despite loss of funding because of its importance to disease prevention, and the establishment of the Fast Track Clinic which arose from emergency room overuse and the need for residents to have a medical home. The CPPW grant targets obesity, promotes physical activity, bike paths, and farmers' markets all which are essential to improve the health of the community. The community benefits from WIC locations throughout the county to provide nutritional education, food vouchers and breastfeeding support. The MDCHD website provides health related news, event information and health alerts. Senior leaders sit on Boards of Directors and Councils. The Administrator was a member of the JHS Task force to evaluate the public hospital and make recommendations for its governance. SL submit an article about their program to the monthly South Florida Hospital News.

1.2c(2) Community Support

Our key community is assigned by the state as the residents and visitors of Miami-Dade County. Areas of emphasis are identified through the SPP and state authorized activities such as the State of Florida Employee Charitable Contribution. SLs share their leadership skills with the community by serving on various boards, councils and coalitions that are directly linked to the organization's mission, vision, values and priorities. SL also encourages employees to be involved in community organizations. Participation is detailed in **Figure 1.2-3**.

SLs and Leaders evaluate and improve public responsibilities

Figure 1.2-1 How Individual Leadership Effectiveness Is Improved

Approach	How It Is Used To Evaluate	How It Is Used To Improve
Sterling Self-Assessment & Feedback Reports	• Opportunities For Improvement	• Quality Initiatives • Results and Succession Planning
180 Degree Evaluation And Leadership Development Opportunities	• Direct Feedback From Staff • Self-Evaluation	• IDPs To Improve Performance • Individual Coaching
Robert-Wood Johnson Nursing Leadership Fellows Program	• Feedback From Peers, Pre And Post Surveys For IDPs	• Development Of IDPs And ID Of Coaching Opportunities
SHO Quality Improvement Peer Review Visit	• Feedback From QI Team With Opportunities For Improvement	• Development Of Formalized Agreements And Action Plans
Employee Opinion Survey	• Direct Feedback From Employees	• Used To Establish Employee team/workgroups/Workgroups • Incorporated Into The SP Process • Development Of IDP For SL
Annual Employee Conference/Retreats/Recognition Ceremony	• Direct Feedback From Employees	• Feedback Used To Improve Next Year's Conference
Business Review Process	• Information Shared At Meetings	• Leadership Development Opportunities

and support to the community through a cohesive system of process management, process improvement and SWOT analysis during the annual SPP. For example, The Consortium for a Healthier Miami-Dade was established in 2003 and is driven by MDCHD as a result of feedback from the community in the areas of chronic disease. The Consortium has seven committees with many partner members focusing on specific issues and geographic areas. For example the Built Environment Committee strives for smart growth. SLs encourage staff participation in activities supporting the community such as the annual toy drive, heart walk, and teaching at local universities. The Mango Writers Festival was established in collaboration with the South Florida Writers Association. It will have its second festival in the fall and feature our PH literary journal, Healthy Stories. Additionally, we work in collaboration with community agencies and government officials for outreach to deliver health promotion and preventive services and immunizations to the community.

Figure 1.2-2 How Public Concerns Are Anticipated and Addressed

Public Area Of Concern	How Anticipated	**How Potential Impact Is Assessed**	**How Proactively Prepared For**
Outbreaks Communicable Diseases	• Monitoring And Surveillance • Partnering With The Community • Statewide Database	• Monitoring At Address Level • Stratification Of Data	• Respond To Individuals and the Community
Emergency Planning	• Emergency Plans • Ongoing Communication and Updates from EOC	• Emergency Logs • Debriefings • Facilities Form • Address Level Mapping Of Impact • Surveillance System	• Staff posted at EOC • SNEC and Medical Management Staffing • HAZMAT Team • Bioterrorism Plan • Incident Command Structure • Staff Training • Event Exercises
Environmental Health Threats	• Feedback From Stakeholders • Risk Associated With Population Served	• Surveys • Audits • Performance Measures • Records Review	• Strategic Objectives • Communication With Service Providers
Refugee/Migrant Health	• INS Meetings • Communication With Public Officials	• Trend Analysis • Benchmarking	• Partnerships • Innovative Programs
Healthy Community	• Public Communication Efforts • Community Education • Working with Other Agencies	• Public Health Advisories / Press Releases • Surveys / Assessments • MAPP • Client Complaints/Inquiries • Health Status Indicators	• Fact Sheets • Partnerships • Consortiums • CPPW

Figure 1.2-3 Approaches Used To Strengthen Key Communities Operations

Level	**Select Community Support Activities / Societal Practices**	**How Evaluated** **Measures**	**How Improved**
Organizational	• Consortium for a Healthier Miami-Dade • Health Fairs/Outreach	• # Of Members • # of Health Fairs	• Direct Feedback • Health Improvement Plan
Senior Leaders	• Barry and FIU University • Community Assessment Statewide Task Force • Department of Elder affairs Advisory Council • Early Learning Coalition • Florida Association of County Health Officers • Florida School Health Association • Florida Sterling Council • Hospital Governance Task Force • Mayor's Task Force on Child Readiness • National Association of City and County Health Officials • Public Health Nursing Council	• # Board/Task Force Memberships • # of Courses Taught	• Implement Changes To Impact Community • Educate Future Public Health Workforce
Employees	• Florida State Employees Charitable Campaign • Toy Drive	• $ Donated • # of toys donated	• Increase Funds and Toys Donated

CATEGORY 2: STRATEGIC PLANNING

2.1 Strategy Development

2.1a(1) Strategic Planning Process

MDCHD began in 1997 a process of strategic planning designed to identify the issues/priorities that must be addressed to meet the health department's mission. Reviewed annually with a three year planning cycle the strategic plan creates a shared blueprint to improve the health of our community. The three Strategic Priorities (SP) selected for 2011-2014 emphasize our purpose as an organization: Prevention and preparedness, Return on investment, and Service excellence. Once the SP are defined a set of Strategic Objectives are developed which leads to key activities. We have added a new feature to our planning process which is business plans. The Strategic Plan (longer term planning) and the Business Plan (short term planning) for implementing the policy direction through specific programs and initiatives are our guiding documents. The business plan captures the MDCHD strategies/key activities in quantifiable form. Business Plans are living breathing documents that need to be continually revisited throughout the year. The Strategic/Business Plans are deployed through the use of action plans for each program and department wide. The key elements of the Strategy Development and Implementation process are shown in **Figure 2.1-1**.

Key participants in the Strategic Planning Process (SPP) include the Administrator a SLT, and staff. The SPP incorporates many listening points to ensure that feedback is taken into consideration when planning. Staff involvement is achieved at program level and during a SWOT process. Staff also gather and analyze external and internal information to determine current issues and opportunities to consider during the strategic planning cycle. Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis methodology guides this information gathering and evaluation activity. MDCHD determines its core competencies through a SWOT analysis. Evaluating the strengths, weakness and opportunities and threats are important in matching our capabilities and resources to our competitors. Engaging the SLs and employees in participating in a SWOT analysis allows for the identification of internal factors and external factors that affect the strategic direction of the department. The strengths identified during our SWOT analysis serve as input to determining Core Competencies. (**Figure P.1-1**) This is validated in Step 4 of the SPP.

Another source of information is the review of important documents that includes the State DOH Five-Year Plan/State law and others. In order to better identify and eliminate potential blind spots MDCHD began conducting an environmental scan process in 2010. This environmental scan includes: historical and current situation and perspectives; economic, regulatory, socio-cultural and technological influences; demographics and health statistics; market segments and customers; and employee satisfaction and stakeholder impact. The analysis phase of Strategic Planning (Steps 1 through 7) ends when conclusions/theories are drawn about the extensive information that has been accumulated. The process then dictates that potential long and short-term opportunities be formulated. With current economic and political factors, it is very difficult to project beyond a three year planning cycle. Many of our associated performance indicators and deployment activities may have a shorter-term duration and some are focused on the current fiscal year. These time frames have been set to align with the requirements of the state Department of Health, which requires a focus on the attainment of "Healthy People 2020" health indicators along with current year requirements for budget alignment.

Improvements in the SPP (**Figure 2.1-2**) have been made to review and revise mission, vision and values and reduce strategic priorities. A purpose statement was developed in 2011. Monthly performance reviews of program performance as it aligns with the SPs are held at the SLT level. The recently instituted result accountability scorecard provides real time data for the Administrator and a means to immediately respond. SLs are responsible for determining and reviewing specific countermeasures to ensure that SPs will achieve targeted performance levels. In addition, employee teams/workgroups may be assigned to assist with specific priorities.

Figure 2.1-1 MDCHD Strategic/Business Planning Process

Strategic Plan (Every 3 Years)	**Timeframe**
1. Set Direction (State and Local Directives)	**January**
2. Environmental Scan	**February through April**
3. Conduct SWOT (Program & Agency wide)	
4. Validate Mission, Vision, Values, Purpose, Core Competencies, Challenges/Opportunities	
5. Validate Key Stakeholders	
6. Validate Key Customer Requirements	
7. Results Review	
8. Develop Strategic Objectives, Indicators, Targets	**May**
9. Determine Key Activities (Action Plans)	**May**
10. Match to Budget	**June**
11. Finalize Plan	**July**
12. Execute Plan	**July-June**
Annual Programmatic and Agency Business Plan	
13. Mini-scan (What's new, What's changed)	**April-May**
14. Update Objectives , Indicators, Targets	
15. Design Detailed Annual Business Plan	**May-June**
16. Implement the Plan	**July-June**
17. Monthly Business Reviews (Program & Agency)	**July-June**

2.1a(2) Strategic Considerations:

Strengths, Weaknesses, Opportunities and Threats: The following key factors are evaluated in the SWOT analysis process (Step 3, **Figure 2.1-1**): Customers & Customer Requirements, Competitors, Technology Changes, Supplier/Partner, Societal & PH Issues, Organizational

Capabilities and Needs, Human Resource Capabilities. These factors are used in the development of MDCHD's Strategic Priorities.

Customer and Market Needs/Expectations/Opportunities: As a state governmental agency, the DOH has legislative mandates which dictate services to be provided by county health departments. MDCHD operates within this framework; however, local priorities and customer needs are considered in the following ways:

- Healthy People 2020 Goals and Objectives – Benchmarks determined by the Centers for Disease Control for disease reduction on a national level.
- Analysis of PH Indicator Data – Tracks 14 key PH indicators by zip code, trends and benchmarks. Examples: Which areas of the county have the highest infant mortality rates or the most babies born to teenage mothers?
- Program-Specific Data – For example, health disparity data on breast and cervical cancer rates prompted MDCHD to develop a program for underserved women.
- Customer Satisfaction Survey Data – MDCHD surveys customers and data is used in considering customer needs – i.e. service hours, language requirements, and satellite locations.
- Participation in Community Coalitions/Boards – As a member/driver of many community agencies, such as the Consortium for a Healthier Miami-Dade, Early Learning Coalition, Miami-Dade Health action Network and Florida School Health Association.
- The administrator is a member of advisory boards for Florida International University and the University of Miami.
- MDCHD's SLT members receive feedback from customers and partners regarding service needs and opportunities for improvement.

Technology, Markets, Competition and Regulation: The SWOT analysis considers competitive threats and opportunities. Through participation in various community partnership activities, MDCHD keeps pulse of the county's competitive environment. There has been an increasing trend in recent years for the state to reduce government services through privatization and downsizing. There is competition among private Health Maintenance Organizations (HMO) and community health providers for patients that receive state assistance through the Medicaid program. MDCHD has been proactive and contracted with private/public providers to operate clinics that we would traditionally operate. The MDCHD has merged immunization clinics and consolidated sites for STD testing.

MDCHD conducted extensive research to determine which peer counties on a national and state level should be utilized for benchmarking purposes. Population size, poverty level, population by age, and population by race/Ethnicity as well as percent of foreign born were compared based on information from the U.S. Bureau of the Census 2010. We selected a total of nine peer counties that were similar in population composition and demographic characteristics; four within Florida and five nationally. These counties are: Hillsborough (Tampa), Orange (Orlando), Duval (Jacksonville), Broward (Fort Lauderdale), Los Angeles, Queens (New York City), Bexar (San Antonio), Dallas, and Harris (Houston). The methodology to determine these counties is described in Category 4.

MDCHD is aware of new trends and technologies in PH and its leaders actively participate on a national level as members of professional associations and members of national workgroups through the Centers for Disease Control and other agencies. The Administrator is a member of the CDC's Office for State, Tribal, Local and Territorial Support advisory committee. The strategic priorities adopted by MDCHD are focused on providing "core" PH services as a result of trends taking place on a national level for PH to concentrate on services to communities rather than personal health services to individuals. This information is included in the environmental scan and included in the SWOT.

Human and Resource Needs: Human resource issues and needs are considered in the SPP on a program-specific basis. These issues include recruitment issues, training needs and new programs or services that may be established. The annual budget for MDCHD reflects staffing and training needs identified during the strategic planning process.

Supplier/Partner Strengths and Weaknesses: Supplier, partner and service provider capabilities are considered within the development of the SWOT analysis. During the SWOT process decisions are made and priorities are set for in-sourcing versus contracting with outside providers based on the documented capabilities of the medical service provider community within the South Florida area. In addition, the capabilities of community partners are considered both in the development of MDCHD Strategic Priorities and in joint planning sessions with various partner agencies. For example, our School Health Program works together with the School Board, hospitals and private providers in the community to determine which schools will receive school health nurses. As an improvement to our process in recent years, we have included many of our key service providers and partners in our strategic planning workshop, have surveyed their opinions or have brought their needs and concerns from other forums into our planning considerations.

Long-term Sustainability: The key to sustainability in PH is preparedness. In 2004, the Trust for America's Health (TFAH) conducted a study of the nation's preparedness/response capabilities to bioterrorism threats. The state of Florida has been recognized as a national leader for its PH preparedness/response capabilities with facilities, training, and testing of emergency plans. We ensure financial and organizational sustainability in emergencies in a variety of ways during our SPP (Step 10, **Figure 2.1-1).** These include our BT/COOP/CRI Plans, and succession planning.

Ability to Execute Plans: Senior Leadership, as part of the annual SWOT analysis, considers operational issues, which may impact our ability to execute our Priorities and aligned activities. For example, as a result of a potential budget shortfall, core programs prioritize human resource needs and shifting of staff is based on strategic priorities.

As a governmental agency, we are always subject to changes in Florida's leadership at the executive and legislative level. The Surgeon General is a political appointee serving at the discretion of the governor. The agency's budget is set by the Florida legislature. The movement to downsize and privatize state government functions continues. These state level actions impact all our Strategic Priorities. Financial and political risks are considered during the SWOT analysis and in budgeting decisions made by SL. We also consider new areas of focus in strategic planning decisions that may come about through legislative action. For example, general revenue which funds the beach monitoring program was reduced but we continue the program as a strategic priority.

The continuing emphasis on financial accountability has allowed MDCHD to maintain its trust fund goal established by the state. We have been successful in seeking other funding sources including grants, funding for special programs by the county and in-kind services through volunteer efforts and partnerships. Flexibility in our work force is maintained through the use of OPS staff for grant-supported and other short-term projects. New funding initiatives (CPPW and Refugee primary care) bring funds for targeted expansion of service and PH improvements in the community.

A key component of the SPP is formal review of the process itself conducted by our SLs. The plan is assessed based on its success in achieving Strategic Targets and based on the organization's successes in carrying out the planning process according to schedule. Monthly reviews at the SL business review meetings keep us on target. **Figure 2.1-2** shows improvements made in the SPP over the past several years.

2.1b(1) Strategic Objectives:

The three Strategic Priorities align with our mission, vision, values and the core PH functions/essential services. The following process is used to determine the organization's Strategic Objectives (Step 8, **Figure 2.1-1**). At the conclusion of the SWOT analysis, all issues identified (particularly weaknesses, opportunities and threats) are prioritized by using a prioritization matrix that rates each issue in terms of impact on customers (internal or external), need to improve, and/or alignment with vision. Each issue is rated and voted upon utilizing an electronic desktop voting mechanism. Those issues scoring highest (along with mandated issues) are combined with similar issues and become our strategic objectives.

Each objective is assigned a set of performance indicators and each indicator has an assigned goal/target level, which is based on current performance levels, trended performance results, benchmark targets and comparative performance. As is more fully explained in item 2.2, there is one set of activities assigned to each objective in order to ensure alignment and deployment. These are accomplished in steps 8 and 9 of the Strategy Development Process. Strategic Objectives, indicators and goals/targets are provided in **Figure 2.2-3.**

2.1b(2) Strategic Objective Considerations:

Our organizational challenges are determined in step four of the strategy development process, and priorities to address these challenges are determined in the prioritization setting process in step five. This ensures that our chosen Strategic Objectives address only those challenges that are deemed to be of highest priority. **Figure 2.2-3** shows how the challenges and advantages discussed in the Organizational Profile are aligned with our current Strategic Priorities and Core Competencies. Also, a major focus of Strategic Priority number 2, Return on Investment and Priority number 3, Service Excellence is to find innovative means to do more with less, through productivity improvements, process improvements, and investments in technology.

The design of our three SPs and their associated objectives with performance goals/targets ensures both a short and longer-term focus on strategic issues. For example, our health indicators (Prevention and Preparedness) are focused on the attainment of Healthy People 2020 targets, while our other two priorities (ROI and Service Excellence) have both short and longer-term components. Also, as stated in Category 1, these priorities create a balanced focus on clients and the community (priority #1), taxpayer and legislature (priority #2) and both internal and external customers (priority #3).

Figure 2.1-2 Improvements to the Strategic Planning Process

Year	Improvement
'98-'01	• Developed Strategic Plan Using Sterling Model • Identified Mission, Vision, Priorities, Key Objectives • Incorporated SWOT Analysis • Linked Employee Opinion Survey Results • Implementation Of Programmatic SPs • Incorporation Of Customer Satisfaction Data
'01-05	• Involvement of Suppliers/Partners in Planning Session • Determined Peer Counties for Comparison Data • Updated Mission, Vision, and Priorities with Employee Input and Voting • Implemented Partner Survey • Implemented Two Year Planning Cycle • Partner Survey Improved • Implemented Streamlined Planning Process
'06-11	• Implemented Three Year Planning Cycle • Conducted Environmental Scan • Adopted State Mission, Vision • Created Purpose Statement • Expanded Core Values • Re-identified peer counties • Reverted to three year planning cycle

2.2 Strategy Implementation

2.2a(1) Action Plan Development

Following the development of Strategic Priorities (SPs), indicators and targets, each SP is assigned a Champion who becomes the lead person for the strategic priority and key activities. Champions are responsible for determining the best approaches to bring about the improvements necessary to reach targets. Each Champion is supported by the rest of the SLT. This is part of our collaborative model. Approaches may include assignment to improvement teams/workgroups or individuals as subject matter experts. In addition, each program is asked to develop action plans based on the key activities for those

priorities that are strongly aligned to their specific program. **(Figure 2.1-2)** This is achieved through the use of following the Strategic Planning Timetable. (**Figure 2.1-1**) **Figure 2.2-3** illustrates selected Key Activities for our SPs.

Figure 2.1-2
MIAMI-DADE COUNTY HEALTH DEPARTMENT
STRATEGIC IMPROVEMENT SYSTEM

SPs are deployed to all levels of the organization through several means including Senior Leadership meetings, and staff meetings. Deployment ensures familiarity with Action Plans that may be assigned to teams/ workgroups. Goals, with measures and targets, are shared to create the quantifiable link between the employee and the organization's goals. Any planned changes to products or services that affect suppliers or partners will be aligned in our SP and key activities and deployed through action plans.

2.2a(2) Action Plan Implementation

Many of our current Key Activities are listed in **Figure 2.2-3**. All others will be available on site. Key activities are both short and long term in nature. For example, the CRI Plan which is part of Strategic Objective 1.2 to maximize and develop all hazards emergency response plans deploys several different strategies and training initiatives that are being carried out over several years, The system of performance indicators is in alignment with our Strategic Objectives and Key Activities. Our indicator program is designed to create "Golden Threads" from Priority to Objective to Program and is able to drill down to drive activity at the work group level. See **Figure 2.2-1** for one example of a "Golden Thread within our WIC program. Similar drill down indicators exist for all of our core PH Programs and for support processes.

Figure 2.2-1 Golden Thread for WIC

2.2a(3) Resource Allocation

To the extent possible, resources are allocated based on the initiatives and priorities highlighted in each fiscal year's Strategic Priorities. By selection of an issue as a SP, Senior Leaders have committed to striving for the associated targets. While we maintain this position philosophically, we operate as a governmental agency, which requires flexibility in funding matters. Funding decisions are made based on state allocation and community needs that are determined in our Community Health Improvement Plan.

2.2a(4) Workforce Plans

As a part of our SWOT analysis, department human resource needs are considered. The result of this process is that goals 3.1 and 3.7 (**Figure 2.2-3)** directly relate to the development of workforce plans. Additionally, in determining the activities required to achieve the various objectives, there are often workforce needs that must be met in order to achieve these objectives. For example there is a strong training requirement associated with objective number 1.2 in the deployment of the CRI Plan.

2.2a(5) Performance Measures

Key performance measures for objectives and action plans are included in the new results accountability scorecard. The measures and status of key activities and any performance gaps are to be reviewed at least monthly by SL (**Figure 2.2-3**) and ongoing by program managers. These measures, in conjunction with the SPs, address day-to-day operational issues and needs. Each program is asked to develop activities and indicators to align with appropriate objectives through the "Golden Thread" process.

Our SPP requires the constant sharing of information throughout the organization. This includes modifications to SPs as well as documented performance in moving the organization to achievement of its stated objectives. As information is available, it is distributed to employees via email at program meetings and displayed collectively on the intranet. Also, individual team/workgroup projects are developed that are linked to SPs. In addition, all employees participate in the Annual Employee Education Conference/Retreat, which highlights results of SPs and showcases program level activities including employee team/workgroup results.

At the end of the fiscal year, outcomes are published and presented to customers, partners, and other stakeholders in an Annual Report. Performance in key processes and programs, both core and support areas, provides a barometer of how well the organization is implementing strategies and meeting targets.

Improvements are made by responding to the data in a timely manner. Owners are responsible for meeting SP targets by tracking activities and reviewing data submitted. In addition, a review of alignment and deployment activities is formally undertaken as part of the SPP (Step 9, **Figure 2.1-1**). Scheduled prior to the start of the Strategic Plan development cycle, this evaluation provides the opportunity for improvements to be incorporated in future processes.

Local contributions to the priorities by DOH are also reviewed. DOH provides status reports for both internal progress on key measures and performance of all counties including our peers. Improvements are made through monthly business results meetings and during yearly Strategic Planning efforts and related benchmarking. **Figure 2.2-2** provides examples of improvements made to the strategy implementation process.

2.2a(6)) Action Plan Modification

We review the status of both Objectives and Key Activities during the business review SL meetings. As a part of this review process, we may find that some activities are no longer required and new activities may be needed. An example of agility within this process came during the H1N1 outbreak in 2009. Significant activity and infrastructure was required to respond quickly to this high priority PH issue.

Priorities are set based on allocated budget. Re-evaluation occurs periodically based upon state level funding.

The Business Plan is a direct outgrowth of the SP, in a quantifiable form, improving decision-making and resource allocation. A benefit of using a Business Plan is the direct link between SP and costs and activities. This model is used to monitor performance through variance analysis of goal to actual; linking budget line items to measurable activates and identifying value-added and non-value-added activates.

The Business Plan is an organic document, in that it is continually revisited throughout the fiscal year and may be amended by the finance office. Changes in the environment may require realignment of resources to remain on target and to meet the SPs. In developing the annual budget, programs analyze existing, mandated, and potential services in light of the SP. The Business Plan adds and removes services which are then quantified in the line item budget. They reflect not only the SPs as established by SL, but incorporates feedback from customer and partner surveys. Both financial and human resources must be reallocated to assist the organization in meeting priority needs should there be shortfalls in total budget. For example, when the emergency needs of the state changed there was a large impact on the funding of our SPs and has resulted in the reprioritization of our PH resources to ensure adequate preparedness and response levels. Internal/ communitywide plans were developed to address a pandemic influenza outbreak in 2009 and other PH emergencies.

2.2b Performance Projection

Figure 2.2-3 summarizes the projections for key measures over the next three-year period.

We compare our performance on key indicators with other county health departments (particularly Hillsborough, Orange, Duval, and Broward) and with cities comparable to the Miami-Dade metro area such as Los Angeles, Queens (New York City), Bexar (San Antonio), Dallas, and Harris (Houston). For example, the immunization rate, teenage pregnancy rate, and infant mortality rate are included in these comparisons. We also compare our performance with other CHD and health care provider GSA winners in appropriate areas such as customer satisfaction. Our performance is targeted to meet or exceed the performance of other comparable providers as discussed above. In addition, key national targets are set by the CDC publication Healthy People (HP) 2020. **Figure 2.2-3** lists our projected health indicator results against the HP 2020 targets.

Figure 2.2-2 Improvements to Strategy Implementation

Year	Improvements
'98-'01	• Produced SP and deployed to SLT • 1st Annual Employee Conference • Produced Quality Book for all Employees • Produced Quality Plan for Leadership • Simplified Strategic Plan • Linkage of SP to programmatic SPs
'01-'05	• Change in Organizational Structure • Interaction Among Core Programs • Golden Thread Workshops • Regular Site Visits by Administrator and Public Health Manager • Golden Thread Cards • Programmatic Storyboards • Traffic Light Report • Strategy Map • Indicator Matrix
'05 '11	• Web-based report portal • Web-based process indicators • Hall of Excellence • Strategic Plan operational leads • Web-based customer satisfaction survey results

Figure 2.2-3 Strategic Objectives, Indicators, Goals, Targets and Activities

Strategic Priority (C/A Addressed)	Strategic Objective (Core Competency Alignment Fig P.1-1)	Indicators	Goal/ Target 2011-14	Selected Key Activities
1.0 Prevention and Preparedness **Addressed:** ▪ Funding (C) ▪ Mandates (C) ▪ Brand (C) ▪ Political (C) ▪ Expertise (A) ▪ Medical schools (A)	1.1 Conduct assessment that results in evidence-based community improvement plan that impacts health disparities (Core Competencies 1 & 3)	-% completed. -% Improvement plans developed -% action plans completed	▪ Completed every 2 years. ▪ Strategic plan for Consortium completed. ▪ All committees have an active action plan	▪ Conduct assessment with community partners using MAPP Tool ▪ Develop community improvement plan ▪ Develop action plans to implement various strategies ▪ Analyze epidemiologic data to identify disparities
	1.2 Maximize & Develop emergency plans to meet PPHR & certification requirements (2)	-% annual plan revisions completed	100 % meets recertification	▪ Maintain PPHR Workgroup
	1.3 Environment protection (2)	# initiatives executed	3 initiatives implemented	▪ Continue Green Office initiative
	1.4 Promotion of services (5)	TBD	Community Outreach Plan	▪ Develop plan based on clinic location/ population
	1.5 Improve Public Health Outcomes (ALL)	YPLL	6900 per 100k	▪ Benchmark key industry indicators
		Infant Mortality	26.5 per 100k	▪ Prioritize disparities
		County Rankings	Meet state target	▪ Benchmark key industry indicators
		% Indicators meeting target	70% Meet Targets	▪ Improve health indicators
2.0 Return on Investment **Addressed:** ▪ Central office (C) ▪ Requests (A)	2.1 Revenue maximization	-% of estimated revenues collected	$77,276,996	• Develop Plan for Medical Records Review to ensure opportunities for billing
	2.2 Fiscal performance and accountability	% Programs w/ Scorecard	100%	▪ Create financial performance scorecard
	2.3 Capital improvement plan	% of project completed by 2013	100%	▪ Complete Phase 2 HDC and Little Haiti Clinic
3.0 Service Excellence **Addressed:** ▪ Cultures (C) ▪ Tourists (C) ▪ Salaries (C) ▪ Rewards (C) ▪ Training funds(C) ▪ Partnerships (A) ▪ Media (A) ▪ Staff (A) ▪ Competencies (A) ▪ Diverse(A)	3.1 Balanced/Aligned workforce	-% Workforce Development plan Completed -% staff on teams, workgroups -% Turnover rate -% Satisfied -% Appraisals in compliance	▪ 100% Completed. ▪ Increase participation to 200 ▪ Turnover rate < 15% ▪ Increase satisfaction by 10% ▪ Implement computerized performance appraisal system	▪ Create/deploy Workforce Development Plan ▪ Conduct analysis/ plan for future workforce needs ▪ develop succession/ retention planning process
	3.2 Performance excellence and accountability	-% completion of process	▪ Accredited	▪ Apply for voluntary public health accreditation
	3.3 Stakeholder communication (1)	-# of complaints -# of compliments - Cust. Satisfaction	▪ Deployment of customer inquiry/complaint system ▪ TBD	▪ Implement customer inquiry/complaint system agency wide
	3.4 Standardized service delivery(5)	Programs with appointment system	▪ Appointment System in place	▪ Implement a central appointment plan
	3.5 Customer employee engagement (5)	-Customers engaged -Employees engaged	▪ Methods in place to measure engagement	▪ Research methods to engage employees customers ▪ Develop plans for customer/ employee engagement

CATEGORY 3: CUSTOMER FOCUS

3.1 Voice of the Customer

3.1a (1) Listening to Current Customers

MDCHD serves the community by providing direct and indirect services to the public. Direct service customers are those who receive services directly from the MDCHD. Indirect service customers are those who benefit from our services but do not have direct contact with the Department. Information on customer experiences is collected via customer satisfaction surveys, epidemiological assessments, community health assessments, community meetings, partner organizations and the customer inquiry telephone line. The various listening methods used are listed in **Figure 3.1-1.**

The process of gathering feedback from direct customers via survey has been ongoing since 1999 but has varied prior to April 2011. Between 2006-2008 MDCHD gathered and processed feedback information through the Office of Organizational Development (OOD); due to budget constraints the OOD closed in 2008. After the closing of OOD and before instituting the current feedback methods, each program used their preferred method to gather feedback; either paper-based, electronic, in-person, via telephone, or a combination. Since April 2011, based on a PDCA process, all programs have adopted the DOH standard customer satisfaction survey. The survey, available in paper and electronic formats, was created to standardize listening methods among county health departments (CHD) and improve the collection and comparison of data. This improved survey process provides a continuous flow of customer data with results made available for viewing in the Customer Satisfaction Survey Portal, which is accessible by all MDCHD staff.

The Office of Epidemiology, Disease Control and Immunization Services (EDC-IS) performs community health assessments when a current or potential health crisis is identified. The process in performing a community health assessment involves ten steps, five of which provide current customers a venue for providing feedback. In 2009 the EDC-IS assessment process was used to collect customer information after a confirmed death from Legionnaires' disease. EDC-IS determined there could be a potential outbreak of the disease at the hotel where the person stayed prior to becoming ill. The hotel provided a list of 1,700 current and former guests who stayed at the hotel during the same timeframe of the confirmed case. Those who were reached received surveys which screened them for the disease. The quick actions of MDCHD prevented the further spread of the disease and limited the damage to only seven confirmed and three probable cases.

The MDCHD Office of Communication schedules meetings on an as-needed basis with the local community. These meetings are held to provide customers with an open forum to discuss health related concerns. Healthcare professionals are in attendance to answer questions and to collect feedback from customers. These meetings provide MDCHD with intimate knowledge regarding current and potential health concerns that the public may have. Most recently the MDCHD held a town hall meeting to provide the community surrounding a lead contaminated park with relevant medical information.

The MDCHD works with numerous health partners to listen to the voice of the customer while promoting the health of the community. Our health partners function as reporters of community health information, therefore providing MDCHD with information relating to health needs that cannot be met with their current resources. MDCHD works closely with our health partners to resolve community health concerns and maintain public health. For example, in 2008 the Florida Health Disparities Summit highlighted increased chronic disease disparities amongst the Pan-African south Florida population. Together with the Consortium for a Healthier Miami-Dade and the Florida Heart Research Institute the MDCHD participated in Mission to Health, a project aimed at reducing health disparities amongst the Pan-African community of Miami-Dade County.

The customer inquiry telephone line is available 24-hours a day for customers to contact MDCHD regarding available services and specific customer needs; Monday thru Friday 8am-5pm phone calls are received by MDCHD, outside of those hours the

Figure 3.1-1: Customer Segments, Key Requirements and Listening Methods

Customer Segments	Key Services	Listening Methods
Direct Service Customers	• Health and Nutrition Education • Prevention of Environmental Threats • Disease Surveillance • Immunizations Infectious Disease Screening and Testing • Emergency Preparedness Execution • Family Planning Health Screening • Birth and Death Records • Pre-Natal and Post-Natal Care	• Customer Inquiry Telephone Line • Customer Satisfaction Survey • Website Community Partners • Health Assessments • Data Analyses • Direct Contact with MDCHD Staff
Indirect Service Customers	• Emergency Preparedness Planning • Water, Food and Environmental Monitoring/Regulation • Health and Nutrition Education	• Customer Inquiry Telephone Line • Website • Community Partners • Health Assessments • Data Analyses • Outreach Events • State Corrflow

Poison Control hotline receives and logs the calls on behalf of MDCHD. Both telephone lines provide information on general inquiries and gather any complaints or compliments from customers. For compliment and complaint calls a service ticket is created and subsequently forwarded to the appropriate staff member. The ticket remains open until the issue has been resolved. Staff able to communicate in English, Spanish and Creole is readily available through both telephone lines.

The MDCHD values indirect customer feedback. MDCHD collects information from indirect customers via the opinion survey available on our website and the customer inquiry telephone line. The data collected from these sources is filtered to the corresponding program supervisor for data analysis.

The MDCHD cares about its commitment to the community. The Department actively listens to customers as they change between direct and indirect status—known as the customer life cycle. Initially, direct service customers respond to customer satisfaction surveys to rank their experience and make suggestions for improvements. After any direct services are rendered, the customer may return to being an indirect customer until direct services are again needed. During their interaction with the Department, the MDCHD follows-up with the customer through reminder calls, notices, and announcements where the customer is encouraged to continue services with the Department and feedback from the customer is sought. Programs such as STD and HIV/AIDS are unable to communicate freely with customers due to Health Insurance Portability and Accountability Act (HIPAA), state and federal regulations.

Miami-Dade County is comprised of numerous nationalities with different cultures and the Department encourages the staffing of service sites with personnel that are able to communicate clearly with our customers in their language of choice. English, Spanish and Creole are the dominant languages in our county and we are staffed and equipped to provide verbal and written feedback in the customers' language of preference. We also have the ability to translate services into any language.

Previously, DOH regulations prohibited the use of social media sites. However as of August 12, 2011, DOH has launched a pilot trial for utilizing Facebook and Twitter pages. This new means of communication will give local CHDs the ability to connect with a larger part of the community that uses technology as its main source of information. Currently, the project is in its trial phases. The Office of Communication intends to maximize this tool in the future when DOH approves social media for CHDs.

3.1a (2) Listening to Potential Customers

The MDCHD listens to potential customers through outreach events, community partners, health assessments, the customer inquiry telephone line and the website. Each of these mechanisms provides for collection of information that helps the Department identify and address the needs of the community.

Each program attends outreach events related to the program's strategic initiatives. At these events, potential customers are given the opportunity to interact with staff and provide feedback related to services which is crucial to the development of outreach programs and initiatives. Outreach events present a solid platform to connect with the community and inform the public of MDCHD services available to them by providing additional marketing of our services thus allowing us to gain a larger market share of potential customers. Examples of these events include the annual World TB Day and the HIV Test Control outreach campaign.

The Consortium for a Healthier Miami-Dade (Consortium) is an initiative that consists of over 100 organizations working together through the leadership of the MDCHD and the Health Council of South Florida. The Office of Community Health and Planning provides the staffing for this initiative. Through this collaborative the MDCHD is able to implement community assessments, surveys, and activities. The Consortium provides an avenue for community leaders to provide feedback. In 2008 the community participated in the Mobilizing for Action through Planning and Partnerships (MAPP). The MAPP process, conducted every three to four years, is a community-wide strategic planning tool that is used for improving community health. Through the Consortium partners participate in four key assessments: 1) community themes and strengths; 2) local public health system; 3) community health status; and 4) forces of change. From these assessments three key community problems were identified: the importance of health navigators to assist clients in accessing care; awareness of living a healthier lifestyle; and the need to reduce health disparities within various populations. The Consortium is addressing these needs through the eight established committees that are guided through the Executive Board. The committees are: Children Issues, Elder Issues, Health and the Built Environment, Health Promotion and Disease Prevention, Marketing and Membership, Oral Health, Tobacco Free Workgroup and Worksite Wellness. The Consortium developed its strategic plan and each committee has its own work plan to guide its work. Through this collaborative, the Consortium applied for a grant in 2009, awarded to MDCHD in March 2010, which would help provide the means to address two of the needs identified in the community assessment. The Consortium uses a combination of surveys, focus groups and SWOT analysis in addition to the MAPP process to guide its work.

Community health assessments are a major avenue MDCHD uses to solicit feedback from potential customers. These assessments involve distributing, collecting and analyzing surveys, in paper-based or interview format. Through these assessments potential customers can voice their needs and concerns related to their health and that of their family, the health of the community and how they feel MDCHD can help in meeting their health goals. Results of these assessments are given to MDCHD programs and partners for use in Strategic Planning and in creating new programs or securing additional grant funding to meet community health needs.

Potential customers are given the opportunity to provide feedback using the customer inquiry telephone line and/or website. Customer information is used to better understand community requirements including what services are needed, who is in need of services and where to focus such services.

Customers may also request a paper-based customer satisfaction survey in their desired language from the MDHCD.

3.1b (1) Satisfaction and Engagement

In 2008, representatives from several CHDs met with DOH administration to discuss creating a uniform customer satisfaction survey that would be standardized across all CHDs. What resulted was a nine item survey that is available in both paper-based and electronic formats. This survey includes seven standard questions that use a five-point Likert scale and two open-ended questions that solicit additional information about customer requirements. In April 2011, MDCHD began using this new survey format with all direct customers.

Customer satisfaction is deemed to be achieved when a customer response reflects above the neutral criteria by indicating “agree” or “strongly agree.” on a 5-point Likert rating scale. Customer engagement is deemed to be achieved with a rating of "strongly agree."

The customer satisfaction survey is intended for use by direct customers. Indirect customers report satisfaction through the customer inquiry telephone line and website. The customer inquiry telephone line records three types of calls; complaints, compliments, and general inquiries. Satisfaction and engagement are determined in the same manner as the direct customer satisfaction survey. Two additional questions will be added to the customer satisfaction survey that will better assist MDCHD in measuring customer engagement: Would you return to MDCHD? and Would you recommend MDCHD services?

In March 2010 MDCHD released a Community Partner Strategic Planning Survey. The survey collected information that rated how partners viewed the department and to determine what partner needs were not being met. The results of the survey are assisting SLs to make changes to the Strategic Planning process that would better engage community partners. Through this survey it was identified that community partners would benefit from receiving a modified strategic plan that explained the unified mission between the partner and the department.

The MDCHD Hospital Preparedness Consortium (HPC) manages the participation of MDC hospitals in emergency planning. Through the HPC all members are given a venue to participate in emergency drills so that the hospitals and MDCHD are prepared during a public health emergency. The use of engagement tools is key, as they promote high member participation. The HPC accomplishes this through the many activities it hosts throughout the year including drills, meetings and trainings. The HPC continuously maintains contact with its members and collects feedback after each event. Their suggestions are given utmost consideration as their role in emergency planning is vital for the health and safety in MDC

3.1b (2) Satisfaction Relative to Competitors

Customer satisfaction is compared to other CHDs using results of the customer satisfaction survey as previously discussed. MDCHD uses St. John’s CHD, winner of the Sterling Award in 2009, as a benchmark for customer satisfaction. The state also compiles data on all CHDs and publishes a State Snapshot Report showing both a macro and micro comparison of indicators including customer satisfaction.

Programs such as the Women’s Health & Preventive Services (WHPS) and Immunization Services have substantial direct competition for customers; including clinic based, private practice and hospital based providers. Comparing satisfaction among providers is difficult since their customer service questionnaires vary greatly from the MDCHD.

3.1b (3) Dissatisfaction

Customer dissatisfaction is determined through response data collected from the customer satisfaction survey, the customer inquiry telephone line and the website.

Results from the customer satisfaction survey that have been graded neutral and/or below, are considered to be a sign of dissatisfaction. Increased negative responses to questions indicate to program supervisors that requested services are not being provided to the satisfaction of customers. Because data trends are available regularly, supervisors can track improvements on a monthly basis or as needed to determine level of satisfaction.

Staff also determines dissatisfaction with MDCHD services based on client calls that are categorized as complaints. After each complaint call, staff generates a service ticket that is routed to program supervisors for follow-up. The ticket is not closed until the customer has received adequate follow-up.

In 2008, MDCHD administered the Customer Satisfaction Survey and determined that the most common cause of customer dissatisfaction was customer wait times. Data showed that a large percentage of cycle times exceeded two hours. SLs established a workgroup to address this issue. As a result, the workgroup created a program aimed at reducing wait times that would be piloted at the Family Planning Program at the Health District Center. The pilot program began October 2010 using a managed appointment system aimed at increasing the numbers of customers with scheduled appointments while reducing the number of walk-in customers. The goal was to decrease wait times greater than two hours by 50% from 37% to 19%. Early data reports have triggered the use of the pilot in four other locations beginning September 2011. This plan directly addressed the SP Service Excellence 3.4 by improving customer satisfaction through a standardized service delivery process.

3.2 Customer Engagement

3.2a (1) Product and Service Offerings

Many of the programs and services provided by MDCHD are mandated by the state or provided under the authority of a federal, state or local funding source. These include; Epidemiology, STD, TB, Public Health and Preparedness, Vital Records, and Environmental Health which are all state mandated. Certain other programs may be offered at our discretion as long as we can secure funding sources to keep them operational.

The major source for identifying product and service requirements is through epidemiological studies and needs assessments. These assessments are conducted during a potential or active health threat. However, a program may request a

county health assessment at any time from EDC-IS, if required for a grant application. Health assessments may include analyzing data through Florida CHARTS and other health databases, performing in-person interviews, distributing surveys and collaborating with partners, such as HCSF to perform large scale assessments. The decision to conduct assessments is determined by SLs and Administrator. Data used to guide the work of MDCHD comes from the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), Florida CHARTS and the yearly community health profile and community report card prepared by the HCSF. Results of the various assessments are used by MDCHD programs and available to the public via the Office of Communication. Results of these findings specify which health concerns are the most prominent, providing MDCHD the opportunity to realign programs to address community health issues. Results of the county health assessments are used to apply for additional grants to fund new programs that target particular health needs. As previously stated, the MAPP process identified the crucial role that healthy lifestyles plays in the health of the population and the need to reduce disparities in health status and outcomes among various populations.

The 2010 Miami-Dade County Health Report Card evaluated 58 health indicators and graded the county according to state and federal standards. Several of those indicators, such as adult and teen obesity and adult and teen fruit and vegetable intake are currently being addressed by the Communities Putting Prevention to Work project (CPPW). In 2010 MDCHD was awarded a grant for $14.7 million for the CPPW. Each of the initiatives of the CPPW project was created as a result of a 2006 Community Health Survey and the MAPP process that concluded that MDC residents were living an unhealthy lifestyle. Through CPPW the various components that affect obesity among children and adults in MDC are being addressed by engaging the community in evidence based strategies that implement policy, systems and environmental changes. Culturally appropriate community and workplace interventions are geared toward increasing physical activity, improving nutrition and decreasing television and computer screen viewing time. Specific interventions being implemented include a mass media campaign, farm to school program, physical activity programs in the MDC Public Schools, access to healthy foods in convenience stores, farmers markets, breastfeeding practices at hospitals, active transportation and recreation, safe routes to schools and worksite wellness. Projects like CPPW show the commitment of the MDCHD in providing new and innovative ways to serve the current needs of the population.

A majority of new discretionary services are created as a result of countywide needs assessments. The HCSF collects and releases countywide health, education, economic and policy status information for the general population. The MDC Health Profile was released in 2010 as well as a MDC Community Health Report Card. Both of these documents highlighted health areas that are in need of additional resources. Based on results from these documents, the MDCHD created several initiatives. For example, the Health Profile determined there was a problem with individuals arriving to the emergency room for non-urgent/non-emergency issues. Based on this information the Miami-Dade Health Action Network was formed in partnership with HCSF in 2008. The purpose of this network was to develop a sustainable approach to providing health care services to the uninsured residents of the county. The first project implemented was a partnership between MDCHD and the county hospital that resulted in the creation of an emergency diversion clinic called the Fast Track Clinic in February, 2009. This clinic is operated and managed through the MDCHD and is funded by grants.

In coordination with HCSF, MDCHD provides an interactive web-based health education system, Miami Matters to the community. This website also connects visitors to community resources, an education library, demographic and community health information and support. This free tool, available in five languages, contains the latest health assessment information.

As stated above, a primary means for us to identify needs and provide new services has been through attainment of grant funding. There have been recent state mandated changes to the grant approval process. We are working within these requirements and will continue to apply for grants that advance our SPs. Other examples of service offerings begun as a result of needs assessments and grant attainment are in **Figure 3.2-1.**

Figure 3.2-1: Grant Initiative Examples

Program	Grant and Begin Date	Initiatives
Community Health and Planning	CPPW, 2010	Promoting and providing ways for MDC residents to lead healthier lifestyles
Epidemiology	Drowning Prevention, 2006	Education to parents, children, and schools on how to prevent drowning
HIV/AIDS	Take Control, 2006	Education and rapid HIV screening
School Health	Satellite School Health Services Initiative, 2010	School health services to rural schools
Tuberculosis	Teleradiology, 2010	Electronic radiology services
Women's Health	CRCCP, 2009	Colorectal cancer education/screening

3.2a (2) Customer Support

Customers have three ways to interact with the Department; in-person, via telephone and through the website.

Each employee is required to complete the following trainings within three month of original hire date: code of ethics, cultural diversity awareness and a three part performance improvement training which provide staff with basic customer support awareness. Furthermore, during new employee orientation, training staff reviews proper phone etiquette and work attire. As part of the performance evaluation, staff is graded on customer service through a five point competency scale, part of the MDCHD Performance Evaluation Competency Dictionary. By maintaining a trained, professional and welcoming staff,

customers are more likely to seek support and services and staff will have the tools to provide Service Excellence.

The customer inquiry telephone line received over 30,000 calls during the 2010-2011 fiscal year. By providing a 24-hour customer contact, MDCHD is enabling customers to have access to support. The customer inquiry telephone line is advertised at each service site, posted on our website and staffed by multilingual personnel. Furthermore, the ticket generation process ensures that inquiries are answered on a timely manner by personnel who can appropriately address the problem at hand.

MDCHD's website, www.dadehealth.org, provides customers with a significant amount of information; including program specific contact information, links to customer satisfaction surveys, customer inquiry telephone line and external links to county, state and federal resources. Each program is required to have a page on the website that provides a synopsis of the program, its objectives and contact information.

All published MDCHD educational materials are required to include the Department's Mission, Vision and Values in addition to contact information for the specific programs.

After each direct service encounter, staff encourages customers to complete the customer satisfaction survey. The surveys are available in English, Spanish and Haitian Creole. Staff is available to assist customers with completing the survey.

Some programs, such as School Health, cannot retrieve customer feedback due to customers being underage. As a result, they collect feedback at an organizational level, in this case the Miami-Dade County Public School System. School Health distributes a Principals Survey annually for completion by the head of each school receiving School Health services. This 10 item survey ranks School Health services on a 5-point Likert scale. Results are used to make improvements at each individual school as necessary.

Program supervisors are directly responsible for overseeing customer satisfaction of their programs. Support requirements vary by program and are determined based on client medical needs. For example, TB has a 24 hour hotline where clients can call to contact staff; the nature of the disease requires surveillance within the first 24 hours following treatment. Furthermore, each program has a culturally diverse staff that can communicate in various languages.

There are standard MDCHD and DOH policies that each employee is required to comply with. Examples include completing customer service and other related trainings within three months of hire, abiding by the DOH dress code and working towards meeting MDCHD's mission, vision and values. Other key service requirements, such as short wait times, are secured for customers by supervisors of each program. WHPS for example, ensures that each clinic reduces its wait and cycle times by scheduling every client for an appointment.

3.2a (3) Customer Segmentation

Many of the services offered by MDCHD are state or federally mandated such as TB, EDC-IS, and Public Health and Preparedness. Thus, these services and how we provide them to customers are determined by State or Federal regulations. Due to this mandate most of our direct service clients are segmented by program and may also be segmented by geographic location where service is provided. In addition to mandates, SLs and program supervisors collect data from EDC-IS and other sources to determine distribution means and methods. These results indicate where a particular health need exists, why it exists and who it is affecting. Collectively the data assists in determining where MDCHD services should be used as well as identifying the need for new services. For example, Chlamydia has been the most commonly occurring sexually transmitted infection for many years and its screening and treatment is mandated by the State under the STD program. However, through a county study, it was determined that a particular group within a small area of the county had increased susceptibility. As a result, the STD program applied for and received a grant to provide additional services towards reducing the occurrence of infection within that group.

WHPS is the program most affected by direct competition. Their customers can seek services from MDCHD, community health centers, private physicians, hospitals and family planning clinics. In order to sustain the customer base, WHPS continuously improves the quality of services and adds new products and services as needed. This occurs as a result of quarterly quality assurance/quality improvement meetings. At these meetings, staff discusses customer support/satisfaction rates at each of the six family planning service sites. Results can vary, but responses that address dissatisfaction or new suggestions for products and services are given priority. The director then determines what actions will follow, including whether there are sufficient funds and resources to make the suggested changes. If funds are not available to support new initiatives, then grant opportunities are pursued. This process involves identifying funding sources, collaborating with EDC-IS and other partners to collect assessment data and applying for the grant. The activities are also linked to the three MDCHD Strategic Priorities as reflected by goals 1.1 and 2.2.

3.2a (4) Customer Data Use

There are three types of customer data being used: 1) community health assessments and epidemiology data to drive strategic initiatives and the pursuit of grant funding for new or enhanced programs; 2) individual customer/patient data to determine what specific service offerings are most appropriate for that individual; and 3) customer satisfaction and complaint data to improve our support services.

After identifying a common complaint through the customer satisfaction survey, programs may use data sources such the HMS system to collect customer data. As previously mentioned, the 2008 Customer Service Survey revealed client cycle times to be the most frequent complaint; this was further confirmed after pulling data from the HMS system.

The HMS system allows programs to collect customer data and evaluate progress. Information such as cycle times and missed appointment rates are two of the items that are commonly used as quality indicators. After collecting this data, programs determine how they can improve. Recently, WHPS instituted a general appointment line after realizing their missed

appointment rate continued to increase. This line allows customers to have direct access to making appointments and allows the program to have a designated staff member to make appointment reminder calls.

In 2011 WIC created Got WIC, a team charter aimed at increasing caseload after a 7% decrease between February 2010 and February 2011. Data which measured participation, percent eligible served, non-participation rates and no show rate were used to determine the drop in caseload. Got WIC will use the QIC method, which includes five countermeasures, to reverse the decrease in caseload.

3.2b (1) Relationship Management

A main method for attracting and building relationships with customers is through marketing campaigns. Advertising publicizes the products and services available at the county level to all residents and visitors. In addition MDCHD uses the marketing campaigns to educate the public. The Make Healthy Happen Miami campaign was launched in February 2011. The program logo can be seen on public transit vehicles, television advertising, and billboards and in each MDCHD email, as every employee has the logo attached to their signature. This campaign advocates living a healthy lifestyle by providing educational material and having support systems available to the community.

Advertising and/or marketing companies may be used to assist in the creation of some campaigns. If not, the program establishes a workgroup which meets to discuss design and details. Once the design is complete and budgetary parameters are determined, the campaign must be routed through the Administrator and Office of Communication. This step has been mandated to ensure the campaign is aligned with our mission, vision and values.

MDCHD also publishes several documents and distributes e-newsletters to the public. The E-Healthbeat, Annual Report and Healthy Stories are all publications that are consistently updated and available on the website.

The Consortium for a Healthier Miami-Dade is a program managed by MDCHD. This group includes representatives of MDCHD and community partners. They collaborate to plan and implement projects to improve the health of MDC residents. Through this group, members and non-members are given the opportunity to advertise community events using the Community Health Outreach Program (CHOP). The Consortium members meet on a monthly basis to discuss topics of interest and to implement their initiatives.

The Office of Communication maintains contacts with state and federal agencies, as well as community partners and media outlets to ensure critical health information reaches as much of the community as possible The Office of Communication is always available to the public and critical information is posted on their program page on the website.

Through invitations from CHOP and the Office of Communication, MDCHD makes every attempt to attend community health events. These events are great opportunities to engage the public, establish relationships and attract potential customers. During the fiscal year July 2010-June 2011 there were 93 CHOP invitations and a MDCHD person attended nearly every one of them or sent free educational materials.

Most service sites are conveniently located near public transportation ensuring customers who have limited access to transportation are not denied MDCHD services. Furthermore, service sites are located in areas where there is a high demand for need.

Once a MDCHD program provides service to a customer it tries to refer that customer to other programs if applicable. For example, a customer who receives a positive pregnancy result from Family Planning may be referred to WIC and Healthy Start for further pre-natal needs and education. This action promotes interagency cohesion while ensuring customers are receiving the full spectrum of care that MDCHD can provide.

The Office of Communication provides the community with the most up-to-date health information via community meetings, press releases, media availabilities, person-to-person contact and mass mailings. Community meetings are held as a result of current or potential health risk that a specific community needs to be informed of immediately. Press releases contain information that MDCHD has deemed to be of community importance based on health risks and is distributed county-wide. Recently, a press release was distributed to caution residents and visitors about mosquito bites after a confirmed case of Dengue fever in Miami-Dade County. Person-to-person and mass mailings are used to address public health concerns to individual customers. For example, customers who have a registered drinking water well were sent letters explaining the importance of routine water treatments to ensure safe drinking water.

3.2b (2) Complaint Management

Customer complaints received in person are managed at the program level, usually by on-site supervisors. MDCHD encourages programs to address complaints at the lowest level possible providing the customer with a shorter resolution time. Supervisors and staff make every reasonable attempt to ensure customers leave the site with their complaint resolved. Some programs have designated specific staff members to address and log complaints. These programs rout complaints to this individual in order to better track complaints and their frequency.

Complaints received from customers via the customer inquiry telephone line, customer satisfaction survey or from Administration are dealt with differently. Customer inquiry telephone line complaints generate a service ticket that is forwarded to a designated staff member of each program. This individual follows up with the customer and closes the ticket only when the customer has agreed that the complaint has been resolved. Complaints from the customer satisfaction survey are managed by work groups within each program. Plans are in place for each program to meet quarterly to address frequently reported complaints. Complaints to Administration are received from state program offices or the Office of the Governor via Corrflow. These complaints are handled first by administration staff who forwards the complaint to program supervisors for resolution if required.

CATEGORY 4: Measurement, Analysis and Knowledge Management

4.1 Measurement, Analysis and Improvement of Organizational Performance

The MDCHD has a comprehensive data collection, analysis and utilization system that has been developed to plan, manage and improve operations at all levels of the organization. Comparative analysis and benchmarking are essential to ensuring that MDCHD processes deliver high quality services to the customer. Information and process performance are analyzed using process management, problem solving processes, and other quality management tools and techniques. Organizational performance is systematically reviewed during agency meetings and workgroups and is improved through best-practice sharing and innovation.

4.1a (1) Performance Measures

A wide variety of financial and non-financial information and data are utilized for day-to-day operations, to ensure regulatory compliance, to monitor action plan performance and to drive process improvements throughout the organization.

The MDCHD uses key performance measurement indicators to track daily operations, manage processes and support organizational decision making. The general methods for selecting, collecting, aligning and integrating data are dependent upon the mandates of external sources, funding agencies and the requirements of our customers and partners. Key indicators are mandated by various state and federal government sources such as: Healthy People 2020 (CDC), a County Performance and an Administrative Snapshot (DOH) of key indicators, and specific program indicators.

High level indicators used to measure performance such as low birth weight and vaccine preventable disease cases are entered into various databases by multiple programs within the organization. The programs also analyze data and track trends. Lagging indicators are immediately identified and corrective action plans are put in place and a new plan-do-check-act (PDCA) is initiated. These indicators are reviewed and discussed at the program and Senior Leadership level on a monthly basis. Some performance indicators are developed internally to better determine program and process-level results, such as client cycle time, customer satisfaction rates and provider productivity. While we are required to track and report mandated measures, one challenge of the agency has been to combine multiple indicators to comprehensively facilitate our planning and improvement efforts.

During the SPP, key measures (examples shown in **Figure 4.1-1**) are reevaluated to determine the need for continued tracking or amending. These indicators are reported, monitored and linked to strategic objectives and associated activities (action plans). A variety of factors contribute to identifying which indicators will be monitored continuously. We use our SP, customer and process requirements and programmatic mandates to determine what should be measured. SLs identify lagging performance and call for corrective action plan development, with target objectives and due dates.

The MDCHD used an indicator matrix that facilitated communication and analysis in alignment with our strategic priorities. Many measures are established externally at the federal, state or local level. For example, one set of measures is the Community Health Assessment Resource Tool Set (CHARTS) indicators, maintained by the DOH. This is a primary source of data for our health-related indicators, which include the majority of our core and mandated program and process outcomes.

The indicator matrix was used for performance reviews both at the top level of the organization and through a drill-down process. This process enabled review at departmental, programmatic and process levels, along with day-to-day review of key indicators such as financial indicators and clients served.

During our review cycle, SLs examined our process, and discussed ways to improve the matrix collection tool. While the measures used within the indicator matrix have been

Figure 4.1-1 Examples of Main Types of Data and Indicators

Type of Info	Report Name (System)	Examples Of Measures	SP Impact
Customers/Market	Customer Satisfaction/ Complaints (CCIS)	% Satisfied	1,2,3
	Client Health Information (HMS)	Client Medical Records	1,2,3
Epidemiological Data	Disease Rates (CHARTS, MERLIN)	# Reported Cases Per 100,000	1
	Comparative Disease Rates	# Reported Cases Per 100,000	1
	Program Results (CHARTS, MERLIN, EHD)	Varies By Program	1,2
Financial Risks	Cash Reserves Vs. Plan (FIRS, FLAIR)	% Cash Reserves	2,3
	Administrative Overhead (HMS)	% Of Total Budget	1,2,3
HR Capabilities	Required Training Completed (Trak-IT)	% Completed On Time	1,2,3
	Employee Satisfaction (ESS)	% Satisfied	1,2,3
	Timesheets	% Completed on time	2
Business Capabilities	Indicator Matrix (MDCHD)	% Meeting Standard	1,2,3
	Clients Served (HMS, EHD, WIC)	# Served	2,3
	Administrative Snapshot	% Compliance	2
Supplier, Partner, Provider	Contracts Monitored (MDCHD)	% On Time	2,3
	In-Kind Contributions (MDCHD)	$ Received	2,3
Emergency Response	FDENS Response	% Response	1

updated annually each year since 2000, in 2010-2011 we restructured the indicator matrix process. SLs reviewed the measurement system and redesigned it using the following guidelines: measures must be critical to the success of the department; measures should be controllable based on direct program activities and partnerships; measures must enhance the field of evidence-based Public Health (PH) practices and measures used should be comparable to similar organizations within the state and nationally.

The MDCHD is currently implementing a new centralized system known as the Results Scorecard tool (RS). The current version of our top-level scorecard is listed in **Figure 2.2-3**. The scorecard is divided into two categories, performance measures and community indicators and consists of three Strategic Priorities which align with our 12 PH Domains. All programs/units will be required to measure, track and update programmatic key performance and outcome measures to the RS monthly (tracking may also occur quarterly or annually based on the availability of data). Departments determine their own key performance measures (in alignment with the organizational top level balanced scorecard) which are used to create a departmental scorecard and plan of action in support of organizational goals. The RS includes features that will be used by the agency to monitor the execution and performance of program activities as well as the benefits and consequences. The RS will reflect changes in strategy, regulatory requirements or specific areas of focus. This data will be used to support the Strategic Planning Process, for leadership reviews and to drive action planning for improvement initiatives either system-wide or at the unit level. The RS will be fully implemented in December 2011.

Financial information is available via DOH provided databases (FLAIR, FIRS) and includes many key financial indicators such as revenue and spending plan performance, cash reserves, collection, and write-off information. This information is provided by standard monthly reports and ad hoc report-writing capability. Financial indicators as well as revenue-to-expense ratios are used by the agency to monitor organization performance and facilitate decision making. They measure in terms of cash flow, asset utilization and liquidity.

4.1a(2) Comparative Data

The use of comparative methodology to support operational and strategic priorities and performance objectives as established by SLs is one of MDCHD's priorities. Comparative information is used to inform us of "where we stand" relative to comparable CHDs and organizations from within and outside the state. Benchmarking information provides impetus for major change and improvement and helps lead to a better understanding of our processes and performance; where we are headed and where we need to be.

Key processes are mapped by the appropriate process owners. Outcome indicators are established to measure performance and impact factors. These indicators are reviewed to determine the level performance against a comparison, a recognized standard or best-in-class performer. Processes and indicators requiring comparisons are prioritized by identifying those exhibiting a significant gap in performance and linkage to the achievement of the mission and vision, strategic priorities or the greatest impact on core and support program/processes.

Today, there is an abundance of comparative data available in the field of public health. Comparative data for many PH outcome and performance indicators for key processes is easily accessible. Sources of data include the County Health Ranking report, the Community Health Status Indicators report, FL CHARTS, and the Miami Matters Dashboard System. We have access to statewide outcome measures and criteria established by DOH and the federal government. These measures link either to strategic priorities and/or are drivers for core processes. Although these measures provide comparisons with other in-state health departments, we are particularly interested in the results of other metro counties.

The MDCHD developed an algorithm to determine which data source(s) should be utilized for comparisons and benchmarking**.** We conducted extensive research to determine which peer counties on a national and state level should be utilized for benchmarking purposes. Population size, poverty level, population age group, and race/Ethnicity as well as percent of foreign born, were compared based on data from the 2010 census. We selected nine peer counties that are similar in population composition and demographic characteristics; four within Florida and five nationally. They are: Hillsborough, Orange, Duval, Broward, Los Angeles, Queens (New York), and Bexar, Dallas, and Harris, Texas. High performing organizations with similar functions such as Sterling Award recipients, St. Johns County Health Department and the City of Coral Springs were also selected as benchmarks.

Comparative data from high performing organizations is systematically used during SPP to identify benchmarks and to facilitate process improvement and innovation. Best practices from selected peer-counties are used during the planning process for new services and programs. For example, the MDCHD contacted four peer counties to identify methods of health care provider education regarding immunization practices. Information was used to develop a series of outreach efforts and initiatives to enhance immunization practices.

4.1a(3) Customer Data

A focus on customers and the community is an important value within the organization. As stated in Category 3, customers fall into two categories: the entire population of residents and visitors to the County and direct service recipients (clients) of the MDCHD. Customer requirements and service needs are determined by state statutory mandates as well as by the MDCHD's approach to targeting services to those with the greatest need based on statistical data (**Figure 3.1-1**). Customer-focused measures include an external and internal customer satisfaction survey (available on MDCHD internet and intranet), random client interviews and comment cards, an automated Client Complaint/Inquiry System allows the general public to submit inquiries or comments, and input from advocacy groups and partners. Both the Florida Community Health Assessment Resource Tool Set (CHARTS) and Miami Matters are important tools for determining if and how changes should be made to provide the best service to our customers and the community. Epi and community assessment needs data

obtained through CHARTS and Miami-Matters are used to identify areas of need to better facilitate program processes.

Customer data including client comments and feedback are used to drive performance improvement and strategic decision making by the agency. For example, multiple customers seeking immunization services communicated a desire to obtain a specific vaccine not being offered. MDCHD examined cost versus benefits and began providing this service.

The MDCHD uses the Footprints application to record and track customer service requests by department. It has an integrated customer survey component with Dashboards and reports for monitoring satisfaction and outcomes. Through this application, we are able to investigate and acknowledge all customer complaints and compliments. Customer data collected from Footprints is given to the appropriate department supervisor for corrective action and follow-up if necessary. Customer feedback is also used during the SPP to develop strategies and activities to improve service delivery.

4.1a(4) Measurement Agility

The MDCHD uses several approaches to ensure the performance measurement system is able to rapidly respond to unexpected organizational or external changes. Our process begins with an assessment of the issue. From this assessment actions are identified and developed and resources allocated accordingly.

To help us keep current with our measurement needs, our data collection system has undergone significant improvement both at the state and local level. This has greatly improved reporting, tracking and comparative data capability within the state. Locally, we have improved the ease of obtaining data through our indicator matrix and Microsoft SharePoint.

An additional approach involves researching new information in the field of PH health to keep up to date and facilitate best practices. Emerging information provides ideas about how to improve our current measurement system. This is achieved through subscribing to and circulating journals, such as the *Morbidity and Mortality Weekly Report* which provides the latest PH research data. For example, during the 2009 H1N1 pandemic, we combined data published with our local data to develop an action plan to address the situation. This also enabled us to disseminate the most accurate and up to date information to the community.

4.1b Performance Analysis and Review

Performance analysis and review of key indicators occurs continuously throughout the year. It takes place during the SPP, through the development of improvement activities by assigned workgroups and during monthly reviews of key measures, trends and variance from targets.

To assess the performance of our Strategic Priorities along with associated indicators, monthly business reviews are held. These reviews are led by our Administrator and attended by all senior leaders. During these reviews, we focus on those indicators that are not currently meeting targets and develop an action plan to address gaps and facilitate improvement. Minutes resulting from review meetings are utilized to disseminate information throughout the organization and to track planned improvement activities. Similar review processes exist for our core programs.

Data from surveys, SWOT analyses, key measures and outcomes, are reviewed and analyzed during the SPP. Some analysis or stratification may have already been completed in advance for presentation and review. A gap analysis from the end of the year performance and past year's objectives helps to set targets and evaluate how well we are performing. This allows SLs to identify priorities to focus on in the upcoming year's annual business objectives. Improvement teams and workgroups may be assigned actions to address priorities identified. Team members analyze process indicators through a PDCA approach to identify root causes and to determine appropriate countermeasures. Partners, suppliers and service providers may also be asked to participate in the improvement efforts. Data systems may be developed to track performance improvement. As countermeasures are identified and implemented, teams determine whether a desirable change has resulted. If countermeasures show little or no change, teams conduct further analysis and modify actions accordingly. As shown in **Figure 4.1-2**, a variety of improvements have been made over the past several years within the agency.

Ongoing training of staff at the following levels has improved data analysis: 1) the team improvement process (PDCA); 2) measurement procedures; 3) problem diagnostics; 4) process management methods; as well as 5) general performance improvement concepts. In addition, training has been provided to both the SLT in flow-charting of work processes, process management, methods of stratifying data and graphically presenting critical sources of performance variance. Skills are used during data reviews throughout the organization.

Statistical and geographic analysis including trending, correlation and regression analysis and pattern identification is used by programs within the agency to track epidemiological data throughout the county zip codes and/or census track levels. This analysis may result in funding or grant requests and subsequently impact program and agency level plans. For example, after identifying lead contamination at a community park in Miami-Dade County, we determined the number of children that may have been exposed. Areas within census track levels possibly affected were identified through Geographic Information Systems (GIS) mapping. Planning and field teams were developed to conduct an investigation, educational outreach and lead screening to families that lived within a two mile radius of the community park. Data collected from the investigation was used to leverage federal funding for the Lead Poisoning and Healthy Homes Program.

The MDCHD monitors product and service costs as part of ongoing management of operations to ensure resources are used wisely. Fiscal status is reviewed broadly based upon major funding categories using FLAIR. FLAIR provides a detailed analysis of monthly financial reports, including budget, cash flow, unit costs, revenue and financial reserve versus plan, bill processing and provider monitoring.

During the SPP, key performance indicators related to historical costs of services and resources are reviewed to project anticipated costs, allocate resources, and set priorities.

Data systems give a current budgetary status, as well as past spending with historical comparisons for utilization of services and costs at other county health departments.

The monitoring and understanding of finances within the agency enables improvement teams and workgroups to understand cost versus benefit. As part of our PDCA Improvement Process, teams may conduct a cost-benefit analysis. From these projects, innovations and savings can be tracked. These projects have resulted in significant savings, reduced cycle time, increased satisfaction and direct service time, reduction in paperwork and standardization.

At the program level, measures are developed to trend and track core and support process performance. This data reflects operational staff performance, and allows staff to connect local level performance up through the organization to the macro process level. In turn, staff can see how they contribute to targets at their level and the associated contribution to the overall targets. Data enables local supervisors and staff to gauge their progress throughout the year and determine whether interventions will be needed to achieve targets.

4.1c(1) Best-Practice Sharing

Best practices are developed throughout MDCHD and shared in a variety of ways based on the intended audience. For example, the Performance Improvement Process uses dashboards and a scorecard approach to measure and track programmatic and organizational metrics that are embedded throughout the departments and include performance reviews. Results help identify best practices which are shared as lessons learned on various forums such as daily office huddles, programmatic meetings and in groups such as the Weekly SLT meeting, HMS Users Committee, Nursing Council, and the Clinic Services Redesign Workgroup. An example of best practice sharing evolved from a workgroup chartered to develop a more competent PH workforce and increasing local capacity to respond to PH emergencies by providing a conduit for all hazards preparedness information. As a result the Disaster Preparedness Program Liaison Workgroup was chartered with a mission of increasing the MDCHD's capacity to respond to all hazard PH emergencies by developing a ready workforce. The workgroup has evolved from a strictly information sharing venue to a group that is not only sharing information received but also in the writing of program specific response plans, creation of exercises, and preparation of the workforce for deployment activities.

4.1c(2) Future Performance

We use the results of review findings and analysis to trend and project future performance levels as follows. First we review trend data over the past several years to determine the rate of change of the indicator. We review any new Strategic Objectives and/or activities that are planned that may impact that rate of change. Finally, we identify any benchmark or best practices that may assist in improvements. Based on the above steps, we project future performance. Current performance projections for key indicators are shown in **Figure 2.2-3.**

4.1c(3) Continuous Improvement and Innovation

Our method for driving continuous improvements and innovation stems from the strategic planning and activity development process as described in 4.1b. We use our leadership review process, best practice identification, use of comparative/peer data, and information identified through various local, state and national sharing forums as opportunities to identify and drive innovation. For example: the MDCHD implemented an innovative electronic tracking system in 2008. The Footprints system services many business processes including: IT Service Desk, IT Customer Survey, IT Purchasing, Facilities & Custodial requests, Safety Inspection system, and Environmental Health Well Water tracking system. The Footprints system electronically reports measurements and service levels based upon key performance indicators. This web-based platform has allowed for automation of tasks, tracking and reporting of items that impact our key indicators and has enhanced business processes by moving them from a paper-based to an electronic format.

4.2 Management of Information, Knowledge and IT

4.2a(1) Properties:

Accuracy: MDCHD has systematic electronic and manual accuracy checking mechanisms to ensure the accuracy of official data. This process includes the following steps, which are undertaken monthly: data verification; data entry control; error identification and correction; follow-up to ensure compliance; and issuance of compliance reports.

Our HMS, EH Database and Statewide DOH systems have mechanisms built in to screen inaccuracies or incompleteness during data entry. Fields are coded with mandatory data requirements and employ logic to catch common errors. These systems also have routines to cross reference to validate data ensuring consistency. Error reports are generated to inform process owners of potential errors. During the post validation process, errors are either corrected on the spot or sent to the information owner for correction or verification to ensure accuracy. Our Epidemiology program deploys a host of scripted routines to scrub, mine, validate and flag incoming disease data. Less technical processes are also used to ensure that data and measurements are accurate. These include audits by our State Office or federal funders. During these audits information accuracy is checked and verified. When discrepancies are found, corrective actions are prescribed. Work performed by staff is periodically checked through onsite facility inspections and medical record reviews.

Proactive and reactive measures have been put into place to elevate accuracy and compliance. Strategies include, “mandatory” training for appropriate employee and supervisors, and increasing the refresher course availability. We have also made performance reports available through our user-friendly and easy to access HMS reporting portal. This has simplified understanding and has contributed to an increase in compliance. Also, a local Process Indicator Workgroup has been established to research and share issues, experiences and resolutions to common interests. The workgroup is responsible for standardizing methods used to capture, analyze, and report business results.

Figure 4.1-2 Measurement/Analysis Improvements

Year	*Improvements*
'97-'01	• Indicators For Strategic Processes Established • PDCA Improvement Teams Began • Core And Support Process Indicators Identified • Process Management Training Initiated
'02-'05	• Methodology for Comparisons and Benchmarking • Help Desk • Deployment of on-line Reporting Applications • Started Using FIRS, MERLIN, Crystal Reports, • Indicator Matrix • Indicator Availability Through Share Point • CHARTS
'06-'11	• Performance Measures Tracked Graphically • Converted from HCMS to HMS • Scorecard Indicators Tracked Electronically • Customer Satisfaction Application • HMS Report Portal • Footprints

Integrity: Integrity, Security and Confidentiality are overlapping principles of data management and are addressed jointly through the following three factors: Technical, Architectural and Behavioral. Data integrity is achieved through the collection of methods, systems, policies and procedures designed to preserve state of data, ensuring that data kept is an accurate and exact reflection of data collected, which is in turn an accurate and exact picture of reality.

Integrity is addressed by technical and architectural controls. Technical controls involve restricted electronic access to data available only to authorized individuals (known as logical access controls). This restricted access is accomplished through user ID and password authentication. Technical protection is also achieved through parity checking algorithms to ensure that data counts and calculations are accurate and no data bytes have been lost during a data transfer operation.

Architectural protections prevent unauthorized physical access to data storage devices. This includes double penetration checkpoints, event logging, and physical separation of personnel. Encryption is used to restrict access to protected information, maintain client privacy, and to prevent tampering.

Behavioral aspects are deployed through policies and protocols that establish mandatory trainings on information security and confidentiality; background checks; acknowledgement of security and confidentiality statements of understanding; prohibiting the sharing of users ID and passwords, forced frequent password changes, disallowing the recycling of password and prohibiting the performance of activity by one user with another user's ID. These are contained in DOH Security Policies, Protocols and Procedures.

Reliability: Improvements in network architecture, connections, wiring reconfiguration, server platforms, and expanded availability and compatibility of software and hardware, network reliability has been significantly improved. Intelligent switching configurations have resulted in a reduction in excessive/conflicting communication packets that could result in congested network traffic, low speeds and computer lockups. Virtual server technology has improved reliability and maximized server resources.

Operating System, application and productivity software are now rapidly patched and updated through automated systems. Compliance with the latest code is assured by continuous network scans and vulnerability reporting. Systems missing critical updates are flagged for immediate intervention. Systems and data connections are continuously monitored to alert IT staff of outages, anomalies and restoration of services.

The reliability of systems and computers has been increased by implementing a process to refresh servers, network hardware, and computers per a defined lifecycle schedule. This has been accomplished with limited funding by maximizing grant and special funding opportunities. Our Footprints Service Desk system has automated much of this process.

Timeliness: We ensure timeliness of data through of real time web-based applications and reporting systems. For example, our HMS has a reporting portal available to all staff. This allows for both canned and ad-hoc client-centric reports. Other systems also allow for report access in a similar fashion.

Security and Confidentiality: Data security and confidentiality is ensured by the Information Security Coordinator through DOH Information and Security Policies. Policies and protocols delineate the functions of Information Custodians at every site where client data is handled, and prescribe the acceptable methods for accessing, using and maintaining data. MDCHD also engages in an annual Information Security Risk Self-Assessment, and gathers opportunities for improvement as well as best practices. The DOH Information Security Policies and Protocols oversee retention, collection, transportation and disposition of records and files, physical security controls to protect unauthorized entry into certain areas of buildings, and mandatory trainings, background screenings and signed employee statements. Quality Control procedures assess the adequacy of security policies and to recommend policy changes where needed.

MDCHD implemented a computerized program for medical records retention, retrieval and disposal to ensure HIPAA and DOH policy compliance. This has lowered risk of litigation, storage costs and ensuring records retention for appropriate lengths of time.

4.2a(2) Data and Information Availability:

MDCHD uses multiple online-data-systems including the Health Management System (HMS), Community Health Assessment Resource Tool Set (CHARTS), People First, Fiscal Information Resource System (FIRS), Merlin and Epi-Com to compile, analyze and communicate organizational outcomes and performance indicators. Information on organizational performance is disseminated through MDCHD intranet (internal customers) as well as the internet (external stakeholders). Information addressing PH interventions and events are made available to the public at our public website (www.dadehealth.org). Our Epi program also hosts a regional website as part of its ESSENCE program. This system collects admission data from community hospitals and distills it into meaningful disease surveillance information which is republished on its public website. This provides intelligence information required to quickly recognize and report incidents.

The HMS application collects client demographic, service and financial information which is available through reports within the application and through external secured web portals. The various reports from HMS are used to track continuity of care, financial status, and other productivity and employee information. There are multiple methods for staff to access key program and process information. This includes hard copies and on-demand paperless reports, vital statistics and financial information. Employees, also have real-time access to computerized sources of this information. Our server environment is intelligently distributed between local data center and the State's Share Resource Center. All servers employ a level of fault-tolerance and provide for data redundancy. Both employees and the public (via the internet) have access to needed information via this arrangement.

4.2a(3) Knowledge Management:

Organizational knowledge is managed via means already discussed. Workforce knowledge is collected and transferred via an intranet system that includes local and state policies, process documentation, and various data systems and reports. On-line employee training and courseware is available via the Trak-IT system. Knowledge and best practices are also widely shared through SLT meetings and the various staff and workgroup meetings. Knowledge is widely shared with customers, suppliers, partners and collaborators via the external internet both at the local and state DOH level. In addition community knowledge is shared through various consortiums throughout the county along with other state and national forums. For example MDCHD recently presented its performance improvement story at a conference facilitated by the CDC. Knowledge of local, state and national innovations is continually shared by the state DOH, other CHDs, and at the national level through organizations such as the Public Health Foundation and the CDC.

4.2b(1) Hardware and Software Properties:

Technology standards, purchasing procedures and adherence to best practices form the foundation for assuring hardware and software quality, reliability and user-friendliness. Technology standards include a "Standard Desktop" with common office automation and email software, and useful utilities. Baseline build and configuration standards address servers and applications development platforms. This ensures effective electronic communications and data sharing.

Standards are adopted by recommendations of the state IT Standards Workgroup, in which we participate. The workgroup consists of state and local IT leadership who test hardware and off-the-shelf software products. Standards are published, provided through the intranet to DOH employees, and included in the criteria for approving purchase requests. Through this Workgroup, the hardware and software standards in use at MDCHD are kept current with mainstream technology and matched to business needs. MDCHD has recently led an effort to standardize Windows 7 in DOH.

Networks, systems and computers are monitored in real-time to ensure optimal operations and to identify required short term and long term network adjustments. Help desk user surveys, and ongoing logging of common themes emerging from trouble calls, lead to improvements in systems.

IT has developed a plan to ensure continuous improvement of performance measurement and data management systems. Its guiding principle is to provide fiscally responsible and sustainable services to meet business needs. The MDCHD has developed a "Technology Alignment" council composed of select SLs to evaluate requests for new projects and technology. Decisions are based upon alignment of efforts with the SP, and the availability of resources and funding.

Firewalls are deployed in our service sites and administrative offices to protect against attacks and monitor network traffic for patterns that may compromise data integrity and security. Anti-virus systems are used to perform automatic scanning of network servers and Exchange (e-mail) servers.

User friendliness is ensured in several ways. All new applications are provided as web-based systems to ensure ease of access and use. When new applications are under development, statewide user groups are formed to ensure meeting end user requirement and can be easily used by staff. Examples include the MIS and HMS Users Groups.

4.2b(2) Emergency Availability:

Servers, applications, database and files are backed up daily and on a four week tape rotation. Prior week tapes are kept offsite in a secure climate. Data backups are monitored and alerts are emailed to the Network Administrator in event of failure. Some systems can be restored from backup within an hour while others within eight hours time.

All servers employ built in fault tolerance. Disks are "mirrored or striped" and designed to function normally in the event of drive failure. Redundant and uninterrupted power systems are in place. MDCHD data center and computer areas are climate controlled and temperature monitored. Our main data center has back-up air conditioning, power, and fire control systems.

Emergency availability of technology and response to outages are established by the COOP-IT. This business driven plan identifies mission critical systems and specifies recovery times. The COOP-IT is a living document that guides continuity and recovery for major and minor IT events or PH incidents. It is tested annually to ensure the integrity of backup system; that systems are recoverable and to identify and address any deficiencies. The plan is updated as new systems are introduced into a production environment.

The COOP-IT leverages relationships with the DOH and neighbor county health departments. Yearly testing is conducted using shared virtual disaster recovery servers and satellite communications provided by our regional State disaster preparedness coordinator and with our nearby peers. Procedures, innovative practices, documentation and lessons learned are shared and have proven to be of tremendous value.

Our EOP uses a mix of technologies in "drive away" kits to ensure emergency access. Wireless broadband air cards, virtual private network (VPN), secure WiFi hotspots and laptop computers are maintained in a ready to use state. We also maintain communications devices such as emergency cell phones, smart phones, satellite phones, and two-way radios.

CATEGORY 5: WORKFORCE FOCUS

5.1 Workforce Environment

5.1a(1) Capability and Capacity

The MDCHD ensures its workforce has the required capability to deliver the services it provides. In order to do so, it uses a classification system developed by Florida Department of Management Services (DMS). Each position has a set of knowledge, skills and abilities (KSAs) previously identified which allows the supervisor to match positions with the right individuals. Supervisors can add additional KSAs they consider to be important based on the job functions and requirements. Job Specific competencies also exist and these are reviewed during the performance appraisal process. Through this appraisal, supervisors are able to identify what areas in which an employee may be excelling or falling short of what is expected. The evaluation process also involves an individual development plan (IDP) in which employees identify the competencies they consider to be appropriate for their jobs. It also provides an opportunity to identify new skills that may be needed for the future position they may be aspiring to obtain. This dialogue allows supervisors to provide feedback to the employee and the employee is also able to share the limitations that he/she is experiencing to achieve full potential. This enables employees and supervisors to identify opportunities for training to ensure proper capability.

The past several years, the MDCHD has maintained its staffing levels relatively unchanged. Managers and supervisors work to ensure employees' workload is appropriate. We are currently piloting an application that allows managers to measure productivity in two of our programs/units. One of them is the Refugee Health Assessment Clinic and the other is the Women's Health Program. Using this application, clinic administrators and managers can identify the workload of the clinical staff and see how it compares to their peers. This application will be instrumental in identifying the proper ratios for clinical staff to clients. In other programs such as WIC, case load has always been reviewed to identify areas where the needs services are growing which has enabled the program to anticipate need to enhance (or reduce) capacity. In recent years MDCHD has created very few new positions to assist in the delivery of its services. However, in several occasions, new staff has been brought on board due to grants being received. A large portion of our staff are doing more than they were a few years ago, but we recognize they cannot be overworked if we want to maintain a healthy engaged workforce.

5.1a(2) New Workforce Members

In order to recruit new talent, the supervisor in need of an employee will use the job description that has been developed for that particular position. When the position is advertised, it is accompanied by a set of qualifying questions to eliminate those applicants who don't possess specific characteristics to be considered for a position. These characteristics may include specific KSAs as well as licensing or credential requirements. Applicants are interviewed by a panel consisting of small groups of employees. Panel interviews allow us to increase assessment accuracy and save time. Depending on the level of the position, candidates may be called in for multiple interviews which include involvement from SLs and additional key staff. The interview sessions allow for the interviewers to identify not only if the candidate possesses the KSAs but also the emotional intelligence needed to join our workforce by using behavioral interviewing. All candidates, regardless of position, must go through a final interview with our Administrator. During this last interview, the Administrator discusses the mission, vision, values and asks key questions to confirm that the candidate selected is the right choice for the position being filled.

Selected candidates undergo a background screening conducted in partnership with Florida Department of Law Enforcement. Each new employee goes through a three day intense orientation before they report to their work location. They may be required to attend additional trainings such as a Basic Supervisory Training (for supervisors) or job specific training.

In order to continue to improve the quality of orientation sessions, we interview employees 90 days after their start date to identify opportunities to improve the orientation process. Orientation team members review the material periodically to ensure employee orientation stays accurate and relevant.

To retain staff, the MDCHD provides an array of benefits including health insurance, flexible schedules, tuition waivers, annual and sick leave, cross training and professional development. This allows staff to find a work life balance while employed at the MDCHD.

Our workforce represents the diverse community in which we operate. We see a tremendous benefit since we are able to have a workforce that understands the community and identifies with it. The interviewing panels mentioned previously are usually diverse which allow us to have multiple perspectives when recruiting employees. We also recruit within the various diverse communities in our county to ensure that we serve the various populations within our county with employees who understand their needs.

5.1a(3) Work Accomplishment

The MDCHD has a structure composed on programs and support units which have very specific functions. The programs provide services while the units assist with the functions needed to support the programs such as budgeting, custodial and information technology services. SLs manage these programs and units to ensure the SPs are supported. The State DOH provides guidance to our programs and units to ensure we do our part to support the overall mission and vision. Besides the programs and units, the work is also accomplished using teams, workgroups and committees. These groups are created to assist in the accomplishment of specific key activities in our strategic plan. The MDCHD capitalizes on its core competencies to develop and enhance partnerships and to clearly mark its role in the county. These competencies allow us to work with the community and to be a credible voice when public health is the issue being addressed. As our purpose states, we exist to prevent disease and improve the health of the Miami-Dade County community. Our core competencies help us gain the public's trust when it comes to addressing the public's health. We deliver our services and

accomplish the work we perform successfully by deploying our Strategic Objectives and the associated Activities as described in category 2. Continued focus on these objectives ensure both a customer and business focus and an alignment with our Core Competencies as shown in **Figure 2.2-3**

5.1a(.4) Workforce Change Management

In order to adapt to the changes in capability and capacity, the MDCHD has proven to be an organization that demonstrates agility. By frequently reviewing staffing levels and being fiscally responsible, we are able to maintain an organization that is prepared for sudden changes by having minimal impact on our staff. We have cross trained staff so that they can handle multiple functions when presented with a staffing shortage. For example, our clinical administration support staff handles eligibility at the front desk, can also assist in other areas such as registration, medical records or cashiering functions.

On the few occasions where we have experienced a workforce reduction due to funding cuts, we were able to identify positions adversely affected employees could apply for. For example in 2008 when we went through a workforce reduction, we were able to retain a portion of those employees. Other staff was given guidance and support to assist them in finding new employment. For example, we linked these individuals with the Agency for Workforce Innovation, which assists them in preparing them for future employment. Just as we have faced workforce reductions, we have also been challenged with rapid needs for growth, as it happened in 2009 with the influenza virus, H1N1. In this case, we provided quick orientations, trained in groups, provided dual employment opportunities and we also worked with staffing agencies and volunteers to ensure we had the capacity to address such an important event.

5.1b(1) Workplace Environment

The MDCHD cares for its employees and their work environment. We strive to provide them with a work setting where they feel safe and comfortable. Staff is required to take specialized trainings, such as Violence in the Workplace, when they begin employment and annual trainings are provided to reinforce a safe environment. The Employee Satisfaction Survey addresses issues related to our workforce and their safety and security.

The MDCHD has an active Safety Committee with representatives from all departments. They primarily focus on safety and security of our workforce and our visitors. Furthermore, we also have staff assigned to perform risk management functions which include tracking incident reports and ensuring corrective action plans are in place to avoid incident recurrence. **Figure 5.1-1** shows some of the activities regarding health, security and safety of our staff.

Throughout the year, employees have multiple opportunities to get health screenings which are done by our Office of Community Health and Planning. These events at our various facilities make it convenient for staff to voluntarily be screened and learn about their BMI, blood pressure, and cholesterol. They are given recommendations on what they can do to improve their health. Last fiscal year, 60% of our employees took advantage of the health screenings. In addition, we also have a Worksite Wellness Program. The staff plan and implement various health related activities for employees to participate. Most recently, they kicked off the Make Healthy Happen Miami Challenge, where employees compete in a ten week challenge that encourages healthier living and physical activity. Over three dozen staff registered for this challenge. The winner will be announced and recognized at our upcoming employee conference. Other wellness activities include tobacco cessation classes, Zumba classes and yoga sessions.

5.1b(2) Workforce Policies and Benefits

Policies are usually generated from our State Office, but local policies have been created to fit the needs of our organization. These policies can all be found in our intranet via an online catalog which facilitates finding policies based on keywords or policy name. These policies guide our workforce and set parameters for compliance, work ethics and accountability. Some of these policies are created or tailored to particular needs of our workforce. For example, recently we deployed a breastfeeding policy which allows nursing mothers to take care of their needs without feeling embarrassed, stressed or uncomfortable.

Our employees receive the same benefits as all state government employees. These benefits include a variety of health and life insurance programs, deferred compensation plans, and medical/dependent reimbursement accounts. Other benefits include nine paid holidays, a personal holiday, tuition waivers, retirement, unemployment/worker's compensation, annual leave, sick leave for personal and for immediate family use, sick leave pool and donations, family medical leave, family support work program, administrative leave, military leave, one hour per month to attend school/community activities, educational leave with and without pay, other leaves of absences without pay and EAP. In addition, we provide our workforce benefits that contribute to a healthy work life balance by providing flexibility to accommodate medical appointments, childcare, dependent, educational and personal needs. Some of these benefits can be tailored to specific groups based on employment status and profession. For example, nurses may join the Florida Nurses Association, the only state organization that advocates for nurses regardless of nursing specialty or practice setting.

5.2 Workforce Engagement

5.2a(1) Elements of Engagement

FDOH conducts an Employee Satisfaction Survey every two years. The MDCHD staff have an opportunity to participate and the results are segmented within each county health department. We are able to review employee opinions on a number of dimensions (Clarity, Standards, Responsibility, Flexibility, Teamwork & Cooperation, and Rewards and Recognition). Program Directors review the survey results with their managers, supervisors and employees and develop corrective action plans to address areas of concern.

Besides employee satisfaction, the questions and responses also allow us to examine employee engagement. A number of questions asked on the survey assist the MDCHD in determining employee engagement. The MDCHD used the Gallup Organization's Q12, a 12-question survey that identifies strong feelings of employee engagement. Results from the survey show a strong correlation between high scores

and superior job performance. We identified several questions in the employee satisfaction survey that were very similar to the questions in the Gallup survey. For example, employees are asked if they feel that they have the materials, equipment and support to do their work. Also, they are asked if they can explain how the work they perform contributes to the mission. Finally, another example is a question addressing if the employees feel that their work climate supports them in sharing their opinions. Since the Employee Satisfaction Survey is deployed every two years, a separate Employee Engagement Survey is being developed to be deployed in between. The first survey is scheduled to be deployed November 2011 and then every two years.

Furthermore, to ensure engagement, we also ensure our staff knows what is expected at work. This is done through the performance appraisal process, where the supervisor thoroughly reviews each job expectation with the employee at the start of the evaluation period.

Figure 5.1-1 Promoting Health, Safety and Security

Service	Method	Indicator
Health	• Employee Assistance (EAP) • Vaccines (Hepatitis, Flu.) • TB/PPD Screening • Health Fairs • Drug Testing • Stress Reduction • Walking Clubs • Wellness Program	• Participation in Wellness Activities • % screened & referred for BP/Cholesterol
Safety/ Ergo-nomics	• Infection Control Council • Safety Committee • Safety/Violence In The Workplace Training • Blood Borne Pathogens Training/Safety Equipment • TB Exposure Control Plan • HIV/AIDS • Emergency Plan Training • Biomedical Waste Plan • CPR & AED Training • CPR Training/deployment • First Aid Training • Employee Hotline • Ergonomic Equipment • Security Enhancements	• # Needlestick Injuries • % Employees Fit Tested with N95 Respirators • % Employees trained in CPR & First Aid • # Workers Comp Cases Resulting in Lost Days
Security	• Security Staff • Restricted Access • Employment Identification • Alarm/Surveillance Systems	• Number of Incident Reports
Prepared-ness	• COOP Plan • NIMS Training Initiative	• % trained in NIMS

5.2a(2) Organizational Culture

Even before an individual becomes an employee of the MDHCD, they have been exposed to the Mission, Vision, Values and Purpose that hold our organization's culture together. The Administrator discusses these items with each prospective hiree. It is important for new members of our team to understand that they must be willing to support and share these beliefs. This is reinforced in multiple ways. For example, they are written on the back of each employee's identification card to serve the staff as a reminder. They are posted on our intranet site and they are also found in large posters disseminated throughout our facilities. We encourage open communication among staff and different programs in a variety of ways (See **Figure 1.1-2**). It is important for staff to feel comfortable in expressing their concerns or sharing their ideas with their supervisors and co-workers. Because of the size of our organization, we are not able to have frequent face to face meetings with the entire workforce. Therefore, we have one employee conference annually where employees get together to learn, get trained, become aware of what is happening and what has been accomplished at all levels of the organization in order to celebrate together. We also address the challenges we face as an organization and as employees. Programmatic retreats and staff meetings take place throughout the year to deliver a similar message, but the topics are more specific to the program. All meetings of this nature promote camaraderie and assist in deploying one message pertaining to our vision, mission and values. We take advantage of multiple other means of communication such as email, local and state intranets, employee hotline, SharePoint sites, employee newsletters and annual reports. Our Administrator conducts "shadow visits" which allow her to have personal time with the staff at all programs. It is an opportunity for them to present issues to her, discuss ideas to solve problems, address needs, and clarify concerns.

At our different sites we promote a friendly work environment by allowing celebrations to take place, whether they are to recognize staff, a departmental accomplishment or a holiday celebration. This creates additional opportunities for co-workers to network and appreciate each other at the workplace. Staff are encouraged to participate in workgroups, committees or teams. Employee workgroups are established based on strategic priorities (SPs) and/or to address issues of concern to our clients. Employees have been trained in a structured problem-solving process based on the PDCA improvement model and in use of quality tools. They are encouraged to actively participate in team meetings and to propose action plans to the SLs to monitor progress made in the implementation of recommendations. Cross-functional workgroups are identified on a need basis during the SPP or during business review meetings, and are linked to SPs and process improvements. For example, a team was established to address clinical cycle times to address the long periods of time it took for our clients to receive the services they needed.

The issues selected for workgroups are prioritized based on our SPs, indicator performance, key activities and resources. These are either issues that cut across the organization such as the

clinic cycle time, or issues that are prioritized at the program level. Examples of the latter include uniform documentation of Family Planning Clinic records, and reducing time spent in investigating communicable disease cases. Workgroups are composed of cross-functional, culturally diverse staff at different levels with the desired expertise. These workgroups are established, coached, and monitored following MDCHD team coordination process. At any given time we may have as many as 25% of employees involved on teams/workgroups.

We embrace diversity in our organization and we take advantage of the benefits this brings. We are a very diverse workforce and community, yet we continue to train our staff in diversity because it is important to learn from each other and appreciate the differences that exist due to our backgrounds and personal characteristics. We also promote cultural activities reflective of our diverse workforce. Celebrations include Black History Month and Hispanic Heritage Month. We provide on-site continuing education courses for licensed professionals, and support employee special events through the Image Committee. We also honor our diverse disciplines by celebrating Nurses Week, Administrative Professionals Day, Doctor's Day and Social Worker's Week.

5.2a(3) Performance Management

The MDCHD is accountable for its employee's performance evaluations. The organization has supported the performance evaluation process using a paperwork system. However, this will soon change as we develop an automated performance appraisal process to assist workforce development and organizational improvement. This new system will track and monitor employee evaluation timeliness, gauge overall personnel performance, identify areas of strengths and weaknesses, gather the intelligence required to capitalize on opportunities for improvement and enable the organization to benchmark performance with peers. We expect this system to be deployed by the third quarter of 2012.

Each employee's duties and responsibilities are outlined in a position description. They have job specific performance standards that provide measurements used to drive high performance. With employee input, supervisors review and update these standards at least yearly and whenever there is a major change in duties and responsibilities. Those standards, along with DOH core standards, are reviewed within the first year of employment and at least yearly thereafter during the performance planning cycle. Each employee receives an annual formal performance evaluation and following state recommendations, they also receive a semi-annual appraisal. The evaluation system is based on a combination of meeting expectations, performance standards and achieving job-related competencies. Each employee is rated on a one-to-five scale, with those being rated a five showing outstanding performance. A rating of 3 means the employee is meeting expectations. Anything above a 3 indicates the employee exceeding expectations. At the present time due to our financial environment, employees are not receiving merit increases even if they have outstanding evaluations. However, we still make every effort to properly compensate employees for their work as allowed within budget limitations. Miami-Dade County passed a living wage ordinance for its staff and contractors. MDCHD benchmarked this policy and implemented the same minimum salary requirements to ensure a living wage for its staff in 2005.

In order to recognize our staff for their contributions we rely on co-workers, supervisors and managers to show their appreciation. Our Employee Activities Committee encourages nominations and the selection of the "Employee of the Month", which recognizes one employee who has provided significant contributions towards operational improvements, productivity and public service. The Employee of the Year will be selected in January 2012 from the twelve employees recognized throughout the year. All employees recognized are invited to join the Administrator and her Senior Leadership in a recognition and appreciation breakfast.

The committee also promotes employee recognition by involving the workforce and seeking ideas to provide instant recognition. Staff are also recognized annually for their service anniversaries. This year at our employee conference, we will recognize the staff who are retiring or have recently retired. We plan to make this a tradition for upcoming years.

5.2b(1) Assessment of Engagement

As mentioned previously, the Employee Satisfaction Survey allows us to identify levels of engagement in our health department. The employee survey result is segmented by time in current position, level of education, job title, position classification and program area. Other assessments we have chosen to look at engagement include participation in competitions and contests. For example, for this year's employee conference we created a contest in which staff would create their own video commercial to promote their programs or units. The contest was very well received and over 15 videos were submitted for consideration. Additional measures we use to determine engagement include the unprecedented percentage of employees completing the employee satisfaction survey in 2010 which was 88%. In addition to these examples, we monitor closely employee turnover and absenteeism rates. Our turnover rate has remained consistent for many years. We review reasons for employees leaving their employment. We also monitor disciplinary actions and grievances which are indirectly tied to employee engagement.

5.2b(2) Correlation with Business Results

In a study done by Gallup, Inc. in 2009, with more than 150 public and private sector organizations participating, it is shown that there are significant positive correlations between employee engagement and a number of key business results including customer loyalty, productivity, employee safety, absenteeism, patient safety and quality. While we have not undertaken a similar study ourselves there is no reason to assume that it is not relevant to the MDCHD. With that in mind we are focused on improving employee engagement through employee workgroups, improved recognition programs and employee development opportunities.

5.2c(1) Learning and Development System

We support the educational and developmental needs of our employees throughout their careers in a variety of ways. The training available ranges from the basic programs, such as

New Employee Orientation and BSTP, to supporting continuing education requirements, and promoting learning and development of staff in areas such as quality management and leadership development. New employees receive a three day orientation that starts on their hire date. This program includes an overview of DOH and MDCHD, personnel information related to pay, employment, benefits, career development, Code of Ethics, Customer Service, Safety/Violence in the Workplace, Emergency Preparedness and Responsibilities, Information and Security, OSHA, EEO/Sexual Harassment, HIV/AIDS, TB Control, and Sterling Model. In addition, some programs such as WIC, STD and School Health provide extensive pre-service program specific training to all new employees**.** Employees also receive the necessary trainings concerning the activities to promote health, safety and security which are listed on **Figure 5.1-1.**

In addition, by discussing with their supervisors career interests, goals and by reviewing the IDPs, employees can plan to take special trainings, on-line classes, and/or attend educational and professional conferences. Since most courses are of benefit to the department as well as to the individual, they are treated as part of the employees' work assignment. The department also provides educational leave and tuition waivers to enable employees to further support the departments and individual educational activities. All employees, in addition to program specific trainings, receive annual updates in OSHA, HIPAA, Information and Security, EEO and Workplace Safety. Some employees also receive First Aid and CPR training and we continue to support their efforts to receive continuing education credits.

In addition to be used as a document to help identify current training needs, through the IDP process, employees identify the position they would like to have in the future and it allows them to communicate with their supervisor to determine what additional development might be required.

Through the use of the Trak-It system, the MDCHD is able to upload trainings relevant to the employee's jobs and the organizations core competencies. We periodically research what training opportunities are available for our workforce and we coordinate these trainings to be brought to our health department. For example, recently a large number of employees participated in a Performance Improvement Learning Series offered by the Florida Sterling Council. This training took place every other week (total of 8 weeks) and addressed process management and improvement. Topics covered included tools for tracking performance, choosing the right improvement methods and analytic problem solving.

We also have secured trainings that take place during lunch time for individuals who may have a specific interest on a subject such as enhancing public speaking skills. We coordinate the same session to happen simultaneously in multiple facilitates to allow ease of attendance. We have implemented mandatory trainings through Trak-It. We also provide classroom training even with the challenge of being scattered throughout the county. We have coordinated training such as QIC Story in 2010.

In 2011 we developed a Workforce Development plan to be implemented in 2012. This plan will assess workforce needs and based on those needs, trainings will be planned and scheduled. Any trainings and development activity provided must support our SPs and be related to an employee's job duties and responsibilities. We are currently identifying different organizations and institutions with whom we can partner to deliver the trainings identified. **Figure 5.2-1** outlines steps used determine and develop workforce training.

Figure 5.2-1 Training Design Process	
1.	Identify Need for Education Or Training (assessment, employee request, supervisor request, etc.)
2.	Determine Requirements
3.	Ensure Curriculum Availability
4.	If not Available, Design, Outsource Or Purchase
5.	Develop Training Plan
6.	Schedule Training
7.	Deliver Training
8.	Evaluate Satisfaction And Effectiveness

5.2c(2) Learning and Development Effectiveness

Our formal trainings include an evaluation that is reviewed to determine if needs were met and whether students thought the training was valuable. Student evaluations address presentations, presenters, and topics. This information is used to plan future trainings. Trainings may include a pre-test to measure knowledge on the subject and a post-test to determine effectiveness. Learning is evident when an employee implements principles from a particular training such as the QIC Story.

5.2c(3) Career Progression

We ensure the continuity of leadership in several ways. We facilitate Leadership Development Workshops for middle managers. We identify future leaders who are mentored by their SLs and may be granted delegation of authority. With delegated authority, they are able to experience making decisions and leading staff. Employees also have opportunities to interact directly with SLs to address issues and solve problems. This experience allows them to experience how the SLT works.

Some staff have also been given opportunities to participate in coaching sessions to enhance their leadership skills and decision making. For all levels of the organization, we provide cross training, shadowing and overlapping. This assists us in maintaining continuity of the work and services being provided. The IDPs also play an important role in career progression because managers and supervisors can determine what career paths employees are interested in taking and can support them by giving them the tools needed to succeed.

CATEGORY 6: OPERATIONS FOCUS

6.1 Work Systems

6.1a (1) Design Concepts

Most of the MDCHD work system is determined and designed by the Florida Legislature with further instructions provided by the state DOH. This legislature produces laws, statutes and administrative code, and policies and guidelines that are followed statewide. We also have federally funded programs that are similarly designed. Since much of our work system is designed by others and comes with expected performance and evaluations systems, the opportunity to innovate is somewhat limited. However, our Senior Leaders (SLs) are able to design and innovate new Work Systems not mandated by the state using the "View of the Work System" tool, **Figure 6.1-1** along with a PDCA-based design process (**Figure 6.1-2**. Our SLT, with input from all departments, using the strategic planning process, determines if the overall work system is in alignment with statutory requirements, with the Public Health Essential Services (**Figure P.1-2)** and with our organizational culture. Our core competencies are derived from the Public Health Foundation and the Essential Services to enable us to carry out our work system.

SLs meet annually to review the Strategic Plan and assess that the work system is in alignment with our Core Competencies. If a change or innovation is needed for a work system, this becomes an agenda item for the group and is discussed and acted upon using an Action Plan. These changes may involve our workforce, community partners, contractors, vendors, and our support processes.

We capitalize on Core Competencies by aligning them with our Mission and Strategic Priorities and our Core Programs. We also align any new programs or processes with our core competencies. Capitalizing on these competencies allows us to be an irreplaceable resource in our county as we have attained core competencies in areas that are unique within the county. Alignment between programs, processes and Core Competencies are shown in **Figure 6.2-1**

In-source versus outsource decisions are made during our strategic planning process based upon: 1) Are we mandated to provide the service; 2) Is the service enhanced by our unique core competencies; 3) Does a community partner have a core competency in this program area; and 4) Cost: internal vs. external.

After working on the strategic plan, SLs identify key activities that cannot be performed by the MDCHD. The group determines who locally is able to provide the needed resources. Funding is only one of several considerations. If certain activities have been identified in the strategic plan, it is because the organization considers them extremely important to the health and well-being of our community. If we identify goals that may not be reachable, a review of the strategic plan must be conducted. Through the use of cost-benefit analysis and resource allocation exercises, the SLs determine if such activities can be met. If the MDCHD is not in a position to meet a particular goal by itself, it determines if there might be an agency who could partner with us for this purpose.

For example: The Emergency Room Diversion Fast Track Clinic (FTC) began as a result of a project in 2008. MDHAN, a group of community organizations including MDCHD, used information from community health assessments to determine there was a major need for additional healthcare services for the uninsured. The Fast Track Clinic was its first initiative. The work system for this project was determined through collaboration from MDCHD Administration, Jackson Health System (JHS) Emergency Department Physicians, and Jackson Health System administrators. Collectively they determined the need based on the service demand, potential client flow, available funding on which the clinic would be structured and to offer services similar to a primary care center. Data from non-emergent services rendered at JHS, such as quantity of customers and customer needs, was used in the planning process of the Fast Track Clinic.

The Fast Track Clinic is now fully operational. In an attempt to enhance the clinic system, the MDCHD recently applied for a grant. This additional funding has allowed us to extend our services and workforce. One of the most important aspects of the FTC visit is the additional services that we render to the client. We have health educators who educate and counsel the client concerning both their medical condition as well as the importance of regular primary care. This service has also reduced the overload at hospital emergency rooms and allowed those advanced facilities to deal with serious medical problems that could not be handled at another location.

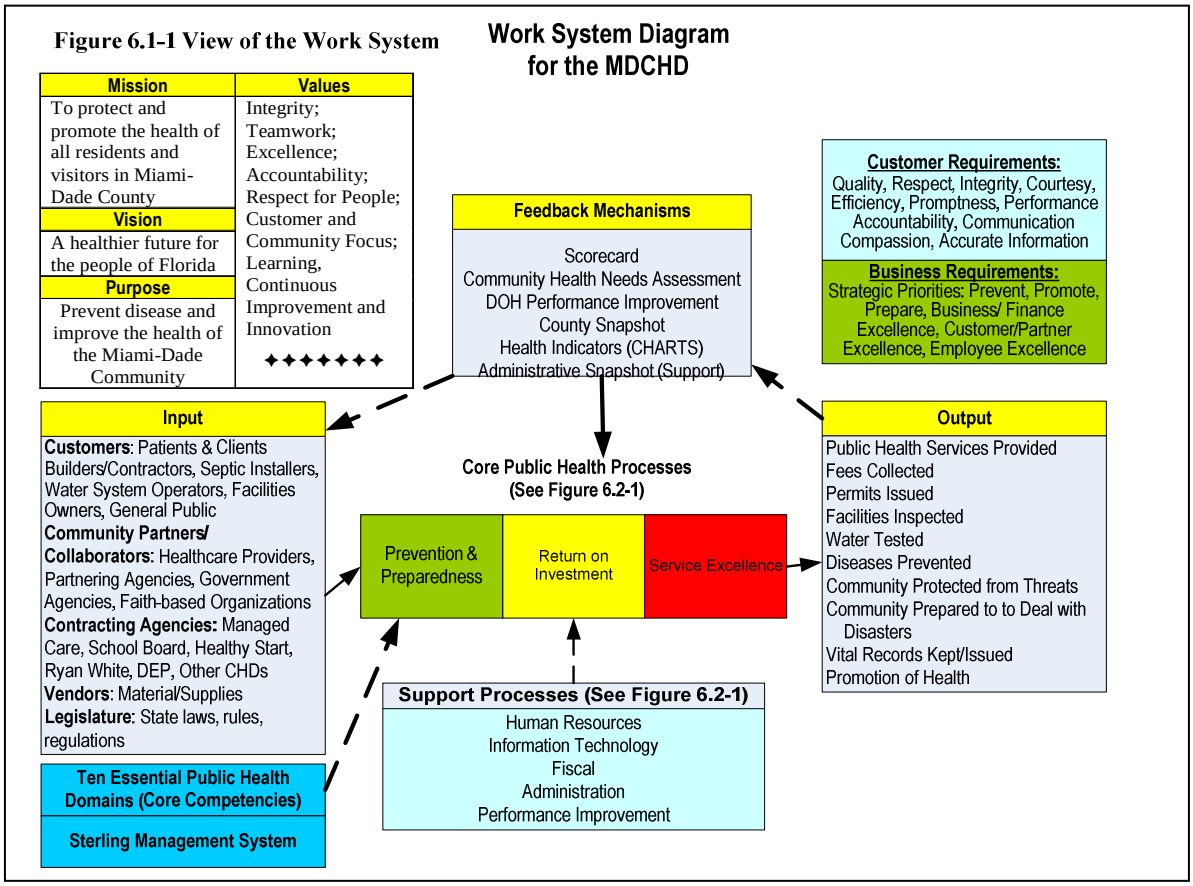
6.1a (2) Work System Requirements

Most key work system requirements are pre-determined for us through the various mandates that come from local, state and federal agencies that provide us with the funding for these programs. For example, there are numerous federal requirements for the Women, Infants and Children (WIC) program and partner requirements determined by the Healthy Start Coalition for our Healthy Start Program. New or additional work system requirements are determined via the listening and learning methods shown in **Figure 3.1-1**. For example, customer and market requirements for our services are determined by feedback received as a result of internal assessments and controls and external audits, client surveys, the Community Public Health Assessment process and numerous health related statistics. Our key partners provide input either through the direct establishment of process requirements (as was done by the Miami Dade County Building Department during the development of the inspection and permitting process for all county departments including the Miami-Dade County Health Department's Environmental Health Division) or through their participation in various community projects such as the Community Health Needs Assessment. We also collect this information through various listening initiatives such as our Community Partners Survey. Our key work system requirements include the Customer Requirements and Business Requirements listed in **Figure 6.1-1** along with the specific programmatic requirements previously discussed.

6.1b (1) Work System Implementation

Work is accomplished through a range of work system elements as described in **Figure 6.1-1**. This includes: workforce, suppliers, medical and non-medical contractors, federal, state, local, and community partners and collaborators, and customers. It also includes data from multiple sources such as employee and client satisfaction surveys, our Health Management System (HMS) and Financial and Information Reporting System (FIRS) data, contracts, MOUs and MOAs, scorecard report, external audits, and 24/7 information/comment phone line. These are used to manage our systems. The work system is in place and does not change much from year to year. When it is determined in the strategic planning process that a major workforce element must be adjusted, employee teams and workgroups may be deployed to evaluate and implement changes. The PDCA (**Figure 6.1-2**) process is consistently used in the organization to track work system performance and improvement. This process assures the MDCHD work system delivers good customer value and achieves organizational success and sustainability.

Figure 6.1-1 View of the Work System



An example of a major work system design and implementation project is with the implementation of the Clinic Administrative Support Services (CASS) model which was a key activity in our prior Strategic Plan. The final location for implementing the CASS model was the MDCHD's flagship Health District Center (HDC). The CASS model consolidated the clinic support services and staffing (client appointments, registration, eligibility, medical records, cashiering and billing) under a Center Administrator. Prior to CASS, each clinical area managed its own support processes. Planning for the HDC CASS implementation began two years in advance with SLs and other stakeholders meeting with architects to plan the interior space and client flow with centralized CASS processes in view. As building completion approached, senior leaders and program managers worked together to plan the transition. Activities included: selecting a Center Administrator, restructuring tables of organization to implement CASS, orienting and training staff for cross programmatic duties and new supervision structure, coordinating consolidation of medical records, drafting processes and procedures for client identification and flow throughout the building, while maintaining confidentiality.

Just prior to opening to the public, all HDC staff participated in testing client flow and procedures with two 'mock' clinics and used PDCA to adjust and improve. As a result, the transition to a new building and new staff and services structure was smooth with minimal impact to client services.

Figure 6.1-2 PDCA Process Improvement System

Steps	
PLAN	1. Prioritize Processes
	2. Determine Ownership
DO	3. Determine Customer Requirements
	4. Flowchart (Map)
	5. Determine Indicators
CHECK	6. Monitor Performance
ACT	7. Identify Opportunities
	8. Take Action

Figure 6.1-3 Design of New Program/Services

Step	Process
1	Proposal for new/ enhanced service
2	Validate need
3	Leadership team review
4	Create design action team
5	Design service/implementation plan
6	Initiate pilot
7	Evaluate pilot
8	Approval by Senior Management
9	Implement new/ enhanced service

6.1b (2) Cost Control

Cost control is ensured though our Financial Management process. Our program initiatives are funded through federal, state and local allocation in addition to insurance payments and fees charged to clients. Funds received are deposited in the County Health Department Trust Fund. Surplus and deficit funds, including fees or accrued interest, remain in the Trust Fund. The Trust Fund account is assessed continually during the year and at year end. During our budget planning process, we use an automated system that allows program managers to monitor their revenues and expenditures on a monthly basis. This enables all programs to identify errors and deviations from the expected estimates and to request corrective actions.

Through the use of the PDCA improvement process, (**Figure 6.1.2**), we continuously monitor our cost operations. We have several key financial indicators that are monitored in order to identify savings opportunities. These include the Revenue Report, Variance Report, Analysis of Funds Equity, and Error Reports. These reports allow us to identify cost savings opportunities and to analyze expenses and revenue trends for our work system. Through a regular review of process performance indicators, we take preventive measures to avoid serious financial downfalls.

The Office of Financial Management also provides quality reviews (e.g. Internal Control Questionnaires) and reports (e.g. Billing, Accounts Payable, Purchasing and Travel Error Reports). These reports/reviews ensure appropriate internal controls are maintained, errors are identified and corrections made promptly. This reduces the processing time for the analysis of the performance indicators, and financial data. The corresponding reports confirm improvement in many areas over time and allow management to identify areas where additional training and/or cross-training is needed.

The Cost control process described above enabled reduction of average processing time of invoices from five days to three days, saving manpower of fiscal staff. The implementation of billing Denial Reports assisted in reducing the Medicaid denial rate from about 23% to 4%.

6.1c Emergency Readiness

MDCHD is actively involved in planning and response to meet public health needs and responsibilities in times of emergency or disaster. A Strategic Priority of the Department is to assure that in the case of an emergency the delivery of essential public health services will be quickly restored and maintained in order to meet the needs of the affected population. By implementing the National Incident Management System (NIMS), along with its major component, the Incident Command System (ICS), we operate within a comprehensive framework when dealing with other agencies during events resulting from natural or man-made disasters. This system provides guidelines and direction to incorporate training and exercises that are conducted routinely throughout the year. We also join hospital and community partners and Medical Reserve Corps (MRC) volunteers according to our Public Health Preparedness Program training and exercise matrix. All our exercises are Homeland Security Exercise Evaluation Plan (HSEEP) and NIMS compliant. After Action Reports are prepared as part of the improvement process cycle. These approaches are pre-requisites recommended by the Public Health Accreditation Board (PHAB) and are required to meet and sustain national standards and Project Public Health Ready (PPHR) certification.

The MDCHD IT Department has a comprehensive Continuity of Operations Plan (COOP)-IT, a written procedure that has been crafted to support the business needs of the agency. It is fully described in item 4.2b(2).

The Emergency Operations Plan (EOP) establishes the framework and guidance to insure that an effective system of emergency management remains in place at all times. The MDCHD COOP is structured as follows; every program within the department is responsible for establishing, reviewing, revising, training and providing exercises for their COOP. Each program has a designated Disaster Preparedness Program Liaison (DPPL) whose responsibilities include assuring all staff is familiar with the organizations all–hazards plans. Our DPPLs also have the responsibility for fit testing of their program staff.

6.2 Work Processes

6.2a (1) Work Process Design

Existing Key Work Processes are reviewed on an annual basis and changes are made as needed to improve work flow or to accommodate new State rules or Federal regulations. Process indicators are monitored on a monthly basis to ensure good performance. When a new process has to be developed we convene a workgroup and use the PDCA-based processes described in **Figures 6.1-2 and 6.1-3.** New, enhanced or realigned services may be required by legislation or generated from within and implemented via action plan.

Upon input from customers and/or legislative mandate, the SLT reviews appropriateness of the new service and whether it is aligned to Strategic Priorities. If appropriate, the new requirement or service is assigned to a team. Community partners, literature review, and benchmarking contribute to the development of program and service design. The team is selected based on subject matter expertise of staff as well as stakeholders who are versed in the appropriate regulatory and administrative issues that ensure success. The team examines

methods to improve and fund the implementation of new technologies as part of the design process.

Our program/work/design process establishes process measures (including cycle time), and outcome measures that meet targeted requirements. After the design is completed, new programs or initiatives are generally piloted with changes to the design made as necessary. Upon completion of the pilot project, the program/work design owner presents results to the Senior Leadership Team. The project lead is charged with the responsibility to modify and coordinate final completion of a new program/service.

For example, in 2010 a workgroup was chartered to reduce client wait times. Client waiting time was the area of highest customer dissatisfaction in a 2008 Customer Satisfaction Survey. This workgroup is implementing a systematic client centered appointment system across all Programs and Centers. The workgroup completed a client survey in July 2010 which validated that clients in all programs preferred an advance appointment rather than walk in services. The HDC Family Planning Program was selected as the pilot clinic to develop and implement an HMS appointment scheduler matched to provider availability. The pilot began October, 2010 and the process is now being implemented at the remaining 5 Family Planning Centers.

6.2a (2) Work Process Requirements

We determine key work requirements through various needs, including systematically following set Florida Statues, rules, regulations, policies and procedures, determining our customers needs by doing internal and external customer satisfaction surveys, community assessments, benchmarking with other counties and agencies, in workgroups and committees. In addition, county profiles and assessments are conducted. We use process maps with expected outcomes and/or look at department gaps. Our key processes and their requirements are shown in **Figure 6.2-1**.

Key process requirements have been identified for all MDCHD core PH and Support processes. For example Environmental Health implements the state health office requirement to issue repair and new septic tank permits within two days and eight days respectively. Key process indicators are monitored by program managers and SLT monthly. PDCA **(Figure 6.1-2**) is used to address work process improvement.

6.2b (1) Key Work Process Implementation

All of the MDCHD key work processes and their requirements are part of the single work system described in **Figure 6.1-1**. Our Core Public Health Processes and our key support processes are also depicted in the figure.

All of the MDCHD key processes have been mapped and have identified and tracked in-process and outcome measures and staff have used the PDCA methodology (**Figure 6.1-2**) to identify and implement process improvements. Process management and improvement efforts involve key customers, suppliers and partners as appropriate. Key in-process and outcome measures for our key processes are provided in **Figure 6.2-1.** Managers for the key programs and processes are responsible for implementing the process management model (**Figure 6.1-2).** Senior Leaders and program managers are responsible for monthly reviews to ensure processes have adequate control and day-to-day management. Teams are in place to review key process performance and staff has received training in process management.

Staff or teams are trained on a specific key work process before deployment. Program managers and SLs systematically review and document process performance (i.e. process performance measures and/or agency indicators) Process performance is reviewed at a frequency (i.e. daily, weekly, monthly.) dictated by the process. PDCA process management tool has been systematically utilized by all staff to manage and improve on the department's key work processes. In addition to the PDCA method, the MDCHD is in the process of including a Scorecard report and LEAN as means to manage and improve its existing key work processes.

Data collected from our key work processes are charted, tabulated, analyzed, reviewed and benchmarked by program managers and SL at frequencies dictated by the process itself. The PDCA model is used by staff at all levels (i.e. program managers, SL, process owner, etc.) to improve the performance of any specific key work process. Process deficiencies are identified, recommendations are proposed to eliminate deficiencies, and corrective action plans are designed with a specific owner and finally deployed to achieve targeted improvement. The systematic application of the PDCA model throughout the MDCHD has helped many work processes to significantly improve over time.

As an example: the MDCHD Septic Tank Program permitting Process clearly shows how we improve the performance of our key work processes. During the last major increase in the local building industry during the period from 2003 to 2004, the Septic Tank Program was unable to meet the requirements of customers and partners who needed septic tank permits processed in a timely manner. At that time, it was determined that the program had insufficient staffing and the fees that were in place for these services did not meet the cost of hiring additional employees. Customer satisfaction surveys completed by individual private customers, as well as by septic tank and general contractors, revealed the perception that obtaining a septic tank permit took too much time. To address this problem we used the PDCA system with our partners from the local Building Department to improve the process. This effort resulted in a move to co-locate with our partner agencies in order to provide one-stop customer service. This process was improved further in 2009 with the implementation of a Concurrent Plan Processing review. As a result the Septic Tank program improved its permit issuance process from an average of 12 days in 2005 to four days in 2009 with a 95% satisfaction rate.

6.2b (2) Supply Chain Management

In the MDCHD we have two different types of suppliers medical and non-medical. Non-medical suppliers provide products such as office and computer equipment, janitorial supplies and furniture. For these suppliers the supply chain is completely managed by the state DMS. Medical suppliers provide various contracted medical services. The quality and

quantity of these services are managed locally by the program mangers utilizing a specific MOA or MOU. In general the supply chain consists of many different activities: delivering products, services, shipping, and managing inventory.

Technology plays a large part in the organization and selection of vendors. Any potential supplier must first be registered in the state operated Myfloridamarketplace system (MFMP). MFMP is the state of Florida logistic and accounting system. It brings supply chain functions on line and makes information available for team collaboration, wherever our employees, vendors, partners and suppliers are located. MFMP business functionality enables MDCHD to provide easy access to supply chain information. Vendors are selected using a competitive bid process. There are several categories of contracted vendors, such as State term contract, Alternate contract source, State purchasing agreement, Respect and Pride. Each of these categories uses a strict vendor selection process. The major criterion of the selection is whether a vendor is responsive and responsible. MDCHD staff strives to develop and implement sound procurement practices and build strong relationships with our suppliers. For example, we participate in the various Local Business Procurement Fairs and we adhere completely with the state and the Miami-Dade County policies concerning the selection of minority businesses. Procurement requirements are established to ensure that we get the best/lowest price for services, consistent with our strategic priority to maximize return.

In addition, the MDCHD has developed unique and innovative methods designed to create a balanced market place. One example is the department's efforts to improve local businesses by encouraging minority community businesses to participate in the state procurement process. MDCHD has worked closely with the School Board and the Economic Advocacy Trust by participating in procurement fairs where minority businesses can learn how to qualify and bid for public contracts. Similarly, the department is an active member for the Miami-Dade Economic Advocacy Trust (MDEAT), a County program that involves communities in economic development efforts to ensure an equitable participation of minority businesses.

Supplier Performance is measured based on the compliance with the terms of any agreed upon MOAs or MOUs. Suppliers are evaluated primarily in terms of timely delivery and good customer service. Suppliers not performing to the specification are contacted to determine the problem. Once the cause is established as to why they are not performing as required, we try to correct the issue for future orders. If the problem cannot be corrected, the contracted vendor is reported to the DMS. If other vendors are available, we may order from them. Poorly performing discretionary spending suppliers are placed on a list of nonresponsive vendors.

Following is an example of an innovative partnership that has resulted in improved services available to our customers. Teleradiology is the electronic transmission of radiologic images from one location to another for the purposes of interpretation and/or consultation. The radiologic examination at the transmitting site is performed by qualified personnel trained in the examination to be performed. All radiologic images are uploaded in a repository and the transfer is done overnight to the contracted provider for reading and interpretation. Radiologic reports are encrypted and made available electronically within two days. Teleradiology services are available at four MDCHD clinic sites. Users at the different sites may simultaneously view images and discuss patient care and treatment. Teleradiology services provide timely availability of images and image interpretation in emergent and non-emergent clinical care areas. It promotes efficiency and quality improvement. The value of this technology is the short turnaround times in getting the radiologic reports. It improves customer satisfaction by reducing the waiting time in the clinics. It also contributes to early diagnosis, timely and better management/treatment of the TB patients. The system is also used to enhance educational opportunities for medical students, nurses, and clinicians. The result of this effort is that the TB program no longer has to buy radiologic supplies. Also patients spend less time in the clinic waiting room.

6.2b (3) Process Improvement

The MDCHD improves its process performance through the systematic deployment of the PDCA methodology described in detail in section 6.2b(1) and shown in **Figure 6.1-2**.

To achieve better performance, we standardize processes across all clinical areas. By developing procedures and protocols based on State and National Standards, we hold employees accountable for their work products; evaluate employees on a regular basis and provide feedback. We also perform observations, do corrective action plans, train staff, and assess the department using quality assurance and quality improvement tools. We reduce variability and improve quality based on the data provided by our management tools such as, Crystal reports and scorecard reports. We have also begun LEAN as a key process improvement tool.

Employees and supervisors are encouraged to improve processes and services. A management team meets to discuss opportunities for improvement during monthly business review meetings. Program services are improved as feedback is generated from surveys, AARs and customer/ partner feedback. We also use the PDCA process, surveys, corrective action plans, workforce development and trainings via online, webinars, conference calls and person to person.

An example of using the PDCA methodology is with our Medicaid denial rate discussed in area 6.1b(2). A high percentage of clinical services revenues are billed and collectable through Medicaid. A workgroup was chartered to reduce Medicaid denial rates. A Pareto chart was completed to determine the major reason for denials. Reasons included eligibility staff not understanding the Medicaid FIMMIS system to determine Medicaid eligibility details and the correct method to record Medicaid insurance details in HMS; provider coding errors; and denials due to no authorization for services by the Medipass primary care physician.

Countermeasures were developed and implemented resulting in a significant decrease in denial rates and an increase in revenues for MDCHD.

Figure 6.2-1 How Programs/Processes (Core and Support) Processes Are Managed				
Core Programs	**Key Processes**	**Key Process Requirements**	**Key Performance Indicators**	**Cat. 7**
1.0 STD	• Detect, Treat and Prevent Transmission and Provide Partner Services	• Reduce STD Incidence	• Infectious Syphilis incidence per 100K	7.1a
			• % High Titer Syphilis Records Disposition w/in 14 days	7.1b(1)
			• % of Infectious Syphilis Cases Treated w/in 14 Days	7.1b(1)
2.0 TB	• Identify, Treat and Prevent Transmission	• Reduce TB Incidence	• TB Incidence per 100,000 Population	7.1a
			• % of TB Patients Completing Therapy W/in 12 months	7.1b(1)
3.0 School Health	• Refer/ follow-up abnormal student vision screenings	• Increase vision referral completion rate	• Percent of completed vision referrals with confirmed additional evaluation and/or treatment.	7.1b(1)
4.0 WIC	• Education and Eligibility Determination	• Increase prenatal clients certified for WIC	• % First Trimester Entry into WIC	7.1b(1)
	• Education	• Increase WIC Breastfeeding	• % Of WIC Infants Initially Breastfed	7.1b(1)
5.0 Special Immunization	• Provide Childhood Immunizations	• Increase Childhood Immunization Rates	• % Children Under Two Fully Immunized (HIGH)	7.1b(1)
6.0 Environmental Health	• Permitting process for new OSTDS application	• Timely issuance of New Permits	• % of New OSTDS Permits Issued in 8 days or less	7.1b(1)
	• Community Hygiene Compliance inspection s	• Timely Completion of Inspections	• % of Required Inspections Completed within the Required Timeframe.	7.1b(1)
7.0 Epidemiology	• Monitor /Investigate and Prevent Communicable Diseases	• Improve Prenatal/ Infant/Child Health • Reduce Communicable & Vaccine Preventable Diseases	• Health Status Outcomes (All)	7.1a (All)
			• % Surveillance cases reported from the CHD to BOE within (21 days before 2011, 14 days starting 2011	7.1b(1)
8.0 HIV Surveillance	• HIV Prevention	• Reduce NIR Rate	• % of HIV Cases Classified as NIR	7.1b(1)
		• Reduce NIR Rate	• % of AIDS Cases Classified as NIR	7.1b(1)
9.0 HIV/AIDS	• HIV Prevention	• Increase Access to HIV Testing	• Number of tests performed by our testing sites per basis	7.2a(1)
			• Number of testing sites registered per year	7.2a(1)
10.0 Women's Health	• Provide access to birth control, preconception and interconception counseling.	• Prevent unplanned pregnancies • Reduce/Prevent repeat births to teens	• % of Repeat Births to Teens (Age 15-19) • % Women's Health record review compliance	7.1b(1)
11.0 Vital Records	• Issues Birth and Death Certificates	• Timely and Accurate Records Reporting	• Number of Birth and Death Certificates Issued.	7.1b(1)
12.0 Refugee Health	• Health Assessment to newly arriving refugees in Miami-Dade County	• Increase % of newly arriving refugees completing assessments	• % of Newly Arrived Refugees with Access to Health Assessment Services	7.1b(1)
		• Decrease average days for refugee health assessments	• Average days of Refugees Screened within 90 Days	7.1b(1)
13.0 Preparedness	• All Hazards Plans (AHP)	• AHP developed, reviewed and revised	• CHD Public Health Preparedness score (% of all hazards preparedness plans that meet state and national standards)	7.1b(2)
	• Mass Prophylaxis Plan	• MPP strategies implemented	• % technical assistance score (Mass Dispensing)	7.1b(2)

and Response	(MPP)			
	• FDENS alert system	• Maintain critical communication	• % of FDENS users alerted who confirmed within 60 minutes	7.1b(2)
	• Healthcare system collaboration	• Hospitals Consortium strategies implemented	• % of county hospitals actively participating in hospital consortium forums which include Region7 collaboration	7.2a(2)
	• PHP Training	• Trainings delivered	• % of staff completed mandatory PHP training courses	7.3a(1)
	• Vol. Management Plan	• Volunteers strategies implemented	• % of increase of MRC volunteers credentialed and trained	7.3a(1)
14. Community Health	• Chronic Disease Prevention and Control	• Consortium strategies implemented • Community Assessments Performed.	• # Activities performed by Consortium overall	7.2a(2)
Support	**Key Processes**	**Key Process Requirements**	**Key Performance Indicators**	**Cat. 7**
15.0 Financial Management	• Budget • Accounts Payable • Accounts Receivable • Billing	Manage Operating Budgets: • Revenue Collections • Actual Expenditures • Outstanding Receivables • TF Balance 7-9.5%	• % Compliant P-Card Payments (Current)	7.4a(3)
			• % Prompt Payment (Current)	7.4a(3)
			• Medicaid denial rate by month	7.5a(1)
			• Revenue to Expense Ratio	7.5a(1)
			• Fee Collections as % of total revenue	7.5a(1)
			• Trust Fund balance year end	7.5a(1)
			• Accounts Receivable > 365 days- Segregate by type	7.5a(1)
			• % of Programs with 5% of budget	7.5a(1)
16.0 Clinic Admin Services	• Clinical Core Process	• Reduce Cycle time	• Average Client Cycle Time	7.1b(1)
			• % of clients with cycle time > 2 hours	7.1b(1)
17.0 Human Resources	• Human Resource Administration • Workforce Development	• Improve HR Policy Administration • Improve Employee Satisfaction/ Engagement • Improve Workforce Development	• % of Employees who completed the mandatory training	7.3a(10
			• % of Performance Appraisal Compliance	7.3a(1)
			• % of Staff belonging to a workgroup or committee	7.3a(3)
			• Employee Survey Response Rate	7.3a(3)
			• Satisfaction w/Training and development (From survey)	7.3a(4)
18.0 Legal	• Legal Services • Supplier Contract Management • Information Security Management	• Increase favorable resolutions	• % of Cases Resolved Favorably	7.1b(1)
		• Reduce settlement agreements	• # of Settlement Agreements	7.1b(1)
		• Improve contract monitoring	• % of Contracts Monitored Within 6 months	7.1b(1)
		• Payables Processing	• % of Invoices Received and Processed within 5 days	7.1b(1)
19.0 Health Management Systems (HMS)	• Health Management Component (HMC)	Increase % of medical records entered within 7 days	• % of Records Entered Timely	7.4a(3)
	• Employee Activity Records compliance	• Increase percent of staff reporting completed hours.	• % of EARs Compliance	7.4a(3)
20. Information Technology	• Service Desk Performance • IT Availability	• Timely IT services • Increase availability of network and applications	• % of Help Desk Calls Abandoned	7.1b(1)
			• % of Network Availability	7.1b(1)
			• % of HMS Application Availability	7.1b(1)

CATEGORY 7: RESULTS

7.1 Product and Service Outcomes

7.1a Customer-Focused Product and Service and Process Results

Figure 7.1a-1 shows the 2010 and 2011 County Health Rankings (CHR) by Health Outcomes compared to Miami-Dade County (MDC) and FL peer counties. The CHR are a key component of the Mobilizing Action Toward Community Health (MATCH) project. The health of a community depends on many different factors including: individual health behaviors, education and jobs, quality of health care and the environment. MDC ranked top in county health for both 2010 and 2011 compared to FL peer counties. In 2011, MDC ranked 8th out of Florida's 67 counties. The CHR by Health Outcomes Report was first conducted in 2010. *(Data source: Community Health Rankings web*)

Figure 7.1a-1 County Health Rankings by Health Outcomes

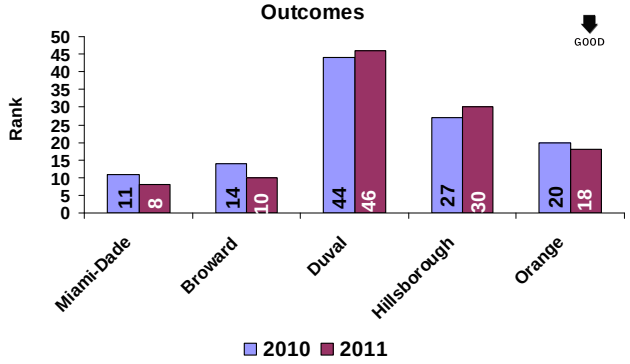


Figure 7.1a-2 shows the Years of Potential Life Lost (YPLL) per 100,000 population under 75 years of age in MDC compared to FL-State and the FL-Best Peer. YPLL is an estimate of the average years a person would have lived if he or she had not died prematurely. The YPLL for MDC was better than both FL-State and the FL-Best Peer from 2005 to 2009. Official 2010 data is not yet available for many of the key health indicators in 7.1. *(Data source: FL Charts and US Peer County/State web)*

Figure 7.1a-2 Years of Potential Life Lost per 100,000 Population Under 75 Years of Age

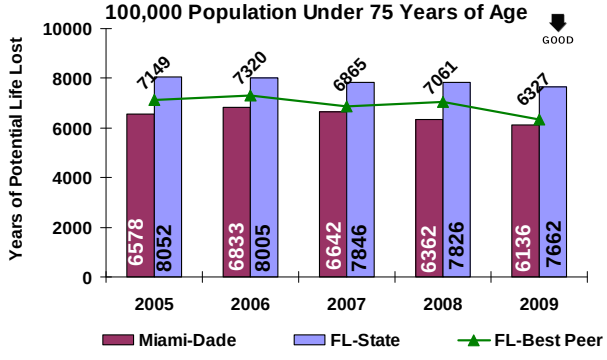


Figure 7.1a-3 shows the percent of adults who were reported overweight with a body mass index (BMI) of 25 to 30 based on the BRFSS survey. MDC has steadily decreased the percentage of overweight adults from 2002 to 2010. *(Data source: FL Charts and US Peer County/State web)*

Figure 7.1a-3 Percentage of Adults Who Are Overweight

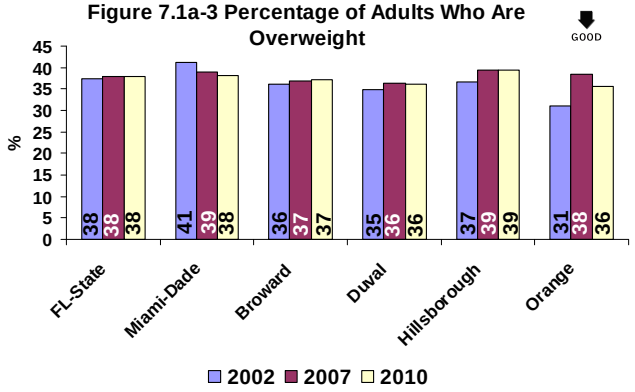


Figure 7.1a-4 represents the age-adjusted mortality rate per 100,000 population for MDC compared to FL-State, FL-Best Peer and US-Best Peer. The age-adjustment rate allows communities with different age structures to be compared. MDC has continually decreased its age-adjusted mortality rate from 2005 to 2009 and remained below FL-State since 2005. *(Data source: FL Charts and US Peer County/State web)*

Figure 7.1a-4 Age-Adjusted Mortality Rate per 100,000 Population

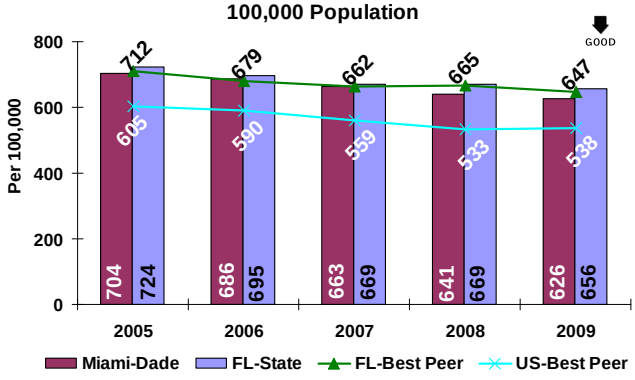


Figure 7.1a-5 shows the infant mortality rate per 1,000 live births for MDC compared to FL-State, FL-Best and US-Best Peer. This indicator is used to compare the health and well-being of a community. The infant mortality rates for MDC were better than FL-State from 2005 to 2010. MDC ranked better than the FL best peer in 2008 and 2010. The Healthy People 2020 target is ≤ 6.0/1,000 live births. *(Data source: FL Charts and US Peer County/State web)*

Figure 7.1a-5 Infant Mortality per 1,000 Live Births

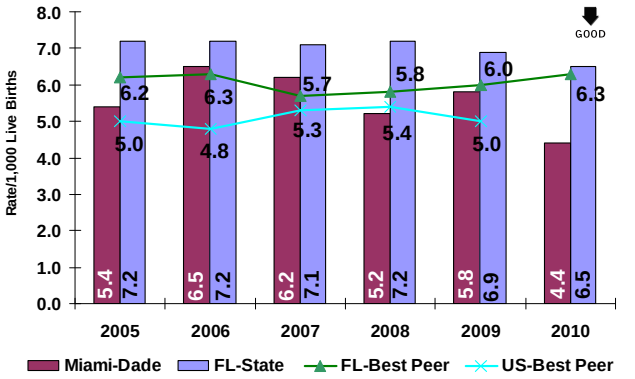


Figure 7.1a-6 shows the infant mortality rates by race and ethnicity for MDC. During the 20th century, U.S. infant mortality rates improved by 90%. However, Black infants are much more likely to die than White infants. The Black infant mortality rate has declined from 32 in 1970 to 11.5 in 2010. *(Data source: FL Charts and US Peer County/State web)*

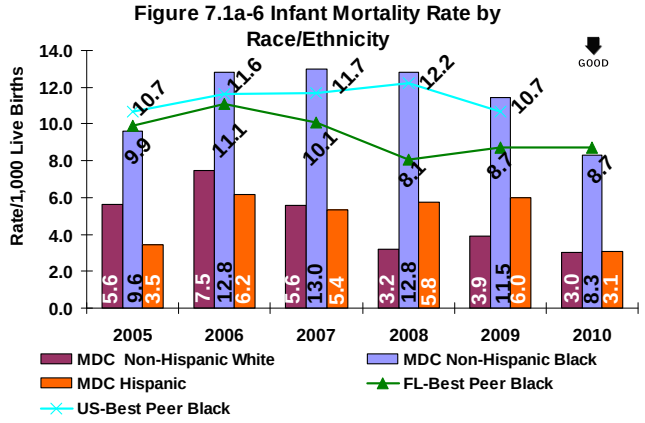


Figure 7.1a-7 represents the percent of live births to mothers aged 10 to 17 years in MDC from 2005 to 2009. The percent of live births to mothers aged 10 to 17 years has decreased since 2007. MDC overall was lower than FL-State. *(Data source: FL Charts and US Peer County/State web)*

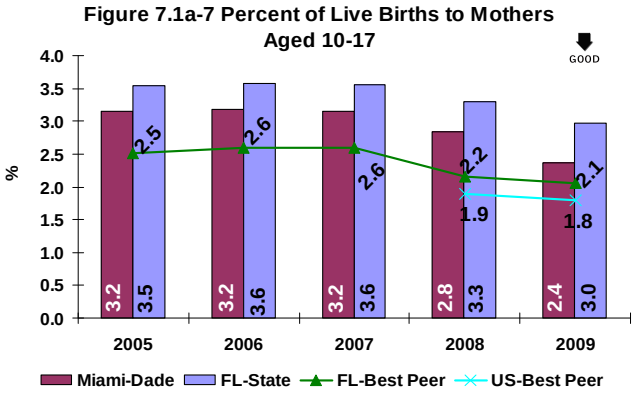


Figure 7.1a-8 represents the percent of repeat live births to mothers aged 15 to 19 years in MDC compared to FL-State, FL-Best and US-Best Peer from 2005 to 2009. In 2009, the percentage was comparable to FL-State. *(Data source: FL Charts and US Peer County/State web)*

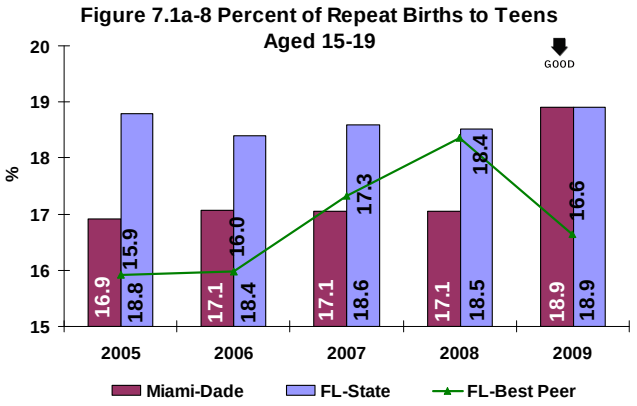


Figure 7.1a-9 shows the percentage of low birth weight (< 2,500 grams) infants for MDC from 2005 to 2009. The Healthy People (HP) 2020 target is ≤ 7.8%. *(Data source: FL Charts and US Peer County/State web)*

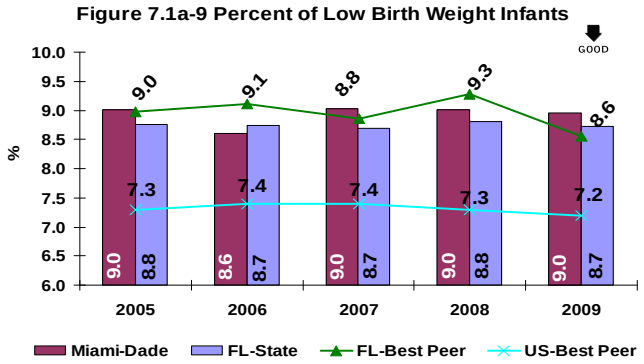


Figure 7.1a-10 shows the rate of reported primary and secondary syphilis cases per 100,000 population compared to FL-State, FL-Best and US-Best Peer. Although the rate in the US declined to 89.7% during 1990–2000, it increased during 2001–2010. Syphilis remains a major health problem in the South and in urban areas nationwide. The MDCHD STD program conducts outreach/education to reduce the incidence. The HP 2020 target is ≤ 1.4 (Female) 6.8 (Male) /100,000. *(Data source: FL Charts and US Peer County/State web)*

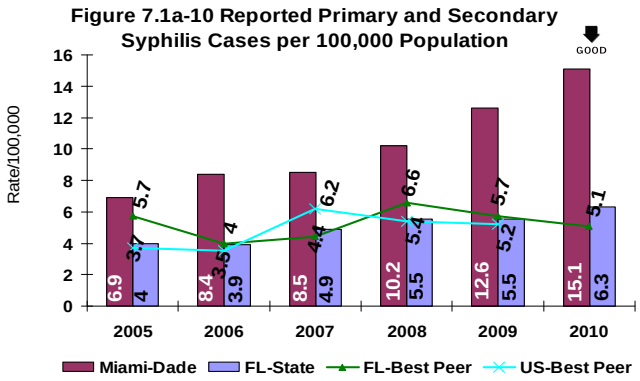


Figure 7.1a-11 represents the AIDS rate per 100,000 population in MDC compared to FL-State, FL-Best and US-Best Peer. Since 2008, the AIDS rate has decreased in MDC. The results indicate the success of our HIV/AIDS program. *(Data source: FL Charts and US Peer County/State web)*

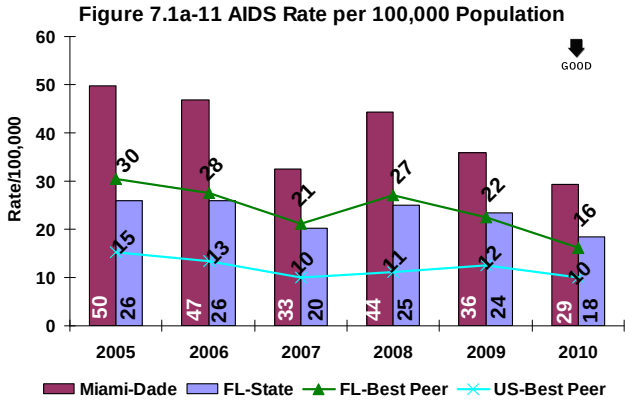
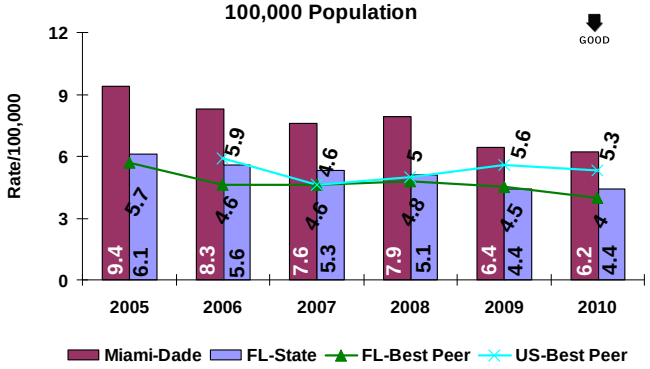


Figure 7.1a-12 represents the rate of reported tuberculosis (TB) cases per 100,000 population in MDC compared to FL-State, FL-Best and US-Best Peer. The rate of reported TB cases per 100,000 has declined from 2005 to 2010 in MDC. The decline is attributed to the outreach efforts of the MDCHD TB program. The HP 2020 target is ≤ 1.0/100,000. *(Data source: FL Charts and US Peer County/State web)*

Figure 7.1a-12 Reported Tuberculosis Cases per 100,000 Population



7.1b Operational Process Effectiveness Results

7.1b(1) Operational Effectiveness

Figure 7.1b(1)-1 represents the percentage of TB therapies completed within 365 days from 2003-2008 in MDC.

Figure 7.1b(1)-1 TB Completed Therapy Within 365 Days

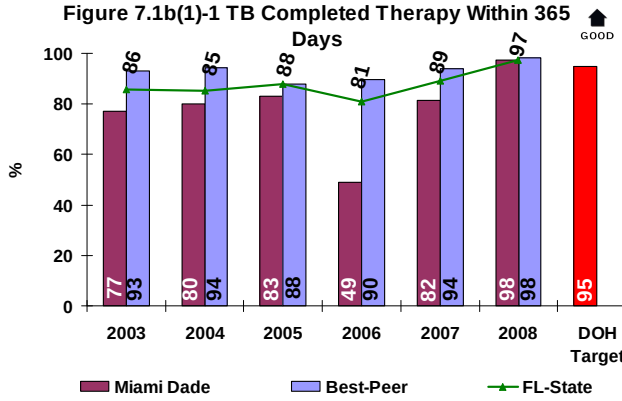


Figure 7.1b(1)-2 compares the average client cycle time among MDCHD clinics from 2008 to 2010. Patient flow and cycle time is crucial to our clinic practice efficiency and capacity. This in turn affects revenue and patient satisfaction. An employee workgroup was initiated in June 2010 to reduce client cycle time. The MDCHD target is < 2 hours. *(Data source:HMS)*

Figure 7.1b(1)-2 Average Client Cycle Time in MDCHD Clinics

Year	District	Little Haiti	West Perrine
2008	1:25	1:35	1:23
2009	1:26	1:21	1:13
2010	1:23	1:10	1:17

Figure 7.1b(1)-3 and Figure 7.1b(1)-4 represents data for newly arrived refugees from 2006 to 2010. Figure 7.1b(1)-3 shows the percent of newly arrived refugees with access to health assessment services. This has increased from 87.3% in 2006 to 94.5% in 2010. Figure 7.1b(1)-4 represents the average days between day of arrival and day of health assessment. These numbers decreased from 19 days in 2006 to 12.4 days in 2010. Among services received by newly arrived refugees, MDC exceeded FL-State and our FL-Best Peer in 2009 and 2010. The target is < 90 days. A shorter number of days and higher percentage receiving health services, may result in more efficient control of imported infectious diseases. *(Data source: Refugee Domestic Health Assessment System)*

Figure 7.1b(1)-3 Percent of Newly Arrived Refugees With Access to Health Assessment Services

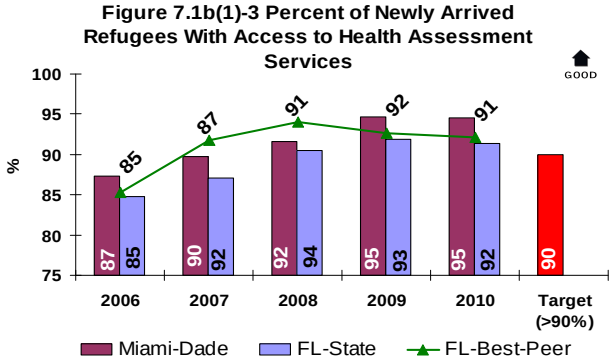


Figure 7.1b(1)-4 Average Days for Refugee Screening Between Day of Arrival and Day of Health Assessment

Year	MDC	FL State	FL Best Peer
2006	19	25	32
2007	20	26	30
2008	17	23	31
2009	13	22	33
2010	12	22	37

Figure 7.1b(1)-5 represents the percent of first trimester entry into the Women, Infants and Children (WIC) Nutrition Program. The percent of first trimester entry into WIC among pregnant women has increased in MDC from 47.7% in 2006 to 61.7% in 2010. The positive trend indicates that our strategies in this area have been successful. This is due to targeted outreach and prenatal appointment availability.

Figure 7.1b(1)-5 Percent of First Trimester Entry into WIC

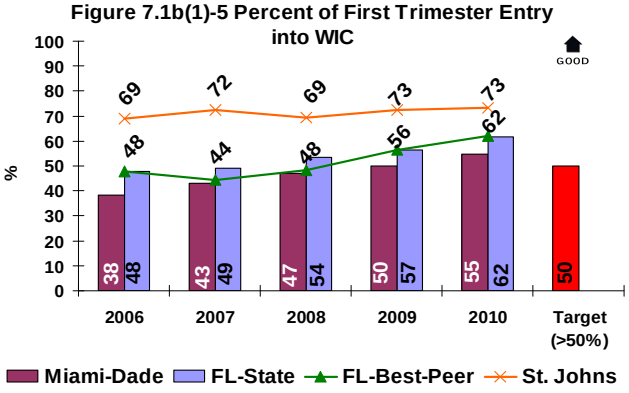


Figure 7.1b(1)-6 represents the percent of infants initially breastfed. Breastfeeding protects babies from a multitude of illnesses. In MDC, the percent of infants initially breastfed increased from 71% in 2006 to 75.4% in 2010. In the last two years the program has added peer counselors and increased breastfeeding specialists' availability at each site. The upward trend indicates success in our efforts to promote breastfeeding.

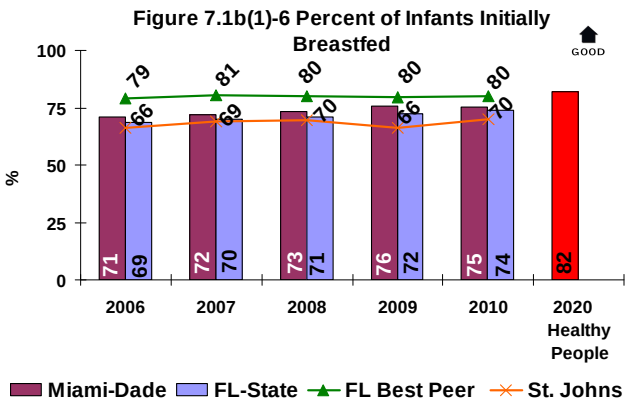


Figure 7.1b(1)-7 shows the percentage of vision referrals by school health providers with confirmed additional evaluation and/or treatment in MDC compared to FL-State and the FL-Best Peer. The percent of vision referrals in MDC increased by almost half in 2010 compared to 2009. The implementation of key processes intended to improve performance and outcome measures was instrumental in the success of improving the returned referral rate. *(Data source: DOH/County Health Department Annual Reports)*

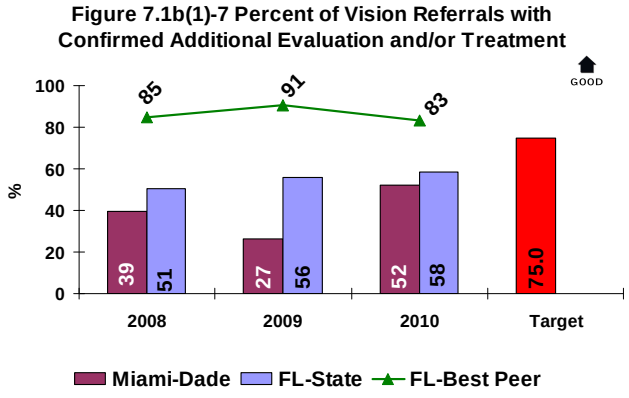


Figure 7.1b(1)-8 represents the percent of two-year-old children immunized in MDC compared to FL-State and the FL-Best Peer. MDC had a higher percentage of two-year-olds immunized compared to FL-State from 2005 to 2010. This is a key indicator of the effectiveness of our Immunization Program. High immunization rates may result in low vaccine preventable disease rates. *(Data source: FL DOH web)*.

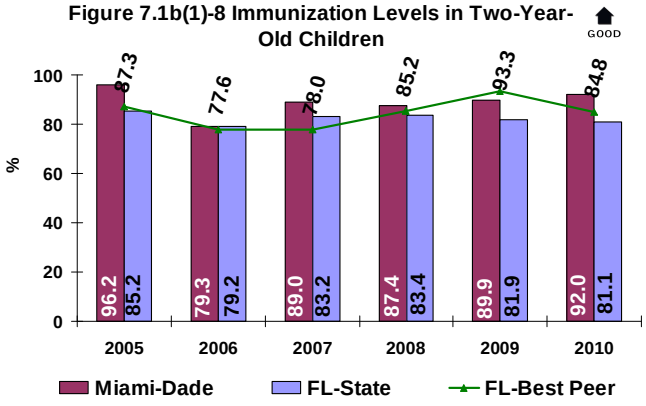


Figure 7.1b(1)-9 represents the vaccine preventable disease rate per 100,000 population in MDC compared to FL-State and the FL-Best Peer. MDC had a lower vaccine preventable disease rate compared to FL-State from 2005 to 2010. *(Data source: FL Charts)*.

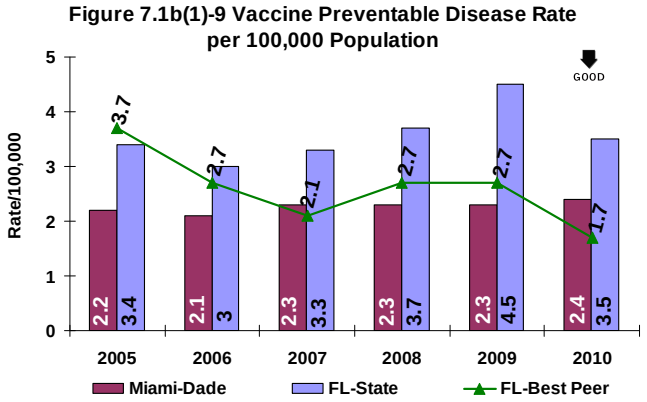
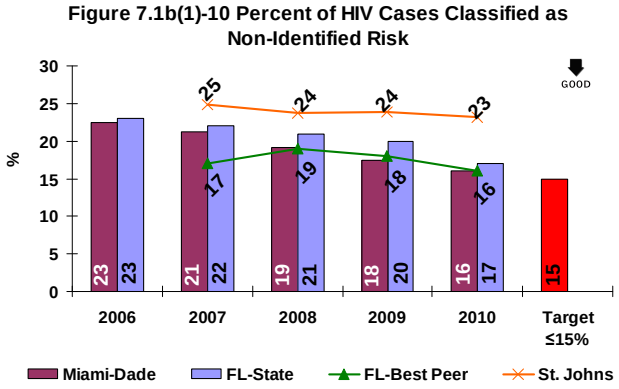


Figure 7.1b(1)-10 and **Figure 7.1b(1)-11** shows the percent of HIV/AIDS cases classified as non-Identified risk in MDC compared to FL-State, FL-Best Peer and St. Johns County. The percent of HIV and AIDS cases classified as non-identified risk was lower than FL-State from 2006 to 2010. MDC met its target of ≤15%. The information refers to the total number cases with non-identified risk through December of each year. *(Data source: HIV/AIDS Surveillance report).*



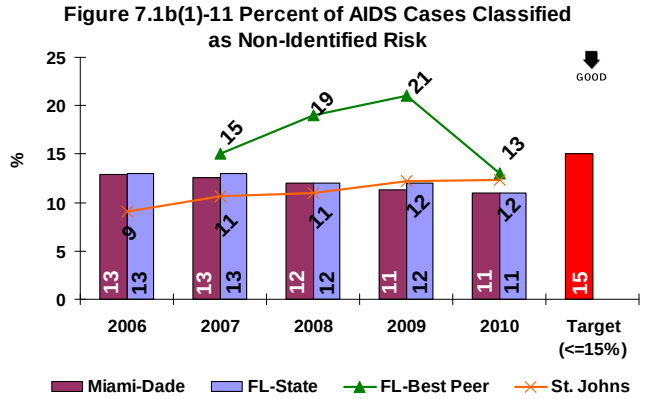


Figure 7.1b(1)-12 shows the percent of new Onsite Sewage Treatment Disposal Systems (OSTDS) permits issued ≤ 8

days for MDC compared to FL-State and the FL-Best Peer. Since 2008, MDC has exceeded its target.

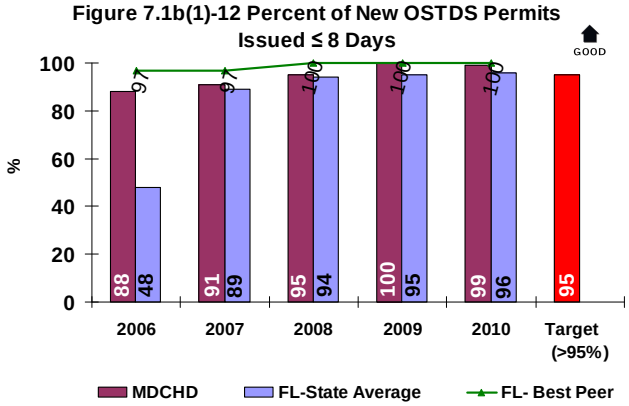


Figure 7.1b(1)-13 represents the percent of required Environmental Health inspections completed within the required timeframe. The target is > 95%.

Figure 7.1b(1)-13 Percent of Inspections Completed in Required Timeframe

	2008	2009	2010
Percent	79.0	92.0	89.0

Figure 7.1b(1)-14 shows the overall women's health record review compliance by quarter. Clinic record review data is based on 7 MDCHD clinics/sites.

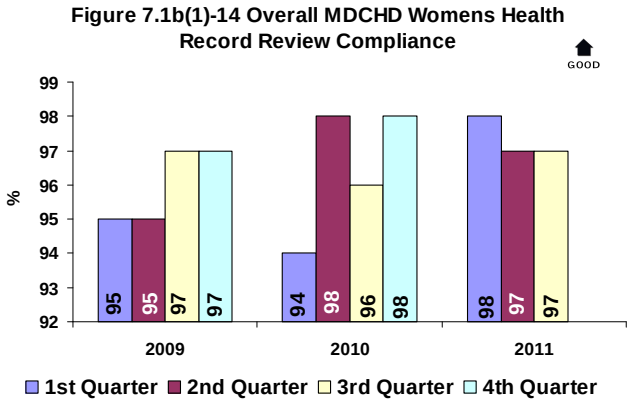


Figure 7.1b(1)-15 shows the percent of cases resolved favorably for the MDCHD by the Legal Department. The target is 100%.

Figure 7.1b(1)-15 Percent of Legal Cases Resolved Favorably

	2006	2007	2008	2009	2010
Percent	99	99	99	99	99

Figure 7.1b(1)-16 Represents the number of settlement agreements by the MDCHD Legal Department. The target is zero settlement agreements.

Figure 7.1b(1)-16 Number of Legal Settlement Agreements

	2006	2007	2008	2009	2010
Number	0	0	1	0	3

Figure 7.1b(1)-17 represents the percent of contracts monitored within six months. The target is 100%.

Figure 7.1b(1)-17 Percent of Contracts Monitored Within 6 Months

	2008	2009	2010
Percent	92	90	95

Figure 7.1b(1)-18 shows the percent of invoices received and processed within five days. The target is 100%.

Figure 7.1b(1)-18 Invoices Received/Processed Within 5 Days

	2008	2009	2010
Percent	93	89	89

Figure 7.1b(1)-19 represents the percent of surveillance cases that have to be reported from the MDCHD to the Bureau of Epidemiology (BOE) within 21 days. MDCHD has steadily increased the percent of reporting from 2006 to 2010 and has exceeded the target. A higher percent of reporting helps identify potential disease risks and outbreaks and allows for timely implementation of preventative measures and educational outreach. *(Data source: FL Merlin system).*

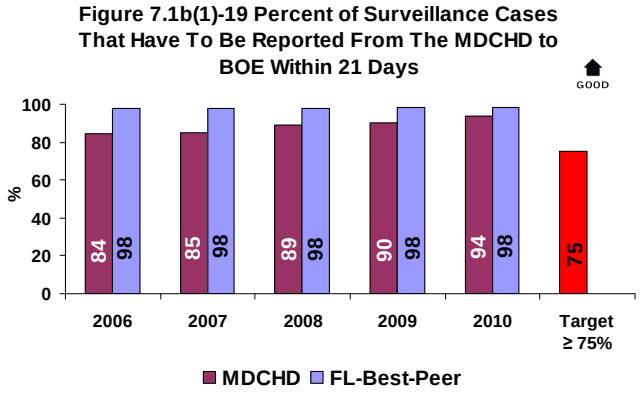


Figure 7.1b(1)-20 shows the percent of high titer syphilis field records disposition within 14 days from 2008 to 2010.

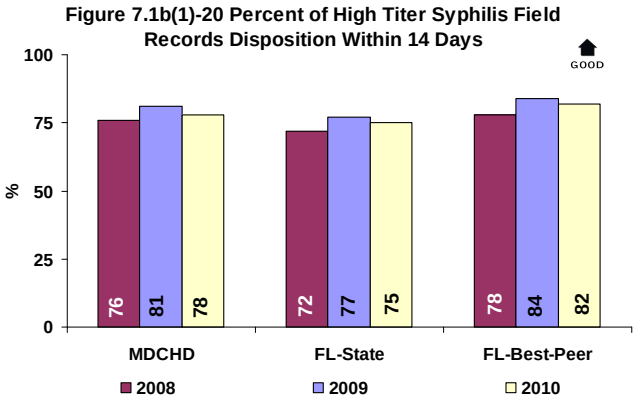


Figure 7.1b(1)-21 represents the percent of infectious syphilis cases treated within 14 days from 2007 to 2010.

Figure 7.1b(1)-21 Percent of Infectious Syphilis Cases Treated Within 14 Days

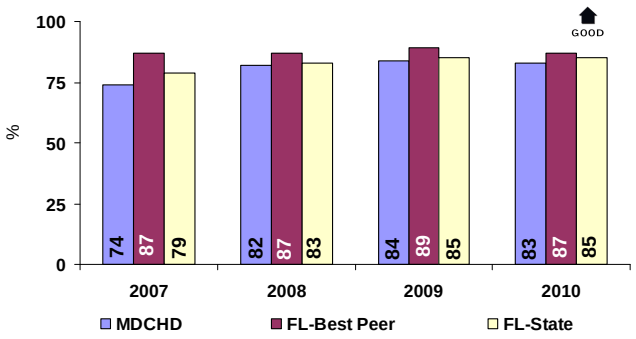


Figure 7.1b(1)-22 represents the number of new HIV/AIDS testing sites that register annually in MDC compared to Broward and Palm Beach County. The goal is to increase the number of sites registered in order to increase testing.

Figure 7.1b(1)-22 Number of HIV/AIDS Testing Sites That Register Annually

Year	MDCHD	Broward	Palm Beach
2010	4	7	2
2011	11	6	4

Figure 7.1b(1)-23 represents the number of HIV tests performed by MDCHD testing sites on a yearly basis compared to Broward and Palm Beach Counties.

Figure 7.1b(1)-23 Number of HIV Tests Performed

Year	MDCHD	Broward	Palm Beach
2007	49201	25156	30297
2008	59439	37396	34111
2009	62470	43993	33819
2010	65065	49507	35145

Figure 7.1b(1)-24 shows the percent of network and health management system (HMS) availability.

Figure 7.1b(1)-24 Percent of Network And Health Management System Availability

Year	HMS Uptime	Network Uptime	Target
2008	99.9	99.9	≥ 99.9%
2009	99.9	99.9	≥ 99.9%
2010	99.9	99.9	≥ 99.9%

7.1b(2) Emergency Preparedness

Figure 7.1b(2)-1 shows the MDCHD public health (PH) Preparedness Score. The score represents the percent of all preparedness plans that meet state and national standards. The target is 100%.

Figure 7.1b(2)-1 MDCHD PH Preparedness Scores

	2008	2009	2010
Percent	25%	50%	80%

Figure 7.1b(2)-2 represents the percent score of technical assistance from the CDC and state reviews of the Strategic National Stockpile (SNS) plan (mass dispensing). This score reflects the level of preparedness. Data for 2010 is not available for MDC because no technical assistance review was conducted by the state due to the 2009 H1N1 outbreak.

Figure 7.1b(2)-2 Percent Score of Technical Assistance From TheCDC and State Reviews of SNS Plan (Mass Dispensing)

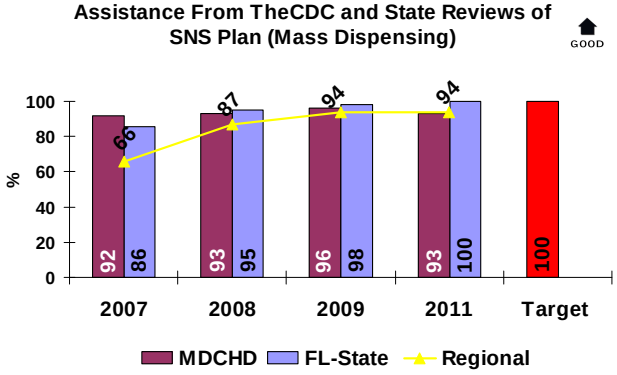


Figure 7.1b(2)-3 represents the percent of MDCHD FDENS users alerted who confirmed alert during tests and real events within 60 minutes. Florida Department of Health's Emergency Notification System (FDENS) is a CDC mandated web-based emergency notification system. The target is 100%.

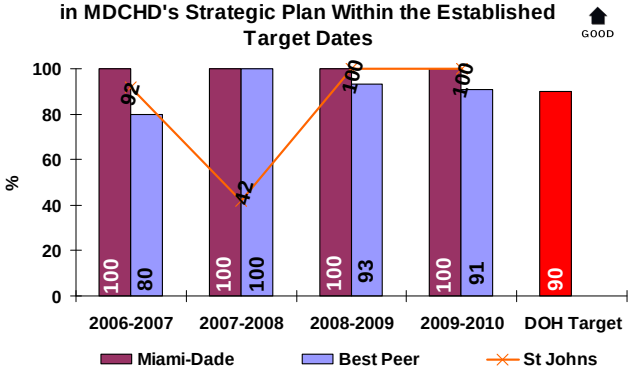
Figure 7.1b(2)-3 Percent FDENS Users Alerted Who Confirmed Alert Within 60 Minutes

	2008	2009	2010	2011
Percent	90%	88%	83%	86%

7.1c Strategy Implementation Results

Figure 7.1c-1 displays the percent of objectives accomplished in MDCHD's strategic plan within the established target dates.

Figure 7.1c-1 Percent of Objectives Accomplished in MDCHD's Strategic Plan Within the Established Target Dates



7.2 Customer-Focused Outcomes

7.2a(1) Customer Satisfaction

Figure 7.2a(1)-1 & 2 shows the MDCHD external customer satisfaction results compared to St. Johns and other FL Peer Counties. MDCHD has utilized the Florida Department of Health (DOH) customer satisfaction survey tool and methodology since the 2010-2011 fiscal year. The customer satisfaction rate has significantly improved and sustained since 2007; and above our 90% target rate. **Figure 7.2a(1)-3** represents the percent of customer satisfaction by question for the new survey tool referenced above. **Figure 7.2a(1)-4**

shows the percent of customer satisfaction segmented by program for the 2010-12 timeframe. The data 2011-2012 is provisional information.

Figure 7.2a(1)-1 Percent of External Customer Overall Satisfaction

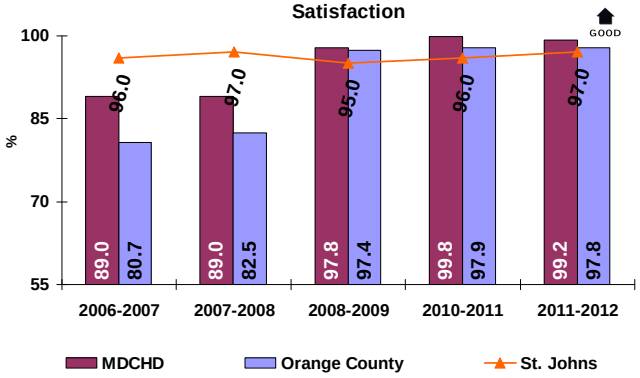
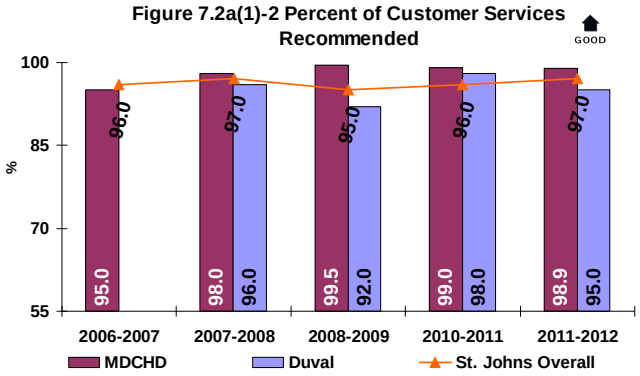


Figure 7.2a(1)-2 Percent of Customer Services Recommended



*: The data were obtained from WIC program 2010-2011 survey.

Figure 7.2a(1)-3 Percent of Customer Satisfaction by Question

Question	2010-2011	2011-2012*
I got service that I need	98.4	98.7
I was serviced in a timely manner	97.0	97.2
The service/information was clear and understandable	98.5	99.1
The staff was friendly and polite	98.5	99.1
The staff was helpful	98.5	98.8
The staff was well informed	98.5	98.9
Overall customer satisfaction	98.9	99.3

*:provisonal data

Figure 7.2a(1)-4 External Customer Satisfaction by Program, 2010-2012

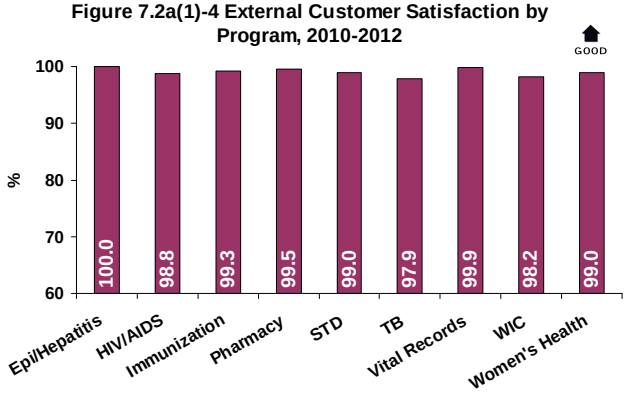


Figure 7.2a(1)-5 represents the percent of clients dissatisfied with MDCHD services.

Figure 7.2a(1)-5 Client Dissatisfaction Rate

	2009-2010	2010-2011	2011-2012
Percent	0.13	0.2	0.2

7.2a(2) Customer Engagement

Reference Figure 7.1b(1)-1 which demonstrates that our customers are compliant with obtaining follow-up TB treatments.

Figure 7.2a(2)-1 represents the percent of MDC hospitals actively participating in hospital consortium forums including Region 7 collaboration. Target is 100%.

Figure 7.2a(2)-1 Percent of MDC Hospitals Actively Participating Forums

	2008	2009	2010	2011
Percent	74	94	71	89

Figure 7.2a(2)-2 shows the number of community activities performed by MDCHD Consortium for a Healthier MDC. Target is 10 activities.

Figure 7.2a(2)-2 Number of Activities Performed by Consortium

	2006	2007	2008	2009	2010
Number	35	18	27	24	33

7.3 Workforce-Focused Outcome

7.3a(1) Workforce Capability and Capacity

Figure 7.3a(1)-1 shows the number of incidents per 100 workers in MDC compared to the FL-Best Peer for fiscal years 2006 to 2010. MDC has maintained a low percentage of incidents from 2006 to 2010.

Figure 7.3a(1)-1 Number of Worker Compensation Incidents Per 100 Employees

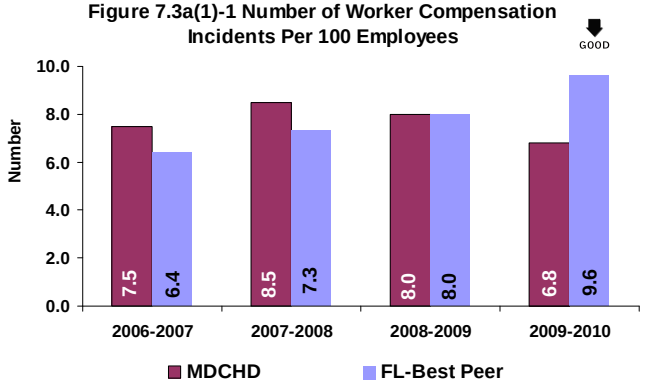


Figure 7.3a(1)-2 represents the number of Full Time Equivalent (FTEs) that are career service and other personnel services (OPS) for MDC from 2006 to 2011.

Figure 7.3a(1)-2 Number of FTEs Career and OPS

Year	Career	OPS	Total
2006	810	97	907
2007	796	78	874
2008	787	102	889
2009	781	92	873
2010	757	110	867
2011	771	100	871

Figure 7.3a(1)-3 shows revenue per FTE. We have been able to improve productivity even as our employee count has been reduced.

Figure 7.3a(1)-3 MDCHD Revenue per FTE

Year	FTE	Revenue/per FTE
2007-08	874	$82,289
2008-09	889	$80,930
2009-10	873	$89,972
2010-11	867	$91,256

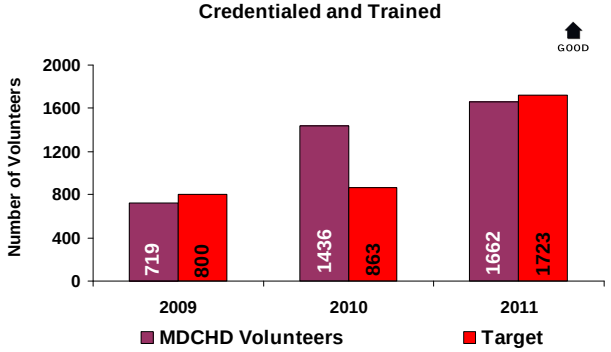
Figure 7.3a(1)-4 represents the percent of MDCHD staff that completed mandatory public health preparedness (PHP) training courses as per training policy DOHP 310-01-11 from 2008-2010. The target is 100%.

Figure 7.3a(1)-4 Percent of Staff Completing Mandatory PHP Training

	2008	2009	2010	2011
Percent	100	100	100	100

Figure 7.3a(1)-5 shows the augmentation of Medical Reserve Corp (MRC) volunteers credentialed and trained from 2009 through 2011. MDCHD target goal is to exceed 20% higher recruitment than the previous year. Recruitment in 2010 was high due to the H1N1 pandemic.

Figure 7.3a(1)-5 Augmentation of MRC Volunteers Credentialed and Trained



7.3a(2) Workforce Climate

Figure 7.3a(2)-1 shows that the MDCHD has completed 100% of all required fire drills and safety inspections for each of the past five years. This compares with the best peer also remaining at 100%. The FL Best-Peer is also at 100% for both fire drills and safety inspections.

Percent Required Fire Drills & Safety Inspections Completed

	2006	2007	2008	2009	2010
Fire Drills	100%	100%	100%	100%	100%
Safety Insp.	100%	100%	100%	100%	100%

7.3a(3) Workforce Engagement

Figure 7.3a(3)-1 shows the percent of overall employee satisfaction from 2004 to 2010 for MDCHD compared to FL-State and the FL Best-Peer. The overall employee satisfaction for the MDCHD was better than FL-State from 2004 to 2010. This survey is conducted by the DOH every two years. Due to the economic downturn, employee pay, benefits and work load have been significantly impacted. This trend is consistent with statewide results.

Figure 7.3a(3)-1 Overall Employee Satisfaction

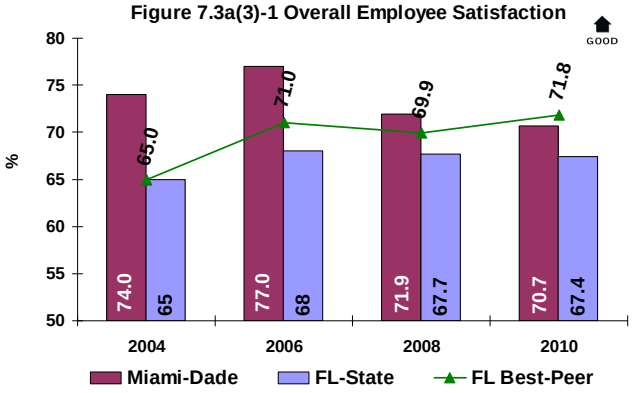


Figure 7.3a(3)-2 represents the employee survey response rate for MDCHD compared to FL-State and the FL Best-Peer from 2004 to 2010. High response rates show that employees trust that their concerns will be addressed by management. Since 2004, the employee survey response rate has steadily improved.

Figure 7.3a(3)-2 Employee Survey Response Rate

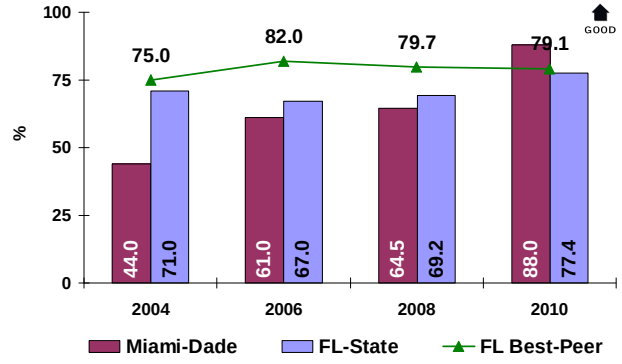


Figure 7.3a(3)-3 shows the results of the 2010 Employee Satisfaction Survey by six climate dimensions that are essential to employee engagement. This is on a 5-point Likert scale.

Figure 7.3a(3)-3 Employee Satisfaction by Engagement Climate Dimension

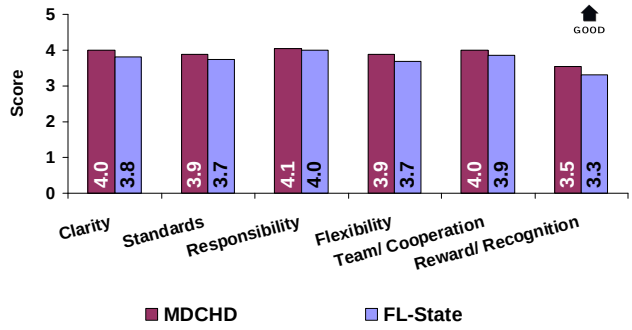


Figure 7.3a(3)-4 shows the results of the 2010 Employee Satisfaction Survey segmented by key question and compared to the FL-State FL Best-Peer and St. Johns County Health Department, GSA recipient.

Figure 7.3a(3)-4 The Percent of Employee Satisfaction By Key Areas

Key Area	MDCHD	FL-State	FL-Best Peer	St. Johns
Q01. Proud to work for the Department of Health	90.0	83.5	86.2	82.0
Q03. Confidence in management	74.4	59.1	60.9	61.8
Q06. Managers put quality first	72.5	56.9	59.8	62.9
Q12. Office supports healthy behaviors	73.2	72.7	71.7	79.8
Q14. Pursue career development training	69.8	60.6	66.6	59.5
Q15. Trust my supervisor	72.9	72.5	74.0	76.4
Q16. Internal policies applied fairly	55.9	44.4	47.5	57.3
Q21. Discusses suggestions for improvement	72.6	69.4	73.5	76.4
Q22. Employees recognized for quality	57.8	53.8	60.3	77.5
Q23. Managers recognized my accomplishments	62.9	49.7	51.1	64.0
Q25. Work cooperatively	85.1	82.5	80.5	93.3
Q37. All support needed to do my job	88.9	83.1	84.2	87.6
Q38. Supervisor emphasizes improvement	79.2	72.0	75.7	83.1
Q42. Had the job-related-trainings	84.7	77.9	77.5	74.2
Q51. Received support from my supervisor	81.3	78.7	83.4	78.2
Q53. Participate in planning improvements	47.0	32.7	42.4	42.5
Q54. Leadership development opportunities	48.9	37.7	64.9	47.1
Q58. Overall Satisfaction	70.7	67.4	71.8	72.4

Figure 7.3a(3)-5 represents the employee satisfaction for MDCHD by program area for 2008 and 2010. The DOH survey instrument was completely redesigned in 2008 and much of the data is only available for two survey periods.

Figure 7.3a(3)-5 Employee Satisfaction by Program Area

Program Area	2008	2010
Administration	92.0	81.3
Vital Statistics	52.6	65.0
School Health	63.7	75.8
Refugee Health	65.5	74.6
WIC	73.4	65.5
Womens Health	61.3	66.7
Epidemiology	91.7	83.7
Environmental Health	66.6	57.0
HIV/AIDS	62.5	48.4
STD	80.0	75.0
TB	84.6	79.2
MDCHD Overall Satisfaction	71.9	70.7

Figure 7.3a(3)-6 shows the percent of MDCHD employees that feel they have the supplies and technical support needed to do their job from 2006 to 2010.

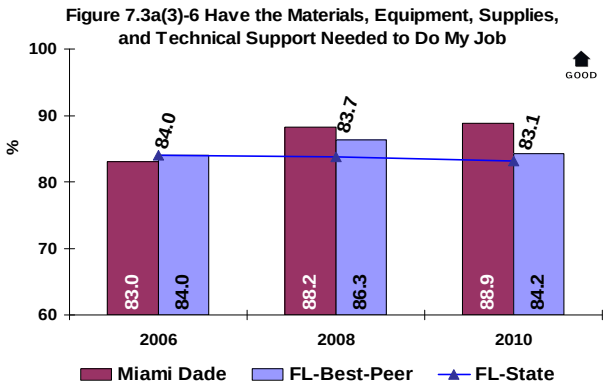


Figure 7.3a(3)-7 shows the percent of MDCHD employees that feel their work contributes to the DOH Mission from 2006 to 2010.

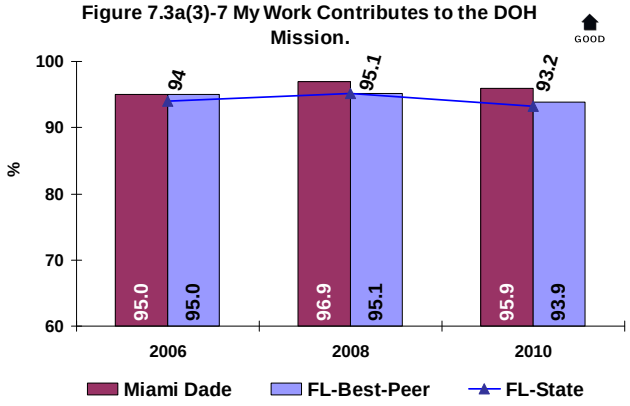


Figure 7.3a(3)-8 shows the percent of MDCHD employees that feel their work climate supports them in sharing their opinion from 2006 to 2010.

Figure 7.3a(3)-8 My Work Climate Supports Me Sharing My Opinion

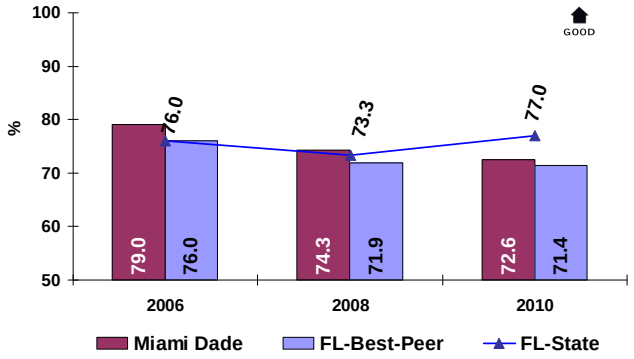


Figure 7.3a(3)-9 shows the percent of MDCHD employees involved in teams, workgroups, committees and councils from 2006 to 2011.

Figure 7.3a(3)-9 Percent of Employees Involved in Teams, Workgroups, Committees and Councils

	2006	2007	2008	2009	2010	2011
Percent	8.8	10.1	11.8	13.8	15.9	20.2

7.3a(4) Workforce Development

Reference **Figure 7.3a(1)-3** which shows compliance with mandatory training requirements and **Figure 7.3a(3)-4** questions 14 and 54 which show employee satisfaction with development opportunities.

Figure 7.3a(4)-1 shows the percent of compliance for mandatory trainings required by DOH Policy through the orientation cycle and annual information security and privacy awareness training between 2008 and 2011.

Figure 7.3a(4)-1 Percent of Compliance of Mandatory Trainings

	2009	2010	2011*
New Hiring	100	100	100
Security & Privacy	100	100	99

*Provisional data

7.4 Leadership and Governance Outcomes

7.4a(1) Leadership

Reference **Figure 7.3a(3)-4** questions 3, 6, 15, 23, 37, 38, and 51 that show key indicators of SL communication and engagement with the workforce.

7.4a(2)-1 Governance

Figure 7.4a(2)-1 shows the number of audits and actions completed on time.

Figure 7.4a(2)-1 Number of Audits and Actions Completed on Time

Year	Purpose	Total Audit Times	# of Findings	Action Plans Completed on time
Financial Services - Auditing				
2009	Invoices error	4	5	Yes
2010	Invoices error	4	1	Yes
2011	Invoices error	3	4	Yes
MDCHD- Office of Financial Management				
2009	Cash/Collection	4	9	Yes
2010	Cash/Collection	5	9	Yes
2011	Cash/Collection	4	4	Yes
Department of Housing and Community Development				
2009	CDBG Grant	1	0	N/A
2010	CDBG Grant	1	0	N/A
2011	CDBG Grant	1	0	N/A

7.4a(3) Law and Regulation

Figure 7.4a(3)-1 represents the percent of both records and EARs entered into the HMS (within the state standard of 14 days from the date of service) for MDCHD. Results for this graph are obtained from the Timeliness Report that is prepared monthly by the Office of Health Statistics and Assessment in Tallahassee. Target performance is ≥ 95%.

Figure 7.4a(3)-1 Percent of Service Records and EARS Entered on Time Into HMS

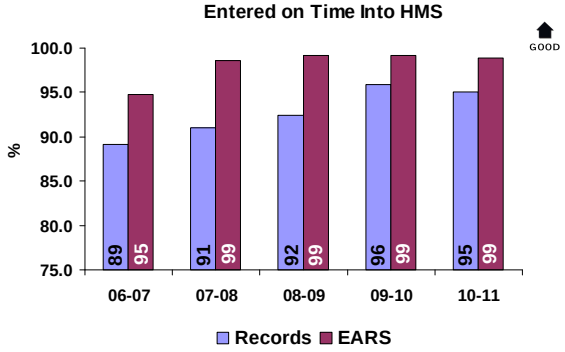


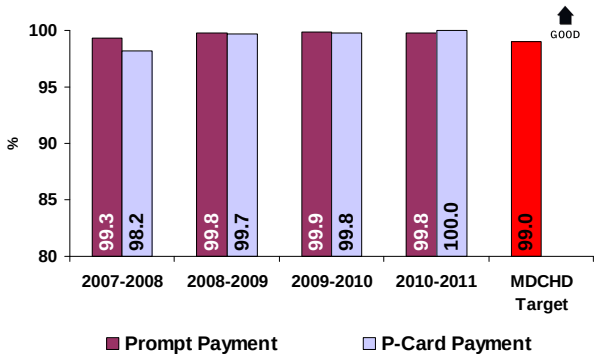
Figure7.4a(3)-2 represents the water, sewage and community programs from 2006 to 2011 for MDCHD compared to FL-Best Peer and FL-State. The review for SHO for cycle 2009 - 2011 is not available.

Figure7.4a(3)-2 Percent of SHO-Program Annual Score

Category/Year	MDCHD	FL-Best Peer	FL-State	Target
SHO-Water Score				
2006 - 2008	91	95	N/A	>90
2009 - 2011	81	96	90	>90
Composite Score				
2006 - 2008	92	94	81	>90
2009 - 2011	75	94	83	>90
SHO-Community Score				
2006 - 2008	88	95	92	>90
2009 - 2011		92	94	>90

Figure 7.4a(3)-3 shows the percent of prompt payment and P-card payment by the MDCHD Financial Management Department.

Figure 7.4a(3)-3 Percent of Prompt Payment (Current)



7.4a(4) Ethics

Figure 7.4a(4)-1 shows the number of disciplinary actions by type for validated incidences of employee misconduct.

Figure 7.4a(4)-1 Number of Disciplinary Actions by Segment

Segment	2007	2008	2009	2010	2011
Oral Reprimands	1	3	14	5	0
Written Reprimands	5	18	7	14	15
Dismissals	7	8	4	0	8
Suspensions	1	0	2	0	2
Totals	14	29	27	19	25

7.4a(5) Society

Figure 7.4a(5)-1 represents the number of toys collected and donated annually by the MDCHD.

Number of Toys Collected and Donated Annually

	2006	2007	2008	2009	2010
Number	250	250	264	287	237

Figure 7.4a(5)-2 shows voluntary employee contributions to the Florida State Employees' Charitable Campaign, the only state sanctioned donation program, for MDCHD compared to the FL-Best Peer. Employee participation increased from 2009 to 2010.

Figure 7.4a(5)-2 Voluntary Employee Contributions to The Florida State Employees' Charitable Campaign

County	2008		2009		2010	
	$ Raised	# Of Donors	$ Raised	# Of Donors	$ Raised	# Of Donors
Miami-Dade	11,057	140	8,099	78	8,737	158
FL-Best Peer	12,759	197	9,770	132	6,980	103

Figure 7.4a(5)-3 shows the percent of custodial products meeting green standards for MDCHD from 2008 to 2011. FL-Best Peers are not tracking this data. Target is 100%.

Figure 7.4a(5)-3 Percent of Custodial Products Meeting Green Standards

Year	2008	2009	2010	2011
Percent	75	99	99	99

Figure 7.4a(5)-4 represents the number of students trained by the MDCHD from 2008 to 2011.

Figure 7.4a(5)-4 Number of Students Trained by MDCHD

	2008	2009	2010	2011
Number	20	20	50	43

7.5 Financial and Market Outcomes

7.5a(1) Financial Performance

Figure 7.5a(1)-1 represents the total revenue for MDCHD for fiscal years 2007 to 2011. For the past two years, total revenue has been lower than the projected budget. This is in part due to both economic and environmental circumstances. As a result, the MDCHD is effective at using minimum financial input to receive maximum outcomes. See **Figure 7.3a(1)-2a.**

Figure 7.5a(1)-1 Total Revenue

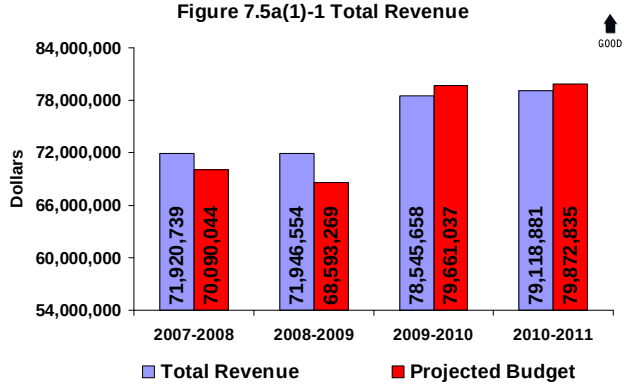


Figure 7.5a(1)-2 shows MDCHD's revenue-to-expense ratio for fiscal years 2007 to 2011. Since 2008, we have maintained a revenue-to-expense ratio above that of the FL-Best Peer and St. Johns County. The revenue-to-expense ratio measures performance in terms of profitability and asset utilization.

Figure 7.5a(1)-2 Revenue-to-Expense Ratio

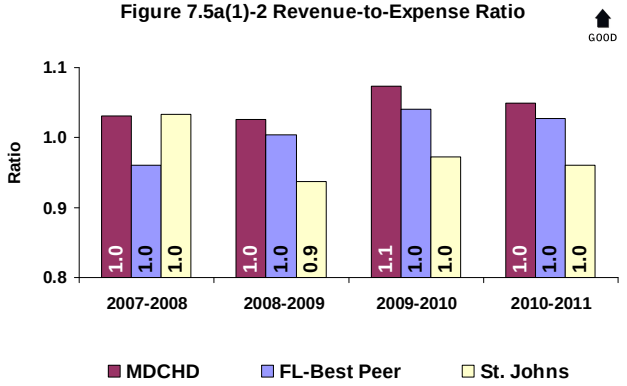


Figure 7.5a(1)-3 represents the total revenue per capita for MDCHD compared to FL-Best Peer for fiscal years 2007 to 2011. Despite low total revenue per capita, MDCHD consistently attains successful outcomes.

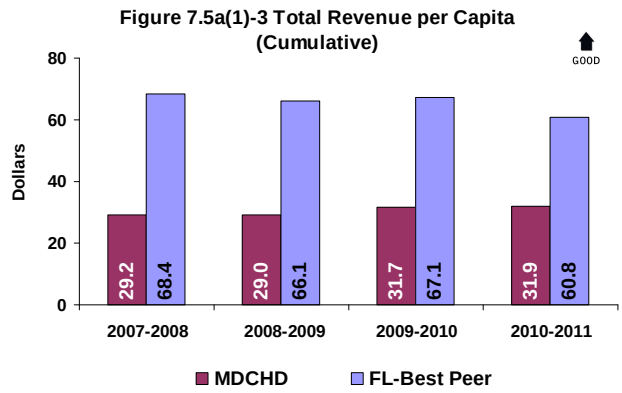


Figure 7.5a(1)-4 represents the Medicaid denial rate by month for MDCHD County for fiscal year 2008-2011. We have significantly improved our billing quality through workgroup implementation.

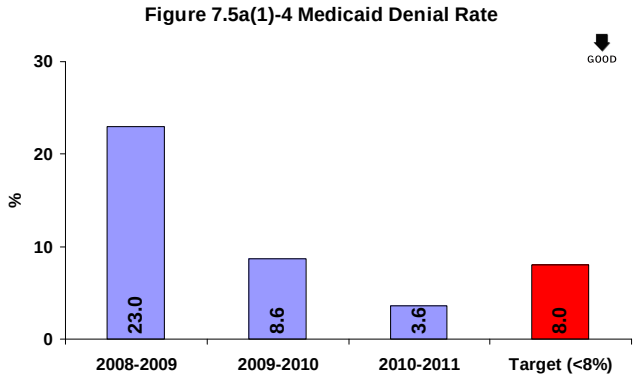


Figure 7.5a(1)-5 represents fee collections as percent of total revenue for MDCHD for fiscal years 2007 to 2011.

Figure 7.5a(1)-5 Fee Collections (As Percent of Total Revenue)

	07-08	08-09	09-10	10-11
Percent	10.90%	13.30%	13.90%	14.23%

Figure 7.5a(1)-6 represents the percent of CHD FTE's total that are viewed as administrative for the MDCHD from 2006 to 2011. This indicator reflects employees that function under indirect support services. The cost associated with the FTE's is prorated and allocated to all operational programs. The performance target is ≤ 10%.

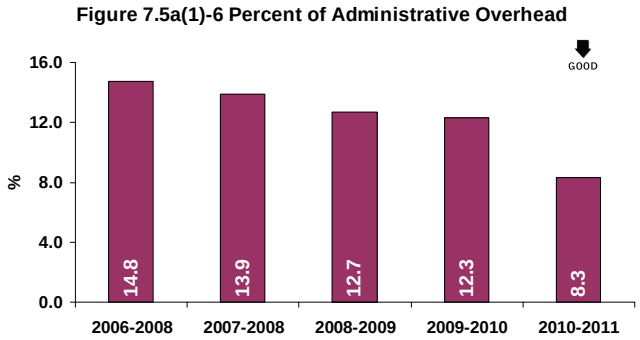


Figure 7.5a(1)-7 represents the trust fund balance at year end for MDCHD compared to FL-Best Peer.

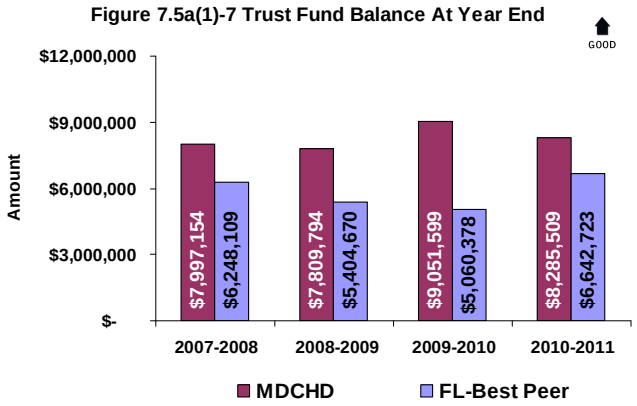


Figure 7.5a(1)-8 shows accounts receivable greater than 365 days for MDCHD segregated by type. Target is 0%.

Figure 7.5a(1)-8 Percent of Accounts Receivable> 365 Days

Year	Medicaid	Medicare	HMO	Client
07-08	4.4	10.7	11.7	42
08-09	11.7	30.3	76.8	33
09-10	2.1	7	30.6	12.9
10-11	0	3.3	0	0

Figure 7.5a(1)-9 shows grant and donation funds as a percent of the total budget for MDCHD for fiscal years 2007 to 2011.

Figure 7.5a(1)-9 Grant and Donation Funds (as % of total budget)

	2007-08	2008-09	2009-10	2010-11
Percent	1.52	2.08	2.66	8.53

Appendix D

Sullivan County, TN
Tennessee Center for Performance Excellence Award Application

This application is for the Tennessee Center for Performance Excellence Award. The methodology employed by this awards program is based on the National Malcolm Baldrige Criteria for Performance Excellence program.

Sullivan County Regional Health Department

"The Road to Good Public Health"

154 Blountville Bypass
Blountville, TN 37617

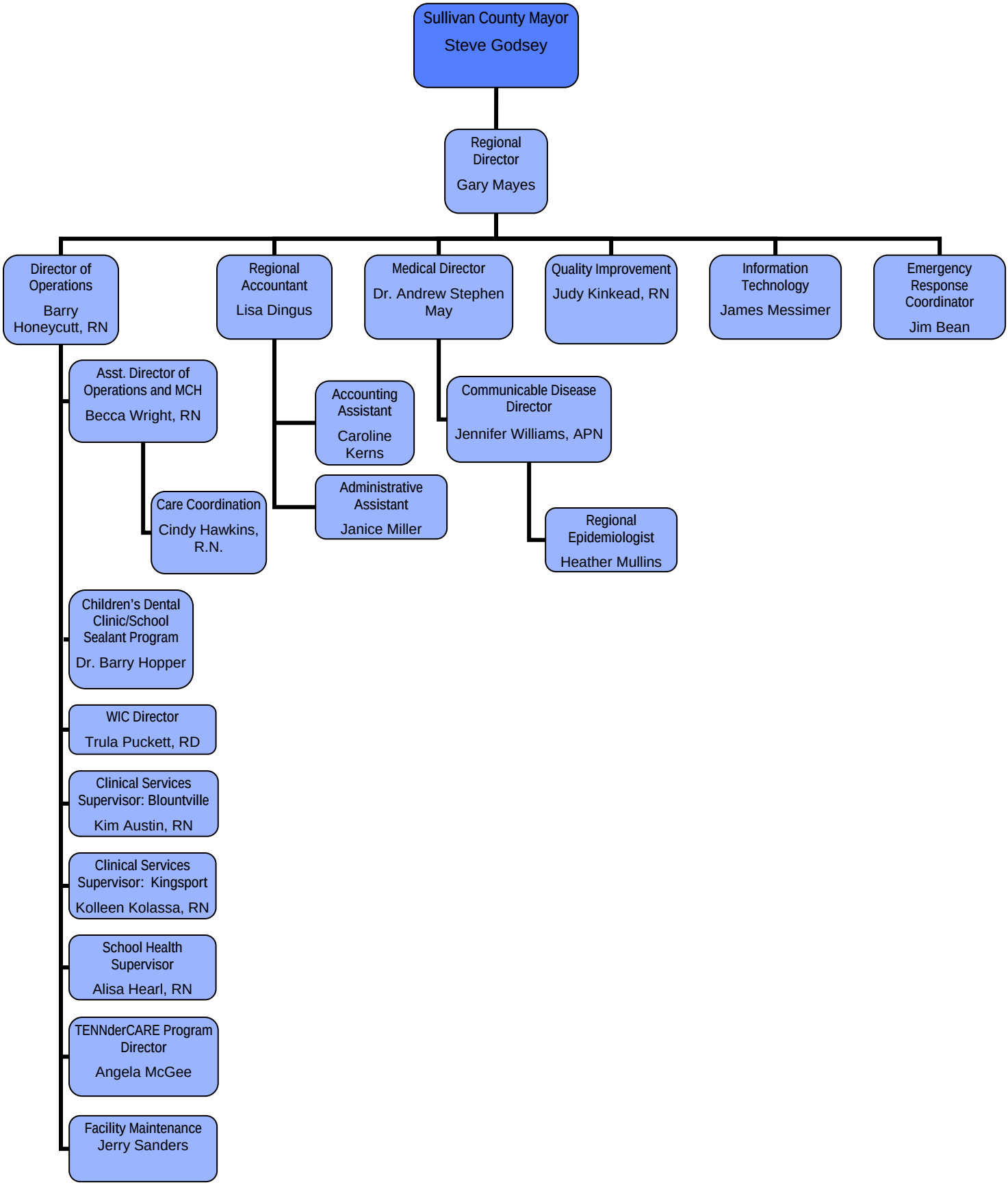
2011 Tennessee Center for Performance Excellence

Award Application

Level IV—Excellence Award

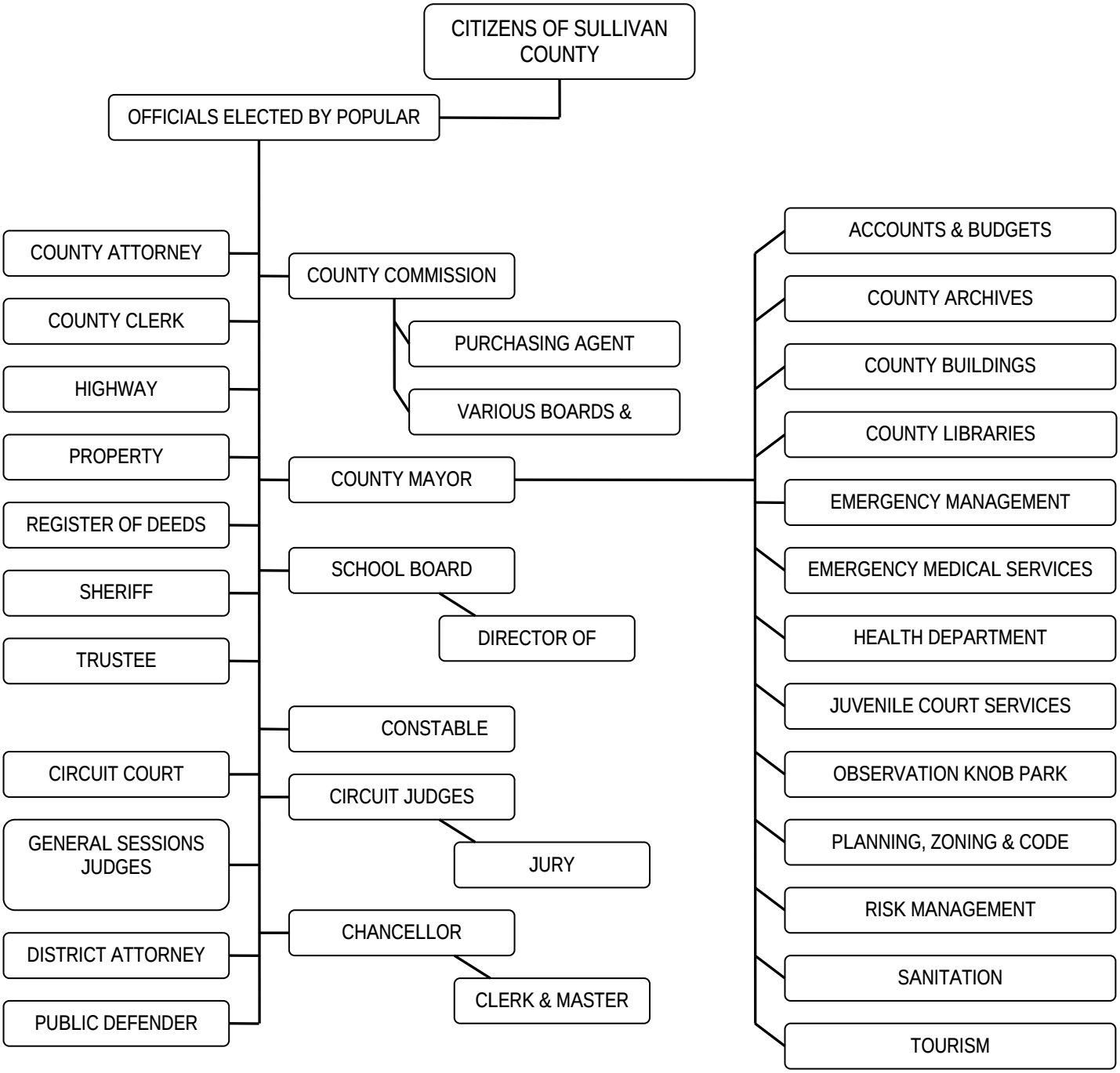
Sullivan County Regional Health Department

Organizational Chart



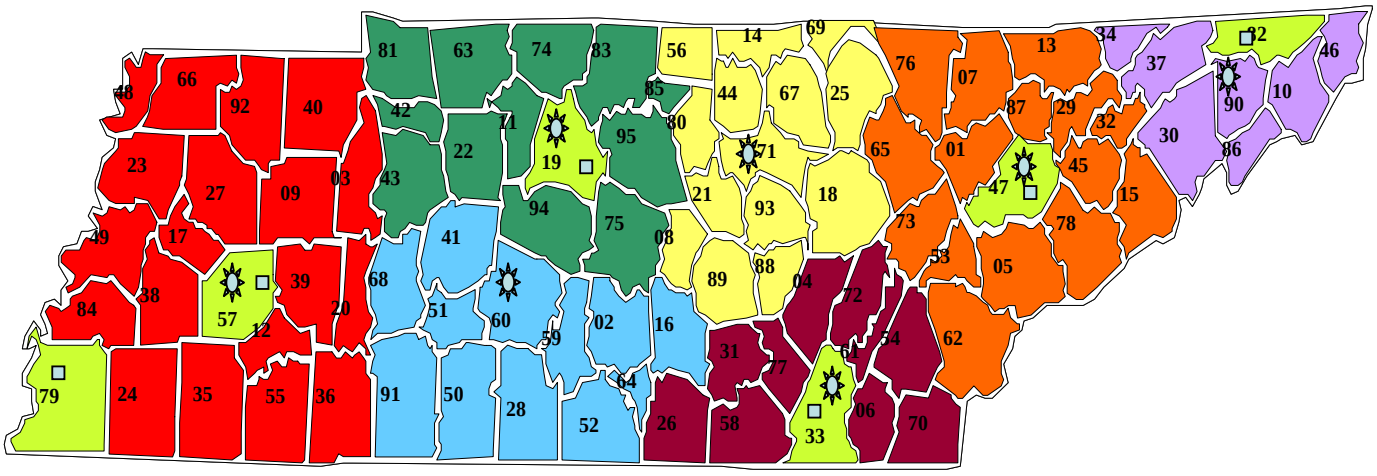
Sullivan County Government

Organizational Chart



State of Tennessee

County, Regional, and Metro Health Departments



West		Mid Cumberland		South Central		Southeast		Upper Cumberland		East		North East	
#	County	#	County	#	County	#	County	#	County	#	County	#	County
03	Benton	11	Cheatham	02	Bedford	04	Bledsoe	08	Cannon	01	Anderson	10	Carter
09	Carroll	22	Dickson	16	Coffee	06	Bradley	14	Clay	05	Blount	30	Greene
12	Chester	42	Houston	28	Giles	26	Franklin	18	Cumberland	07	Campbell	34	Hancock
17	Crockett	43	Humphreys	41	Hickman	31	Grundy	21	DeKalb	13	Claiborne	37	Hawkins
20	Decatur	63	Montgomery	50	Lawrence	54	McMinn	25	Fentress	15	Cocke	46	Johnson
23	Dyer	74	Robertson	51	Lewis	58	Marion	44	Jackson	29	Grainger	86	Unicoi
24	Fayette	75	Rutherford	52	Lincoln	61	Meigs	56	Macon	32	Hamblen	90	Washington
27	Gibson	81	Stewart	59	Marshall	70	Polk	67	Overton	45	Jefferson	24/7	423-979-3200
35	Hardeman	83	Sumner	60	Maury	72	Rhea	69	Pickett	53	Loudon		
36	Hardin	85	Trousdale	64	Moore	77	Sequatchie	71	Putnam	62	Monroe		METROS
38	Haywood	94	Williamson	68	Perry	24/7	423-634-3124	80	Smith	65	Morgan	#	County 24/7
39	Henderson	95	Wilson	91	Wayne			88	Van Buren	73	Roane	19	Davidson 615-340-5616
40	Henry	24/7	615-650-7000	24/7	931-380-2532 ext 146			89	Warren	76	Scott	33	Hamilton 423-209-8000
48	Lake							93	White	78	Sevier	47	Knox 865-215-5093
49	Lauderdale							24/7	931-528-7531	87	Union	57	Madison 731-423-3020
55	McNairy									24/7	865-546-9221	79	Shelby 901-544-7600
66	Obion											82	Sullivan 877-592-6902
84	Tipton												
92	Weakley												
24/7	731-423-6600												

Regional Offices Metro Offices

Organizational Profile

P.1 Organizational Description

a. Organizational Environment

(1) Sullivan County Regional Health Department (SCRHD) is a regional health department that provides public health services to approximately 154,552 residents and is one of six metro health departments in the state of Tennessee. SCRHD operates in two different site locations within the county, Kingsport and Blountville. Each site includes a children's dental clinic as well as a fully operational health department.

SCRHD offers a wide variety of products and services that are provided in clinical and population-based settings. (Figure P.1-1) SCRHD follows the federal poverty guidelines where most services are provided on a sliding fee scale.

Figure P.1-1 Clinical & Population Based Services

Services	Arena	Programs
Clinical Service	C	Physical Exams Immunizations/ International Travel Women, Infant, and Children (WIC) Family Planning (FP) Women's Health (WH) Tennessee Breast & Cervical Communicable Diseases (CD) Employee Health Lead Poisoning Prevention
Dental	C/P	Children's Dental Clinic Oral Health Education
School	C	School Based Nursing Program School Based Preventive Dental
Home Visiting & Care Coordination	P	Children's Special Services (CSS) Help Us Grow Successfully (HUGS)
Health Promotions	P	Injury Prevention Teen Pregnancy Prevention Tobacco Prevention Chronic Disease Education Sexual Assault Prevention
Disease Control	P	Surveillance and Epidemiology
Emergency Preparedness	P	Preparedness and Response
Vital Records	P	Birth/Death Certificates
TENNderCARE	P	EPSD&T Outreach

C=clinical, P=population

The Institute of Medicine (IOM) states that, "Public health is what we, as a society, do collectively to assure conditions in which people can be healthy". Each of the above listed programs are key to SCRHD's success in meeting this highly regarded definition of public health. SCRHD entrusts the delivery of the above mentioned health care services to patients and stakeholders through highly motivated and well trained workforce.

(2) SCRHD is a governmental organization whose purpose is focused on improving health status of Sullivan County residents. SCRHD reflects its mission, vision, and values (MVV) (Figure P.1-2) as its role in the community develops and expands.

Figure P.1-2 Mission, Vision, Values, Core Competencies

Mission

To identify and respond to the public health needs and improve public health status of Sullivan County citizens through education and service with a highly motivated and well trained workforce.

Vision

To be a national model and leader in providing public health services.

Values

Through our decisions and actions with our patients and their families, key communities, partners, and each other, we show our commitment to five values:

1. *Service*: Caring and compassion to all of our customers
2. *Leadership*: Through collaboration and innovation
3. *Fiscal Responsibility*: Stewards of public money
4. *Integrity*: Honesty in all we do
5. *Excellence*: Pursuing a higher professional standard

Core Competencies

Education, Prevention, Community Need, and Workforce

SCRHD has developed four core competencies: Education, Prevention, Community Need and Workforce. These core competencies were derived from the Center's for Disease Control and Prevention (CDC) ten essential public health services, the Public Health Foundations core competencies for public health professionals and the Performance Excellence Criteria. Each of the core competencies is essential in the fulfillment of the stated mission.

(3) SCRHD has a nonunion workforce of 118 employees. The workforce varies in educational levels ranging from high school diploma to specialty medical and dental degrees. Both licensed and non-licensed personnel are employed within SCRHD (Figure P.1-3). All SCRHD employees fall within one of three workforce segments in order to accomplish the mission: Administrative, Clinical, and Non-Clinical staff. Employees of SCRHD embody the core values of Service, Leadership, Fiscal Responsibility, Integrity, and Excellence. These core values are key elements that assist in engaging the workforce in accomplishing the mission and vision of SCRHD.

Special health and safety requirements for employees are dictated by safety guidelines overseen by the Safety Committee and by mandatory annual OSHA training. The Safety Committee meets semi-annually and is chaired by SCRHD's Emergency Response Coordinator. These meetings allow an opportunity to discuss issues such as incident reviews, safety drills, employee safety, and workplace hazards.

Key workforce benefits include: medical and dental insurance, county paid life insurance, 16.26% county paid retirement program, paid holidays, personal days, sick days, and a compressed work week which is offered to all full time employees.

Figure P.1-3 Staff Profile

Gender	Male	10%
	Female	90%
Race/Ethnicity	White	97.5%
	African American	2.5%
	Hispanic/Latino	1.7%
Education	Postgraduate	14%
	Two-four years of college	63%
	Vocational	12%
	High School	11%
Employment status	Full time	72%
	Part time	28%
Staff Group	Administrative	13%
	Clinical	58%
	Non-Clinical	30%
Governmental classification	County	37%
	State	5%
	Contracted	58%

(4) SCRHD has four primary facilities and serves, on average, 22,500 clients (58,000 visits) per year. The Blountville site is the headquarters for SCRHD, and predominantly serves residents from Bristol and the surrounding areas. The Kingsport site is centrally located within the City of Kingsport. The SCRHD Children Dental Clinics serve approximately 2,100 children annually. The fourth SCRHD facility houses the Public Health Emergency Preparedness Program staff. Clinics operate Monday through Thursday from 7:30 AM to 6:00 PM and Friday's 8:00PM to 5:00PM, with the exception of the Dental Clinics which are closed on Fridays.

Clinical and dental facilities include: reception areas, examination rooms equipped to perform medical and dental services, and printed educational material. Clinic based laboratories are capable of performing microscopy's, urine dipsticks, pregnancy testing, lead testing, and hemoglobin analysis. A limited number of medications are dispensed from the clinics including: contraception, vaccines, and antibiotics. Communications and services are enhanced through technologies such as: password protected computer access, email, Microsoft Office software, Crystal Reporting software and Internet access. SCRHD has established a website (www.sullivanhealth.org), Facebook, Twitter accounts and an employee intranet known as the Sullivan Health Electronic Interface Library Access or SHEILA. Each of these outlets is used to better facilitate communication and available services to all stakeholders. SCRHD's computer infrastructure, equipped with fully managed switching and router systems, consists of personal computers, servers, an IBM AS400, and redundant systems for backup, and is capable of operating should utilities fail or Internet provider service be disrupted.

The Blountville site serves as the Regional Health Operation Center (RHOC) during health emergencies. Emergency equipment consists of: weather radios, cell phones, a satellite phone, emergency public radios, wireless data transmission, amateur radio capability, and a Web-Based Emergency Operation Center (WEB EOC). One area of technologies and expertise for SCRHD is the monitoring of immunizations.

An electronic security system monitors vaccine temperature regulation, notifying the on-call manager when a vaccine temperature is out of range. The security system also prevents clients from entering unauthorized areas, therefore helping to restrict access during times of vaccine shortage.

(5) Federal Regulatory requirements include Tennessee Occupational Safety and Health Administration (TOSHA), Clinical Laboratory Improvement Amendments (CLIA), and Health Insurance Portability and Accountability Act (HIPAA). Tennessee Code Annotated (TCA) health section mandates legal statutes for public health laws. SCRHD operates under Title VI, Title II, and Title X of the Federal Register. SCRHD maintains licensure to dispense medications under Tennessee Board of Pharmacy. Professional licensed providers operate under the Tennessee Board of Health in their respective disciplines. National Fire Protection Association (NFPA) standards are enforced. Medical waste is disposed via approved alternative medical waste treatment methods according to Tennessee Department of Environment and Conservation (TDEC). Financially, SCRHD operates in accordance with Governmental Accounting Standards Board (GASB) and is audited by both state and county governing agencies. The Public Health Accreditation Board (PHAB) was incorporated in 2007 and was created to promote and manage the national accreditation program for public health. PHAB completed beta testing in June 2011 and plans to begin accepting applications in the Fall 2011 or early 2012. SCRHD has plans in place to pursue accreditation once it becomes available.

b. Organizational Relationships

(1) SCRHD is a county government agency with two primary over-seeing bodies that governs and guides services -- the Sullivan County Commission and the Tennessee Department of Health. The legislative body of Sullivan County is the Sullivan County Commission which consists of 24 elected commissioners, who meet monthly, with representation from Sullivan County departments. The county commission provides primary oversight and governance for all Sullivan County governmental departments, including SCRHD. SCRHD's Regional Director is directly accountable to the county mayor, who leads the Sullivan County Commission. SCRHD's program directors ensure that all Tennessee Department of Health contract guidelines are met. The state monitors their programs through state and federal audits, timely program reports, and the Patient Tracking Billing and Management Information System (PTBMIS).

(2) SCRHD's key patients and stakeholder groups include patients and families, community, staff, partners, and payers. (P.1-4) SCRHD acknowledges the many contributions made by the employees and consider them a key stakeholder group

An example of meeting stakeholder expectations is being culturally competent by communicating effectively with diverse populations. SCRHD implemented the use of language line to assist in communicating with non English speaking clients even though the population is less then the required guidelines set forth by Title VI. Educational

information is made available in various languages to better meet the patient's needs and expectations.

Figure P.1-4 Customer and Stakeholder Requirements

Requirement	PF	C	S	PT	PY
Safety	X	X	X		X
Effective, high-quality care	X	X		X	X
Efficient, cost-effective care	X	X			X
Timely and convenient access to care and information	X	X	X		X
Electronic Communication	X	X	X	X	X
Knowledge, skills, and tools to do the job	X	X	X	X	
Culturally Competent	X	X	X		
Fair pay and benefits			X		

PF= Patient and Families, C=Community, S=Staff, PT=Partners, PY=Payers

(3) SCRHD could not carry out the mission without the services and support received from suppliers and partners (Figure P.1-5). The most important supply chain requirements are low cost/high value, and on-time delivery of supplies.

Figure P.1-5 Suppliers/Partners

Suppliers Partners	Roles
Sullivan County Commission	Financial Support, Community Support, Governance, Employee Benefits, and Ancillary Services (i.e. Purchasing and Print Shop)
Tennessee Department of Health	Program Funds, Program Management, and Continuing Education
Centers for Disease Control and Prevention	Program Funds, Statistical Information Vaccine Guidance, and Continuing Education
Community and business groups	Provide funds, time, activity space, Networking
Local Hospitals	Partnering for medical services and resources
Information and Communication vendors	Phone systems Electronic Communication

The community and business groups play a vital role in the innovation process at SCRHD. SCRHD has partnered with many community groups -- from both profit and nonprofit sectors -- to provide comprehensive services to customers. An example of a community partnership is through the Sullivan County Health Council (SCHC). The council serves a vital role in community assessment, community action planning, and health directives. The SCHC is a group of community leaders including local and regional industry, private and hospital medical sectors, where SCRHD serves in an advisory role.

Another example of community partnerships involves the Women's Health program. SCRHD'S Women's Health program has partnered with a local hospital system to provide mammography services for patients referred from the health department as long as they meet specific program requirements. This partnership allows symptomatic and non symptomatic uninsured patients to be screened for breast cancer and follow-up care.

SCRHD is diverse in its partnerships and encourages two-way communication with each group (Figure P.1-6).

Figure P.1-6 Communication Mechanisms

Group	Related Through	Communication Mechanisms
State of Tennessee	All SCRHD State Program Contracts, Some Program Data and Vital Records	Email, Phone, Fax, Quarterly Regional Director and MSEC Meetings, Weekly State Conference Calls, Audits, WEB EOC
CDC and Federal Agencies	Vaccine for Children (VFC), Multiple Program and Immunization Guidelines, Federal Monitoring and Regulation via TDOH	Phone, Fax, Emails, Conferences, Program and Administrative Meetings, and Audits
Community Health Partners	Client Service	SCHC, Community Meetings / Forums, Contracts, Phone, Fax, Emails and Personal Contact
Public	Client Services, Health Promotion and Community Outreach	Website, Media Releases, Interviews, Civic Presentations, Health Education, Health Alerts, Phone, Fax, and Email
Taxpayers	Use of tax payer funding	Representation at public meetings, published reports, and phone

P.2 Organizational Situation

a. Competitive Environment

(1) Sullivan County Regional Health Department operates in a unique competitive environment for funding. SCRHD is in competition for funding allocations with other Sullivan County departments (i.e. education and corrections) from the Sullivan County Commission. SCRHD is also in competition with state and metro health departments for funding from the state of Tennessee.

Although Sullivan County Regional Health Department is in a competitive funding environment we are in a collaborative relationship with the private sector to provide health care services to improve public health outcomes. An example of working collaboratively pertains to an increasing numbers of EPSD&T exams and sharing of immunization schedules. SCRHD has developed a Key Community's workgroup that annually evaluates all key collaborators. Sullivan County Regional Health Department serves all citizens within Sullivan County. However, SCRHD can serve non-county residents for programs such as Women, Infants, and Children (WIC), Family Planning, and influenza vaccine administration.

(2) Public health is an ever changing environment. To remain financially stable and support continuing growth and improvement, SCRHD ensures operational efficiency and productivity, decreased expenses, capitalizes on the use of IT to reduce waste and promote productivity, and expand and strengthen its access to grant funding. SCRHD's key environmental changes that affect competitiveness are outlined in Figure P.2-1.

Figure P.2-1 Key Environmental Changes

Key Changes	Impact Examples
Rising cost of health care services and treatment	Rising cost of contraceptives has reduced supply options
Flat or falling county, state and federal funding sources	Decrease in funding (i.e., salaries, supplies, and travel) limits program effectiveness
Increasing number of residents with barriers to accessing adequate health care services	Reallocating resources to ensure health care for the uninsured and underinsured population are met.
Increased competitiveness for hiring and retaining nurses and other specialty positions	High employee turnover impacts quality of health care, organizational knowledge, and team cohesiveness.
Economical and health care reform uncertainty	Increase in uninsured patient visits within various health department clinics, decreased reimbursement due to sliding fee scale, increased requirements based of reform mandates.

SCRHD has developed various opportunities for innovation to address many of the key changes. Three major innovations include a communication center, auto-dialer for appointment reminders and modification of clinical flow due to remodeling of patient waiting and check-in areas.

SCRHD has collaborated with the community to provide services for the uninsured population. From this collaborate effort; Appalachian Mountain Project Access (AMPA) was created to provide free medical care to the uninsured adult population at or below 150% poverty level. Within this effort SCRHD provides office space at our facility for AMPA.

(3) TDOH provides a limited amount of comparative and competitive data for all regions and metros within Tennessee. The first criterion for comparative data is in areas of similarities in population, demographics, and income. Comparison data is also available on a state and federal level. Customer Satisfaction comparative data is made available by Sullivan Luallin through a yearly survey and is compared with other health care providers across the nation. Goal setting can be accomplished via Healthy People 2020 (CDC). Limitations exist on the availability of similar data from peer communities and timeliness of the data. SCRHD utilizes a hybrid of national, state, and local data for performance comparison. Although national and state data is available in many cases, establishing a best in class performance level within the state can be challenging due to the lack of available comparative data.

b. Strategic Context

SCRHD faces numerous strategic challenges because of its role as a governmental agency in public health service. These challenges are identified through the strategic planning process (SPP) and are addressed in the strategic plan. (Figure 2.1-4) Key strategic challenges and advantages are broken up into seven Key Result Areas as defined in P.2c. and identified by SCRHD's Performance Excellence Council (PEC) (Figure P.2-2).

Societal responsibility is the cornerstone of public health. Public health focuses on the improvement of health outcomes within a community as opposed to clinical healthcare which focuses on the individual. As stated in the IOM's definition of public health and confirmed by the mission of SCRHD; societal responsibility is viewed as a key strategic advantage.

Figure P.2-2 Key Strategic Challenges and Advantages

Area	Strategic Challenges	Strategic Advantages
Management Practice	Increase the utilization of continuous process improvement across all departments.	Strategic Planning Process (SPP)
Human Resource Development	Retain a productive, satisfied, and qualified workforce	experienced static workforce, cross-trained
Financial Systems	Balance SCRHD mission against a tight fiscal environment to continue service to our county.	team work to maintain balanced budget
IT and Data Systems	Leverage available information technology resources to enhance organizational knowledge and effectiveness.	CareSpark, Shared Health, e-prescribe, communication center, auto dialer, TWIS
Customer Focus and Satisfaction	Meet or exceed the performance expectation of patients, the community and external partners.	four years of satisfaction survey data, Rays of Sunshine, C^3, Stakeholder Satisfaction Survey
Public Health Capacity	Strengthen/develop community and interagency partnerships	Accreditation
Health Status	Address poor health status and inadequate access to care in the Sullivan County.	AMPA, Community Health Status Evaluation

SCRHD receives federal and state grants (approximately $3.1 million from the Tennessee Department of Health). These funds have not kept pace with the growing economic changes within the health care industry. SCRHD has an annual budget of $6.7 million for the 2010-2011 fiscal year funded in part by $3.6 million from community tax revenues.

c. Performance Improvement System

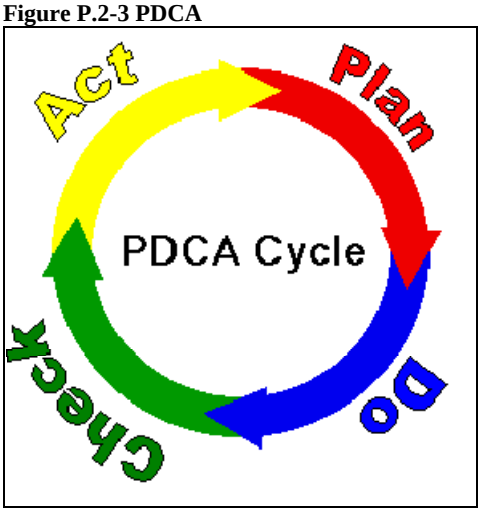
Sullivan County Regional Health Department adopted the Baldrige Criteria as a business framework in 2005. In 2007 SCRHD obtained a level two certification with the Tennessee Center of Performance Excellence (TNCPE). The PEC has since encouraged and deployed principles of performance management, strategic planning, and process improvement across all levels of SCRHD.

Sullivan County Regional Health Department has developed seven Key Result Areas (KRAs) which are used to determine success relative to other organizations that provide similar health care services. These seven KRAs include: management, human resources, financial, information technology (IT) and data systems, customer focus and satisfaction, public health capacity, and health status.

In order to address Performance Management, SCRHD has established Global Performance Indicators (GPIs) that are directly linked to strategic objectives in the strategic plan. A listing of these indicators is found in Figure 4.1-1. These measures are vital components of SCRHD and assure the sustainability of the organization. Departmental Performance Indicators (DPIs) have been developed for each department within SCRHD. These are determined by each department and viewed as being what is most important to that department and what makes them successful. These processes were established to allow SCRHD to align its priorities, task requirements, and performance with the organization's MVV.

SCRHD currently uses a continuous cycle of PDCA (Plan, Do, Check, Act) model for quality improvement (Figure P.2-3). This technique is utilized when an evaluation of performance measurements (GPIs or DPIs) show an unusual change and require immediate cycles of learning and opportunities for innovation.

Figure P.2-3 PDCA



Sullivan County Regional Health Department has numerous success stories from the utilization of the PDCA quality improvement process. Examples of these include the increase in EPSDT exams, patient flow, four day work week, new WIC encounter, auto dialer and flu clinic structure.

Category 1: Leadership

1.1 Senior Leadership

a. Vision, Values, and Mission

(1) In 2002, Sullivan County Regional Health Department (SCRHD) underwent significant changes in its senior leadership (i.e., Regional Director, Medical Director) resulting in its first strategic planning retreat. It was at this time that SCRHD's initial Mission, Vision, and Values (MVV) for the organization were drafted. SCRHD's vision for the future was created through a constructive dialogue between the new Regional Director and employees during an employee meeting. In January 2008, the mission and vision were reevaluated and modified during the strategic planning retreat. (Figure P.1-2) Since then, senior leaders have defined a systematic process for establishing, updating, and deploying the MVV across the organization during the annual retreat.

Mission, vision, and values are deployed throughout the organization and to all stakeholder groups in many different ways, including communication boards, framed posters, meeting agendas, SHEILA, Facebook and SCRHD's website. Mission, vision, and values are also displayed at the beginning of all presentations. SCRHD integrates the MVV when evaluating all organizational and operational improvement opportunities.

Senior leaders' actions reflect a commitment to the organization's values through personal interactions with employees, partners, volunteers, and suppliers. As a relatively small, community-based organization, SCRHD understands the importance of strengthening relationships and arriving at shared community values. Senior leaders and staff make a special effort to reach out to the community and to each other when sharing our MVV. To emphasize this point, the job description and performance evaluations for all employees include ties with organizational values.

(2) Senior leaders promote an organizational environment that requires legal and ethical behavior, while reflecting the values of SCRHD. SCRHD promotes an environment for ethical behavior through the following:

- (Senior leaders) modeling ethical behavior
- Ethics policies and training
- An "open door" policy and "blame-free" environment
- Health Insurance Portability and Accountability Act (HIPAA) training for all employees
- Performance evaluation includes such topics as ethical behavior and integrity

Based on the sensitive nature of the work provided by SCRHD; HIPAA requirements, patient information confidentiality, and related privacy issues are addressed during training which starts during new employee orientation. SCRHD has a HIPAA compliance officer who monitors to ensure that HIPAA compliance is being met throughout the year. Computer access to records is monitored for appropriateness.

During new employee orientation, all employees receive a personal copy of the Sullivan County Employee Handbook (as described in Item 5.1b (2)). This handbook provides employees with county-wide policies and contact information which empower staff members to directly contact subject matter experts about specific issues. Employees are also encouraged to ask for senior leader support when issues or questions are not resolved to their satisfaction.

SCRHD follows the Sullivan County government ethics policy. It is distributed to all employees annually. Initiatives -- such as the Thumbs Up program described in Item 1.1b (1) and Item 5.2a (3) -- demonstrate outstanding performance or ethical behavior among coworkers. This allows employees to reinforce the organization's values across workgroups. SCRHD operates under several legal and regulatory environment requirements. Each of these are listed in detail in P.1a (5).

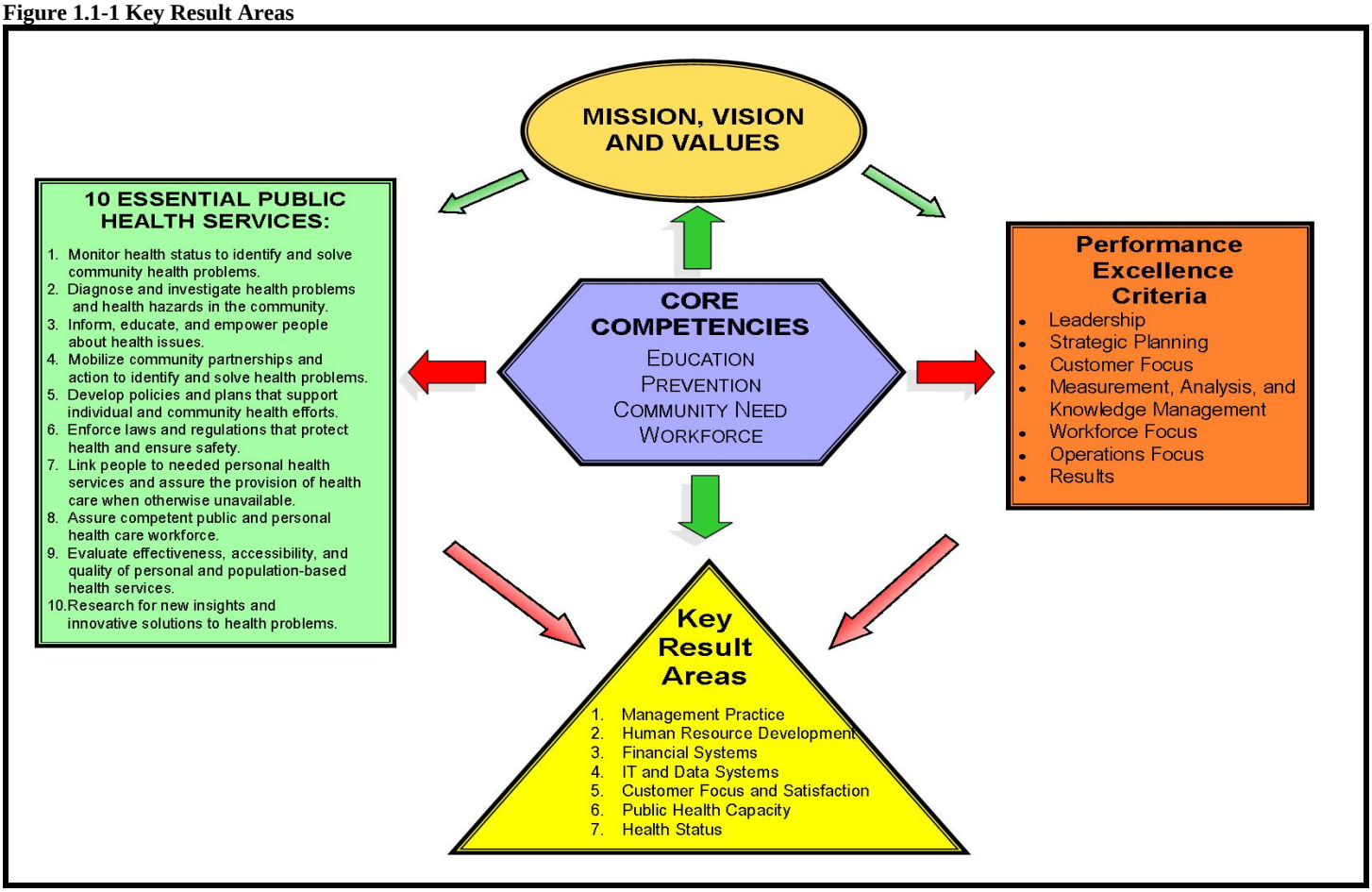
(3) SCRHD's ability to address current organizational needs and to have the agility and strategic management to prepare successfully for the future relies on the intermingling of the seven Key Result Areas, strategic planning, process improvement, and performance management.

SCRHD serves to facilitate improved community health for the citizens of Sullivan County. Toward that end, senior leaders developed a motto and symbol for the health department: "the road to good public health." The Performance Excellence Council (PEC) established a framework consisting of seven Key Result Areas (Figure 1.1-1) to deliver its services to the community. The KRA framework was developed to balance the organization's focus and performance and integrated public health's ten essential services (developed by the Center's for Disease Control and Prevention) with the Baldrige criteria.

The strategic planning process is the cornerstone of sustainable development, as strategic objectives and action plans are linked to current requirements and business needs. SCRHD has developed a systematic strategic planning process that is reviewed and updated at the annual retreat or as needed when organizational, market, or operating environments change. An example of SCRHD agility in a changing environment is responding to the 2009 Novel H1N1 Pandemic. An addition was made to the strategic plan to address this considerable responsibility while maintaining normal operational services.

SCRHD uses the Plan-Do-Check-Act (PDCA) model (Figure P.2-3) across all dimensions of the organization including the creation of an environment for organizational process improvement. Senior leaders create an environment for organizational performance by providing process improvement training to managers. After completion of training, the managers implement a performance improvement project in their department using the PDCA methodology. Managers receive guidance on the project(s) from leaders versed in performance improvement methodologies. Depending on the size of the project, managers form

Figure 1.1-1 Key Result Areas



Performance Improvement Teams (PITs) consisting of staff within their department.

For example, senior leaders implemented a "train-the-trainer" approach after attending an in-house training series on performance improvement. Departmental managers were tasked with educating and facilitating their department through a department-focused process improvement project. In some cases, departmental process improvement teams were formed. Throughout this process, internal subject-matter-experts (e.g., process improvement) were available for consultation with each department lead or team.

The performance improvement environment created by SCRHD's senior leaders is producing positive results. A good example of performance improvement practice involves a nursing-clerk team that was created to reduce the paperwork and cycle time for children's physical exams (also known as Early Prevention Screening Diagnostic and Treatment or EPSDT). Over the course of three months, this team successfully reduced the amount of paperwork required to complete these physicals by 25%. Another example of how performance improvement has been utilized is with the integration of the core competencies in 2009. SCRHD's four core competencies of Education, Prevention, Community Need, and Workforce are strategically important capabilities that are central to fulfilling SCRHD's mission.

To adopt Performance Management, the PEC has established Global Performance Indicators (GPIs) (Figure 4.1-1) that are directly linked to strategic objectives in the strategic plan. These measures are vital components of SCRHD and assure the sustainability of the organization. Departmental Performance Indicators (DPIs) have also been developed for each department within SCRHD. These are determined by each department and viewed as being what is most important to that department and what makes them successful. These processes were established to allow SCRHD to align its priorities, task requirements, and performance with the organization's MVV.

Performance Management has become a systematic process that is assessed at different intervals throughout the calendar year depending on indicator type. DPI's are addressed within each department during their monthly staff meetings. GPIs as well as DPIs are evaluated by all senior leaders every three months during SCRHD's Quarterly Review as well as during the annual Strategic Planning Retreat.

SCRHD's mission is key to creating a workforce culture that delivers a consistently positive experience for patients and stakeholders. It is repeatedly emphasized by senior leaders that there are two vital components of SCRHD's mission: the customers and the workforce. This culture is SCRHD'S foundation for creating a sustainable organization.

Workforce learning is vital in keeping the staff up to date with current policies and practices in public health as well as enhancing leadership skills. SCRHD provides a variety of opportunities for workforce learning. The Southeast Public

Health Leadership Institute (SEPHLI), Incident Command System (ICS) training, Pals Business Excellence Institute (BEI), Tennessee Center for Performance Excellence Examiner Training, and the Tennessee Public Health Workforce Development Consortium are a few examples of programs that have been utilized by SCRHD staff members to enrich organizational learning and development of future organizational leaders. In 2011, East Tennessee State University, College of Public Health, received funding from the U.S. Health Resources and Services Administration to establish Tennessee's first Public Health Training Center called LifePath. LifePath will offer academic and non academic training for the Public Health workforce. SCRHD is collaborating with LifePath administrators to ensure the successful deployment of this important initiative.

SCRHD's PEC has consulted with an external performance improvement expert for guidance in the performance excellence journey. Senior leaders are committed to learning from the performance success of others, and they have proactively sought out performance management training opportunities and lessons learned from former TNCPE and Baldrige winners.

Senior leaders have implemented succession planning for staff with cross training and staff work assignment rotations. Senior leadership participates in several upper level meetings both weekly and monthly for information sharing. In the event of senior leader vacancy, the remaining leaders have the knowledge about the leader's current projects and daily operations to ensure that departmental requirements are met until the position is filled.

Senior leaders become involved in succession planning, when feasible, to enhance organizational agility. For example, in June 2007, the county commission approved a SCRHD request for a new position -- Assistant Director of Clinical Services (Operations). In addition to serving as a backup to the Director of Clinical Operations during periods of leave (e.g., annual leave), this nurse is also prepared to possibly fill this position in the event of a vacancy.

Senior leaders create and promote a culture of patient safety with the help of a Safety Committee that has been active since 1999. This committee is chaired by SCRHD's Emergency Response Coordinator (ERC) and is given the charge of identifying issues within the organization related to safety and risk management. The group compiles data from Incident/Accident reports filed internally. The Safety Committee tracks all incident reports and each individual action plan that has been developed to address the incident and reports them directly to the Regional Director. An additional component of assuring patient safety is the annual safety training that is conducted with all staff members as well as a procedures manual on all safety policies that is made available to staff members. (Figure 5.1-2)

b. Communication and Organizational Performance

(1) Senior leaders encourage two-way communication and engage the workforce using a variety of methods, as shown in Figure 1.1-2. A wide range of communication methods enable real-time access from both internal and external customers (e.g., community partners). This is particularly important during public health emergencies, which is noted in detail in 6.1c. Key decisions are usually communicated to employees through email notification or the Regional Director's staff meeting.

After conducting an employee satisfaction survey in 2008, results showed that communication from senior leaders to staff members was an area in need of improvement. After reviewing the survey results, the PEC developed a program to dismantle the communication barrier. "Healthy Rounding" was launched in March 2009. Rounds are conducted on a weekly basis by administrative staff members to a predetermined department. A "Healthy Rounding" document was developed that listed potential questions that could be asked to staff members during their rounding visit. Both the question document and rounding calendar are made available for staff members so they are aware of when their departments round will take place and what questions could be asked of them. More information on the "Healthy Rounding" program will be discussed in Item 5.1.

Senior leaders take an active role in establishing reward and recognition programs for the workforce. One example, the Thumbs Up Program, was implemented in June 2007. Thumbs Up is an employee recognition program where acts of excellence in customer service or work performance, observed by staff or senior leadership, are documented on a Thumbs Up form and posted on a bulletin board centrally located to be viewed by the staff and they are also displayed on SHEILA so that it can be viewed throughout the entire organization regardless of site location. The post remains on the bulletin board for one month and then it is filed in the employee's personnel file. Within the first two weeks of implementation, over twenty posts were recognized.

(2) Senior leaders create a focus on action to accomplish objectives, improve performance, and reach the shared vision through established processes that encourage strategic action planning implementation. The communications methods (described in Figure 1.1-2) allow for action follow-up through the strategic planning process as well as outline SCRHD's methods to communicating key decisions. SCRHD improves its results by aligning Global (GPIs) and Departmental Performance Indicators (DPIs) with its strategic plan (Figure 4.1-1 and Item 4.1(a)). Senior leaders track performance and action plan status at the Quarterly Review (QR) meetings, while departmental managers evaluate departmental performance at monthly meetings held at the departmental level. At QR, the PEC and senior leaders review all GPIs and DPIs identified in the Category 7 (Results) section. The task of balancing value for customers and stakeholders falls first with the PEC (e.g., disposition) and then with the departmental managers (e.g., resource allocation). Appropriate modifications to approved action plans, implementation timelines, and performance expectations are critical to achieving balance and realism in performance management.

Figure 1.1-2 Communication Methods

Method	Frequency	Participants	Primary Focus
Internet (Organizational website, Facebook, Twitter)	Daily	All	Access hours, services provided, public health news, important public health updates and employment information,
Shared Drive	Daily	Staff	Access online directory, documentation and policies
SHEILA/SHEL.E	Daily	Staff	Provide timely updates, storing house of Rays of Sunshine, Thumbs Up recipients, a new implementation of the Shared Drive
Staff Meetings	Monthly	Staff	Share program progress and updates, recognize staff, introduce new staff, and solicit any concerns.
Cell Phones	As Needed	Staff	Provide quick access to managers during daily operations and emergencies.
Staff Orientation	As Needed	Staff	Meet with departmental directors to learn about their program, HIPAA, etc
Newsletters	Quarterly	Staff	Recognize staff, departmental updates
Bulletin Boards	As Needed	Staff	Recognize staff, performance updates, program promotions
Managers Meeting	Monthly	Managers	Organizational progress and updates; strategic planning
Director's Semi-Annual Employee Meeting	Biannually	All	Organizational progress and updates
Tactical Meetings	As needed	Admin. Staff	Used during project planning and implementation.
Healthy Rounding	Weekly	Admin. Staff	Listen and learn, workforce engagement
Administrative Staff Meeting	Monthly	Admin. Staff	Organizational progress and updates
Health Alert Network	As Needed	Managers, TDH, Hospitals and Physicians	Dissemination of emergency data and information
Amateur Radio	As Needed	Volunteers	Back-up system during primary communication failure
Quarterly Review	Quarterly	Senior Leaders	Integrate quarterly inputs into strategic planning, action planning and performance management instruments
Strategic Planning Retreat	Annually	Senior Leaders	Annual update on performance, review and revisions to strategic plan, organizational SWOT analysis
Performance Excellence Council	Monthly	PEC members	Review of performance excellence initiatives, progress update
WEB EOC	As needed	Outbreak Team	Used during an outbreak investigation to provide a centralized communication center.

1.2 Governance and Societal Responsibilities

a. Organizational Governance

(1) Sullivan County Regional Health Department reviews and achieves fiscal accountability through a systematic evaluation process. One component of the evaluation process includes the use of internal and external audits. Internal audits are performed by Quality Improvement (QI) personnel during predetermined intervals throughout the year. These audits consist of over 200 items that address a variety of topics ranging from risk minimization, availability of services, and medical encounters. The QI manager reports the findings of her most recent audits during the monthly managers meeting. External audits are performed by county and state officials. These audits evaluate the performance of the programs that are available at SCRHD as well as the financial performance of local, state and federal funds. The majority of these audits are conducted annually however some may be done on an as-needed-basis. Follow up is required with each completed audit to address all findings and recommendations. Corrective action plans are developed to attend to all listed items which are then used for process improvement within the organization.

The second component in achieving fiscal accountability includes the use of budgetary reviews. These are conducted with all managers during the monthly meetings as well as quarterly during each Quarterly Review (QR). Transparency in operations is accomplished by public publication of the annual comprehensive audit, along with a detailed review at the monthly managers meetings.

Protection of stakeholders is accomplished through policies and procedures which are monitored for compliance. For example, the vaccine storage policy states that the refrigerator and freezer containing vaccines must stay within specified temperature parameters. This is monitored and recorded daily by the staff nurses and checked by management and ensures vaccine safety and financial interests of our stakeholders.

All managers are held accountable for their responsibilities by their direct supervisor. The managers are evaluated yearly on their job performance by their direct supervisor. They meet quarterly with the regional director for a director's update on their program. Managers are also held accountable during the Quarterly Reviews and Annual Strategic Planning Retreat when they are asked to present their action plan status and results of their DPI.

(2) The performance of senior leaders is evaluated on a yearly basis. The regional director is evaluated by all departmental directors as well as the county mayor. Managers complete a job evaluation survey administered by human resources. The results of this survey are then shared with the county mayor, who, in turn, conducts the regional director's performance review. From this review, the regional director develops any necessary action plans or changes in implementation style.

In February 2009 an improvement was made on the evaluation forms to include annual goals and improvement processes. Each senior leader is evaluated by their direct supervisor using this new evaluation form. (Item 5.2c (1))

The county commission provides primary oversight and governance for all Sullivan County governmental departments, including SCRHD. SCRHD's Regional Director is directly accountable to the county mayor, who leads the Sullivan County Commission. It is the responsibility of the county mayor to evaluate the performance of members of this governance board.

b. Legal and Ethical Behavior

(1) SCRHD addresses adverse impacts on society and anticipates public health concerns on health care services and operations through several methods. One method utilized during the 2009 H1N1 Pandemic involved the use of the Flu Call Center. The Call Center was staffed with highly trained and knowledgeable employees that answered questions and addressed concerns regarding H1N1 illness, vaccinations, and disease prevention as well as scheduled appointments for up-coming H1N1 clinics. The monthly monitoring of DPI's by departments and quarterly by senior leaders is another method in which SCRHD is proactive in addressing public concerns regarding services and operations.

In March 2009 the PEC developed a new process to further anticipate the needs of our customers and patients. Customer Care Comments (C^3) was developed as a way of capturing real time feedback from our customers in an attempt to better understand how to meet and exceed the expectations that our customers deserve. SCRHD invites every person who comes through the door of one of our facilities to evaluate the level of service and care that they received and provide comments, whether they are good or bad. Every comment provided to us is thoroughly examined and used as a way of improving our services to our customers.

SCRHD's public information officer is instrumental to providing health information to a variety of media sources in the event of a public health emergency (e.g., notice of public health emergency). It is important that vetted health information, instruction, and contact information be communicated in a timely, accurate, and effective manner. During emergency scenarios, SCRHD collaborates with other community organizations to verify that information is accurate, effectively disseminated and a coordinated response is implemented.

This process was successfully implemented in 2007 during a rabies outbreak which required coordination with the Tennessee Department of Health (TDH), Virginia Department of Health (VDH), and the Northeast Regional Health Office (NERHO) to present a coordinated statement to the public and health care officials regarding recommendations for protection and treatment. Another example of proactive coordination involved the 2009 H1N1 Pandemic and collaborations with TDH, Mountain Empire Public Health Emergency Preparedness Coordination Council (MEPHECC), H1N1 Pediatric Planning Group and the three school systems that are located in Sullivan County.

The Public Health Accreditation Board (PHAB) was incorporated in 2007. Since then the process for accrediting all local, state, and tribal health departments has been undergoing significant reviews and modifications for implementation. PHAB will begin collecting applications for accreditation in 2012. SCRHD has designated three senior leaders to be site visit examiners to assist PHAB in finalizing accreditation criteria. SCRHD's key processes, measures, and goals for surpassing legal, regulatory and accreditation requirements are addressed in Figure 1.2-1

(2) Legal and ethical compliance is critical to the integrity of the organization and the citizens of the county it serves. Questions of ethics can be referred to the county ethics committee. Ethics training is mandatory for all employees. SCRHD leadership has an "open door" policy to encourage dialogue about ethical behavior and foster employee empowerment. However, there is "zero tolerance" for breaches in ethical behavior involving patient confidentiality. After review, if a deviation of standard practice is found a written reprimand or termination may be issued depending on the severity of the breach. All staff are instructed at the time of employment in HIPAA regulations and consequences or violations. Ethical behavior and compliance with legal and regulatory requirements are assured by:

- Reports of unethical behavior by leadership
- Annual audits
- Budget Committee Oversight by the Sullivan County Commission
- Operational records are open to the public for review, but patient records remain confidential.

c. Societal Responsibilities and Support of Key Communities

(1) Societal well-being is the foundation of SCRHD's mission and the framework of core public health. This belief is evident throughout each aspect of the Strategic Planning Process as well as the daily operations of SCRHD. Environmental, social and economic systems to which SCRHD contributes can be found in the Key Communities notebook which will be made available at site visit.

Figure 1.2-1 Legal, Regulatory, and Ethical Behavior Requirements

Requirement	Key Process	Measure	Goal
Corporate Compliance and Ethics	Trained in ethics	% Managers trained	100%
Fiduciary Responsibility	Internal and external audits	Audit results	No irregularities of key program functions
Program Responsibility	External audits	Audit results	No recommendations for improvements
HIPAA	Training	% Compliance % Staff trained	100% compliance 100% trained
Licensure	Licensing for health professionals	Staff licensure	100%
	Licenses for county owned motor vehicle drivers	Driver's license	100%
Safety	Job-specific training for staff	% Staff trained	100%
Accreditation	Meeting specified criteria guidelines as set forth by PHAB	Awaiting further guidance from PHAB	Nationally Accredited Public Health Department

In celebration of the 2008 Public Health Week, employees started a recycling program. This program has continued with the collection of plastic bottles and aluminum cans as a way of becoming greener at SCRHD. Other ways in which SCRHD has tried to lessen its environmental impact includes the removal of duplicate bulbs from light fixtures and the placement of signage to encourage employees to turn off lights when not in use.

(2) Senior leaders actively support and strengthen key communities by encouraging and empowering employees to participate in and contribute toward local, regional, and national charities and associations.

As part of the strategic planning process, the PEC identified three key communities – educational, medical, and community service. In the educational arena, learning focus is primarily in the areas of professional training and educational services to the community. Medical support is given to local physicians and the two major hospital systems in our community, along with provision of direct medical services and referral sources for those in need. Community service provides auxiliary and supportive resources to the citizens of Sullivan County, through support of United Way, food drives etc. SCRHD also partners with many others to provide coordinated medical services, emergency preparedness integration with local, regional, and state response services.

A Key Communities work group made up of various staff from different programs in SCRHD was created. This work-group was tasked with formulating a listing of all the various organizations that SCRHD employees are involved with, whether it be work related or on a voluntary basis. An email was sent out to all SCRHD employees as well as senior leaders asking them to give a listing of each organization that they are affiliated with and which type of key community category did it fall into. They were also asked whether their relationship with the listed organizations was voluntary or work related. Once these listings were returned to the work-group, they were compiled into one large document and a gap analysis was conducted among the workgroup members to assess for any areas where a relationship was lacking or not being covered. The key community's workgroup convenes on a yearly basis to review the most current listing and assess for any gaps or potential revisions. The goal is to ensure that we are actively supporting and strengthening our key communities and enriching SCRHD's core competency of community need in order to fulfill the mission of SCRHD. A comprehensive listing of SCRHD's community partnerships is available.

In 2004, SCRHD established a dedicated day of free check-ups in recognition of national Women's and Men's Health Days. On Health Days, an array of examinations and screenings (examples include screenings for blood pressure, cholesterol, prostate cancer, skin cancer, PAP smears, pelvic exams, and colon cancer blood tests) are provided without charge (Figure 7.4-6). Free Women and Men's Health Day has been in existence for the last 8 years and allows health screenings for individuals who may not have been able to attain it otherwise. Senior leaders are also active in co-ordinating health department services with charitable organ-izations that provide care to the underserved populations within our community (e.g., Healing Hands, Friends in Need).

In October 2010, senior leaders of SCRHD assisted in the preparation of the first Remote Area Medical® (RAM) to be held in Sullivan County. "RAM is a non-profit, all volunteer organization dedicated to serving mankind by providing free health care, dental care, eye care, veterinary services, and technical and educational assistance to people in remote areas of the United States and the world." It was during this event that more than 1,000 patients were seen and provided over $550,000 worth of free vision, medical and/or dental care.

The RAM Event, Women's and Men's Health Days, and allowing staff to participate in events such as United Way's Day of Caring (2007 and 2008) during work hours; senior leaders are emphasizing the link between the community-level volunteerism, SCRHD's core values as well as each of the four core competencies of Education, Prevention, Community Need and Workforce. Various members of the Management Team have continued to participate in United Way's annual Day of Caring.

Category 2: Strategic Planning

2.1 Strategy Development
a. Strategy Development Process

(1) SCRHD's strategic planning process is an integrated, systematic, and adaptable approach to reaching its vision of becoming a national model and leader in public health services. The Performance Excellence Council seeks periodic input from all customer levels – county commission, the health council, employees, state government, and the general public – to establish expectations, to respond to environmental changes, and allow for organizational learning. Figure 2.1.1 shows the major elements of SCRHD's strategic planning process (SPP).

SCRHD began formal strategic planning in 2001 after a significant change in health department leadership – a new regional director and medical director, both with prior experience in performance management. Our Regional Director believes the entire management team (MT) has an important role to play in paving the "road to good public health." Therefore, both directors and key stakeholder groups participate in the planning process to ensure alignment with organizational mission, vision, and values. In 2005, the Baldrige business model was adopted and a cross-functional Leadership Team (LT) was established to accelerate the strategic development process. In 2008, this group adopted the team name Performance Excellence Council (PEC). Each year SCRHD completes a calendar year of strategic planning activities, following a process similar to the Plan-Do-Check-Act cycle described in Item 6.2b (4). For example, in January or February, the senior leaders conduct an annual retreat – a combination of strategic planning, performance reviews, and SWOT analysis.

SCRHD's SPP naturally creates opportunities for key partners to assist with potential blind spots. All key stakeholder groups have input into the SPP:

- Patients & community representatives
- Staff members
- Health council members
- County Commissioners
- Regional public health partners, including infection control practitioners, emergency responders, physicians, epidemiologists, and laboratorians
- State Department of Health leadership
- Education partners

SCRHD has gained a renewed appreciation in the importance of hearing the voices of key partners since the events of September 2001 to the more recent emergence of 2009 H1N1 Pandemic. As a result of these events SCRHD has bolstered its number of community partners and the mechanisms by which we communicate with them. For example, multiple collaborations among states were utilized and new partnerships were developed to address the multiple issues that surfaced because of the 2009 H1N1 Pandemic. Relevant findings of partner groups such as this are incorporated into SCRHD's SPP.

SCRHD conducts an annual SWOT analysis during the strategic planning retreat. The results of this analysis--strategic challenges and advantages -- can be found in Figure P.2-2. SCRHD has also developed four core competencies: Education, Prevention, Community Need and Workforce. These core competencies were derived from the Center's for Disease Control and Prevention (CDC) ten essential public health services, the Public Health Foundations core competencies for public health professionals and the Performance Excellence Criteria. Each of the core competencies is essential in the fulfillment of the stated mission. (Figure 1.1-1)

SCRHD's planning process has two time horizons: a one-year (short term) and a three-year (long term) time line. As shown in Figure 2.1-2, each strategic objective includes a designation of short term, long term or both. These time horizons are set by the PEC and based on priorities, available resources, and established performance targets. The timing of funding approval – from both the TDH and the Sullivan County Commission – plays an important role in establishing time horizons for the strategic plan.

The SPP addresses these time horizons by reviewing progress on all strategic objectives and their associated action plans on a quarterly basis. The PEC reviews input from the action plan developer through written (e.g., report of progress and performance) or oral presentation. Departmental action planning updates are also provided at the QR meeting to enable organizational learning and motivation across departments. The frequencies of all action plan reviews are based on predetermined time horizons.

(2) SCRHD relies primarily on the MT to constantly search for data and information sources that may impact key strategic elements. Subject matter experts can also fulfill the important role of collecting data and information from the list of potential sources listed above. This relevant data and information is relayed through a member of the MT and transferred to the PEC at the monthly managers' meeting. If identified as having potential strategic importance, this data and information is analyzed in detail at the next QR. The majority of strategically important measures have established performance projections that are based on an understanding of past performance, rates of improvement, and assumptions about future internal changes, innovations and external environment as well as state mandated performance measures. These projections allow the MT to assess for organizational sustainability in comparison to other like entities.

Strong community partnerships enable SCRHD to observe early indications of shifts in political will and perceived public health need within our region. SCRHD collected data and information on the growing uninsured population in Northeast Tennessee, with a special focus on the lack of oral health services to low-income residents. Through the SPP, SCRHD developed and implemented an action plan to offer dental services – primarily to low-income children – as a new line of service within the health department. Listening to community partners played a key role in determining the long-term organizational sustainability of such a venture. Seven years

Figure 2.1-1 Major Elements in the SPP

Month	Activity	Input(s)	Output(s)	Participants
January	▪ Annual Retreat ▪ SWOT Analysis ▪ Partner Review 1	▪ Strategic plan (SP) and action plans (prior year) ▪ Internal and external scans (2.1(a)2) ▪ Input from key customers, stakeholders, partners ▪ Performance Summary GPIs & DPIs (prior year) ▪ Partner sharing/feedback o Senior Leaders	▪ Balance short & long term actions (sustainability review) ▪ Updated MVV & SP ▪ Proposals to address blind spots	▪ PEC ▪ Senior leaders ▪ Selected staff members
February	▪ Partner Review 2	▪ Partner sharing/feedback o Health Council o General Public o All staff ▪ Strategic plan & timeline ▪ Employee Survey Review	▪ Proposals to address blind spots ▪ Input into SWOT analysis ▪ Possible revisions to SP & MVV ▪ OFIs	▪ Partners (HC, GP, AS) ▪ PEC and/or senior leaders ▪ Virtual feedback via SHEL^{O}E
April	▪ Budget Review 1 ▪ QR 1 ▪ Future Technology Assessment (FTA)	▪ Proposed budget (County & TDH) ▪ Performance measures (GPIs & DPIs) ▪ Strategic plan and action plans ▪ Input from key customers, stakeholders, partners ▪ External trends in technology	▪ Revisions to budget ▪ Input into QR & strategic action planning ▪ Adjustments to SP and action plans ▪ Recommendations to 3 year IT Plan	▪ Partner (CC & TDH) ▪ Senior leaders ▪ PEC ▪ Selected staff members ▪ IT staff
July	▪ Budget Review 2 ▪ QR 2	▪ Budget Review ▪ Performance measures (GPIs & DPIs) ▪ Strategic plan and action plans ▪ Input from key customers, stakeholders, partners	▪ Revisions to budget ▪ Input into QR & strategic action planning ▪ Adjustments to SP and action plans	▪ Senior leaders ▪ PEC ▪ Selected staff member
September	▪ Partner Review 3	▪ Partner sharing/feedback o All Staff ▪ Customer Satisfaction Survey Review	▪ Adjustments to SP and action plans	▪ All Staff
October	▪ Budget Review 3 ▪ QR 3	▪ Review approved budget (County) ▪ Performance measures (GPIs & DPIs) ▪ Strategic plan and action plans ▪ Input from key customers, stakeholders, partners	▪ Input into QR & strategic action planning	▪ Senior leaders ▪ PEC ▪ Selected staff members
November	▪ Partner Review 4	▪ Partner sharing/feedback o County Commission o Tennessee Depart. of Health (TDH) ▪ Strategic plan & timeline	▪ Proposals to address blind spots ▪ Input into SWOT analysis ▪ Possible revisions to SP & MVV ▪ OFIs	▪ Partners (County Commission, TDH) ▪ PEC and senior leaders

after start-up, the dental clinic continues to grow in scope and services, and is considered a public health success story within the community.

The SWOT analysis is an important component of the SPP. Both internal and external inputs allow SCRHD to stay in touch with major shifts or changes within the economic environment.

The following types of inputs are examples of potential sources of data that may affect the SPP:

- Health priorities and plans from TDH, regional counties, and community groups
- Employee meetings & satisfaction survey feedback
- Customer satisfaction survey & other VOC methods
- Healthy Rounding
- Review of health industry best practices and benchmarks
- Program evaluation feedback reports (external)
- Annual fiduciary review cycle within State and local Government
- External audit of IT security and reliability systems
- Stakeholder Survey (new for 2011)

For example, one way in which analysis of relevant data that may affect our SPP is conducted is by listening to two of SCRHD key stakeholders – the customers and the employees.

The survey data from each of these groups are thoroughly analyzed by the PEC and key themes are generated. These themes are shared at the monthly mangers meeting to prompt immediate feedback from the MT. Once a consensus is met, these items are presented at the employee meeting to inform all staff and are then implemented into the SP. Systematic collection and analysis of this data is imperative to fulfilling the SPP and adhering to the mission of SCRHD. In 2011, a stakeholder survey was developed utilizing Survey Monkey that would assess the satisfaction with SCRHD among key stakeholders including county and city leaders, community partners and state level program directors.

The SPP also allows SCRHD to be better prepared for shifts in technology and ensure organizational sustainability through a 3yr IT plan. This plan consists of establishing electronic health records (EHR), a fully automated backup system, voice over IP phone system, continued SHEILA modifications, and encryption of the main frame in order comply with regulatory standards. More information regarding IT infrastructure can be found in Item 4.2. The core competencies are the foundation of SCRHD's MVV. They assist in the determination of the strategic plan by way of the KRAs.

SCRHD's ability to execute the SP was made evident at the 2010 Strategic Planning Retreat. At that time, several objectives that had been in place since 2007 were rolled off the SP due to integration and deployment into the SCRHD culture. The 2009 H1N1 Pandemic displayed agility and the rapid execution of new plans to meet our stakeholders' requirements and expectations. SCRHD was best in state in the deployment of the H1N1 vaccine in 2010. (Figure 7.1-8)

b. Strategic Objectives

(1) SCRHD's strategic objectives and time table for accomplishing them are displayed in Figure 2.1-2. The SPP ensures that strategic objectives remain on schedule or are deliberately extended due to changing priorities. The PEC reviews progress on all strategic objectives – down to each related action plan at QR meetings. The SPP ensures that the most important goals receive the highest work priority for the calendar year. Figure 2.1-3 provides a listing of SCRHD's most important goals for 2010 and 2011.

(2) Figure 2.1-4 displays the 2011 SP. The SP is designed to ensure that all challenges are segmented into the seven KRAs and correlated to the strategic objectives. In turn, action plans with estimated completion timelines are created as sub-elements to accomplish each strategic objective. The PEC has responsibility to ensure that SCRHD's strategic objectives balance short- and long-term challenges and opportunities. The PEC utilizes the QR process as the mechanism to verify that balance exists within the needs of key stakeholders. The SPP also includes other checkpoints to ensure balance, sustainability and innovation.

As stated in P.1a (2), SCRHD's core competencies are Education, Prevention, Community Need and Workforce. Each of these elements is vital in providing good public health services and paving "the road to good public health". Each strategic objective is related to some component of one or more then one of the core competencies. The potential for the addition or modification of a core competency would be addressed during the annual strategic planning retreat, or if needed during a called PEC meeting. The deployment of competency changes would be made through the monthly managers meetings and departmental meetings.

One example of how SCRHD's SPP allowed for opportunities for innovation of health care services and processes was with the adoption of crystal reporting methods. This reporting mechanism allowed a breakthrough in how various departments obtained important, timely measures relative to their department's goals (aka DPIs). The easy retraction of important organizational and departmental performance measures through this system allows a focus on the key results that make SCRHD successful all the while creating value for stakeholders.

The use of electronic medical information through programs such as Shared Health and CareSpark was another technological innovation that was apart of SCRHD's SP for 2009. These programs allow a more integrated approach in caring for patients that visit SCRHD by having greater access to their health information.

Mechanisms are in place to enable SCRHD to make real-time modifications to the strategic plan based on rapid changes within the environment, adapt to sudden shifts in market conditions and ensure that strategic objectives balance short and longer term challenges and opportunities. During each QR, the PEC discusses any changes to the SWOT analysis that was completed at the planning retreat based on input from key community partners and SCRHD's MT. In the case of an urgent or dramatic environmental change (e.g., TDH) the Regional Director holds a special administration meeting to review the implications to SCRHD's strategic plan. Once this meeting is complete, further discussion and review is brought before the MT at their monthly managers meeting. Decisions and requests for feedback are then deployed out to all staff via departmental meetings with their director. Once this process is complete, the PEC will reconvene to make the necessary changes to the SP.

2.2 Strategy Implementation

a. Action Plan Development and Deployment

(1) Action plan development begins with the involvement of the entire MT in the SPP. After the strategic plan is reviewed and confirmed by the MT, the PEC recommends an action plan lead for each strategic objective. The action plan lead serves as the liaison for reporting performance, status and recommendations to the PEC. An action plan tool has been developed to assist stewards in the compilation and management of the specified action plans. This same tool can be used at the department level in order for a consistent development of all action plans, both DPI and GPI, throughout the organization. SCRHD key short and longer term action plans (APs) have direct linkage to key strategic objectives also known as GPIs (Figure 2.1-4). Many departments within SCRHD develop specialized APs that pertain to key requirements that make them successful these are better

Figure 2.1-2 SCRHD's Strategic Objectives

Strategic Challenges	Strategic Objective(s)	Term	Stakeholders	Performance Measure
Management Practice				
Deploy principles of performance management, strategic planning, and process improvement across all levels of SCRHD.	Enhance organizational effectiveness through the adoption of Performance Excellence principles.	ongoing	PF/C/P/S	TNCPE Award level
	Increase the utilization of continuous process improvement across all departments	ongoing	PF/C/P/S	# of PIs utilized by individuals and teams
Human Resource Development				
Retain a productive, satisfied, and qualified workforce	Create a workforce development plan with a special focus on personal learning and skill development	short	PF/C/P/S	Deployment of SHEILA & SHEL.E, Succession Plan
Financial Systems				
Balance mission to serve against tight fiscal environments at federal, state and local levels.	Maintain or increase financial stability through grant funding opportunities	ongoing	PF/C/P/S	Increase in number of services provided through additional funding.
IT and Data Systems				
Leverage available information technology resources to enhance organizational knowledge and effectiveness.	Maintain mechanisms that communicate public health status and health information for key stakeholders	long	C/P/S	Completion of Community Health Assessment & Profile
	Enhance organizational knowledge system	short	PF/S	organizational knowledge process
Customer Focus & Satisfaction				
Meet or exceed the performance expectations of patients, the community and external partners.	Improve customer (patient/stakeholders) satisfaction to enhance loyalty.	ongoing	PF/C/P/S	Customer sat. rates, key themes implementation
Public Health Capacity				
Strengthen/develop community and interagency partnerships.	Pursue Accreditation through the Public Health Accreditation Board (PHAB)	Long	PF/C/P/S	Receive Accreditation
Health Status				
Address poor health status and inadequate access to care in the Sullivan County.	Continue process for evaluating health status and developing priorities that impact public health outcomes	Short/ Long	PF/C/P/S	Complete re-eval to access for new health priorities

Term definitions: short=by end of 2012; long=by end of 2013 Stakeholders: Patients/Families=PF; Communities=C; Partners=P; Staff=S

Figure 2.1-3: Goals for 2010 and 2011

Goal	Key Result Area Alignment
Deploy performance improvement principles via Performance Improvement Teams (PITs) and action plan utilization	Management Practice (Leadership)
Workforce Capability Training Program	Human Resource Development
Increase capacity for grant writing opportunities	Financial
Update Sullivan County's Community Health Assessment	IT and Data Systems, Health Status
Develop and Deploy the use of SHEILA and SHEL.E	IT and Data Systems, Human Resource Development
Address Customer Satisfaction Survey themes: implement new phone system, tackle wait time issues	Customer Focus
Familiarization with Public Health Accreditation principles in pursuit of submitting application	Public Health Capacity

Figure 2.1-4 SCRHD's Strategic Plan with Action Plan by Key Result Area

Sullivan County Regional Health Department Strategic Objectives and Action Plan Deployment Matrix

Mission : To identify and respond to the public health needs and improve public health status of Sullivan County citizens through education and service with a highly motivated and well trained workforce.

Vision: To be a national model and leader in providing public health services.

	Strategic Objectives	Action Plan	Mgt. Steward	Value Added Performance Goal	2011	2012	Short/Long Term Projected Date Complete
1 Leadership	(a) Enhance organizational effectiveness through the adoption of Performance Excellence principles.	Support SCRHD staff to serve on the TNCPE Board of Examiners	Mayes	Apply for Level 4 to increase organizational knowledge of performance excellence practices.	2	2	continuous cycle
	(b) Increase the utilization of continuous process improvement across all departments.	Reinforce performance improvement system and tools with staff through various workshops	May	Number of PITs utilized by individuals & teams to increase workforce efficiency and organizational sustainability.	3	3	continuous cycle
2 HR Development	Create a workforce development plan with a special emphasis on personal learning and skill development	1.) Create a process to determine opportunities for training and skill improvement to keep a qualified and engaged workforce.	OLC	Create a well trained workforce.	Deployment of SHEILA & SHEL.E	Conduct gap analysis for training opportunities	short term - 2012
		2.) Create a process for leadership development and succession planning.	May	Have a succession plan in place for all key positions.	Develop succession plan	Deploy succession plan	short term - 2011
3 Financial	Maintain or increase financial stability through grant funding opportunities	Increase capacity for grant writing across the organization	Mayes	Increase services provided through additional funding.	establish contract with grant writing firm	# of additional services	continuous cycle
4 IT & Data Systems	(a) Maintain mechanisms that communicate public health status and health information for key stakeholders.	Reevaluate community health assessment methods	May/Mullins	Successful reevaluation of Community Health Assessment methods in order to update Sullivan County's health assessment data.	Research appropriate methods for CHA.	update Community Health Assessment	long term
	(b) Enhance organizational knowledge system	Complete deployment for organizational learning and SHEILA utilization.	OLC	Deployment of written process that describes organizational knowledge	deployment of process		short term - 2011
5 Customer Focus	Improve Customer Satisfaction to enhance loyalty.	Train staff on best practices for customer relationship building.	OLC/Honeycutt	Improve customer relationships and loyalty. (Based on 90th Percentile scores of "our practice" question on customer satisfaction survey)	2011- ? 2010- 27.1%	Sullivan Luallin stated goal-50%	Continuous Cycle
6 PH Capacity	Pursue Accreditation through the Public Health Accreditation Board (PHAB)	Education of program, Analysis of current HD status based on standards and development of process to pursue accreditation	Kolassa/ Austin	Assure the community that SCRHD is meeting the public health practice standards.	continue PHAB education opportunities	submit accreditation application	long term
7 Health Status	Continue process for evaluating health status and developing priorities that impact public health outcomes.	Reevaluation of Community Health Status and Priorities through coordination with state partners (Dr. McCabe)	May/Mullins	Complete reevaluation to access for new health priorities.	coordination of resources for collection of health status data	updated graphs and #'s	long term

known as DPIs. Action planning and deployment are required for all efforts addressing strategic challenges and objectives.

Key planned changes in SCRHD's health care services and programs are strictly impacted by local, state and federal funding. Public Health was not immune to the financial stressors that were affecting most Americans during 2008 and 2009. Due to the lack of revenue generated from local sales and property tax, all county departments were required to cut their budgets. SCRHD displayed agility and meaningful innovation in order to maintain the current services and programs with a decrease of $800,000 in funding. During this time unemployment rates and those without insurance made a dramatic increase which paralleled SCRHD's increase in services. Although funding has been drastically cut, SCRHD has not had to layoff any staff members. Some of SCRHD's previous planned changes that have now been implemented include completion of a new dental clinic in Kingsport and the implementation of new surveys for customers and employees.

(2) Action plans are deployed throughout the organization with the use of SHEILA, employee meetings, and departmental meetings. All new action plans are reviewed by the PEC and dispositioned according to feasibility, available resources, and performance guidelines. All organizational action plans undergo a systematic evaluation during each QR and are available for review during monthly PEC meetings if changes are required. Once action plans results are achieved, a heavy emphasis is placed to "maintain the gain" on key outcomes resulting from action planning.

(3) Multiple processes are used to ensure that financial and other resources are available to support the accomplishment of all organizational action plans. Departmental meetings are held on a monthly basis for review of pertinent items to that department as well as follow-up on the designated DPI. Budget reviews are held during monthly managers meeting to assess current financial status of all departments and the organization as a whole. The QR is used as a check point to evaluate all action plans and ensure the financial viability of SCRHD.

(4) The workforce is the second of two key elements that make up the mission of SCRHD. Maintaining employee satisfaction and loyalty is one of SCRHD most critical organizational needs. SCRHD has developed key workforce development (WFD) plans that are integrated into each yearly strategic plan. KRA 2: Human Resource Development was developed to help "focus on the employee" and make the most of an employee's full potential and incorporate these into SCRHD's mission, goals and both short and longer term objectives. A WFD team was produced in response to meeting the very important objectives set forth for this particular KRA. The team is composed of members from the MT, PEC as well as staff members from various departments. This group's task was to create a WFD plan that had a special focus on employee communication, retention, competencies, and recognition. A few of the plans that have been developed to address potential impacts on the workforce members and addresses changes to workforce capability and capacity are as follows:

- Improved employee evaluations/competency based job descriptions
- Yearly satisfaction assessment via an employee survey
- Healthy Rounding implementation (as a result of employee survey key theme finding)
- Development of the Organizational Learning Committee (OLC) and SHEILA.

(5) Action plan progress is measured in terms of percent completion (action steps), timeliness and sustained performance. In most cases, APs have direct linkage to either Global (GPI) or Departmental Performance Indicators (DPI). (Figure 4.1-1 for listing of Global Performance Indicators). This is accomplished by evaluating performance for inconsistencies across work groups or with programs with heavy reliance on external partnering. The PEC and MT review results of action plan completion and GPI and DPI status during each of the three QR meetings and a thorough year end review during the Strategic Planning Retreat. It is of the utmost importance that each of these indicators are easily accessible for review by all staff via SHEILA which ensures that all key deployment areas and stakeholders are covered.

(6) The need to modify an AP may be identified at any level within the organization; however, proposed revisions that affect strategic objectives by a team or an individual must be approved by the PEC. Other APs and revisions can be approved at the department or program level. When revisions are time sensitive or urgent and cannot wait for the strategic QR, the AP lead sends an email request for "action plan revision" directly to the PEC liaison. The PEC liaison takes responsibility to seek real-time disposition from the PEC by either calling an emergency PEC meeting or by forwarding the results back to the AP lead. Disposition options include "approved," "approved with modification," "disapproved," "disapproved (to be reviewed at the next quarterly review)," and "urgent meeting required for resolution." The action plan lead is responsible for communicating the modified plan to any team members involved. A good example of how a shift in current plans was implemented to prepare for a rapid emergence of new plans was displayed during SCRHD's response to the 2009 H1N1 Pandemic.

b. Performance Projection

Projections are required prior to submission to the PEC for approval. Short-term (1 Year) and long-term (3 Year) performance targets are provided in graphical form and discussed by the PEC and MT at each QR meeting. A systematic review of all data and the information that frames performance assists in ensuring alignment throughout SCRHD and necessitates the fulfillment of SCRHD's mission. Performance is compared to SCRHD performance targets, comparison group performance, and best-in-class performance. Where possible, state and national (e.g., Health People 2020) performance objectives are utilized. Many of the performance projections that have been set for some GPIs and most DPIs are values that have been mandated by state and national program contracts. SCRHD strives to do a predetermined percentage higher then what is required for any particular program contract. SCRHD keeps its employees

abreast of performance progress with the use of performance boards and easy access to performance indictors through SHEILA. Gaps in performance are integrated into the action planning process (e.g., modifications). Through the SPP, the PEC ensures that the most important performance indicators are closing the performance gaps with comparable organizations and public health facilities.

Category 3: Customer Focus

3.1 Voice of the Customer

a. Patient and Stakeholder Listening

(1) Sullivan County Regional Health Department understands the importance of listening to customers and stakeholders in order to fulfill the mission and vision of the organization. SCRHD uses various methods to obtain actionable information and feedback on services that are offered. Figure 3.1-1 lists the multiple methods used by SCRHD to listen to patients and stakeholder groups as well as the frequency with which each method occurs.

Figure 3.1-1 Patient and Stakeholder Listening Methods

Method	Frequency	Market Segment
▪ Customer Care Comments (C^3)	Continuous	P
▪ Customer Satisfaction Surveys	Yearly	S
▪ Stakeholder Survey	Yearly	S
▪ Email	Continuous	P,S
▪ Employee Survey	Yearly	S
▪ Healthy Rounding	Continuous	P,S
▪ Phone calls	Continuous	P,S
▪ Rays of Sunshine	Continuous	S
▪ SCRHD website survey	Continuous	P,S
▪ Social Media (Facebook, Twitter)	Continuous	P,S
▪ WIC 1-800 number	Continuous	S

P=Patient, S=Stakeholder

Prior to 2008, SCRHD did not have a formalized process to acquire satisfaction and dissatisfaction information. The Performance Excellence Coordinator at that time began researching various organizations that specialized in customer service and satisfaction surveys. In 2008, the administrative staff of SCRHD began working with California based Sullivan Luallin to assist in SCRHD's initiation of its first formalized customer satisfaction survey that allows analysis against a database of over 300,000 across 53 different medical specialties. Sullivan Luallin is also able to provide comparison data for the two Dental Clinics within SCRHD. This allows SCRHD to obtain feedback on this particular market segment as well as a comparative analysis with other Dentistry groups across the U.S. In 2011, the PEC instituted the use of Survey Monkey to assess satisfaction among SCRHD's various stakeholders and partners. A set of five questions are compiled in the survey program and is distributed to stakeholders and partners of SCRHD (Figure P.1-5). This distribution occurs within the same time frame as the annual customer satisfaction survey.

The use of social media was adopted by SCRHD during the spring of 2009. During the beginning of the 2009 H1N1 Pandemic, important public health messages were changing on a weekly if not daily basis. It was during this hectic time that members of the MT instituted the use of Facebook and Twitter to allow for quick and easy updates to pertinent health information. What made the use of social media so important for this particular public health event was that this disease was affecting the population group that most frequently utilized social media outlets. Once public health messages became more consistent and infrequent, a weekly meeting was held for the next several months to discuss the most pressing H1N1 issue at that time and see that it was displayed through each of the social media outlets.

In order to encourage customer feedback SCRHD needed to develop a process to capture information across the various stages of their relationship with staff as well as enable SCRHD to receive immediate and actionable feedback on the quality of health care services that are being offered. Telephone calls and emailing have been used and will continue to be used as a listening method utilized by SCRHD for their customers and stakeholders. The yearly customer satisfaction survey does an excellent job of giving the MT and PEC an analysis of satisfaction and dissatisfaction; however an in house process for gathering continuous feedback was needed.

In September 2008, a small group of PEC members convened to brainstorm on ways to capture continuous feedback related to the quality of services provided to customers of SCRHD. After several meetings and research into best practices, a process was developed along with an action plan to see that each step of the development and deployment was carried out. This process, now known as C^3 or Customer Care Comments, was brought before the PEC for review and approval. In February 2009 training was conducted for all managers and staff on how the process was developed and what is the expected outcome of this new process. A target date was set and in March 2009 the C^3 process began. A thorough explanation of C^3 will be given in Item 3.2b (2).

(2) A variety of methods are in place to listen to former and potential patients and/or stakeholders to obtain feedback on available health care services. One way in that SCRHD is able to listen to former and potential customers as well as customers of competitors are during Free Health Check Up Days that take place in the Spring each year. Free Women and Men's Health Day has been in existence for almost nine years and provides health screenings for individuals who may not have been able to attain it otherwise. These free health screenings are available to anyone regardless of county of residence, insurance or income status. It has been noted that several of those that do attend have insurance as well as a primary care physician but prefer to attend this event due to the overwhelming care and compassion expressed to them by staff members, the quick but thorough care given to them by SCRHD providers and the abundance of various other health information made available to them by the vendors that attend each year.

Other opportunities that allow SCRHD to listen to former and potential customers as well as those of competitors include various health fairs, specifically the EPSDT Summer Check Up Day. This is a collaborative event with Volunteer State

Health Plan, area school systems, and SCRHD to provide free well care, dental, and vision exams prior to school entry. The majority of families that attend this event are not health department patients, are privately insured and see a primary care physician.

Both the Health Education and TENNderCARE staff are vital in obtaining feedback from these types of patients due to the fact that they are considered the external outreach for SCRHD. Both of these departments within SCRHD are continuously interacting with the community through various outreach programs, health fairs and public speaking arrangements. Their ability to collect feedback from all patient types whether they be former, potential or those of competitors are invaluable to the functioning of listening to the voice of SCRHD customers.

In April 2011 an online survey was deployed using a Survey Monkey format. This survey is very similar in content to the C^3. This avenue for customer feedback gives patients/stakeholders the opportunity to offer comments and suggests for improvement to SCRHD by those that were not or chose not to do so while at an actual site location.

To restate an important fact that was mentioned in the Organizational Profile, although SCRHD is in a competitive funding environment; SCRHD is in a collaborative relationship with the private sector to provide health care services and improve the health of the community. All staff of SCRHD believe that working in competition with other healthcare providers defeats the purpose of public health. In order to fulfill not only SCRHD's societal responsibility to the health of the community but also the stated mission of SCRHD, collaboration among all sectors is the key to obtaining the vision of being a national model and leader in providing public health services.

b. Determination of Patient and Stakeholder Satisfaction and Engagement

(1) Two groups embody the mission of SCRHD, the patients and the employees. Determining the satisfaction and engagement of both of these groups is essential in achieving the vision of SCRHD. SCRHD uses multiple methods to determine patient and stakeholder satisfaction and engagement. The customer satisfaction survey is the most in-depth tool that SCRHD uses to assess for patient satisfaction. An annual employee survey allows for a determination of satisfaction and engagement among one the most important stakeholders of the organization. (Item 5.2b (1)) Other ways of determining satisfaction and engagement include feedback through the C^3, Ray of Sunshine, Healthy Rounding, employee evaluations, and the stakeholder satisfaction survey.

The customer satisfaction survey has developed into a systematic process since its inception in 2008. Prior to the implementation of the survey, an action plan was developed to assist in the steps that needed to be taken to create a sustainable survey process from the approval phase, distribution, collection, analysis, and communication of findings to the staff. This action plan was presented to the PEC for evaluation. Once approval was received the action plan was set into motion. A document was developed to ensure that each staff member understood their role and responsibilities during the survey process. Specific roles and responsibilities were given to the PEC, Clerical Staff, the Clinic Services Coordinator for each site and All Staff in general. There is also a section of Roles and Responsibilities dedicated to Sullivan Luallin which listed SCRHD's expectation of the survey company.

The annual survey starts the first or second week of May and ends the first week of June. This allows SCRHD time to collect the amount of surveys needed to ensure a statistically valid sample size for meaningful analysis. The surveys are segmented and labeled with each of the three site locations: Blountville, Kingsport and Dental. It consists of six categories: *Your Appointment*, *Our Staff*, *Our Communication with You*, *Your Visit with the Provider(s)*, *Our Facility* and *Your Overall Satisfaction*. The range of categories allows SCRHD to assess each component of the customer's visit and easily determine areas where improvement may be needed among each site. (Figure 7.2-1 and Figure 7.2-2)

Since its initiation in 2008, SCRHD has evaluated the usefulness of the survey and made modifications to the action plan in order to assess satisfaction for patients visiting not just SCRHD but for certain clinics. Several program areas (WIC, Family Planning, HUGS and CSS) within SCRHD require that a satisfaction survey be conducted among the program participants. In 2009, as opposed to having two surveys to complete for certain customers, a small amendment was made in the responsibilities for the Clerical Staff. Upon check in of the patient, the Clerk will label the top right hand corner of the survey signifying whether or not that patient is being seen within one of the clinics that require an additional survey analysis. Prior to the shipment of the completed surveys to Sullivan Luallin for statistical analysis, copies of the surveys that require a separate evaluation will be made. The Regional Epidemiologist will analyze the survey responses and generate a report based on the findings for these specific patient groups.

A process was developed in order to assess for satisfaction among the participants of the Help Us Grow Successfully (HUGS) and Children's Special Service (CSS) home visiting programs. Copies of the survey were made and labeled with either HUGS or CSS. Each HUGS nurse and CSS nurse were given an allotted number of surveys to distribute to their patients along with a self addressed, stamped envelope. This allowed SCRHD to assess satisfaction and engagement in this particular customer group that do not normally visit a SCRHD site location.

Another program area within SCRHD that wished to assess satisfaction among its participants was the School Based Dental Prevention Program. The School Based Dental Prevention Program is a statewide; school based preventive dental program targeting children in grades kindergarten through eighth in schools with 50% or more free and reduced lunch. Portable equipment is used by dental staff to provide dental screenings, referrals, and follow-up to dental providers to address unmet dental needs in this population. Health education and preventive sealants are provided to the target

school population as well as information regarding TennCare eligibility and the application process. In 2008, the Director of this program and the Epidemiologist developed a survey that would illicit feedback from the administrators of the schools whose students had been visited that year. Questions included on the survey pertained to the scheduling of the school visits, the thoroughness and understanding of the educational materials provided to the parents, students and teachers, the ability of the exam/screening process to be conducted with minimal interruptions, and the listing of any positive or negative feedback that has been received from parents or children who have been recipients of dental services. These surveys are analyzed and compared to the survey results from the prior year to detect improvement or opportunities for improvement.

There are two important components of the Customer Care Comment program that allows SCRHD to capture immediate and actionable information for use in exceeding patients and stakeholders' expectations and secure their engagement. Question number four of the C^3 card states, "*How likely are you to recommend SCRHD to someone for services?"* This question is presented on a 1 to 5 Likert scale; with 1 being poor and 5 being excellent. During each QR the MT evaluates the average score that is given for this question for those cards that have been submitted during that quarter. (Figure 7.2-7) This question proves to be a very valuable measurement for evaluating and ensuring a positive patient and stakeholder experience. The final question located on the C^3 card gives the customer the opportunity to offer suggestions or comments on the services that they have received at SCRHD. It is this question the prompts either an immediate response from a program director to address a customers complaint or a Ray of Sunshine that promotes workforce engagement and encouragement. The Ray of Sunshine program, which focuses on workforce engagement and satisfaction, will be discussed in depth in Item 5.2a (1).

All of these processes have been developed in an attempt to produce actionable information that can be frequently analyzed and used to determine customer satisfaction and engagement. Ensuring that SCRHD is doing everything possible to serve the needs of the customer's and stakeholders so they choose to actively seek public health services and provide positive referrals to others are key ingredients to mission accomplishment and vision attainment.

(2) Since SCRHD is a government run entity, having access to data from competitors that offer similar services is very challenging to find. SCRHD looks forward to working with the public during large events such as the Free Health Check Up Days and the EPSDT Summer Check Up Days in order to "get a feel" of how SCRHD is doing in providing health care services to the community compared to other health care organizations. Unfortunately this type of benchmarking does not offer actual quantitative measures. Having an extensive benchmarking database for comparison measures is one of the primary reasons why SCRHD chose Sullivan Luallin to conduct the annual customer satisfaction survey.

Once the annual customer satisfaction survey is completed, all of the surveys are mailed back to Sullivan Luallin for statistical analysis and benchmarking. During SCRHD's four years of working with Sullivan Luallin, two of the three site locations (Blountville and Kingsport) have been compared against a data base of over 300,000 surveys from Multi-Specialty and Primary Care Provider (PCP) groups. During the same time frame SCRHD's Dental Department has been benchmarked against nearly 1,000 Dentistry providers within the United States. This benchmarking capability allows SCRHD to determine how well we are meeting the satisfaction level of customers relative to their satisfaction with other fairly similar providers.

In order to improve the health of the public, the Public Health Accreditation Board (PHAB) is developing a national voluntary accreditation program for state, local, territorial and tribal public health departments. The goal of the accreditation program is to improve and protect the health of every community by advancing the quality and performance of public health departments. Certain senior leaders from SCRHD have been actively participating in various nationwide webinars and conference calls to familiarize the organization to what will be required to meet PHAB accreditation standards. PHAB will begin accepting applications for accreditation in 2011. It is the belief of SCRHD that because of its deep involvement with performance excellence ideals and methodologies, attaining PHAB accreditation is well within reach and will further solidify the vision of being a national model and leader in providing public health services. Once this program goes into effect appropriate comparison information may become available that will allow SCRHD to obtain satisfaction information from other organizations that are providing similar health care services. SCRHD perceives the accreditation standards developed by PHAB to be a minimal level of functioning as opposed to TNCPE and the Baldrige Criteria which is focused on continuous improvement.

(3) Much of how SCRHD determines patient and stakeholder dissatisfaction on a real time basis is through the use of the C^3 process (Item 3.2b (2)). However, an approach has been developed that allows SCRHD to capture actionable information from the annual customer satisfaction survey once analysis has been completed by Sullivan Luallin.

A final analysis report from Sullivan Luallin is mailed back to SCRHD, complete with a summary report, 90^{th} percentile report, statistical significance report, and individual site reports. Each of these reports compares the current year's results to the previous years as well as benchmarks. Also included is a listing of all comments written-in by patients. This final report is first reviewed by the Regional Epidemiologist to assess for current levels, trending, etc. The report is then reviewed by the PEC with input from the Regional Epidemiologist. This group will develop a rough "top 3" to introduce to the MT. The top 3 will consist of the top 3 area's that are considered opportunities for improvement. Sullivan Luallin's report is then presented to the MT at the next monthly managers meeting. At this time summary results of current year, patient comments, and

overall analysis compared to previous years, and the draft "top 3" are reviewed. The MT has the opportunity to review these findings and present them to their staff members at their next scheduled staff meeting in order to collect feedback from each segment of the SCRHD workforce. The feedback garnered from the workforce is reviewed at the next scheduled managers meeting and official "top 3" items are solidified as improvement projects for the following year. Available improvement results are presented to all workforce members during the next employee meeting in September.

This process is used to ensure thorough deployment of customer satisfaction and dissatisfaction initiatives among all SCRHD workforce. It also allows for the increased opportunity for enhanced learning's on ways to meet and exceed stakeholder's requirements and expectations.

3.2 Customer Engagement

a. Health Care Service Offerings and Patient and Stakeholder Support

(1) Customers, customer groups and market segments for SCRHD (Figure P.1-4) are identified based on criteria guidelines set forth by federal and state agencies that are funding programs, employee, and community health needs. Recommendations from the Center for Disease Control and Prevention (CDC), Healthy People 2020 and guidelines from federal and state agencies guide SCRHD programs toward the market segment.

In keeping with the mission of responding to and improving the health of Sullivan County citizens, regional trends in morbidity and mortality are influential in choosing direction and focus for SCRHD. Cardiovascular disease, cancer, and diabetes are recognized as being just a few of the issues faced by the population and are largely viewed as requiring major lifestyle modifications to influence change. SCRHD works to impact these trends via the Health Promotions department but focuses much of the attention to health care service areas where direct patient services can be provided to meet the requirements and exceed the expectations of the various market segments.

Program agreements with the state government provide funding as well as guidelines for administration. Examples include Women, Infants and Children's (WIC) program, Family Planning, and Communicable Disease.

SCRHD operates in a unique environment in that it is a major facilitator of healthcare by working cooperatively rather than competitively with the private sector. Examples of where SCRHD works in conjunction with area hospitals and community organizations to provide services to citizens of Sullivan and surrounding counties include Free Health Check-Up Days that take place in April, the offering of the first Remote Area Medical (RAM) Clinic for the Tri-Cites region in October 2010 and the Access to Breast Care Program (ABC) which provides screening mammograms for the uninsured and underinsured. Various other community cooperative partnerships that allow for expanding relationships with existing patients and stakeholders are listed in Figure 3.2-1.

It was noticed by SCRHD MT that appointments to one of the most visited clinics, Family Planning, was starting to decline. After an assessment as to why this was so, it was determined that this was due to the loss of some of the more popular contraceptives that SCRHD had previously made available.

Figure 3.2-1 Community Cooperative Partnerships

Partner	Area
Emergency Response	▪ Mountain Empire Public Health Emergency Coordination Council (MEPHECC) ▪ Tennessee Emergency Management Agency (TEMA) ▪ Federal Emergency Management Agency (FEMA) ▪ Local EMS and EMA ▪ IEPC
Hospitals	▪ Disease reporting ▪ Mammogram referrals ▪ Hospital response coordinator ▪ Public Health Grand Rounds ▪ Community health fairs ▪ Appalachian Mountain Project Access (AMPA) ▪ H1N1 Pediatric Communication Group
Local Physicians	▪ EPSDT ▪ Vaccine for children ▪ Immunization purchases ▪ Sentinel Provider Network (SPN)
NERHO	▪ CPI Funding ▪ TB patient referrals ▪ HIV patient referrals

SCRHD was able to reintroduce new birth control options to patients in order to meet existing patient's requirements, exceed their expectations and attract new patients.

The state recognized campaign that SCRHD developed during the 2009 Novel H1N1 Influenza season allowed for citizens to visit SCRHD that would not have normally done so in the past. Although that unparalleled flu season brought about many challenges, it provided SCRHD the opportunity to leave an impression upon all who visited one of the clinics and expanded the ability for SCRHD to form new relationships with those that would have never visited one of the facilities otherwise.

(2) SCRHD determines its key mechanisms to support use of health care services through various instruments including internal surveys, mass and social media outlets and telephone. In 2008, SCRHD began working with Sullivan Luallin, a healthcare customer service consulting firm based out of California. For the last four years, SCRHD has utilized Sullivan Luallin for the development, analysis and benchmarking of a yearly customer satisfaction survey. The survey feedback is used to determine satisfaction among all visitors to SCRHD and specifically analyzes the satisfaction of patients visiting Family Planning and WIC. The survey is also made available to those customer groups (home visiting participants) that do not visit SCRHD facilities. Surveys are distributed by the visiting nurse along with a stamped envelope so that the patient can mail the survey back once it is completed. Other ways that SCRHD determines its key mechanisms to support the health care services is through the

feedback given by customers via the Customer Care Comments (C^3). The C^3 program will be discussed in more detail in Item 3.2b (2).

SCRHD utilizes media communication and other community organizations in order to enable patients and stakeholders to seek information about available health care services. SCRHD has monthly interview spots on one of the local news radio shows, conducts regular television interviews to address current public health concerns and supplies relevant public health literature/SCRHD brochures to area agencies that may come in contact with customers that require public health services. SCRHD ensures that each new employee completes a thorough orientation allowing them to meet each program director that will give him/her an introduction to all health department programs and to facilitate full service in how they respond to public health needs and try to improve the public health status of Sullivan County citizens.

The popularity of social networking has become an important tool used by SCRHD to communicate with the public. SCRHD began utilizing Facebook and Twitter in late summer and early fall of 2009. With all of the changing information during the H1N1 Pandemic, it was imperative that SCRHD provide the latest information to the public. Facebook and Twitter allowed SCRHD to provide breaking news and changes to the public in a matter of seconds. The SCRHD website was and is still an integral component of communication to provide more in depth updated public health information, coming events, and available services to our patients and the community as a whole. "Robo Call" was also employed to conduct random phone calls to Sullivan County residents informing them of up coming vaccination clinics. During the heat of the H1N1 Pandemic, weekly meetings were held with the Public Information Officer, Regional Director, Medical Director, Director of Clinical Operations, Communicable Disease Director, Emergency Response Coordinator and Epidemiologist to update each of these communication mechanisms with the latest information and clinic dates.

SCRHD telephones have business and after-hours voice mail systems for routine messages. SCRHD has an after-hours on call system staffed by an answering service which routes calls to the manager on call. The managers and staff also respond to the Tennessee Health Alert Network (THAN) when there is a public health emergency. In the fall of 2006, SCRHD's on call system was tested by the RAND Corporation and scored a 100%, rating SCRHD as a Best Practice example for the entire nation.

Being able to adequately communicate with non-English speaking patients is one of the largest key support requirements recognized by SCRHD. SCRHD's ability to uphold all regulations set forth by Title VI are strictly adhered to. Title VI of the Civil Rights Act of 1964 provides that no person shall be subjected to discrimination on the basis of race, color, or national origin under any program or activity that receives Federal financial assistance. A number of programs in the Bureau of Health Services Administration (HSA) receive federal financial assistance from the Department of Health and Human Services and, therefore, must comply with the provisions of Title VI. This policy deals specifically with assuring that Limited English Proficient (LEP) persons, who are eligible for federally-assisted programs or services, receive the language assistance necessary to afford them meaningful access to public health services. Each new hire with SCRHD completes Title VI training and is oriented on how to use SCRHD language interpretation service program, *Language Line*. Yearly audits are conducted by the Quality Improvement Director to assess for compliance in Title VI. Translated printed materials are made available to those with Limited English Proficiency (LEP) as required by Title VI regulations.

Three other mechanisms are used to provide key support to our patient groups and stakeholders. The use of CareSpark, Shared Health, and the Tennessee Web Immunization System (TWIS) has allowed SCRHD to better anticipate the health care needs of patients. CareSpark is a non-profit regional health information exchange working to improve health in a 34 county area of east Tennessee and southwest Virginia through the collaborative use of health information. Shared Health works in ways that are very similar to CareSpark in that its mission to help improve the quality of health care by securely connecting medical information across a patient's network of clinicians, and engaging and empowering patients with access to their own health information. TWIS allows authorized users to obtain comprehensive immunization information on patients, update or initiate new patient records, links to other web sites as indicated to get more specific information on vaccines, vaccination strategies or current information from the Tennessee Immunization Program. The use of these programs allows SCRHD to have access to patients' pertinent health information in order to better respond to their needs and fulfill the mission of SCRHD.

(3) Sullivan County Regional Health Department uses several types of sources in order to retrieve information to identify current and anticipate future patient and stakeholder groups and market segments as well as their requirements and changing expectations. As mentioned previously, patient and stakeholder listening methods as detailed in Figure 3.1-1 are some of the foremost approaches used to meet requirements and changing expectations of current customers. However, because customers, customer groups, and market segments for SCRHD (Figure P.1-4) are identified based on criteria guidelines set forth by federal and state agencies, identifying current and anticipating future customers that could take advantage of the available programs at SCRHD is accomplished by review and analysis of valuable sources of data.

One of the key sources of data that is useful in ascertaining who are SCRHD's current and future customers are data collected from government agencies that provide information on county demographics. Some of these sources include the Center for Disease Control and Prevention, the U.S. Census Bureau, the Tennessee Department of Health and the Division of TennCare which is a government-operated medical assistance program designed for people who are eligible for Medicaid. Insurance status, age groups, and poverty level are

just a few of the measures that are evaluated in order to assess what programs can do the greatest good for the community and who can qualify to take advantage of such programs. The U.S. Census Bureau provides information on demographic/population estimates that are segmented by race and ethnicity, age, and sex; social characteristics including household type, education attainment, school enrollment; economic characteristics like employment status, income and poverty level. The U.S. Census Bureau also provides information regarding small area health insurance estimates that provides an idea of health insurance coverage across all states and counties. As noted previously many of the programs available at SCRHD are contingent upon income guidelines and poverty levels, age, and insurance status, e.g. School Based Dental Prevention Program, ABC Program, and WIC. Each of the data sources allow SCRHD the ability to prepare for certain increases in program usage or assess which programs are not being utilized to its fullest potential based on community need.

The Sullivan County Health Council (SCHC) is an assembly of community partners and organizations that are dedicated to improving the health and quality of life of Sullivan County residents. The responsibility of the SCHC is to determine some of Sullivan County's most pressing health problems with the aid of various community assessments as well as substantial input from community members. Work consists of formulating action plans and encouraging implementation of these plans through community partners. The result of everyone's collaboration will exhibit improvements to some of the most urgent health issues facing Sullivan County's population with the aspiration of improving health and quality of life within the community.

In 2007 the SCHC completed a Community Health Status Assessment as part of a renewed assessment of the county's state of health. The data used to formulate this assessment was retrieved by the State of Tennessee's Health Information Technology (HIT) site which provided various disease and mortality trends and rates among various segments of the population as well as data relative to how Sullivan County compared to the rest of the state. Other sources of data for this particular project consisted of hospital inpatient, outpatient, and general hospitalizations data that were made available through an agreement with the Health Statistics Department of the Tennessee Department of Health. The results collected through this project are reviewed with the SCHC and are assessed for improvement projects or an evaluation of community projects that are presently underway to address the most impressive issues.

After completion of SCHC's first Community Health Status Assessment in 2007 it became apparent that the information collected within this document became very valuable across multiple disciplines. The assessment results have been requested for review by various educational and healthcare industries for their own target programs as well as grant applications. Due to the overwhelming abundance of requests, the Community Health Status Assessment in its entirety was made available in CD format as well as online at www.sullivanhealth.org. The Community Health Status Assessment has become a part of SCRHD's Strategic Plan due to the valuable information that it discloses in assessing for current health trends that are affecting the Sullivan County community. This is one of many tools that allow SCRHD to identify and anticipate stakeholder groups, determine which groups to pursue for current or future services and adjust to their changing requirements and expectations.

Since SCRHD is a government run entity, having access to data from competitors that offer similar services is very challenging to find. SCRHD is in a collaborative relationship with the private sector to provide health care services and improve the health of the community. However sources of data do allow for consideration of patients and stakeholders of competitors. CareSpark, Shared Health, and TWIS are online health information exchange systems that allow for a more integrated approach in caring for patients that visit SCRHD. Many local health care facilities provide these systems with important patient data that are useful to public health providers including immunization and EPSDT physical history. By having greater access to a patient's health information, a SCRHD employee has the ability to see what services or lack there of have been provided to a particular patient in the private sector. This ensures that SCRHD is identifying and responding to the public health needs of customers even when they are unaware that these essential needs may have not been met.

(4) Much of the information utilized by SCRHD to improve marketing and health care service offering information to build a more patient and stakeholder focused culture and identify opportunities for innovation are made available by the governmental agencies that are funding the particular program. The Women, Infants, and Children (WIC) program is one of the most utilized programs at SCRHD and ranks as one of the highest in the state in percent eligible population served (Figure 7.1-6). WIC is a federal program designed to provide supplemental food to low-income pregnant, postpartum and breastfeeding women, infants and children until the age of five and is based upon certain income guidelines. The program provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals for health care. WIC has proven to be effective in preventing and improving nutrition related health problems. This program underwent significant changes in 2009 to include more variety, to decrease saturated fat, and to increase fruits, vegetables and whole grains. This new package provided greater flexibility to accommodate cultural food preferences of WIC participants. The process in marketing this new food package was a massive undertaking that required several months of preparation and the hard work of each SCRHD workforce member.

Other methods where patient and health care services offering information is used for marketing improvement and organizational innovation is through the quarterly performance management evaluation of GPIs and DPIs. It is during the QR that each global and departmental performance measure is evaluated to ensure that they are performing at appropriate levels for the current year and meeting the organizational strategic goals and mission. It is at this meeting where

managers discuss the opportunities for improvements in organizational services and processes to address under-performing measures.

More generalized strategies to identify opportunities for innovation include various task forces to which SCRHD participates. The Mountain Empire Public Health Emergency Preparedness Coordination Council (MEPHECC) is a collaboration among Northeast Tennessee, Southwest Virginia, North Carolina, and Kentucky Emergency Preparedness personnel, Communicable Disease directors and Epidemiologists. This multi-state group meets bimonthly to discuss current emergency response and preparedness planning initiatives and epidemiological topics of interest that are currently occurring in their particular region. This collaboration proved to be beneficial to SCRHD prior to and during the 2009 H1N1 Pandemic in order to be better prepared for the task that lie ahead and receive various inputs as to how different regions were handling the assignment. The Mountain Empire Epidemiology Task Force (MEETF) is a subset of MEPHECC and is a voluntary association of Northeast Tennessee and Southwest Virginia health departments that work to bring attention to epidemiological concerns of regional interest. This task force has partnered with various educational and health care organizations to raise awareness on pertinent health issues that are impacting the Mountain Empire Region such as sexually transmitted infections (STIs), MRSA, Rabies, Hepatitis C, seasonal and H1N1 influenza.

Each of these approaches along with basic marketing and visits to clinics whose patients could benefit from public health services; allows SCRHD to use its patient, stakeholder, market and health care service offering information to improve and build a more focused culture for patients. All the while make meaningful change to improve health care services, processes, and organizational effectiveness and create value for stakeholders

b. Building Patient and Stakeholder Relationships

(1) Acquiring customers for each program and for population based service is accomplished through internal and external community outreach efforts. These efforts are aligned with key customer and stakeholder requirements (Figure P.1-4).

Internal outreach is the process of identifying customers who can benefit from additional services SCRHD provides that the customer currently is not utilizing. Each employee at SCRHD is responsible for internal community outreach. Employee orientation is designed to accomplish this task. Through SCRHD's employee orientation process, each program manager at SCRHD meets with the new employee to give an overview of his or her respective program and discuss eligibility requirements. This provides the employee with the knowledge to identify customers that are eligible for these programs and directs them to the appropriate person at SCRHD for enrollment.

External community outreach is accomplished via several departments at SCRHD. TENNderCARE for example, is an outreach program that targets families with the goal of updating their children's immunizations and performing EPSDT physicals. TENNderCARE reaches approximately 15,000 people eligible for services each year and triages those eligible to either their private physician or health department.

The Health Education staff focuses on four main areas: teen pregnancy, sexual assault prevention, tobacco, and chronic disease. The Health Education staff educates the community with evidence-based intervention programs, which include a discussion, when necessary, of the programs provided at SCRHD associated within their focus area.

SCRHD's ability to meet patient's requirements and exceed their expectations in each stage of their relationship with the organization is contingent upon assessing the feedback that is provided to us by the patients, stakeholders and employees. In April 2008, it was decided that in order to better serve the community and address the needs of the workforce, the MT implemented extended hours for service delivery system wide. As opposed to operating five days a week eight hours a day, SCRHD shifted to being fully operational four days a week 10 hours a day, with Friday's being "walk-in" only and staffed by a "skeleton crew" of 2 nurses and one clerk in each site. This change was well received by both the cliental and workforce by extending the hours for those patients that worked late and addressing the workforce concerns of increasing gas prices by only having to travel to work four days out of the week. This process change was thoroughly review by the MT and underwent SCRHD's PDCA process improvement model. After one year of implementation, the four day work week was reassessed by the MT as well as the workforce to determine if continued support existed. This process improvement approach of increasing engagement, meeting requirements and exceeding the expectation of our patients and stakeholders is still in effect today.

The H1N1 Pandemic Vaccination campaign proved to be another area in which SCRHD was able to increase loyalty and exceed expectations of the patient. A vaccine deployment process was established prior to receipt of the H1N1 vaccine. A call center was instituted to address the overwhelming amount of community concerns and questions as well as to schedule appointments for upcoming clinics. As opposed to having a "first come first serve" type of approach which could lead to long lines and angry customers, the call center was utilized to schedule a specific amount of appointments for weekly clinics strictly dedicated to administering the H1N1 vaccine. This process allowed thousands of patients to be vaccinated in a very short amount of time and gave SCRHD the distinction of being first in the state in the administration of the H1N1 vaccine per capita throughout the entire H1N1 season. (Figure 7.1-8) This event also demonstrated the need for a new phone system to better meet the high demand in patient and community calls.

Several other initiatives have been developed in order to build and manage the relationship of patients and stakeholders: the establishment of a central communication center that handles all phone calls coming into SCRHD as opposed to being handled by staff that are assisting patients, sliding fee scales that allow patients to be seen for a reduced cost or free based on their income, the Clinic Flow Through Analysis group that

assess efficiency in clinic operations and the receipt of the American Recovery and Reinvestment Act (ARRA) funding for free vaccination opportunities to certain at risk populations.

(2) Employees of SCRHD are empowered to handle most of the complaints that they encounter. However, each face-to-face complaint about staff or clinic processes is handled on a real time basis by the departmental manager. When a customer expresses a concern with a frontline employee, the employee immediately notifies his or her supervisor and it is the supervisor's responsibility to resolve the complaint. The employee may also advise the complainant to complete a C^3 card and place it in the box provided. Customer Care Comments (C^3) is a process that Sullivan County Regional Health Department developed as a way of capturing real time feedback from our customers in an attempt to better understand how to meet and exceed the expectations that customers deserve. SCRHD invites every person who comes through the door of one of the facilities to evaluate the level of service and care that they received and provide comments, whether they are good or bad. Every comment provided will be thoroughly examined and used as a way of improving services to customers. SCRHD stakeholders pride themselves in providing exceptional services to customers and continue to maintain a vision of becoming a national model and leader in providing public health services.

The C^3 process begins when a customer places one of the cards into the box provided. A member of the PEC checks each of the boxes daily. There are two locked boxes located in the Blountville and Kingsport office and one box located in the Dental clinic. A spreadsheet has been developed to track all of the information listed on the card. The PEC member that collected the card from the box must fill out the first four columns in the spreadsheet. If the comment is designated as a compliment then the Ray of Sunshine process will be utilized. If the comment is designated as a suggestion or opportunity for improvement, the PEC member will deliver the comment card to the respective program director/manager.

If a phone number is given, the manager will have 2 working days to contact the customer and acknowledge the receipt of the comment and inform them that the complaint is being looked into so that we can better serve our customers. If it is noted that this has been a reoccurring comment, it will then be that manager's duty to look into the problem and address the problem or determine a resolution. This may require the aid of fellow employees, administrative staff, or the performance improvement mechanism, PDCA.

The manager will then have 10 working days to respond back to contributor, thanking them again for their suggestion, and discuss the resolution or proposed course of action. It is possible that the manager may be able to provide resolution to problem/suggestion during the "2 working day" contact, particularly if this concern is something that is currently being addressed. (Parking, wait time, etc.)

If no phone number is given, the manager will have 2 working days to access the customer care comment log located on the Share Drive and denote receipt of comment by filling out column E. They will then have 10 working days to access customer care comment log and fill out column F of spreadsheet with proposed resolution or how they addressed the problem. Each comment card is reviewed during the monthly managers meetings and possible resolutions or opportunities for improvement are discussed.

The epidemiologist compiles quarterly reports on the data retrieved from the comments and distributes to SCRHD staff. (Figure 7.2-3 and Figure 7.2-4) This data is also reviewed during the Quarterly Review meetings as well as the annual Strategic Planning Retreat.

The key difference in the processes between C^3 and the annual Customer Satisfaction Survey distribution is that with the C^3, customers are free to pick up comment cards at any time throughout the year and not at the request of a staff member. This will allow SCRHD to fully address customer satisfaction and dissatisfaction in a real time, personal, and recurring manner and to ensure that complaints are resolved promptly and effectively.

Category 4: Measurement, Analysis, and Knowledge Management

4.1 Measurement, Analysis, and Improvement of Organizational Performance

a. Performance Measurement

(1) Key performance indicators (PI) are selected during the annual Strategic Planning Retreat. The Management Team (MT) ensures that all approved performance indicators have a collection plan, are integrated into operations, aligned with strategic objectives and the MVV as well as maintain an action planning process. The MT designates each PI as a Global Performance Indicator (GPI) or a Departmental Performance Indicator (DPI), depending on its strategic importance to the organization (Figure 4.1-1). Many of the designated PI are aligned with contractual agreements with the State and Federal Government. Emphasis is placed on selecting a limited number of indicators that will drive targeted performance in SCRHD's seven Key Result Areas. (DPI's are not shown due to space limitations, but will be available for site visit review.)

Key short and long term financial measures are determined in a variety of ways. These measures are based on the three main funding sources which are State and Federal grant appropriations, Sullivan County Commission mandates and economic vitality, which includes county property and sales taxes. Over the last 4 years, SCRHD has had to cut 800,000 dollars out of the local funds/budget. (Figure 7.5-2)

Even with a very large cut in the budget, SCRHD has maintained all services with no employee layoffs thanks to effective strategic planning and performance improvement processes.

Figure 4.1-1 Global Performance Indicators

Global Performance Indicator	Key Result Area	Category 7 Item
Child Physical Exams (EPSDT)	Health Status	7.1
Child Dental Exams	Health Status	7.1
% WIC pop served in Sullivan County	Health Status	7.1
Organizational Show Rates	Management Practice, Public Health Capacity	7.1
Customer Satisfaction	Customer Focus	7.2
Employee Satisfaction	Human Resource Development	7.3
Turnover Rates	Human Resource Development	7.3
Healthy Rounding Performance	Management Practice	7.4
Expenditure Comparison	Financial	7.5
Revenue Comparison	Financial	7.5
*DPI's available for viewing at site visit		

Short term financial budget review is conducted on a monthly basis during the managers' meeting. Year-to-date revenue sources and expenditures are reviewed as well as the budgetary status of each program within SCRHD. Long term financial measures and planning are defined in one year increments. Capital planning, which includes larger purchases, is conducted in up to three year increments in conjunction with the Budget Committee of Sullivan County.

Progress toward PI goals is integrated into the MT's strategic decision-making process. Performance progress is shared with employees, suppliers, partners, and volunteers in a variety of methods. Performance indicators and performance progress are presented in reports and graphs through the use of SHEILA, email, bulletin boards, and report cards to allow for broad and timely distribution. SCRHD emphasizes the link between each employee's performance and the GPIs to optimize the opportunity for performance innovation within the seven key result areas.

All GPI and DPI indicator data are reviewed on a monthly basis by departments and a quarterly basis by the MT. A detailed analysis of each of these allows for an opportunity in innovation. In the event that a PI is not performing as expected, the MT initiates a process improvement plan. This process improvement plan may involve various workforce members within SCRHD depending on their area of expertise. Several performance improvement teams (PITs) have been deployed in response to data analysis of the performance indicators.

For example, an EPSDT PIT was developed to simplify the process of seeing a patient that required this type of exam. The result of this performance improvement team increased clinic efficiency and allowed SCRHD to complete a record numbers of exams. Another example of organizational decision making and innovation related to data and information involves results collected from the annual customer satisfaction survey. Data collected from this survey showed that customers were not pleased with SCRHD's telephone system along with the complicated phone tree. Based on scores and comments from this survey, a team was assembled to determine the requirements needed to surpass the expectations of the customers. A new computer based phone system was implemented October 15, 2010 that is better equipped to handle the call volume and shorten the time that customers are left on hold. The new phone system provides a wealth of data analysis opportunities that allows the MT to evaluate various performance aspects of the phone system. Based on collected performance indicator data, each of these teams developed ways to make meaningful change to improve health care services, processes, and organizational effectiveness to create new value for customers and stakeholders.

(2) SCRHD uses multiple sources of comparative data, including regional peer and 'best-in-state' comparison groups. Key comparative data comes from TDH, national studies, Healthy People 2020, local government agencies, and Sullivan Luallin. SCRHD selects the best available comparative data to provide a challenge to ultimately be the best in class. To ensure a systematic approach to the utilization of comparative data across the organization, the PEC and MT reviews and approves all recommendations related to comparative data for all performance indicators. Key comparative data – along with organizational performance projections -- are included on many performance graphs for PEC and MT review. On a quarterly basis, the MT uses this comparative data to identify gaps in performance and refine targets for improvement

(3) The selection of Voice of the Customer (VOC) data and information is effectively used in a proactive and continuously innovative manner to capture the stated, unstated, and anticipated requirements of SCRHD patients and stakeholders. The ultimate goal in the effective use and deployment of VOC data is to achieve customer engagement. SCRHD uses the methods outlined in Figure 3.1-1 to support operational and strategic decision making and innovation. The analysis of C^3 and annual customer satisfaction survey data has provided valuable customer feedback which has been implemented into the SPP for innovative improvements. Many of the new initiatives that have been deployed within SCRHD have resulted from the work of PITs that have been assembled due to VOC feedback. Two overarching themes that were discovered based on C^3 and survey feedback were the telephone system and WIC wait time. These initiatives will be discussed further in Item 4.1c (3).

(4) The use of the Quarterly Review and the Strategic Planning Retreat allows SCRHD to respond to rapid or unexpected organizational or external changes. During the QR, each performance measure is reviewed, evaluated and discussed to assess for performance, alignment and integration with the seven KRAs and the Strategic Plan. The Annual Strategic Planning Retreat not only allows for a year end evaluation of performance measures but a systematic SWOT analysis that details SCRHD's strengths, weaknesses, opportunities, and threats for the year under review. SCRHD has utilized performance data to develop a Community Health Assessment that is used to assess health care service needs and directions within the service area. This systematically collected information has been utilized by a variety of

organizational committees to work towards the improvement of public health determinants and health outcomes.

b. Performance Analysis and Review

SCRHD utilizes several mechanisms to analyze organizational performance and capabilities. These mechanisms include the monthly managers', departmental and PEC meetings, the Quarterly Review meetings as well as the annual Strategic Planning Retreat. It is during this time that measures are reviewed for performance and the possible initiation of PITs is discussed. These mechanisms afford each employee the opportunity to internalize the strategic objectives (broken down into the seven Key Result Areas) and tie their performance to the organization's performance. At any time, SCRHD's performance measures are available for viewing by any and all staff on SHEILA. The types of analyses performed may include program audits to assess financial health, statistical data reporting using crystal report methods, short and long term trending using rate comparison and time period evaluation. SCRHD is able to assess its success and performance relative to comparable organizations through the use of data generated by published public studies such as Healthy People 2020, available state-wide data, indicator requirements which are mandated by grant contracts, and customer satisfaction benchmarking provided by a private organization, Sullivan Luallin. SCRHD measures progress relative to strategic objectives and action plans through the review of the SPP during the annual retreat and is conducted throughout the year with the review of DPI's/GPIs, related action plans and their association with the strategic objectives of the organization.

SCRHD's SPP is the primary method for assessing organizational success. In February of each year, the PEC along with the MT meet to reassess strategic objectives, prior year performance relative to strategic objectives and actions plans, as well as environmental changes within the region or the health care sector. During each SPP, a SWOT analysis is conducted with input from all MT members. Items listed within each section of the SWOT are tied to its relevant KRA. An integral part of the SP Retreat includes a thorough analysis of the previous year's SWOT and the items that were influenced or impacted during the year under review. These systematic reviews are influential in responding to changing organizational needs and challenges in the operating environment.

c. Performance Improvement

(1) Monthly managers meetings, quarterly reviews and annual strategic planning retreats allow a venue for performance reviews and sharing of best practices. Because SCRHD maintains two separate locations for providing general public health services; the sharing of best practices and lessons learned occurs quite frequently. During any performance review, if an obvious difference is identified within a GPI or DPI between locations, an occasion becomes available to discuss opportunities for improvement for the underperforming site. The Healthy Rounding process is another area in which a best practice, developed by one department, was deployed across the entire organization. Instead of waiting for the next "round" to occur in a department, a "Healthy Rounding Ideas" form was developed and posted within each department. This allowed employees to document thoughts or suggestions between rounding periods for their department.

(2) The majority of strategically important measures have established performance projections that are based on an understanding of past performance, rates of improvement, and assumptions about future internal changes, innovations and external environment as well as state mandated performance measures. These projections allow the MT to assess for organizational sustainability in comparison to other like entities. These projections are used as a key planning tool for SCRHD.

(3)Several mechanisms have been developed to assess for underperforming indicators or processes. Based on the indictor or process under review, a PIT is established, a gap analysis is conducted, and an action plan developed to promote opportunities for innovation in the indicator or process. It is important to note that performance improvement teams are comprised of various members spanning all levels within the SCRHD workforce. This may include both senior leaders as well as front line employees based on their level of expertise and the indicator or process under evaluation. These all inclusive actions are taken to ensure effective deployment to all work groups and functional-level operations within SCRHD to promote support for possible improvement strategies.

The most recent PIT to be deployed is also in response to feedback received from the 2010 customer satisfaction survey. Patient wait times were an obvious concern and were noted as being an area where improvement was essential. A multifaceted team was assembled to brainstorm for various strategies including ways to decrease wait times in waiting areas and clinic rooms as well as suggestions that may make wait times more tolerable for patients. The Customer Satisfaction Action Planning Group has developed an action plan that includes innovative ways to influence WIC wait times. One such innovation includes the installment of WIC kiosks within both the Blountville and Kingsport office. SCRHD is one of two health departments within the state of Tennessee to utilize this approach. Successful deployment of this action plan may be visualized immediately with the satisfaction of customers and quantitatively with feedback garnered from the 2011 customer satisfaction survey.

Past performance improvement teams instituted at SCRHD have evaluated: Open Access appointment scheduling to reduce the frequency of "no shows", Clinical Throughput evaluations to streamline clinical processes, institution of a four day work week for the majority of SCRHD staff with a skeleton crew to secure the public health needs on the fifth day.

All newly introduced or updated work processes and designs that are deployed at SCRHD must go through the Plan-Do-Check-Act (PDCA) performance improvement system after its first year of implementation or as determined by the performance improvement team. The PDCA cycles allows

for an evaluation into the maturity, deployment, and functionality of the most recent process or practice changes. The results of the performance improvement teams and PDCA evaluation are shared with staff during departmental, manager and employee meetings, Sullivan County Commissioners, and program directors at both the state and federal level.

4.2 Management of Information, Knowledge, and Information Technology

a. Data, Information, and Knowledge Management

(1) SCRHD ensures accuracy, integrity, reliability, timeliness, security and confidentiality of organizational data, information and knowledge through various means. Each staff member of SCRHD receives thorough orientation and is assigned a preceptor who instructs the new employee on proper chart and patient data information management. Accuracy, integrity, reliability, timeliness, security, and confidentiality are verified by internal and external audits by SCRHD's Quality Improvement Officer, the Tennessee Department of Health, and the Sullivan County Comptrollers Office. Any discrepancies noted within these audits require a corrective action plan that addresses issues stated within a specified time frame. Specific ways in which the integrity and reliability of data, information and knowledge are ensured include nightly backup of PTBMIS, Exchange, Fileserver, Dentrix, and Antivirus Programs.

Both Blountville and Kingsport clinics can operate during a power outage for several days, due to the installation of standby generators. To ensure continued availability, all computer servers are connected to an uninterruptible power supply system. They are also enabled with dual power supply systems to all for redundancy. All servers are running mirrored or RAID disk Array. For Internet service, availability is assured through a contractual agreement with two separate cable and DSL Internet services providers (ISP). During an unplanned failure of one ISP, the alternate is available for the continued supply of Internet service to employees and volunteers. SCRHD obtained a local area network storage unit (SANS) which allows for expansion in data growth within a secure environment and also works with the backup system to provide data integrity.

Timeliness of data, information, and knowledge is evident through the use of real-time Crystal Reporting of PTBMIS information and Shared Health access. CareSpark, Shared Health and TWIS have proven to be very valuable resources when ensuring patient health status such as immunizations and EPSDT's. Another avenue used to ensure timeliness of data includes electronic billing through the Dental Department as well as for those that are TennCare/Medicare insurance holders. The clerical team conducts an encounter review on a daily basis to ensure that all encounters are finalized and billable.

Data security and confidentiality is critical to HIPAA compliance. To minimize downtime, all computers are protected with the latest software to combat spyware and computer viruses. All computer users must use passwords to access the SCRHD network and data. The Internet is secured with a firewall. The servers are in a climate-controlled locked area which is only accessible by authorized personnel. Other ways in which security and confidentiality are assured is through systematic password changes, Shared Health audits, storage of backup tapes at an offsite location, regular virus updating, HIPAA training for all staff, VPN accessibility and background checks. Release forms are detailed in the level of information that can be released and require a signature. Any potential breach of security is immediately forwarded to the Clinical Services Coordinator or Medical Director for confirmation and investigation. Legal consultation is available through the county attorney or with the state legal council for controversial issues. Electronic information can be encrypted, and computers have multiple levels of boot up security at both the bios and program levels. With an employee termination, computer access is immediately terminated.

(2) SCRHD makes knowledge assets available through its employees, the use of technology, and documentation. These accumulated intellectual resources are delivered to the public, the workforce, community health partners, government entities, and patients.

Figure 4.2-1 IT Reliability and Security Mechanisms

Management Tool	Result
Virus & SpyWare Protection	All PCs and file servers are virus and spyware protected
PC system standardization	Uniform software selection (e.g., spam blocker) enhances user-friendliness
Login Access	System access requires unique logins to enhance security
System Back-Up Procedures	Data and information is backed up each night, and restored in the case of emergency
Controlled Purchasing	All hardware and software is purchased according to established standards
IT Help desk	Personal service features such as cell phone access to IT staff

Employees provide the most personal means of delivering health information to the primary customer – the general public. In an effort to improve health status, employees share health information through patient care interaction, health education presentations, community health promotion campaigns, and home-care outreach.

SCRHD continues to leverage technology to make data and information available to key customers, suppliers, and stakeholders. The SCRHD website is continuously updated with pertinent public health information, upcoming events, and detailed information regarding all programs and services available. In 2009, social media (Facebook and Twitter) and the initiation of the SCRHD Speakers Bureau were used extensively to keep the public informed of the H1N1 Influenza Pandemic, available immunization clinic locations, and important prevention and treatment information. Facebook and Twitter are still frequently used to advertise upcoming health events and quick tip public health information.

SCRHD shares the Tennessee Web Immunization System (TWIS) information with private providers through the CareSpark system. Making this needed data and health information available to healthcare providers will assist in the improvement of immunization rates which in turn will have a positive impact health status.

SCRHD is wired for the future. Wireless access to email and the Internet have been in place since 2003. While most employees have dedicated computer workstations, for those who do not, a workstation is available at each clinic location for general use.

Data and information is also shared through the printed media. Employees and volunteers receive the SCRHD newsletter, benefits information packages, and healthy living reminders. When urgent health information needs to be shared (e.g., press release on rabies case), SCRHD utilizes blast fax capability to reach multiple clinical and community partners. In many community outreach efforts, printed material (health information) is shared with the individual or the audience to raise awareness or promote health behavior change.

As mentioned in P.1-6, a variety of communication mechanisms are in place to make data and information accessible to the TDH, CDC, County Commissioners, and other external partners. In particular, the Web-Based Emergency Operations Center (WEBEOC) has been integral in aligning communication during the event of an outbreak investigation. SCRHD can allow restricted access to this program for all who are involved in the investigation. This web based communication forum allows for a centralized location for investigation updates and decreases the chance for miscommunication via multiple emails and phone calls.

(3) In 2010, the Organizational Learning Committee (OLC) was developed in response to an acknowledged lack of systematic approaches for managing organizational knowledge within SCRHD. One of the goals formulated by the committee was the assembly of a workforce capability matrix that would refer to the organization's ability to accomplish its work processes through the knowledge, skills, abilities, and competencies of the workforce. This matrix would assist in SCRHD's ability to build and sustain relationships with patients, stakeholders, and community partners; to innovate and transition to new technologies; to develop new health care services and work processes; and to meet changing health care, business, market, and regulatory demands. The second goal of the OLC was to develop an organizational learning and knowledge sharing database. In order to build knowledge assets that would be shared throughout the organization, the OLC transformed the employee intranet site to an improved interface called SHEILA. The Sullivan Health Electronic Interface Library Access (SHEILA) is divided into three components: Motivators, SHEL.E, and Portals. Each of these three divisions contain pertinent information and program applications which are utilized at a personal, departmental, and organizational level to enhance workforce engagement and drive opportunities to effect significant, meaningful change towards innovation.

The Sullivan Health Electronic Library of Enlightenment (SHEL.E) is used in a variety of ways. It can be used as a source to collect and transfer workforce knowledge via the workforce capability matrix, the transfer of workforce information and of relevant knowledge through departmental based resources, rapid identification and best practice sharing through the organizational learning and knowledge sharing process; and the assembly and transfer of relevant knowledge for use in facilitating innovation within SCRHD's strategic planning process by allowing staff direct access to the most recent strategic plan, timeline, and performance management of organizational GPIs and DPIs.

As previously mentioned, SCRHD frequently uses various social media outlets such as Facebook, Twitter and the www.sullivanhealth.org website to provide organizational knowledge to patients, stakeholders, suppliers, partners and collaborators. Transfer of knowledge to the public is critical in the event of crisis or outbreak. SCRHD strives to work with multiple media outlets to include TV, radio, and print as much as possible on a routine basis to build trust during a crisis. SCRHD's Public Information Officer coordinates contacts with the media. Information to be released is corroborated on multiple levels internally and externally (State of TN, State of VA, NERO, etc.) for accuracy and consistency. Routine information is also shared via pamphlets and printed information with clients during their visits.

New methods have recently been implemented within SCRHD to transfer knowledge pertaining to patient laboratory information. The use of electronic lab reporting through LabCorp allows SCRHD to respond to abnormal test results in a more timely manner then previous procedures to better facilitate patient care.

b. Management of Information Resources and Technology

(1) SCRHD IT infrastructure allows employees and volunteers to communicate and share information efficiently across all work locations. Key reference and policy documents (e.g., Administrative Handbook) are available through a set of shared folders that are accessible from all workstations. Key personnel also have secure remote assess through dial-up or Virtual Private Network (VPN) connection. Clinical and operational data is likewise accessible throughout all SCRHD work sites through the Patient Tracking Business Management Information System (PTBMIS). Aggregate data from this system is delivered to the TDH on a daily basis. In order to ensure redundancy and reliability of organizational information, backups are completed nightly and stored at an off site location and all networks are monitored using a CACTI system. SCRHD also has two information technology workforce members on site to facilitate with any hardware or software glitches.

Several advancements in SCRHD's information technology infrastructure have increased the reliability, security and user-friendliness across the organization and has established a best practice within the industry. The installment of fiber optic cable from the Blountville site to Dental and Kingsport improved communication speed and provided a substantial

cost savings. Communication between the Dental site and Blountville was improved by 60,000% with a one time expenditure of $10,000 that will replace an annual cost of $6,000. Communications between the Blountville and Kingsport sites have improved by 300% at the same cost. The new phone system was installed with a $100,000 grant that improved the agility to drive the annual cost savings of the communication improvement.

(2) The IT department follows a 5-year plan that is aligned with the industries best practice. The 5-year plan is reviewed on a yearly basis. The findings from this review are integrated into the SCRHD's SPP. IT staff also collaborate with suppliers to be aware of changing industry standards or emerging trends. Requests for IT improvements from employees are shared directly with the IT staff at managers' meetings. Many of the technological advancements that have been implemented within SCRHD were recognized during the SWOT analysis during the annual strategic planning process.

The IT emergency plan is a component of SCRHD's overall Emergency Preparedness Plan. It requires information redundancy (information backup to tape and off-site storage), as well as recovery and online capability in the event of an emergency. The most critical IT system (PTBMIS) would be the first to become redundant using the automated IT system back up procedure. SCRHD conducts quality control audits to ensure an extremely high level of reliability and security on critical IT systems.

During emergency situations, IT staff members are required to respond to the clinic site in question to provide technology and communication trouble-shooting services. IT participates in mock drills for emergency preparedness, testing backups and ensuring system recovery capability.

Timeliness of data, information, and knowledge are especially important during public health emergency situations. The timely dissemination of information during a disease outbreak investigation can enhance SCRHD's ability to control the spread of a communicable disease. During the 2009 H1N1 Pandemic emergency response, the timely exchange of data and information shaped the community's ability to respond appropriately and cope with the difficult circumstances surrounding public health's response. SCRHD has established redundant communication systems for use during potential public health emergencies as described in Figure 1.1-2. Message maps for key public health emergencies have been prepared in advance for rapid modification and use by our Public Information Officer and emergency response team.

Category 5: Workforce Focus

5.1 Workforce Environment

a. Workforce Capability and Capacity

(1)Workforce capability, capacity needs, skills, competencies, and staffing levels are assessed by administration based on licensure, federal and state grant requirements, and organizational needs. Along with contractual requirements and licensure, the Organizational Learning Committee (OLC) was tasked with addressing workforce capability and capacity needs. The development of the OLC was initiated based on feedback from employee survey results where numerous requests were made regarding workforce training. One of the two goals developed by OLC was to assemble a workforce capability matrix that would refer to the organization's ability to accomplish its work processes through the knowledge, skills, abilities, and competencies of the workforce. The matrix is comprised of a listing of required training materials for new hires and is segmented by departments for ease of use. Members of the OLC worked with departmental directors to compile a list of trainings that are required in order for each new hire to effectively perform his or her job duties. Another capability component addressed by the OLC is the opportunity for organizational learning through webinars or other training to improve workforce knowledge and skills. Employees can submit requests and suggestions for trainings through SHEL.E where they are reviewed by the OLC and presented to the PEC for strategic importance in the fulfillment of SCRHD's organizational mission. The OLC conducts a periodic gap analysis to determine training needs or skill development that may not have been suggested. Another avenue that will be used by SCRHD to increase workforce capability is ETSU's College of Public Health LifePath program. LifePath will offer academic and non-academic training for the Public Health workforce. SCRHD is collaborating with LifePath administrators to ensure the successful deployment of this important initiative.

Other ways in which SCRHD assesses for workforce capability and capacity needs, skills, competencies and staffing levels is through a two day new hire orientation, monthly skills monitoring of clinical staff by Clinical Services Coordinators, and Medical Lab Evaluation (MLE), which is completed three times a year to assess for competency of the staff conducting in house lab procedures in accordance with Clinical Laboratory Improvement Amendments (CLIA). SCRHD's QI director is also a vital part in assessing for skills and competencies levels of workforce members through various audits. Audits such as Risk Minimization and Comprehensive Health Maintenance, which is used to assess for correctness and thoroughness of chart documentation, are state mandated and systematically conducted throughout the year within each program at SCRHD.

Another area in which workforce capability is valued and enhanced is through performance improvement teams. These teams may be assembled at various times throughout the year based on results from customer satisfaction or employee surveys, in response to underperforming GPIs or DPIs, or to address a workflow process that is not functioning efficiently. Performance improvement teams employ various workforce members to sustain relationships with patients, stakeholders and community members, to remain innovative and develop new health care services and work processes.

Capacity levels at SCRHD are frequently delegated by federal and state funding through grants, as well as Sullivan County financial support. Members of the administration and departmental directors anticipate demand during various times throughout the year, specifically influenza season and early fall prior to the beginning of the school year. It is during these

times of increased workforce demand that workflow processes and assignments may be modified to account for the demand level within different site locations and clinics. There are instances when federal or state contracts receive additional funding which allows SCRHD to hire additional staff members. For example, both the WIC and Immunization Program received additional grant funding, which allowed the hire of additional WIC staff and an Immunization Educator. The addition of these employees assists with the efficient clinical throughput of WIC clients within this department and enhances immunization education opportunities to private physician's offices with the goal of improving the public health status of Sullivan County citizens.

(2) The Senior leaders of SCRHD collaborate with local universities and community colleges to educate students about public health and to encourage them to consider careers in public health. Many program directors participate in guest lectures to nursing students at local universities. This process gives the nursing students information on public health nursing and is used as a recruiting tool for SCRHD. SCRHD also partners with the ETSU College of Public Health for Internship/Field Experience placement for undergraduate and graduate level students. This is also a great recruitment tool for SCRHD that has resulted in a great number of new hires at the completion of the internship and graduation. The medical director provides public health training to residents through the ETSU College of Medicine. Not only does each of these opportunities provide a great avenue for recruiting well trained workforce members, but, more importantly, it allows hands-on experience and exclusive education into the world of public health that is not acquired in a classroom setting.

SCRHD uses other strategies to recruit, hire, place and retain new workforce members. The recruiting and hiring process for all job openings begins with an internal posting. If the position cannot be filled internally, it is posted externally. Employees and senior leaders view this "hire-from-within when possible" approach as a win-win scenario, improving retention and effectiveness by maintaining organizational knowledge. Social networking via Facebook and Twitter is a new avenue that is used to publish job postings following the internal posting process. All open position opportunities are posted on the SCRHD website along with the application for employment. When filling a new position, SCRHD must follow the delegated policies and requirements for hiring that have been set forth by that particular grant as well as licensure requirements. Detailed job descriptions and requirements are developed by departmental directors for those positions that are not supported by grant funding agreements. SCRHD uses the interview process to share the organization's Mission, Vision, Core Values, and Core Competencies to ensure that each candidate is in alignment with those key organization beliefs. Each new hire, dependent upon department, is assigned a preceptor who is given the responsibility of teaching the new hire the skills they need to perform their job requirements, a tool that is used by SCRHD to retain qualified workforce members is through a mentoring program. Many departments have developed a check off list that is used to track which competencies the new hire has mastered and which require more training time. These tools are viewed as being essential in motivating workforce members to perform to the best of their ability in responding to the needs of the public.

SCRHD is an equal opportunity employer and acknowledges the importance of cultural sensitivity and competency when addressing public health issues. In order to appropriately and successfully respond to the mission and vision of SCRHD, providing public health services, education, and resource direction in a culturally competent manner is of the utmost importance, the SCRHD workforce mirrors the diversity of the general population of Sullivan County. (Figure 5.1-1)

Figure 5.1-1 Workforce Diversity

	Sullivan County, TN*	SCRHD
White	95.9%	97.5%
African American	2%	2.5%
Other Races	1.2%	0%
Hispanic/Latino	1.1%	1.7%

* Based on U.S. Census Bureau Statistics 2005-2009 Estimates

Although having a demographically and culturally diverse workforce is important when providing public health services, it is also important to have a certain degree of professional diversity as well. Prior to joining SCRHD, many of the employees worked within the private sector. The varying degree of professional diversity among the workforce brings new insight and opportunities for innovation during the formulation of a performance improvement team.

(3) SCRHD organizes and manages the workforce to accomplish the work of the organization, capitalize on organizational core competencies and address strategic challenges and action plans through key approaches such as the SPP, organizational meetings and key community outreach. Workforce members have an understanding of the role that they play in improving public health as a SCRHD employee. Much of this understanding comes by way of the program guidelines that have been developed by the state or government contract agreement or through the county approved job description. Several components within the SPP allow integrated organization and management of SCRHD workforce. The annual Strategic Planning Retreat provides an opportunity for an organizational SWOT analysis to check for environmental factors that may necessitate a reorganization of the workforce. Alignment with the seven KRA`s is essential during the SWOT and facilitates accomplishment of action plans (Figure 2.1-4) and strategic goals (Figure 2.1-2), addresses strategic challenges and capitalizes on strategic advantages (Figure P.2-2) to achieve the mission and vision and assure sustainability of SCRHD.

SCRHD has established four core competencies which are strategically important capabilities that are central to fulfilling the mission. Education, Prevention, Community Need, and Workforce are thoroughly evaluated during the annual Key Community analysis. (Item 1.2c) Other approaches that are used to capitalize on these four core competencies are through SHEILA/SHEL.E, employee evaluations, and Healthy Rounding.

Employees from across the organization work together to exceed performance goals and expectations. Systematic sharing and evaluation of GPIs and DPIs, customer and employee feedback, along with county health rankings and Healthy People 2020 objectives, reinforce a patient, stakeholder, and health care focus. The work accomplishment and achievement of performance expectations have become highly celebrated.

(4) At SCRHD, the workforce is prepared for changing capability and capacity with workforce development and training. The public health sector – with its constantly changing program requirements and funding levels -- inherently requires an ability to quickly respond to a changing environment. SCRHD emphasizes to its employees the importance of flexible response to unexpected challenges. The most recent example is the 2009 H1N1 Pandemic which required an immediate shift in focus and realignment of priorities. Also, emergency plans developed by SCRHD following the 2001 terrorist attacks were initiated to respond to the public health needs and maintain public health status of the community. It was during this time period that SCRHD was able to meet the immediate needs of the community and maintain continuity of care in other clinics with no additional workforce. With supplemental funding from state partners, workforce members were compensated for overtime. SCRHD was best in state in the deployment of the H1N1 vaccine in 2010. (Figure 7.1-8)

The annual SWOT analysis that takes place during the strategic planning retreat is an approach which is used to assess upcoming changes in capability or capacity needs based on any funding changes and economic downturn. Impromptu meetings can also be arranged in the event of unexpected capacity needs. Various process changes have been developed to account for these instances. Due to changes in administrative responsibilities, staff can be pulled from different site locations to provide coverage during staff shortages. Cross training is an important tool to minimize the impact of workforce reductions. Preventing the occurrence of workforce reductions is essential to maintaining workforce capacity and ensuring SCRHD's ability to accomplish work processes and successfully deliver healthcare services. Through the use of a preceptor program and clear job responsibilities, SCRHD strives to prevent workforce reductions. As a result of the economic recession, increase in the number of WIC participants was identified during the annual strategic planning retreat. Several months later additional funding was made available to this program to account for the increase in participation. This additional funding resulted in the hiring of two part-time clerks and two full-time nurses.

b. Workforce Climate

(1) Workplace health, safety, and security are a top priority at SCRHD (Figure 5.1-2). SCRHD has maintained an active Safety Committee since 1999. This committee's function is to identify issues within the organization related to safety and risk management. The group compiles data from Incident/Accident reports filed internally (Figure 7.3-4). Incident reports are filed within 24 hours of an event, and reviewed by the applicable department manager, administrative director, and regional director. Actions plans are created and implemented without delay to eliminate unsafe environments, correct behaviors leading to errors, and reduce employee lost time injuries. The Safety Committee tracks all incident reports and each individual action plan, reporting directly to the Regional Director. All employees receive annual safety training and a procedures manual on all safety policies. A new safety training process was implemented in 2011. Employees are directed to review select videos and presentations and complete a quiz designed through Survey Monkey. This format increased training compliance and decreased unnecessary paper trails and the loss of valuable work time.

Figure 5.1-2 Workplace Health, Safety, and Security

Category	Policies & Procedures	Measure
Health	▪ Annual (Employee) TB Test ▪ N-95 Fit testing for designated staff *(Communicable Disease and PHIT Team)*	100% Compliant
Safety	▪ Emergency protocols & drills ▪ Safety drills ▪ Safety committee meetings ▪ Wall and employee badge posted fire evacuation routes. ▪ Safety (retractable) syringes ▪ Workplace safety training ▪ OSHA training	Lost time injuries Incident reports
Security	▪ Electronic (badge) access control doors ▪ Security system ▪ Workplace violence policies	Security breaches

The Safety Committee has implemented protocols for responding to violent threats (from patients) and medical emergencies. When an employee feels threatened by a customer, he or she has been instructed during orientation to tell the hostile customer that a manager will be paged to discuss the issue. The employee then pages on the intercom, calling "Mr. Anderson" to the location the event is taking place. This activates the entire management team to go to this location to assist the employee and 9-1-1 is activated. Similarly, "Dr. Strong" is used for medical emergency activations.

Employees are empowered to intervene when serious or immediate safety issues are identified. SCRHD tracks lost time injuries and other workplace safety measures required by OSHA. Employees are encouraged to seek out best practices, such as engineering controls (e.g., safe retractable needles) to prevent injuries or exposures to employees and patients. The majority of SCRHD safety suggestions come directly from employees and is submitted directly to the Safety Committee. For example, staff recognized that the parking area at the Kingsport Clinic needed better parking lot lighting. The request was approved and funded, minimizing risk to patients and employees. SCRHD has implemented a modified process for administering seasonal influenza vaccine to minimize injury incidence in at risk patients. During high volume periods, SCRHD staff may now administer flu vaccines for any patient with limited mobility in the patient's car. This helps reduce the number of patient falls and is viewed as a customer friendly service enhancement.

(2) During orientation, each new employee receives a Sullivan County Employee Handbook. This handbook contains rules, regulations and guidelines; general personnel policies; employee classifications and compensation; attendance and leave policies; and employee benefits. One component that has historically been influential in workforce satisfaction is Sullivan County's exceptional benefit package. Sullivan County offers the best overall benefits package when compared to other large employers within the region.

Benefit package highlights include the following:

- Health insurance (plus drug card & vision coverage)
- Dental & Life insurance
- 12 holidays / year (15 holidays during election year)
- 12 sick days / year (with portability)
- 3 personal days
- Tennessee Consolidated Retirement System – vested after 5 years – 16.26% county paid retirement (up from 14.79%)
- Deferred Compensation – 457

5.2 Workforce Engagement

a. Workforce Performance

(1) SCRHD uses multiple methods to determine the key elements that affect workforce engagement and satisfaction (Figure 5.2-1).

Figure 5.2-1 Workforce Engagement Determination Methods

Method	Time
Strategic Planning Retreat	Annual
Quarterly Review	Quarterly
Employee Meetings	Semi-Annually
Departmental Meetings	Monthly
Healthy Rounding	Weekly
Open Door Policy	Ongoing
Best Practices	Quarterly
Workforce Engagement Survey	Yearly

In order to determine the key factors that affect workforce engagement and to better understand the workplace climate; managers and supervisors actively seek feedback from their employees (Figure 1.1-2), partners and customers. SCRHD uses Ray of Sunshine and Customer Care Comment (C^3) feedback to help determine workforce engagement and satisfaction via the customer and organizational partners. The Ray of Sunshine process was developed and deployed in 2008 and as a way to encourage workforce development as well as increase knowledge of recognition that is given to the organization and its various programs. These acknowledgements are not only given by the patients who are served daily, but also stakeholders and others that SCRHD may come into contact with during various day to day activities. The Ray of Sunshine and C^3 processes have been developed to allow for segmentation of site location and workgroups. This segmentation allows for a more thorough analysis of not only workforce engagement but customer engagement and satisfaction.

(2) SCRHD fosters a culture that is characterized by open communication through the use of an open door policy that encourages employees to voice their opinions, not only to their direct supervisors, but to senior leaders. The Healthy Rounding process was developed in 2009 as a result of feedback from the workforce engagement survey. Results from this survey conveyed to the PEC that improvements were needed to further open the lines of communication and offer more opportunities for discussion between senior leaders and workforce members. The deployment of this process has encouraged a more open communication between these two workforce segments and has a direct influence on high-performance work and workforce engagement. SCRHD believes that having front line staff members and managers working together on important strategic organizational matters has a direct impact on workforce engagement and ensuring high-performance work. Front-line workforce members are invited to take part in SCRHD's yearly strategic planning retreat, quarterly reviews, TNCPE Board of Examiners, and are vital contributors to performance improvement teams (PITs). Each of these participation opportunities allow for the sharing of diverse ideas and thinking among workforce members. This ensures not only alignment with the structure, core competencies and workforce development of SCRHD but also integration with the mission, vision, and values of the organization.

(3) SCRHD's workforce performance management system supports high-performance work and workforce engagement through the systematic evaluation of GPIs and DPIs, annual workforce engagement survey's; annual, individual goal-based employee evaluations, a detailed orientation process for all new employees, daily manger-to-staff interactions that promote teamwork and workforce competencies. SCRHD functions under the governance of the Sullivan County Commission and has little control over employee compensation and benefit packages. Because of this disadvantage, SCRHD makes it a priority to see that workforce members are rewarded, recognized and provided incentives for performing to the best of their abilities through means other then monetary. Annual service awards are presented during the Christmas luncheon for state and county employees who have reached 5, 10, 20, 25, and up to 50+ year milestones in their public health careers. A new tradition was started in 2009. Aside from service awards, humorous awards are provided to various staff members based upon incidents that have occurred throughout the year. This segment of the Christmas luncheon is met with much trepidation as well as excitement.

In 2007, the Thumbs Up program was developed to recognize examples of commendable performance of employees. When an employee performs in an exemplary manner, a fellow employee or manager documents details on a Thumbs Up sheet and emails the details of the Thumbs Up to all workforce members. The Thumbs Up gets posted on the respective bulletin board as well as on SHEILA for all to see. The Ray of Sunshine and Customer Care Comment processes also provide an opportunity for employee or department recognition.

The foundation of SCRHD's performance management system is based upon performance in various GPIs and DPIs that are integrated into the MVV's which delineates the focus

for the organization. Each GPI or DPI is created with an associated action plan that is aligned with one of the seven organizational Key Result Areas (KRA). Workforce members are important contributors to action plan development, deployment and success particularly those that are involved in PITs. SCRHD has learned to celebrate and award recognition with the successful implementation of organizational or departmental action plans that leads to the improved performance of GPIs or DPIs.

b. Assessment of Workforce Engagement

(1) SCRHD utilizes the SPP and other internal methods (Figure 5.2-1) to assess workforce engagement and satisfaction. In 2007, SCRHD collaborated with Panoramic Feedback to deploy the first formal engagement survey to each workforce member. A systematic process has been developed to deploy, evaluate and respond to the feedback provided within this survey. The workforce engagement survey is distributed via email to each workforce member during the month of October. The survey is composed of twenty-two questions that range from workforce environment to workforce loyalty. Employees are allowed one month to complete the survey and submit anonymous responses directly back to Panoramic Feedback for analysis. SCRHD receives a formal feedback report from Panoramic Feedback during the month of November or December. This feedback is thoroughly analyzed and reviewed by the PEC, the MT and then presented to the workforce during the next occurring semi-annual employee meeting. Key themes are identified within the feedback and if warranted, a PIT is initiated to facilitate improvement opportunities. "*I would recommend employment in this organization to others*" and "*Over the last 6 months, have you given serious thought to leaving to go to another company*?" are two particular questions that are highly regarded as being key determinants of workforce satisfaction and engagement. SCRHD has utilized the workforce engagement survey to assess workforce satisfaction and loyalty for the last four years.

Another formal method for assessing workforce engagement and satisfaction is through annual employee evaluations. It is during this time that supervisors have a formal opportunity to discuss workplace performance and address areas where dissatisfaction may be evident with each staff member under their program. These evaluations differ depending on job classifications and requirements. Other more informal methods of assessing workforce engagement are through the Healthy Rounding process as well as monthly manager and departmental meetings. Global Performance Indicators such as turnover rate segmented by job classification and reasons for leaving SCRHD, directly correlate with workforce engagement and are reviewed during each QR and the annual strategic planning retreat.

(2) Panoramic Feedback provides survey feedback to SCRHD during the month of November or December. Before this feedback gets distributed for review, additional statistical analysis is conducted by the Regional Epidemiologist to assess for changes in comparison to the previous year's score. Once this analysis is completed the report is thoroughly reviewed by the PEC where key themes are identified for possible improvements. The report is then presented to all managers at the next scheduled monthly managers meeting. Managers are encouraged to review the report and be prepared to present their comments and recommendations at the next scheduled managers meeting. After receiving comments from PEC and the MT, the results of the survey are presented to all staff at the next employee meeting. Based on the feedback from the survey, actions may or may not be taken to initiate a PIT to address any item that requires further analysis for improvement. Approaches that have been initiated based on feedback from the workforce engagement survey includes: Healthy Rounding, The Organizational Learning Committee (OLC), SHEILA, SHEL.E, and the Workforce Training Matrix.

SCRHD's foundation is based upon the Mission which highlights two very important subjects: customers and workforce. Two Key Result Areas encompass these important subjects: KRA 2 and KRA 5 and align with key organizational results found within KRA 7. SCRHD has delegated the performance indicators found within each of these KRAs as Global Performance Indicators (GPIs). The success of each of these indicators is critical in order to uphold the organizational mission and strive to achieve the vision of being a leader in providing public health services. These GPIs are key essential elements for pursuing improvements in the health outcomes of the Sullivan County community.

c. Workforce and Leader Development

(1) SCRHD has begun a new focus on the learning and development system within the organization. Feedback from the workforce engagement survey revealed that employees wish to receive access to a greater number of learning and training opportunities to enhance workforce knowledge and capabilities. SCRHD utilizes various techniques to allow employees the opportunity to learn about organizational structure, activities, and undertakings through the SPP and performance improvement methodology. Staff members are invited to participate in the yearly strategic planning retreat each QR, and have direct involvement in the development of action plans when analyzing their respective DPIs. It is during the strategic planning process that the core competencies of SCRHD are evaluated and a SWOT analysis is conducted to assess for strategic challenges and advantages. Employees are also an integral part in the development and deployment of PITs which are used as a method to enhance services that have a direct impact on patient and employee satisfaction while managing for innovation.

In 2009, SCRHD developed new employee evaluation templates that allowed for the assessment of learning and development needs as identified by the employee. At a predetermined time during the year, supervisors will complete an evaluation on each of their staff members. Supervisors have been instructed to review the results of the evaluation with the staff member and highlight the opportunity for that employee to review the evaluation on their own and identify at least three professional goals they hope to achieve before the next evaluation cycle. The supervisor is also given the opportunity to provide encouragement to that staff member by identifying their potential for leadership or professional

development through various trainings. Once this has been completed the evaluation will be returned to the supervisor for final review and submission to human resource personnel. The ability for employees to set individual goals that are acknowledged by direct supervisors and upper level management assesses workforce engagement and organizational morale. This focus increases the potential opportunities for organizational and personal learning to strengthen workforce motivation and provide excellence to those that are being served.

Ethical health care and ethical business practices are two of several organizational learning opportunities that are reviewed during each employee evaluation and begins during new hire orientation process. (Figure 5.2-2) The Sullivan County government has developed an ethics policy that must be reviewed and authorized by all new county hires and on a yearly basis there after. Ethics training can also be provided by the County Director of Human Resources. New executive regulations have allowed SCRHD to be proactive in assuring the occurrence of ethical practices within the clinical setting. As required by law, any new employee who will have direct contact with patients within the organization must have a complete background check prior to hire. A final approach that SCRHD uses to monitor and ensure ethical business practices and procedures is through regular monitoring of clinical and non-clinical activities by management team members and internal as well as external audits by quality improvement administrators throughout the county, state and federal government.

Figure 5.2-2 Workforce Learning

Staff Status	Learning
New Hire	Safety & OSHA Title VI Phone System Fit Testing *(as applicable)* NIMS MSDS Job Specific Training Employee Handbook Policy and Procedure manual Departmental Education
Employee (County/State)	Safety & OSHA updates NIMS Tennessee Consortium Ethics in Government State Supervisor Training Emory University Training TNCPE Sharing Days TNCPE Board of Examiners Work Related Conferences
Employee (State)	Sexual harassment Title VI Supervisor Training

As discussed in Item 4.2, the OLC has been tasked with improving the approach with which the workforce can enhance their professional capabilities through learning and development programs. With the development of a systematic approach for this endeavor, a gap analysis will be conducted to identify the probability that an opportunity has not or will not be missed where a workforce member may wish to become further trained in a particular area and ensure the functionality of the process.

The reinforcement of new knowledge and skills on the job as well as the transfer of knowledge from departing or retiring workforce members, is something that SCRHD goes to great lengths to achieve in order to minimize the impact on work processes, customer service and expectations. A large percentage of workforce members have been cross-trained within their department to continue to provide public health services to the community in the event someone is unable to perform those duties. There are many instances where workforce members are called to work within an entirely different site location based on staffing levels at any particular time. It is due to the significance that the MT and other leaders have placed on the concept of cross-training that when a workforce member retires or departs for any reason, the flexibility and development skills of SCHRD employees become even more evident. Multiple approaches are used to strengthen new knowledge and skills including preceptor and mentoring of each new hire; the attendance of state program meetings where pertinent, job related information is transferred; and the effective utilization of the Thumbs Up and Rays of Sunshine programs enhance workforce engagement and individual self-confidence.

With each piece of the learning and development system, integration with the organization's strategic direction and mission is essential. Responding to the public health needs and improving health status while maintaining a highly motivated and well-trained workforce cannot be achieved without a thorough focus on the needs and expectations of not only the patient's that are served but the stakeholders who support the vision of SCRHD.

(2) The effectiveness and efficiency of SCRHD's learning and development system can be evaluated multiple ways. One way is through the annual evaluation that is provided to each employee by their direct supervisor. It is the supervisor's responsibility to review with his or her employee the individual goals that he or she had set, his or her ability to accomplish those goals or the barriers which he or she confronted that prevented him or her from doing so. The workforce engagement survey and customer satisfaction survey are also good methods to measure SCRHD's deployment of learning and development opportunities. A final approach by which evaluation concerning learning and development can be assessed is through the systematic review of performance measures. Departmental meetings, QR meetings and the annual retreat provide occasions with which GPI and DPI measurements are reviewed and assessed for needed improvement. An underperforming measure could be the result of a lack in training or the proper development of those performing the work assignment.

(3) Effective career progression begins with the practice of workforce cross training to provide coverage throughout the many and varied programs delivered within SCRHD. Cross training allows for immediate short term workforce capability and maximizes workforce resources during shortage periods. It also facilitates growth and knowledge in various areas with diversified experience in the resident workforce allowing many position vacancies to be filled internally. This decreases training time and requirements when the need arises. SCRHD

promotes continued education among employees, thus enabling career opportunities within its workforce. Examples include SEPHLI training for a number of staff members, Performance Excellence promotion and examiner development and continuing medical and nursing education programs. As members are recognized for their leadership capabilities, many are groomed to first fill in leadership and management positions, and then as openings arise, allowed to apply for those positions which are usually filled from within the organization. The workforce training matrix also allows for the recognition of, along with the training needs required for continuing workforce development, career progression and succession.

SCRHD also partners with many educational institutions, including ETSU College of Medicine, Public Health, and Nursing; Milligan College of Nursing; and King College of Nursing at the undergraduate, graduate, and advanced post graduate levels. An example of fruit borne from this initiative allowed our Lead Program vacancy to be filled by a public health graduate of ETSU who completed her internship here. Another successful example is the progression of our resident epidemiologist who advanced from a Public Health Representative in Communicable Disease to Health Council Coordinator, to Regional Epidemiologist and continues to work on the completion of her Master's degree. A number of Family Practice residents who have trained under the medical director have sought out occupations in the local public health arena, thus enlarging the area pool of physicians with Public Health expertise. LifePath, a new and exciting training opportunity is now becoming available for SCRHD employees from ETSU College of Public Health. LifePath would allow employees' access to informal continuing education, formal course work, degree opportunities, and supplemental funding, all while allowing continued baseline employment and income.

Senior leadership succession requires both short term and long term planning to allow for continuity of leadership in the event of absences or vacancies. Cross training remains a mainstay for the short term absences to cover daily functions and operations. Long term absences or vacancies would require an external search to fulfill the unique skills required for the organization. Succession Planning Examples for Senior Leadership is as follows:

1. The Regional Accountant: the Insurance Billing Specialist would see all billings are completed; the Administrative Assistant has been cross trained in facilitating payroll completion. The Regional Director or Director of Operations would oversee invoice management. The County Accountant would also fill in short term as she has held this position in the past. The county Human Resources director would oversee new hire and personnel issues. In the long term, an external search would be under taken to ultimately fill this position

2. The Director of Operations position was created and designed with continuity of daily operations in mind for potential absences of the Regional Director.

3. The Medical Director has cross coverage arrangements for short term absences with the Medical Director in the Northeast Regional Health Office (NERO). In the event of an emergency outbreak or call up of the PHIT team, SCRHD has arranged for the Infectious Disease Director of a local hospital system to provide urgent coverage. A long term absence or vacancy would necessitate coverage with the Chief Medical Officer at TDH, in conjunction with NERO, while a physician search was conducted. A detailed schematic of SCRHD's succession plan for all management and leadership positions will be available at site visit.

Category 6: Operations Focus

6.1 Work Systems

a. Work System Design

(1) Work system design at SCRHD is based upon two components: the four core competencies and the seven KRAs (Figure 1.1-1). Both of these components are derived from the ten essential public health services (Figure 6.1-1) as identified by the Centers for Disease Control and Prevention (CDC) and the Malcolm Baldrige Business Model. Monthly departmental and manager meetings, QR, Healthy Rounding, PITs, and feedback from surveys allow SCRHD to manage for innovation within the various work system designs. For example, during the 2009 H1N1 pandemic response SCRHD relied on various suppliers, partners, and collaborators to deliver vaccine and provide community education. The work system designed for this response required the collaboration with the TN Department of Health, private physicians, community and educational organizations, and intra/inter-state partnerships to produce and deliver health care services and business and support processes. Each segment of this system encompassed the three core elements of Assessment, Policy Development, and Assurance within the ten essential public health services which allowed for seamless integration into the mission of SCRHD. SCRHD is able to capitalize on the core competencies due to their alignment with the ten essential public health services and the seven KRAs. This alignment will enhance SCRHD's ability to effectively respond to the public health needs of the community.

Figure 6.1-1 Ten Essential Public Health Services

Decisions on which processes at SCRHD will be delivered internally versus externally are determined at the level of the administrative staff with input from managers and program directors. In determining if a process will be delivered internally, the administrative staff considers budget constraints, employee expertise, and alignment of the process with the MVV of SCRHD. With resolution and compatibility in these three areas, the process will remain internal. If compatibility within these areas is not determined the process within that particular work system may be delegated to an external resource. For example, because the expertise to conduct and compare customer and workforce satisfaction could not be completed internally, these key work processes were designated to be managed externally. Other methods that are used to evaluate internal versus external resources are the yearly SWOT analysis conducted during the strategic planning retreat and the PDCA performance improvement cycle which is used to continuously innovate work systems and execute core competencies. (Figure 6.1-2)

Figure 6.1-2 PDCA Model

Step	Process
Plan	Root cause(s) is identified and a plan for the change is developed.
Do	Implement the change(s) on a small scale.
Check	Check to see if the desired results are obtained.
Act	If the change(s) is successful, a larger scale implement of the process is enacted. If the change(s) is not successful, another plan of action is created and ran through the PDCA cycle.

(2) Key work system requirements are primarily determined at the administrative and managerial level with input from various stakeholders and alignment with SCRHD's core competencies of Education, Prevention, Workforce and Community Need as well as the MVV. As previously stated with evaluating work system design concepts, work system requirements are also evaluated through a resource gap analysis by administrative staff with input from departmental managers who work directly with that particular work system. Other items used to determine work system requirements include the feedback provided to SCRHD through the annual customer satisfaction survey, workforce engagement survey along with Healthy Rounding, and the newly deployed partner/stakeholder survey. These surveys are distributed to clients receiving SCRHD services, all employees of SCRHD, and an extensive list of government, state, local, and community partners or stakeholders who collaborate with SCRHD. It is the expectation that each of these methods will assist in analyzing the extent to which work system requirements are being met and maintained. Also, in what respect could the requirements be inadequate or lacking. For example, when developing the concept for an organizational management and learning system, known as SHEILA, administration determined that SCRHD was in need of someone with expertise in webpage design and management. When conducting the hiring process for a second Information Technology employee, administration had previously identified the need for this requirement in order to effectively address workforce capability and development.

b. Work System Management

(1) SCRHD's work systems are structured around the organization's core competencies and KRAs which are based upon the Ten Essential Public Health Services. (Figure 6.1-3) These key work systems are managed and improved utilizing the PDCA continuous assessment and improvement model. (Figure 6.1-2) Administration, MT and staff members compile data and feedback from stakeholders through deployed approaches in order to establish where improvements are needed. Improvement may be established either globally or as a pilot study. Performance Improvement Teams comprised of designated MT and staff members monitor and apply the PDCA model from beginning of the process and throughout the continuous assessment and implementation of the plan. SCRHD incorporates the PDCA model to facilitate an environment of constant assessment, evaluation, and improvement to meet the needs and exceed the expectations of the customers, suppliers, partners and stakeholders. The impact of SCRHD's delivery of healthcare services through efficient operating work systems enhance the contributions made to the well-being of the environmental, social, and economic systems of Sullivan County and are a direct reflection on the sustainability of SCRHD.

(2) SCRHD has established a performance environment indoctrinated with the understanding of cost control, efficiency, and excellence for patients and stakeholders. A recent National Profile of Local Health Departments survey conducted by the National Association of County and City Health Officials (NACCHO) revealed that 44% of those surveyed stated that their current budget is less then the previous year and 50% stated that the next year will be less then the current year. The same study showed that 47% have had a loss of staff either through layoffs or attrition and 42% have had to make cuts to at least one program. SCRHD has not been exempt from the financial difficulties that have been endured by many. Cost control is monitored and achieved by budgetary review at each monthly manager's meeting as well as constant review by administrative staff and program managers. Accounting and administrative staff maintain an open and continuous dialogue with program managers and staff concerning cost control needs and successes.

SCRHD staff maintains a proven track record of safety above national benchmark standards in providing patient care and procedures. Nursing staff are trained and provided facility orientation for six weeks after which a post test is administered before they are open to practice without a mentor. Patient care policy and safety issues are discussed bi-weekly in clinical services staff meetings. Changes in protocol and medical policy are reviewed by QI, Protocol Committee, and the Medical Director prior to implementation in the facility. Clinical Services Coordinators perform duties to consistently monitor safety issues in clinical areas. Any medication errors or safety breaches are reported immediately with supported documentation via the SCRHD incident report form. This report is submitted to the Director of Operations and reviewed by the Director, Medical Director, and the Safety Committee on an ongoing basis.

Figure 6.1-3 Work System Structure

Public Health Essential Service	Description	Core Competency Alignment	SCRHD Work System
Monitor Health	Monitor health status to identify community health problems	Prevention, Community Need	• Epidemiologic Surveillance • Community Health Assessment • Community Health Screenings
Diagnose and Investigate	Diagnose and investigate health problems and health hazards in the community	Prevention, Community Need	• Epidemiologic Surveillance • Disease Outbreak Investigation
Inform, Educate, and Empower	Inform, educate and empower people in regards to health issues	Education, Community Need	• Community education outreach • In-clinic education
Mobilize Community Partnerships	Mobilize community partnerships to identify and solve health problems	Education, Community Need	• Sullivan County Health Council • Working with community boards
Develop Policies	Develop policies and plans that support individual and community health efforts	Education, Prevention, Community Need	• Working with local and state politicians • Developing in-house public health policies for practice
Enforce Laws	Enforce laws and regulations that protect health and ensure safety	Education, Prevention, Community Need	• Working with local and state enforcement agencies
Link to and/or Provide Care	Link people to needed personal health services and assure the provision of health care when otherwise unavailable	Prevention, Community Need	• In-house clinical services • Referral services
Assure Competent Workforce	Assure a competent public health and personal healthcare workforce	Education, Prevention, Community Need, Workforce	• Staff training • Community training • LifePath • SHEILA/SHEL.E
Evaluate	Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Education, Prevention, Community Need, Workforce	• Epidemiologic studies • Quarterly Review • Strategic Planning Retreat • PHAB
Research	Research for new insights and innovative solutions to health problems	Education, Prevention, Community Need	• Assisting local universities • Data collection for community agencies, TDOH, and CDC

c. Emergency Readiness

A disaster preparedness and an Emergency Operations Plan (EOP) are part of SCRHD's policy and procedures manual that each employee has ready access and is part of their new employee orientation as discussed in item 5.2c. These policies address: threats of personal harm ("Mr. Anderson"), bomb, fire, severe storm procedures, mail incident plan, and the bioterrorism emergency response team preparedness procedure guidelines. Periodic unannounced fire drills are performed throughout the year and are supervised by the QI director. "Dr. Strong" is used for medical emergency response.

Emergency preparedness and readiness has become a vital operation for SCRHD. Emergency preparedness within the organization also includes the computer redundancy, computer email with double redundancy, PTBMIS backup through the state system and developing our SAN system for back up of all essential data documents, email as discussed in Item 4.2a(1). Communication methods during an emergency include an 800 megahertz communication system, manager cell phones, and ham radio.

Each member of SCRHD has been required to take courses in the National Incident Management System (NIMS) Figure 6.1-4, as required by CDC and state guidelines. After completion of the NIMS course work, a certificate of completion is provided to the Emergency Preparedness (EP) staff as evidence of completion. The EP staff tracks the percentage of completion for each category of NIMS (Figure 7.1-14).

Figure 6.1-4 NIMS Personnel Training Requirements

NIMS Training	Requirements
ICS-100	▪ Entry Level First Responders and Disaster Workers ▪ First Line Supervisors ▪ Middle and Upper Management
ICS-200	▪ First Line Supervisors ▪ Middle and Upper Management
ICS-300	▪ Middle and Upper Management
FEMA IS-700	▪ Entry Level First Responders and Disaster Workers ▪ First Line Supervisors ▪ Middle and Upper Management
FEMA IS-800	▪ Middle and Upper Management

Externally, SCRHD expects to respond to disasters and other ESF-8 functions as designated in SCRHD's Emergency Operations Plan. Emergency preparedness has included pandemic flu planning, smallpox, mass clinic vaccinations, dispensing of the ChemPack, and pre-deployment for large events such as the Bristol Motor Speedway races. SCRHD was the first in the nation to forward deploy ChemPacks and conduct exercises for Strategic National Stockpile (SNS) for medications with practicing joint exercises with the entire community to include hospitals, EMS, hazmat, and leadership personal within county. SCRHD's Public Health Investigation Team (PHIT) composed of a physician, epidemiologist, CD

Director, and CD Nurse, trains yearly to respond to urgent infectious diseases and outbreak instances.

6.2 Work Processes

a. Work Process Design

(1) The design and innovation of SCRHD's work processes is similar to the design used to develop the organization's work systems. (Item 6.1a (1)) Due to SCRHD's organizational structure and size ensuring alignment within these two operational designs presents the opportunity for agility and continuous operational improvement. Although input is garnered from the MT pertaining to work system design; MT expertise is essential in the development of key work processes due to their knowledge of process functionality. The initiation of PITs allows the incorporation of new technology, evidence-based medicine, and organizational knowledge. The PITs are developed based on the expertise needed for that process improvement and will include key MT members as well as front line staff.

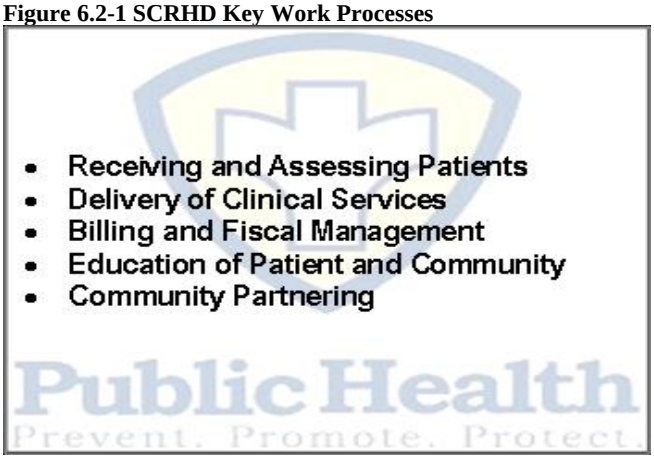
Examples for the incorporation of new technology into key work processes include: the addition of WIC kiosks in both the Blountville and Kingsport clinics, creation of the Communication Center, implementation of a new phone system, and the addition of a generator in Kingsport for the assurance of vaccine safety. Each of these new technologies came about as a result of customer feedback and PITs. The institution of these approaches has allowed SCRHD to manage for innovation by improving organizational products, services, and processes that create value for stakeholders.

Another area in which SCRHD has incorporated evidence-based medicine and health care service excellence is in the delivery of H1N1 and influenza vaccines within each of the school systems represented in Sullivan County. Input into the delivery of this type of service was received from various partners throughout the state, across state lines, and the CDC. By immunizing children in the school setting immunization rates increased and service delivery was more accommodating for those families that were unable to attend clinics elsewhere. Cost control was ensured for this process by developing an immunization team composed of current staff, as opposed to contracting with outside agencies. Cycle time, productivity, and cost control are fundamental components in the development of any organizational process or action plan produced by a PIT for process and performance improvement.

(2) SCRHD utilizes the strategic planning process to determine key work process requirements. Input from customers, stakeholders, and employees guides administration in determining needs within the organization. The SPP and process requirements are directly aligned with MVV and the core competencies of SCRHD.

Key work processes within SCRHD are identified and delineated by the Ten Essential Public Health Services, Administration, and MT. (Figure 6.2-1) Key process requirements mirror key requirements of work systems. However, the key requirements for the work processes, which are outlined in Figure 6.2-1, are directly aligned with key customer and stakeholder requirements (Figure P.1-4). SCRHD customers and stakeholders expect safe, effective, efficient, and timely services. These same characteristics are requirements for the operation of key work processes within SCRHD.

Figure 6.2-1 SCRHD Key Work Processes

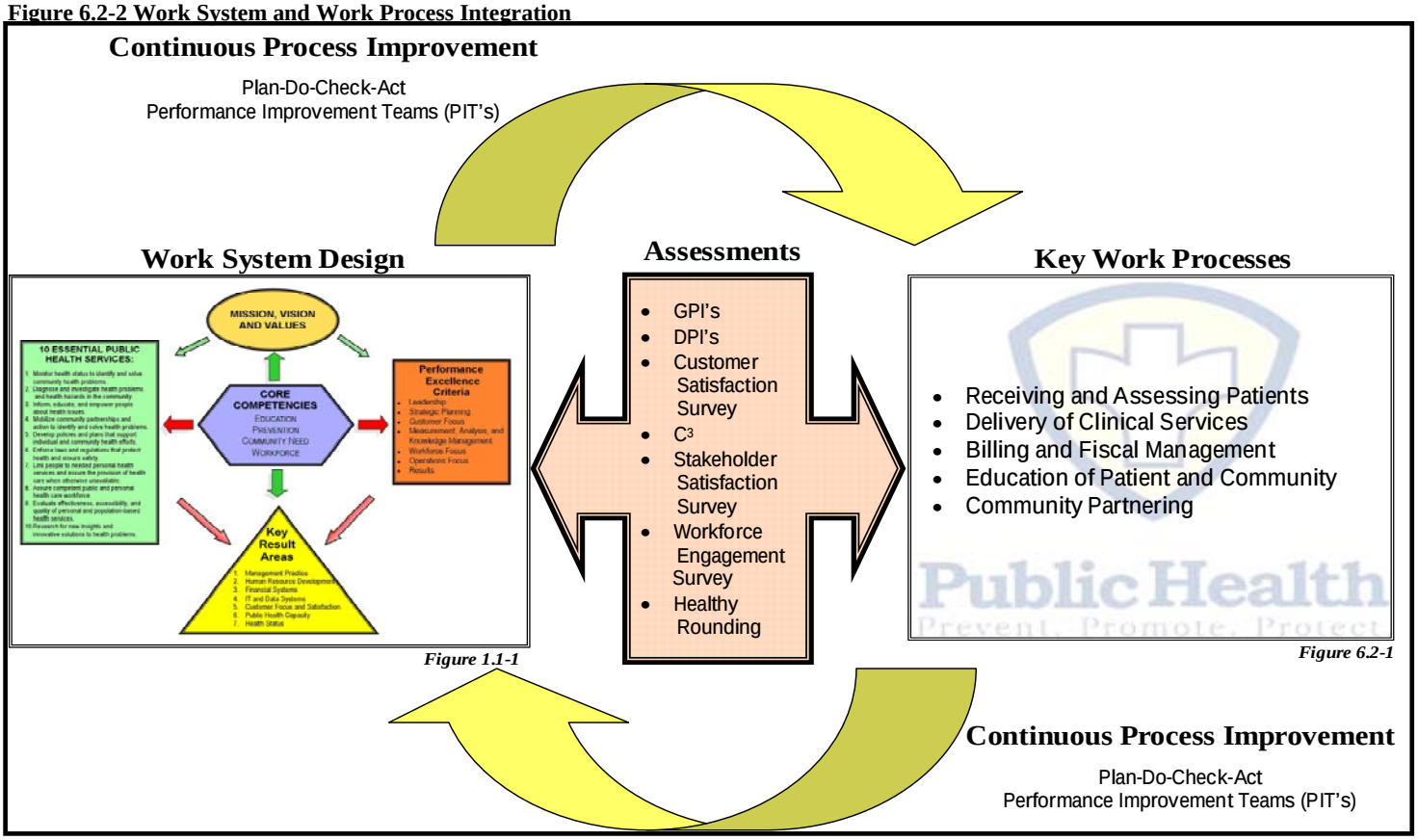


b. Work Process Management

(1) The key work processes within SCRHD are directly linked with work systems through the various assessment methods, continuous process improvement, alignment with the MVV, and core competencies. (Figure 6.2-2) The daily operations of SCRHD allows the opportunity for feedback from customers and stakeholders through the use of the C^3 program, internal monitoring, managerial oversight by MT members, and systematic measurement of satisfaction of customers, stakeholders, and employees. SCRHD's key performance measures for the improvement of work processes include: GPIs, DPIs, Annual Customer, Stakeholder and Employee Satisfaction Surveys, C^3, and Healthy Rounding. The Baldrige Framework has been instrumental in allowing SCRHD to progress from an organization that was reacting to problems to one that now has integrated approaches to improve work processes and achieve better performance. The control of work processes are assured through the use of internal and external audits and recommendations by the Safety Committee.

(2) A key element to addressing each patient's expectations is listening. Voice of the Customer data and feedback are integral in managing and addressing the expectations of customers and the community. The annual customer satisfaction survey and real-time methods such as C^3 and the online survey available at www.sullivanhealth.org provide opportunities for SCRHD to monitor the needs and expectations of customers. The stakeholder satisfaction survey is another method that is used to evaluate SCRHD's effectiveness in meeting the needs and expectations of customers that are referred to SCRHD from other community organizations. Outcomes related to setting realistic patient expectations are addressed when utilizing the PDCA model and its applications to all processes and work systems. Meeting the expectations of the patients and other stakeholders seeking services at SCRHD is the cornerstone of the stated MVV.

Figure 6.2-2 Work System and Work Process Integration



Patient decision making and patient preference are key elements when engaging in the process of scheduling and assessing patients who request SCRHD services. Each encounter with someone who is seeking services at SCRHD is met with a concerted effort to gain knowledge of what the client needs. This requires a wealth of knowledge on the services that are provided at SCRHD as well as keen sense of empathy on the part of the employee assisting the patient. The achievement of factoring a patient's preferences into his or her visit with SCRHD requires listening and subjectively gathering the needs of the patient before objectively considering any physical or medical assessments. This practice is a fundamental element of providing great public health services.

(3) Because SCRHD is a government run entity, the purchasing and supply chain management process functions quite different then a privately owned business. The supply-chain structure utilizes the Sullivan County Purchasing Department to perform estimating, purchase orders, requisitions, and bid procurement services. For example, on supplies that are frequently ordered, the Sullivan County Purchasing Department will bid out those products to various companies in search of the lowest cost to alleviate financial stress where possible. The prequalification of suppliers is accomplished through the Purchasing Department. In the event that suppliers are unable to meet the standards agreed to by SCRHD and the Purchasing Department, a new supplier would be instituted and the previous would not be considered for future purchases. SCRHD operates in another interesting position in regards to supply-chain management specifically for those products that are supplied through state grants or contracts. Much of the funding provided to programs offered at SCRHD is done so through federal or state grants. Developed within these grants are contracts for various products through predetermined providers. SCRHD has very little control over the supply-chain management of these supplier contracts. Issues related to program/grant/contract suppliers are addressed via program contacts or directors at the state level with the TDH or CDC.

(4) Consistent and systematic use of the PDCA process enables SCRHD to ensure that work processes meet design requirements and align with work systems. The PDCA process is used in various formats but is specifically used by SCRHD among members of a selected PIT. (Figure 6.2-3)

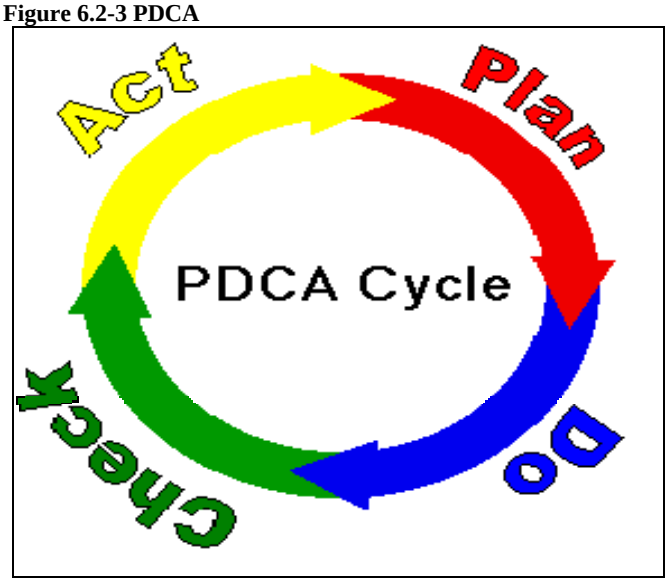
The first step is the PLAN phase, in which the problem is identified, the importance clarified, cause identified (using root cause or other tool), gap analysis performed, and a remedy proposed. Project objectives, pilot or implementation dates, cycle number, and baseline data are documented.

In the second step, DO, a remedy or plan is proposed and usually implemented in a pilot format, with active problem solving and learning during the initial time period. Rapid cycle turnaround is encouraged, so as not to over-exert the team over a long time period. Changes or modifications that may be required are documented using the "who, what, when, and how" format.

In the third step, CHECK, effectiveness of the pilot program is performed. At this time, hurdles in the implementation process, knowledge gained, process revisions, and measures with gap closure are reviewed. Data is gathered and reviewed to see if the desired objectives have been reached.

Finally, ACT incorporates expanding and embedding the new process into the staff culture, monitoring to ensure "holding the gains," and organizational learning feeding back into the planning cycle once again.

Figure 6.2-3 PDCA



The need for continuous improvement in work processes is assessed by customer, stakeholder, and employee feedback, as well as performance data derived from real time client input and GPI/DPI performance management. Providing thorough training, as well as cross-training, to all workforce members and ensuring a consistency in operational flow and clinic layout reduces the likelihood of variability within work processes among each site location. These activities are well rooted in SCRHD's endeavor to be a national model and leader in providing public health services and maintaining the mission to improve public health status of Sullivan County citizens through education and service with a highly motivated and well trained workforce.

Category 7: Results

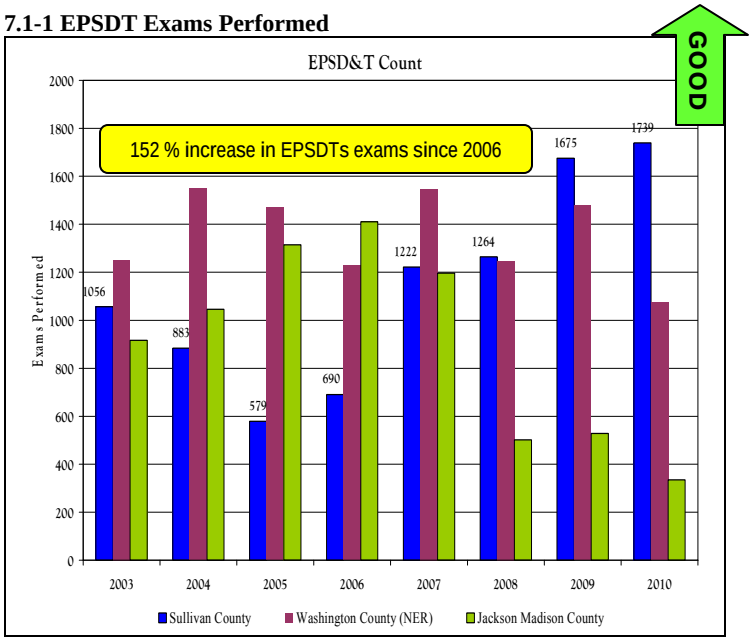
7.1 Health Care and Process Outcomes

a. Patient-Focused Health Care Results

SCRHD has identified several key measures that are indicators of health care outcomes and process performance which are important to and directly serve patients and stakeholders. Each of these measures provides a focus on how SCRHD is creating value for the community and improving the health status of Sullivan County citizens. Many of the measures displayed below are GPIs and are strategically important to the success of SCRHD and the fulfillment of the stated Mission of the organization.

Early Periodic Screening, Diagnosis and Treatment, or EPSDT, is a program of checkups and health care services for children from birth until age 21 to detect and treat health problems. EPSDT checkups are FREE for all children who have TennCare. In Tennessee, the EPSDT program covered by TennCare is called TENNderCare. EPSDTs were determined by the TDH to be a high priority area due to their importance in assuring immunizations, assessing for developmental delays and abnormal physical conditions.

7.1-1 EPSDT Exams Performed

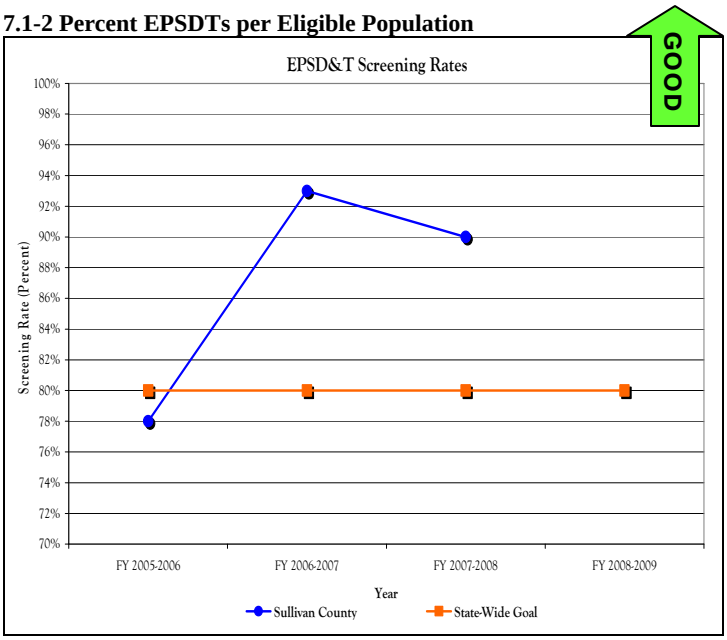


The two comparative counties displayed in Figure 7.1-1 most closely resemble Sullivan County demographically. It is important to note that EPSDT exams may also be provided by the private sector. The data represented in Figure 7.1-1 only includes exams that have been provided by SCRHD and the local health departments within the comparison counties. SCRHD has outperformed the comparison counties since 2008 due to the success of one of the first PITs as detailed in Item 4.1a(1).

Figure 7.1-2 provides a better representation of how Sullivan County performs in comparison to the rest of the state of Tennessee.

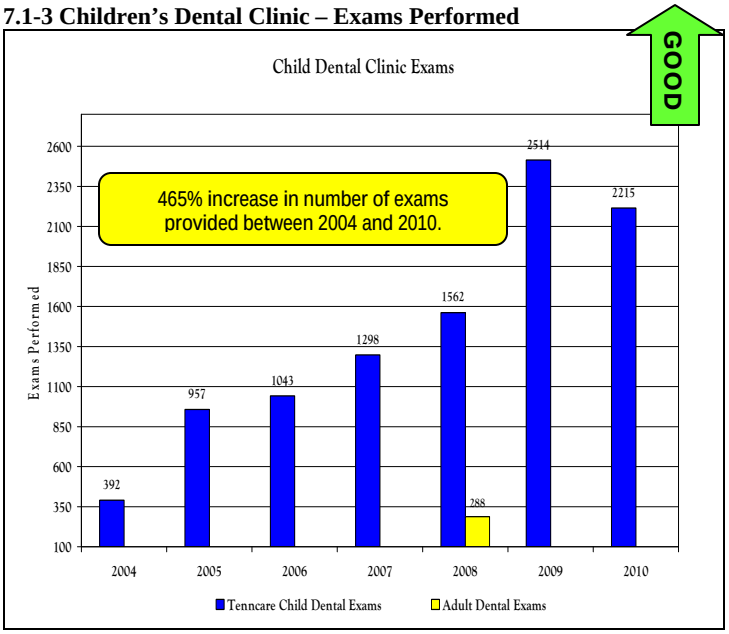
The percent of EPSDTs administered per eligible population displays a more meaningful assessment of how Sullivan compares to the state average as opposed to if one were reviewing crude numbers of exams performed. Percent eligibility data for FY 2008/2009 and FY 2009/2010 has not been released by the state for review.

7.1-2 Percent EPSDTs per Eligible Population



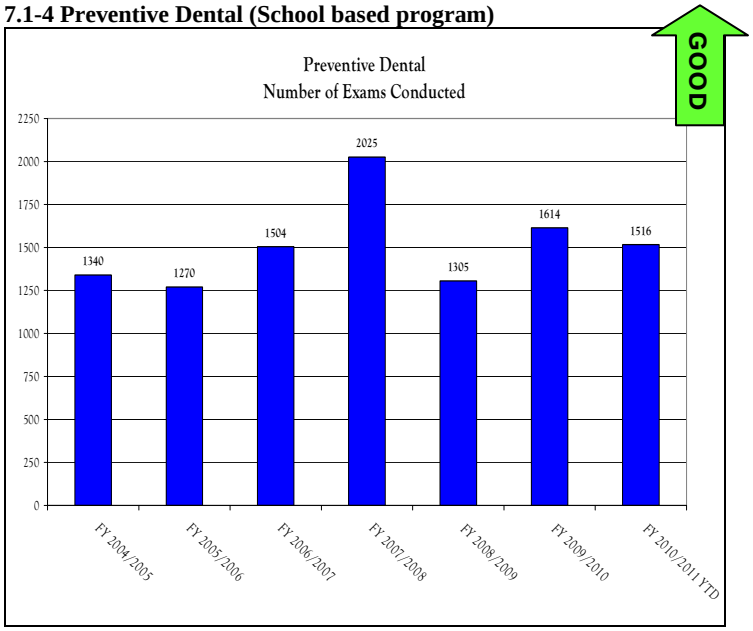
Oral disease is recognized as one of Tennessee's leading health issues. Sullivan County ranks among the top in emergency department visits for dental needs. The results of this graph demonstrate SCRHD's improvements for the children in Sullivan County. Community awareness, internal referrals, and high customer satisfaction scores have contributed to these results and the success of the children's dental clinic in Sullivan County. In 2008, SCRHD received a small amount of grant money to provide dental services to adults. This service met a great need and demand. The grant allocations for this service were quickly depleted and have not been made available since 2008.

7.1-3 Children's Dental Clinic – Exams Performed



The School Based Dental Prevention Program is a statewide, school based preventive dental program targeting children in grades kindergarten through eighth in schools with 50% or more free and reduced lunch. Portable equipment is used by dental staff to provide dental screenings, referrals, and follow-up to dental providers to address unmet dental needs in this population. Health education and preventive sealants are provided to the target school population, as well as information regarding TennCare eligibility and the application process. Because oral health is a recognized concern in Sullivan County; the Preventive Dental program is systematically integrated into the MVV of SCRHD. The overarching goal for this program is to provide better dental care at a younger age, so that long term dental needs are mitigated and Sullivan County's oral health reflects positive improvement.

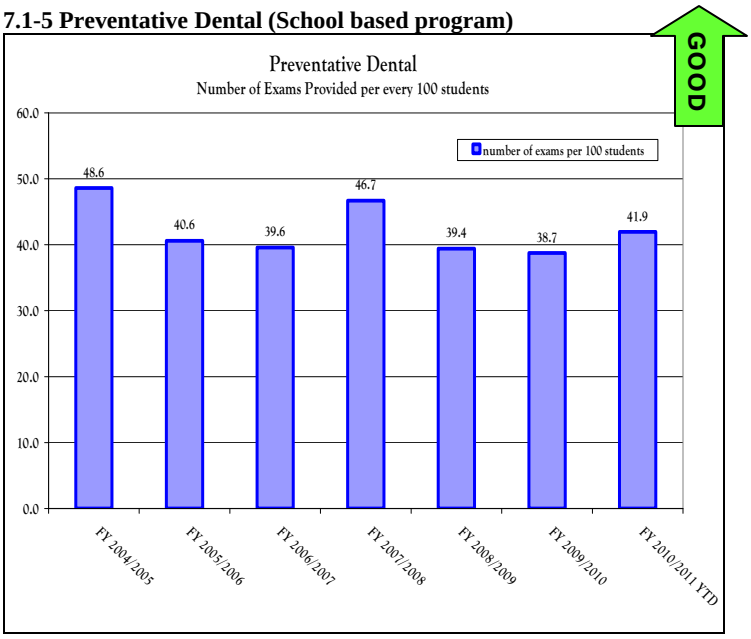
7.1-4 Preventive Dental (School based program)



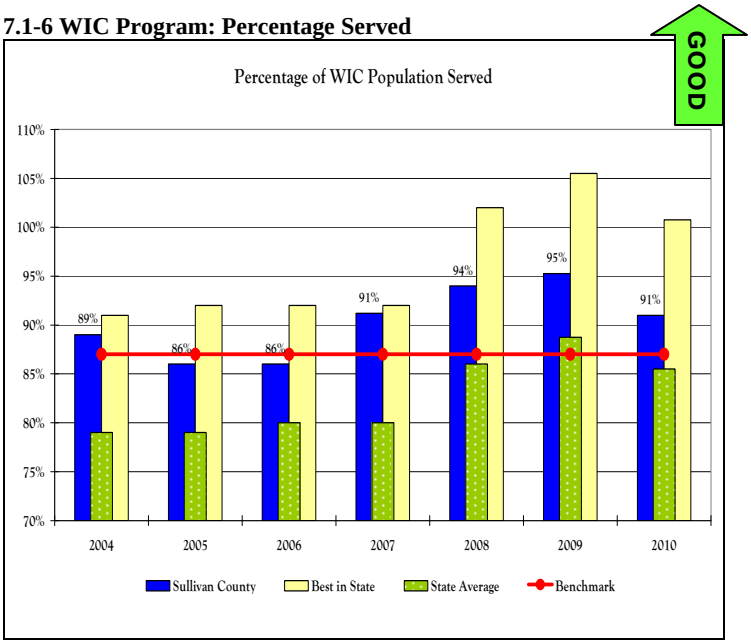
The fiscal year for the Preventative Dental program mirrors the school year for the three school systems served. Figure 7.1-4 reflects the number of exams conducted during each fiscal year. This graph also reflects the variety in eligible populations between the schools that are selected for visits that fiscal year. Figure 7.1-5 has been developed to illustrate a more meaningful analysis of the success of the program within the three school systems served in Sullivan County, where nearly one out of every two students has received a dental exam.

WIC is a vital program for mothers and children in Sullivan County. Research has demonstrated that at-risk women and children who participate in WIC have better health outcomes than those who do not participate in the program. The success of WIC is dependent upon community outreach to those at-risk groups that are eligible for the program. Recent economic decline has placed more responsibility on SCRHD to improve performance within this program. Figure 7.1-6 provides a snapshot to determine how well SCRHD is providing WIC services to the eligible population in Sullivan County. The denominator used to calculate this measure is based upon the year 2000 Census numbers and is adjusted for every ten years. Once the 2010 Census data is made available a more accurate determination for the present date can be analyzed.

7.1-5 Preventative Dental (School based program)



7.1-6 WIC Program: Percentage Served



Increasing childhood flu vaccination coverage (Figure 7.1-7) is important in preventing hospitalizations and deaths from influenza. Vaccination rates are a central measure in disease prevention utilizing the concept of herd immunity to protect the relatively smaller number that may be unable to receive the vaccine. In general, herd immunity rates have the greatest benefits after approaching 80 percent. The Flu Vaccine now has a universal vaccination recommendation from the CDC to prevent disease in all those desiring to decrease their risk for flu infection. Flu is particularly dangerous in the elderly, young children, and pregnant populations. Healthy People 2020 set an objective to increase the percentage of children that receive an annual influenza vaccine with a target of 80%. Sullivan County has continuously been number one in the state for the administration of flu vaccines to children and has achieved the goal established by Healthy People 2020.

7.1-7 Immunizations: Vaccine Coverage (24-Month Survey)

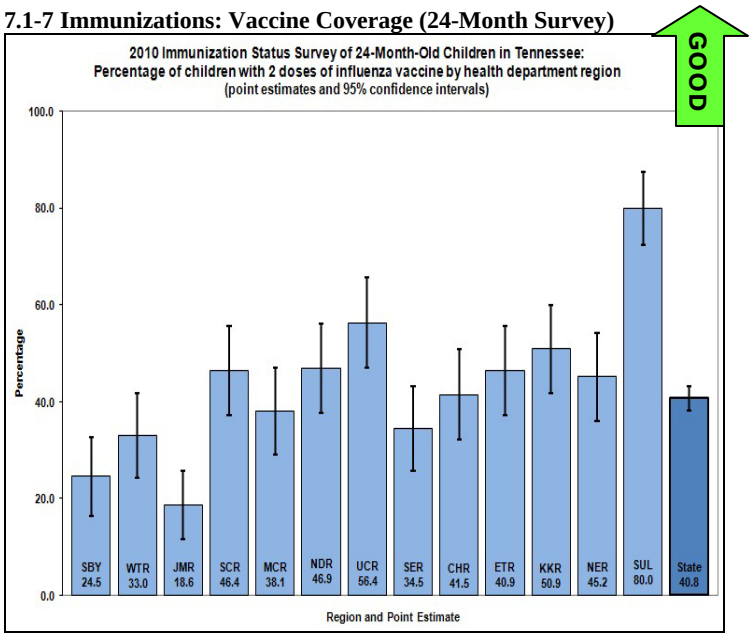
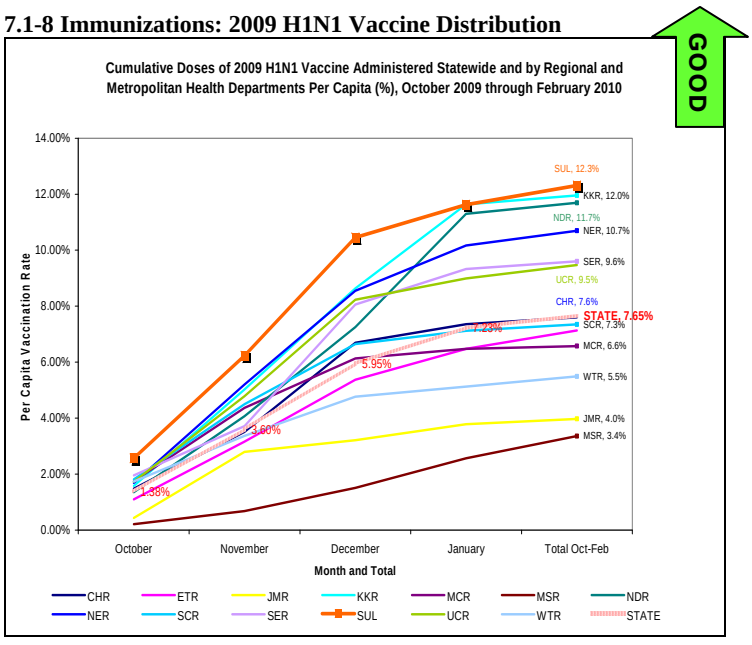


Figure 7.1-8 demonstrates SCRHD's highly efficient and systematic process that was used to deploy the 2009 H1N1 Influenza vaccine. With the aid of streamlined clinical processes, the Flu Call Center and a dedicated workforce that acknowledged the precedence of the task, SCRHD was number one in the state for administering the H1N1 vaccine throughout the entire season. Increasing the number of H1N1 vaccinations and providing continuous education to the community regarding H1N1, averted hospitalizations and deaths within Sullivan County. The use of the Tennessee Web Immunization System (TWIS) was also instituted during the 2009 H1N1 Vaccination Campaign (Item 3.2a (2)). TWIS remains a key knowledge management asset (Item 4.2a (1)) to SCRHD that allows greater access to patients' pertinent health information in order to better respond to their needs and fulfill the mission of SCRHD.

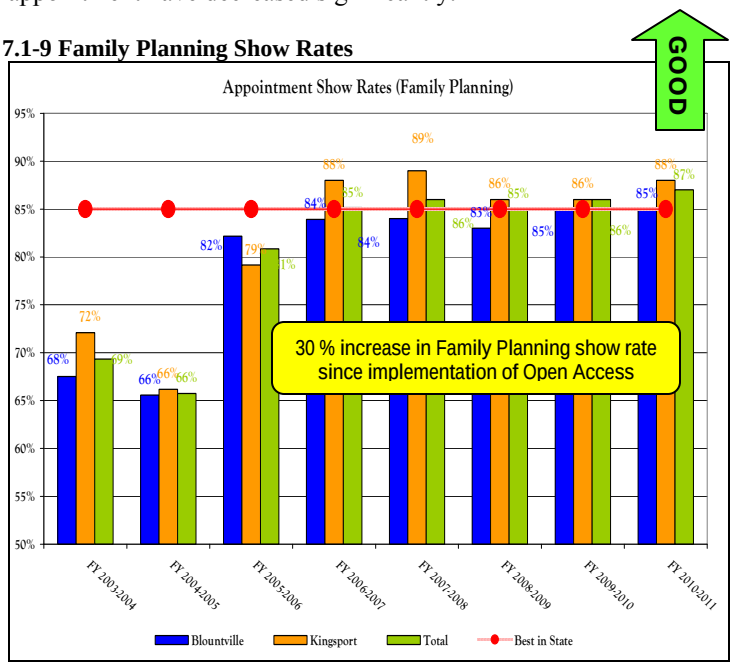
7.1-8 Immunizations: 2009 H1N1 Vaccine Distribution



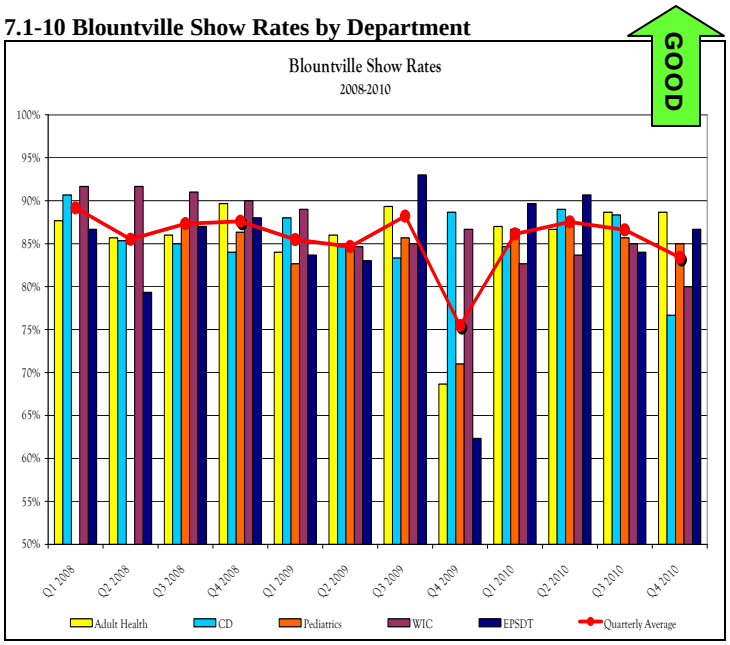
b. Operational Process Effectiveness Results

(1) Operational performance of SCRHD's key work systems and process (Figure 6.2-2) relies heavily on receiving and assessing patients in an efficient manner. In 2006, Open Access was initiated within the Family Planning clinic (Figure 7.1-9) to curtail the issue of decreasing show rates. In an effort to increase clinic efficiency and provide more services to a greater number of clients, SCRHD researched best practices, and, through process improvement, implemented a new program called Open Access Scheduling. This allows patients to call the same day for an immediate appointment or late in the day for an early morning appointment the following day. The Open Access method is now utilized for the scheduling of the majority of all clinics within SCRHD. Since the implementation of this new scheduling system, show rates have improved dramatically and problems with getting an appointment have decreased significantly.

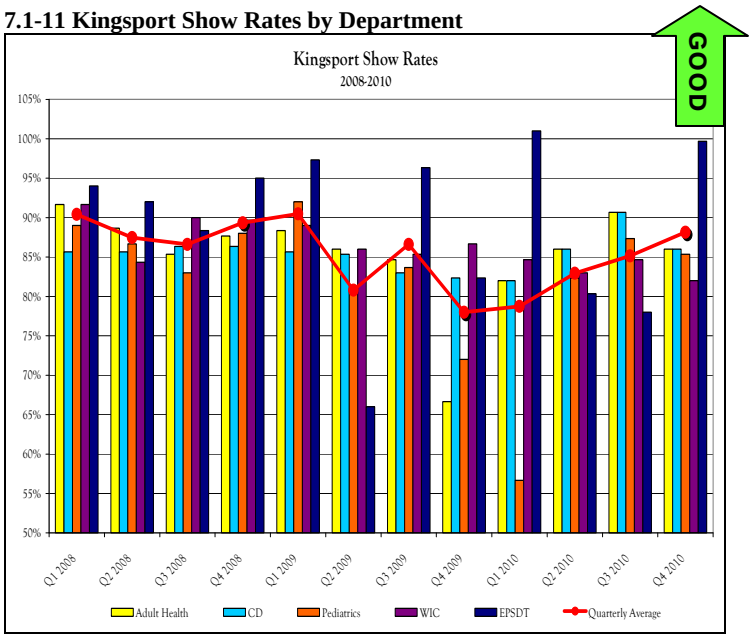
7.1-9 Family Planning Show Rates



7.1-10 Blountville Show Rates by Department

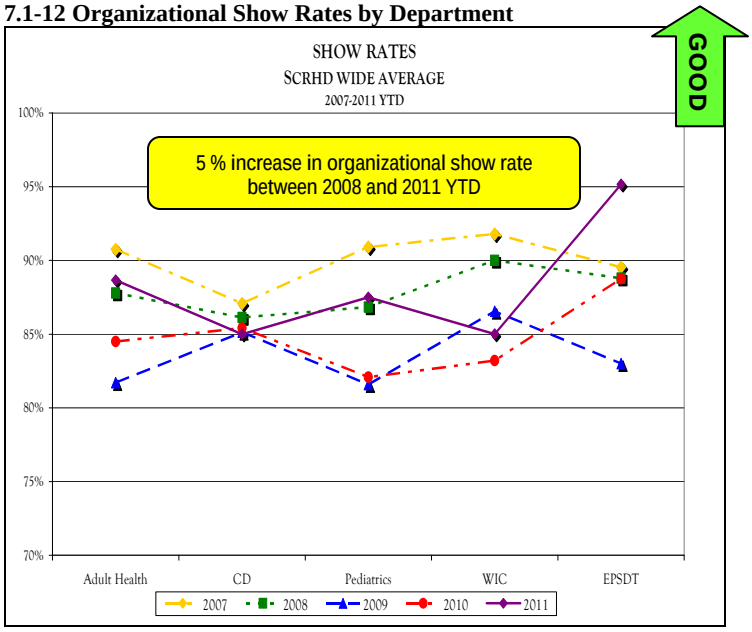


7.1-11 Kingsport Show Rates by Department



The institution of the new phone system in 2010 should also improve show rates within each site due to the patient's ability to schedule appointments, as well as cancel appointments (Figures 7.1-10 and 7.1-11). Another process improvement to increase show rates was the institution of appointment reminders for WIC clients.

7.1-12 Organizational Show Rates by Department



(2) Public health plays a critical role in emergency preparedness and response (Item 6.1c). All SCRHD staff must be trained in local response protocols and the National Incident Management System (NIMS). (Figure 7.1-14) Shortly after 9/11, public health focus shifted to Bioterrorism. Following Hurricane Katrina, Bioterrorism was expanded to include Disaster Preparedness. Presently, the Bioterrorism Program has now been renamed Public Health Emergency Preparedness and includes all Hazards Planning. With this growth has come increased responsibility in SCRHD's level of response to the community in fulfilling Public Health's role in the event of an emergency.

Figure 7.1-14 NIMS Training 2010/2011

NIMS Training Class	Personnel requiring training	Personnel completed training	Completion Percentage	TDH Goal
IS-100	116	104	90%	100%
IS-200	51	51	100%	100%
IS-300	18	15	83%	100%
IS-400	4	4	100%	100%
IS-700	116	104	90%	100%
IS-800	18	17	94%	100%

Emergency Preparedness personnel have moved away from the responsibility of only assessing command staff via call-in drill time (Figure 7.1-15) Program changes have prompted the development of a variety of response teams that include the PHIT, RHOC personnel, MT, Communicable Disease Staff, or general workforce. SCRHD utilizes the THAN for emergency notification and activation and test's the various subgroups on a systematic basis to ensure SCRHD's readiness in the event on an emergency. (Figure 7.1-16)

Figure 7.1-15 Simulated Response (Call-In Drill)

Criteria	2005 (n=17)	2007 (n=22)
Total drill minutes	120	120
Average response time to report for duty (in minutes)	27.1	24.3
Percent of command staff responding within drill period	100%	95%

Figure 7.1-16 Updated Simulated Response Results

Date	Group Called	Personnel Responding	Personnel Called	Percentage Successful
Nov-07	Hospitals	47	89	53%
May-09	BDS	9	9	100%
Sep-09	RHOC	9	18	50%
Feb-10	SNS	12	19	63%
Jun-10	BDS	7	9	78%
Nov-10	RHOC	9	19	47%
Nov-10	PHIT	6	6	100%
May-11	RHOC	11	18	61%
May-11	SNS	11	18	61%
Jul-11	RHOC	12	18	67%

c. Strategy Implementation Results

Formal strategic planning for SCRHD began in 2001. Since that time SCRHD has undergone significant changes in the process with which the strategic plan is evaluated, modified and deployed. Multiple strategies have been used to assess for the appropriate planning process that could benefit SCRHD. These strategies have included meetings with professionals whoe proficient in strategic planning and performance excellence principles, as well as numerous training opportunities, such as Pals' Business Excellence Institute, annual TNCPE Conference workshops, and the placement of nine SCRHD workforce members on the TNCPE Board of Examiners since 2007. Public Health functions much differently then private health care organizations.

Because of this, there is little guidance provided for public health organizations seeking to align their unique work processes with performance excellence principles. Because of the above listed opportunities, several years of instruction and guidance have been accumulated that have allowed SCRHD to have a systematic approach to the accomplishment of the organizational strategy and action planning process. Figure 7.1-17 demonstrates SCRHD's maturity within the SPP. Although there may be a multitude of objectives that an organization wishes to achieve, prioritization and streamlining are essential in accomplishment of strategically important action plans. From 2009 to the present year, SCRHD has not only restructured the SP, but has been able to "roll-off" several objectives that have become systematic processes within SCRHD. The present day strategic objectives are directly aligned with SCRHD's seven KRAs and the four core competencies of Education, Prevention, Community Need, and Workforce.

Figure 7.1-17 Cumulative Strategic Action Plan's

Year	Number of Strategic Action Plans at Beginning of Year	Number of Strategic Action Plans at Year End
2007	19	19
2008	25	24
2009	27	32
2010	12	12
2011 YTD	10	-

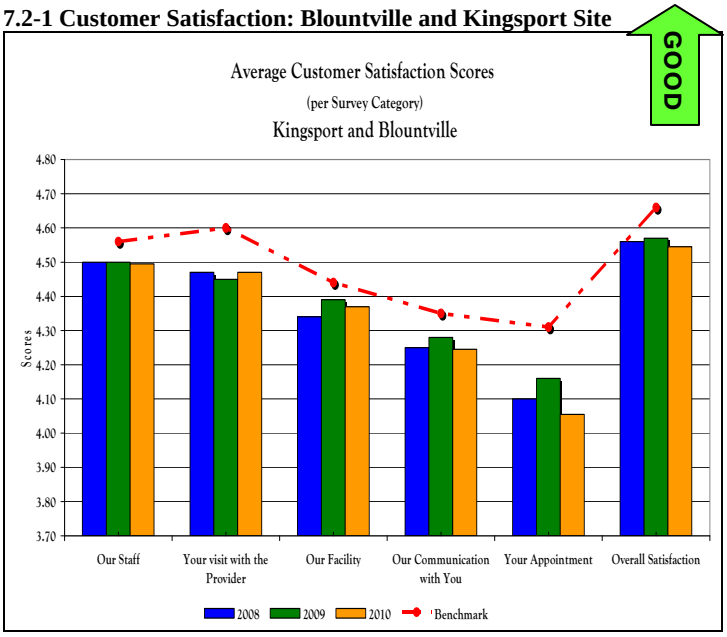
7.2 Customer-Focused Outcomes

a. Customer-Focused Results

(1) SCRHD uses a variety of mechanisms to monitor the satisfaction and dissatisfaction of SCRHD customers, as well as their perceived value of services Customer satisfaction is a very important component to the success and sustainability of SCRHD. As made apparent through the mission of SCRHD; customers and employees are the central figures that drive excellence and a focus on results to create value. In 2008, SCRHD began working with Sullivan Luallin to provide a systematic method of assessing the satisfaction and engagement levels of customers. Sullivan Lullian has the capability of comparing SCRHD to a database of over 300,000 medical and dental providers and segments results by site to help target improvement opportunities. The results provided to SCRHD over the last three years have prompted the initiation of PITs that have worked to improve satisfaction in the areas identified within the analysis of the results. SCRHD has just completed the 2011 customer satisfaction survey cycle. Results from the 2011 survey should be available upon site visit.

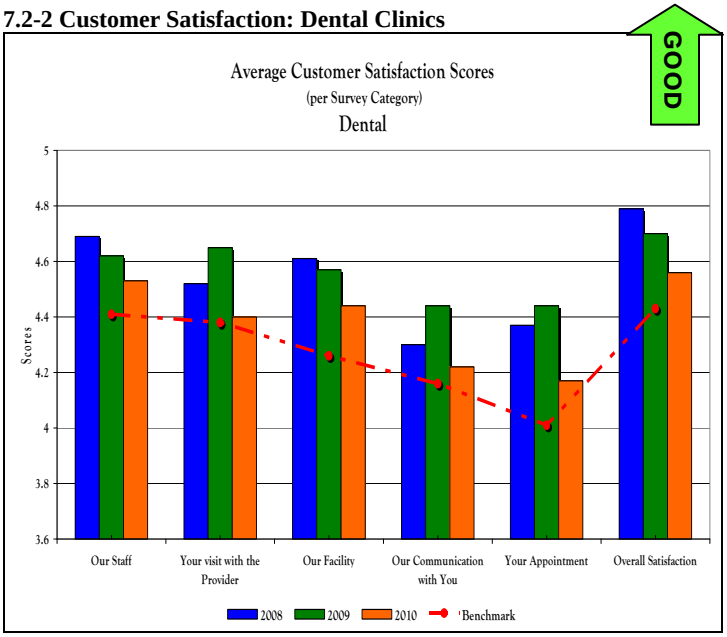
Figure 7.2-1 indicates that questions within the "Your Appointment" category require the most attention to improve satisfaction among SCRHD customers. Following the receipt of the 2010 scores, a PIT was developed to address wait times in various clinical areas. It is the expectation that 2011 survey should exhibit some improvement within this survey category. Other improvements that were made based on the survey analysis included a new phone system and communication center that improved the efficiency in the handling of all calls coming into SCRHD. It is important to note that the database within which SCRHD is being compared does not include any local public health facilities but private groups and providers.

7.2-1 Customer Satisfaction: Blountville and Kingsport Site



An added bonus in collaborating with Sullivan Luallin was their ability to compare SCRHD's Children's Dental Clinic to private dental providers across the United States. Satisfaction scores among SCRHD's dental clinics consistently perform better then the benchmark in each category. This measure illustrates the success of such a much needed service within Sullivan County.

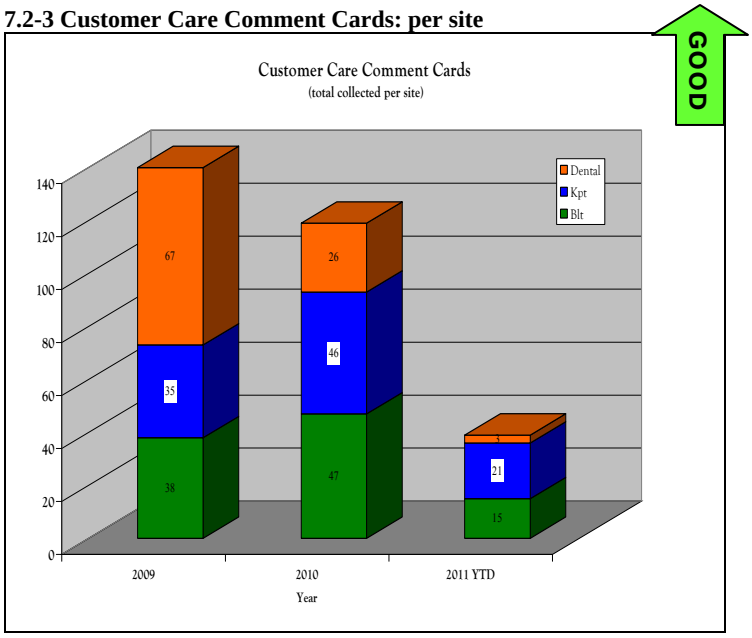
7.2-2 Customer Satisfaction: Dental Clinics



The C^3 Program (Item 3.2b(2)) was developed and deployed in 2009 as a way to monitor satisfaction levels within each site location of SCRHD when the annual survey process was not being conducted. The program has been used to collect real-time feedback from customers visiting SCRHD and determining areas of satisfaction and dissatisfaction during their visit (Figure 7.2-3) Evaluating these cards on a regular basis assist MT members in identify trends in dissatisfaction and provides opportunities for immediate corrective responses.

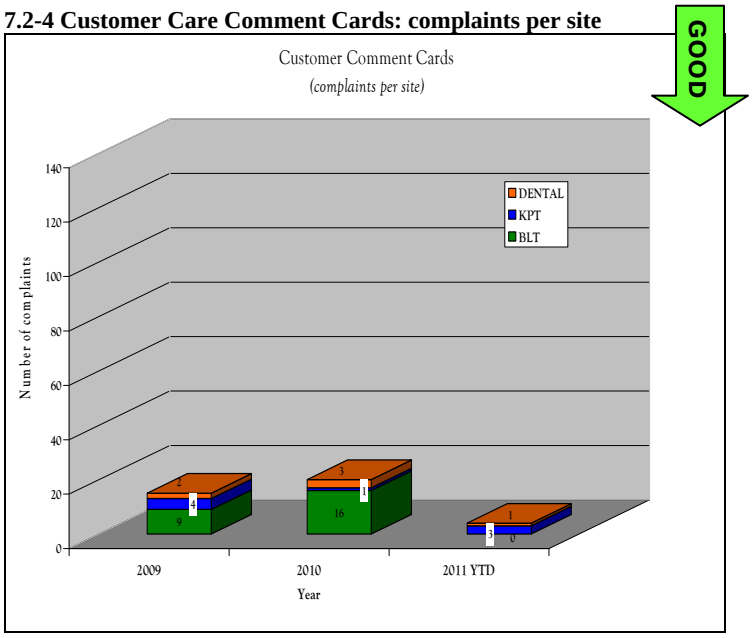
The C[3] Program has also been utilized as a way to encourage workforce engagement through the giving of Rays of Sunshine (Item 5.2a (1)) based on the comments left by customers. This approach has the ability to monitor each of the two key components of SCRHD's mission.

7.2-3 Customer Care Comment Cards: per site



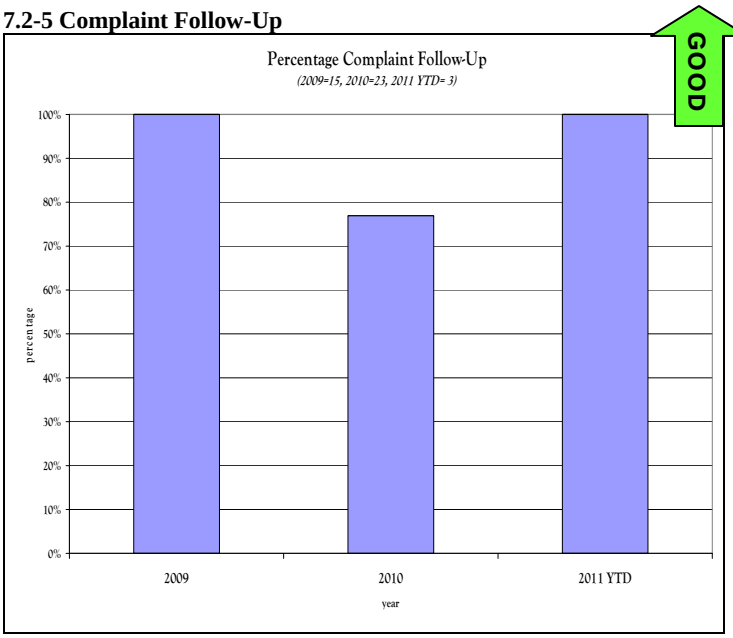
Figures 7.2-4 and 7.2-5 further segments each year's comment cards to identify dissatisfaction/compliant trends and assess for complaint follow-up.

7.2-4 Customer Care Comment Cards: complaints per site



SCRHD MT members are diligent in providing follow-up (Figure 7.2-5) from C[3] that contain a complaint. This follow-up may come in the form of contacting the customer making the compliant (if phone number or name is supplied), employee corrective action, or an evaluation of the process under scrutiny. Each of the complaints received are thoroughly reviewed and, if warranted, are shared during the monthly managers' meeting.

7.2-5 Complaint Follow-Up



(2) Although satisfaction data is critical to the future success of SCRHD, engagement data is a profound predictor of performance, loyalty and overall satisfaction. Both the annual customer satisfaction survey and the ongoing C[3] Program have questions that directly relate to customer and stakeholder engagement. Figure 7.2-6 displays the results of the specific question on the annual survey that addresses engagement. From 2008-2010 ≥95% of those surveyed have stated that they would "Definitely Yes or Probably Yes" recommend SCRHD to others.

7.2-6 Patient and Stakeholder Engagement: Satisfaction Survey

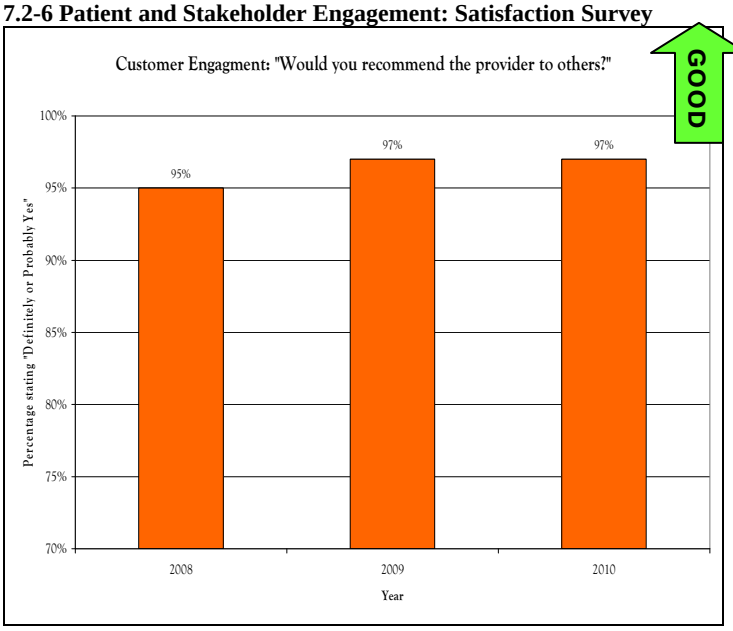
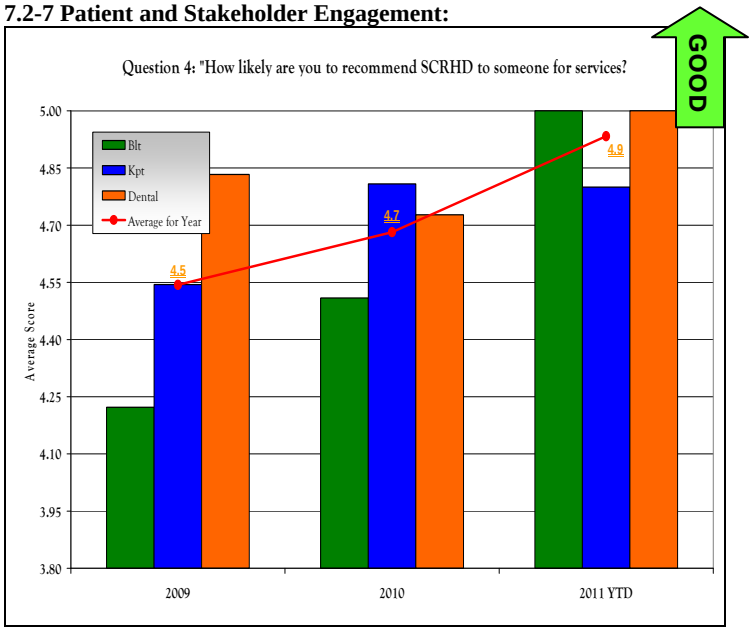


Figure 7.2-7 displays the results Question 4 from the C[3] over the last three years. These results are segemented by site location and demonstrate an overall average increase since its inception in 2009

7.2-7 Patient and Stakeholder Engagement:



In 2011, SCRHD identified the need to acquire satisfaction and engagement data from key state, county and community stakeholders. Survey Monkey was utilized to email a short questionnaire to a variety of partners across the state. This assessment would provide a snapshot of how well SCRHD is meeting or not meeting the needs to maintain a strong relationship between these organizational partners. Figure 7.2-8 provides a listing of the questions within the survey and the response percent for each. SCRHD will utilize this data to influence opportunities for improvement in relationship building. SCRHD has plans to implement this survey again in 2012 to coincide with the annual customer satisfaction survey. Forty percent of the respondents were classified as being a *community partner*; 40% stated *county government*; and 20% stated *state government*.

7.2-8 Patient and Stakeholder Engagement: Stakeholder Survey

	Response Percent				
Do you believe SCRHD to be a value added organization within the community?	Definitely Yes 67%	Yes 33%	Maybe 0%	No 0%	Definitely No 0%
How effectively does SCRHD collaborate with your organization?	Excellent 60%	Good 27%	Satisfactory 0%	Needs Improvement 13%	Unsatisfactory 0%
How well does SCRHD communicate with your organization?	Excellent 53%	Good 20%	Satisfactory 7%	Needs Improvement 20%	Unsatisfactory 0%
How would you rank the quality of services provided at SCRHD?	Excellent 47%	Good 40%	Satisfactory 0%	Needs Improvement 0%	N/A 13%
What is your overall satisfaction with SCRHD?	Very Satisfied 60%	Satisfied 27%	Somewhat Satisfied 13%	Very Dissatisfied 0%	N/A 0%

7.3 Workforce-Focused Outcomes

a. Workforce Results

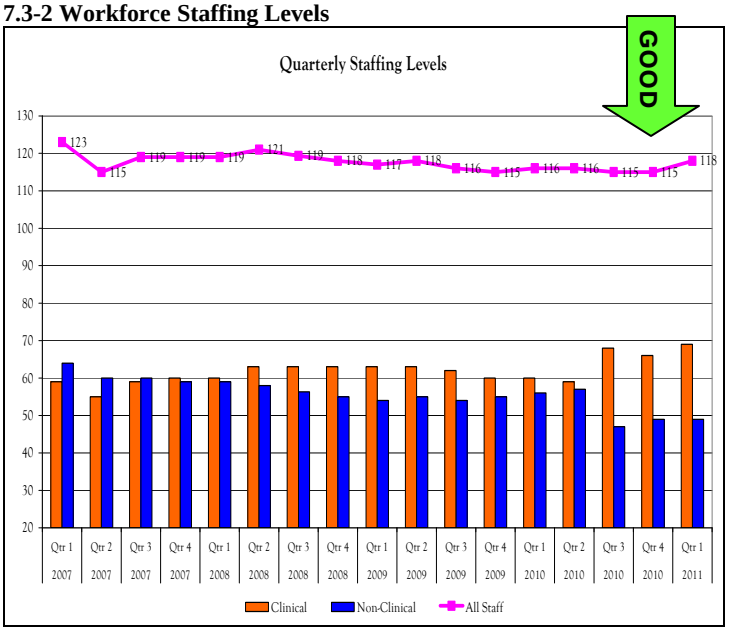
(1) SCRHD is proud of the fact that staffing levels have not been affected during a very challenging financial period. Capacity levels at SCRHD are frequently delegated by federal and state grants and Sullivan County financial support. There are certain times throughout the year when an increase in workforce demand is anticipated. It is during these time periods that the concepts of cross training, efficient process improvements and a dedicated workforce have been appreciated and expected. Figure 7.3-1 illustrates how SCRHD has segmented the workforce groups into Clinical, Non Clinical and Administrative/Management. This segmentation has allowed for an ease in capacity and capability measurement and trending.

7.3-1 Breakdown of Staff Workgroups

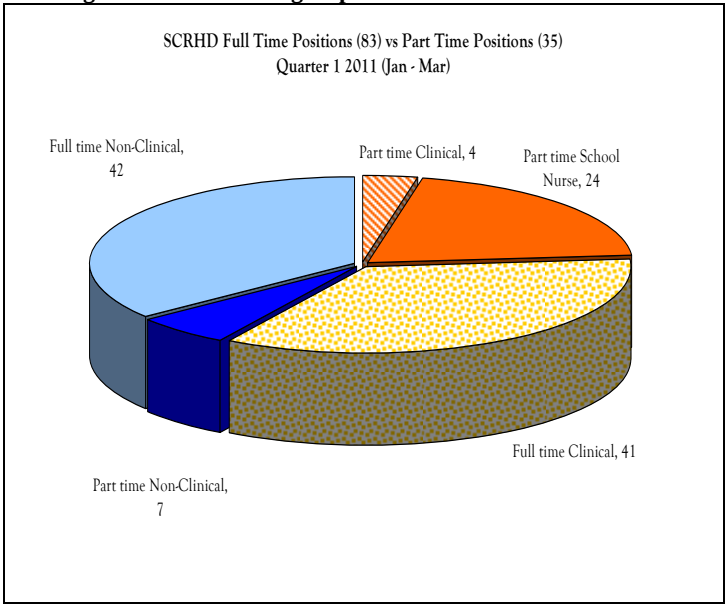
Clinical	Non-Clinical	Administrative (Management)	
Nutrition Educator	Administrative Assistant	Regional Director	
Registered Dietician	Accounting Assistant	Medical Director	
Breast Feeding Peer Counselor	Systems Administrator I	Director of Operations	
Breastfeeding Coordinator	Systems Administrator II	Regional Accountant	
School Nurse, RN	TENNder Care Coordinator I	Clinical Services Supervisor	
School Nurse, LPN	TENNder Care Coordinator II	WIC Director	
Dental Director	TENNder Care Outreach Worker	School Nurse Supervisor	
Dentist	WIC Vendor Coordinator	CDC Supervisor	
Dental Assistant	Hospital Coordinator	Office Manager	
Hygienist	Epidemiologist	MCH Director	*State Position*
Clinical Nurse, RN	Health Educator	HUGS/CSS Supervisor	*State Position*
Clinical Nurse, LPN	Clerk	Personnel Coordinator	*Not filled*
Public Health Representative	Maintenance	Emergency Response Coordinator	
Advanced Practice Nurse	Quality Improvement		

Figures 7.3-2 and 7.3-3 provide quarterly staffing levels segmented by work group. Overall, the majority of the workforce population consists of clinical staff which includes 24 part-time school nurses. These positions are funded by the Sullivan County Department of Education but managed and supervised by SCRHD, which is a very unique arrangement in the school health arena. On average the general workforce census has remained steady at a yearly average of 118.

7.3-2 Workforce Staffing Levels



7.3-3 Segmentation of Workgroups



Workforce capability and skill levels are assessed for via various methods such as new hire orientation, competency testing and PITs. (Item 5.1a (1)) SCRHD is comprised of a wide variety of professional and educational background levels (Figure P.1-3). Having a highly trained workforce is a key condition in the mission of SCRHD. Ensuring that availability of continued educational opportunities and trainings has been identified as an area to address in the workforce engagement survey and has been undertaken by the OLC. In 2010, the OLC began working on a workforce capability matrix that allows easy access through SHEILA to a listing of trainings ranging from new hire requirements to departmental specific education. Another approach to increase access to and awareness of workforce training opportunities has been the development of a training suggestion email system. Due to space limitations, the workforce capability matrix will be available for viewing during site visit.

(2) Key indicators that assess for workforce health, safety, and security are evaluated on a regular basis by the Safety Committee and other appropriate staff members. An analysis of the data collected from incident/accident reports is conducted by this committee and opportunities to prevent future incidents are discussed. (Figure 7.3-4)

Figure 7.3-4 Safety and Health

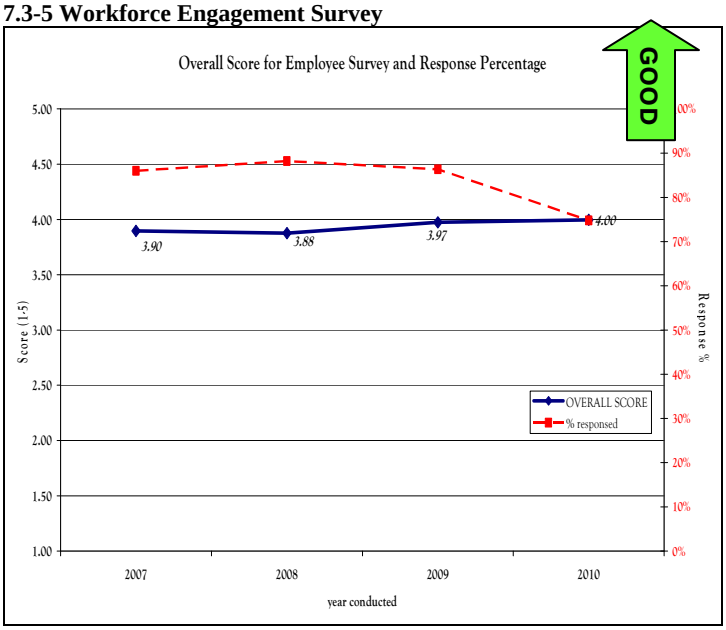
	Safety Incidents (Total)	Lost Time Injuries	Sharps Injuries	Annual TB Compliance
2004	26	0	1	100%
2005	19	3	2	100%
2006	12	0	1	100%
2007	12	0	1	100%
2008	8	0	0	100%
2009	6	2	0	100%
2010	7	0	2	100%
2011 YTD	3	0	0	100%

All SCRHD employees receive annual safety training which includes a review of all security procedure and alerts. Figure 5.1-2 provides a detailed listing of the various health, safety, and security measures that have been incorporated into the SCRHD. Item 5.1b (1) highlights the benefit package included as a SCRHD employee.

Annual Employee training occurs each year during the months of February and March. This process was streamlined several years ago to include on-line independent self study that covers mandatory compliant topics such as OSHA (Occupational Safety and Health Administration), Blood Borne Pathogens, Facility Safety, and HIPAA (Health Information Portability and Accountability Act). In 2011, Tennessee's Public Health Emergency Preparedness Program instituted a new mandate that also required instruction and review on Emergency Preparedness along with the topics mentioned above. Employees are given approximately 6 weeks to complete these courses and are tested now using a Survey Monkey exam with the capability to randomize each employees test questions. A percentage of 80% or greater is considered passing; over the past 3 years SCRHD has had 100% completion.

(3) SCRHD began using a standardize workforce engagement survey in 2007. Results from the survey demonstrate that overall satisfaction among SCRHD staff has increased since 2007 (Figures 7.3-5). Results from this survey, particularly areas in need of improvement, are thoroughly reviewed and evaluated by PEC, MT members and presented the employees at the next scheduled employee meeting.

7.3-5 Workforce Engagement Survey



Some questions within the survey have shown marked improvement over the last four years. Figure 7.3-6 lists the response to question seven of the survey. This measurement is an important assessment of workforce satisfaction and engagement for SCRHD. Since 2007, communication has been presented as a theme made evident throughout each survey cycle. Administrative and the PEC have discussed the use of multiple approaches to improve this matter which has led to the development of Healthy Rounding.

7.3-6 Workforce Engagement

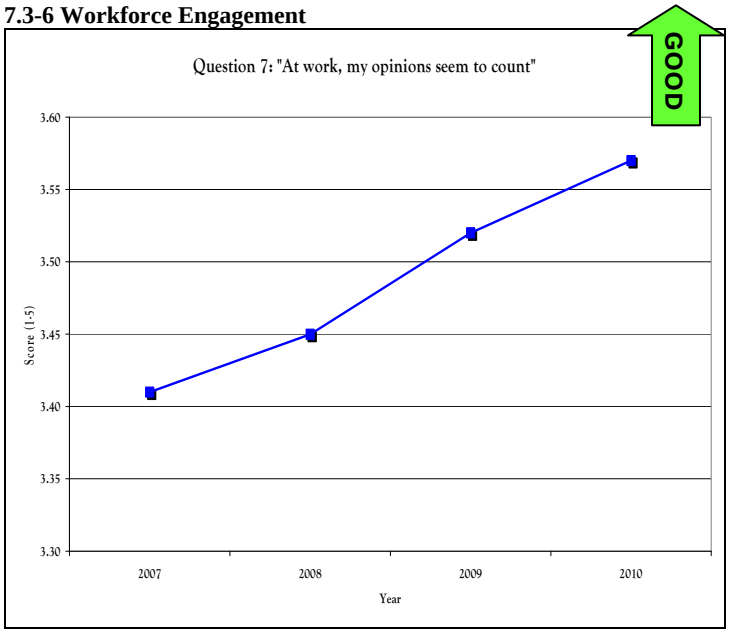
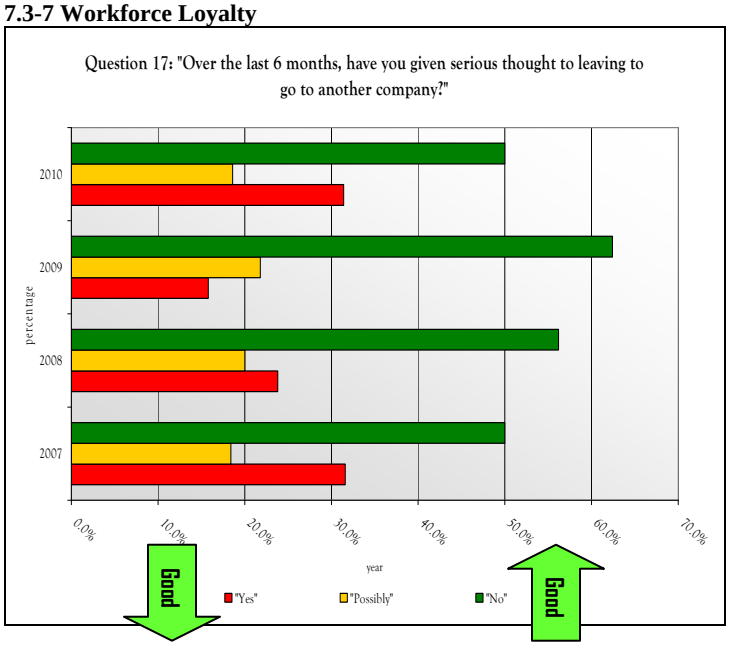


Figure 7.3-7 presents data based on question seventeen of the survey. The PEC and MT members have met a challenge in reviewing workforce satisfaction. It has been acknowledged that financial compensation, in particular salary increases, is controlled by the governance structure of the Sullivan County Commission. This necessitates administration to find non-monetary methods to supplement employee moral and satisfaction. Opportunities in which appreciation is demonstrated includes: employee picnics, annual employee celebration day which consists of lunch which is prepared and served on site by Administration and MT members for both the Blountville and Kingsport locations, Christmas luncheon, and celebration of departmental successes.

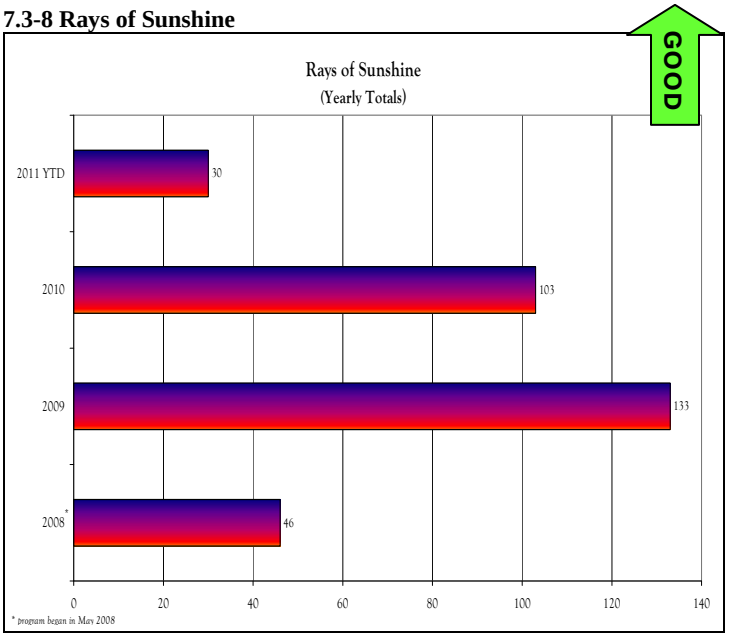
7.3-7 Workforce Loyalty



Another indicator that can be used to assess for workforce satisfaction and engagement includes data collected from the Ray of Sunshine Program (7.3-8).

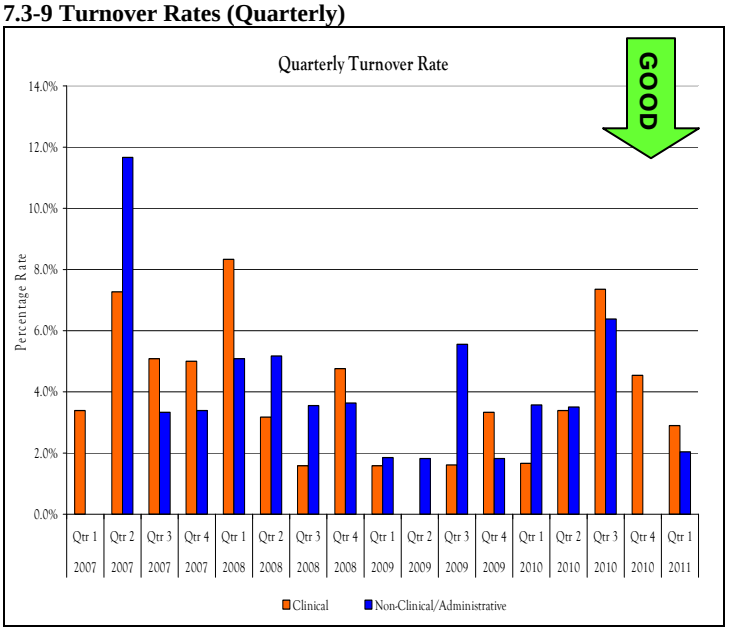
Rays of Sunshine are compliments that are given to workforce members by customers, partners or other stakeholder groups. These compliments can be written on a C^3 or personally taken by a workforce member via face to face meeting, thank you card, email or telephone call. Workforce members have come to appreciate the Ray of Sunshine program and often discuss who received the latest recognition.

7.3-8 Rays of Sunshine

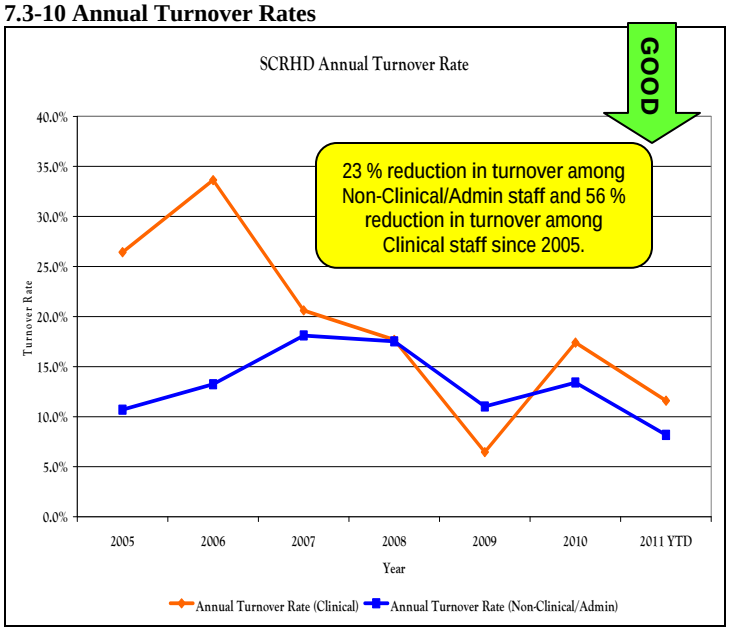


SCRHD analyzes quarterly and annual turnover rates segmented by workgroup. Figures 7.3-9 and 7.3-10 demonstrate a significant decrease in quarterly turnover rates since 2007 and annual turnover rates since 2005. These results may be attributed to process improvements that have been the result of workforce engagement survey findings as well as the successful implementation of the Ray of Sunshine Program, improved staff development support, and a more effective recognition approach through the Thumbs Up Program.

7.3-9 Turnover Rates (Quarterly)



7.3-10 Annual Turnover Rates



(4) Based on key theme findings from the workforce engagement survey; SCRHD has begun a new focus on the learning and development system within the organization. Because SCRHD's Mission statement and a core competency is based on the foundation of providing a highly motivated and well trained workforce; the OLC was developed to assess current training programs and allow greater access to further training opportunities. The workforce capability matrix is in the beginning stages of development and is the holding place of available educational support that are segregated by required organizational learning's and departmental specific trainings. Other strategies that have been implemented to increase workforce and leader development have been the use of new employee evaluation templates that allow for individual goal setting and SHEIL/SHEL.E interfaces that encourage organizational learning and sharing. Each of these components will be available for review at site visit.

Other opportunities that have been made available to encourage workforce and leader development has been the support of selected staff members to serve on the TNCPE Board of Examiners (Figure 7.3-11); departmental specific webinars; organization wide trainings pertaining to pertinent public health issues; and numerous, program specific educational conferences that take place throughout the state of Tennessee.

Figure 7.3-11 SCRHD TNCPE Board of Examiners

Year	Number of Examiners Trained
2007	2
2008	4
2009	0
2010	1
2011	2

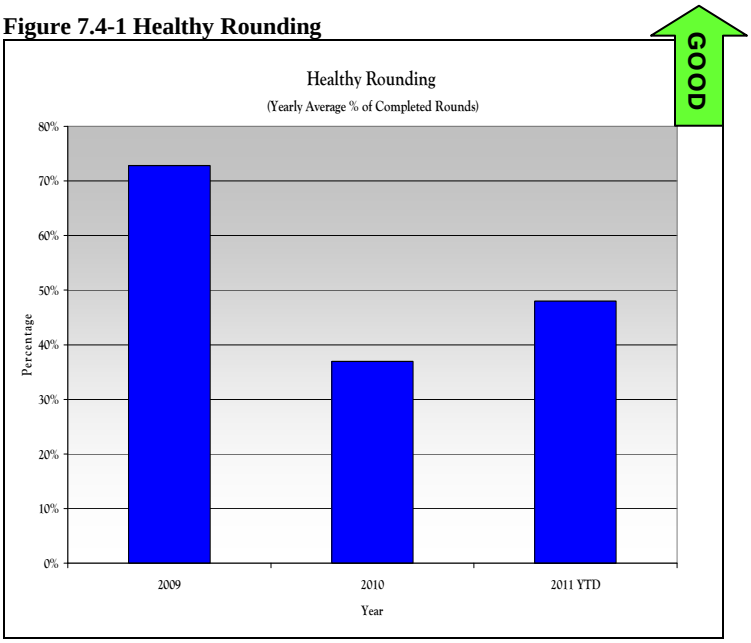
7.4 Leadership and Governance Outcomes

a. Leadership, Governance, and Societal Responsibility Results

(1) The leadership of SCRHD utilizes various methods to communicate and deploy the MVV of the organization. Figure 1.1-2 provides a listing of utilized communication methods, the frequency with which they occur, the participants involved and the primary focus for the communication. Biannual employee meetings are an opportunity for the Regional Director to talk of specific issues regarding the functioning of the organization. (i.e. budget, strategic planning, workforce engagement survey results, customer satisfaction survey results, new process improvement initiatives, etc.) These meetings were once met with great trepidation and included very little dialogue from workforce members. This biannual meeting opportunity has now become common practice within SCRHD where the Mission and Vision are clearly well-known among all represented and conversation is welcome and valued.

Healthy Rounding was implemented in March 2009 as a result of workforce engagement survey results that revealed need for improvements in communication between leadership and workforce members. As notated in Figure 7.4-1 Healthy Rounding is still in the beginning stages of deployment throughout the entire organization. Although Healthy Rounding is still considered a relatively new process within SCRHD; workforce members have stated that each round by an administrative member is anticipated with any improvements made as a result of a "Healthy Round" being greatly appreciated.

Figure 7.4-1 Healthy Rounding



(2) SCRHD's governance system is greatly integrated with fiscal accountability, legal and regulatory requirements. Financial performance and healthcare outcomes are closely governed by the program directives through the TDH, CDC and the Sullivan County Commission. Budgets are reviewed and approved by the county commission who provide public transparency and oversight.

Numerous agencies provide audits (Item 1.2a (1)) with results demonstrated in Figure 7.4-2.

(3) SCRHD is audited extensively internally by county, state, and federal governments. (Item 1.2) Federal audits are mostly for programs involving grant funding. State audits monitor program results and financial performance. Internal audits consist of programs outputs and outcomes. Fiscal audits are done by State offices each year. One of SCRHD's core values is fiscal responsibility which includes being stewards of public funds. For the past ten years SCRHD has had no material weakness findings. Program audits are shared internally with respective program directors and other personnel. State audits are shared with the County Commission and are available in public locations for SCRHD customers. This particular characteristic demands a higher degree of accountability then in private sector business. SCRHD possess an above average audit history across all levels of the organization.

Figure 7.4-2 Annual Audit Summary

	2008	2009	2010	2011 YTD
	Audits	Audits	Audits	Audits
Federal	0	0	0	Scheduled for August
State	16	26	20	6
County	1	1	1	1
SCRHD (QI)	8	8	8	8

All findings from audit evaluations have corrective action procedures that are initiated to ensure compliance. These corrective action procedures and compliance actions will be available for review at site visit.

SCRHD is committed to applying for accreditation in the near future. The PHAB has completed Beta testing of the proposed standards to be used during an accreditation assessment. PHAB will begin accepting applications to apply for accreditation in Fall 2011 or early 2012. SCRHD has strategically planned to conduct a self assessment prior to formally applying for accreditation in 2012 or 2013.

(4) SCRHD takes the issue of confidentiality very seriously and it is a critical component of the Comprehensive Audit conducted but SCRHD's QI Director. The challenge of electronic interfaces has introduced a new area of confidentiality and the potential for breaches. SCRHD systematically monitors for violations to HIPAA standards, access to CareSpark, Shared Health, and appropriate legal Medical Record releases to ensure ethical compliance and confidentiality.

Figure 7.4-3 Confidentiality Surveillance

	2008	2009	2010	2011	Goal
HIPAA	0	0	0	0	0
Shared Health	n/a	0	0	0	0
CareSpark	n/a	0	0	0	0
Medical Record Release	0	0	0	0	0

Ethics training has been conducted county wide and is a part of each new employee's orientation. (Item 1.1a (2))

Many of the audits conducted by SCRHD's QI Director as well as state, federal and program audits assess for continuous ethical behavior.

Annual training for MT members is currently scheduled for the next mangers meeting conducted by Sullivan County's Human Resource Director.

Figure 7.4-4 Ethical Behavior in Senior Leadership

Year	Violations	Target	Corrections
2002	0	0	N/A
2003	0	0	N/A
2004	0	0	N/A
2005	0	0	N/A
2006	0	0	N/A
2007	0	0	N/A
2008	0	0	N/A
2009	0	0	N/A
2010	0	0	N/A
2011 YTD	0	0	N/A

(5) SCRHD is very involved in the fulfillment of societal duties that contribute to community health and an overall improvement in public health. SCRHD's MVV, Core Competencies, and Seven KRAs directly align with the belief that a strong relationship among all represented key communities within the county will correlate with improved health status of its inhabitants. Key indicators that SCRHD uses to assess fulfillment of this objective is the numbers of key communities served by workforce members (Figure 7.4-5), Free Health Check-Up Day attendance (Figure 7.4-6) and EPSDT Check-Up Days attendance (Figure 7.4-7).

The Key Communities subgroup meets annually to review SCRHD's community associations and determine if the three identified groups of key communities (Community, Medical, and Educational) are being appropriately served. After a staff survey, the organizations served are segmented into the above categories by both volunteer status and work related status. A gap analysis is then performed to ensure all areas have been served or addressed.

Figure 7.4-5 Key Communities

	2009		2010		2011	
	Work-Related	Volunteer	Work-Related	Volunteer	Work-Related	Volunteer
Community	64	53	63	52	61	52
Medical	36	16	34	15	35	13
Educational	41	3	41	3	40	2
Total	**141**	**72**	**138**	**70**	**136**	**67**

Figure 7.4-6 details attendance information for Free Health Check-Up Days over the last eight years. An array of examinations and screenings (examples include screenings for blood pressure, cholesterol, prostate cancer, skin cancer, PAP smears, pelvic exams, and colon cancer blood tests) are provided without charge during these events.

Several success stories and Rays of Sunshine have been given as a result of these events. More importantly people are provided screenings for conditions they otherwise would not have received.

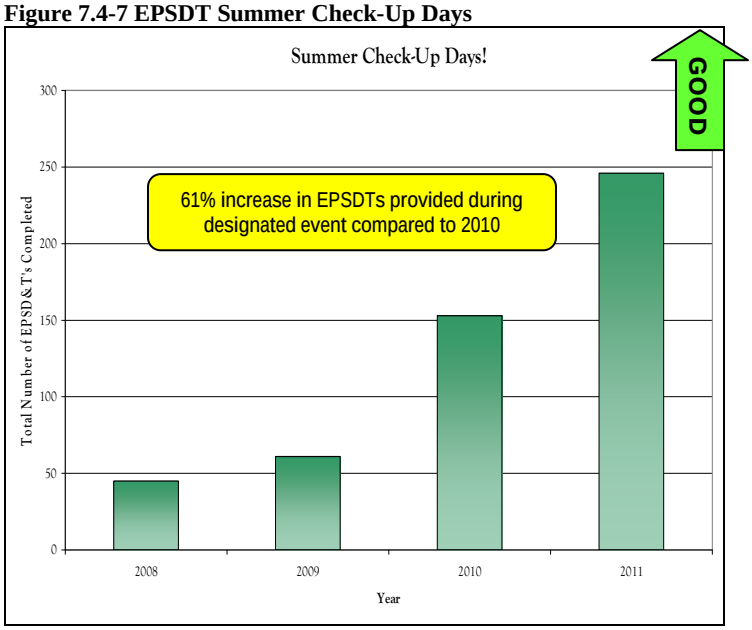
A multitude of attendees from these events have been given diagnoses of high blood pressure and cholesterol, as well as more serious cases of diabetes, breast and prostate cancer.

Figure 7.4-6 Attendance for Free Health Check-Up Day

Year	Men	Women	Total
2004	n/a	135	135
2005	61	161	222
2006	96	284	380
2007	168	295	463
2008	156	209	365
2009	combined		199
2010	107	236	343
2011	120	224	344

EPSDT Summer Check-Up Days (Figure 7.4-7) initially began in 2008 as a cooperative community intervention program in conjunction with Blue Cross Blue Shield of Tennessee to facilitate increased numbers EPSDT exams for school aged children. Along with games, prizes, backpacks, and access to multiple vendors whose focus was on education and health, the children were able to receive a free preventive examination with vaccinations.

Figure 7.4-7 EPSDT Summer Check-Up Days



In 2011, a modified strategy was piloted that rearranged the Check-Up Day from a single day, off site occurrence, to a multi-day, on site event. This process change allowed for a larger number of families to be served and did not limit attendance to a one day event.

7.5 Financial and Market Outcomes

a. Financial and Market Results

(1) Financial and marketplace budget performance is a very transparent process within SCRHD.

SCRHD tracks a number of financial measures in different departments based on the needs of each department's day-to-day management activities and processes. New findings or changes within the budget are openly discussed at the monthly managers' meeting to allow staff to better manage their individual program funds. Global aspects of budget challenges are shared during biannual employee meetings.

Figure 7.5-1 shows SCRHD's revenues and net collections for the past four years, segmented by source. SCRHD works very hard to maintain financial solvency by keeping costs in line with the approved budget for each fiscal cycle. SCRHD has maintained relatively high collection rates even for self-pay patients. In addition, since 2008, SCRHD has received higher percentage of grant funding.

Figure 7.5-1 Revenue per fiscal year with current FY projected

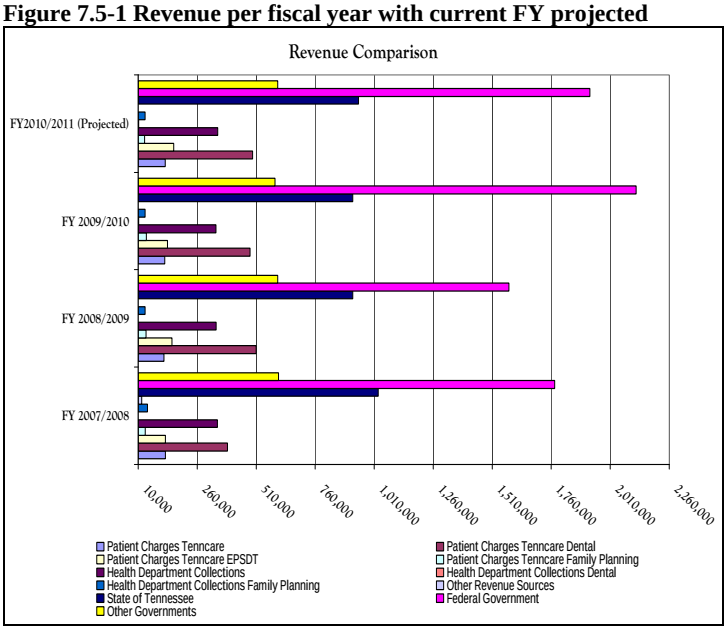
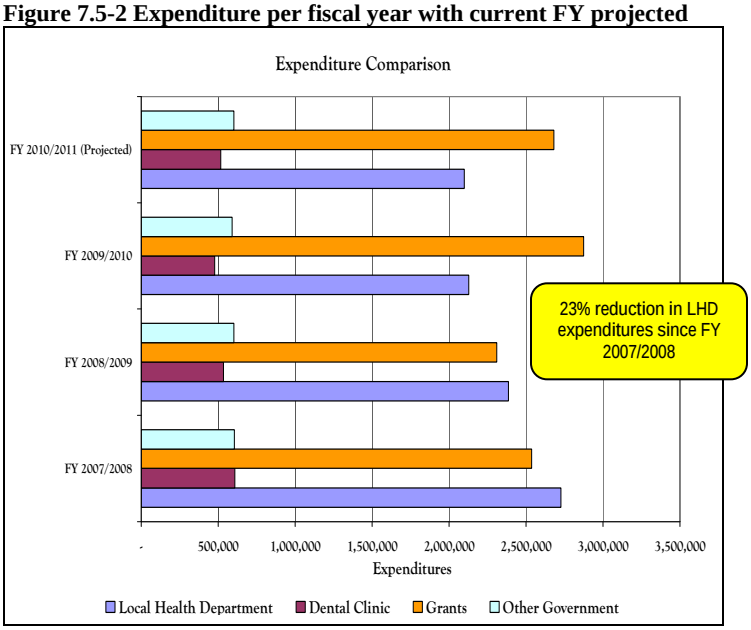


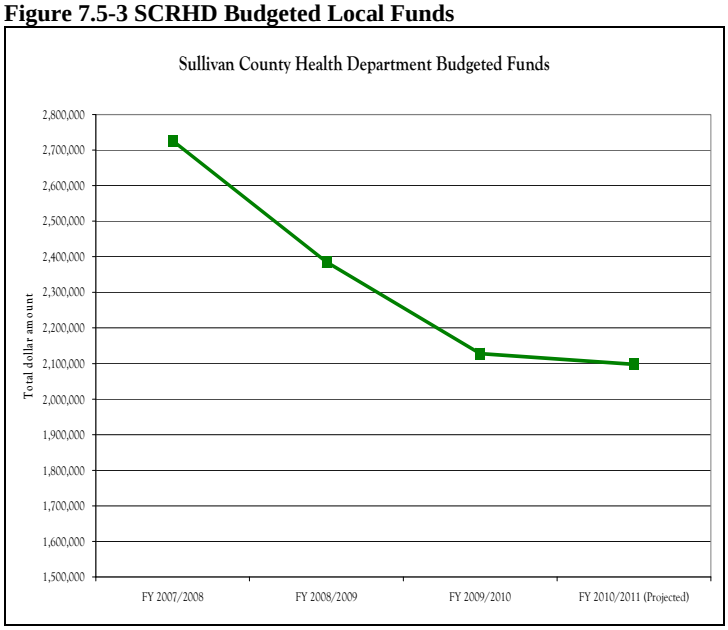
Figure 7.5-2 Expenditure per fiscal year with current FY projected



SCRHD has consistently met the budget targets established by Sullivan County Commission and generated expenditures margins to foster sustainability. (Figure 7.5-2) A key component of achieving budget targets is the management of salary costs, turnover rates, employee engagement, and customer loyalty. Alignment of workforce and customers with the MVV's of SCRHD improves productivity and ensures sustainability or the organization. SCRHD has made a concerted effort over the last three years to ensure that all grants are fully self funded and do not require local budget funding due to county budget reductions. This allows SCRHD to remain financially solvent thus preserving the workforce capacity to sufficiently fulfill the MVV of the organization.

SCRHD has endured similar budget reductions as has been experienced by local health departments across the United States. Evidence from NACCHO's National Profile of Local Health Departments survey (Item 6.1b (2)) presents statistics that confirm the difficulties that are being faced by public health institutions. Figure 7.5-3 further extrapolates the "Local Health Department" expenditure amount notated in Figure 7.5-2 and demonstrates the nearly $800,000 reduction in budgeted local funds from FY 2007/2008 to Projected FY 2010/2011. However, it is important to note that unlike many local health departments within NACCHO's survey, SCRHD has increased efficiency and the number of those served while maintaining workforce capacity.

Figure 7.5-3 SCRHD Budgeted Local Funds



(2) SCRHD considers marketplace performance much differently then privately owned healthcare organizations. As such, marketplace outcomes translate into healthcare outcomes which are aligned with SCRHD's mission of improving the health status of Sullivan County residents. These outcomes are best demonstrated in healthcare service results to include EPSDT (Figure 7.1-1, 2), Dental (Figure 7.1-3, 4, 5), WIC (Figure 7.1-6), and Immunization (Figure 7.1-7, 8) rates. These services are designed to target segments of the population that have the least access to care and the greatest risk of poor health outcomes.

Through prevention, education and clinical services (Core Competencies), SCRHD has been allowed the unique opportunity to improve the public health status and thus the achievement of the organizational mission.

Glossary of Terms and Abbreviations

A

AARA
American Recovery and Reinvestment Act

ABC
Access to Breast Care: Program allowing for free breast screening for those in need.

A-Staff
Administrative Staff

AMPA
Appalachian Mountain Project Access

AP
Action Plan

APHA
American Public Health Association

B

BT
Bioterrorism

C

CACTI
A frontend Computer SQL database management system that allows for data gathering, data analysis, and graph creation

Call Center
Process utilized to handle phone calls during emergencies or with periods of high call volume

CareSpark
Project to improve health through the electronic sharing of health information between physicians, pharmacies, laboratories, and hospitals.

C^3
"C cubed" – Customer Care Comments, cards filled out for customer feedback

CD
Communicable Disease

CDC
Centers for Disease Control and Prevention

CHEM Pack
Chemical antidote kits

CLIA
Clinical Laboratory Improvement Act

Community Mitigation Coordinator
Pubic Health Information officer

Contract Employee
SCRHD employee funded through a specific contracted State or Federal program with all employee benefits through the county.

County Commission
Governing body for Sullivan County

County Employee
SCRHD employee funded through SCRHD budgeted funds with all benefits through the county.

Crystal Reporting
Method or program used for mining of data from specified data sets

CPI
Community Project Initiative

CSS
Children's Special Service

D

Dentrix
Dental Electronic Health Record

DPI
Departmental Performance Indicators

DSL
Digital Subscriber Line

E

EHR
Electronic Health Record

EPSD&T
Early Prevention Screening Diagnosis and Treatment

EMA
Emergency Management Agency

EMS
Emergency Medical Service

EP
Emergency Preparedness

ERC
Emergency Response Coordinator

ESF
Emergency Support Function

ETSU
East Tennessee State University

Exchange
Microsoft Exchange Server

F

Fileserver
Microsoft server program for storing files

Fiscal Responsibility
Wise use of government funding. One of the core values

Fit Testing
A proves of testing to insure N95 respiratory mask fit appropriately

FP
Family Planning

FEMA
Federal Emergency Management Agency

Friends in Need
Community Indigent Care Clinic serving the Kingsport area

G

Gap Analysis
A tool that helps companies compare actual performance with potential performance.

GPI
Global Performance Indicators

H

H1N1 Pandemic Flu
A novel strain of widespread influenza in 2009, often misquoted as "Swine Flu".

Healing Hands
Community Indigent Care Clinic serving the Bristol Area

Healthy People 2010/2020
Systematic national approach/initiative to health promotion and disease prevention with established goals.

Healthy Rounding
Monthly Rounding with employees performed by Administrative Staff

HIPAA
Health Insurance Portability Accountability Act

HIT
Health Information Technology

HIV
Human immunodeficiency virus

HR
Human Resources

HSA
Health Services Administration

HUGS
Help Us Grow Successfully

I

IBM AS400
Operating computer system hardware used to transfer data to the state

IEPC
Integrated Emergency Preparedness Council

ISP
Internet Service Provider

IT
Information Technology

K

Key Communities
Educational, Medical, Community Service

KRA
Key Result Areas

L

LabCorp
A commercial laboratory providing lab services for SCRHD

Language Line
Language assistance telephone line used for persons with limited English proficiency skills to assist them in receiving health services.

LEP
Limited English Proficiency

LifePath
A new program developed by ETSU College of Public Health for degree and non-degree program learning devoted to Public Health Education especially those already working in the field.

LT
Leadership Team

M

MAPP
Mobilizing for Action through Planning and Partnerships: A community-wide strategic planning tool for improving community health

MCH
Maternal Child Health

Medicare
National health insurance program primarily for those over age 65

MEETF
Mountain Empire Epidemiologic Task Force – a subcommittee of MEPHECC

MEPHECC
Mountain Empire Public Health Emergency Council

Message Mapping
A system used in preparation for media or public dissemination of information covering the most common and anticipated questions that may be requested.

METRO
Metropolitan Health Department: TN health department with a shared relationship between its respective county and state governances though funding, contractual agreements, policies.

MLE
Medical Lab Evaluation

MRSA
Methicillen Resistant Staph Aureus

MSDS
Material Safety Data Sheet

MSEC
Medical Staff Executive Committee for Tennessee Department of Health

MT
Management Team

MVV
Mission, Vision, and Values

N

NACCHO
National Association of County & City Officials

NERHO/NERO
Northeast Regional Health Office

NFPA
National Fire Protection Association

NIMS
National Incident Management System
Comprehensive national approach to incident management enabling all government, private sector, and non-governmental organizations to work together during domestic incidents.

O

OLC
Organizational Learning Committee

OSHA
Occupation Safety and Health Administration

P

Pandemic
Global infection of a population

Panoramic Feedback
An external company administering and analyzing the confidential workforce engagement survey.

PCP
Primary Care Provider

PDCA
Plan, Do, Check, Act

PEC
Performance Excellence Council

PHAB
Public Health Accreditation Board

PHIT
Public Health Investigation Team

PI
Performance Indicators

PIO
Public Information Officer synonymous with Community Mitigation Officer

PITs
Performance Improvement Teams

Private sector
Medical community delivering care outside public health realm

PTBMIS
Patient Tracking, Billing, and Management Information System: A State automated patient information system used for billing and tracking information.

Q

QI
Quality Improvement

QR
Quarterly Review

R

RAM Clinic
Remote Area Medical Clinic

RAND Corporation
A national corporation utilized for testing Public Health Response

Rays of Sunshine
Program to recognize and capture compliments delivered to the staff by our customers.

RHOC
Regional Health Operations Center

Robo-call
An automated dialing system for message delivery

Root Cause Analysis
Process involving the cause (root) of a problem or event with focus on systems and processes rather than the performance of an individual

Rural Regions
Regional Subdivisions of the Tennessee managed directly by Nashville delivering public health services

S

SANS
Storage Area Network System

SCHC
Sullivan County Health Council

SCRHD
Sullivan County Regional Health Department

SCRHD Speakers Bureau
A speaker's bureau bank of experts utilized during the H1N1 Pandemic for scheduling and presenting information to the public

SEPHLI
Southeast Public Health Leadership Institute

Share Drive
SCRHD staff computer storage drive used to share common information

Shared Health
Program that allows access to the Blue Cross Blue Shield health data base set for their patients

SHEILA
Sullivan Health Electronic Interface and Library Access

SHEL.E
Sullivan Health Electronic Library of Enlightenment

Sliding Fee Scale
Payment or fee scale based upon an individual's income used in determining service cost; is in accordance with the TDOH Rules and Regulations Governing Fees for Medical Care Services.

Sullivan Luallin
A private survey company used to conduct and analyze our customer feedback survey.

SNS
Strategic National Stockpile
The United States' national repository of antibiotics, chemical antidotes, antitoxins, vaccines, life-support medications, IV administration supplies, airway maintenance supplies and medical/surgical items. The SNS is designed to supplement and re-supply state and local public health agencies in the event of a national emergency, especially bioterrorism, anywhere and at anytime within the United States or its territories.

Social Media
Webpage, Facebook, Twitter

SOS
Spotlight on Service, a training program provided for staff by Sullivan Luallin

SP
Strategic Planning

SPN
Sentinal Provider Network. A network of reporting community physicans and health care organizations that voluntarily report flu numbers and submit specimens for testing to the department of health.

SPP
Strategic Planning Process

State Employee
Hired prior to 1989, state employees are funded through TDOH sources and have all benefits through the State of TN. State employees are governed by both State and SCRHD policies.

STI
Sexually Transmitted Infections

Survey Monkey
A Web based survey tool

SWOT
Strengths Weaknesses Opportunities Threats

T

TB
Tuberculosis

TCA
Tennessee Coded Annotated

TDEC
Tennessee Department of Environment and Conservation

TDH
Tennessee Department of Health

TEMA
Tennessee Emergency Management Agency

TENNCare
Tennessee State program for delivering Medicaid services

TENNderCARE
Outreach program for facilitating TENNCARE patients to obtain their routine physical exams, ie EPSDT Outreach

THAN
Tennessee Health Alert Network

Thumbs Up
Method of Recognition for outstanding staff performance as observed by other members of staff

Title II
Federal Statue including American with Disabilities Act (ADA) providing civil rights protection for qualified individuals with disabilities.

Title VI
Federal Statute enacted as part of the Civil Rights Act of 1964 prohibiting discrimination on the basis of race, color, and national origin in program and activities (Includes LEP).

Title X
Federal program created in 1970 authorized through the Public Health Service Act; is devoted solely to the provision of family planning and reproductive health care.

TOSHA
Tennessee Occupational Safety and Health Administration

TNCPE
Tennessee Center for Performance Excellence

TWIS
Tennessee Web Immunization Service

V

VDH
Virginia Department of Health

VFC
Vaccine for Children: A Public Health grant program through the state designed to provide vaccines for children and is obtained through Federal contracts with CDC.

VOC
Voice of the Customer

VPN
Virtual Private Network
Provides offsite managers access to SCRHD's computer system.

W

WebEOC
Software designed to deliver real-time emergency information to any size Emergency Operations Center or exchange information between multiple centers and the field.

WFD
Workforce Development

WH
Women's Health

WIC
Women, Infants and Children Program

Appendix E

St. John's County, FL
Malcolm Baldrige National Quality Award Application

This application is for the 2012 Malcolm Baldrige National Quality Award. Having received its state-based Baldrige program award, the Governor's Sterling Award, the St. John's County Health Department is eligible to apply to the national Baldrige award program.

APPLICATION FOR:

2012
MALCOLM BALDRIGE
NATIONAL QUALITY AWARD

SUBMITTED BY:

St. Johns County Health Department
1955 U.S. 1 South, Suite 100
St. Augustine, FL 32086
Telephone: 904-825-5055

May 2012

TABLE OF CONTENTS

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1. Your Organization

Official name	Florida Department of Health - St. Johns County Health Department
Other name	St. Johns County Health Department.
Prior name	*(if changed within the past 5 years)*

Headquarters address: 1955 U.S. 1 South, Suite 100
St. Augustine, FL 32086

2. Highest-Ranking Official

☐ Mr. ☐ Mrs. ☐ Ms. ☒ Dr.

Name	Dawn C. Allicock, M.D., M.P.H.
Job title	Director/Health Officer
E-mail	Dawn_Allicock@doh.state.fl.us
Telephone	(904) 825-5055 Ext. 1003
Fax	(904) 823-2580

Address: ☒ Same as above

3. Eligibility Contact Point

Designate a person who can answer inquiries about your organization. Questions from your organization and requests from the Baldrige Program will be limited to this person and the alternate identified below.

☐ Mr. ☒ Mrs. ☐ Ms. ☐ Dr.

Name	Brenda Fenech-Soler
Job title	Executive Assistant/Public Information Officer
E-mail	Brenda_Fenech-Soler@doh.state.fl.us
Telephone	(904) 825-5055 Ext. 1004
Fax	(904) 823-2580

Address: ☒ Same as above

Overnight mailing address: ☒ Same as above *(Do not use a P.O. box number.)*

4. Alternate Eligibility Contact Point

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name	Noreen Nickola-Williams
E-mail	Noreen_Nickola-Williams@doh.state.fl.us
Telephone	904-825-5055 x 1091
Fax	(904) 823-2580

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5. Application History

a. Has your organization previously submitted an eligibility certification package?

☐ Yes. *Indicate the year(s). Also indicate the organization's name at that time, if different.*

Year(s)	
Name(s)	

☒ No

☐ Don't know

b. Has your organization ever received the Malcolm Baldrige National Quality Award?

☐ Yes. Did your organization receive the award in 2006 or earlier?

☐ Yes. *Your organization is eligible to apply for the award.*

☒ No. *If your organization received an award between 2007 and 2011, it is eligible to apply for feedback only. Contact the Baldrige Program at (877) 237-9064, option 3, if you have questions.*

☐ No

c. *(Optional; for statistical purposes only)* Has your organization participated in a state or local Baldrige-based award process?

☒ Yes. Years: 2006, 2008, 2009, 2011

☐ No

6. Award Category

See pages 5–6 of the 2012 Baldrige Award Application Forms *booklet.*

a. Award category *(Check one.)*

Your education or health care organization may use the Business/Nonprofit Criteria and apply in the service, small business, or nonprofit category. However, you probably will find the sector-specific Criteria more appropriate.

For-Profit	Nonprofit
☐ Manufacturing	☐ Nonprofit
☐ Service	☐ Education
☐ Small business (≤ 500 employees)	☒ Health care
☐ Education	
☐ Health care	

b. Industrial classifications. List up to three of the most descriptive NAICS codes for your organization (see page 17 of the *2012 Baldrige Award Application Forms* booklet). *These are used to identify your organizational functions and to assign applications to examiners.*

921	621	924

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7. Organizational Structure

a. For the preceding fiscal year, the organization had in

- ☐ up to $1 million
- ☒ $1.1 million–$10 million
- ☐ $10.1 million–$100 million
- ☐ $100.1 million –$500 million
- ☐ $500.1 million–$1 billion
- ☐ more than $1 billion

⇨

- ☐ sales
- ☐ revenue
- ☒ budget

b. Attach a line-and-box organization chart that includes divisions or unit levels. In each box, include the name of the unit or division and the name of its leader. Do not use shading or color in the boxes.

☒ The chart is attached.

c. The organization is _____ a larger parent or system. *(Check all that apply.)*

☐ not a subunit of *(Proceed to item 8.)*

☐ a subsidiary of ☐ controlled by ☐ administered by ☐ owned by

☒ a division of ☐ a unit of ☐ a school of ☐ other _____

Parent organization	Florida Department of Health	Address	2585 Merchants Row Boulevard Tallahassee, FL, 32399
Total number of paid employees*	*Approx 16,000*		
Highest-ranking official	H. Frank Farmer, Jr., M.D., Ph.D., FACP	Job title	State Surgeon General
Telep☐one	850-245-4321		

Paid employees include permanent, part-time, temporary, and telecommuting employees, as well as contract employees **supervised by the organization. Include employees of subunits but not those of joint ventures.*

d. Is your organization the only subunit of the parent intending to apply for the award? *Based on the parent organization's size, the program may accept multiple applications within or across award categories from subunits (see page 7 of the* 2012 Baldrige Award Application Forms *booklet).*

☒ Yes ☐ No *(Briefly explain below.)* ☐ Don't know

e. Attach a line-and-box organization chart(s) showing your organization's relationship to the parent's highest management level, including all intervening levels. In each box, include the name of the unit or division and its leader. Do not use shading or color in the boxes.

☒ The chart is attached.

f. Considering the organization chart, briefly describe below how your organization relates to the parent and its other subunits in terms of products, services, and management structure.

We provide Public Health services for St. Johns County under the direction of the parent organization.

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g. Provide the title and date of an official document (e.g., an annual report, organizational literature, a press release) that clearly defines your organization as a discrete entity.

Title: 2011 St. Johns County Health Department Business Plan Date: 2011

Attach a copy of relevant portions of the document. If you name a Web site as documentation, print and attach the relevant pages, providing the name only (not the URL) of the Web site.

☒ Relevant portions of the document are attached.

h. Briefly describe the major functions your parent or its other subunits provide to your organization, if appropriate. *Examples are strategic planning, business acquisition, research and development, facilities management, data gathering and analysis, human resource services, legal services, finance or accounting, sales/marketing, supply chain management, global expansion, information and knowledge management, education/training programs, information systems and technology services, curriculum and instruction, and academic program coordination/development.*

Parent establishes Rules, High Level Policy, High-level Budget and High-level Programmatic requirements, Provides Enterprise-level Information Management Systems and Infrastructure, and Legal Counsel

8. Eligibility Determination

See also pages 5–7 of the 2012 Baldrige Award Application Forms *booklet.*

a. Is your organization a distinct organization or business unit headquartered in the United States?

☒ Yes ☐ No *Briefly explain.*

b. Has your organization officially or legally existed for at least one year, or since April 2, 2011?

☒ Yes ☐ No

c. Can your organization respond to all seven Baldrige Criteria categories? Specifically, does your organization have processes and related results for its unique operations, products, and/or services? For example, does it have an independent leadership system to set and deploy its vision, values, strategy, and action plans? Does it have approaches for engaging customers and the workforce, as well as for tracking and using data on the effectiveness of these approaches?

☒ Yes ☐ No

d. If some of your organization's activities are performed outside the United States or its territories and your organization receives a site visit, will you make available sufficient personnel, documentation, and facilities in the United States to allow a full examination of your worldwide organization?

☐ Yes ☐ No ☒ Not applicable

e. If your organization receives an award, can it make sufficient personnel and documentation available to share its practices at The Quest for Excellence Conference and at your organization's U.S. facilities?

☒ Yes ☐ No

If you are unable to respond to any item, call (877) 237-9064, option 3, before submitting this form.

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If you checked "No" for 8a, 8b, 8c, 8d, or 8e, call the Baldrige Program at (877) 237-9064, option 3. 0276

Questions for Subunits Only

f. Is your subunit recognizably different from the parent and its other subunits? For example, do your customers distinguish your products and services from those of the parent and/or other subunits? Are your products or services unique within the parent? Do other units within the parent provide the same products or services to a different customer base?

☒ Yes. *Continue with 8g.*

☐ No. *Your subunit probably is not eligible to apply for the award. Call the Baldrige Program at (877) 237-9064, option 3.*

g. Is your organization a subunit in education or health care? (*Check your eligibility on page 6 of the* Baldrige Award Application Forms *booklet.)*

☒ Yes. ***Proceed to item 9.***

☐ No. *Continue with 8h.*

h. Does your subunit have more than 500 paid employees?

☐ Yes. *Your organization is eligible to apply for the award.* ***Proceed to item 9.***

☐ No. *Continue with 8i.*

i. Is your subunit in manufacturing or service?

☐ Yes. Is it separately incorporated and distinct from the parent's other subunits? Or was it independent before being acquired by the parent, and does it continue to operate independently under its own identity?

☐ Yes. *Your subunit is eligible in the small business category. Attach relevant portions of a supporting official document (e.g., articles of incorporation) to this form.* ***Proceed to item 9.***

☐ No. *Continue with 8j.*

☐ No. *Your subunit probably is not eligible to apply for the award. Call the Baldrige Program at (877) 237-9064, option 3.*

j. Does your subunit (1) have more than 25 percent of the parent's employees, *and* (2) does your subunit sell or provide 50 percent or more of its products or services directly to customers/users outside your subunit, its parent, and other organizations that own or have financial or organizational control of your subunit or the parent?

☐ Yes. *Your organization is eligible to apply for the award.*

☐ No. *Your organization probably is not eligible to apply for the award. Call the Baldrige Program at (877) 237-9064, option 3.*

9. Supplemental Sections

The organization has (a) a single performance system that supports all of its product and/or service lines and (b) products or services that are essentially similar in terms of customers/users, technology, workforce or employee types, and planning.

☒ Yes. *Proceed to item 10.*

☐ No. *Your organization may need to submit one or more supplemental sections with its application. Call the Baldrige Program at (877) 237-9064, option 3.*

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10. Application Format

If your organization applies for the 2012 award, in which format will you submit your application?

☒ 15 paper copies **and** a CD (must be postmarked on or before May 15, 2012)

☐ CD only (must be postmarked on or before May 1, 2012)

11. Use of Cell Phones, Cordless Phones, and Voice-over-Internet Protocol (VoIP)

Do you authorize Baldrige examiners to use cell phones, cordless phones, and VoIP to discuss your application? *Your answer will not affect your organization's eligibility. Examiners will hold all your information in strict confidence and will discuss your application only with other assigned examiners and with Baldrige Program representatives as needed.*

☒ Yes ☐ No

12. Site Listing

You may attach or continue your site listing on a separate page as long as you include all the information requested here. You may group sites by function or location (city, state), as appropriate. Please include the total for **each column** (sites, employees/faculty/staff, and volunteers). *If your organization receives a site visit, the Baldrige Program will request a more detailed listing. Although site visits are not conducted at facilities outside the United States or its territories, these facilities may be contacted by teleconference or videoconference.*

Example

	Sites (U.S. and Foreign) *List the city and the state or country.*	**Workforce*** *List the numbers at each site.* *Check one or more.* ❒ Employees ■ Faculty ■ Staff	**Volunteers** (or ❒ N/A)	*List the % at each site, or use "N/A" (not applicable).* *Check one.* % of ❒ Sales ❒ Revenue ■ Budget
	Coyote Hall Albuquerque, NM	381 Faculty 200 Staff	25	95%
	Cactus Hall Bernalillo, NM	17 Faculty 2 Staff	3	5%
Total	**2**	**600**	**28**	**100%**

**The term "workforce" refers to all people actively involved in accomplishing the work of your organization, including paid employees (e.g., permanent, part-time, temporary, and telecommuting employees, as well as contract employees supervised by the organization) and volunteers, as appropriate. The workforce includes team leaders, supervisors, and managers at all levels.*

Your Organization

Sites (U.S. and Foreign) *List the city and the state or country.*	**Workforce*** *List the numbers at each site.* *Check one or more.* ☒ Employees ☐ Faculty ☐ Staff	**Volunteers** (or ☒ N/A)	*List the % at each site, or use "N/A" (not applicable).* *Check one.* % of ☐ Sales ☐ Revenue ☒ Budget
1955 US 1 South, Suite 100, St. Augustine, FL, 32086	99	NA	92%
4040 Lewis Speedway	12	NA	8%

If you are unable to respond to any item, call (877) 237-9064, option 3, before submitting this form.

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	St. Augustine, FL, 32084			
Total	2	111		**100%**

**The term "workforce" refers to all people actively involved in accomplishing the work of your organization, including paid employees (e.g., permanent, part-time, temporary, and telecommuting employees, as well as contract employees supervised by the organization) and volunteers, as appropriate. The workforce includes team leaders, supervisors, and managers at all levels.*

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13. Key Business/Organization Factors

List or briefly describe the following key business/organization factors. Please be concise, but be as specific as possible. Provide full names of organizations (i.e., do not use acronyms). *The Baldrige Program uses this information to avoid conflicts of interest when assigning examiners to your application. Examiners also use this information in their evaluations.*

a. Main products and/or services and major markets served (local, regional, national, and international)

Provides core public health services to residents and visitors of St. Johns County, Florida including: Communicable Disease Control/Prevention, Environmental Public Health, Clinical Health Care Services (Pediatrics and Pediatric Dental, Women's Health, Immunizations, Communicable Disease), Public Health Preparedness and Response

b. Key competitors (those that constitute 5 percent or more of your competitors)

No direct competition (other than for funding) for State and Federal mandated public health services, Competition from providers of Clinical Services for Pediatrics and Women's Health

c. Key customers/users (those that constitute 5 percent or more of your customers/users)

Direct Service Customers who are direct recipients of services provided, Indirect customers (the community at large) who are recipients of community-based services such as Disease Prevention, Environmental Public Health and Community Planning. No single customer contitutes more than 5% of business.

d. Key suppliers/partners (those that constitute 5 percent or more of your suppliers/partners)

Suppliers include all the vendors, from which goods and services are purchased, including laboratory services, medications, and the equipment and supplies necessary to conduct business. None constitute greater than 5% of business.

e. Financial auditor	f. Fiscal year (e.g., October 1–September 30)
Florida Department of Health Division of Administration	July 1- June 30

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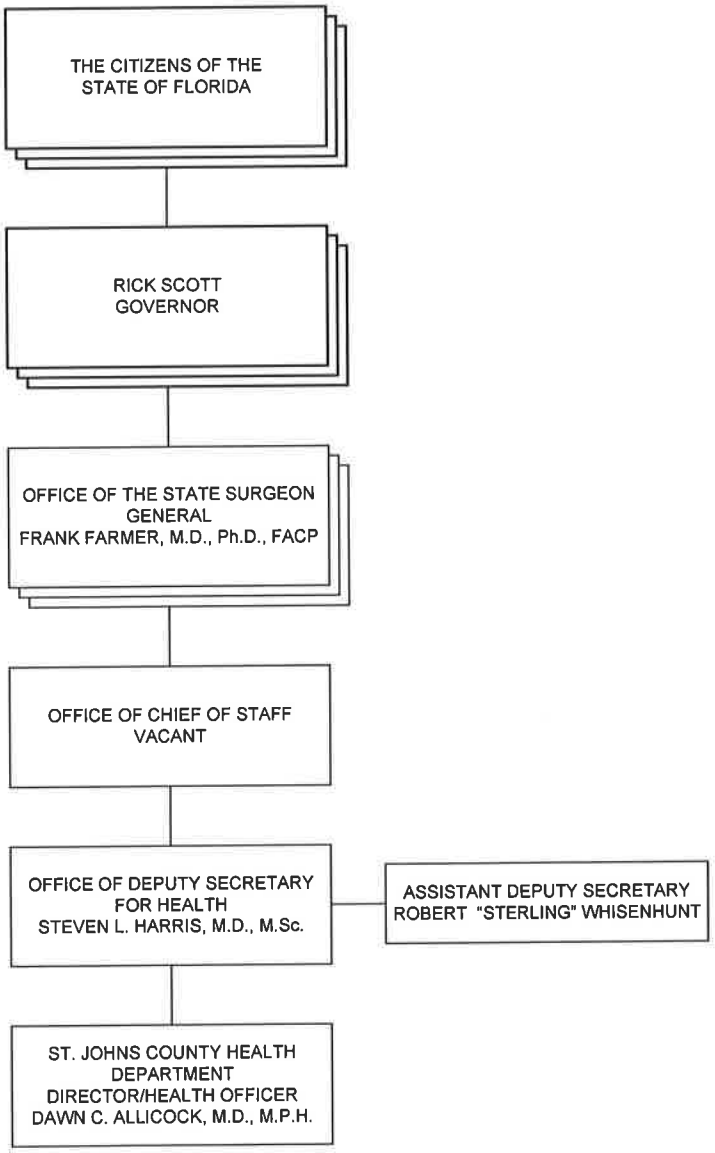
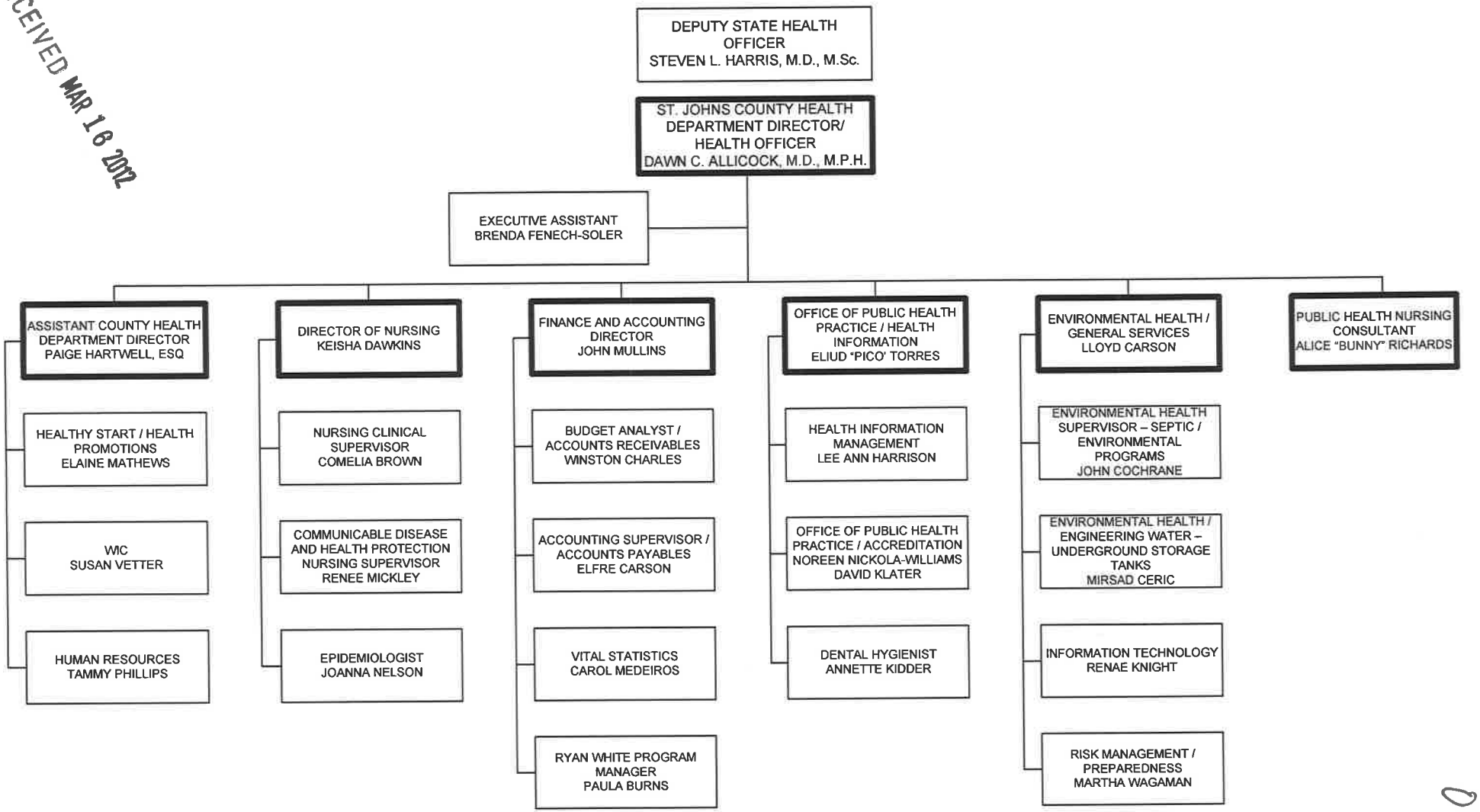
STATE OF FLORIDA
DEPARTMENT OF HEALTH
ST. JOHNS COUNTY HEALTH DEPARTMENT
FEBRUARY 2012



STATE OF FLORIDA
DEPARTMENT OF HEALTH
ST. JOHNS COUNTY HEALTH DEPARTMENT
FEBRUARY 2012



Note: Senior Leadership Team ☐

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2012 Award Application Form

Malcolm Baldrige National Quality Award

OMB Clearance #0693-0006
Expiration Date: March 13, 2013

1. Your Organization

Official name	Florida Department of Health - St. Johns County Health Department
Mailing address	1955 US 1 South, Suite 100 St. Augustine, FL 32086

2. Award Category and Criteria Used

a. Award category (Check one.)

- ☐ Manufacturing
- ☐ Service
- ☐ Small business. The larger percentage of sales is in *(check one)* ☐ Manufacturing ☐ Service
- ☐ Education
- ☒ Health care
- ☐ Nonprofit

b. Criteria used (Check one.)

- ☐ Business/Nonprofit
- ☐ Education
- ☒ Health Care

3. Official Contact Point

Designate a person with in-depth knowledge of the organization, a good understanding of the application, and the authority to answer inquiries and arrange a site visit, if necessary. *Contact between the Baldrige Program and your organization is limited to this individual and the alternate official contact point. If the official contact point changes during the application process, please inform the program.*

☐ Mr. ☒ Mrs. ☐ Ms. ☐ Dr.

Name	Brenda Fenech-Soler
Title	Executive Assistant/PIO
Mailing address	☒ Same as above
Overnight mailing address	☒ Same as above *(Do not use a P.O. box number.)*
Telephone	904-825-5055, Ext. 1004
Fax	904-823-2580
E-mail	brenda_fenech-soler@doh.state.fl.us

4. Alternate Official Contact Point

☐ Mr. ☐ Mrs. ☒ Ms. ☐ Dr.

Name	Noreen Nickola-Williams
Telephone	904-825-5055, Ext. 1091
Fax	904-823-2580
E-mail	noreen_nickola-williams@doh.state.fl.us

5. Release and Ethics Statements

Release Statement

I understand that this application will be reviewed by members of the Board of Examiners.

If my organization is selected for a site visit, I agree that the organization will

- host the site visit,
- facilitate an open and unbiased examination, and
- pay reasonable costs associated with the site visit (see page 4 of the *2012 Baldrige Application Forms* booklet).

If selected to receive an award, my organization will share nonproprietary information on its successful performance excellence strategies with other U.S. organizations.

Ethics Statement and Signature of Highest-Ranking Official

I state and attest that

(1) I have reviewed the information provided by my organization in this award application package.

(2) To the best of my knowledge,

- this package contains no untrue statement of a material fact and
- omits no material fact that I am legally permitted to disclose and that affects my organization's ethical and legal practices. This includes but is not limited to sanctions and ethical breaches.

D Allicock, MD	04/06/12
Signature	Date

☐ Mr. ☐ Mrs. ☐ Ms. ☒ Dr.

Printed name	Dawn C. Allicock, M.D., M.P.H.
Job title	Director
Applicant name	St. Johns County Health Dept.
Mailing address	☒ Same as above
Telephone	904-825-5055, Ext. 1003

Fax	904-823-2580

If you are unable to respond to any item, call (877) 237-9064, option 3, before submitting your award application package.

GLOSSARY OF TERMS AND ABBREVIATIONS

ABC	Assuring Best Care Clinic for pregnant women
Administrative Snapshot	Florida Department of Health report that provides comparative results for financial and administrative performance indicators
AP	Action Plan
BAT	Strategic Business Alignment Tool
Bioterrorism	Terrorism involving the use of biological agents
BLS	Basic Life Support
BOCC	Board of County Commissioners
BRFSS	Behavioral Risk Factor Surveillance System
CASA	Clinic/Provider Assessment Software Application
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive weapons
CD	Communicable Disease
CDC	Centers for Disease Control and Prevention
CHA/CHIP	Community Health Assessment/Community Health Improvement Plan
CHARTS	Community Health Assessment Resource Tool Set – Florida Department of Health's public health information database system
CHD	County Health Department
CHHR	County Health Rankings Report
Consortium	Northeast Florida Consortium – A group of 11 surrounding county health departments, plus SJCHD that partner to share best practices and certain administrative services
COOP	Continuity of Operations Plan
COOP-IT	Continuity of Operations Plan for Information Technology
CPR	Cardiopulmonary Resuscitation
CSR	Client Service Record
DOH	Department of Health
EAP	Employee Assistance Program
EARS	Employee Activity Reporting System
EEO	Equal Employment Opportunity

EH	Environmental Health
EMR	Electronic Medical Record
EOC	Emergency Operations Center
EPH	Environmental Public Health
EPI (Epi)	Epidemiology - Communicable disease prevention, surveillance and control
ESS	Employee Satisfaction Survey
F.S.	Florida Statutes
FDENS	Florida Department of Health Emergency Notification System
FACHO	Florida Association of County Health Officers
FDMS	Florida Department of Management Services
FDOH	Florida Department of Health
FIRS	Financial Information Reporting System
FIS	Financial Information System
FLAIR	Florida Accounting Information Resource
Florida KIDCare	An umbrella of children's health insurance programs for low income families
FPHA	Florida Public Health Association
FPHLI	Florida Public Health Leadership Institute
FQHC	Federally Qualified Health Center
FSECC	Florida State Employees Charitable Campaign
FTE	Full Time Equivalent Employee
GIS	Geographic Information System
GPS	Global Positioning System
GSA	Governor's Sterling Award – The State of Florida's Baldrige-based award
HHS	United States Department of Health and Human Services
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HLC	Health Leadership Council

HMO	Health Maintenance Organization
HMS	Health Management System
HR	Human Resources
HP 2020	Healthy People 2020 – US Health and Human Services initiative that provides a science-based approach to 10 year national objectives for improving the health of all Americans.
HS	Healthy Start – A state funded program providing educational and case management services for Florida's pregnant women and newborn infants.
HSEEP	Homeland Security Exercise Evaluation Program
ICQ	Internal Control Questionnaire
ICS	Incident Command System
ICSI	Institute for Clinical Systems Improvement
ID	Identification
IDP	Individual Development Plan
IDS	Intrusion Detection System
IT	Information Technology
KSAs	Knowledge, Skills and Abilities
LHD	Local Health Department
MAPP	Mobilizing for Action through Planning and Partnerships – Community Health Assessment Process
MDCHD	Miami-Dade County Health Department
MERLIN	Communicable Disease Reporting System
MFMP	MyFloridaMarketPlace – The State of Florida's online exchange for buyers and vendors
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MVV	Mission, Vision and Values
MRC	Medical Reserve Corps
NACCHO	National Association of County and City Health Officials
NCQA	National Committee for Quality Assurance
NEPP	Neighborhood Emergency Preparedness Program
NIMS	National Incident Management System

NQMC	National Quality Measures Clearinghouse
NVSS	National Vital Statistics System
OPHP	Office of Public Health Practice
OPPAGA	Office of Program Policy Analysis and Government Accountability
OPS	Other Personnel Services
PARTNER	Program to Analyze, Record and Track Networks to Enhance Relationships – A social network survey and analysis tool
PD	Position Description
PDA	Personal Digital Assistant
PDCA	Plan-Do-Check-Act
PH	Public Health
PHA	Public Health Accreditation
PHAB	Public Health Accreditation Board
PHI	Protected Health Information
PHMC	Public Health Mobile Center
PHPBRN	Public Health Practice-Based Research Network
PIO	Public Information Officer
PMI	Florida Department of Health Clinical Practice Management Institute
PPHR	Project Public Health Ready – NACCHO/CDC's criteria for assessment of emergency preparedness
PSA	Public Service Announcement
QA/QI	Quality Assurance/ Quality Improvement
REHOST	Florida Department of Health's Environmental Health Database
RN	Registered Nurse
SJC	St. Johns County
SJCHD	St. Johns County Health Department
SL	Senior Leader
SLT	Senior Leadership Team
SME	Subject Matter Expert
SO	Strategic Objective

SP	Strategic Priority
SPEC	Sterling Performance Excellence Committee
SpNS	Special Needs Shelter for public health emergencies
SPP	Strategic Planning Process
STD	Sexually Transmitted Disease
Surveillance	Tracking the spread of disease
SWAT	Students Working Against Tobacco
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
Tabletop Exercise	Facilitated discussion/simulation of an event to test its effectiveness
TB	Tuberculosis
TBD	To Be Determined
TRAK-IT	Florida Department of Health's learning management system
VPN	Virtual Private Network
WD	Workforce Development
WIC	Federally funded nutrition program for Women, Infants and Children
WIP	WIC Information Program
YPLL	Years of Potential Life Lost (before age 75, per 100,000 population)

ORGANIZATIONAL PROFILE

P.1 Organizational Description

P.1a Organizational Environment

P.1a (1) Service Offerings:

Public Health (PH) is a specialized science that focuses on the community as its client for the provision of disease control health protection services. Under the auspices of the Florida DOH, St. Johns County Health Department (SJCHD) provides essential PH services (ESSPH) to the nearly 200,000 residents and more than 6 million annual visitors to our County. Services are directly provided by Health Department staff through the various Service Centers listed in **Figure P-1.** These Centers provide services within the framework of the Public Health domains as defined by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). Services are provided at two main sites that are strategically located on a main county artery (US 1) and through community-level health promotion. Additionally, services are provided at various locations throughout the county via our Public Health Mobile Center. SJCHD is the acknowledged leader of our community's ***Public Health System*** which includes private, public, and voluntary entities that contribute to the delivery of healthcare and community services that affect Health Factors and Health Outcomes. SJCHD supports partner agencies to optimize efforts to positively impact the community's health and welfare.

P.1a (2) Vision and Mission:

As an agency of state government, SJCHD is accountable to the public. Our purpose is to provide essential PH Services to the St. Johns County (SJC) community through our Core Competencies. Our local mission, vision and values statements mirror those of the FDOH. Our purpose statement was developed to reflect the culture we have created in SJCHD. We have a caring, compassionate culture where the client and the public are our first concern.

The leadership of SJCHD supports a culture based on honesty, integrity and personal responsibility; that fosters diversity and mutual respect; an atmosphere of creativity, empowerment and teamwork; and trust, loyalty and compassion as the foundation of the values and beliefs that drive how we conduct business. Staff members are encouraged and provided opportunities to

Figure P-1 – St. Johns County Health Department Programs and Services (All Are Direct Services Provided by SJCHD)

Public Health Domains (Essential Services)	Health Department Services (Domain Alignment)	# of FTE	Key Delivery Mechanisms
1. Monitor health status and understand health issues **2.** Protect people from health problems and health hazards **3.** Give people information they need to make healthy choices **4.** Engage the community to identify and solve health problems **5.** Develop PH policies and plans **6.** Enforce PH laws and regulations **7.** Help people receive health services **8.** Maintain a competent PH workforce **9.** Use continuous quality improvement tools to evaluate and improve the quality of programs and interventions **10.** Contribute to and apply the evidence base of PH **11.** Maintain administrative and management capacity 12. Maintain capacity to engage the PH governing entity	**Public Health System Leadership (All)** • Medical and PH Services • Influential Leadership (Engagement of Community Leaders) • PH Strategic Planning	2	C,M,O,F,P,I
	Disease Control & Health Protection (1,2,3,4,5,6,7,9,10) • Surveillance & Outbreak Investigations - Epidemiology (STD, TB, HIV/AIDS, Hepatitis, Reportable Diseases) • Immunizations • New or Emerging Infectious Disease Threats • Environmental Public Health (Sanitary Nuisance Investigation, Water Programs & Facilities, Onsite Sewage Systems Permitting)	27	C,M,O,F,P,I
	Emergency Preparedness and Community Support (1,2,3,4,5,6,7,9,10) • Public Health Preparedness and Response • Neighborhood Preparedness Programs	1	M,O,F,P,I
	Office of Public Health Practice & Policy (1,2,3,4,5,7,9,10) • Public Health Statistical Analysis and PH Informatics • Community-level Health Promotion via Collaborations & Partnerships	4	M,O,F,P,I
	Clinical Services (1,2,3,4,7,9,10) • Pediatric Primary Healthcare Services • Pediatric Dental Services • Communicable Disease Management & Treatment • HIV/AIDS Medical Management • Family Planning Services	24	C,M,O,P
	Women and Infants Case Management Services (1,2,3,4,7,9,10) • Healthy Start Program Services • Pregnancy Referral & Linkage Services (ABC) • Women, Infants and Children's Nutritional Services (WIC)	26	C,M,O,F,P,I
	Vital Statistics (1,2,3,6,9,10) • Provision of Birth & Death Certificates	1	O,P,I
	Internal Support Services (1,2,3,4,7,8,9,11) • Fiscal Sustainability • Human Resource Management • Information Technology • Administration	16	C,F,M,O,P,I
Key - Delivery Mechanisms (C)-Clinic (M) PH-Mobile Center (O)-Office (F)-Field (P)-Phone (I)-On-line			

participate in decision making and provide input towards achieving Agency goals. Staff continually develops innovative strategies to accomplish the agency's mission, vision, values, purpose, and core competencies as shown in **Figure P-2**.

P.1a (3) Workforce Profile:

SJCHD workforce is currently comprised of 109 staff (101 FTE), including 84 full-time employees and 25 part-time and temporary employees. 26% hold professional licenses. The Health Department staff is 73% female and 63% is age 40 or over. We are: 79% White, 10% Black, 5% Other. 6% are Hispanic. This closely mirrors the population of SJC.

Figure P-2 – Core Competencies, Mission, Vision, Values

Core Competencies	Alignment with	
	Mission/ Strategic Priorities	PH Domains (Fig. P-1)
1. Collaborations and Partnerships	M,P1,P2,P3, P4	1,2,3,4,5,7, 8,9,10
2. Public Health Emergency Preparedness & Response	M,P1,P3	1 - 10
3. Epidemiology	M,P1,P3	1 - 10
4. Environmental Public Health	M,P1,P3	1 - 10
5. Holistic, Efficient and High Quality Public Health Services	M,P1,P2, P3, P4	All
Key to Above - Mission = M, Priorities = P1. Promote/Protect, P2. Business/Finance, P3. Customer/Partner, P4. Employee		
Mission	**Values**	
To protect and promote the health of all residents and visitors in St. Johns County Florida.	• *Integrity* • *Commitment to Service* • *Respect* • *Excellence* • *Accountability* • *Teamwork* • *Empowerment*	
Vision		
A healthier future for the people of Florida		
Purpose		
St. Johns County Health Department - A Center of Excellence in Public Health		

Currently, several of our Physicians & Dentists are bi-lingual. We have employees proficient in both English, Spanish, and several other languages. 70% of staff have education and training beyond high school, including 41% with a bachelor's degree or higher, and 16% hold post graduate degrees. Employees are represented by three collective bargaining units: the American Federation of State County & Municipal Employees; the Florida Nurses Association; and the Federation of Physicians & Dentists.

Our employees receive the same benefits as all state government employees. These benefits include health and life insurance programs, deferred compensation plans, medical/dependent reimbursement accounts, paid holidays, retirement, unemployment and worker's compensation, annual leave, sick leave for personal and for immediate family use, sick leave pool and donations, family medical leave, family support work program, administrative leave, military leave, one hour per month to attend school/community activities, educational leave with and without pay and EAP.

We have an incident reporting policy to address employee and client accidents, injuries and incidents. This policy includes a risk management/safety committee to identify and respond to these issues. As with any health care agency, we pay particular attention to safety requirements regarding blood-borne pathogens and infectious disease exposure, in addition to other safety requirements covered under state law.

We use the evidence-based ***Gallup Q12*** questions as a measure of key factors for staff engagement. The annual FDOH employee survey assesses our employees engagement level on most of these factors. (See Item 7.3)

P.1a(4) Assets:

SJCHD's main facility is located on US 1 (in St. Augustine) and Environmental Public Health (EPH) is six miles away at the County Courthouse complex (for the convenience of the County's permitting process). The buildings for both of our sites are owned and maintained by SJC. We utilize a Public Health Mobile Center that enables us to provide our services at multiple locations around the county.

We use current technology, vital for an efficient work environment, to maximize employee productivity and client services. Our computer system is comparable to a similar sized-private sector organization's infrastructure. All employees have access to a computer on site and are trained by the IT staff as needed for specific programs/applications. All computers are linked to the FDOH Wide Area Network via high speed T-1 data communications lines; high-speed broad-band and laptop with Blackberries VpN internet service for remote access (PHMC, home, Special Needs Shelter, etc.). We implemented a touch screen client satisfaction survey system in 2009 to provide real time and continuous flow of client satisfaction data. In 2011 we assisted in the development of Healthy Communities Network (Dashboard) and in 2012 we launched an internal real-time dashboard to monitor key process measures such as clinic cycle time.

We use medical equipment typical of organizations providing healthcare (e.g. Electrocardiogram machines, nebulizers, dental equipment including digital and panoramic x-ray, and lab equipment). We also have access to county vehicles (trucks, cars, vans). Global Positioning Systems, PDAs and GIS applications are available for field use.

P.1a (5) Regulatory Requirements:

We are subject to local, state and federal regulations related to the provision of services, employment, and occupational health and safety. SJCHD is also subject to HIPAA and health care provider licensure requirements.

Florida Statute (F.S.) Chapter 381 describes the general provisions for public health. F.S. Chapter 154 establishes county health departments and delineates the core services to be provided by health departments in the areas of EPH, communicable disease control, and primary health care. The department's functions and funding levels are determined by the state legislature. The statutes describe the unique partnership that exists between the FDOH and the Board of County Commissioners (BOCC). This partnership is written in a "core" contract between the two governmental entities, which allows county government to regulate specific local health issues through county ordinances and allows the Health Department to charge county fees for some services. Lastly, we operate under numerous other regulations, laws, and

requirements that apply to grant projects, contractual services, and specialized programs within the Health Department.

Although SJCHD has no mandated accreditation or certification requirements, in 2012 we applied for voluntary PH Accreditation through a new process overseen by the Public Health Accreditation Board (PHAB). Accreditation will serve as a comprehensive assessment of PH processes that enable compliance with standards regarding the provision of the Essential PH services (See **Figure P-1**).

In 2010, we were certified nationally as Project Public Health Ready, a CDC/NACCHO PH preparedness and response standard. Currently, 270 of approximately 2,700 Local Health Departments in the US maintain this certification.

P.1b Organizational Relationships

P.1b (1) Organizational Structure:

We are led by our Director, Dawn Allicock, M.D., M.P.H. who reports to the deputy Secretary for Health of the FDOH which is in the executive branch of state government, directed by the Governor. We work in cooperation with the BOCC and other stakeholders in the local PH system to determine county specific health-related priorities and actions. Dr. Allicock and her Department Directors comprise the SJCHD Senior Leadership Team (SLT). The SLT provides expertise to assist in key decision making. A second level of leadership is the Sterling Performance Excellence Committee (SPEC) which includes all supervisory employees and other employees in key positions. Employees are organized into Service Centers and programs, and report to supervisors who report to Directors.

Governance is provided through reviews and audits conducted by the state Office of the Inspector General and the Office of Program Policy Analysis and Government Accountability (OPPAGA). FDOH conducts ongoing quality improvement reviews. Some programs have additional programmatic monitoring by federal, state or regional governing bodies.

P.1b(2) Customers and Stakeholders

SJC encompasses 609 square miles with a 2010 census population at 190.039. There has been a 54.3% increase in population for 2000-2010 time period versus a 17.6% increase for Florida. Through the past decade, SJC has been among the fastest growing counties in the United States.

Most of our Core PH programs are provided for the community at large, while we provide other services for more focused markets/clients/patients. Customers identified as indirect may intermittently become direct customers/patients in response to emerging situations. Regardless, our key customer groups have many similar expectations. **Figure P-3** shows our key customer and community partner groups, and their requirements and expectations.

The poverty level in the county is 8.7%, and 15.7% of residents are 65 years or older. Some conditions which present challenges within the county are schools at capacity, crowded roads, falling property values, and subsequently falling tax revenues. To ensure all residents receive necessary Core PH services and have access to needed health care, we provide targeted interventions in areas of the county with poor health outcomes, and in our higher-risk neighborhoods.

P.1b(3) Suppliers and Partners:

Suppliers and partners are important to performance. Suppliers include all the vendors, from which goods and services are purchased, including laboratory services, medications, and the equipment and supplies necessary to conduct business. We also contract with local healthcare providers and medical staffing services to provide specialty care and provide coverage for critical vacancies. Suppliers are expected to adhere to state and federal regulations related to business practices, and to provide the best products/services on time at the best price. Suppliers are contracted through the state's purchasing system.

One key partner is the BOCC. The county government supports the facilities used by the Health Department (about 50,000 square feet rent free). Also, out of their general fund, county government provides a small portion (4%) of the financial support necessary to maintain PH services.

Other important partners/collaborators include entities whose missions relate to local health outcomes and health factors. The most important requirements for partners include: commonality of mission; accountability; performance; teamwork; and integrity. These are highlighted in **Figure P-3**. We have numerous successful relationships with partners and collaborators in the local PH system. Some of these are contractual and others reflect strong professional relationships between SJCHD staff and other agencies. We communicate with suppliers mainly through the use of technology (automated state purchasing system, e-mail, websites, faxes, telephones). Although technology plays an important role, "live-and-in-person" communication is integral, whether through public committees or one-on-one individual meetings.

We partner with the Healthy Start Coalition for implementation of the local Healthy Start program for infants and pregnant women. We partner with SJC Head Start to provide dental and nutritional services. We also partner with Florida Department of Environmental Protection and St. Johns River Water Management to provide groundwater protection services.

In addition to contractual relationships, we partner with many community organizations and individuals who work toward accomplishing community health. As the leader of the local PH system, SJCHD chairs the county Health Leadership Council (HLC). Through the HLC, a Community Health Assessment and Community Health Improvement Plan is completed every three years, most recently in 2011. This enables SJC to undertake significant improvements in the PH system that are beyond the capacity of any of the individual members. Partners in the HLC are involved in community and organizational innovation through various partnerships that take on projects such as the reduction of Infant Mortality, and the development of a community balanced scorecard.

Figure P-3 - SJCHD Key Customers, Partners and Collaborators	
Key Groups	**Specific Group Requirements & Expectations**
Direct/ Indirect Customers/Patients	
• General Public (County residents, businesses and visitors) (**Indirect**) • Patients/ Clients **(Direct)**	• Protection from Disease & Disaster • Accurate Information • Accessibility • Timely Service • Courtesy/Respect • Knowledgeable Staff
Community Partners/Collaborators	
Hospitals; Federally Qualified Health Center; Health Care Providers; Board of County Commissioners; County Public Safety and Response Services (Sheriff's Office, Fire Rescue, County Emergency Management); local School Board	• Emergency Response Leadership/Support • Service Coordination • High Quality PH Services • Open Direct Communication

P.2 Organizational Situation

P.2a Competitive Environment

P.2a (1) Competitive Position:

SJCHD is considered to be a medium-sized health department by the FDOH. For the past ten years SJC has been among the fastest growing counties in the US. Despite this growth, we have been able to provide expanded and value added Core PH services throughout the county in spite of reduced resources.

SJCHD provides Core PH services, statutorily mandated services and certain federally funded programs that have no direct competitors. These include Disease Control and Health Protection, Epidemiology, Surveillance, Vital Statistics, PH Preparedness and Response, specific EPH activities, WIC, and Clinical Care of PH Significance.

SJCHD does have competition for funding and clients, particularly clients with insurance, from private and publicly funded healthcare providers in the areas of direct patient services: Pediatric Primary Care and Dental. SJCHD serves many clients without access to medical insurance.

Numerous agencies, organizations and providers serve as partners in the Local PH System. There is cooperative competition between SJCHD and many of these agencies. Examples include: Healthy Start, and chronic disease prevention.

While SJCHD does not have direct competition for a number of its programs, it must compete with other agencies for its workforce and funding. Therefore we must provide efficient high quality PH services that are clearly valued by the community.

P.2a (2) Competitiveness Changes

PH programs measure success by analyzing health outcome measures with comparisons to other CHDs and to statewide and national health indicators, goals and targets.

In 2010 the Florida State Legislature passed a bill requiring DOH to evaluate and justify its programs and provide recommendations for restructuring and reduction. This action has significantly impacted our priorities and programs. Funding has been reduced by the legislature annually for the past 5 years. Since FY 06/07, State funding for SJCHD has been reduced by 27%. Federal funding is now following the same trend. Since FY 09/10, SJCHD has experienced a 31% reduction in federal funds. SJCHD must be agile to adjust to these changes.

State imposed limitations on salary (no pay increases for the last six years) and reductions in benefits are impacting the retention and recruitment of professional staff. SJCHD's ability to innovate and seek grants has been limited due to DOH and legislative restrictions/directives. For example, utilization of social networking tools such as Facebook or Twitter are restricted. Also, we are unable to pursue grant funding opportunities or make program changes that may be deemed as competing with private businesses. Therefore we must continually find innovative ways to partner in order to impact important health outcomes.

P.2a(3) Comparative Data:

Until recently, comparative PH data was difficult to obtain, but in the last several years, information sources have become much more robust. There are now several major sources of comparative industry data including the County Health Rankings report (done for the past three years by the University of Wisconsin and the Robert Wood Johnson Foundation); the Community Health Status Indicators report by the CDC which identifies and provides comparative results for SJC and 26 national peer counties; and the Florida CHARTS system which provides various health statistics. The Northeast Florida Counts dashboard system also provides a large variety of community data from numerous systems that are consolidated by the dashboard tool. There are many other sources of comparative information (particularly at the state level) to obtain disease rates, financial, employee, and customer data. While there are many sources of PH outcome information available as listed above, PH processes are not commonly measured and comparisons are often limited to agencies engaged in the performance excellence journey. We also compare ourselves outside of our industry to high performing organizations who have similar processes. These include other Sterling Award (Florida) and Malcolm Baldrige Award recipients. Miami-Dade County Health Department in Florida is a three-time Sterling Award recipient and is often used for these comparisons. Sullivan County (Tennessee) was recognized by the Tennessee State Program and is also used as appropriate.

P.2b Strategic Context:

We have identified several challenges and advantages during our strategic planning process. See **Figure P-4.** One main advantage is access to various community entities that deliver and aid in the delivery of essential PH services. We actively partner with this group of private and public entities to strengthen prevention, preparedness, and education of county residents. Our most pressing challenge is to find continued revenue to sustain key PH processes as various sources of state and federal funding are reduced and become more restrictive. Our long-term performance excellence journey has served us well in this regard.

P.2c Performance Improvement System:

The overall approach to maintaining an organizational focus on performance improvement and organizational learning is through strategic planning and systematic evaluation and improvement methods. The SPP described in **Figure 2.1-1** outlines the ongoing evaluation of organizational objectives and opportunities to develop action plans to close gaps. A Balanced Scorecard is used to deploy goals, action plans and results on a monthly, quarterly and annual basis.

We use several systematic approaches to ensure the continuous evaluation and improvement of our services, systems and processes. These include a SLT and SPEC-level review process, process management, employee problem-solving teams and workgroups, community needs assessments and improvement plans, and the systematic assessment of our management system using Baldrige-based assessments and feedback. Our approach to systematic knowledge and skill-sharing is accomplished through our team-based employee involvement structure and sharing at all levels, regular team reviews, bi-weekly leadership meetings and wide availability of data and information.

SJCHD has shown improvements in many work processes and outcomes through the use of formal quality improvement techniques and processes. For example, we have hired business management consultants to guide us through the Baldrige Process and to assist with Strategic Planning. We have made three-day 360 degree leadership workshops available for senior and mid-level leadership, and have provided process management and improvement workshops for many of the staff. This training has been implemented via a number of teams and workgroups that are using these methods to make performance improvements.

One major initiative was the revitalization of the SJC Health Leadership Council (HLC). The roster of the HLC was deliberately reworked to include both decision-makers and working members from a broad cross-section of representatives of the local public health system. The Council was re-chartered and worked to develop new mission, vision and values. The HLC uses the nationally recognized MAPP (Mobilizing for Action through Planning/Partnerships) process as a strategic approach to community health planning and improvement.

As a part our Strategic Planning, several years ago, a concerted effort to increase staff enrichment and workforce development was made. Dr. Allicock implemented a staff enrichment/ workforce development program. Currently, we have twice-monthly half day enrichment/training sessions, and a very active and current online training (Trak-it) library. We also operate in-depth supervisor training and comprehensive multi-day new employee orientation.

Teams contribute greatly to our strategy for continuous improvement. Action plans for teams and committees are posted on the shared document drive accessible by all staff. The PDCA process is utilized for innovations and programmatic changes. Staff has the flexibility in choosing the type of PDCA tool that best meets their needs. Recognition takes place in monthly all staff meetings to both publicly recognize high performance and also to encourage continued innovation. The most important improvement initiatives that are discussed in this application are listed in **Figure P-5.**

Figure P-4 SJCHD Strategic Challenges/ Advantages

Type	Strategic Challenges (C) & Advantages (A)
Population-based & Individual Health Care	▪ Funding Decreases and Continued Uncertainty (C) ▪ Possible Mandated Service Reductions (C) ▪ Public Perception of Public Health (C) ▪ Community Partnering (A)
Operational	▪ Adequate Funding and Staff (C) ▪ Medicaid Reform and its financial impact (C) ▪ Continuity of Operations in Emergency/Disaster (A) ▪ Clear Policies and Procedures (A) ▪ Process Management (A)
Societal	▪ Strong Community Partnerships (A) ▪ Addressing Core PH Concerns with Severe Resource Limitations (C)
Human Resource	▪ Staff Recruitment and Retention (C) ▪ Employee Motivation (C) ▪ Training/Cross Training (C) ▪ Senior Leaders' Development Planning (A) ▪ Lack of Competitive Pay (C)

Figure P-5 Improvement Initiatives

Year	Improvement Initiatives
2004	• Began the Sterling/Baldrige Journey • Multiple Disasters resulted in active Disaster Response and more robust Disaster Response Planning
2005	• First Community Health Needs Assessment (MAPP) • Participated in the Florida Sterling Quality Challenge
2006	• Initiated the West Augustine (Westside Wildflower) Community Initiative
2007	• Applied for the Florida GSA • Developed the SJCHD White Paper
2008	• Public Health Mobile Center Deployed • Second Community Health Needs Assessment (MAPP)
2009	• Florida Governor's Sterling Award (GSA) Recipient • Deployed Real-time Touch Screen Customer Satisfaction Survey
2010	• Project Public Health Ready Certified • Public Health Accreditation Player in Pilot Program
2011	• Third Community Health Needs Assessment (MAPP) • NE Florida Counts Dashboard Initiated • Florida GSA Sustained Performance Excellence Award
2012	• Deployed Real-time Internal Dashboard System • Applied for initial Voluntary PH Accreditation

CATEGORY 1 LEADERSHIP

1.1 Senior Leadership

1.1a Vision, Values and Mission

1.1a (1) Vision and Values:

Setting: A key function of our leadership system has been to set and deploy the direction of the organization through the development and deployment of the mission, vision, values, purpose and strategic priorities. This top-down and bottom up process originally started in 2004 when the SLT of St. Johns County Health Department (SJCHD) hired a consultant to assist in the development of an updated strategic plan. We reviewed our existing strategic plan, conducted facilitated focus groups involving all staff, and solicited staff input into what should be included in our mission, vision and value statements. SLs incorporated results of staff focus groups into updated mission, vision, and values (MVV) statements. Until 2007, we continued to validate and refine our mission, vision and values as a part of step 1 of our annual Strategic Planning Process. (See **Figure 2.1-1**). While prior to 2007 it was expected that our mission, vision and values statements would align with the state DOH, in 2007 with the advent of a new Surgeon General, there was a mandate that all units of DOH would use the state's mission, vision and values statements as their own. In 2011 as part of our Strategy Development process, a purpose statement was added by SLT to reflect the culture we have created in SJCHD. These statements are shown in **Figure P-2**.

Deploying: In order to make our organization's values "real", the SLT demonstrates and communicates the vision, values and expectations of the organization through direct communication and role modeling. We have deployed our mission, vision, values, and purpose in a number of ways. For example, the SLT conducts one-on-one meetings with all new employees to reinforce the mission, vision, values and priorities of the organization. Periodically, SLs present talking points on our mission and individual values to managers, supervisors and staff. Feedback from employees regarding their work environment and recommendations for improvement also is gathered, compiled into themes and provided as input into the strategic planning process. The SLT conducts programmatic business reviews that reinforce the organization's mission, vision, values, and priorities.

The Baldrige process and the organizational vision were originally introduced (in 2004) and initiated at an all-staff off-site event involving presentations by our Baldrige consultant, SLs and selected staff. In addition, our values are directly deployed to staff, commencing with the recruitment and selection process and new employee orientation whereby the mission, vision, values, and expectations are communicated and reinforced. For example, prior to final approval for hire, the Director interviews all candidates who are being considered for key leadership and management positions. An introduction to organizational performance excellence is included as part of the orientation process. Our mission, vision and values are printed on employee ID badges and displayed on posters at key locations for all employees and patients/clients. The appearance of the "Sterling Strand" approved by Dr. Allicock on every employee's desktop is another technique implemented by the Director to reinforce the organization's mission, vision, values and priorities. These "Strands" contain a message to all staff that promotes the ideals of Baldrige management, often with a tie in to one or more of our core values. Sterling Strands vary from one paragraph to one page in length and are updated several times a year. Employees' performance standards also are designed to support our MVV, and priorities.

In 2005, Dr. Allicock introduced a unique concept of four-hour Staff Enrichment/Workforce Development days. These are conducted twice monthly on the First Friday and Third Thursday. While First Fridays are used for individual and service center development activities, the Third Thursday consists of a four-hour all-staff Enrichment/Workforce Development session. In addition to conducting staff training, this day is used to reinforce our mission, vision, values, and purpose. For example, we had an SJCHD employee Olympics that showcased the goals and objectives of individual departments while building employee creativity, respect and loyalty across departmental lines. We also facilitate team meetings specifically formed to address identified opportunities for improvement; and show films (such as *Contagion* and *Unnatural Causes*) dealing with PH issues affecting our employees and our community.

Each week individual Service Centers conduct a departmental 45 minute Pass-up/Pass-down session. This information and idea sharing reinforces the values of accountability, integrity and empowerment throughout the organization.

Our website www.stjohnschd.org, and Business Plan/Annual Report communicate the organization's MVV, purpose, priorities and business results to patients/clients, suppliers and partners. Our MVV are also posted throughout our buildings and in every conference/meeting room making them apparent to any visitors or community partners. All contracts for services are vetted based on meeting the SJCHD's mission, vision, values and priorities prior to approval.

Senior Leader Actions: SLs are actively involved in implementing all aspects of the Performance Excellence Model (**Figure 1.1-1**) including commitment to values. Examples of their personal actions are provided in **Figure 1.1-2**.

1.1a(2) Promoting Legal and Ethical Behavior:

SL is responsible for maintaining a highly regulated and ethical organization. Immediately upon assuming her position as Director, Dr. Allicock set the tone for requiring and fostering legal and ethical behavior by outlining the legal and ethical expectations for our organization. At her first "All-Staff" meeting, Dr. Allicock presented the legal and ethical expectations for the organization and its employees. Employees not adhering to our high legal and ethical standards are subject to appropriate disciplinary action. Underscoring our commitment to legal and ethical behavior, our former Chief Legal Counsel was promoted to Assistant Director and sits on the SLT.

Special topics are covered during bi-weekly SLT meetings such as the purchasing and contracting process, media relations, risk assessments, and county budget issues that all touch on legal and ethical policies. Having an SLT member with 20 years of legal experience and 14 years in PH ensures we keep legal and ethical obligations in the forefront of all decision making. In addition, quality assurance/quality improvement processes are in place to ensure compliance of

Figure 1.1-1 SJCHD Performance Excellence Model

Public Health		
Baldrige Performance Excellence Model	**12 Public Health Domains (Essential Services & National Public Health Accreditation Standards)**	**Healthy People 2020 Goals (From CDC)**
Organizational Profile: Environment, Relationships, and Challenges --- 1. Leadership 2. Strategic Planning 3. Customer Focus 4. Measurement, Analysis and Knowledge Management 5. Workforce Focus 6. Operations Focus 7. Results	1. Monitor health status and understand health issues 2. Protect people from health problems and health hazards 3. Give people information they need to make healthy choices 4. Engage the community to identify and solve health problems 5. Develop public health policies and plans 6. Enforce laws & regulations 7. Help people receive health services 8. Maintain a competent public health workforce 9. Use continuous quality improvement tools to evaluate and improve the quality of programs and interventions 10. Contribute to and apply the evidence base of public health 11. Maintain administrative and management capacity 12. Maintain capacity to engage the PH governing entity	• Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death. • Achieve health equity, eliminate disparities, and improve the health of all groups. • Create social and physical environments that promote good health for all. • Promote quality of life, healthy development, and healthy behaviors across all life stages.

Figure 1.1-2 Senior Leaders' Personal Actions

Leadership System Elements	Examples of SLT Personal Actions
Mission Vision Values Purpose Guiding Principles Strategic Priorities	• Discuss Values in Employee Orientation • Leadership Training • Prospective Employee Interviews • Website/Intranet • Employee Forums • Role Modeling ICREATE • Customer Service Training
Legal, Ethical and Regulatory Compliance	• Discussion at Employee Meetings • Role Modeling • Risk Manager/ Risk Management Team
Sustainability: Including Performance Improvement & Achieving Mission/Vision & Objectives, Innovation	• Daily Operations Meeting • Performance Evaluations • Business Results Review/ Action Plans • Pass up/Pass down • Performance Excellence Training • Project Public Health Ready
Creating Workforce Culture that Delivers Positive Patient/Client Experience	• Pass up/Pass down • Customer Service Training • Role Modeling • Every Person Every Time Initiative
Environment for Organization/ Workforce Learning	• First Friday/Third Thursday Staff Development/Enrichment Days • Employee Workgroups/Teams • Individual/Team Recognition • SLT Accessibility • Individual Development Plan Review • PH Nurse Mentoring Program • Annual Staff Retreat
Develop/Enhance Leadership Skills	• Performance Excellence Training • Participation of Operations Meeting
Learning Succession Planning, Future Leader Development	• 360 Degree Leadership Training • SL Mentoring

legal and ethical standards. All employees and contracted vendors are required to sign the Confidentiality and Security Statement of Understanding which are non-negotiable requirements. SLs continually communicate and role model zero tolerance for non-compliance. SLs and supervisors check with the state legal department whenever there might be a legal or ethical concern. The assigned attorney is available to all staff in person, by telephone or e-mail. Staff and senior managers know they do not have to "guess" at the right answer and deal with the consequences later. They can get the correct information in advance to make the best possible decision.

Dr. Allicock has created a cross functional Internal Risk Management Team and appointed a full time Risk Manager to address issues and policies involving the concerns of information security and patient confidentiality. The Assistant Director regularly consults with this team. By identifying areas or situations that are prone to potential security and confidentiality breaches, this team recommends proactive changes in existing policies and procedures to better safe guard confidential information and internal security. A change suggested by this team to limit the number of "secure" fax machines was implemented. This change has significantly decreased the potential of staff inadvertently breaching the confidentiality of a patient.

SLs are very engaged in all aspects of legal and ethical compliance from setting internal policies and processes, to implementing DOH policy, to visibly communicating these policies (and possible consequences for non-compliance), and recognizing outstanding performance. Trainings in ethics policies are provided at New Employee Orientations and annually for all staff. New and existing supervisors receive annual training in situational legal and ethical issues from the CHD attorney and participate in small group question and answer sessions with the attorney.

1.1a (3) Creating a Sustainable Organization:

The deployment of our Performance Excellence Model (**Figure 1.1-1**) drives sustainability. It provides us with a management

model (Baldrige), the essential PH services we must provide and the high level goals that we strive to accomplish. Strategic planning (**Figure 2.1-1**) and Leadership Review (**Figure 1.1-3**) processes ensure that the organization continues to grow and prosper. Frequent performance reviews in these varying formats enable quick decision-making and organizational agility which has been a foundation for our success.

Figure 1.1-2 shows how SLs are personally involved in assuring sustainability. For example, several years ago the heightened threats of manmade and natural disasters brought preparedness and response to the forefront of the business of PH. SLs identified Prevention and Preparedness as one of our Strategic Priorities and have aligned our resources to support the multifaceted activities for this critical priority. Since that time our focus on preparedness has enabled development of a Continuity of Operations Plan (COOP) to ensure Essential Services will be continued in the event of disaster, a Risk Management Process and a full time Risk Manager and certification as "Project Public Health Ready".

Environment for Performance Improvement: SLs are committed to performance excellence and continuous improvement and consistently strive toward higher levels of performance. The Baldrige Model for Performance Excellence was adopted in 2004. The SJCHD Performance Excellence Model was developed by combining the Baldrige Model, the 12 Public Health Accreditation Domains, and the Healthy People 2020 Goals (See **Figure 1.1-1**). Implementation of the SJCHD Performance Excellence Model promotes the change of culture for the SJCHD. Dr. Allicock is fostering an environment which is proactive and empowers employees to make decisions at the front-line level. This allows SLs to focus on strategic issues and the employees on day-to-day issues. For example, the Administrative Services Director/ Human Resource Manager coaches supervisors to better equip and empower them to work with their staff in dealing with specific human resource issues. He teaches supervisors to use behavioral interviewing, to rewrite position descriptions and define competencies to ensure hiring and retention of the right employee for the right job.

From the date that employees join the organization, they receive training in quality improvement tools. Employees are actively engaged in the continuous improvement process through employee teams/workgroups, councils, and committees. The various SL Review Processes (**Figure 1.1-3**) drive us to keep our eye on the accomplishment of Strategic Objectives and Performance Improvement through the multi-level reviews of benchmark performance levels, best practices and the status of improvement projects. In 2010 an Office of Public Health Practice was set up to drive Performance Improvement and the knowledge of Quality Science into the organization. This office consists of a Senior Leader who is currently engaged in a Masters of Quality Management program, a full time employee currently undergoing Lean Six Sigma Certification, and a part-time employee who has many years experience as a quality consultant and is a long-time Baldrige Examiner. This group is currently focused on several Quality Improvement projects, attaining voluntary PH Accreditation and applying for the Malcolm Baldrige award.

Culture that Delivers Positive Customer Experience: SLs have created an environment very focused on creating positive customer experiences through frequent customer service training starting with employee orientation and continuing during First Friday/ Third Thursday Staff Enrichment sessions. In order to get a continuous flow of patient/client satisfaction data, SLs implemented a Touch Screen patient/client satisfaction survey in 2009 and in 2011 an internal dashboard to continuously monitor and resolve any clinic flow bottlenecks. Also in 2011 we began the "Every Person Every Time" initiative. This initiative provides every employee with a tool kit that describe our customer service standards and the usage of *Key Words at Key Times* to provide a "**GREAT**" customer service experience for every customer every time.

Environment for Organizational/Workforce Learning: Our commitment to performance improvement is illustrated by the establishment of our Staff Enrichment/Workforce Development days. In our third Thursday sessions of the month, staff is engaged in training which includes PH Education, Program Specific Training, Professional Development, Mandated DOH Training, and Baldrige activities (which provides training and work time for chartered improvement teams). Also, employees have access to a wide range of on-line training via the "Trak-It system and as a part of the annual appraisal process they are asked to complete an Individual Development Plan (IDP) to address job-related skill gaps and future development desires.

Leaders conduct weekly “Pass Up/Pass Down” sessions with staff within their departments. These sessions provide a fixed opportunity for supervisors to “Pass Down” any current issues with staff and for staff to “Pass Up” any concerns or improvement ideas. Very often, these “Pass Up/Pass Down” sessions are devoted to brainstorming solutions to problems that have come up within the specific program or the SJCHD.

Develop and Enhance Leadership Skills: Dr. Allicock has implemented a number of systematic approaches that lead to organizational improvement. For example: participation in many types of leadership training including a special supervisory training with pre and post employee survey assessments; a 360 degree leadership assessment training for SLs and high potential mid-level managers. Also the collaborative leadership approach used by Dr. Allicock serves as a tool to develop the leadership skills of new SLT members. Most important decisions are vetted by the entire SLT in their twice-weekly meeting before the Director makes a final decision. Newer leaders acquire decision making skills by participating in this process and are often assigned to relieve the more senior SLT members in their absence. In the Daily Operations meeting, Leaders of various levels meet to plan the day. This ensures communication of unusual circumstances and staffing decisions to ensure that clinical operations function smoothly. Through this daily meeting even the newest leaders learn the necessary organizational and decision making skills to be successful in a small very agile organization.

Succession Planning and Development of Future Leaders: SLs actively participate in Leadership Development Planning and the development of future leaders for the organization. Future leaders are identified, encouraged, and provided with opportunities to enhance their needed knowledge and skills in preparation for succession. Future leaders are identified and mentored by SLs. Each SLT member is asked to mentor and

Figure 1.1-3 Senior Leadership Review Process

Type of Review	Frequency	What is Reviewed?	Who Attends?	How SLs Create Focus on Action
Operations	Daily	• Workload and capacity	SLT & Selected Supervisors	• Incident Command Process for decisions • Action Log kept and reviewed
Senior Leadership Team	Every Monday plus as Needed	• Short/ long-term plans • Pending changes from DOH and Legislature	SLT & Others as Required	• Review any pressing concerns • Short term actions determined • Action Register kept and reviewed
Strategic Plan Progress Review	Semi-Annually	• Strategic Plan/ Action Plans/ Benchmarks • Programs/Plans	SLT	• Reassess Action Plans • Determine Need for New or Revised Action Plans
Scorecard Review	Quarterly	• Service Center Indicators	SPEC (Includes SLT)	• Review Indicators • Take action to reverse trends
DOH Snapshot/ Dashboard Review	Monthly	• Administrative Indicators	SLT	• Identify what goals not being met • Address proactive ways to correct.
Financial Review	Every Monday	• Budget/ Spending • Cash Balance • Expenditures • Salaries	SLT	• Respond to Finance/Accounting Director suggestions • Address corrective action through chain of command
Service Center Review	Bi-Weekly SPEC Meeting	• Service Center Scorecard • Productivity • Program/ Process Best Practices	SPEC (Includes SLT)	• Issues reported to SLT • Knowledge Sharing/ Problem Discussion • Service Center Reports • Actions Registers • Pass-up/Pass down meetings

develop at least two people. Those being mentored are identified for potential via evaluation, program performance, and behavior in alignment with mission/vision/purpose/values of the SJCHD. This is done by conducting regularly scheduled interactive sessions, case scenarios, and providing developmental assignments. They are also asked to relieve their Supervisor as appropriate. We accomplish Leadership Development planning through several means. This includes IDP's, 360 degree training, and peer coaching for leaders.

SLs are strongly encouraged to advance their formal education and encouraged to use the skills acquired to further support the achievement of our mission. Potential candidates for leadership development are identified and referred by SLT to be enrolled in supervisory and leadership development training prior to their promotion to leadership assignments. Budget permitting, those being mentored may be provided the opportunity to attend the Florida Public Health Leadership Institute (FPHLI) to develop leadership skills.

Those SLs and other key positions retiring in the next two to five years have been identified and a plan developed to ensure that their competencies and institutional knowledge will not be lost to the organization. An example of the fulfillment of this planning is the former Legal Counsel who successfully competed for the job of Assistant Director who was mentored by the incumbent Assistant Director.

Create and Promote a Culture of Patient Safety: The Risk Manager and Risk Management Team (that includes SLs) meet monthly and are responsible for inspecting the premise to identify and mitigate any patient safety risks. Issues concerning patient safety are often discussed and emphasized both in all-staff meeting and in mandated training sessions.

Environment for Accomplishment of Strategic Objectives: SLs lead the effort to develop and deploy an annual short and long-term Strategic Plan (See Category 2). In this process, they use data and input from a variety of internal and external sources. Strategic priorities (SPs) are established to concentrate efforts and resources on a few critical priority issues. SLs are responsible for ensuring that the SPs are deployed and targets are set and achieved. We have four organizational priorities: **1) Promote/Protect Health and Quality of Life 2) Business/Finance Excellence, 3) Customer/Partnership Engagement, 4) Employee Engagement/ Accountability**.

Progress toward attaining Strategic Objectives and completion of Action Plans are reviewed and refined as needed as shown in **Figure 1.1-3.**

1.1b Communication and Organizational Performance

1.1b(1) Communication:

In 2006 SLs implemented an "all staff" annual retreat. This day is used as a primary means of communication and organizational learning. For the last several years, the retreat has been improved by having each Service Center present their "Center Profile" and also present their key accomplishments for the year. This serves as a means of educating staff on the functions and key accomplishments of the SJCHD.

As already discussed, there are numerous frequent means of communicating including the various Leadership Review meetings (**Figure 1.1-3**). In 2005 a SJCHD Communications Committee was formed to improve information sharing practices, both internally and externally. The Committee's purpose was to ensure that clear, timely and accurate information is communicated to, and from, internal and external customers through effective and fast communication

processes. In 2010 this function was absorbed by the Office of Public Health Practice (OPHP). Among other issues, OPHP seeks to make Pass Up/Pass Down communication processes more effective, improve internal communications practices and ensure that information communicated externally from the CHD is up-to-date and accurate.

Two-way Communication and Key Decisions: Leaders conduct weekly "Pass Up/Pass Down" sessions with staff within their departments. These sessions provide a standing opportunity for supervisors to "Pass Down" any current issues and key decisions with staff and for staff to "Pass Up" any concerns or improvement ideas. Other examples of leadership involvement in communications can be seen in **Figure 1.1-2.**

Bi-weekly SPEC meetings serve as a key means of communicating important decisions and provide information for supervisors to pass down to their staff and seek input. Standard agenda typically include: Report from Director, which may include strategic plan deployment and updates, legislative issues, internal and external threat, and emerging issues of PH concern.

Senior Leader Role in Reward and Recognition: SLs are subjected to many state laws which present constraints, however they pursue creative means to support and donate their own funds to provide meaningful recognition activities. A formal Employee Engagement Team has been empowered to focus on employee involvement and recognition. The Director personally reviews and signs all recommendations for the Employee of the Month, Employee of the Year, Service Center of the Quarter, Satisfaction Guaranteed Award, and the Sterling Star Award. The Employee of the Month is recognized at our monthly All-staff meetings. In 2010 this process was changed to a monthly "Takes the Cake" award where an employee literally takes home a cake baked by a SJCHD employee. For the past several years, Dr. Allicock has given her own annual Performance Excellence Award to an employee making a significant contribution to the Performance Excellence journey.

1.1b(2) Focus on Action:

SLs create a focus on action and the accomplishment of objectives, performance improvement and the attainment of the vision in several ways. The SLT has a bi-weekly business review that focuses on local and state SPs identified in the strategic planning process (SPP). The SPEC (a combination of SLT, supervisors, and key employees) meet bi-weekly to review the status of the SPs (using a scorecard format), key activities and business results, identify gaps, develop action plans, and share best practices. The local SJCHD Balanced Scorecard and other priority results along with State Health Status Indicators are measured, reviewed and deployed at least quarterly. The Balanced Scorecard shown in **Figure 2.2-4** and created as a part of the SPP provides leaders with a key tool for conducting this review and deploying to their staff. This approach ensures a balancing of value for our patients/clients, community partners and other stakeholders through the four SPs. Our first priority: **Promote/Protect Health and Quality of Life,** drives a focus on our core PH business functions and thus the PH patient/client; **Business/Finance Excellence,** drives a focus on the legislature, the BOCC, and taxpayer who help pay for our services; **Customer/Partnership Engagement,** creates additional focus on our direct and indirect service patient/clients as well as the community partners that are critical to good community health; **and Employee Engagement/ Accountability** drives a focus on our staff, without whom we cannot exist.

The SL review process (**Figure 1.1-3**) facilitates a plan-do-check-act (PDCA) approach to drive and continuously monitor and evaluate our Performance Excellence efforts. This is accomplished by incorporating employee engagement, strategic priorities, and process management with the fundamental principles of making decisions based on facts and patient/client satisfaction. For example, in 2011 our key Community Partnering organization, the St. Johns County Health Leadership Council meeting was convened the focus on the improvement of Community Health. As a part of the development of its Community Health Assessment and Improvement Plan, it implemented a Community Balanced Scorecard. Its purpose is to drive improvement activity within SJCHD and in numerous community partner agencies. This is leading to better community health in a number of areas including several that are outside of the scope of our Health Department (such as improving Mental Health care and improving cancer treatment). The Community Balanced Scorecard is a new tool that identified through; literature review and has only recently been highlighted in PH Quality Improvement literature.

1.2 Governance and Societal Responsibilities

1.2a Organizational Governance

1.2a(1) Governance System:

We are led by our Director, Dr. Allicock, who reports to the Deputy State Health Officer of the DOH. The SLT is our top level of leadership that consists of the Director, the Assistant Director, and key organizational leaders as shown in **Figure P-6**. SLs oversee all core public health and support functions that encompass the entire organization. The SLT is responsible for setting direction, executing the mission and making high-level policy decisions. An important responsibility for the SLT is the various Leadership Review meetings (**Figure 1.1-3**) where SLs focus on meeting local and state SPs.

Service Center managers and supervisors, who are direct reports to SLs, and selected other employees, make up the SPEC, which provides the programmatic level of leadership to the organization. A joint twice-monthly business review process is in place for SPEC. A key priority of SPEC is to ensure programmatic linkage to the state and local SPs and communication of critical information.

Operations are streamlined utilizing the PDCA model to minimize costs to the taxpayer. Accountability for leadership actions, fiscal accountability and protection of stakeholder interest is ensured locally through organizational and programmatic quality assurance and improvement, business reviews, the various performance indicators and internal/external auditing processes. On a State level, the Office of Policy Performance and Government Accountability (OPPAGA) reviews key program and fiscal processes. Our programmatic fiscal reviews are subject to audits by the State Attorney's Office and Federal Auditing. Florida has one of the nation's most stringent transparency laws and we are fully compliant with Florida's "Government in the Sunshine" laws. We freely share information with our patients/clients, community partners and anyone who requests public

information. This includes community assessments, the budget review process and any programmatic and/or contractual audit results.

1.2a(2) Performance Evaluation:

Each SL performs a yearly self evaluation based on a set of documented Performance Standards and Associated Indicators. These standards are expressed in measurable terms and are in alignment with SJCHD Strategic Priorities, applicable Service Center strategic plans, and all laws, regulations and policies as appropriate. These Performance Standards include: Clinical/ Program performance, Fiscal Accountability (Includes Budget Performance), Leadership (Includes self development), Flexibility/ Teamwork, Internal Customer Focus (Includes Workforce Development), and Planning/Organizing/ Reporting. The objective is to provide clear standards and to provide incentive for high performing leaders. Upon providing this self-evaluation to the Director, each SL's performance is reviewed by the Health Department Director and he/she receives input for their Individual Development Plan (IDP). The Director receives an annual performance review by her supervisor at FDOH based upon a similar set of Performance Standards. Other methods used by the SLs to evaluate their performance are shown in **Figure 1-2-1.**

Figure 1.2-SL Performance Evaluation System

Approach	How Used to Evaluate	How Used To Improve
Baldrige Self-Assessment & Feedback Reports	• Opportunities For Improvement	• Quality Initiatives • Action Plan Development
360 Degree Evaluation & Leadership Development Opportunities	• Direct Feedback From Staff • Leader Self-Evaluation	• Development of IDPs • Individual Coaching
Business Review Process (SPEC/SLT)	• Information Shared At Meetings	• Leadership Development Opportunities
SL Performance Evaluation Process	• Annual Review of all SLT members by Director • Annual Review of Director by DOH	• Goal and Competency -based review • IDP developed to plan for and make personal leadership improvements

1.2b Legal and Ethical Behavior

1.2b(1) Legal/Regulatory Behavior and Accreditation:

We anticipate and proactively address public concerns about our services and operations in several ways (See **Figure 1.2-2**). SLT is involved in numerous activities designed to anticipate, assess and prepare for public concerns. For example, as the leader of the local PH System we collaborate with local, state and regional agencies and individuals to provide comprehensive response to natural or manmade disasters. The SJCHD-led HLC (previously discussed) serves as a means for various county agencies to identify overall health concerns and through its Community Health Assessment (CHA) and Community Health Improvement Process (CHIP) conducted every three years, to find appropriate means to prioritize the most important concerns. This process is discussed in detail in area 3.1a. This process was improved in 2011 to include the development of a Community Health Balanced Scorecard.

In 2004 SJC experienced four hurricane events. At that time our newly appointed SJCHD Director, realized that we were not fully prepared for emergent events with the current part-time regional planner that was available. In response a full-time Risk Manager position and Risk Management Committee were established to address all safety, security and preparedness issues to include incident reporting, plans and staff training. Staff regularly plan, facilitate and participate with community partners in various types of exercises to prepare for disasters. All staff are trained in basic ICS (Incident Command System) and NIMS (National Incident Management System) with leadership staff receiving more advanced training.

ICS/NIMS training is has been incorporated into new employee orientations. We participate in a multi-agency regional Epidemiology (EPI) strike team to respond to potential disease outbreaks or acts of bioterrorism. To help improve public health initiatives, SJCHD initiated the SJC Medical Reserve Corps (MRC) as part of a national network of medical and PH volunteers. The MRC unit provides training and exercises opportunities for local volunteers so that they will be prepared to assist or relieve first responders in emergencies affecting PH. Two SJC communities have been identified to participate in a new Neighborhood Emergency Preparedness Program (NEPP) designed to provide residents with the tools they need to develop their own emergency plans, train in such topics as home health care, CPR, safety, and first aid. NEPP increases the awareness and capabilities of residents allowing them to assess, prioritize, and address their own preparedness needs, creating a better organized, equipped, and resilient community. These workforce training and exercise programs, plan improvements, and community preparedness efforts led to the recognition of SJCHD as fully meeting or exceeding the highest standards of preparedness established in the criteria for "Project Public Health Ready" in 2010.

In Florida and most other states, Health Departments are not subject to any mandatory accreditation. However, SJCHD is pursuing voluntary National PH Accreditation in 2012 and has elected to be among the first group of health departments in the US to be reviewed for PH Accreditation based on the 12 Domains of PH shown in **Figure 1.1-1**.

Key processes and measures for addressing legal and regulatory compliance and minimizing adverse impacts are shown in **Figure 1.2-3**.

1.2b(2) Ethical Behavior:

SJCHD must meet state and federal mandates designed to safeguard the well being of our clients and protect the interests of our various stakeholders. Expectations of compliance with ethical practices are conveyed to all employees starting with New Employee Orientation, where the Employee Handbook (including a Code of Ethics) is distributed, reviewed and signed by each employee. Preventive and corrective disciplinary actions are taken as necessary**.**

Figure 1.2-2 How Public Concerns Are Anticipated and Addressed

Public Area of Concern	How Anticipated & Addressed	How Proactively Prepared For
Disease Control & Health Protection	Monitoring and Surveillance (Epidemiology, Environmental PH) Information Sharing with Partners Monitoring Statewide Databases	PH Accreditation Assure Competent PH Workforce Communication/Collaboration with Partners Strategic Objectives
Emergency Preparedness & Response	All Hazards Preparedness Plans Bioterrorism Surveillance (CBRNE) Ongoing Communication and Updates from Response Agencies	Certified Project PH Ready SJCHD is Health & Medical Lead at EOC All Staff Training in Preparedness/ Response Communication/ Collaboration with Partners Development of Medical Reserve Corps
Access to Health Care	Develop Health Care Safety Net Community Health Assessment Collaborate with Other Agencies Health Factors	PH Accreditation Assure Competent PH Workforce Communication/Collaboration with Partners Strategic Objectives

Figure 1.2-3 Key Processes to Address Potential Impacts, Legal and Ethical Concerns from Operations

Potential Impact Area	Key Processes	Measures	Goals
Regulatory/ Legal • Federal & State Statutes • HIPAA • Medical & Professional Licensure • Labor Relations • Contract Management	• Legal & SME Review of Statutes • Training/Orientation • Appropriate Certifications • QA Process • Assessments And Action Plans • Disciplinary Process	• Compliance With Regulatory Requirements • Reportable Incidents • # Disciplinary Actions • # Substantiated EEO Cases • # Substantiated Employee Grievances	• No Reportable Incidents • 100% Compliance With Mandatory Training • No legal suits filed
Accreditation/Certification • Voluntary National PH Accreditation • Project PH Ready Certification	• Assessment, Action Planning and Document Review • Exercise Plans	• Accreditation by PHAB • NACCHO Certification	• Accreditation in 2012 • Re-certification in 2014
Risks • Workplace Violence • Breach of Confidentiality • Workforce Safety • Patient Safety	• Security System (Guard, SONITROL, Check-in System) • Walk-Thru Inspections/Monitoring • Annual Assessments • Training Compliance • Background Screening • Risk Management Team	• # Breaches of Confidentiality • # Reportable Incidents	• 100% Compliance with Incident Reporting • No Reportable Security/ Safety Incidents
Ethics • Good Governance • Fiscal Stewardship • Employee Conduct	• Internal Control Questionnaires & Audits (ICQ) • Mandatory Training • Signed Affidavits/Attestations	• ICQ Scores • # Reported Violations • % Attestations Completed	• ICQ Scores > 95% • 0 Reported Violations • 100% Attestations Completed
Natural Resource Conservation	• Green Plan • Purchase of hybrid vehicles • Electronic Medical Records • Server Centralization	• % Completion of Green Plan • $ Savings Green Initiatives • Meaningful Use of EMR	• 100% by 2015 • $400 monthly • By 6/30/2012

In addition to online ethics training through the TRAK-IT system, our Legal Department conducts ethics training for employees that includes role playing and examples of how Ethics policies apply to SJCHD. Employees are encouraged to utilize their chain of command when in doubt. Employee concerns may be communicated to their manager or supervisor, our Legal staff, Risk Management, the Inspector General, EEO Office or the Comptroller.

Key compliance processes include monitoring mandatory training records, contracts, incident reporting, and individual employee behavior. (See **Figure 1.2-3**).

1.2c(1) Societal Well-Being:

Our purpose is to provide and/or ensure delivery of PH services to the residents and visitors to SJC. This is intrinsic to our core processes and drives our annual strategic planning process.

The well-being of the environment is addressed daily by our Environmental PH Service Center. Social and economic systems are considered in annual strategic planning along with Community Health Assessment Process done every three years.

In November 2010, we implemented a "Green Plan" in an effort to support "green" decisions and behavior; to establish more sustainable choices in public service operations by implementing energy conservation methods to lower utility costs, energy consumption, and carbon footprint emissions.

1.2c(2) Community Support:

Our key community is defined by our Department of Health mission, "**To protect and promote the health of all residents and visitors in St. Johns County".** Our assigned community

is SJC. Staff are encouraged to participate in community boards and action groups that are aligned with our PH mission and to perform volunteer activities in the local community. Examples include: membership in the Healthy Start Coalition; Florida PH Association; PH member of the Local Emergency Planning Committee; SJC Good Samaritan Volunteer Clinic; Member of the Head Start Health Advisory Committee, Staff Member to the Health & Human Services Advisory Council; Infant Mortality Task Force; Teen Pregnancy Taskforce; Tobacco Free Partnership; St. Johns River Rural Health Network; and St. Johns County Medical Society.

We are restricted by the state in our ability to solicit financial contributions for charitable organizations other than the Florida State Employees Charitable Campaign (FSECC). During the annual campaign, our Employee Engagement Team has developed several innovative methods to solicit contributions for FSECC despite the fact employees have not had a pay increase for six years. These include: a cake auction that annually raises more than $1000, wear jeans to work days, and a number of other team-building activities that employees enjoy. Our per capita giving rate to the FSECC has consistently exceeded expectations.

CATEGORY 2 STRATEGIC PLANNING

2.1 Strategy Development

2.1a Strategy Development Process

2.1a(1) Strategic Planning Process:

The annual SJCHD Strategic Planning Process (SPP) **Figure 2.1-1** is used to create and deploy longer-term Strategic Objectives (SOs) and both short and long-term action plans. We currently use a one-year (short-term) and three-year (long-term) planning cycle that is designed to align SJCHD's Strategic Priorities (SPs) with those of the 12 Essential Public Health Domains and the Healthy People 2020 goals as shown in our Performance Excellence model **Figure 1.1-1**, along with state plans and directives, and coupled with needs, expectations and recommendations of our various patient/client and stakeholder groups. It aligns services, resources, and capabilities with our vision and mission statements to ensure future success. The SPP champion is the SJCHD Director. The key process participants are the Director, the SLT and the SPEC. The key elements of the process are shown in steps 1-8 of **Figure 2-1-1**. Key elements of Strategy Implementation are shown in steps 9-11.

The original SJCHD Strategic Plan was developed in 2005 shortly after Dr. Allicock became the Director with the help of an outside consultant who is a Baldrige examiner. The process has been improved each year through the usage of a scoring tool (step 12) to determine which aspects of the process are in need of improvement. Additionally, improvements have come as a result of feedback from Baldrige-based assessments and benchmarking with award recipients.

The Director and SLT collectively review any guidance received from the state DOH (Step 1). In 2011 there was guidance regarding the desires of the new Governor and Surgeon General along with anticipated impact of legislation that was passed in 2010 that affects services to be provided by CHDs. In step 2, SLs confirm the organization's Mission, Vision, Values and Purpose Statements. Key Challenges and Advantages from the previous planning cycle are reviewed in Step 2 and new Challenges and Advantages are identified as part of the annual SWOT analysis in Step 7. Additionally, current and proposed Core Competencies are reviewed, aligned with the Public Health Domains, and agreed upon through the usage of a decision matrix. We choose core competencies based upon: strategic importance to the organization; difficulty for others to imitate; and providing a competitive advantage. SJCHD Core Competencies were first determined in 2008 based upon a definition developed by the Public Health Foundation and have been reviewed/refined each year since.

Figure 2.1-1 SJCHD Strategic Planning Process

Annual Planning Process	Who	When
Strategy Development		
1. Set Direction (State and Local Directives)	**From State DOH to SLT**	**Each Jan.**
2. Validate Mission, Vision, Values, Purpose, Core Competencies, Challenges/Advantages	**SLT and selected others**	**Feb. to May**
3. Environmental Scan		
4. Review Existing Plans, Results, Audits		
5. Validate Key Patient/ Client/ Stakeholder Requirements		
6. Develop Short and Long-term Planning Assumptions		
7. Conduct Internal/External SWOT	**SLT with Staff Input**	
8. Develop Strategic Priorities, Objectives, Measures, Targets/Projections, Timetables	**SLT**	
Strategy Implementation		
9. Align with Service Centers/ Determine Key Action Plans	**SLT, SPEC, Partners**	**May and Year-round**
10. Align with Budget/ Finalize Plan	**SLT**	**June**
11. Review Plans and Progress	**SLT and SPEC**	**Twice-Monthly**
Process Improvement		
12. Evaluate/Improve Process	**SLT**	**Jan.**

While there has been an Environmental Scan conducted each year, the 2011 scan (Step 3) was much more comprehensive to ensure that any potential blind spots were identified. During the Scan, SLs gather, present, and analyze external and internal information to determine current issues and opportunities to consider during the strategic planning cycle. The 2011 Scan included a review of the political situation, funding constraints, mandates from the State DOH, new partnering opportunities, trends in the science of PH, community needs and changing demands, culture needs and changes, and staffing issues. The analysis phase of Strategic Planning ends when planning assumptions are drawn from the extensive information that has been accumulated and reviewed. A SWOT analysis and prioritization matrix concludes the information gathering and

evaluation activity. The process then dictates that potential long and short-term opportunities be formulated. Finally, using a Balanced Scorecard format, longer-term SPs along with Strategic Objectives (SOs) associated with each priority are developed. SPs tend to be long-term in duration (three years plus) and have changed little over the years. SOs are developed in support of the SPs and may be short or longer-term. Our associated performance measures, targets and deployment activities may have a shorter-term duration and many are focused on the current fiscal year in order to stay aligned with guidance from the state.

All levels of staff participate in the strategic planning process by providing information to SLs through Pass Up activities and the Action Planning process (See Item 2.2). An alignment matrix of Service Center SOs is developed and prioritized to align with our top level health department Balanced Scorecard. Service Center action plans are written to mesh with the Balanced Scorecard (see **Figure 2.2-4**) and to ensure that SOs are adequately addressed.

Bi-weekly, Service Center performance reviews are held by the SPEC to review progress being made on SOs and associated Action Plans (APs). A SL is assigned the role of "Champion" for each SO and is responsible for determining and reviewing specific APs to ensure that SOs will achieve targeted performance levels. In addition, Employee Teams may be assigned to assist with specific objectives.

2.1a(2) Strategy Considerations:

Strengths, Weaknesses, Opportunities and Threats: A SWOT analysis is the culmination of steps 1 through 6 of the SPP. Data is accumulated, reviewed by the SLT, planning assumptions are made and finally the SWOT is completed in step 7. The following key factors are evaluated in the SWOT analysis process: Patients/Clients and their Requirements; Competitors; Technology Changes; Supplier/Partner; Societal & PH Issues; Organizational Capabilities/Needs; and Human Resource Capabilities. A prioritization matrix is used to identify the highest priority factors that are to be included in the development and refinement of the SJCHD's SPs and SOs.

Early Indications of major shifts in Technology, Markets, PH Services, Patient/Client Preference, Competition and Regulation:

PH Services and Patient/Client Preference: As a state governmental agency, the DOH has legislative mandates which dictate many of the services that are required to be provided by all county health departments. The SJCHD operates within this framework; however local priorities and patient/client needs are considered in the following ways:

- Healthy People 2020 Goals and Objectives – Benchmarks determined by the CDC for national health improvement
- Analysis of PH Indicator Data – Tracks key public health indicators by trends and benchmarks. Examples include: Areas of the county having the highest infant mortality rates or the most babies born to teenage mothers
- Program-Specific Data– For example, Healthy Start Screening Results are used to determine how many mothers may be eligible for a state program for high-risk infants.
- Patient/Client/Partner Satisfaction Data – SJCHD surveys patients/clients/partners and this data is used in considering patient/client needs – i.e. service standards, service hours, language requirements, and satellite locations.
- Community Health Assessment – As discussed in area 1.1b(2), SJCHD partners with the HLC to develop a comprehensive Community Health Assessment and Improvement Plan (CHA/CHIP). Many of our key community partners are members of the HLC and participate in the development of the CHA/CHIP. This assessment was last completed in 2011 and information is reviewed as part of the SCAN and considered in the SWOT.

Technology, Markets, Competition, Economy and Regulation: The Scan and SWOT analysis considers changing technologies, competitive threats, socio-economic conditions and new regulation. Through participation in various community partnership activities, SJCHD keeps a finger on the pulse of the competitive environment. There has been a trend in recent years for the state to reduce the scope of government. This is leading CHDs to focus more on Disease Control and Health Protection.

For our individual health care services, there is competition among private Health Maintenance Organizations and community health providers for patients that receive state assistance through the Medicaid program. SJCHD has been proactive by strategically planning for Medicaid patient attrition following anticipated Medicaid reform, privatization, and the resulting loss of revenue.

We partner with the Board of County Commissioners (BOCC) in the delivery of essential PH services. We face competition with regard to the limited county funds available. We address this threat by having ongoing dialogue with our BOCC and educating them about the value of PH services in our community. We also have addressed the BOCC's and community's concerns regarding access to services by procuring and deploying our Public Health Mobile Center (PHMC) into underserved communities and at full service schools in SJC. We continue to improve our efficiency and productivity, and we have instituted a marketing strategy to generate public awareness regarding the value of PH generally and the SJCHD specifically.

SJCHD is aware of new trends and technologies in PH and has adopted SPs that are focused on providing "core" public health services (in alignment with the 12 Public Health Domains). On a state and national level, the trend is for PH to concentrate on services to communities rather than personal health services for individuals. We stay aware of these trends in the following manner: 1) provide input for PH innovations (Such as NE Florida Counts) being developed at the federal and state level; 2) participate in Beta testing for new programs and applications; 3) participate as members on committees; and 4) attend conferences.

Examples of recent technology include Geographic Information System (GIS) capability, which allows mapping of emerging public health issues down to the neighborhood level. The use of tablet computers and networking has allowed field service workers more flexibility and greater efficiency in their jobs. SJCHD's Disease Control Program has an electronic web-based surveillance system with high-speed access lines. For Immunizations we use an electronic registry that is linked statewide. Technology needs are addressed as part of the budgeting process and submitted as part of each program's

operational budget requirements for the year. SJCHD makes it a priority to upgrade computer hardware and software and improve the computer network.

Changes in the regulatory environment are reviewed during the Scan and considered in the SWOT process. For example, implementation of Personal Protection Equipment requirements were addressed in the Strategic Planning Process resulting in the development of an action plan and allocated resources to improve PH preparedness levels.

Long-term Sustainability: During the Scan (step 3), we consider factors that impact long-term sustainability including finances, human resource needs and the changing political environment for PH. After the completion of the Scan and SWOT, we revisit our list of Core Competencies, determine what changes in Core Competencies may be required, and we revisit the Decision Matrix to determine what (if any) additional Core Competencies may be required in the future.

Upon development of our SOs (step 8), we determine the appropriate measures and set performance targets/projections based upon our previous performance, performance of identified peer counties both within Florida and nationally (see area 4.1a(2), the performance of similar high performing organizations (Baldrige or state award recipient) and the expectation of the CDC as expressed in HP 2020.

Ability to Execute: As part of the Scan and SWOT analysis, SLs consider operational issues, which may impact our ability to execute our SPs and align activities. For example, as a result of a potential budget shortfall, Service Centers may need to prioritize human resource needs and shift staffing based on strategic priorities.

As a government agency, we are subject to changes in Florida's leadership at the executive and legislative level. The Surgeon General of DOH is a political appointee serving at the pleasure of the Governor. The FDOH's budget is set by the Florida legislature. At the State level there has been shortfalls for the past five years. In 2012-13 it is anticipated that there will be an additional budget decrease. While we search for grants there is an acknowledgement that these are limited and tend to be short term in nature and cannot provide long term stability for PH initiatives and strategies. We have also been severely limited in our ability to accept certain federal grants and in accepting grants of more than $50,000. These factors affect the ability to execute our SPs.

These financial and political risks are considered during the SWOT analysis and in budgeting decisions made by the SLT. We also consider new areas of focus in strategic planning decisions that may come about through legislative action. For example, PH Preparedness is an area given additional focus at state and federal levels depending on PH risk. To ensure we have adequate staff and resources to take an all hazards approach to PH risks, SJCHD augments state and federal funding levels as required.

The continuing emphasis on financial accountability has allowed SJCHD to avoid the layoffs experienced by many of the Florida CHDs during the past five years, and we have maintained an adequate cash reserve. New funding initiatives include increasing revenue by improving clinic management services and productivity. We have also looked at what services are offered by our local partners and have streamlined our services to compliment, rather than compete with, those partners for limited funding.

As seen in step 12 of **Figure 2.1-1**, a key component of the SPP is a formal review of the process itself conducted by our SLT. The plan is assessed by using a plan evaluation tool that examines our success in achieving targets/projections and in carrying out the planning process according to schedule.

2.1b(1) Key Strategic Objectives:

After completion of the SWOT and prioritization matrix (step 7) SPs are reviewed and refined, SOs in support of the SPs are developed and measureable goals, targets and timetables are developed for each objective. See **Figure 2.1-3.**

2.1b(2) Strategic Objective Considerations:

Strategic Challenges and Advantages are addressed in our SPs and SOs as shown in **Figure 2.1-2**. The SOs along with the targeted performance levels drive opportunities for innovation by setting targets that push us to be among the best and among the first in the nation to accomplish specific goals and targets. For example, we strive to be among the first CHDs in the nation to achieve voluntary PH accreditation (SO 2.2). We also strive to be among the best performing counties in the US in terms of Health Factors and Health Outcomes. (SOs 1.2 & 1.3) These targets will not be attained without innovative approaches being used.

Figure 2.1-2 How Strategic C/A Addressed

Challenges (C)/ Advantages (A)	Addressed by SO #
▪ Funding Uncertainty (C)	2.1
▪ Mandated Service Reductions (C)	2.2
▪ Public Perception of Government and PH (C)	3.1, 3.2
▪ Community Partnering (A)	3.1
▪ Highly Skilled PH Professional Staff (A)	2.2, 4.1, 4.2
▪ Medicaid Reform and its financial impact (C)	2.1
▪ Continuity of Operations in Emergency/ Disaster (A)	1.1
▪ Clear Policies and Procedures (A)	2.2
▪ Process Management (A)	2.2
▪ Strong Community Partnerships (A)	3.1
▪ Addressing Community Health Concerns with Severe Resource Limitations (C)	1.2, 1.3, 1.4, 2.1, 3.1
▪ Staff Recruitment and Retention (C)	4.1, 4.2
▪ Training/Cross Training (A)	4.2
▪ Senior Leaders' Development Planning (A)	4.2
▪ Unable to Provide Competitive Pay (C)	4.1

Core competencies are addressed as shown in **Figure 2.1-3.** The need for new Core Competencies is determined in step 2 of the SPP and revalidated after the SOs are determined in Step 8. While there are no new Core Competencies identified for this planning cycle, they would be accounted for in SO 4.2, Improve Workforce Capability and Capacity.

By setting short and longer-term targets we balance our pursuit of both short and longer-term challenges/opportunities and as previously stated, through the usage of a Balanced Scorecard approach our SOs balance the need of the various stakeholders.

Figure 2.1-3 2012-16 SJCHD Scorecard & Core Competency Alignment

Strategic Priorities	Core Comp. Alignment (Figure P-2)	Strategic Objectives	Measures	Baseline 12/31/11	Target/Projections		Selected Action Plans
					6/2013	6/2016	
1.0 Promote & Protect Health & Quality of Life	All 5	1.1 Assure Community PH Preparedness and Response	1.11 Project Public Health Ready Re-Certification	Certified	Certified	Re-certified	-Preparedness Planning, Training & Exercising
		1.2 Improve Health Outcomes	1.21 Health Outcomes Ranking	-Health Outcomes Ranking Baseline #3 In State	Top 10% of National Peers	Top 10% of National Peers	-Infant mortality Task Force -Community Scorecard -EPI Indicator Review
		1.3 Improve Health Factors	1.31 Health Factors Ranking	-Health Factors Ranking Baseline #1 In State	Top 10% of National Peers	Top 10% of National Peers	-Teen Pregnancy Task Force -STD Reduction - Sanitary Nuisance Response
		1.4 Impact CDC Winnable Battles	1.41 Infant Mortality Health Equity	-White 5.2 per 1,000 Live Births -Black 4.2 per 1,000 Live Births	-White 5.1 -Black 4.1	-White 5.0 -Black 4.0	-Infant Mortality Task Force
		1.5 Monitor Health-related Quality of Life Indicators	1.51 Years of Potential Life Lost	6,082 prior to age 75 per 100,000	5,946	5,900	-ID Improved Health-related Quality of Life Indicators
2.0 Business/ Finance Excellence	1 & 5	2.1 Ensure Financial Sustainability	2.11 % Trust Fund Balance (Cash Reserve)	6.1%	8.0%	8.5%	-Trust Fund (Cash Reserves) Management
			2.12 % Revenue Self-Generated	53%	53%	53%	-Develop/maximize Self-generated revenue sources
			2.13 Planned Revenue to Planned Expense Ratio	95%	96%	97%	-Budget Management
		2.2 Maximize Efficiencies, Effectiveness, and Assure Standards of Excellence	2.21 National Voluntary PH Accreditation by 2012	Not Accredited	Accredited	Accredited	-Voluntary PH Accreditation Document Collection
			2.22 Apply for Malcolm Baldrige	No application	Site Visit	Recipient	-Baldrige Preparation
3.0 Customer & Partnership Engagement	All 5	3.1 Champion Collaboration of Public Health System	3.11 Community Satisfaction Score	Community partner satisfaction - 94%	95%	95%	-Implement PARTNER tool
			3.12 CHIP % Objectives Met	10%	15%	25%	-Community Scorecard
		3.2 Enhance Customer & Stakeholder Engagement Focus	3.21 Client Engagement - % Top 2 Boxes	97.2% % Rating 4 & 5 in Q 7 & 8 of Patient/client survey (Top 2 Boxes)	97%	97.5%	-Every Person Every Time
			3.22 Client Engagement - % Top Box	84.3% - % Rating of 5 in Q 7 & 8 of Patient/client survey	86%	88%	
4.0 Employee Engagement/ Accountability	**All 5**	4.1 Improve Employee Engagement	4.11 Employee Satisfaction - %	From 2011 ESS 72%	75%	80%	- Employee Recognition Plan Review (PDCA)
		4.2 Improve Workforce Capability and Capacity	4.21 Cultural Competence Staff Development	100% Staff Completed Module 1 Curriculum	50% Comp. Module 2	100% Comp. Module 2	-PHA Cultural Competence Assessment -Cultural Competency Curriculum
			4.22 Current position descriptions, IDPs, & Evaluations	100%	100%	100%	-Substantial completion of IDPs
			4.23 Required Training Completed	100%	100%	100%	-Workforce Development Plan

A focus on financial sustainability (SO 2.1) and Workforce Capability/Capacity (SO 4.2) ensures readiness for unanticipated shifts in market, political and financial conditions.

2.2 Strategy Implementation

2.2a Action Plan Development and Deployment

2.2a(1) Action Plan Development

Action Plans (APs) are developed in step nine of the SPP (**Figure 2.1-1**). Following the development of SP's, SOs, measures, and targets, each SO is assigned a Champion who becomes the lead person for the objective and expected outcomes. Champions are responsible for determining the best approach to ensure improvements necessary to reach goals/targets and to assess progress toward reaching those targets as a part of the leadership review process (**Figure 1.1-3**). The primary approach used for each Service Center is to develop APs for those SOs that are strongly aligned to their specific Center. This is achieved through the use of an alignment matrix (step 9 of the Strategy Implementation Process). Approaches may also include assignment to improvement teams/workgroups or individuals as subject matter experts for AP development. Once it is determined that a Service Center or workgroup is responsible for developing an AP, a standard format is used that includes the name and owner of the plan, an estimated completion date, a measurable target to be achieved upon completion, resources required, and the specific action steps to be taken with assigned responsibility for completion date of each step. **Figure 2.1-3** lists selected APs for each of our SOs. The complete listing is available on site. This process was improved in 2011 by establishing links to enable easier drill down from the Top Level Scorecard to the various Service Center level APs.

We do not anticipate any major changes to services provided in the current year; however due to legislative initiatives and funding challenges we may experience changes or decreased services. Therefore, we have developed contingency plans with our community partners to ensure continuity of services.

2.2a(2) Action Plan Implementation:

The SPEC is the primary vehicle used to ensure and oversee the deployment of APs. Service Center managers are responsible for developing and deploying APs within their center. Also, as appropriate, teams and individuals may own all or portions of APs. After APs are developed and resourced (SPP, step 9), progress is reviewed in the twice monthly SPEC meetings. This is accomplished on a scheduled round robin basis where a Service Center is asked to review the progress on the completion of its APs in each SPEC meeting. All action plans and Service Centers undergo this review process at least quarterly. The SLT oversees the progress being made on AP deployment and often will ask a Service Center manager to report during an SLT meeting. If it appears that a particular AP may not be sustainable, the SLT and SPEC determine relevant alternate strategies and new or modified APs.

APs are communicated within SJCHD via Service Center and All-Staff meetings, pass-up/pass-down sessions, and SharePoint site; and they are displayed on internal bulletin boards. Key results of APs are available via our Annual Report and are sometimes presented during County Commission meetings. Our strategic planning documentation is available to the General Public via a public records request. Additionally, our Balanced Scorecard is posted on the SJCHD Internet site.

It is rare that APs are deployed to commodity suppliers as these suppliers work almost entirely under contracts overseen by the state. However, APs are routinely deployed to community partners during regular ongoing partnership consortium meetings. This is done through partnering agreements (either formal or informal) where the various partners agree to support key issues affecting community health. For example, Infant Mortality and Teen Pregnancy Task forces have been deployed within the community. These task forces have developed APs that help address our SOs 1.2, 1.3 and 1.4 respectively. Also, the HLC has developed APs in support of the Community Health Improvement Plan (SO 3.1) and several other SJCHD SOs. An improved approach was implemented in 2011 with our HLC members being asked to develop APs in support of the HLC's SOs, using the same AP format that we use internally in SJCHD. This has enabled a more robust tracking and reporting process which takes place in bi-monthly HLC meetings. There are various other community partnerships with similar alignment with SJCHD APs.

2.2a(3) Resource Allocation:

As a part of the action planning process, each specific AP is quantified in terms of the cost to implement versus quantified benefit (in dollars or in improved or expanded services). As a part of the annual budgeting process, funds are allocated for the fulfillment of major (high cost) actions. Low cost actions are absorbed within the already allocated Service Center budgets. In the current economic environment, where funds are scarce and subject to likely further budget reduction, we prioritize which projects are to be funded or not funded based the cost benefit analysis.

In order to ensure that funds are available to meet current obligations, we operate under a state-approved spending plan which is continually monitored along with our health department trust fund.

2.2a(4) Workforce Plans:

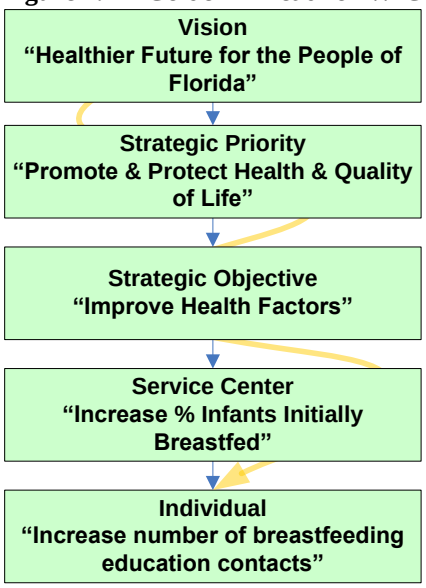
Human resource plans are developed as a part of the SPP process (Step 8, **Figure 2.1-1**). Based on our long-term and current year plans, we determine the organization's human resource needs in terms of staffing requirements, capacity increases, competency needs, training and development needs and any associated human resource program needs (such as performance management and recognition systems). SP 4 and SOs 4.1 and 4.2 fully address workforce engagement, capability and capacity needs, while the owners of all APs are asked to address any specific workforce or development needs as they develop their APs. For example, there is a comprehensive workforce development plan that addresses the need for PH Preparedness (SO 1.1).

2.2a(5) Performance Measures:

Key performance measures for short and long-term SOs and selected APs are provided in **Figure 2.1-3**. Alignment is ensured

through the use of an alignment matrix (Step 7) and through deployment to partners as already discussed. Each Service Center develops APs with appropriate measures and targets to align with appropriate SOs through a "Golden Thread" process. An example of a Golden Thread for the WIC Service Center is shown in **Figure 2.2-1**. Through the SPP, "Golden Threads" are developed for every Service Center and reviewed at SPEC meetings. The Balanced Scorecard approach, the usage of the alignment matrix and the "Golden Thread" ensure that measures are fully deployed and fully aligned. The community's success in meeting Scorecard objectives is included in SJCHD SO #3.12 **Figure 2.1-3**.

Figure 2.2-1 Golden Thread for WIC



2.2a(6) Action Plan Modification:

At the SPEC meetings we review the status of SOs and APs. As a part of this review process, we may find that some actions are no longer required, new APs may be needed and existing APs may need to may need to be modified. Following the review of key strategic measures and targets (See **Figure 2.1-3**), leaders are responsible for determining the best approaches to bring about the needed improvements necessary to reach targets. Approaches may include assignment to improvement teams or to individuals who are subject matter experts. For example, most APs regarding PH Preparedness (SO 1.1) are assigned to the Risk Manager.

In our PH environment, it is not unusual that new or revised APs may need to quickly be deployed either due to a PH emergency or from legislative changes. In these instances (or whenever a project requires quick deployment) we implement an Incident Command Structure. For example in 2009, the Incident Command Structure was deployed in order to provide our local response to the nationwide H1N1 influenza epidemic. Within hours, APs were developed to respond internally and with our community partners. Within this response most of our normal AP deployment activity was temporarily curtailed in order to respond to an urgent community need while maintaining our day-to-day services.

2.2b Performance Projections:

Figure 2.1-3 summarizes projections for key measures over the next one to four-year period.

We compare our performance with key indicators of identified peer counties within Florida; 26 nationwide peers; and with known high performing organizations with similar processes. Our performance is projected to meet or exceed that of other comparable providers as discussed above. In addition, other key targets are national benchmarks set by the CDC publication Healthy People 2020 and those targets set for us by the FDOH. **Figure 2.1-3** lists our projected scorecard results. Performance against benchmarks and comparisons is provided in Category 7.

When our projected performance fails to equal those of comparable organizations, we determine the benefit versus the cost of implementing additional actions. In many cases, PH key indicators are measures of Health Factors and Health Outcomes which take many years of focused improvement activities to make significant gains and to close performance gaps. It is difficult, expensive and often non-productive to try to rush improvement of these indicators. Whenever possible APs are based on proven evidence-based practice and we expect our results to continue to improve over time.

As stated in **Figure 2.1-1,** the SJCHD SPP goes through an annual improvement process through the usage of a scoring tool at the completion of the planning cycle. This tool and Baldrige-based feedback reports have led to numerous improvements over the past several years including better alignment in the AP development and review process, a more comprehensive Environmental Scan process, better deployment of APs to partner organizations through a Community Balanced Scorecard process, the development of a current year business plan that mirrors the SPP, and the attainment of better national benchmarks and comparative organizations.

CATEGORY 3 CUSTOMER FOCUS

3.1 Voice of the Customer

3.1a Patient and Stakeholder Listening

3.1a(1) Listening to Current Patients/Stakeholders:

SJCHD has two types of customers, direct service recipients (Patients/clients) and Indirect (the General Public). Patients/Clients receive services provided by one or more of our Service Centers as listed in the Profile **Figure P-1.** These include Vital Statistics, Health Care and Communicable Disease and Environmental PH services that are provided directly to individuals. The General Public customer is a resident or visitor to SJC and receives the services (often unknowingly) of our PH Preparedness, Disease Detection and Preventive Services, and certain Environmental PH services which constitute the Core Public Health Services listed in the left hand column of **Figure P-1**. The listening methods for these two customer types vary significantly as shown in **Figure 3.1-1.**

Many of our customer service requirements are dictated by federal or state laws, rules, and regulations that pertain to programs that are funded through these sources. One method used to listen to patients/clients to obtain actionable information includes a Touch Screen Survey which is an eight-question survey deployed in the various services centers (see area 3.1b(1). With the real-time touch-screen system, SLs and managers can take immediate action to note and remedy any issues that may be causing patient/client dissatisfaction. A second listening method is our website that includes continuous availability of information pertaining to SJCHD and our services along with links to other websites that may be of interest. This website provides several means for customers to provide information about services and/or information they have received or desire including a Web Based Comment

system which enables a quick means for patients/clients to ask questions or voice a complaint or comment via email and receive a fast response.

The Ryan White Consumer Advisory Board (CAB) is a primary mechanism for engaging patients/clients receiving our HIV services in the planning, implementing and evaluating of the SJCHD HIV program. The CAB is comprised of persons living with HIV/AIDS that receive medical and case management services at SJCHD. The board convenes monthly to develop and assess goals, partake in consumer preparation activities, and to evaluate Ryan White services rendered.

As the leader of the local PH System, we listen to the voice of the General Public in numerous ways. The most significant means of collecting community health information and using this information to determine the most critical needs to be addressed is through our Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) which is completed every three years by the SJC Health Leadership Council (HLC). This undertaking is chaired and facilitated by SJCHD. In mid-2011 we completed our third and by far most comprehensive CHA/CHIP. This was an undertaking that began in June 2010 and culminated with the publication of a 124 page CHA/CHIP booklet in August 2011. Twenty-six Community Partner agencies who represent many different direct and indirect customer/stakeholder groups participated in this process. The CHA/CHIP clearly mobilizes SJC to understand and address the most pressing community health needs but also depicts Community Strategy with specific Objectives, Measures, Targets and Action Plans in order to monitor success. The action cycle for the current CHA/CHIP began in 2011 and will culminate when a fourth CHA/CHIP is completed in 2014. The CHA/CHIP is used by SJCHD as a key driver for our annual SPP (Step 4, **Figure 2.1-1**) and is solidly aligned with Strategic Objective 3.1 and is also aligned with the entire Strategic Priority number 1. The MAPP (Mobilizing for Action through Planning and Partnership) process (See **Figure 3.1-2**) used was developed through a collaboration of the CDC and NACCHO and is recommended for usage by local health departments nationwide. The MAPP assessments completed in Step 3 provide four different approaches to listen to the voice of the General Public.

The MAPP process used to develop and deploy the CHA/CHIP has undergone numerous improvement cycles since the first assessment was completed in 2005. Improvements include a more comprehensive Environmental Scan and Information Review process, a much larger number of participating partner organizations, a dual membership structure for the HLC that includes top organizational leadership and mid-level working members, and the usage of a Community Balanced Scorecard containing specific Strategic Objectives, measures, targets and action plans that were added to the process in 2011 to improve the actionability of the CHA/CHIP and the systematic review cycle. **Figure 3.1-4** provides the 2011 Community Balanced Scorecard developed by the SJC HLC.

Another method of hearing the voice of the General Public is accomplished through the collection and analysis of statistical data which produces considerable information regarding health and wellbeing, and guides SJCHD's decision making with the ultimate goal of prevention of disease and protection from health problems and health hazards.

Figure 3.1-1 Customer Listening Methods

Customer Segments	Listening Methods

Patients/Clients (Direct Service)	• External Customer Satisfaction Survey
	  ○ Real time touch screen technology
	  ○ Paper Surveys
	• Patient/Client Feedback Process
	  ○ Comment Cards
	  ○ Web based Comments
	  ○ Direct Client Contact
	• Ryan White Consumer Advisory Board
	• Community-level Health Promotion Events

General Public (County residents, visitors) (**Indirect**) **(Potential Direct Service Patients/Clients)**	• Web based Inquiries • Community Stakeholder Meetings • Analysis of Statistical Data (CHARTS / Snapshot / programmatic) • Community Health Assessment • County Health Rankings Report • Northeast Florida Counts Dashboard • Community-level Health Promotion Events

Through our Epidemiology Program, we collect information (the voice of the General Public) about numerous reportable diseases and conditions that provide the basic information needed to provide PH Services that lead to the prevention and treatment of diseases of General Public concern. Epidemiology involves statistical analysis of potential PH issues and oversees the identification, investigation, and eradication of such conditions. **Figure 3.1-3** shows the general assessment and investigation process.

Figure 3.1-2 MAPP Process

Step	MAPP Phase and Explanation	2010-11 Process
1	Organize for Success/Partnership Development - HLC is re-established	Completed 6-2010
2	Visioning Process - Guides the community through a collaborative and creative process that leads shared vision and common values.	Completed 8-2010
3	Four MAPP Assessments: • Community Themes & Strengths (Comprehensive Community Survey & Focus Groups) • Public Health System (Uses a Survey Instrument developed by CDC/NACCHO) • Community Health Status (Intensive data review process) • Forces of Change (Identifies Opportunities and Threats to Community Health Status)	Completed 3- 2011
4	Identify Strategic Issues (Agree on a list of most important Community Issues)	Completed 5- 2011
5	Formulate Goals and Strategies (Using a Balanced Scorecard Approach)	Completed 6-2011
6	Action Cycle (Plan/Implement/ Evaluate)	2011-2014

At this time, the DOH does not permit usage of social media (other than internet responses and email) as a means to gather or provide patient/client information.

Figure 3.1-3: General Epidemiology Assessment and Investigation Process

Process Steps
1. Identify reportable disease, condition, or outbreak of concern.
2. Preparation: Gather latest information, policies and procedures concerning identified concern.
3. Follow-up to confirm existence of disease or reportable concern.
4. Conduct follow-up interviews/ assessments to determine those affected, those exposed and extent of those at risk.
5. Develop case definition and framework for follow-up and treatment requirements. Prepare messaging as needed.
6. Determine who is at risk
7. Develop a test hypothesis
8. Implement control and prevention measures as necessary.
9. Ensure that prevention measures are being implemented correctly by individual and/or facility as appropriate.
10. Conduct active surveillance exercises. If additional cases identified repeat process until no new cases have developed after completing follow-up incubation period based on disease or condition.
11. Conclude investigation. Ensure that investigation reports and documentation are completed and reported appropriately.
12. Conduct statistical analysis to determine disease trends

3.1a(2) Listening to Potential Patients/Stakeholders:

Our Indirect customers are our potential direct service patients/ clients. The listening methods used and mentioned above for our General Public customers are simultaneously providing us with information regarding potential direct service patients /clients. New community organizations (stakeholders) with interest in healthcare and PH are asked to participate on the HLC as soon as we become aware of their involvement in the community. For example, a new Mental Health Provider and a Federally Qualified Health Center that have recently come into the county were invited to become members of the HLC. We use our website as a key listening device for both former and potential patients/clients. For example, we recently received constructive feedback via the website from a former patient/ client who has moved out of state. This led to a review of the STD testing process resulting in an update to our procedure.

3.1b Determination of Patient & Stakeholder Satisfaction & Engagement

3.1b(1) Satisfaction and Engagement:

We measure patient and stakeholder satisfaction and engagement via touch screen survey and we use paper surveys for special events or in areas where there is no touch screen available. Upon completion of service in all of our key Service Centers, patients/clients are asked to complete an eight question survey via a touch-screen computer that is available as they check out of the center. The touch-screen system uses a 5-point Likert scale. Those rating us at top-box (5 out of 5) are deemed to be engaged and are willing to recommend SJCHD to a friend. Survey information is immediately usable for taking both short-term and long-term improvement action. There is a large tabulation screen in each Service Center where daily satisfaction results are continuously displayed to all staff. If there is a sudden decline in results, it becomes immediately apparent to managers and staff and corrective action is taken in real time. There is also a large master screen located outside of the SJCHD Director's Office where the day's results for each Service Center are displayed. SLs continually monitor the day's results and can inquire if a result has suddenly changed in order to facilitate immediate action. Touch-screen and other survey results are tabulated monthly, quarterly and annually so that trends may be observed. The touch-screen system came about in 2009 as a result of an OFI in a 2008 State Baldrige assessment. Prior to that, paper surveys were used. The touch-screen system being used was benchmarked from another CHD in Florida. We have recently added an internet-based customer satisfaction survey on our public website.

In-direct (the General Public) service customers are well-represented by the membership of the SJC HLC. The HLC has been asked to complete a three-question satisfaction survey annually since 2008 as a means of determining partner

Figure 3.1-4 SJC Community Health Balanced Scorecard

Perspective	Strategic Objectives (Lead Agency)	Measures	2014 Target
4.0 Community Health Status	4.1 Reduce % Low Birth-weight Infants (SJC Infant Mortality Task Force)	• % < 2500 grams	• 6.3%
	4.2 Reduce Cancer Morbidity/Mortality Rates per 100k Population (Flagler Hospital)	• Colon Morbidity • Breast Mortality • Lung Morbidity	• 34.6 • 16.9 • 84.0
3.0 Community Implementation	3.1 Reduce Substance Abuse (Various)	• Binge Drinking Rates • Cigarette Smoking Rates • Marijuana Usage	• Adult 19%, Youth 12.2% • Adult 10.1%, Youth 15.2% • Youth 14.6%
	3.2 Increase Access to Dental Care (Wildflower Clinic)	• Hospital ER Admissions for Dental • Dental Visits provided by Wildflower	• 928 • 2,250
	3.3 Increase Access to Mental Health Care (Various)	• Baker Act Recidivism Rate • Time to MH Appointment • Enrollment in MH Treatment	• 18.9% • TBD • TBD
2.0 Learning & Planning	2.1 Develop Community Resource Tool (HLC)	• Complete by 7/2012	• Tool Implemented
1.0 Community Assets	1.1 Improve Public Health System Collaboration (SJCHD)	• University of Colorado "PARTNER" Tool Survey Result	• Ongoing

satisfaction and how to improve the community partnering process. This survey is used as a means of evaluating our community partnerships and taking action as appropriate. For example, the HLC process was improved by asking each member to provide both a Leadership member and working member in 2011 so that working members would have a better understanding of the purpose and goals of the HLC as they take action to implement the Community Balanced Scorecard. We also survey the General Public whenever we participate in Community-level Health Promotion Events.

In 2012, for the first time, the HLC will be completing the PARTNER survey tool developed by the University of Colorado as a more comprehensive means of evaluating the effectiveness of this key partnership. This tool will also provide guidance in how to improve our partnering process.

3.1b(2) Satisfaction Relative to Competitors:

We regularly seek comparative data, however it has been difficult to find reliable data from other CHDs, many of which either survey their patients/clients inconsistently or not at all. We have turned to data available through US Health and Human Services web-based "Hospital Compare" application for customer satisfaction data from local hospitals (Mayo Hospital, Flagler Hospital, and Shands Hospital). Flagler Hospital is located across the street and serves the same population as SJCHD. It is ranked among the top 5% of all hospitals in the nation for clinical performance and is the recipient of the distinguished hospital award from Health Grades and is the only hospital in NE Florida to earn this distinction for six years in a row. Additionally, we benchmark against Sterling (State Baldrige) and Baldrige award recipients.

3.1b(3) Dissatisfaction:

Dissatisfaction is measured both via low-rated responses on satisfaction surveys and via comment cards which are readily available at each Service Center and on line. In the case of the touch-screen, we are able to quickly identify the specific Service Center, date and time of the instance of dissatisfaction, which enables real-time analysis and resolution of the issue. Other surveys used provide information regarding the specific center and/or event and therefore also enable easy analysis of the issue. For comment cards, the specific cause and location of any complaint is identified by the patient/client to enable ease of actionable response. Comment cards are sorted and tracked by cause so that any common causes of complaints may be quickly identified and resolved. Comment cards which request follow up are acted on within one business day via phone (if provided) or letter. One unanticipated problem with the touch-screen device is that children find it interesting and sometimes provide random responses to surveys. We have moved touch screens to get them out of the reach of children but the system is not completely fool proof.

3.2 Customer Engagement

3.2a Service Offerings & Patient/Stakeholder Support

3.2a(1) Public Health Service Offerings:

Many of the programs and services provided by SJCHD are mandated by the state or provided under the authority of a federal, state or local funding source. These include; Epidemiology, STD, Public Health Preparedness, Vital Statistics, and Environmental Public Health which are all state mandated, WIC, which is federally funded and Healthy Start, which is funded by the local Healthy Start Coalition. Certain other programs may be offered at our discretion as long as we can secure funding sources to keep them operational although in the current economic and political climate, we are strongly discouraged from providing new service offerings and we are not permitted to enter new markets or provide services that are deemed to be competing with private providers.

As a result of the above, our innovation activities are limited to partnering within our community to ensure that patients/clients needs are met, and finding innovative ways to improve the services we already provide. Our key partnering process through the SJC HLC was discussed in depth in item 3.1a(1). The MAPP community planning process (resulting in the production of the CHA/CHIP) is innovative in several ways including the number of partners engaged in the process, the usage of a Community Health Balanced Scorecard **(Figure 3.1-4**) to facilitate very high levels of consensus on the most significant needs, and the assignment of responsibility to various community partners to attempt to meet that need. The result of this process is a very clear understanding of community needs and a means to meet those needs beyond just the capability of this Health Department.

A major means of identifying community and individual patients/clients requirements is through epidemiology and statistical study using the various tools and databases as shown in **Figure 3.1-3.** It is through a combination of these studies plus the MAPP process that guides our Strategic Priorities and Objectives (**Figure 2.1-3**) at any given point in time. For example, the CHA/CHIP has helped to focus our efforts on infant mortality reduction (**SO #1.4**). Infant mortality rates rose in 2006 resulting in the creation of a community Infant Mortality Task Force. Infant mortality reduction is being emphasized both internally in several of our Service Centers (WIC, Healthy Start, Women's Health) and in the Task Force which has identified several evidence-based actions such as reducing tobacco usage among pregnant women, reducing unhealthy pre-pregnancy and pregnancy BMIs and increasing spacing between pregnancies.

At the direct service patient/client level we use the methods listed in **Figure 3.1-1** to determine requirements. In addition an "importance survey" was done in 2008 that resulted in the validation of Accessibility, Timely Service, Accurate Information and Protection from Disease & Disaster as key requirements of our direct service patients/clients. This "importance survey" is being repeated in 2012 to re-validate.

3.2a(2) Patient and Stakeholder Support:

Patients/clients/stakeholders are able to seek information via telephone, in-person visit, internet and through field visits and participation in various community events and forums. As previously mentioned, patients/clients are able to receive services and provide feedback via these same mechanisms.

Via telephone we provide information to patients/clients/ stakeholders about services provided directly by SJCHD and information about services provided by our various community

partners. While we have always provided patients/clients information via telephone, providing good customer responsiveness by telephone has always been a problem in our small agency where employees are often performing multiple functions. In 2009 telephone support was greatly improved by the opening of our new call center. This call center is strategically located to allow for immediate Clinical Triage as well as any unscheduled walk-in patients. It is staffed by one of our most experienced PH nurses, who provides patients with medical and community information and determines whether that patient needs to be seen immediately by one of our medical providers or to seek emergency assistance.

Via the internet, patients/clients have access to an enormous amount of information varying from the services offered, office hours, and numerous sources of public health data and information from various systems including Northeast Florida Counts, Florida CHARTS, CDC, Homeland Security, St. Johns County, and various Florida government agencies.

Some patients/clients support requirements are dictated by federal or state laws, rules, and regulations that pertain to programs that are funded through these sources. Others are dictated by local policy to ensure high levels of patients/clients support. For example, there are state requirements to respond to after-hour immediately notifiable conditions within 15 minutes. Local requirements are for any important calls to be returned within the same 15 minutes.

The SLT with input from various improvement teams determines other key patients/clients support requirements for each mode of access. Our values reflect compassion, efficiency, respect and excellence in all our access mechanisms. For example, Web Inquiries or comments are responded to within one business day and are monitored continuously to facilitate immediate responses for urgent issues. Complaints are addressed immediately as follows: If telephone and address are provided, appropriate SL calls complainant for information and appropriate resolution.

SLT members and supervisors work with the staff to continue to stress the importance of making ease of access a priority. We use an electronic scrolling sign to greet clients with an updated health message as they walk into our lobby. Our staff are trained to cordially direct clients to clinics and services. Signs are placed around the hallways to make it easy for patients/clients to find the services they seek. Staff are encouraged to stop patients/clients who look “lost” and offer to direct them to the proper office or clinic. Departmental process maps reflect the updating, evaluation and training to keep our access mechanisms effective. Staff are also encouraged to park in the most distant parking spots so that those close to the building are available to our patients/clients and visitors. In addition after a PDCA cycle, we recently re-engineered our clinic resulting in quicker service provision for walk-in clients.

We are continually focused on communications to better serve our patients/clients, thus improving ways the public can seek information and utilize our services. Through weekly Service Center meetings, information is passed between supervisors and staff, which give all employees the proper information to share with the public. SJCHD also coordinates information with community stakeholders. Partnering with community stakeholders as previously discussed enables us to holistically meet the needs of our direct-service and indirect service patients/clients.

In 2011, we began our new "**Every Person Every Time**" initiative. This initiative came as the result of benchmarking with several Baldrige Award recipients including Poudre Valley Healthcare. This system emphasizes customer service standards though the usage of "Key Words at Key Times", proper telephone etiquette, providing **GREAT** (Greet, Respect, Engage, Anticipate, Thank) service and patient/client centered care. Employees have received training and reinforcement in All-staff and departmental trainings and it is emphasized in new-employee orientation classes. The "**Every Person Every Time"** initiative is reinforced by leadership rounding and employee recognition programs. This ensures that employees fully support, understand and deploy the SJCHD customer service standards.

3.2a(3) Patient and Stakeholder Segmentation:

Many services offered by SJCHD are state or federally mandated and/or funded. These include: WIC, STD, EPH, Epidemiology, and Healthy Start. Thus, these services and our methods for providing them to patients/clients are largely determined by State or Federal regulations. Due to this mandate most direct service patients/clients are segmented by Service Center/program. Data from various state, federal, Epidemiological studies, and the CHA/CHIP to help pinpoint the specific emphasis required such as the reduction of infant mortality and low birth-weight among non-white populations.

Many of our clinical services such as Women's Health and Pediatric Primary Care and Dental services, have private sector competitors, however for the most part they cater to clients with private insurance, while we primarily provide these services to patients/clients on various government program such as Medicaid. We are currently the only Medicaid Dental provider in the county. Therefore while we provide high quality services for these patients/clients, we do not pursue (and are not permitted to pursue) the clients of our competitors.

In the future, as other health care providers come into the community, we may de-emphasize some direct clinical-based services. Emphasis will be placed on providing population-based PH services and clinical services of PH significance such as communicable disease treatment and management. Thus our segmentation will continue to emphasize populations with identified health problems and any emerging threats such as pandemic influenza or West Nile fever.

3.2a(4) Patient and Stakeholder Data Use:

Patient/client, market and product/service offering information is used to improve marketing, build a more customer-focused culture and to identify innovation opportunities in several ways. The most comprehensive source of customer information resides in the 2011 CHA/CHIP which includes information regarding community demographics, health issues within the community, the wants and desires of more than 1,200 local residents (who responded to the community health survey) and the desires of community leaders in the HLC who have developed the CHIP and have invested resources to address identified needs. The CHA/CHIP has been widely marketed via public services announcements, on the SJCHD web-site and those of partner agencies. Marketing of other services are largely program driven with local marketing primarily through

public service announcements such as the location and services being provided by our PH mobile center and special events such as flu shot administration. Many programs such as WIC, Healthy Start, and our tobacco program are funded by state and national sources and marketing programs. While we benefit from this marketing, we have no input on timing or message.

We widely use patient/client data such as volume of business, satisfaction/engagement results, complaint information, CHA/CHIP data, and epidemiological studies to build a more customer-focused culture and identify opportunities for innovation. Improvements over past few years include the implementation of the touch-screen survey which enables immediate response to changing satisfaction rates, the call center with immediate Clinical Triage, the usage of a Community Balanced Scorecard to drive community health improvement efforts, an intensive clinic process flow analysis and the development of an internal dashboard to monitor clinic wait and cycle times all of which have led to improved process performance throughout SJCHD. Most recently in an effort to improve patient/client engagement we began the innovative "**Every Person, Every Time**" initiative.

3.2b Building Patient and Stakeholder Relationships

3.2b(1) Relationship Management:

While SJCHD does not attempt to compete with private sector provider to build market share, we use the methods already mentioned to acquire, retain, exceed patient/client requirements and increase engagement. Methods include partnering within the community to collaborate on efforts to improve overall community health and to improve internal systems to build engaged and loyal direct-service clients/patients. In addition to efforts mentioned in area 3.2a(4), we engage the community through many partnerships. These include collaboration with the local Healthy Start Coalition for our Healthy Start Program, with county government and many other agencies for PH Preparedness and the development of an ever-ready volunteer Medical Reserve Corps. We partner with not-for profit clinics such as the Wildflower clinic to provide sovereign immunity to medical providers who volunteer their time in the community. This has resulted in a spirit of trust and cooperation between community agencies that did not exist a few years ago.

For direct-service patients/clients, we treat each as if they are our only customer and we focus our initiatives and strategic planning process on improved "**Health and Quality of Life**" for our community and on "**Customer-focused Excellence**" for those we touch directly. Efforts such as immediate Clinical Triage, and "**Every Person Every Time**" bring it together.

3.2b(2) Complaint Management:

The SJCHD complaint management process comprises both formal and informal complaints. Front line staff are empowered to quickly respond to any identified patients/clients related issues. If they are unable to immediately resolve the issue, they encourage the patients/clients to complete a comment card. Comment cards are responded to within one business day via our formal complaint/commendation process as shown in **Figure 3.2-1.** Every complaint that includes contact information is responded to within one business day by an assigned member of the SLT who resolves the complaint with the patient/client if possible. Since many of our complaints deal with issues of client eligibility for services, responses are often centered on finding a service provider to a particular client need. It is the job of our staff and of each SLT member to go the extra mile for each client to ensure satisfaction and engagement.

Through the Customer Comment process, complimentary comment cards are often received from patients/clients. Employees whose names are mentioned in a compliment immediately receive an "Honorable Mention" certificate from the Director with the reason for such mention. "Honorable Mention" recipients are widely recognized through all-staff emails. Often there are a flurry of follow-up emails from various SLs and staff offering their congratulations. This reinforces our Customer-focused culture and the concept of "**Every Person Every Time**"

Figure 3.2-1 Complaint/Commendation Process

Customer Comment Process
STEP 1
Retrieve Customer Comment Cards
STEP 2
Review and Enter Data in Spreadsheet for Analysis
STEP 3
Send Thank You letter to non-actionable commenter
STEP 4
Contact actionable commenter for information and feedback
STEP 5
Resolve or forward to Customer Service Team for further review
STEP 6
Recommendations from Customer Service Team
STEP 7
Implement changes accordingly
STEP 8
Evaluate and Improve Survey and Process

CATEGORY 4 MEASUREMENT, ANALYSIS, & KNOWLEDGE MANAGEMENT

4.1 Measurement, Analysis, Improvement of Organizational Performance

4.1a Performance Measurement

4.1a(1) Performance Measures:

A wide variety of financial and non-financial information and data are utilized for day-to-day operations, to ensure regulatory compliance, to monitor strategy and action plan performance and to drive process improvements. These measures are selected in several ways. The first is through measures mandated by various state and federal government sources. These include: Healthy People 2020 (from the CDC), a Dashboard of public health indicators (from the state DOH), an administrative snapshot of key administrative and financial indicators (DOH), and many specific program-level indicators coming from state program offices (such as Environmental Health) and the federal government (such as for the WIC program). Secondly, a number of performance measures are mandated by funding agencies. These include performance indicators for the Healthy Start program (funded by the Healthy Start Coalition) and the HIV/AIDS program (funded by a grant through the Ryan White foundation). Thirdly, some

performance indicators are developed internally to better determine program and process-level results. These include clinic cycle time and wait times, patient/client satisfaction rates and provider productivity rates.

While we are required to track and report the mandated measures listed above, our challenge has always been to develop and/or use a limited number of measures that are specifically meaningful to the SJCHD to facilitate our planning and improvement efforts. In order to build this more limited set of "Enterprise" measures we began to use a Balanced Scorecard approach in 2004. The purpose of the scorecard is to provide a balanced focus on measures that are important to our success and sustainability for the purpose of strategic planning, departmental, programmatic and process management along with a tool to be used for our improvement initiatives. The current version of our top-level scorecard is listed in **Figure 2.1-3**. The scorecard is divided into four "Strategic Priority Areas": which align with our Core Competencies. This scorecard is used for twice-monthly SPEC reviews and a Service Center level "Golden Thread" drill down process as explain in item 2.2.

The measures within the Balanced Scorecard are reviewed and updated annually by SLs and its creation is included in Step 8, **Figure 2.1-1**, of the SPP. While the measures used within the scorecard have been updated annually each year since 2004, a major initiative took place in 2008 to totally revamp the entire scorecard process. In 2008, the SLT met with a consultant to review the current measurement system and rebuild it based on the following guidelines:

1. Scorecard measures are those critical to the success of SJCHD (should be strategically important).
2. Scorecard measures should be at least somewhat controllable based on the direct activities, programs and relationships of the health department.
3. Measures should be useful for adding to the field of evidence-based Public Health practices.
4. If possible, measures used should be comparable to other similar organizations within the state and nationally.

Scorecard measures have been updated each year since using this guideline. Scorecard performance is reviewed twice-monthly and updated at least annually using data and input from all Service Centers to reflect changes in strategy, regulatory requirements, or specific areas of focus. This data is used to support the SPP (see category 2), for leadership reviews (see category 1), and to drive action planning for improvement initiatives either at the organizational or Service Center level.

All Service Centers determine their own key performance measures (in alignment with the organizational top level balanced scorecard) which are used to create a departmental scorecard and action plans in support of organizational goals. When performance measures are not at or approaching targeted levels, actions are assigned either to individuals or to workgroups to find innovative solutions to problems.

The scorecard and the various department level drill-downs are made available internally through the Share Point portal. Externally a very wide variety of data and information are available at both the www.stjohnschd.org and the state DOH website. These reports (along with a SJCHD business plan and annual report) are shared with those who do not have internet access. A sampling of key organizational measures are listed in **Figure 4.1-1**.

Figure 4.1-1 SJCHD Key Organizational Measures

Type of Measure	Source of Measures	See Figure
Scorecard	Short-term & Long-term Strategic Objectives	Figure 2.1-3
Patient/Client & General Public	Patient Information (From HMS), Satisfaction Information (from Touch-screen system), Comment Card Information, Epidemiology Information (From various sources) County Health Rankings	Figure 2.1-3 and Items 7.1 & 7.2
Service Center	Drill down from scorecard	Throughout Category 7
Short & Long-term Financial	From scorecard plus DOH Snapshot Report.	Figure 2.1-3 and Item 7.5
Process	Key Core and Support Processes	Figure 6.2-1
Human Resource	From scorecard and key HR measures	Figure 2.1-3 and Item 7.3
Compliance	DOH Snapshot Report	See Item 7.4

4.1a(2) Comparative Data:

The use of comparative data to support operational and strategic priorities and decision making has been a focus for several years. Comparative information is used to inform us of "where we stand" relative to comparable counties and CHDs from within and outside the state. Benchmarking information provides impetus for major change and improvement and helps lead to a better understanding of our processes and performance; where we are headed and where we need to be.

A few years ago, comparative information in PH was difficult to obtain and unreliable. Today, there is an abundance of comparative data available both within the state of Florida and nationally. However, there is typically a time lag of 3 - 5 years in acquiring reliable comparative data. Comparative data for many PH outcome and performance indicators for key processes are easily accessible. Sources of data include the *County Health Ranking* report, the Community Health Status Indicators report, FL CHARTS, and the Northeast Florida Counts Dashboard System. We have access to statewide outcome measures and criteria established by DOH and the federal government. These measures link either to strategic priorities and/or are drivers for core processes. Although these measures provide comparisons with other in-state health departments, we are particularly interested in the results of other similar counties.

Thanks to the Community Health Status Indicators report developed by the US Department of Health and Human Services in 2009, SJCHD has identified 26 peer counties nationwide whose population and demographics are similar to St. Johns, making these counties excellent comparatives in terms of key PH data. Of these 26, three are located in Florida (Collier, Lake and Manatee counties) while the other 23 are located in a total of 13 other states. Another major source of comparative data is the *County Health Rankings* report, which is segmented by state and county. *County Health Rankings* is a

research project sponsored by the Robert Wood Johnson Foundation and the University of Wisconsin that ranks nearly every county in the US in terms of "Health Factors: and "Health Outcomes". These rankings are provided only within each state; however the reporting mechanism can be used to compare SJC to the 26 peer counties mentioned above and to nearly all counties in the US.

In addition to comparing PH data among our 26 peer counties, comparative data from other high performing organizations is systematically used during SPP and by Service Centers to identify best practices and opportunities for innovation. These include other CHDs (such as Miami-Dade County Health Department, who is also a Sterling-Award recipient), Sullivan County Tennessee Health Department (State Award Recipient), and various high performing health care organizations and high performing service organizations.

4.1a(3) Patient and Stakeholder Data:

A focus on patients/clients and the General Public is an important value within the organization and is highlighted in Strategic Priority number 3. Patients/clients -focused data is selected as described in area 4.1a (1). As stated in Category 3, patients/clients fall into two categories: the entire population of SJC residents and visitors (indirect); and the direct service recipients (patients/clients) of SJCHD. Patient/client requirements, service needs and data tracking methods are determined by state statutory mandates as well as by SJCHD's approach to targeting services to those with the greatest need based on statistical data. (See **Figure 3.1-1**) Patients/clients -focused measures include external and internal customer satisfaction data from the touch-screen system, comment cards, various epidemiological data, and patient specific data stored in HMS automated medical records as shown in **Figure 4.1-1**. Our newly developed internal dashboard system now enables us to use HMS to continually monitor patient wait and cycle time in our clinical areas, where we previously were only able to get an occasional snapshot of this data. We select data for the General Public through several sources that were discussed in Category 3. These include data the Community Health Assessment, Epidemiologic Studies, Self-reported survey data, and the County Health Rankings Report. These data are used in the SWOT analysis for SP development and for day to day process management in our Service Centers. This has resulted in innovations including a Community Balanced Scorecard, expanded dental services, and the development of the SJC Community Dashboard.

4.1a(4) Measurement Agility:

SJCHD uses several approaches to ensure the performance measurement system is able to respond to rapid unexpected organizational or external changes. The SPP and subsequent "Golden Thread" process ensures that measures within the control of SJCHD are reviewed and updated as least annually. It is our intention that the annual scorecard reflects the latest thinking in PH as we update our scorecard each year. For example, in our current scorecard we added performance measures for a new Strategic Objective 1.5 for Health-related Quality Of Life indicators, even though these indicators are still a work in progress at CDC. As soon as CDC agrees on a set of meaningful indicators, they will be put on our scorecard.

The other forum that enables a rapid review and possible refinement of measures is the schedule of frequent leadership reviews (**Figure 1.1-3**). This ensures that if there is a significant change in direction (such as a PH emergency or change in direction coming from the state) we will quickly plan for the change and determine the appropriate performance measures at the SLT level, and deploy with the SPEC or appropriate Service Center as needed, all within a very short time frame. The Incident Command System [see area 1.2b(1)] enables fast deployment of important changes (including new measures) that must be implemented quickly. For example, during the 2009 H1N1 pandemic, we combined data published nationally regarding H1N1 incidence rates with our local data to develop an action plan to address the situation. This also enabled us to disseminate the most accurate and up to date information to the community.

4.1b Performance Analysis & Review:

As described in **Figure 1.1-3** we use a series of daily, weekly, monthly, quarterly and semi-annual meetings to review organizational performance and capabilities. SLT meets weekly to address internal and external issues with real or potential organizational impact. SPEC meets twice-monthly to report on and share information and review results at the Service Center level. All Service Centers meet weekly (Pass Up/Pass Down) to discuss and address intradepartmental matters and initiatives. Minutes and action registers resulting from the above described meetings are utilized to disseminate information throughout the organization and to track planned improvement activities.

A number of different tools are used to support the activities of these groups to determine root causes and to ensure that appropriate actions are planned and carried out. Methods used include: trend analysis, comparative analysis, SWOT analysis, process mapping, surveys, time studies and pilot projects. In-process measures, as well as departmental and organizational results, enable us to evaluate both the process and the outcome of activities at all levels. For PH related data such as disease rates or environmental hazards, we analyze geographic data (GPS and GIS) with ESRI's ArcGIS Desktop software. This is used to identify areas or pockets of PH concern such as high incident rates of specific disease or conditions. The resulting data and maps can be used in conjunction with investigation procedures to proactively address PH issues where a target response is called for. For financial analysis, we analyze revenues versus expenditures. We compare our unit costs per service to those of other health departments. Those of similar size and providing a similar array of services are most useful for this type of analysis.

We use problem-solving teams/workgroups that analyze data through a PDCA approach (See category 6). Team members analyze process indicators to identify root causes and to determine appropriate countermeasures. Once this preliminary analysis has been completed, additional systems may be developed to track performance. As countermeasures are identified and implemented, teams/workgroups regularly meet

to review and analyze data to determine whether a desirable performance change has resulted from the initiation of each countermeasure. The teams/workgroups continue this analysis and modify accordingly. For example, every quarter the Epidemiology quality review workgroup assesses the performance on nine quality indicators and has used a PDCA approach to focus on proper documentation of case closures. This has resulted in significant improvement since 2009.

4.1c Performance Improvement

4.1c(1) Best-Practice Sharing:

Best practices and lessons learned are shared in a number of ways already mentioned. This includes the various forums shown in **Figure 1.1-3** including the SLT and SPEC. They are also shared in Pass Up/Pass Down meetings, all staff meetings and in the various First Friday and Third Thursday enrichment sessions. Best practices are also shared with other CHD and DOH through share point sites administered by the DOH and through "Best Practice" and "Promising Practice" submittals through the CDC. SJCHD has recently been recognized for best practices in inventory management and for our Head Start/WIC partnership. In 2011, our Epidemiology department received recognition from the state (Florida Tax Watch) for the implementation and sharing of our EPI QA/QI process.

4.1c(2) Future Performance:

We use the results of review findings and analysis to trend and project future performance levels as follows: First we review trend data over the past several years to determine the rate of change of the indicator. We review any new Strategic Objectives and/or Action Plans that may impact that rate of change. Finally, we identify any benchmark or best practices that may assist in improvements. Based on the above steps, we project future performance. As noted previously, key health indicators tend to improve very slowly over time. It takes sustained effort over a number of years, and often with the assistance of partners to makes meaningful improvements in these indicators. Performance projections for our current Strategic Objectives are shown in **Figure 2.1-3**.

4.1c(3) Continuous Improvement and Innovation:

Performance review findings are used to develop priorities for improvement and innovation through the SPP and SLT, and SPEC review meetings. As stated in 4.1b, when results are not meeting expectations, first it is determined by SLT whether this is an existing or potential strategic issue. If a current Strategic Objective is affected, then new or updated Action Plans may be developed. Depending on the complexity of the issue, it may be assigned to an existing work group, a team may be chartered, or an individual assigned. A PDCA approach (along with the tools mentioned in 4.1b) may be used to resolve the issue. At any given point in time there may be six to eight permanent teams along with several ad hoc teams that are focused on a single issue. See **Figure 5.1-1** for a list of teams.

While we have used the PDCA approach for many years, one of our staff is currently being trained as a Lean/Six Sigma Green Belt and in 2012 we will begin at least one project using the more sophisticated statistical methods she is learning.

Priorities for improvement and innovation are shared with our many partners and collaborators through multiple means. The major example of this is our county-wide HLC which meets every two months and has recently published our third CHA/CHIP. The Council is very data driven and is regularly reviewing results reflecting the PH of the community (from the Northeast Florida Counts dashboard and other sources). Through the MAPP process (see **Figure 3.2-1**) the HLC developed the new CHA/CHIP and is taking actions to implement the strategies outlined in the document. Other key examples include major partners such as the School District (to reduce childhood obesity), the Healthy Start Coalition (to reduce infant mortality) and the Ryan White Foundation (for HIV prevention efforts). Many of our current innovations such as the Public Health Mobile Center; the Touch-Screen patient/client survey tool; joining the Public Health Practice Based Research Network (PHPBRN); being a part of the Clinical Practice Management Institute (PMI); and creating the Northeast Florida Counts Dashboard came as a result of our constant sharing of results and assessment findings with our key partner agencies.

4.2 Management of Information, Knowledge & Information Technology

4.2a Data, Information & Knowledge Management

4.2a(1) Properties:

Accuracy: Methods of ensuring that the many types of data and information generated during day to day activity are recorded accurately and are built into programmatic audit procedures. For example, each departmental budget is reviewed with the originator by the director of fiscal services before it is accepted. Each supervisor compares and certifies Employee Activity Records with employee timesheets to ensure that activity record codes and documented time match. Clinical records are reviewed to ensure that providers are following evidenced-based standards of care regarding such issues as the treatment of asthma and prescribing of antibiotics in upper respiratory infections. The SJCHD Director personally oversees a QA process to ensure that records are accurate and evidence-based standards of care are followed.

Additionally, most systems in use have built-in edits to greatly reduce the likelihood of input errors. For example, these programs typically look for certain alpha and numeric fields to be populated correctly, and for social security numbers and patient numbers to match those already in the database. These systems either decline to input invalid fields or produce error reports so that errors may be found and corrected.

Integrity and Reliability: Integrity, Security and Confidentiality are overlapping principles of data management and are addressed jointly through the following three factors: Technical, Architectural and Behavioral. Integrity is specifically addressed by technical and architectural controls. The technical aspects of these controls involve restricted electronic access to data sets available only to those authorized individuals with a need to know. This type of restricted access is accomplished through user ID and password authentication in a secure network environment so that unauthorized access to data is impeded. Technical protection is also achieved through parity checking algorithms to ensure that data counts and calculations are accurate and no data bytes have been lost during a data transfer operation. Anti-virus systems are used to perform automatic scanning of network servers and e-mail servers to detect and deny the intrusion of virus attacks or any other unauthorized access.

Architectural protections ensure that no unauthorized individual has physical access to secure areas. This is accomplished through the use of internal and external badge access entry points and traditional as well as keypad locks. Programs that regularly work with highly confidential Protected Health Information (PHI) are housed in one area with a single badge controlled access point. All PHI is housed in the secure HIM department and must be returned to this department by close of business each day.

Behavioral controls consist of employee training and education in security standards and guidelines. All new employees are trained upon hire and regular security updates are provided via email and all staff training sessions. For example, employees are trained to lock down computers when leaving them unattended and the system will automatically display password protected screen savers based on inactivity at each worksite for more than 10 minutes.

Timeliness: We ensure timeliness of data through real time web-based applications and reporting systems. For example, our HMS has a reporting portal available to all staff. This allows for both canned and ad-hoc client-centric reports. Other systems also allow for report access in a similar fashion. Also a new internal administrative dashboard provides real-time views of information regarding the clinic flow and service delivery times and the touch screen survey system provides immediate access to patient/client satisfaction information.

Security and Confidentiality: Data security and confidentiality is ensured by the Information Security Coordinator and Risk Management Team through the deployment of DOH Information and Security Policies. Policies and protocols delineate the functions of Information Custodians at each site where client data is handled, and prescribe the acceptable methods for accessing, using and maintaining data. DOH Information Security Policies and Protocols oversee retention, collection, transportation and disposition of records and files, physical security controls to protect unauthorized entry into certain areas of buildings, and mandatory trainings, background screenings and signed employee statements. Quality Control procedures assess the adequacy of security policies and to recommend policy changes where needed. Staff receive training in guidelines and procedures during new employee orientation and updates at least annually. Guidelines and procedures are accessible to all on the SJCHD intranet. We are in the process of incrementally implementing EMRs, with a goal of being compliant with Federal Meaningful Use Standards.

4.2a(2) Data & Information Availability:

SJCHD uses multiple state-provided systems including the Health Management System (HMS), Environmental Health Data (EHD), Community Health Assessment Resource Tool Set (CHARTS), People First, Fiscal Information Resource System (FIRS), MERLIN, Epi-Com, and MyFlorida Marketplace (vendor data) to compile, analyze and communicate organizational data and information. We also use several local systems including the touch-screen data, the Administrative Dashboard system, a local Share Point portal, Intranet and shared drive system for storing and accessing locally developed documents and reports. These systems include financial data, patient health information, various performance data, legal/regulatory related data, staffing, and other HR information.

Staff members have easy access to these systems through the availability of computers within all departments. We currently maintain over 150 personal computers to ensure this ease of access. Patients/clients and other stakeholders have access to organizational and educational information via the internet at www.stjohnschd.org.

Patients/clients and partners without internet access have information provided to them in various ways. Pamphlets and educational materials are available on premises, distributed at community events and at community stakeholder meetings. Media releases are utilized to disseminate information to the General Public regarding issues of PH significance. Radio talk show appearances by staff such as the Public Information Officer provide additional sources of education and information for the community. Also, FDENS and Blast Faxes are used to communicate important information to health care providers and other members of the local PH system.

4.2a(3) Knowledge Management:

Organizational knowledge is managed via means already discussed. Workforce knowledge is collected and transferred via an intranet and shared-drive system that includes local and state policies, process documentation, and various data systems and reports. On-line employee training and courseware is available via the Trak-IT system. Knowledge and best practices are also widely shared through SLT meetings, SPEC meetings, Pass-up/Pass-down sessions, First Friday and third Thursday staff enrichment sessions, and the various other staff and workgroup meetings. Knowledge is widely shared with patients/clients, suppliers, partners and collaborators via the external internet both at the local and state DOH level. In addition community knowledge is shared through various partnerships such as the HLC and several others both within the county and in state and national forums. For example Dr. Allicock recently presented our performance improvement story at a conference facilitated by the CDC and at another to PH professionals in Texas. Knowledge of local, state and national innovations are continually shared by the state DOH, other CHDs, and at the national level through organizations such as the Public Health Foundation and the CDC. Organizational knowledge is assembled and used to drive innovation primarily through the SPP Environmental Scan and SWOT processes (Steps 3,4,5,6,7, **Figure 2.1-1**) and through the communications mechanisms listed above.

4.2b Management of Information Resources & Technology

4.2b(1) Hardware & Software Properties:

SJCHD complies with standards and directives set forth by the Florida Department of Health (DOH), Information Technology (IT) Department. DOH established the IT Standards Workgroup that provides a list of approved standards consisting of workstations, laptops, servers, network devices, imaging devices, satellite systems, miscellaneous hardware and software. SJCHD refers to this list on the Standards Workgroup web site before purchasing or loading any type of

hardware or software. Exceptions must be submitted and approved by the workgroup before they can be implemented.

Network reliability is ensured by equipment refresh standards; scheduled maintenance procedures; and automated software/security upgrades. Security and reliability are insured by password authentication, virus protection and backup/recovery procedures. Staff members are trained during new employee orientation and receive refresher training in information security guidelines and procedures annually.

Customer service is provided by IT through a local automated help desk system integrated with email to ensure prompt notification to the technicians. Reporting identifies common trouble tickets and automated online customer surveys monitor satisfaction. Solutions and survey results are documented, shared and incorporated into continuous improvement initiatives in support and management of IT related organizational performance. Applications, using software appropriate for the task, such as, Microsoft Access are developed for departments upon request or as a result of interviews analyzing departmental process maps.

A recent initiative utilizing light weight portable tablets, computers on wheels, and wireless nodes in clinical areas provides complete access to clients' records by the provider. This portability of access enhances the timeliness and accuracy of data input to the clients' electronic medical record.

4.2b(2) Emergency Availability:

In the event of an emergency the SJCHD Continuity of Operations Plan for Information Technology (COOP-IT) is initiated. Mission critical applications are identified in the Disaster recovery Application List describing the application, production servers it uses, the recovery server to be used and amount of disk space required for the data. All identified applications are backed up daily with a two week tape rotation; weekly full data backups with a 4 week rotation; and monthly full system backups with a 12 month rotation. They are stored in a secured area in a fireproof safe with combination and keyed access. Monthly backups are performed on the last Friday of each month. The tapes are transported to a secure off site location and stored in a fire proof safe. Weekly backup tapes are rotated so one full backup is always off site. Only designated IT staff are authorized to transport tapes in accordance with security policy.

The COOP-IT designates an offsite location as an alternate re-location point for IT services. This fully functional "warm" site is located with our Environmental Health Facility. A Drive-Away-Kit contains software, documentation and license information for the recovery area.

The COOP-IT has been tested every year since 2007 with 100% success. All mission critical applications were recovered within two hours and the DOH IT required time for this activity is 24 hours.

PH information is maintained in electronic and paper format with the traditional hardcopy medical record centrally located in the window-free Health Information Management (HIM) area with strictly limited access for physical security and information privacy protection. In the event of an emergency they can be either moved to an elevated position within the HIM area or securely transported to an alternate safe location.

CATEGORY 5 WORKFORCE FOCUS

5.1 Workforce Environment

5.1a Workforce Capability & Capacity

5.1a(1) Capability & Capacity:

SJCHD ensures its workforce has the required capability to deliver the services it provides. In order to do so, it uses a classification system developed by Florida Department of Management Services (DMS). Each position has a pre-determined set of knowledge, skills and abilities (KSAs) which allows the supervisor to match positions with the right individuals. Supervisors can add additional KSAs they consider to be important based on the job functions and requirements. Job specific competencies also exist and these are reviewed during the performance evaluation process. Through this evaluation, supervisors are able to identify the areas an employee is excelling and their opportunities for improvement. The evaluation process also involves an individual development plan (IDP) in which employees identify the competencies they consider to be appropriate for their jobs. It also provides an opportunity to identify new skills that may be needed for a future position they may aspire. This dialogue allows supervisors to provide feedback to the employee and the employee is also able to share the limitations that he/she is experiencing to achieve full potential. This enables employees and supervisors to identify opportunities for training to ensure proper capability.

We are limited in our ability to ensure capacity needs are met. Over the past several years the number of budgeted employees has been reduced by the state and that trend is likely to continue. We are budgeted a fixed headcount and the state uses a system called "Rate" that limits our ability to hire certain positions and to pay employees at a competitive wage. Within these limitations we are able to hire and place employees. In order to ensure that employees are allocated appropriately to each Service Center we monitor and streamline processes to improve productivity and thus minimize the need for additional staffing. On a daily basis we use our Operations meeting to adjust the number of staff assigned to particular Service Centers based on anticipated client load for the day and week and to manage planned and unplanned absence. The Operations meeting began in 2009 as result of feedback from a state Baldrige-based assessment. As much as possible, employees are cross-trained so that they are productive in multiple functions in order to provide maximum flexibility. For example, PH nurses are cross-trained and may be assigned to work in several different types of clinics (such as Pediatric Primary Care, Family Planning and STD) during a given day or week.

5.1a(2) New Workforce Members:

The position description is considered a vital document prior to beginning the hiring process. It primarily outlines the technical requirements including: knowledge, skills, competencies, and specific licensure and any specialty requirements. Moreover, a well-defined position description provides a tool for developing a behavioral profile for the specific position and provides the hiring manager and Human Resources an effective tool to develop a strong pool of highly qualified candidates. The job announcement clearly describes the position duties to prospective employees. It provides applicants with detailed job requirements, training credentials and qualifying criteria.

Applications are rated based on a criteria developed using the knowledge, skills, and competencies detailed in the position description. The technical abilities and credentials listed on the applications provide the hiring manager the opportunity to identify the top candidates for interviewing. Prior to the interviews, the hiring manager consults with Human Resources in order to develop program specific and behavioral interviewing questions. Industry standards indicate behavioral interviewing increases the odds of hiring the right people by two to five times. At the beginning of the interview process every employee must attest that they are willing and able to be called upon to respond to PH emergencies. The team–based interview panel consists of the hiring manager, Human Resources, and a manager or employee with the knowledge of the discipline. Upon completion of the interview, the interview panel forwards their top two recommended candidates for the position to the SLT. SLT schedules a second interview with the top candidates and makes the final recommendation to the Director, of the candidate's capabilities and fit to ensure that new hires align with our agency values and culture. Additionally, all key management and supervisory positions are scheduled for a third interview conducted by the CHD Director.

SJCHD and neighboring counties provide recruitment and selection training as part of a new supervisory training module. In addition, the Human Resource Office provides individual coaching and training for supervisors on an on-going basis.

With the restrictions to paying employees at the market rate, it is a continual challenge to retain staff. We attempt to retain new employees through various methods. These include Cross Training, the ability of working flexible/ staggered hours to accommodate educational and family responsibilities and professional develop planning. Staff is encouraged to participate in teams or work groups and they are encouraged to take advantage of various development opportunities and are provided ongoing recognition. SJCHD also provides an array of benefits including health insurance, tuition waivers, annual and sick leave. This allows staff to find a work/life balance.

We are an equal opportunity employer and our hiring process ensures that a widely diverse group applies for positions at SJCHD through the state mandated People First website. Through the hiring panel process, we ensure that diverse employees participate on selection panels. As PH professionals our services are provided to a wide variety of cultures and our value of "Respect" permeates the organization. Additionally, over the past several years we have instituted various initiatives to ensure that our staff are "Culturally Competent" both in terms of our patients/clients and with those we hire. As part of our SO #4.2 (**Figure 2.1-3**) we recently completed phase 1 of our Cultural Competence Curriculum. We are now taking cultural competency to the next level by implementing an evidence-based nationally recognized *Cultural and Linguistic Competency* self-assessment process for the first time in 2012. We are now implementing additional actions as identified in this assessment.

5.1a(3) Work Accomplishment:

SJCHD has a structure composed of Service Centers and support units which have very specific functions. Service Centers provide designated PH programs and services while the support units assist with the functions needed for support such as financial management, facilities maintenance, human resource and IT services. SLs manage these Service Centers and units to ensure the SPs are supported. The State DOH provides guidance to our programs and units to ensure we do our part to support the overall mission and vision. Besides the Service Centers and support units, work is also accomplished using teams, workgroups and committees. These groups are created to assist in the accomplishment of specific activities as cited in our Strategic Objectives and Action Plans. A listing of our team and committee structure is shown in **Figure 5.1-1**.

SJCHD capitalizes on its core competencies to develop and enhance partnerships and to clearly mark its role in the county. These competencies allow us to work with the community and to be a credible voice when PH issues are being addressed. Service Centers deliver patient/client services and accomplish work successfully by deploying our Strategic Objectives (SOs) and associated Action Plans through the "Golden Thread" process (**Figure 2.2-1**). Continued focus on these SOs ensure patient/client and PH focus, and alignment with Core Competencies as shown in **Figure P-2.**

Figure 5.1-1 Chartered Teams/Committees

Year Began	Teams/Committee Name **Note: Bold** Denotes Currently Active
2005	• "Bravo Team" (Employee Awards and Recognition) • "Miles of Smiles" (Internal Customer Satisfaction) • Communications Team • Medical Records • WIC Improvement Team • Strategic Business Alignment • ProAct Team
2006	• Worksite Wellness Team • **Sterling Performance Excellence Committee** • Safety Committee • External Customer Satisfaction • "Hot Shots" (Immunization Team) • Information and Security Team
2008	• **Senior Leadership Team** (formerly Senior Management Team from 2004 – 2008) • **Employee Engagement Team** (combined Bravo and Miles of Smiles Teams) • **Risk Management** (combined Safety Committee and Information and Security Team) • **Customer Satisfaction & Loyalty Team** (External Customer Satisfaction Team PDCA'd and re-chartered) • Workforce Development Team • **Public Health Mobile Center Team –** Ad Hoc
2009	• **Public Health Accreditation Team -** Ad Hoc
2010	• **QI/QA Committee** • **Clinical Team**
2011	• **Disease Control & Health Protection - Joint Epi, Environmental PH and PH Emergency-Preparedness (JEEP) Team** • **Disease Control and Health Protection – HIV/AIDS Team**

5.1a(4) Workforce Change Management:

SJCHD ensures the workforce is prepared for changing capability and capacity needs through cross-training, IDPs,

Pass Up/Pass Down, and Staff Enrichment Days as discussed throughout Category 5. Many staff are cross-trained and regularly perform work in more than one area giving both SJCHD and the employee flexibility if there is a need to reduce staff or discontinue a particular service

Proactive strategic and financial planning supporting our 12 Essential Public Health Domains has contributed to our ability to maintain staffing levels even when faced with budgetary constraints and limitations. We have maintained the existing workforce structure while continuing to fill mission essential positions. Additionally, we have reduced staff through natural attrition rather than through forced layoffs and anticipate being able to continue in that manner. If we are mandated to discontinue providing services in an area with significant numbers of staff, our plan is to fill as many internal vacancies as possible in other service areas with the affected staff. If that is not sufficient, we will work with our community partners and with the county workforce agency to assist in finding job opportunities or needed training for these employees.

Just as we might be faced with workforce reductions, we have also been challenged with rapid growth. For example, in 2009 during the H1N1 influenza pandemic, we deployed our Incident Command Structure. The result was the provision of quick orientations, just-in-time training, and providing dual employment opportunities. We also worked with community partners, staffing agencies and SJC Emergency Readiness Corps to ensure we had the capacity to address the administration of vaccines to thousands of residents over a very short time frame, while maintaining normal operations.

5.1b Workforce Climate

5.1b(1) Workplace Environment:

To ensure that our staff stays healthy, safe and secure in their work environments, a Risk Manager position and Risk Management Committee were established to address all safety, security, and preparedness issues to include incident reporting, planning and staff training. The Risk Manager conducts quarterly fire, safety, and security inspections of all work areas. She facilitates the Risk Management Committee which is comprised of all supervisors, as well as, other key staff members. The committee collects data from incident reports and other recommendations and develops action plans to address any safety/security issues and enhance current processes. Staff safety and security trainings are held for new hires and annually via all-staff meetings and online classes. We maintain strong relationships and communication lines with law enforcement and fire/rescue agencies for rapid response to any incident. Our facility remains secure through the utilization of a Sonitrol security system and in-house cipher locks which allow only designated individuals to access designated areas. Visitors to our facilities go through a sign-in and sign-out process. All exterior doors are locked except for the main entrance, which allows security staff to monitor visitors and clients effectively. We have also established safe parking areas for staff in the front of the building. We provide several means to ensure employee health. Methods and performance measures for all employee groups are listed in **Figure 5.1-2**.

5.1b(2) Workforce Policies and Benefits:

Our employees receive the same benefits as all Florida State Government employees. These benefits include a variety of health and life insurance programs, deferred compensation plans, and medical/dependent reimbursement accounts. Other benefits include nine paid holidays, one paid personal day, retirement programs, unemployment and worker's compensation, annual leave, sick leave for personal and for immediate family use, sick leave pool and sick leave donations, family medical leave, administrative leave, military leave, one hour per month to attend school-related activities, educational leave with and without pay, other leaves of absence without pay and the Employee Assistance Program.

We have tailored programs to the needs of our workforce by expanding basic benefits to include variable workweeks to accommodate medical appointments, childcare, dependent, educational, and personal needs. We provide on-site availability of continuing education courses for licensed professionals via teleconference, webcasts or workshop attendance. We also have staff participating in the tuition waiver program for professional and personal development.

Figure 5.1-2 Health, Safety and Security Services

Service	Method	Measure
Health Activities	• Employee Assistance (EAP) • Employee Health (Vaccines; TB/PPD screening) • Comprehensive health insurance • Paid Sick Leave	• % New Employees Health Screened within 30 days of hire • $ Value of Staff Immunizations
Safety/ Ergonomics	• Infection Control • Blood Borne Pathogens Training/Safety Equipment • Emergency Preparedness Training • Biomedical Waste Plan • Basic Life Support Training • Ergonomic/Lifting Equipment • Risk Management Team • Safety education seminars • Safety signage	• % Employees Receiving Safety Training • $ Average of Worker's Comp per Employee • Annual Safety Risk Assessment Score
Security	• Personal Security training • IDS & Sonitrol Employee Security Badges	• # State Level Information Security Incident Reports

5.2 Workforce Engagement

5.2a Workforce Performance

5.2a(1) Elements of Engagement:

DOH has conducted third-party Employee Satisfaction Surveys every two years in the even number years through 2010 but due to budget constraints, it has discontinued the survey for 2012. In 2011, we made a process improvement to insure that we have current employee satisfaction and engagement information by retaining the state's consulting firm to repeat the survey for SJCHD. Even-year survey results are available for each county health department in Florida. Through this survey, we are able to review employee opinions on a number of dimensions that impact both satisfaction and engagement (Clarity, Standards, Responsibility, Flexibility, Teamwork & Cooperation, and Rewards and Recognition).

Certain survey questions and responses allow us to examine employee engagement. A number of questions mirror those used in the Gallup Organization's Q12, a 12-question survey

that identifies strong feelings of employee engagement. Gallup's research shows a strong correlation between high engagement scores and superior job performance. The questions on our survey used to determine staff engagement are shown in **Figure 5.2-1.**

Figure 5.2-1 Survey Questions used to assess Staff Engagement (See area 7.3 for results)

Engagement Element	Aligned Survey Questions
Pride and Contribution to Mission	1, 2
Work Environment, Having Tools to do Job	7, 37
Available Development Opportunities	14
Staff's Opinions are Sought and Valued	21, 45, 48
Staff Cooperation	25
Know What is expected on Job	43, 44
Use Skills Effectively on Job	41, 50
Receive Praise on the Job	20
Receive Feedback about Job Performance	29
Preparation for Additional Responsibilities	55

5.2a(2) Organizational Culture:

During recruitment, when advertising for a position, SJCHD's opening statement clearly delineates our Mission, Vision, and Values while describing our performance improvement efforts through the Malcolm Baldrige management model as our performance improvement vehicle. Professional requirements and knowledge, skills and abilities identify what we consider to be vital in assuring a competent workforce.

During the hiring process, we re-emphasize the value of a competent workforce who understand our mission, vision and values and performance improvement initiatives as a foundation of workforce engagement. These are provided in the opening statement of our interview process preceding the technical interview. We explain the importance of both a technically sound employee, but also one who understands and supports the culture of our organization. SLT are involved in a second interview which entails a behavioral interview.

Teams are frequently established as a vehicle to address areas we consider strategically crucial to the continued performance improvement efforts of our organization. Staff at all levels participate on performance improvement teams and ad hoc workgroups. This provides an empowerment avenue for our staff to share their views and have a direct impact on our performance improvement efforts while fostering employee engagement. See **Figure 5.1-1** for a current listing of teams.

Staff enrichment days have been designated as two half-days per month dedicated to both all-staff and service center activities. All-staff days require the attendance of our entire workforce to ensure training, top to bottom communication, and deployment of information which requires the attention of the entire staff. These days are also utilized to recognize our staff with awards, acknowledge accomplishments, welcome new employees, bid farewell to those departing and recognize employee length of service with a plaque or pin.

Twice a month the SLT meets with the SPEC to ensure clear communication of agency Strategic Objectives and Action Plans and other information pertinent to the agencies short and long-term term mission accomplishment or other issues requiring direct communication.

Pass-up/Pass-down is accomplished weekly. This activity provides supervisors and staff an opportunity to discuss upcoming events, ways to improve effectiveness and efficiency, address issues of concern to the employees and clients, employee development, and strategic planning.

During regularly scheduled business reviews/staff meetings, supervisors encourage and solicit employee input and ideas. In addition, supervisors at every level have an open door policy and are available to listen to employees' improvement ideas.

We ensure communication and knowledge-sharing in several ways: sharing minutes and actions plans in SharePoint; publish and distribute an annual report, which although geared for the public, provides up-to-date information on SJCHD; DOH and SJCHD intranet sites provide information to employees relevant to statewide and local PH issues, and links to state information about various programs and trainings.

SJCHD promotes learning at various levels by offering formal and informal opportunities for employees to enhance their skills or learn new skills to further develop their careers. When possible, we exercise career laddering. When a promotional opportunity is available or if an individual position's responsibilities warrant, a reclassification is considered based on funding and agency need. Other methods of fostering a high performing workforce are shown in **Figure 5.2-2.**

5.2a(3) Performance Management:

Upon initial hire and throughout an employee's career, duties and responsibilities are outlined in a specific position description. Job-specific expectations are developed from the position description to ensure they are Specific, Measurable, Achievable, Result Oriented and Time Bound (SMART). Supervisors review job expectations and position descriptions with staff members at least every 12 months or if there is a change in the staff member's primary duties.

Supervisors meet with employees periodically during the 12-month evaluation period to provide and receive feedback. Employees are rated on both DOH core expectations and job specific expectations. The evaluation system is based on a combination of meeting expectations, performance standards and achieving job-related competencies. Each employee is rated on a one-to-five scale, with those being rated a five showing outstanding performance. A rating of 3 means the employee is meeting expectations. Anything above a 3 indicates the employee exceeding expectations. At the present time due to state restrictions, employees are not receiving merit increases even if they have outstanding evaluations. However, we still make every effort to properly compensate employees for their work as allowed within budget limitations, in the form of promotions and reclassifications when deemed appropriate.

During performance review meetings, employees provide input to a defined set of expectations and performance targets. Employees are encouraged to propose suggestions to their

Figure 5.2-2 Approaches Fostering a High Performance Culture

Foster Cooperation, Two-Way Communication and Knowledge Sharing		Foster Goal Setting, Empowerment, Initiative, Innovation	How SJCHD Benefits from Diverse Ideas, Cultures, Thinking
• Regular All Staff and Department Meetings • Ad Hoc Improvement Teams • Committees/ Teams / Workgroups • Training and Collaborative Opportunities • Twice-monthly Enrichment Days	• Pass up, Pass down • Newsletters • Internet/Intranet • Email • Leadership Rounding • Knowledge Sharing Tools • SharePoint	• Strategic planning and Action Plan Development • Teams empowered to make improvements aligned to goals • Individuals empowered to satisfy patients/clients • Recognition programs • "Every Person Every Time" Initiative	• Staff Cultural Competence Enhances Patient Experience • Enhances SJCHD General Public VOC • Increases Innovation in Cross-Functional Teams • Diverse employee body increases health literacy

supervisor to improve their jobs and the organization as a whole. Supervisors and staff discuss the performance evaluation and Individual Development Plans (IDP) at the end of each rating period. Through these processes, we have added value to the Performance Evaluation System.

The workforce performance management system reinforces a patient/client and business focus through the inclusion of behavior and technical expectations in the employee's performance evaluation. The performance evaluation and various employee recognition systems focus on achievement of action plans, the provision of excellent customer service and the overall success of the organization. The employee evaluation system is being improved this year by requiring that each employee receive a mid-year evaluation along with the previously required end of year formal assessment.

The Employee Engagement Team (Rewards and Recognition Program) is chartered to recognize and award individuals and teams who have contributed to the accomplishment of SJCHD's mission, supports organizational patient/client service philosophy, and our values. This process allows and encourages peer to peer recognition where employees may nominate other staff members they feel merit recognition. This process ensures organizational empowerment throughout the hierarchy, allowing all staff members a chance to recognize anyone in the organization. The Employee of the Month award recognizes one employee who has provided significant contributions towards operational improvements, productivity and public service. In 2010 this process was changed to a monthly "You Take the Cake" award where an employee literally takes home a cake baked by a SJCHD employee. For the past several years, Dr. Allicock has given her own annual Performance Excellence Award and/or Public Health Service Award to an employee making a significant contribution to the Performance Excellence journey or contributing the Science of PH. Along with the "You Take the Cake", we recognize staff for the following:

- "Employee of the Year" - Given annually to one of the "You Take the Cake" award recipients for significant contributions to the performance excellence journey
- "Service Center of the Quarter" - Given quarterly to a Service Center who has exceeded their Goals and outstanding Team Work
- "Honorable Mention Certificate" - Provides public recognition for any employee or group of employees receiving a positive customer comment
- "Make Someone a Star Program" and "Employee Thank You Notes" - Peer to peer recognition for demonstrating organizational core values

5.2b Assessment of Workforce Engagement

5.2b(1) Assessment of Engagement:

As already stated, we measure workforce satisfaction and engagement both formally and informally. These include: a DOH employee survey done every two years; and a SJCHD employee engagement survey now done in years where the DOH survey is not conducted; during department-wide ongoing training; and in Pass-up/Pass-down sessions. The employee survey result is segmented by time in position, level of education, job title, position classification and service area.

The Office of Public Health Practice (OPHP) is tasked with ensuring every staff member is afforded the resources available to succeed while strategic objectives and mission are met. Surveys are deployed by OPHP following key events while informal feedback is encouraged from our staff members. These efforts have resulted in updates to the employee recognition process and enhancements to employee evaluation and communications processes.

We use other formal and informal indicators of engagement such as employee grievances, and EEO complaints and number of staff promoted from within as listening points to further understand issues related to employee engagement. Employee satisfaction and engagement data is used in the SWOT analysis and is included in SO #4.1. For example, we learned from the 2010 Employee Survey that staff were not aware of internal promotions. This resulted in a regular agenda item at SPEC and All Staff events to recognize these newly promoted employees. We also implemented a cross-functional Director's luncheon to mentor and team-build with key organizational staff in response to concerns elicited from pass up/ pass down sessions and validated in the employee survey.

5.2b(2) Correlation with Business Results:

In a massive study done by Gallup, Inc. in 2009, with more than 150 public and private sector organizations participating, it is shown that there are significant positive correlations between employee engagement and a number of key business results including customer loyalty, productivity, employee safety, absenteeism, patient safety and quality. While we have not undertaken a similar study ourselves there is no reason to assume that it is not relevant to SJCHD. With that in mind we are focused on improving employee engagement through employee workgroups, improved recognition programs and employee development and enrichment opportunities.

5.2c Workforce & Leader Development

5.2c(1) Learning & Development System:

The key to success of our learning and development system is the IDP. Each employee (with their supervisor) identifies training and development needs in terms of enhancing job-specific skills and in development toward a desired career goal. Job-specific goals align with the closure of skill gaps that may address a strategic challenge or strengthen a core competency. Most skill gaps align with at least one essential PH service. The essential services (**Figure P-1**) provide the foundation for our organizational core competencies.

The SPEC serves as the primary means to develop and implement action plans. The SPEC receives annual training on how to develop action plans, and SPEC members involve their employees in action plan implementation. Along with the activities of the SPEC there is an annual employee offsite retreat that focuses employees on Baldrige, the Agency Scorecard, service center profiles and the action planning process. At the December 2011 retreat each Service Center presented a profile that outlined responsibilities, strategies, balanced scorecard, successes, and opportunities for improvement. By focusing on the Scorecard and Action Plans, there is an automatic focus on strategic challenges and core competencies as both of these concepts are designed into the Balanced Scorecard and "Golden Thread" processes discussed throughout Category 2.

The OPHP ensures the recognition of internal organizational best practices by regularly gathering information to submit to state and national best practices forums. Additionally, this office seeks information on evidence-based best practices from other CHDs and organizations, regardless of industry. An example of this is the implementation of our Centralized Inventory Process and our WIC/Head Start partnership, both of which received outside recognition as best practices.

Key aspects of our learning and development system are first introduced in New Employee Orientation and reinforced at least annually in our First-Friday, Third-Thursday enrichment days. Enrichment day sessions include topics such as Customer Service; Information Security (HIPAA); Ethical Health Care and Practices; PH Preparedness & Response; Cultural and Linguistic Competence; PH Accreditation and the PH Domains; Performance Excellence and numerous job-related development opportunities.

Available training ranges from the basic programs, such as New Employee Orientation and Basic Supervisory Training Program, to supporting continuing education requirements, and promoting learning and development of staff in areas such as quality management and leadership development.

Currently a number of employees are leading the effort for SJCHD to be one of the first Local Health Departments to become accredited by the Public Health Accreditation Board (PHAB). These employees have received a series of online training sessions regarding the PHAB process. Two employees were selected to attend a more comprehensive three-day course presented by PHAB. As shown in **Figure P-1,** Domain 9 states "Use continuous quality improvement tools to evaluate and improve the quality of programs and interventions", and the detailed criteria for domain 9 is a required quality improvement plan. As using the Baldrige model, drives a performance improvement focus in the organization, so does our effort toward achieving and maintaining voluntary PH accreditation.

New employees receive a three-day orientation which starts on their hire date. This program includes an overview of DOH and SJCHD, the Florida PH Orientation, personnel information related to pay, employment, benefits, career development, Code of Ethics, Customer Service, Safety/Violence in the Workplace, Emergency Preparedness and Responsibilities, Information and Security, EEO/Sexual Harassment, HIV/AIDS, TB Control, Performance Excellence, and the Baldrige Model. Employee development in these areas along with discussion at All Staff meetings ensures deployment and understanding of the Organizational Core Competencies.

We ensure that knowledge is transferred from retiring and departing employees through the SJCHD IDP and leadership development plans. This assures the knowledge, skills, and core competencies of employees filling these positions and enable supervisors the opportunity to provide cross-training. This allows for the seamless transition of responsibilities from employee to employee resulting from employee loss or retirement. Institutional knowledge, that knowledge acquired through years of service are captured through our mentorship and succession efforts. Several of our SLs have retired over the past few years. These retirements took place in a planned manner where an eventual successor was trained and mentored over a period of time to acquire the knowledge and skills for a seamless transition. For example, our HR Director retired in February 2012. This was a long planned-for transition where a great deal of mentoring, training and knowledge sharing took place resulting in no appreciable loss of knowledge.

New knowledge and skills are reinforced on the job through the mentoring and coaching previously discussed. In addition, input from our employees, supervisors, and SLT is continuously sought for feedback/recommendations. A particularly effective means of reinforcing training is through our workforce enrichment sessions, where important subject matter (such as Emergency Preparedness, Information Security, Infection Control, Cultural Competency) is regularly reinforced with new and different training and testing. A great deal of training and development activity take place on a just-in-time basis. For example, those heavily involved in the PH Accreditation process received training in that process as the Accreditation Process began.

In 2010 our Senior PH Nursing Consultant began a formal PH Nurse mentoring program. This program is designed for professional nursing staff and includes monthly sessions on a variety of topics relevant to being a high performing PH Nurse.

5.2c(2) Learning & Development Effectiveness:

All formal training (including short sessions done during enrichment days) includes a student evaluation of the training (Level 1) and most of our classes require either a post test or demonstration of skills acquired (Level II). In the employee survey, the workforce also responds to several questions

regarding the availability and effectiveness of learning and development. This data is used by the Office of Public Health Practice to develop an improved training curriculum.

5.2c(3) Career Progression:

We provide a number of means for staff to participate in career progression opportunities. The IDP, used as a part of the Performance Evaluation System, motivates employees to identify, develop, and utilize their full potential. Employees meet annually with their supervisors to review job descriptions and performance standards and to discuss and develop their own IDPs. IDPs focus on enhancing skills and job performance expertise. Employees and their Supervisors jointly determine competencies required for their current and future career objectives. The plans also include goals and target dates. Additionally, employees are motivated by numerous training opportunities. For example, budget permitting, we often recognize employees by enabling high performing employees to attend the annual State Baldrige (Sterling) Conference.

We achieve succession planning for future leaders through several methods. Future leaders are identified and mentored by SLs as described previously. Each SLT member is asked to mentor and develop at least two people. Those being mentored are identified through high performance via evaluation, Service Center performance, and behavior in alignment with mission/ vision/ values. This is done by conducting regularly scheduled interactive sessions, case scenarios, and providing developmental assignments. They are also asked to assume responsibility for their Supervisor as appropriate. We accomplish Leadership Development planning through several means. This includes IDPs, 360 degree Leadership training, and peer coaching for leaders. SLT members are strongly encouraged to advance their formal education. These leaders are encouraged to use the skills acquired to further support the achievement of our mission. Potential candidates for leadership development are identified and referred by SLT to be enrolled in supervisory and leadership development training prior to their promotion to leadership assignments. Our Assistant Director and Nursing Director were part of the Leadership Development program and successfully competed for their positions with other candidates as a result.

When budget is available, those being mentored may be provided the opportunity to attend the Florida Public Health Leadership Institute (FPHLI) to develop leadership skills. Employees attend statewide job-related meetings in order to network with counterparts and learn best practices. In light of current budget constraints many of these meetings are now being accomplished via Web-Ex or Teleconference.

CATEGORY 6 OPERATIONS FOCUS

6.1 Work Systems

6.1a Work Systems Design

6.1a(1) Design Concepts:

Most of the SJCHD single work system is determined by the Florida Legislature with further instructions provided by the state DOH. The Legislature produces laws, statutes and administrative code, policies, and guidelines that are followed statewide. We also have federally funded programs that are similarly designed. Since much of our work system is determined by others and comes with expected performance and evaluation systems, the opportunity to innovate is somewhat limited. However, our SLs design and innovate Work System changes not mandated by the State using the "View of the Work System" tool, **Figure 6.1-1** along with a PDCA-based design process (**Figure 6.1-2**). Our SLT, with input from all departments, uses the strategic planning process to determine if the overall work system is in alignment with statutory requirements, the Essential Services of PH (see **Figure P-1),** and our organizational culture. Core competencies are determined during our SPP. The Core Competencies aligned with the Essential Services of PH enable us to carry out our Work System.

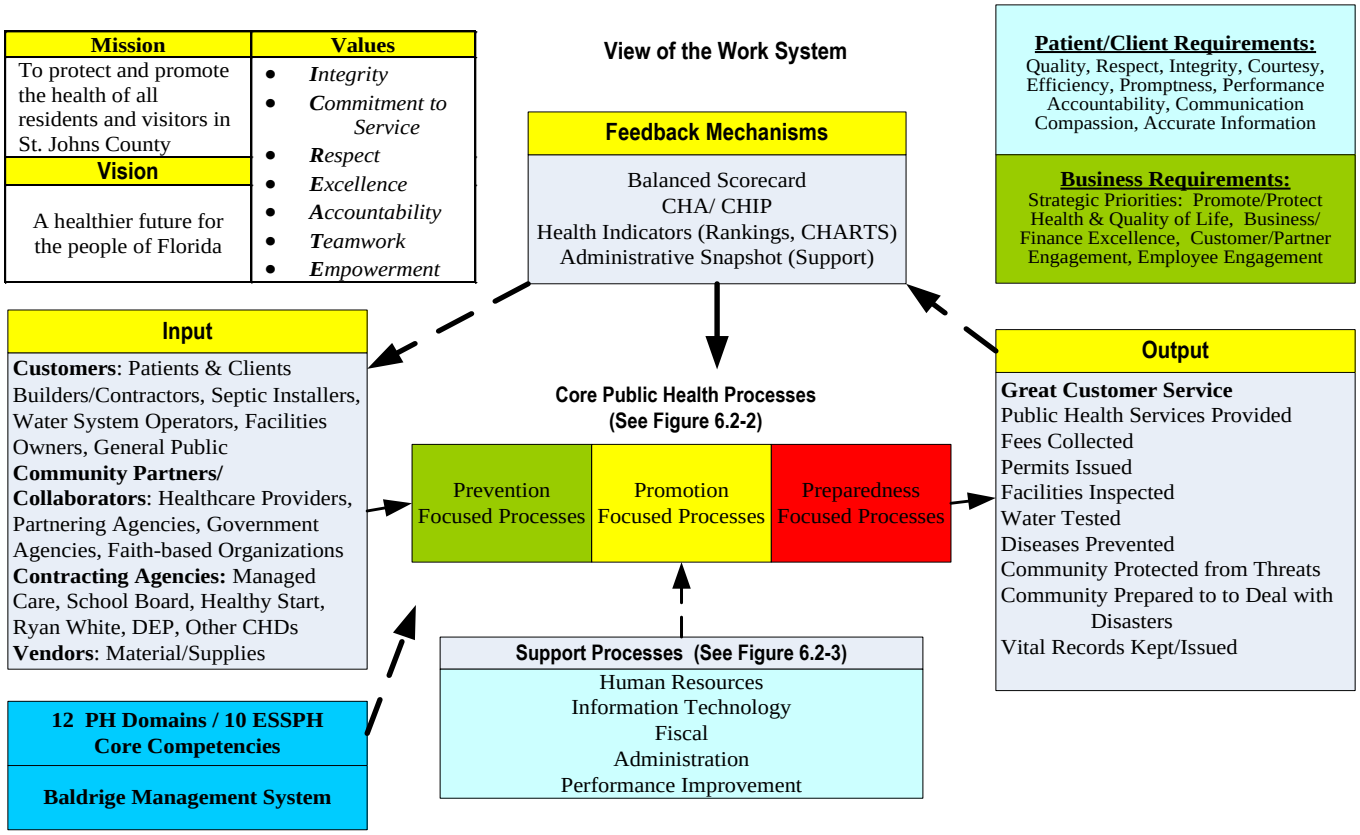
Any needed changes in the Work System or associated key processes that require extensive work (See **Figure 6.1-2)** are included as action plans aligned with one of our four Strategic Priorities. The "View of the Work Systems" tool is built by first populating the tool with our current organization, and ensuring full alignment with core competencies, and the 12 PH Domains by examining the following issues: Are processes that rely on core competencies in-sourced; have processes that rely on the core competencies of others been considered for outsourcing; do we have measures in place to determine effectiveness of processes and the entire work system; do we have the competencies needed to drive innovations? Are we faster, cheaper, better and how do we know?

As stated above, our work system is largely designed by others and our opportunities to make significant changes are minimal. One recent opportunity that involved significant work system changes was the implementation of our Public Health Mobile Center (PHMC), which facilitates the delivery of Dental Services and Community-level Health Promotion to various community locations. The design process listed in **Figure 6.1-2** was used to examine our key processes, associated support processes, patient/client requirements, measurement systems, and the logistics of operating the PHMC. This resulted in changes to our work system to include PHMC measures, added/changed processes in order to provide services remotely.

6.1a(2) Work System Requirements:

Most key work system requirements are pre-determined for us through the various mandates that come from local, state and federal agencies that provide us with the funding for these programs. For example, there are numerous federal requirements for the Women, Infants and Children (WIC) program, and partner requirements determined by the Healthy Start Coalition for our Healthy Start Program. New or additional work system requirements are determined via the listening and learning methods shown in **Figure 3.1-1**. For example, patient/client and market requirements for our services are determined by feedback received as a result of internal assessments and controls, external audits, patient/client surveys, the CHA/CHIP process and numerous health related statistics. Our key partners provide input either through the direct establishment of process requirements or through their participation in various community projects such as the development of the CHA/CHIP. Our key work system requirements include the Customer Requirements and Business Requirements which are listed in **Figure 6.1-1.**

Figure 6.1-1 The Work System - St. Johns County Health Department



6.1b Work Systems Management

6.1b(1) Work Systems Implementation:

Work is accomplished through a range of work system elements as described in **Figure 6.1-1**. This includes: workforce, suppliers, contractors, federal, state, local, and community partners and collaborators, and patients/clients. It also includes data from multiple sources such as employee and patient/client satisfaction surveys, our Health Management System (HMS) and Financial and Information Reporting System (FIRS) data, contracts, MOUs and MOAs, Administrative Snapshot report, external audits, and public comments. These are all used to manage our systems. The work system is in place and does not change much from year to year. When it is determined in the strategic planning process that a major workforce element must be adjusted, employee teams and workgroups may be deployed to evaluate and implement changes. The design process described in **Figure 6.1-2** is used to implement work system changes and track work system performance and improvement.

Our work system is managed and improved as a part of the SPP and Plan review processes discussed throughout category 2. Nearly every step of the SPP (**Figure 2.1-1**) could result in a work system change. For example in recent years, State Directives (Step 1) have resulted in changes to multiple services and processes particularly in the EH Service Center. Changing patient/client/stakeholder requirements (Step 5) may result in a refocusing of our Strategic Objectives. This may result in new/updated action plans which may cause work system and subsequent process improvement efforts through the "Golden Thread" process. For example, multiple processes have been impacted and improved as a result of the community concern for reduced infant mortality rates.

By tying work system improvements to the SPP and Balanced Scorecard (**Figure 2.1-3**), we stay focused on those factors critical to our patients/clients, critical to our stakeholders, and critical to our financial and overall sustainability.

Figure 6.1-2 Design of New Programs/Services

Step	Process
1	Proposal for new/ enhanced service
2	Validate need
3	Leadership team review
4	Create design action team
5	Design service implementation plan
6	Determine Changes to Work System/Work Processes
7	Initiate pilot
8	Evaluate pilot
9	Approval by Senior Leadership
10	Implement new/ enhanced service

6.1b(2) Cost Control

Cost control is ensured though our Financial Management process. Service Center initiatives are funded through federal, state and local allocation, in addition to Medicaid payments and fees charged to patients/clients. Funds received are

deposited in the County Health Department Trust Fund. Surplus and deficit funds, including fees or accrued interest, remain in the Trust Fund. The Trust Fund account is reviewed continually during the year and at year end in order to ensure that revenues and expenditures are tracked in our approved spending plan.

Figure 6.2-1 PDCA Process Management Model

Steps	
PLAN	1. Prioritize Processes
	2. Determine Ownership
DO	3. Determine Requirements
	4. Flowchart (Map)
	5. Determine Indicators
CHECK	6. Monitor Performance
ACT	7. Identify Opportunities
	8. Take Action – Adapt/ Adopt/ Abandon

During our budget planning process, we use an automated system that monitors revenues and expenditures on a monthly basis by program. This enables the Fiscal Service Unit to identify errors and deviations from the expected estimates and to request corrective actions.

Through the use of the Process Management Model, (see **Figure 6.2-1**), we continuously monitor our cost of operations and identify improvement opportunities. We have several key financial indicators that are monitored in order to identify savings opportunities. These include the Revenue Report, Variance Report, Analysis of Funds Equity, and Error Reports. These reports allow us to identify cost savings opportunities and to analyze expenses and revenue trends for our work system. Through a regular review of process performance indicators, we take preventive measures to avoid serious financial downfalls. One recent improvement initiative resulted in a reduction in commodities purchased through the implementation of a centralized inventory control system. This has resulted in more than $100,000 in expense reductions.

We have also improved our partnering process between SJCHD and the County Animal Control for provision of rabies treatment by eliminating re-work and duplication, resulting in reduced expenditures for both agencies. This partnering agreement has reduced the time required by our staff for rabies investigation and treatment from about 1.5 hours per cases (seven or eight cases daily) to less than 15 minutes per case.

We reduce and prevent rework and medical errors in the treatment of our patients to ensure that no harm is done to patients. This is done through root cause analysis which facilitates the identification of basic or causal factors in performance, possible occurrence of a sentinel event and methods to prevent medical errors. Through root cause analysis, we focus primarily on systems and processes rather than on individual performance. This enables us to differentiate special from common causes which helps pinpoint the appropriate preventive action. Recently an error in medication administration was identified and preventive action initiated through root cause analysis.

6.1c Emergency Readiness

To ensure all public health needs are met during and after local emergencies or disasters, SJCHD's SO #1.1 is "Assure Community PH Preparedness and Response" with five overarching goals: prepare for response missions, prevent/preempt acts of terrorism, protect population and infrastructure, respond in an effective and coordinated manner, and recover quickly. Related action plans address training staff in the National Incident Management System's (NIMS) core competencies (preparedness, risk/crisis communications, resource management, and the Incident Command System), exercising and evaluating PH emergency response plans for "all-hazards"; and improving local response capabilities. SJCHD has embraced the Incident Command System (ICS) for emergency response as well as special event management and daily public health operations. Daily planning and tactical meetings are held to evaluate and project operational needs and efficiently allocate available resources. All-Hazards planning combined with routine use of ICS guarantees our staff is trained in ICS concepts and PH's role in a wide variety of scenarios, and that they can integrate easily with those from partnering response agencies during any natural or man-made disaster. After-action reviews are conducted following exercises, incident response, and health promotion events; each providing an analysis of strengths and weaknesses and a forum for modifying plans and developing performance improvement strategies to be implemented. Partnerships with other local response agencies (fire rescue, law enforcement, hospital, emergency management, and non-governmental organizations) have been cultivated to further ensure a collaborative approach to planning, training, exercising, and responding. To assist with information sharing among a variety of preparedness planners, and ensure plans integration and exercise participation across disciplines, SJCHD participates in a Regional Domestic Security Task Force, SJC Mitigation Strategies Workgroup, Northeast Florida Regional Training & Exercise Planning Workgroup, and FL All-Hazards Incident Management Teams Steering Committee.

PH emergencies often create surge requiring escalated surveillance, medical countermeasures, and non-pharmaceutical intervention activities. Even seasonal events can present surge and capacity issues. To mitigate these situations SJCHD coordinates a Medical Reserve Corps (MRC) unit, a cadre of trained medical and non-medical personnel who complement existing personnel during large-scale outbreak investigations, mass prophylaxis or vaccination events, and Special Needs population sheltering operations. The MRC are required to meet the same ethics and competency standards as SJCHD employees and are provided training and exercise opportunities. They bring special skills to both response and post-disaster operations; many are trained to perform radiological monitoring, assist with on-incident responder rehabilitation, and conduct crisis counseling for both victims and responders, allowing regular staff to continue providing core PH services without interruption. To increase capacity during disasters and improve community resilience, the SJCHD Neighborhood Emergency Preparedness Program (NEPP) sponsors two communities with large vulnerable populations. NEPP Community members are trained to be self-sufficient during disaster, and participate in PH response activities such as community impact assessments and mass dispensing.

Since 2010, the SJCHD emergency preparedness program has been certified as "Ready" by the National Association of

County and City Health Officials, Project Public Health Ready (PPHR). PPHR is a rigorous program that promotes a continuous quality improvement model, and provides a comprehensive assessment of three preparedness goals: all-hazards planning, workforce capacity development, and ongoing demonstration of readiness through exercises and incident response. PPHR criteria are determined using best-practice standards developed by CDC and updated annually.

6.2 Work Processes

6.2a Work Process Design

6.2a(1) Design Concepts:

New, enhanced or realignment of services may be required by legislation or generated from within SJCHD, and implemented via action plans. The processes used to design new or enhanced programs, services and their related processes are based on either the PDCA-based Process Management model of continuous improvement (**Figure 6.2-1**), or the Design of New Programs/Services model shown in **Figure 6.1-2.**

Upon input from patients/clients and/or legislative mandate, the SLT reviews the need to determine appropriateness of the new service and whether it is aligned to Strategic Priorities and permitted by State Statute. If appropriate, the new requirement or service is assigned to a team. Community partners, literature, evidence-based studies, best practice review, and benchmarking contribute to the development of program and service design. This helps to ensure that new technology, service excellence, local, state and national PH knowledge, and the need for agility are considered into any new or updated processes/services. The team is selected based on subject matter expertise of staff and stakeholders versed in the regulatory and administrative issues that ensure compliance. The team examines methods to improve and fund any new technologies as part of the design process.

Our program/work process design establishes process measures (including cycle time, productivity, and cost control), and outcome measures that meet targeted requirements from the CDC, state DOH and other agencies, or Strategic Objectives. Key outcome measures are reviewed at all levels. After the design is completed, new programs or initiatives are generally piloted with changes to the design made as necessary. Upon completion of the pilot project, the program/work design owner presents results to the SLT. The project lead is charged with the responsibility to modify and coordinate final completion of a new program/service.

We use the process described in **Figure 6.1-2** to develop new services and **Figure 6.2-1** for improvement activities to enhance patient/client satisfaction and service. For example, in response to an increase in infant mortality rates, we initiated and chair the St. Johns County Infant Mortality Task Force, and implemented an interconceptual program to improve the health of women of child bearing age. A workgroup was formed that included members from the Family Practice Service Center, Faith Based and Community partner agencies. This workgroup developed action plans, researched possible service alternatives, developed service features and performance measures, assessed human resource capabilities and requested needed resources. This resulted in the creation of the Westside Wildflower Project, which today provides free clinical services to a low income community. A similar project resulted in the design and deployment of our Public Health Mobile Center which provides several of the PH services listed in **Figure P-1** at numerous locations around the county.

Another example of this design process can be seen in the current project to refine the clinical flow process. This process is being refined with a purpose of reducing patient cycle time, and increasing provider productivity, in order to make the SJCHD clinic more cost effective and able to provide more patient services within our limited budget. This project is using the Process Management Model and while it is still under way, we have already developed a streamlined process map, new process indicators and an automated dashboard designed to closely monitor patient services as they are being provided. This enables process agility to quickly reprioritize resources, make certain that patient services are provided expeditiously and to identify and eliminate any roadblocks or non-productive time within the process.

The ICS (discussed in area 6.1c) is a flexible, standardized response management system that enables the deployment of response management expertise to all levels of the organization. We use ICS to structure emergency response and in planned events involving large numbers of participants. Major distribution of vaccines, Special Needs Sheltering, and Epidemiologic operations are examples of services structured under ICS. Leaders shift roles during each event to be familiarized with the duties and responsibilities of each member of the team. The ICS model is similar to **Figure 6.1-2**, but due to the urgency of projects, processes steps 1, 2, 7 and 8 are not required. ICS is used for design and implementation of any service that must be implemented quickly and to large numbers of patients/clients. ICS was the used to design and deploy our response to the H1N1 Influenza Pandemic in 2009.

6.2a(2) Work Process Requirements:

We use the Design of new Programs/Services model (**Figure 6.1-2)** and the Process Management Model (**Figure 6.2-1**) for the design of any process improvement initiatives. Work process requirements are determined generally in Step 5 of the Design of Programs/Services model and more specifically in Step 3 of the Process Management Model. For Core PH Processes, (**Figure 6.2-2**) process requirements are often mandated by either a government agency such as the state DOH or the funding agency such as the local Healthy Start Coalition.

Additionally, patient/client requirements are determined using the listening methods identified in **Figure 3.1-1.** Community partner requirements are also clearly identified in the CHA/CHIP and these are often applied at the program and process level. For key Support Processes (**Figure 6.2-3**) process requirements again are often mandated, but also are identified internally through internal customer surveys, complaints, help desk tickets and day to day employee interaction. Business requirements apply to both Core PH and Support Processes, and emanate from our SPs to the program and process level through the "Golden Thread" process described in Item 2.2. Key processes and their requirements are listed in **Figures 6.2-2 and 3**.

Figure 6.2-2 Key Public Health Processes

Key Services	Key Processes	Key Process Requirements	Key Performance Measures/Indicators	Cat. 7
1. PH Leadership System	-Community Partner Collaboration -PH Strategic Planning	-PH System Expertise -Organizational Sustainability	-Key Partner Satisfaction -% Strategic Objectives Achieved -% of Communications System in Place	7.2-7 7.1-43 7.1-18
2. Epidemiology Surveillance	-Identify, monitor and investigate communicable diseases and emerging infectious disease threats	-Surveillance, Investigation and Control of Communicable Diseases and Outbreaks.	-% CDs Reported w/in 14 Days -% Components of Response in Place	7.1-19 7.1-20
3. Immunizations	-Provide childhood immunizations	-Reduce vaccine preventable diseases	-% Fully Immunized at 12 Months -% Fully Immunized at 24 Months	7.1-21 7.1-22
4. PH Preparedness and Response	-Provide PH emergency preparedness, response, & mitigation	-Develop/Maintain/ Implement Emergency Preparedness & Response Plans	-% Timely Response to FDENS Alert -Maintain Project PH Ready Certification -Emergency Preparedness Score	7.1-41 Narrative 7.1-42
5. Environmental Public Health	-Investigate Sanitary Nuisance Complaints -Inspect regulated water systems	-Reduce Environmental PH Threats	-% Nuisances Investigated Timely -% Timely Facilities Inspections -% Timely Water System Inspections	7.1-23 7.1-24 7.1-25
6. Community-level Health Promotion	-Promote healthy lifestyles	-Reduce Tobacco Use -Decrease Obesity	-% Adults Reporting Tobacco Use -% Adults with BMI > 30	7.1-9 7.1-10
7. Pediatric Services	-Provide health screening to prevent illness -Provide Acute & Episodic Care -Dental Care	-Access to Pediatric Healthcare & Dental Care for Medicaid Eligible (Safety Net)	-Time to Urgent Care Appointment -Clinic Average Visit Time -Provider Productivity	7.1-26 7.1-27 7.1-28
8. Communicable Disease Management & Treatment	-Prevention, diagnosis, and treatment (STD, TB) - HIV/AIDS Medical Management	-Positive Results Treated -Reduce Non-compliance	-% Positives Treatment Completion -% HIV Cases with Risk Reported -% TB Medication Compliance	7.1-29 7.1-30 7.1-31
9. Family Planning Services	Provide Family planning educational & clinical services	-Reduce Teen Pregnancies	-Birth Rate in 15-19 Year Olds -Repeat Birth Rate in 15-19 Year Olds	7.1-12 7.1-32
10. Healthy Start	-Provide services for women and infants at high risk for poor pregnancy outcomes	-Improve health outcomes of high risk mothers and infants	-% of High Risk Clients Assessed Relative to Target -Average # Services Provided to Healthy Start Participants	7.1-33 7.1-34
11. ABC Pregnancy Referral & Linkages	-Provide linkages to prenatal services	-Early entry into Prenatal Care	-% Entry into Prenatal Care First Trimester -Repeat Birth Rate in 15-19 Year Olds	7.1-35 7.1-32
12. Women, Infant, and Children Services	-Promote nutrition for infants, children, prenatal women (nutrition services & education)	-Improve Prenatal/Infant/ Child Nutritional Status	-% First Trimester Entry into WIC -% Low Birth-weight for WIC Mothers -% WIC Infants Breastfed for 6 Months	7.1-36 7.1-37 7.1-38
13. Vital Statistics	-Provision of Birth and Death Certificates	-Fast and Accurate Data	-% Client Satisfaction	7.2-2

Figure 6.2-3 Key Support Processes

Support Services	Key Processes	Key Process Requirements	Performance Measures/Indicators	Cat. 7
14. Admin-istration	-Performance Improvement -PH Accreditation -Compliance	-Organizational Excellence and Improvement -National Voluntary PH Accreditation	-Baldrige-based Assessment Score -% Patient/client Satisfied - % Patient/client Loyalty -Accreditation Achieved	7.1-39 7.2-1 7.2-4 Narrative
15. Human Resources	-Recruiting and Retention -Payroll & Benefits -Workforce Development -Workforce Engagement	-Recruit and Retain Competent PH Workforce -Ensure Current Evaluations, IDPs -Mandatory Training - Rewards & Recognition	-% Turnover for Staff w > 1 Yr Service -% Timely Evaluations, PDs & IDPs -% Completed Mandatory Training -Employee Satisfaction Survey Scores -% Nominated for Recognition	7.3-12 7.3-2 Narrative 7.3-5-10 7.3-11
16. Information Technology	-System Maintenance/ Upgrades -Technical Assistance -Data Security	-Current/Accurate Data -Reliability/Security -Timely Request Response	-Average Time to Close Helpdesk Ticket -# of State Reportable Information Security Incident Reports (Cat 2)	7.1-40 7.4-1
17. Fiscal	-Budget Management -Accounts Receivable -Accounts Payable -Contract Management	-Timely/Accurate Reporting -Maintain Cash Reserve -Timely Collections -Manage Expenditures -Contract Monitoring	-Trust Fund Balance (Cash Reserve) -% Self-generated Funds -% Prompt Payments -Accounts Receivables > 120 days -% EARS Timely Entry -% Contracts Monitored Timely	7.5-1 7.5-3 7.4-2 7.5-5 7.4-4 Narrative

6.2b Work Process Management

6.2b(1) Work Process Implementation:

SJCHD key processes are included in our work system diagram (**Figure 6.1-1**). Key PH processes are focused on Prevention, Promotion and Preparedness, the so-called three P's of PH.

Processes are implemented through the usage of the Process Management Model (**Figure 6.2-1**) steps 6, 7, and 8. Process outcomes and in-process indicators are reviewed on a daily, weekly, and/or monthly basis, as appropriate. For example, wait times and patient/client satisfaction levels are continually monitored on a real-time basis and process changes may be made on the spot if service levels or patient/client load warrants. We monitor and plan for daily operations through our "Ops" meeting, where at the beginning of each day patient/client and workforce loads are balanced based on anticipated workload. Process measures are monitored as information becomes available, usually on a monthly basis. Performance is reviewed through our Leadership Review process (**Figure 1.1-3**). When performance is not meeting required levels, improvement opportunities are indentified and action taken, using a PDCA approach that includes a root-cause analysis.

6.2b(2) Patient Expectations and Preferences:

A key difference between PH service and clinical health care services is a focus on population health care versus individual health care. In that respect each patient is interviewed to determine a complete understanding of their individual needs, desires and expectations and receives information about available services that appear to match their needs. It is the job of each health care provider to explain needed treatments and the possible consequences of not receiving that treatment. For example, every patient is asked whether or not they smoke tobacco. Those who do are given information about tobacco cessation programs, along with the likely consequences of continued smoking. Similar counseling for the patient/client and/or parent takes place for any clinical services provided.

The culture of PH is one of teamwork among providers to ensure that the needs of each patient/client are understood and met. Thus, we provide information about SJCHD along with services provided by other community agencies. Upon arrival/registration, patients/clients are asked what are their needs, and what information do they want? Medical providers offer more information as patients/clients are assessed and examined. The job of our Call Center Triage Registered Nurse is to ensure that every patient/client receives appropriate care from providers at SJCHD or are referred to services elsewhere.

6.2b(3) Supply-Chain Management:

We have two different types of suppliers: state managed and locally managed. Most of our suppliers are state managed and we have little input into their selection or pricing. For these suppliers the supply chain is managed by the state DMS. Those few suppliers that are managed locally are primarily service providers. The quality and quantity of these services are managed locally by the program managers utilizing a specific MOA or MOU. The supply chain consists of delivering products/services, shipping, and managing inventory. Any potential supplier (State or local) must first be registered in the state operated Myflorida marketplace system (MFMP). MFMP is an on-line exchange for buyers and vendors making information available wherever employees, vendors, partners and suppliers are located. MFMP enables SJCHD to provide easy access to supply chain information. For contracted vendors, there is selection process. The major criterion is whether a vendor is responsive and responsible. Requirements are established to ensure that we get the best/lowest price consistent with our strategic priority to maximize revenue.

We implemented a new Centralized inventory process in 2009 in order to reduce excessive purchases of commodity products. This system has resulted in more than $100,000 in reduced expenditures since that time. This process received recognition from NACCHO as a national best practice.

6.2b(4) Process Improvement

The improvement of key services and processes uses the PDCA (**Figure 6.2-1**) method. Processes are mapped and measured, and improvement areas identified. Suggestions for improvement are elicited and evaluated for feasibility. Using root cause analysis, the most feasible option(s) are selected and a plan for implementation as a pilot is created. If the pilot is successful, based on data obtained during implementation, the process is standardized. Some of the processes that have been refined in this way include Pediatric and Family Practice clinics, WIC and Human Resource Management. We have piloted our new patient/client flow process resulting in a more efficient, streamlined clinic management process resulting in cost effectiveness and enhanced patient/client service. Other PDCA improvements include response to FDENs alerts, provider productivity, reduction in time to available appointment in the Dental clinic, and increasing community participation in the HLC. Service Centers and improvement teams have been taught the PDCA problem-solving process and have attended Process Management training.

We deploy employee teams/workgroups for areas of improvement generated from patient/client feedback or internal quality data. Improvement opportunities are identified by Service Center staff and presented to the SLT by supervisors for support and approval. Improvements and lessons learned are then widely shared through the SPEC, functional/ cross functional teams, SLT and at all staff meetings.

Process improvement initiatives reduce variability through frequent process monitoring, and through daily control measures such as touch screen surveys, our internal dashboard system and the daily OPs meeting. These methods allow for quick identification any special causal situations that may cause unusual process variation. As previously stated, we are now beginning to use more sophisticated statistical techniques such as Six Sigma, that includes a focus on Statistical Process Control. Our improvement endeavors seek to improve service performance that result in reduced patient/client wait times, increased productivity rates, and sustained client satisfaction.

CATEGORY 7 RESULTS

7.1 Health Care and Process Outcomes

7.1a Patient-Focused Health Care Results

Each county in the US is ranked by University of Wisconsin's Population Health Institute and the Robert Wood Johnson Foundation *County Health Rankings* Report (CHRR) which has been done annually since 2010. This report analyzes how counties rank within their state in terms of Health Outcomes and Health Factors, both strong indicators of a community's overall health status. **Figure 7.1-1** shows the SJC Health Outcomes ranking within Florida on this report. Based on the HHS *Community Health Status Indicators* report, SJC has 26 national peer counties of which four (including SJC) are in Florida. In 2012 St. Johns County ranked **first** in Florida in terms of both Health Outcomes and Health Factors. Data used is from the latest available years which may be anywhere from 2008 to 2010. Only two of the twenty-six national peer counties finished in their state's top 10%. Note that National Benchmarks were not available until the 2011 CHRR report. **Health Outcomes Ranking is SJCHD Strategic Objective (SO) #1.2.**

Figure 7.1-1 County Health Rankings - Health Outcomes

SJC 2010	SJC 2011	SJC 2012	2012 Best Ranking FL Peers	# of SJC's 26 National Peers in Their State's Top 10%
Health Outcomes Out of 67 Florida Counties				
2nd	3rd	1st	4th	2

Figure 7.1-2 shows the rankings for the factors comprising Health Outcomes: Mortality and Morbidity.

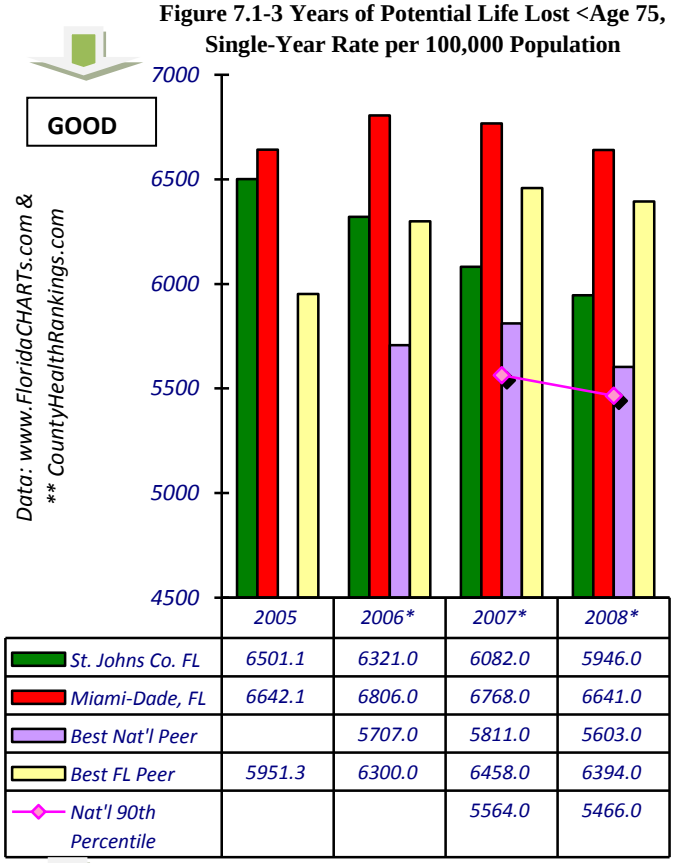
Figure 7.1-2 Health Rankings Mortality and Morbidity

Factors Contributing to Health Outcomes				
SJC 2010	SJC 2011	SJC 2012	2012 Best Ranking FL Peers	# of SJC's 26 National Peers in Their State's Top 10%
Mortality - Out of 67 Florida Counties				
3rd	2nd	2nd	4th	2
Morbidity - Out of 67 Florida Counties				National
4th	3rd	3rd	5th	3

Figure 7.1-3 shows the result for Years of Potential Life Lost (YPLL) before age 75 per 100,000 population. It measures premature death by counting the number of years a person has died prior to age 75. YPLL data is based on birth and death certificate data reported to the National Vital Statistics System (NVSS, part of the CDC). This is a key measure of the overall Public Health of a community and is the factor used to determine the Mortality Ranking in the CH Rankings Report. **YPLL is SJCHD SO #1.5.**

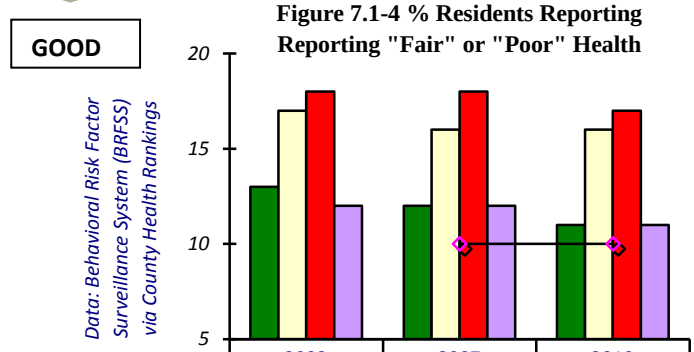
Figures 7.1-4, 5 and 6 show key outcomes that contribute to the Morbidity Factor in the CHRR. **Figure 7.1-4** is the result of a national self-assessment survey showing the percent of people reporting that they are in poor or fair health. This information comes from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey done in 2002, 2007 and 2010. **Figure 7.1-5** shows "*How many days during the past 30 days was your physical health not good?*" as reported in the BRFSS. **Figure 7.1-6** shows the Percent of live births with low birth weight (< 2500 grams). This data is also the NVSS.

Figure 7.1-3 Years of Potential Life Lost <Age 75, Single-Year Rate per 100,000 Population



	2005	2006*	2007*	2008*
St. Johns Co. FL	6501.1	6321.0	6082.0	5946.0
Miami-Dade, FL	6642.1	6806.0	6768.0	6641.0
Best Nat'l Peer		5707.0	5811.0	5603.0
Best FL Peer	5951.3	6300.0	6458.0	6394.0
Nat'l 90th Percentile			5564.0	5466.0

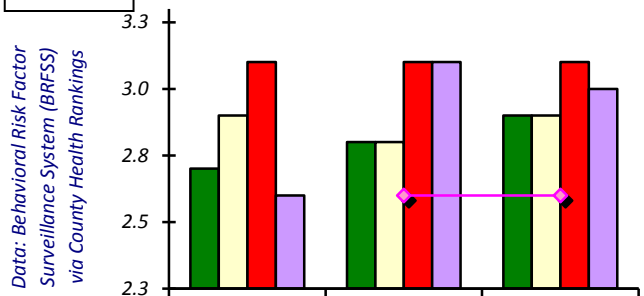
Figure 7.1-4 % Residents Reporting Reporting "Fair" or "Poor" Health



	2002	2007	2010
St. Johns Co., FL	13	12	11
Best FL Peer	17	16	16
Miami-Dade, FL	18	18	17
Best Nat'l Peer	12	12	11
Nat'l 90th Percentile		10	10

Figure 7.1-5 Average Reported Number of "Poor" Physical Health Days in Past 30-days

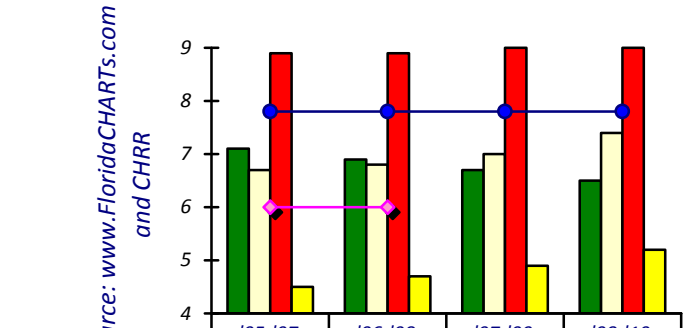
GOOD



	2002	2007	2010
St. Johns, FL	2.7	2.8	2.9
Best FL Peer	2.9	2.8	2.9
Miami-Dade	3.1	3.1	3.1
Best Nat'l Peer	2.6	3.1	3.0
Nat'l 90th Percentile		2.6	2.6

GOOD

Figure 7.1-6 Percent of Low Birthweight Infants (<2500 grams)



	'05-'07	'06-'08	'07-'09	'08-'10
St. Johns, FL	7.1	6.9	6.7	6.5
Best FL Peer	6.7	6.8	7	7.4
Miami-Dade	8.9	8.9	9	9
Best Nat'l Peer	4.5	4.7	4.9	5.2
Nat'l 90th Percentile	6.0	6.0		

Figure 7.1-7 shows the SJC Health Factors ranking within Florida on the *County Health Rankings Report*. In 2012 St. Johns County ranked **first** in Florida in Health Factors. Data used is from the latest available years (2008-10). Only three of the 26 national peer counties finished in their state's top 10%. **Health Factors Ranking is SJCHD Strategic Objective (SO) #1.3.**

Figure 7.1-8 shows the rankings for the Health Factors that best align with the services provided by SJCHD that encourage Healthy Behaviors.

Figure 7.1-7 County Health Rankings - Health Factors

SJC 2010	SJC 2011	SJC 2012	2012 Best Ranking FL Peers	# of SJC's 26 National Peers in Their State's Top 10%
Health Outcomes Out of 67 Florida Counties				
1st	1st	1st	10th	3

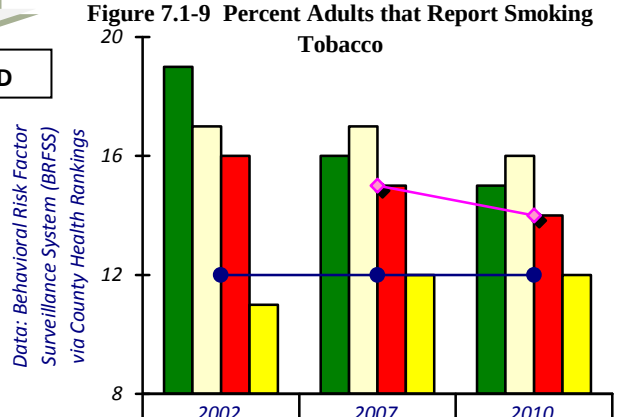
Figure 7.1-8 Health Rankings - Healthy Behaviors

SJC 2010	SJC 2011	SJC 2012	2012 Best Ranking FL Peers	# of SJC's 26 National Peers in Their State's Top 10%
Mortality - Out of 67 Florida Counties				
8th	5th	2nd	3rd	5

Figures 7.1-9, 10, 11 and 12 show key outcomes that contribute to the Healthy Behaviors Factor in the CHRR. **Figure 7.1-9** shows the % of adults smoking from the BRFSS report. **Figure 7.1-10** shows the adult obesity rate (% of adults reporting BMI > 30) also for the BRFSS. **Figure 7.1-11** shows the Chlamydia rate per 100,000 population from the CDC's National Center for Hepatitis, HIV, STD, and TB Prevention. Note that while this rate is increasing in SJC, this reflects a national trend and also reflects our increased surveillance efforts which will temporarily result in increased case rates. The HP2020 target rate is 67. **Figure 7.1-12** shows the teen birthrate per 1,000 females age 15 - 19, from the NVSS. The HP 2020 Target for teen birthrate is 36.2 per 1,000 live births.

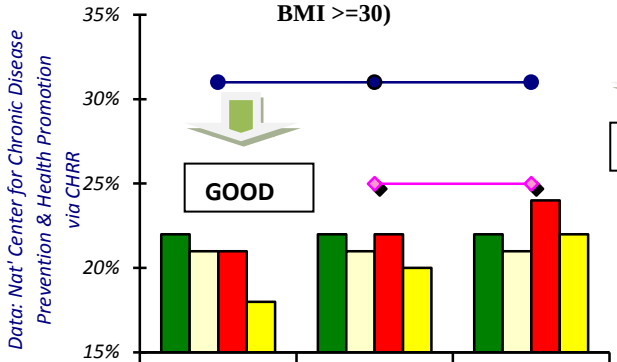
Figure 7.1-9 Percent Adults that Report Smoking Tobacco

GOOD



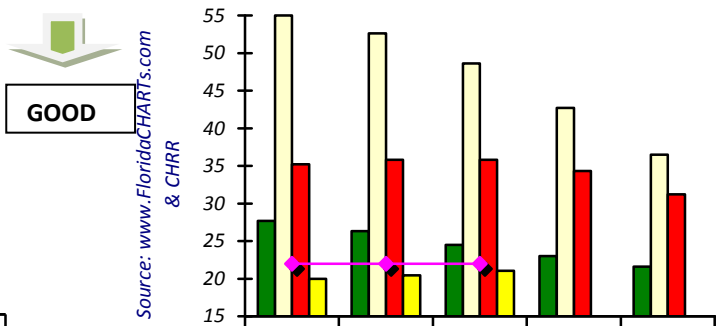
	2002	2007	2010
St. Johns, FL	19	16	15
Best FL Peer	17	17	16
Miami-Dade	16	15	14
Best Nat'l Peer	11	12	12
Nat'l 90th Percentile		15	14
HP 2020	12	12	12

Figure 7.1-10 Adult Obesity (Percent % Reporting BMI >=30)



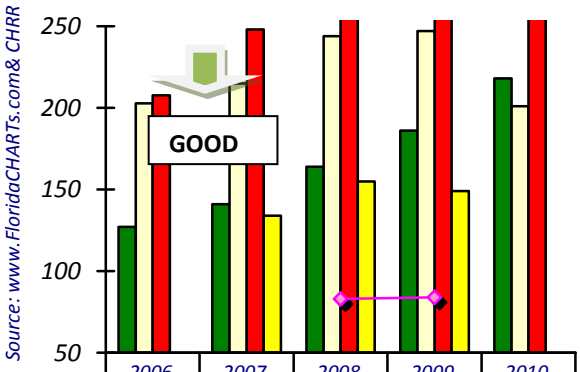
	2002	2007	2010
St. Johns, FL	22%	22%	22%
Best FL Peer	21%	21%	21%
Miami-Dade	21%	22%	24%
Best Nat'l Peer	18%	20%	22%
Nat'l 90th Percentile		25%	25%
HP 2020	31%	31%	31%

Figure 7.1-12 Teen Birth Rate per 1,000 Live Births Ages 15-19, Rolling 3-Year Rates



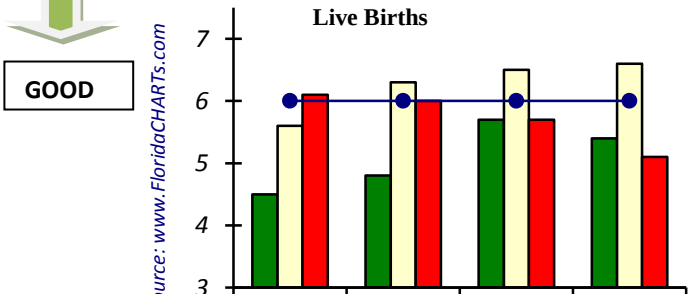
	'04-'06	'05-'07	'06-'08	'07-'09	'08-'10
St. Johns, FL	27.7	26.3	24.5	23.0	21.6
Best FL Peer	55.0	52.6	48.6	42.7	36.5
Miami-Dade	35.2	35.8	35.8	34.3	31.2
Best Nat'l Peer	20.0	20.4	21.0		
Nat'l 90th Percentile	22.0	22.0	22.0		

Figure 7.1-11 Chlamydia Single-Year Rates per 100,000 in Population



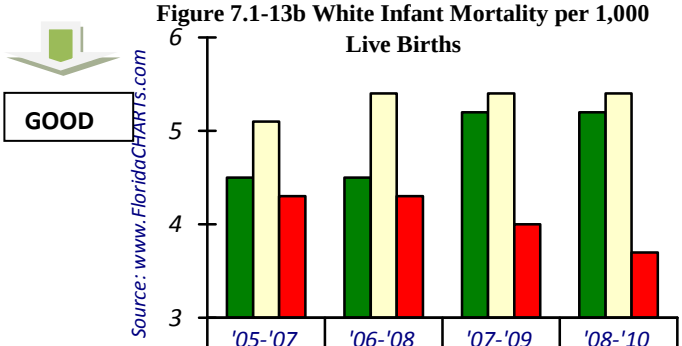
	2006	2007	2008	2009	2010
St. Johns, FL	127.1	141	164	186	218
Best FL Peer	202.8	215	244	247	201
Miami-Dade	207.6	248	315	347	349
Best Nat'l Peer		134	155	149	
Nat'l 90th Percentile			83	84	

Figure 7.1-13a Overall Infant Mortality per 1,000 Live Births



	'05-'07	'06-'08	'07-'09	'08-'10
St. Johns	4.5	4.8	5.7	5.4
Best FL Peer	5.6	6.3	6.5	6.6
Miami-Dade	6.1	6	5.7	5.1
HP 2020	6	6	6	6

Figure 7.1-13b White Infant Mortality per 1,000 Live Births

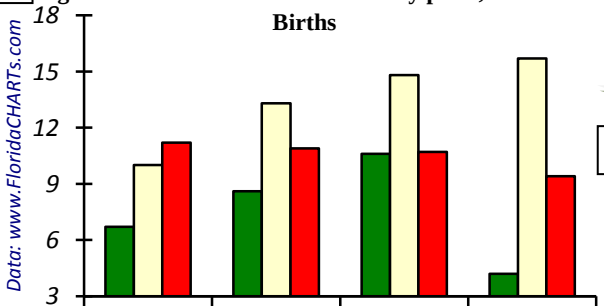


	'05-'07	'06-'08	'07-'09	'08-'10
St. Johns	4.5	4.5	5.2	5.2
Collier	5.1	5.4	5.4	5.4
Miami-Dade	4.3	4.3	4	3.7

The remaining figures in area 7.1a are not factors included in the CHRR, yet they are key indicators of the health and well being of a community. **Figure 7.1-13a, b and c** shows Infant Mortality Rates per for SJC and is broken into Overall, White and Non-white rates. The Infant Mortality Task Force has been focused on reducing these rates. Data is collected through a state database known as Florida CHARTS. Data for 2011 is not yet available for these figures. Infant Mortality is a key driver of *Health Outcomes* and is our **SO #1.4.** The US Infant Mortality rate for 2010 is 6.7. The national *HP 2020* target is 6.0. There are no national benchmarks for Infant Mortality rates segmented by ethnicity.

GOOD

Figure 7.1-13c Black Infant Mortality per 1,000 Live Births

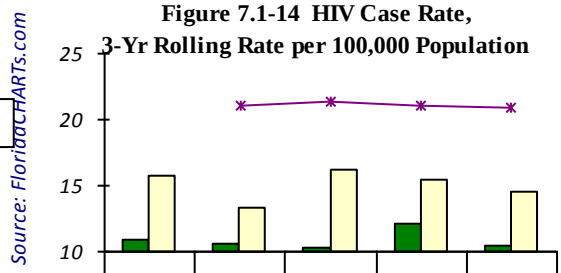


	'05-'07	'06-'08	'07-'09	'08-'10
St. Johns	6.7	8.6	10.6	4.2
Best FL Peer	10	13.3	14.8	15.7
Miami-Dade	11.2	10.9	10.7	9.4

Figures 7.1-14 through 17 provide health morbidity results for critical PH concerns in a community and SJCHD is actively engaged in protection and surveillance activities for these conditions. **Figure 7.1-14** shows HIV rates per 100,000 populations and **7.1-15** shows AIDS rates. With successful surveillance and treatment of HIV patients, they will not convert to full AIDS.

GOOD

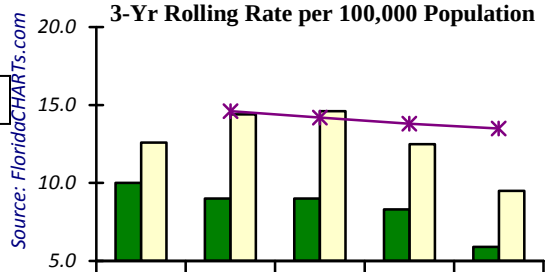
Figure 7.1-14 HIV Case Rate, 3-Yr Rolling Rate per 100,000 Population



	2004-06	2005-07	2006-08	2007-09	2008-10
St. Johns	10.9	10.6	10.3	12.1	10.4
Best FL Peer	15.7	13.4	16.2	15.4	14.5
National Case Rate		21.1	21.3	21.1	20.9

GOOD

Figure 7.1-15 AIDS Case Rate, 3-Yr Rolling Rate per 100,000 Population

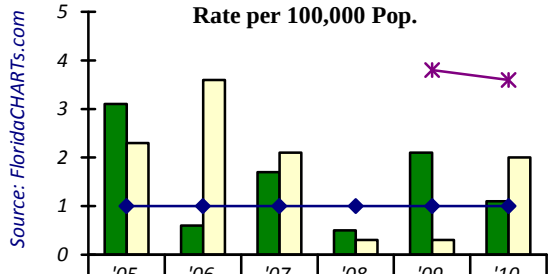


	2004-06	2005-07	2006-08	2007-09	2008-10
St. Johns	10.0	9.0	9.0	8.3	5.9
Best FL Peer	12.6	14.4	14.6	12.5	9.5
National Case Rate		14.6	14.2	13.8	13.5

Figure 7.1-16 shows Tuberculosis case rates. Successful treatment of infectious TB patients will continue to keep these rates low.

GOOD

Figure 7.1-16 Active Tuberculosis Case Rate per 100,000 Pop.



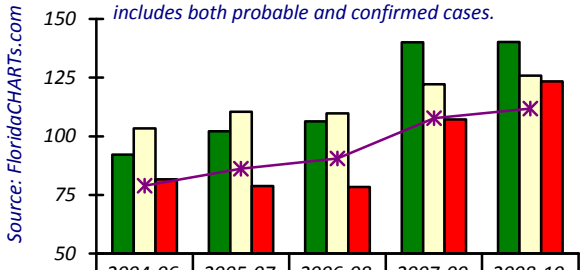
	'05	'06	'07	'08	'09	'10
St. Johns	3.1	0.6	1.7	0.5	2.1	1.1
Best FL Peer	2.3	3.6	2.1	0.3	0.3	2
HP 2020	1	1	1	1	1	1
National Case Rate					3.8	3.6

Figure 7.1-17 shows the overall infectious disease rate. Over the past several years we greatly increased the focus of our disease surveillance and reporting systems, resulting in the expected increase in disease reporting. While it is certainly the desire of our community to keep disease rate low, we must first identify what cases exist before we can effectively prevent.

GOOD

Figure 7.1-17 Total Reportable Disease Case - 3-Yr Rolling Rate

Note: Includes all reportable diseases. Beginning in 2007, data includes both probable and confirmed cases.



	2004-06	2005-07	2006-08	2007-09	2008-10
St. Johns	92.1	102.1	106.3	140.1	140.2
Best Peer	103.3	110.4	109.7	122.2	125.8
Miami-Dade	81.7	78.8	78.4	107.1	123.4
FL State Total	78.9	86.2	90.5	107.7	111.8

7.1b Operational Process Effectiveness Results

7.1b(1) Operational Effectiveness

Note: Most results reported in area 7.1b(1) are for data specific to PH processes in SJCHD and FL. National comparatives are often not available for these measures.

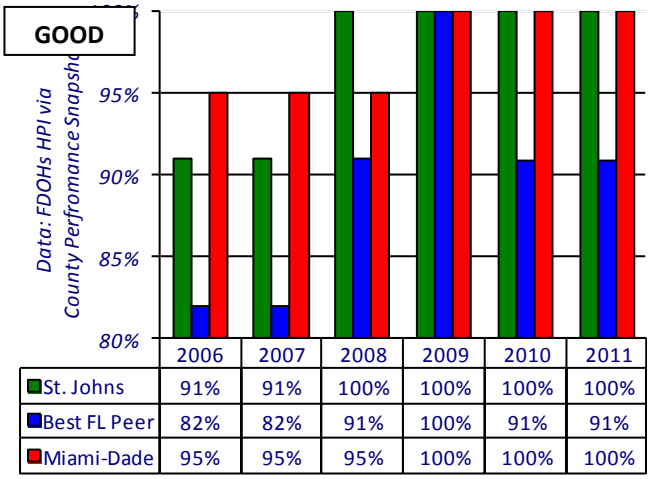
Figure 7.1-18 shows the result of a key leadership system process, the percent of the necessary components of an effective PH leadership system being in place. This measure is tracked for all CHDs in Florida by DOH. It assesses a CHD's readiness to communicate any possible PH event as required.

Figures 7.1-19 and 20 show key results for our PH Epidemiology Surveillance Program. **Figure 7.1-19** shows results for timely disease reporting. Figure **7.1-20** shows results for the core epidemiologic measures that are key to a successful epidemiology program. These measures reflect CHD staff education and their timeliness and completeness of acute disease surveillance and reporting. This measure also reflects the CHD's on-call staff availability 24/7/365.

Immunizations are a key component of an effective PH system. CHDs are evaluated based on infant and two-year old immunization rates. High immunization rates have resulted in an almost total eradication of many communicable diseases over the past fifty years. **Figure 7.1-21** show infant immunization rates and **Figure 7.1-22** shows the rates for two-year olds fully immunized. The national target is 95%.

Figure 7.1-18 Percent of Components of CHD Communication System in Place

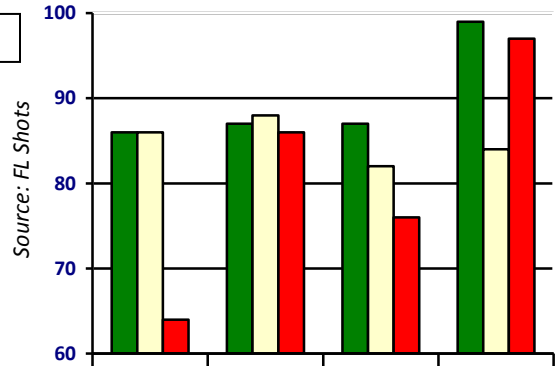
GOOD



	2006	2007	2008	2009	2010	2011
St. Johns	91%	91%	100%	100%	100%	100%
Best FL Peer	82%	82%	91%	100%	91%	91%
Miami-Dade	95%	95%	95%	100%	100%	100%

Figure 7.1-21 % of Infant Client (0-12months) Fully Immunized

GOOD



	2008	2009	2010	2011
St. Johns	86	87	87	99
Best Peer	86	88	82	84
Miami-Dade	64	86	76	97

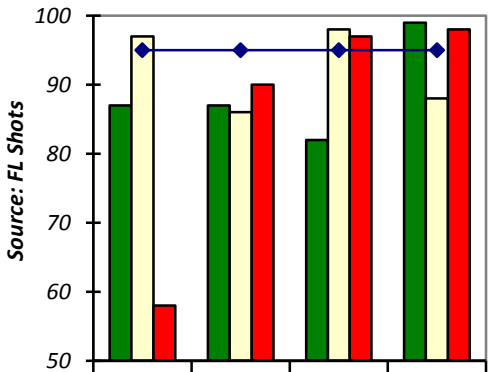
Figure 7.1-19 Timely Disease Reporting by CHD to State

	2008	2009	2010	2011	'12 YTD
St. Johns	100%	97%	100%	98%	100%
Florida Target	75%	75%	75%	75%	75%
Best FL Peer	98%	99%	99%	99%	88%
Miami-Dade	83%	90%	94%		

Source: Merlin

Figure 7.1-22 % of 2-Year Old Clients Fully Immunized

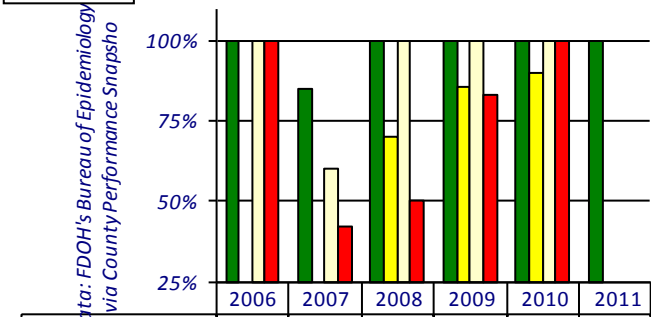
GOOD



	2008	2009	2010	2011
St. Johns	87	87	82	99
Best FL Peer	97	86	98	88
Miami-Dade	58	90	97	98
HP 2020	95	95	95	95

Figure 7.1-20 Percent of Components of PH Response to Disease Reports System In Place

GOOD



	2006	2007	2008	2009	2010	2011
St. Johns, FL	100%	85%	100%	100%	100%	100%
Statewide Average			71%	86%	90%	
Best FL Peer	100%	60%	100%	100%	100%	
Miami-Dade, FL	100%	42%	50%	83%	100%	

Environmental Public Health (EPH) is focused on the safety of our community. Key EPH programs are focused on timely response to any reported PH nuisances, inspections of regulated facilities and inspections of non-public water sources. Inspections are recorded statewide in the EH Rehost database. **Figures 7.1-23, 24 and 25** illustrate the results of these processes. Comparative Data for response to nuisance complaints is not available.

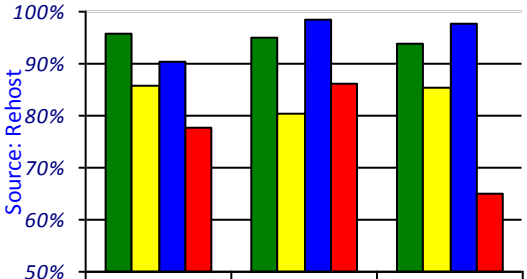
Figure 7.1-23 % of Sanitary Nuisances Inspected w/in 2-Days

	'08	'09	'10	'11
St. Johns	81%	97%	96%	92%

Source: Environmental Health Database ReHost

Figure 7.1-24 Percentage of Facility Inspections Completed for Food Hygeine Program

GOOD



	FY08/09	FY09/10	FY10/11
St. Johns	95.7%	95.0%	94.0%
FL Average	85.7%	80.3%	85.2%
Best FL Peer	90.3%	98.5%	97.6%
Miami-Dade	77.7%	86.2%	65.1%

Figure 7.1-25 % Timely Completion of Water System Inspections

	'07-'08	'08-'09	'09-'10	'10-'11
St. Johns	100%	100%	100%	97%
FL Total	90%	95%	95%	87%
Best FL Peer	89%	97%	100%	100%
Miami-Dade	98%	100%	99%	98%

Source: Environmental Health Database ReHost

Figure 7.1-26, 27 and 28 show results for key process indicators for our Pediatric Health Care clinic, Urgent Care Appointment Availability (a key indicator of accessibility), clinic average visit time, and provider productivity measured by patients seen per day per provider.

Figure 7.1-26 % Urgent Care Patients Offered Same Day Appt

	'08	'09	'10	'11
St. Johns	100%	100%	100%	100%

Figure 7.1-27 Clinic Average Visit Cycle Time

	'08	'09	'10	'11
St. Johns	NA	NA	1:03	1:04
Miami-Dade	1:28	1:20	1:17	NA

Figure 7.1-28 Provider Productivity (Patients Seen per Day)

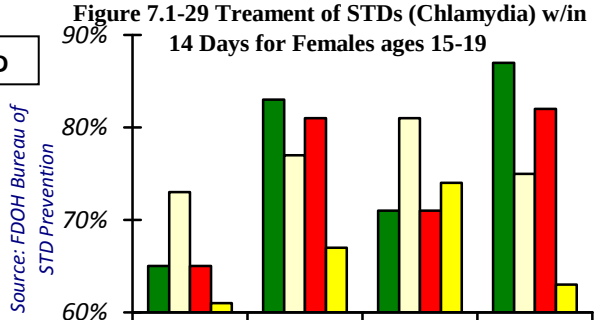
	'09	'10	'11
Physicians	11	12	17
Dentist	11	19	26

Source: HMS

Figures 7.1-29, 30 and 31 show results of our Communicable Disease Management and treatment processes. **Figure 7.1-29** show our improvement in ensuring that young women with Chlamydia are treated for their disease promptly. **Figure 7.1-30** show HIV cases with non-identifiable risk, a key indicator for preventing the spread of HIV and **Figure 7.1-31** shows TB medication compliance rates, key indicators of assurance that active TB cases are cured.

Figure 7.1-29 Treament of STDs (Chlamydia) w/in 14 Days for Females ages 15-19

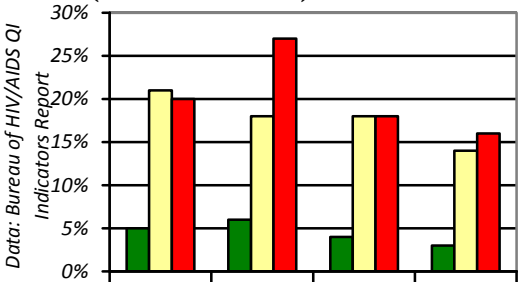
GOOD



	2008	2009	2010	2011
St. Johns, FL	65%	83%	71%	87%
State Total	73%	77%	81%	75%
Best FL Peer	65%	81%	71%	82%
Miami-Dade, FL	61%	67%	74%	63%

Figure 7.1-30 Cumulative Adult HIV NIR Rate in % (Non-Identified Risk)

GOOD



	2007	2008	2009	2010
St. Johns Co.	5%	6%	4%	3%
Best FL Peer	21%	18%	18%	14%
Miami-Dade Co	20%	27%	18%	16%

Figure 7.1-31 - SJCHD Tuberculosis Program

	2006	2007	2008	2009	2010
Patient Compliance w/ Timely Evals (%)	98%	88%	88%	86%	96%

Source: TB Program, Crystal Reports

% of Active TB Patients that Completed Therapy

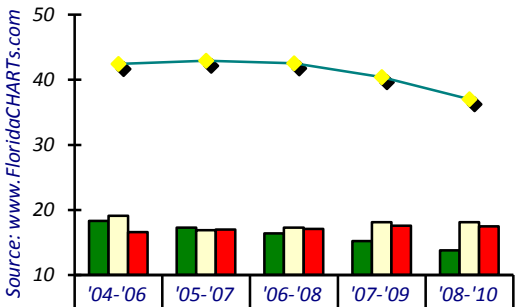
	2007	2008	2009	2010	2011
SJCHD	100%	100%	100%	100%	100%

Data: HMS Care Plan Case Load Report 5/7/12 This data excludes deaths prior to completion of treatment.

Figure 7.1-32 shows the rate of repeated births among 15 to 19 year-old teens. Our Family Planning services are focused on the reduction of this rate.

Figure 7.1-32 Repeat Teen Birth Rate in Percent, Ages 15-19, Rolling 3-Year Rates

GOOD

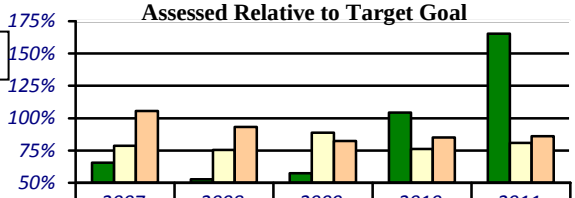


	'04-'06	'05-'07	'06-'08	'07-'09	'08-'10
St. Johns, FL	18.3	17.3	16.4	15.2	13.8
Best FL Peer	19.1	16.9	17.3	18.1	18.1
Miami-Dade	16.6	17.0	17.1	17.6	17.5
FL State Total	42.4	42.9	42.5	40.4	37.0

Figures 7.1-33 & 34 provide key indicators for the Healthy Start (HS) program which is focused on improving pregnancy outcomes for high-risk women. **Figure 7.1-33** shows that in 2010 and 2011, we exceeded our target for High Risk clients assessed for HS services. **Figure 7.1-34** shows average prenatal services provided by HS.

Figure 7.1-33 Percent of Prenatal High Risk Clients Assessed Relative to Target Goal

GOOD



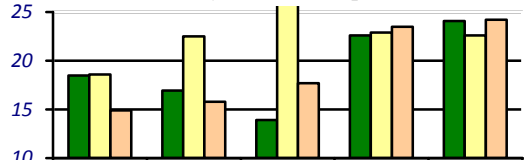
	2007	2008	2009	2010	2011
SJCHD	65.5%	52.8%	57.5%	104.4%	165.4%
Best Peer	78.6%	75.4%	88.8%	76.1%	81.0%
Manatee HS**	105.5%	93.1%	82.4%	85.0%	86.0%

Data: Healthy Start Executive Summary via FloridaCHARTs.com

***Note: Manatee Healthy Start is a 501(C)(3) organization*

Figure 7.1-34 Average Number of Prenatal Services to Healthy Start Participants

GOOD



	2007	2008	2009	2010	2011
SJCHD	18.5	16.9	13.9	22.6	24.1
Best Peer	18.6	22.5	26.9	22.9	22.6
Manatee HS**	14.9	15.8	17.7	23.5	24.2

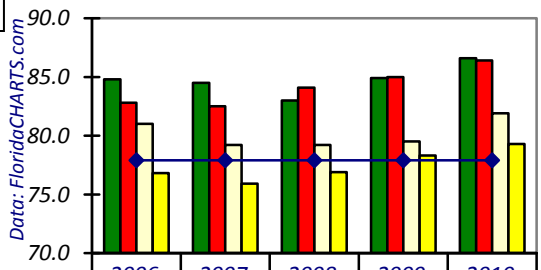
Data: Healthy Start Executive Summary via FloridaCHARTs.com

***Note: Manatee Healthy Start is a 501(C)(3) organization.*

Figure 7.1-35 shows the percent of women receiving prenatal care during the first trimester of their pregnancy. This is a key indicator of favorable pregnancy outcomes and shows the effectiveness of our ABC clinic in linking women to prenatal care. (Access to Care)

Figure 7.1-35 % of Births to Mothers that had 1st Trimester Prenatal Care

GOOD

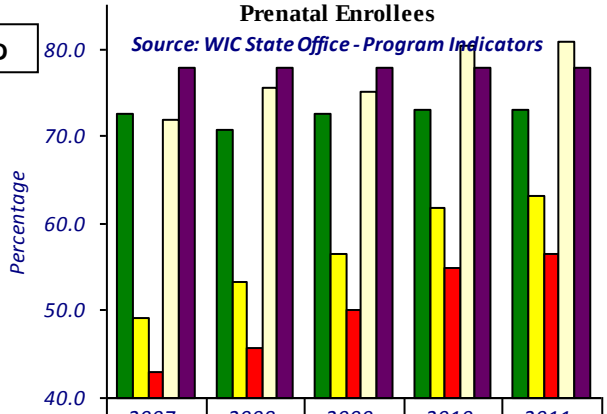


	2006	2007	2008	2009	2010
St Johns, FL	84.8	84.5	83.0	84.9	86.6
Miami-Dade	82.8	82.5	84.1	85.0	86.4
Best FL Peer	81.0	79.2	79.2	79.5	81.9
FL Average	76.8	75.9	76.9	78.3	79.3
HP 2020	77.9	77.9	77.9	77.9	77.9

The WIC program provides nutritional services and education for low income mothers and their children. **Figures 7.1-36, 37 and 38** provide key indicators of the success of this program. **Figure 7.1-36** shows first trimester entry into WIC, **7.1-37** shows % low birth-weight for WIC mothers and **7.1-38** shows % of WIC infants exclusively breastfed for six months.

Figure 7.1-36 1st Trimester Entry to WIC - Prenatal Enrollees

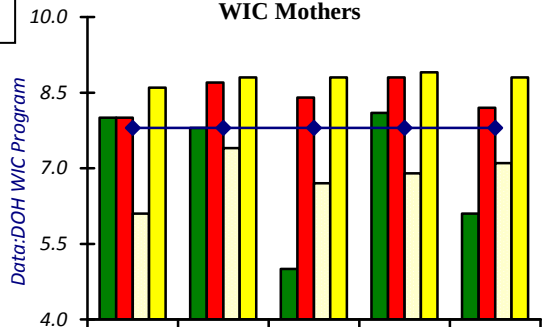
GOOD



	2007	2008	2009	2010	2011
St. Johns	72.7	70.8	72.5	73.0	73.0
FL Average	49.1	53.3	56.6	61.7	63.3
Miami-Dade	43.0	45.7	50.2	54.9	56.6
Best FL Peer	72.0	75.5	75.1	80.4	80.9
HP 2020	77.9	77.9	77.9	77.9	77.9

Figure 7.1-37 % of Low Birth-weight Infants to WIC Mothers

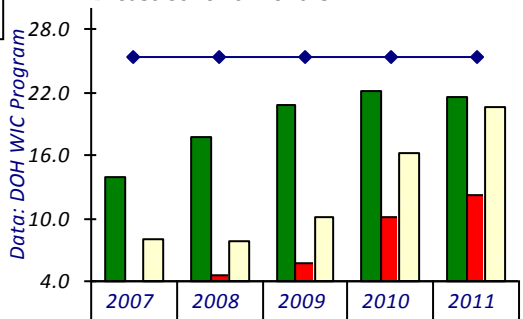
GOOD



	2007	2008	2009	2010	2011
St Johns	8.0	7.8	5.0	8.1	6.1
Miami Dade	8.0	8.7	8.4	8.8	8.2
Best FL Peer	6.1	7.4	6.7	6.9	7.1
FL Average	8.6	8.8	8.8	8.9	8.8
HP 2020	7.8	7.8	7.8	7.8	7.8

Figure 7.1-38 % of WIC Infants Exclusively Breastfed for 6 Months

GOOD



	2007	2008	2009	2010	2011
St Johns	13.9	17.8	20.8	22.2	21.6
Miami Dade	4.0	4.6	5.7	10.1	12.3
Best FL Peer	8.1	7.9	10.1	16.2	20.7
HP 2020	25.5	25.5	25.5	25.5	25.5

Key administrative results include our Baldrige Assessment scores since we began using the Baldrige model in 2004. We have undergone either a formal assessment or self-assessment five times since. **Figure 7.1-39** shows these estimated scores. This is not comparable to others as Baldrige scores are not published.

We are also focused on attaining **National Voluntary PH Accreditation**. We are in the first group of Health Departments nationwide to have applied for PH Accreditation and we are anticipating a site visit by PHAB in late 2012.

Figure 7.1-39 Baldrige Assessment Scores

	2004 Self-Assess.	2006 State Award	2008 State Award	2009 State Award	2011 State Award
St. Johns	225	443	501	738	740

Source: FL Sterling Feedback Reports

Figure 7.1-40 illustrates the average time between submission and resolution of "Information Technology Help Desk Tickets". The goal is to improve customer satisfaction by decreasing the amount of time required to resolve technology issues. The data source for the information is the agency's Help Desk System and is based on a calendar year.

Figure 7.1-40 Average time (Days) to close Helpdesk Tickets

	2007	2008	2009	2010	2011
St. Johns	2.69	2.44	2.27	1.04	1.1
Florida Average	2.29	2.25	2.10	2.06	-
Best FL Peer	1.83	1.38	0.70	0.27	-
Miami-Dade	3.52	4.04	3.42	3.73	-

Data Source: IT.

7.1b(2) Emergency Preparedness

Community Safety is a key driver of *Health Factors*. The FDOH and CHDs have dual responsibilities in preparedness and response, including maintaining the ability to provide core public health services during an emergency, and coordination of the public health and medical system preparedness and response activities. In September 2010, SJCHD received certification for meeting the comprehensive preparedness standards required by **Project Public Health Ready** (PPHR) which is a national framework from which LHD's can comprehensively assess, document and validate capacity for response to any emergency using standard referenced criteria. At that time, only 89 of 692 LHD's across the country were recognized as having met the PPHR requirements. This certification will need to be renewed in 2015.

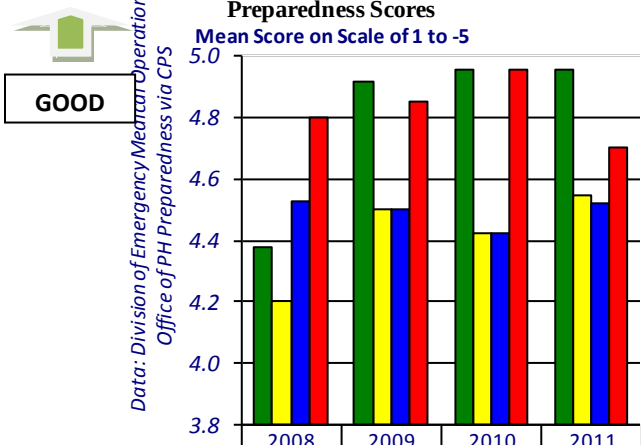
Figure 7.1-41 shows the result of our responsiveness to FDENs alerts, a key measure of preparedness. The HP2020 benchmark is for staff to be fully prepared to respond to an alert in 60 minutes. **Figure 7.1-42** shows the scores for an annual assessment of each CHDs compliance with standards related preparedness in areas such as emergency operations planning, mass prophylaxis, epidemiological surveillance and investigation, preparing employees for response roles, ensuring health and safety of these employees in a response, coordinating health and medical systems planning for the county Comprehensive Emergency Management Plan, ensuring exercises are NIMS and HSEEP compliant, and risk communications.

Figure 7.1-41 % Timely Response to FDENS Alert

	2009	2010	2011
St. Johns	82%	88%	95%
Best FL Peer	66%	61%	67%
Miami-Dade	88%	83%	86%
FDOH	55%	58%	58%

Source: Florida Health Emergency Notification System

Figure 7.1-42 CHD PH Emergency Preparedness Scores



	2008	2009	2010	2011
St. Johns	4.38	4.92	4.96	4.96
Statewide Average	4.20	4.50	4.42	4.55
Best FL Peer	4.53	4.50	4.42	4.52
Miami-Dade	4.80	4.85	4.96	4.70

7.1c Strategy Implementation Results

We developed a SP and Balanced Scorecard for FY 11-12 as we have for the past six years. **Figure 7.1-43** shows that we completed all of our Strategic Objectives for the past 2 years.

Figure 7.1-43 – % of Strategic Objectives Achieved

	2006	2007	2008	2009	2010	2011
St. Johns	80%	92%	42%	100%	100%	100%
Miami-Dade	100%	100%	100%	100%	100%	NA
Best FL Peer	83%	85%	89%	100%	100%	NA

Data Source: FDOH's 2012 County Performance Snapshot

In addition to completing an annual Strategic Plan, SJCHD chairs the County Health Leadership Council in the completion of a Community Health Assessment and Community Health Improvement Plan (CHA/CHIP). **Figure 7.1-44** shows that we have completed a CHA/CHIP on schedule every three years since 2005. Only about 25% of CHDs have ever completed this Community Planning Process.

Figure 7.1-44 – Timely Completion of CHA/CHIP

	2005	2008	2011
St. Johns	Yes	Yes	Yes

7.2 Customer-Focused Outcomes

7.2a(1) Patient and Stakeholder Satisfaction & 7.2a(2) Patient and Stakeholder Loyalty and Engagement

Figure 7.2-1 shows Patient/Client satisfaction results as collected from our touch screen survey tool. **Figure 7.2-2** shows these results segmented by Service Center. Results for these figures denote top 2 boxes (4 and 5) on a 5-point scale. Patient/client engagement is **SO #3.2**

Figure 7.2-1 Overall Customer Satisfaction

	2007	2008	2009	2010	2011
St. Johns CHD	96%	97%	95%	96%	97%
Best FL Peer		94%		98%	100%
Miami-Dade CHD	92%	89%	98%	100%	99%
*Southcentral Foundation (2011 Baldrige)		89%	92%	91%	NA
Sullivan County Tennessee CHD				91%	NA

Data: Locally collected

Figure 7.2-2 Overall Customer Satisfaction Segmented by Service Center

	'07	'08	'09	'10	'11	Best FL Peer
Immun.	72%	91%	98%	99%	98%	100%
STDs	87%	94%	95%	95%	97%	96%
Dental	82%	97%	90%	92%	99%	100%
WIC	100%	97%	97%	95%	99%	97%
Pediatrics	67%	94%	95%	94%	97%	97%
Vital Stats	80%	100%	92%	94%	96%	n/a
EPH	100	100%	99%	99%	100%	100%

Figure 7.2-3 shows top box satisfaction in our patient/client touch screen survey compared to results from three local health care providers that have received recognition for high performance. This is a measure of Patient/Client Engagement.

Figure 7.2-3 Patient Client Satisfaction Top Box Rating

	2009	2010	2011
St Johns CHD	79%	80%	81%
Florida Hospital Orlando	NA	NA	63%
Flagler Hospital	62%	NA	66%
Shands Hospital (Jacksonville)	NA	72%	68%

Data: Locally collected. Note: *Patients who rated the organization in top Box (9&10 for Hospitals, 5 for SJCHD), in every survey question.*

Figure 7.2-4 shows the Patient/Client response to our touch screen survey question regarding willingness to recommend SJCHD to a friend. This is a measure of Patient/Client Engagement.

Figure 7.2-4 Customer Loyalty

	2007	2008	2009	2010	2011
		Average			
St Johns CHD	*59%*	*60%*	*94%*	*95%*	*96%*
Miami-Dade CHD		*89%*	*98%*	*100%*	*99%*
Sullivan TN CHD		*95%*	*97%*	*97%*	*NA*
		Top Box			
St Johns CHD			*77%*	*78%*	*78%*
***Southcentral Foundation**			*71%*	*67%*	*NA*
Flagler Hospital				*71%*	*70%*
Shands Hospital (Jacksonville)				*77%*	*67%*

** 2011 Baldrige Award Recipient. Note: This is measured in top box (9&10 for Hospitals; 5 for SJCHD)*

Figure 7.2-5 shows Patient/Client Dissatisfaction results from the touch screen survey. These results are for Patients/Client rating a 1 or 5 on a 5-Point scale.

Figure 7.2-5 Customer Dissatisfaction Bottom 2

	2009	2010	2011
St Johns CHD	*1.33%*	*1.67%*	*1.06%*
Miami-Dade CHD	*0.13%*	*0.20%*	*0.20%*
***Southcentral Foundation**	*8.30%*	*10.0%*	

Data: Locally collected. Note: *Patients who rated the organization in top Box (9&10 for Hospitals, 5 for SJCHD), in every survey question.*

Figure 7.2-6 show the number of Patient/Client complaints versus complements. 100% of Patient/Clients complaints have been responded to within one business day for the past three years.

Figure 7.2-6 SJCHD Complaints Contacted w/in 1 business day

	2009	2010	2011
# Complaints Received	*74*	*58*	*63*
% Responded to w/in 1 business day	*100%*	*100%*	*100%*

Data: Locally collected.

Figure 7.2-7 shows the response to our annual Community Partner Survey. This survey is used to determine satisfaction for our indirect service clients as these Community Partners represent virtually all key population group within SJC. This compares with Sullivan County, TN where 87% of respondents believe that the CHD adds value and Miami-Dade County where 100% of Partners felt that Miami-Dade CHD provides high quality services. (**SO #3.1**)

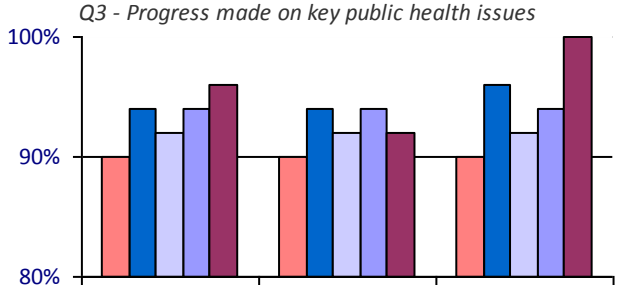
The HLC has developed and is implementing the Community Balanced Scorecard (**SO #3.1**). This scorecard was developed in 2011 and is currently about 10% complete.

Figure 7.2-7 - % Community Partner Satisfaction

GOOD

Health Leadership Council Survey

Q1 - Membership is a valuable use of time
Q2 - Resulting data is important to my agency
Q3 - Progress made on key public health issues



	Q1	Q2	Q3
2007	90%	90%	90%
2008	94%	94%	96%
2009	92%	92%	92%
2010	94%	94%	94%
2011	96%	92%	100%

Data: Locally Collected

7.3 Workforce-Focused Outcomes

7.3a(1) Workforce Capability and Capacity

Figures 7.3-1 and 2 shows results related to staff promotions from within and completion of all Individual Development Plans (IDPs) and maintaining current position descriptions.

Figure 7.3-1 % of Staff Promoted from Within

	'05-'06	'06-'07	'07-'08	'08-'09	'09-'10	'10-'11
SJCHD	11%	10%	10%	23%	12%	18%

Data is collected locally by HR & OPHP

Figure 7.3-2
Percent of IDPs, Evaluations, and updated Position Descriptions Completed on Time

	2008	2009	2010	2011
SJCHD	*100%*	*100%*	*100%*	*100%*

Data is collected locally by HR & OPHP.

7.3a(2) Workforce Climate

Since August 2011, 100% of new employees screened for immunizations within 30 days of hire and 100% have received appropriate health screenings for the past three years. In the last two year we spent approximately $4,000 per year providing staff immunizations.

Figure 7.3-3 shows that our Risk Management processes have been highly effective in keeping our workforce safe. **Figure 7.3-4** shows the result of our annual risk/safety assessment.

Figure 7.3-3 - Average Cost of Worker's Comp Claims Per Employee

	'06-'07	'07-'08	'08-'09	'09-'10	'10-'11
SJCHD	$125	$267	$19	$110	$27
MDCHD	$171	$258	$399	$457	$471
Best FL Peer	$240	$98	$228	$407	$51

Figure 7.3-4 - Annual Risk/Safety Assessment Scores (%)
From CHD Performance Snapshot Report

	2007	2008	2009	2010	2011	2012
SJCHD	64	87	93	83	92	100
MDCHD	79	100	100	100	100	NA
Best FL Peer	67	93	97	93	96	NA

7.3a(3) Workforce Engagement

We have been conducting workforce engagement surveys (administered by the DOH) every two years since 2002. In 2008 the survey was significantly updated and few of the questions align with the new survey tool. In 2011 we conducted our own survey using the same consulting company as the DOH survey.

It is relatively easy to get comparative satisfaction and engagement results from health care providers that are not a part of FDOH. However, circumstances within FDOH and other state of Florida government agencies are unique and make outside comparisons not very relevant. For example, we have not been permitted to provide any pay increases for the past six years, and many employees are now significantly underpaid for the type of work they do. Also, we are not permitted to use any DOH funding for employee recognition. This makes engagement a huge challenge. **Figure 7.3-5** shows overall workforce satisfaction compared to other FDOH agencies. Workforce satisfaction is **SO #4.1**.

Figure 7.3-5- Overall Workforce Satisfaction

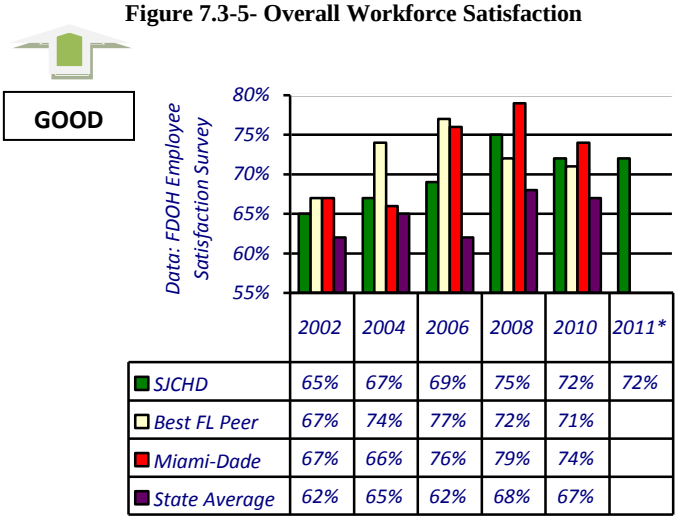


Figure 7.3-6 shows our survey response rate and **7.3-7** shows segmented satisfaction levels. Due to the small size of several of our Service Centers, some segmented satisfaction data is not available. Engagement by longevity and education are available on site.

Figure 7.3-6 Satisfaction Survey Response Rate

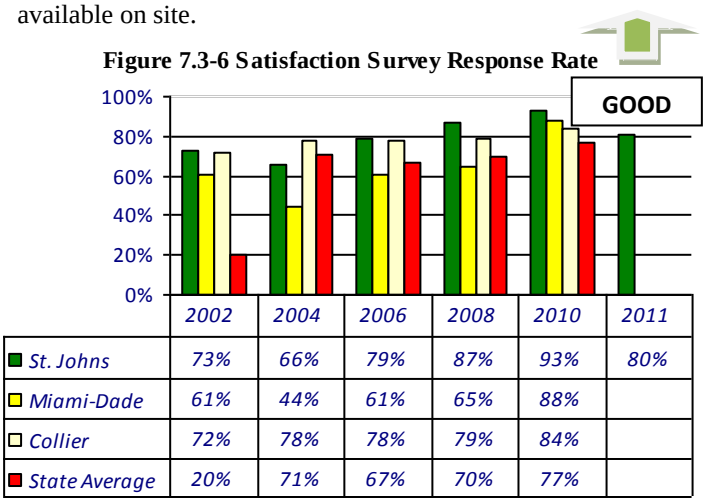


Figure 7.3-7 - Employee Satisfaction by Segment

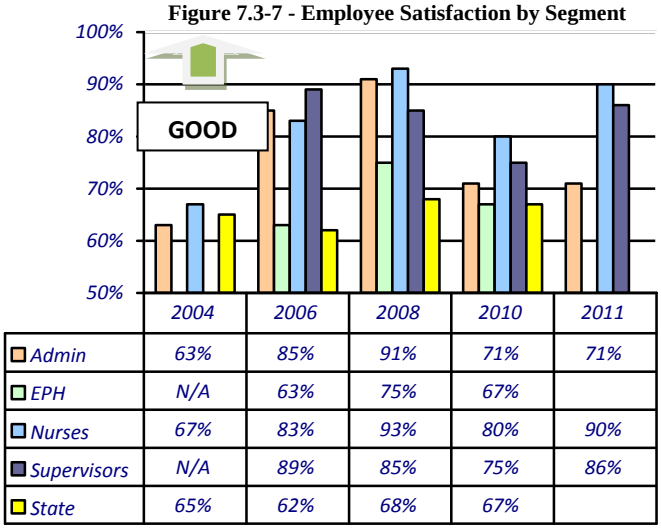


Figure 7.3-8 shows the results of the employee survey segmented by dimension.

Figure 7.3-8 - Satisfaction by Dimension of Engagement
On 5-Point Likert Scale

	Clarity			Standards		
	'08	'10	'11*	'08	'10	'11*
SJCHD	3.80	3.91	3.99	3.70	4.00	4.05
Best FL Peer	4.05	3.96	-	3.99	3.91	-
MDCHD	4.02	4.01	-	3.88	3.88	-
State Avg	3.90	3.82	-	4.0	3.73	-
	Responsibility			**Flexibility**		
SJCHD	4.00	4.13	4.19	3.70	3.93	3.94
Best FL Peer	4.14	4.11	-	3.91	3.86	-
MDCHD	4.06	4.05	-	3.88	3.89	-
State Avg	4.10	3.99	-	3.90	3.93	-
	Team/Cooperation			**Rewards/Recognition**		
SJCHD	3.90	4.10	4.21	3.30	3.62	3.71
Best FL Peer	4.07	4.02	-	3.65	3.42	-
MDCHD	3.99	3.99	-	3.57	3.54	-
State Avg	4.10	3.86	-	3.60	3.32	-

*Source: FDOH's Statewide Bi-annual Employee Survey *2011 SJ Only*

Figure 7.3-9 Shows Workforce Engagement based on the engagement factors shown in **Figure 5.2-1.**

Figure 7.3-9 Workforce Satisfaction Segmented by Key Engagement Factors	2008 SJCHD	2010 SJCHD	2011 SJCHD	2010 Best FL Peer	2010 MDCHD
Q1. I am proud to tell people that I work for the Department of Health	*86.2%*	*82%*	*83.8%*	*85.7%*	*90.0%*
Q2. I can explain how the work I perform contributes to the DOH mission.	*95.7%*	*91%*	*91.9%*	*94.7%*	*95.9%*
Q7 I am satisfied with my current physical working conditions	*81.7%*	*75.3%*	*74.3%*	*68.7%*	*73.7%*
Q14. I am able to pursue career development training opportunities.	*74.7%*	*59.5%*	*62.1%*	*60.1%*	*69.8%*
Q20. My supervisor recognizes my work accomplishments	*80.9%*	*83.1%*	*83.7%*	*79.2%*	*73.6%*
Q21. My supervisor discusses actions taken on employee suggestions for improvement.	*80.7%*	*76.4%*	*77.0%*	*76.0%*	*72.6%*
Q25. Within my work unit, we work cooperatively to get the job done.	*89.4%*	*93.3%*	*93.2%*	*87.2%*	*85.1%*
Q29. I receive coaching from my supervisor that helps improve job performance on a routine basis.	*62.4%*	*67.4%*	*66.2%*	*67.9%*	*66.3%*
Q37. I have the materials, equipment, supplies, and technical support needed to do my job.	*88.1%*	*83.1%*	*89.1%*	*89.2%*	*88.9%*
Q41. I have opportunities to use initiative in my job.	*80.4%*	*73.1%*	*85.1%*	*80.7%*	*75.1%*
Q43. I receive understandable written performance standards.	*NA*	*79.8%*	*86.3%*	*85.9%*	*80.9%*
Q44. My performance standards accurately describe the majority of the work I do.	*76.4%*	*75.2%*	*76.7%*	*83.3%*	*78.6%*
Q45. I am evaluated fairly based on my performance standards	*78.6%*	*73.1%*	*73.9%*	*75.7%*	*70.4%*
Q48. I have opportunities to work with my supervisor in setting realistic work objectives for my job.	*75.9%*	*71.2%*	*74.3%*	*76.1%*	*74.1%*
Q50. My job makes good use of my skills and abilities.	*79.6%*	*74.7%*	*81%*	*81.7%*	*82.1%*
Q55. My supervisor prepares me for additional responsibilities.	*64.1%*	*69.0%*	*68.5%*	*61.0%*	*60.9%*
Q58. Total Overall level of Satisfaction	*75.3%*	*72.4%*	*71.6%*	*74.2%*	*70.7%*

Figure 7.3-10 shows Workforce Satisfaction for other areas of importance.

Figure 7.3-10 Workforce Satisfaction by Other Key Areas	2008 SJCHD	2010 SJCHD	2011 SJCHD	2010 Best FL Peer	2010 MDCHD
Q3 - Confidence in management	68%	68%	78%	68%	74%
Q6 - Managers put quality first	71%	71%	74%	66%	73%
Q10 - I feel safe	91%	91%	97%	79%	85%
Q12 - Office supports healthy behavior	95%	94%	95%	85%	73%
Q15 - Trust my supervisor	77%	77%	80%	78%	73%
Q22 - Employees recognized for quality	75%	75%	75%	59%	58%
Q24 - Climate supports me sharing my opinion	78%	77%	87%	82%	73%
Q34 - Supervisor discusses important issues	77%	77%	82%	77%	75%
Q38 - Supervisor emphasizes improvement	89%	89%	89%	80%	79%
Q54 - Leadership development opportunities	47%	47%	73%	36%	49%

Figure 7.3-11 - % of Staff Members Nominated for "You Take the Cake"*

	'07-'08	*'08-'09*	*'09-'10*	*'10-'11*
SJCHD	*15%*	*33%*	*14%*	*41%*

Data is collected locally by HR & OPHP.
Awards internal to SJCHD.

Figure 7.3-12 - % of Staff Turnover for those w/ Tenure Greater than 1 Year of Employment

	2007	2008	2009	2010	2011
SJCHD	12%	11.4%	5.1%	8.5%	11%

NOTE: Local monitoring consists of the review of the number of staff with greater than 1 year of employment who exit the agency excluding retirements.

Since we are unable to provide any pay increases to our workforce, recognition is critical to satisfaction and engagement. **Figure 7.3-11** shows the number of employees nominated for the monthly "You Take the Cake" recognition program.

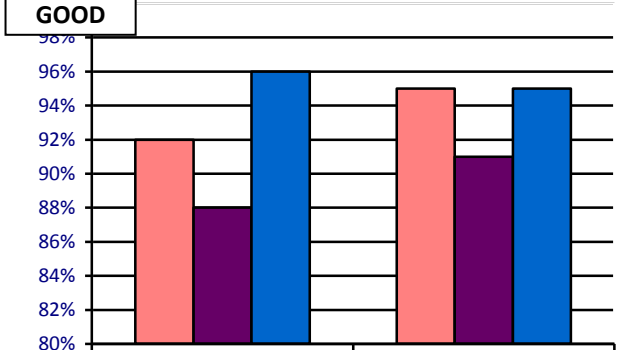
We have found that despite our strong hiring process, some new employees find that they cannot live on our low salaries and others find that they are not really cut out to be Public Health Professionals. Therefore Turnover rate after a year on the job (**Figure 7.3-12**) is better predictor of long-term engagement. There are no like to like comparatives available for this indicator as the state track any turnover other than layoffs. We have had no layoffs at SJCHD.

7.3a(4) Workforce Development

Since 2006 we have completed 100% of all mandated training. Much of this training is done in our twice-monthly staff enrichment sessions. We have also completed the first module of a Cultural and Linguistic Competency series of training and exercises (**SO #4.2**).

Figure 7.3-13 shows staff satisfaction results for All-staff training events since 2010. **Figure 7.3-9** questions 14, 29 and 55 show employee engagement results concerning training and development opportunities.

Figure 7.3-13 - Satisfaction Results from All-Staff Training Events



	Overall Satisfaction	Useful
2010	92%	95%
2011	88%	91%
'12 YTD	96%	95%

7.4 Leadership and Governance Outcomes

7.4a(1) Leadership

There are several indicators of effectiveness for SL communications to deploy the mission, vision, and values and to create a focus on action. **Figure 7.1-18** shows that SJCHD has implemented all necessary components needed for an effective CHD communications system. **Figure 7.3-9 Question #2** shows that SJCHD employees have a high level of understanding of the mission and **Figure 7.3-10, Questions #6, 34 and 38** shows that Leaders communicate effectively and emphasize quality and performance improvement.

7.4a(2) Governance

During the past three years, we have undergone external audits by various state and federal agencies in the following areas: Healthy Start, WIC, Medicaid, Immunizations, Family Planning, Information Security, Environmental Public Health and Administration (includes Fiscal Performance). There were no significant negative findings for any of these audits and action plans were developed for all audit recommendations within 60 days.

We also do annual internal self-assessments for Fiscal Performance, security and QI reviews in most Service Centers. There have been no significant negative findings in any of these areas.

7.4a(3) Law, Regulation and Accreditation

Figure 7.4-1 shows the number of reportable security violations for SJCHD. This number has remained very low for the past five years.

Figure 7.4-1 - Number of Reportable Security Incidents

	2007	2008	2009	2010	2011
SJCHD	6	7	1	5	3

Data tracked locally.

There have been no instances where legal settlements have been made in the past four years.

Figures 7.4-2, 3 and 4 show the results for several key state regulatory requirements for prompt payment of supplier invoices, keeping the administrative rate percentage low, and for timely employee time reporting.

Figure 7.4-2 - Prompt Payment Compliance

	'07-'08	'08-'09	'09-'10	'10-'11
SJCHD	100%	100%	100%	100%
Best FL Peer	100%	98%	100%	100%
MDCHD	100%	100%	100%	100%

Data: FIRS, Admin Dashboard

Figure 7.4-3 - Administrative Rate

	'07-'08	'08-'09	'09-'10	'10-'11
SJCHD	13.6%	13%	12%	8%
Best FL Peer	12.6%	13%	12%	13%
MDCHD	13.9%	13%	13%	9%

Data: FIRS, Admin Dashboard

Figure 7.4-4 - % Timely Completion of *"Employee Activity Records"*

	'07-'08	'08-'09	'09-'10	'10-'11
SJCHD	96%	98%	99%	100%
Best FL Peer	89%	99%	98%	95%
MDCHD	97%	99%	95%	97%

Data: FIRS, Admin Dashboard

We have a very small number of locally administered supplier contracts. All have been monitored on time as required by the state for at least the past five years.

As stated previously, there is currently no requirement for Health Departments to be accredited. However, we are focused on attaining **National Voluntary PH Accreditation** through the PHAB. We are among the first group of HDs nationwide to have applied for PH Accreditation and we anticipate being among the first to be site visited and accredited by PHAB in late 2012.

We are required to be ready for any PH emergency at any time but there is no mandated certification requirement. In September 2010, SJCHD received certification for meeting the comprehensive preparedness standards required by **Project Public Health Ready** (PPHR) which is a national framework from which LHD's can comprehensively assess, document and validate capacity for response to any emergency using standard referenced criteria. This certification will need to be renewed in 2015.

7.4a(4) Ethics

There have been no suspected or substantiated ethics violations over the past five years. The semi-annual Employee Survey provides evidence of stakeholder trust in leadership (See **Figure 7.3-10, Questions #3 and 15**). Also, the annual survey of the Health Leadership Council (**Figure 7.2-7)** provides evidence of the overall community's trust in the leadership of SJCHD. While there have been no ethics violations there have been a small number of employee disciplinary actions as depicted in **Figure 7.4-5.** There have been no monetary settlement agreements for the past four years.

Figure 7.4-5 Number of Disciplinary Actions by Type

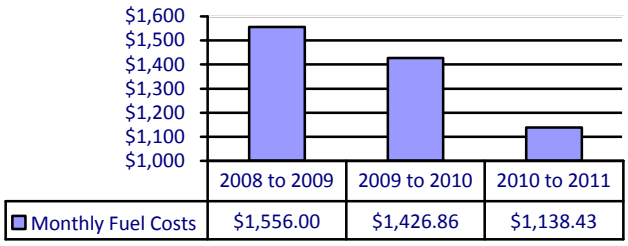
	2008	2009	2010	2011
SJCHD - Oral Reprimands	2	3	0	1
MDCHD - Oral Reprimands	3	14	5	0
SJCHD – Written Reprimands	6	17	9	10
MDCHD - Written Reprimands	18	7	14	15
SJCHD – Dismissals	2	0	2	0
MDCHD – Dismissals	8	4	0	8
SJCHD – Suspensions	0	0	0	2
MDCHD – Suspensions	0	2	0	2
Data: Human Resources				

7.4a(5) Society

In November 2010, webegan the implemention of a "Green Plan" in an effort to be a leader by supporting more "green" decisions and behavior; to establish more sustainable choices in public service operations by implementing energy conservation methods to lower utility costs, energy consumption, and carbon footprint emissions. This initiative was begun with the purchase of several hybrid vehicles to replace vehicles that were due to be retired. **Figure 7.4-6**, shows cost-savings related to hybrid vehicle usage.

GOOD

Figure 7.4-6 Monthly Fuel Costs through the Usage of Hybrid Vehicles



The Florida State Employees' Charitable Campaign, known as the "FSEC Campaign" or "FSECC", is the only state-sanctioned charity drive among state employees in the workplace. In **Figure 7.4-7**, the average dollar FSECC contribution per Employee is illustrated.

Figure 7.4-7 FSECC Average Contribution per Employee

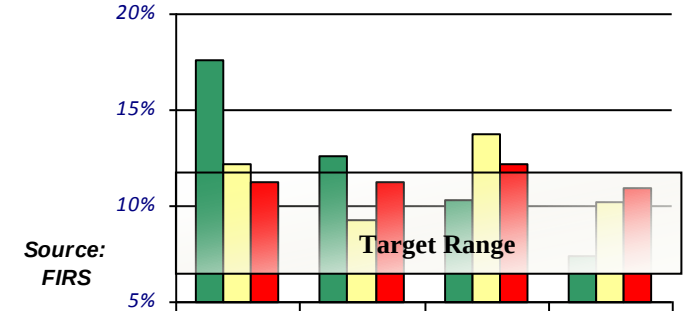
	2008	*2009*	*2010*	*2011*
SJCHD	*$22*	*$29*	*$41*	*$42*
Best FL Peer	*$31*	*$19*	*$29*	*$41*
Miami-Dade	*$13*	*$10*	*$10*	*NA*
Data collected locally by HR.				

7.5 Financial and Market Outcomes

7.5a(1) Financial Performance

Our goal is to keep one month's expenses in cash on hand. The target or "comfort range" for the Cash Reserve Balance is at least 8%, and may be utilized to account for any unforeseen expenses or dips in revenue. The State Mandated Minimum is 6.0%. This data is important to us because it illustrates our ability to consistently manage our cash flow and that we have been able to maintain our cash balance. Current direction from FDOH is to maintain a cash balance from 6% - 11%. **Figure 7.5-1** shows our Cash Reserve Balance. Cash Reserve is part of **SO #2.1**.

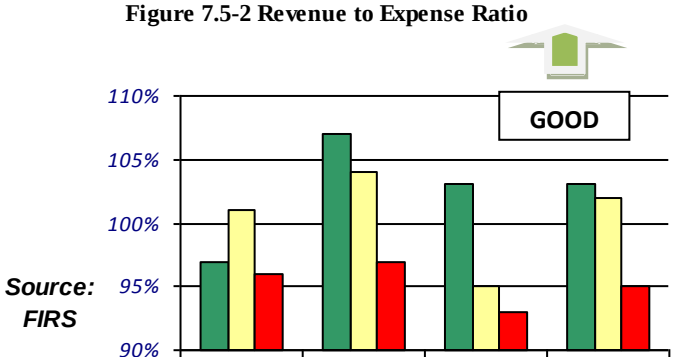
Figure 7.5-1 Cash Reserve Balance



	07-08	*08-09*	*09-10*	*10-11*
St. Johns	*17.60%*	*12.60%*	*10.30%*	*7.40%*
Best FL Peer	*12.20%*	*9.30%*	*13.70%*	*10.20%*
Miami-Dade	*11.30%*	*11.30%*	*12.20%*	*10.90%*

Figure 7.5-2 depicts budget management in terms of revenue versus expense ratio. Despite continuous budget cuts over the past five years, we have been able to fund our CHD programs and remain "in the black". The DOH target is 90% to 110%. Revenue to expense is part of **SO #2.1**.

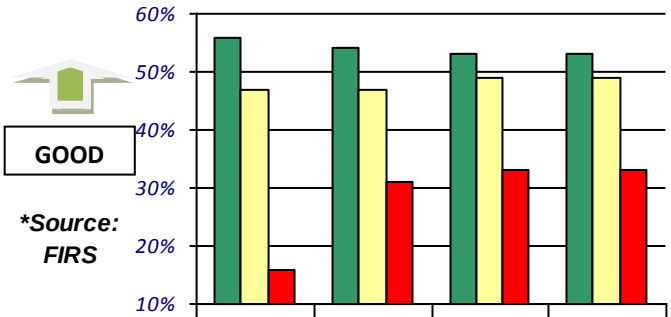
Figure 7.5-2 Revenue to Expense Ratio



	07-08	08-09	09-10	10-11
St. Johns	97%	107%	103%	103%
Best FL Peer	101%	104%	95%	102%
Miami-Dade	96%	97%	93%	95%

It is important to have a significant percentage of self generated funding particularly during an economic downturn when state and federal funding is limited. The higher the self generated funds the more self sufficient and flexible we are to meet the needs of our community. **Figure 7.5-3** illustrates the percentage of self-generated funding. % Self-generated Revenue is part of **SO #2.1**.

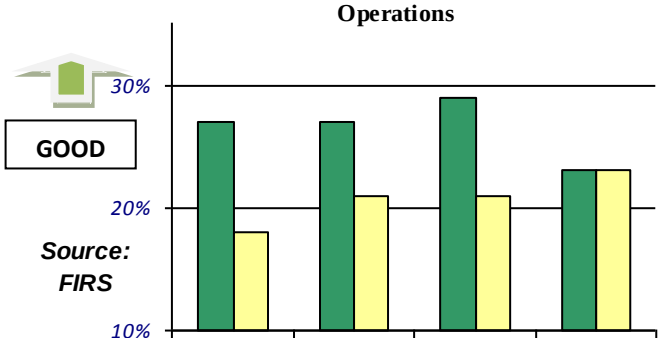
Figure 7.5-3 % of Self-generated Funding



	07-08	08-09	09-10	10-11
St. Johns	56%	54%	53%	53%
Best Peer	47%	47%	49%	49%
Miami-Dade	16%	31%	33%	33%

Figure 7.5-4 shows the percentage of total revenue derived from the provision of clinical services. This is important because this is a major source of self-generated funding.

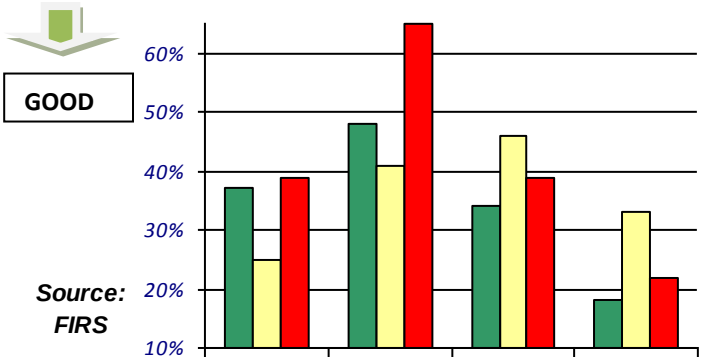
Figure 7.5-4 Revenue Generated from Clinic Operations



	07-08	08-09	09-10	10-11
St. Johns	27%	27%	29%	23%
Best Peer	18%	21%	21%	23%

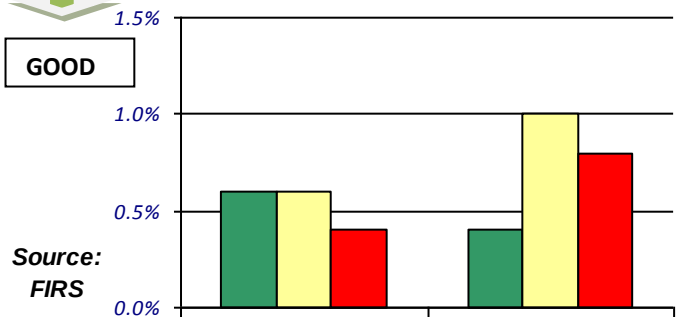
The general rule-of-thumb is that accounts that are uncollected after 120 days from the date of service will remain uncollected. **Figure 7.5-5** shows performance with "Accounts Receivable over 120-Days". **Figure 7.5-6** show % Accounts Receivable over 360 days. These are revenues that must be written off and will never be collected.

Figure 7.5-5 % Accounts Receivable > 120 *Days*



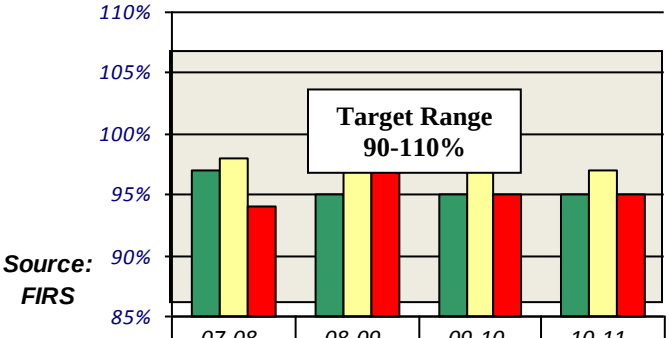
	07-08	08-09	09-10	10-11
St. Johns	37%	48%	34%	18%
Best Peer	25%	41%	46%	33%
Miami-Dade	39%	65%	39%	22%

Figure 7.5-6 % Accounts Receivable > 360 *Days*



	09-10	10-11
St. Johns	0.6%	0.4%
Best Peer	0.6%	1.0%
Miami-Dade	0.4%	0.8%

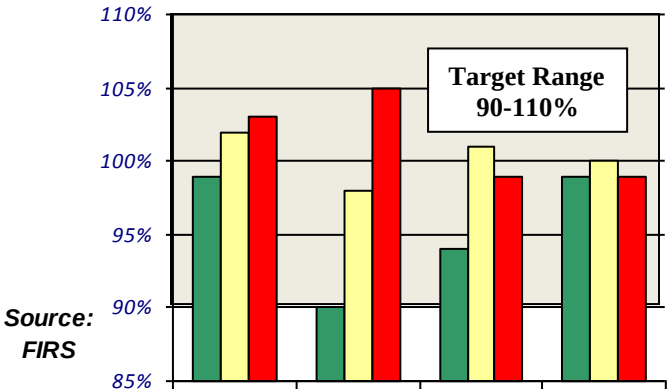
Figure 7.5-8 Expense to Budget Ratio



	07-08	08-09	09-10	10-11
St. Johns	97%	95%	95%	95%
Best Peer	98%	99%	98%	97%
Miami-Dade	94%	99%	95%	95%

Figures 7.5-7 and 8 both show the effectiveness of our budget management process. **Figure 7.5-7** shows the actual Revenue to Budget ratio and **Figure 7.5-8** shows Expense to Budget ratio. Without strong budget management it would be difficult to sustain the organization with budgets so tight. In both cases the requirement is to stay within +/- 10% of budgeted amounts.

Figure 7.5-7 Revenue to Budget Ratio



	07-08	08-09	09-10	10-11
St. Johns	99%	90%	94%	99%
Best Peer	102%	98%	101%	100%
Miami-Dade	103%	105%	99%	99%

7.5a(2) Marketplace Performance

Figure 7.5-9 shows our indicator of marketplace performance, the number of services provided to our patients/clients. This shows that despite budgetary reductions, through streamlining our processes and maximizing efficiencies, we have been able to provide increasing numbers of services to our patients/clients and the community. As every CHD provides a unique array of services to different populations, comparisons are not meaningful. **Figure 7.5-10** shows our increased productivity as a result.

Figure 7.5-9 SJCHD Total Services Provided

	2008	2009	2010	2011
Clinical Services	49,294	45,995	67,665	88,858
Dental Services	16,267	22,000	23,735	34,535
Immunizations	24,560	27,256	23626	24,569
Epidemiologic Investigations	1,000	1,050	1,170	2,167
WIC Services	26,162	31,899	32,446	31,875
EH Inspections	2,384	2,351	2,318	2,360
HS Services	12,684	12,392	26,088	33,837
Total Services	**132,351**	**143,393**	**177,048**	**218,201**

Source: HMS

Figure 7.5-10 SJCHD FTE Productivity

	2008	2009	2010	2011
Total Services	132,351	143,393	177,048	218,201
Total FTE	114	117	112	106
Services per FTE	**1,161**	**1,226**	**1,581**	**2,059**

Source: HMS

Appendix F

Washington State Department of Health
Washington Quality Award

This is a Lite Assessment Application for the Washington State Quality Award. It was submitted in April 2008 by the Washington State Department of Health.

Washington State Department of Health

Washington State Department of Health

Washington State Quality Award
Lite Assessment Application
April 2008

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Post Office Box 47890 Olympia, Washington 98504-7890
Tel: (360) 236-4010 • FAX: (360) 586-7424
TDD Relay Service: 1-800-833-6388

April 1, 2008

Washington State Quality Award Program
Administrative Office
P.O. Box 609
Keyport, WA 98345

RE: Department of Health WSQA Lite Application

The enclosed WSQA lite application provides a review of the Department of Health's performance identified in the Baldrige framework. This journey has been valuable to our staff to evaluate our performance management system and apply quality principles.

I am proud to be the Washington State Secretary of Health and I'm looking forward to the results of this review so that we can continue to protect and improve the health of people in our state.

Sincerely,

Mary C. Selecky
Secretary

Enclosure

Table of Contents

Eligibility Determination Form

This form is valid for one year from the date signed.

Applicant

Organization Name (as you would like it to appear on an award, should you be a recipient):

Washington State Department of Health

Address:

Town Center 1
101 Israel Road SE
Tumwater, WA 98504

Sector

Check appropriate box to indicate sector and organization size.

☐ Business ☐ Not-for-Profit ☐ Healthcare

☒ Public ☐ Education

1500 Number of Employees

Criteria Selected by Applicant (see Criteria for Performance Excellence above):

☒ Criteria for Performance Excellence ☐ Healthcare ☐ Education

Application Level Application Fee (see fee table on Web site) to be submitted with application

☒ Lite (Assessment) $**300** Desired submission date of application: ☐January 1 ☒April 1 ☐ July 1 ☐October 1

☐ Full Examination $

Examiner Commitment:

Name of Examiner: **Susan Ramsey** E-mail: **susan.ramsey@doh.wa.gov** Phone: **(360) 236-4013**
Submission date of Examiner Application: **3/16/07**

Name of Examiner: E-mail Phone
Submission date of Examiner Application:

Name of Examiner: E-mail Phone
Submission date of Examiner Application:

Examiners must commit the year prior, during, or post application submission.

Applicant Headquarters

Indicate if the applicant's headquarters are located in the state of Washington. If the headquarters are not in Washington, please provide a brief explanation.

☒ Yes ☐ No

Explanation:

Applicant Size and Site Locations

Percent of Employees Located in the State of Washington: **100%**

Total Number of Sites: **6**

List a brief description and complete address for each site.

1. Town Center1, 2 & 3	**101 Israel Road SE**	**Tumwater, WA 98504**
2. Point Plaza East	**310 Israel Road SE**	**Tumwater, WA 98501**
3. Public Health Labs	**1610 NE 150th St**	**Shoreline, WA 98155**
4. WA State Dept of Health	**1500 West 4th Ave.**	**Spokane, WA 99201**
5. WA State Dept of Health	**309 Bradley Blvd.**	**Richland, WA 99352**
6. Marketing Center Creekside Three @ CenterPoint	**20435 72nd Ave. S. Suite 200,**	**Kent, WA 98032**

Subsidiary Organizational Unit or Division

Indicate if the applicant is a unit, division, or other component of a larger parent organization. If the applicant is part of a larger parent organization, complete each of the additional items in this section.

☐ Yes, applicant is part of a larger parent organization

☐ No, applicant is not part of a larger parent organization

Parent Organization Name

Address

Highest Ranking Official of Parent Organization

Title

Telephone Number

Indicate if other units within the parent organization offer similar products or services. If other units do offer similar products or services, please provide a brief explanation.

☐ Yes ☐ No

Briefly describe any major business support functions that are provided to the applicant by the parent organization.

Highest Ranking Applicant Official in the State of Washington

Name: **Mary Selecky**
Title: **WA State Secretary of Health**
Address: **Town Center 1**
101 Israel Road SE
Tumwater, WA 98501
Telephone Number: **(360) 236-4030**

Official Contact Person

Name: **Susan Ramsey, Director**
Address: **Town Center 1**
101 Israel Road SE
Tumwater, WA 98501
Telephone Number **(360) 236-4013** Fax Number: **(360) 586-7424**
E-mail **susan.ramsey@doh.wa.gov**

Fee

Enclosed is the eligibility fee. Make the check or money order payable to:
Washington State Quality Award.

Ethics

Answering "yes" to any of the following questions requires further explanation; however, this does not imply that the applicant will be automatically disqualified. Provide supporting explanations on a separate page that is included with this Eligibility Determination Form. A member of the Panel of Judges may contact the applicant for additional information.

Has the applicant been fined during the past five years for violating environmental laws?

☐ Yes ☒ No

Have any of the applicant's senior executives/corporate officers been convicted of a felony during the past three years?

☐ Yes ☒ No

Has the applicant been fined for income tax delinquency during the past three years?

☐ Yes ☒ No

Is the applicant currently in the process of bankruptcy proceedings?

☐ Yes ☒ No

Has your organization been convicted, settled or received sanctions or adverse actions under law (including malpractice, fraud, etc.) regulations, accreditation or contract in the past 3 years?

☐ Yes ☒ No

Are you aware of anything about your organization that would bring embarrassment upon the Washington State Quality Award or the Governor if your organization was to be publicly recognized?

☐ Yes ☒ No

Disclosure and Release Statement

I attest that the information provided in this Eligibility Determination Form and the Application to be provided is accurate and true to the best of my knowledge. Full disclosure of any circumstances that may negatively affect the Award has been made with the submission of the Eligibility Determination Form. I understand that the Award program may verify this information, and that untruthful or misleading information may result in forfeit of the Award. Furthermore, I certify that our organization is not engaged in any activity past or present that could be deemed embarrassing to the State of Washington, The Honorable Governor of the state of Washington or the WSQA. I understand that I must immediately notify WSQA if our status changes in any of these areas during the next 12 months and that I may be asked to revalidate this disclosure during the 12 months.

I also understand that members of the Washington State Quality Award Board of Examiners will review this application. I agree to host the Examiner team and facilitate open and unbiased evaluation of our organization if we are selected for a Site Visit. I understand that our organization will be responsible for paying all reasonable travel and related expenses for the site evaluation team.

I also understand that with the submission of our application, our organization commits to providing at least one individual from our organization as an Examiner in at least one of the following application cycles: the year prior to our application, this application year or the next application year.

Signature of Highest Level Organization Official

6/1/07

Date

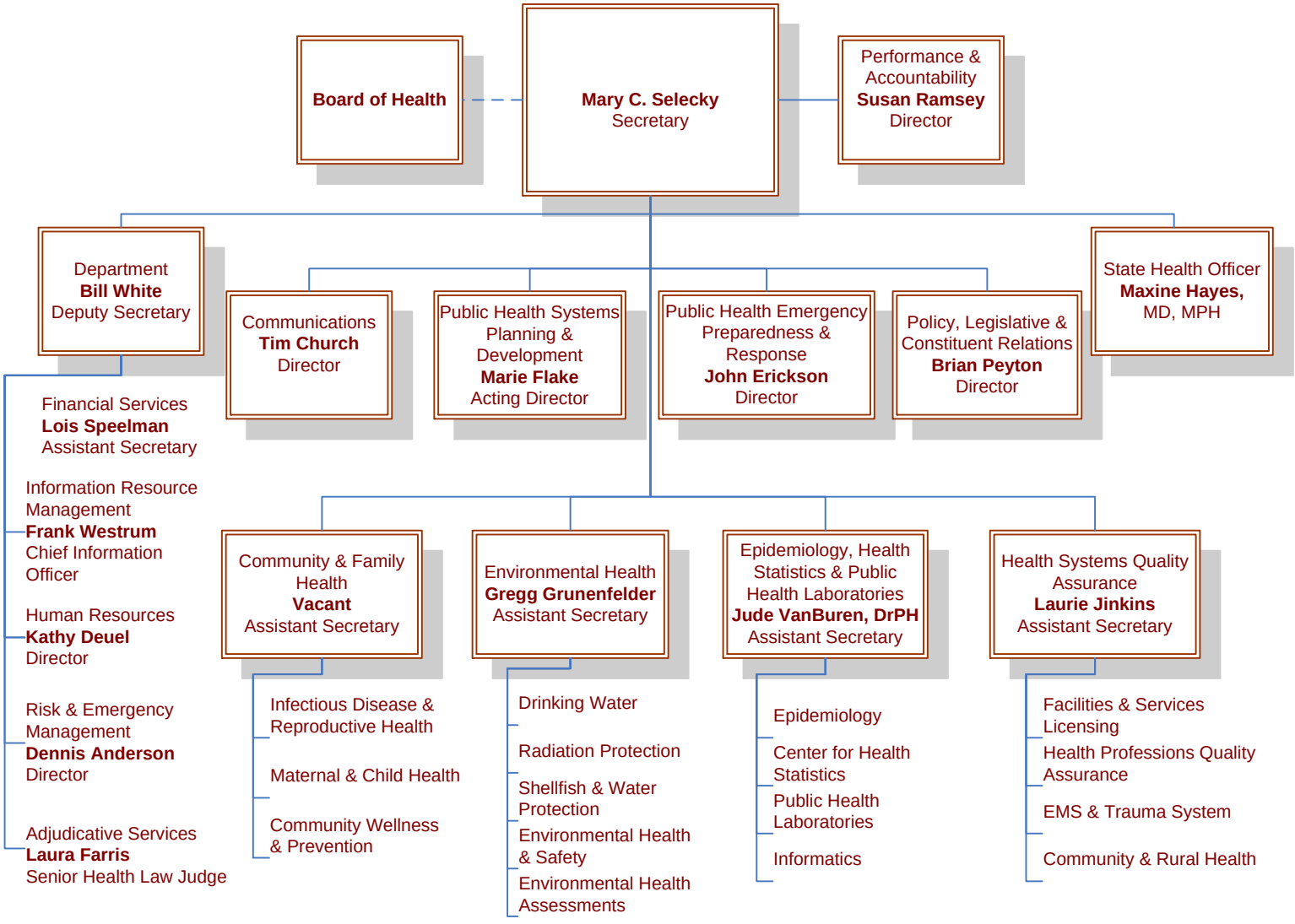
Name: **Mary Selecky**
Title: **WA State Secretary of Health**
Address: **Town Center 1**
101 Israel Road SE
Tumwater, WA 98501
Telephone Number: **(360) 236-4030**

Send these documents to:

Washington State Quality Award
P.O. Box 609
Keyport, WA 98345

P.2 Department Organizational Chart

Department of Health Organization



ITEM P: PREFACE: ORGANIZATIONAL PROFILE

P.1. ORGANIZATIONAL DESCRIPTION

Washington's Department of Health (DOH), or the department, was created in 1989 (Chapter 43.70 RCW). It is an executive branch agency of state government. The Secretary reports to the Governor and is accountable to the legislature and the people of Washington.

P.1.a. Organizational Environment

The department works with federal, state and local governments and non-governmental organizations to:

- improve and protect health in Washington.
- promote healthy behaviors.
- maintain high standards for quality health care delivery.

P.1.a (1) Major Services

Chronic Disease Prevention

Prevention is the cornerstone of public health. The department works through many channels to provide health promotion resources, materials, and evidence-based strategies to educate and inform the public on how to be healthy and prevent disease. We provide technical assistance in community planning with the goal of making the healthy choice the easy choice. Activities include tobacco prevention and control; promotion of regular physical activity and proper nutrition; chronic disease prevention and disease management strategies; cancer prevention and control; and cardiovascular disease prevention and control.

Drinking Water Protection

The Drinking Water program works with the State Board of Health, local water systems, and communities to make sure that drinking water is safe and reliable. Activities include monitoring water quality tests; conducting inspections of water systems; enforcing regulations and safety measures; assisting water systems during planning, design, and construction of new facilities and upgrades; training and certifying water system operators; ensuring proper wastewater treatment; and providing funding for water system improvements.

Public Health Emergency Preparedness and Response

Public health agencies play a key role in making sure our communities are prepared for emergencies. The department works with local health jurisdictions (LHJ), hospitals, emergency managers, tribes and others to help prepare our state for everything from natural disasters to bioterrorism threats. As part of this work, the department coordinates the development of state, regional, and local public health emergency response plans. We also work with emergency responders and others to provide training and exercises on topics such as mass vaccination and risk communication.

Community Environmental Health

The department works with public health partners and businesses to protect the community from hazards in the environment by educating the public about how to make and keep their environment safe and healthy. Some examples include developing environmental public health standards for small and medium-sized septic systems and swimming pools; helping the public prevent disease spread by animals; monitoring sources of radiation, radioactive materials, and radioactive waste; providing resources to clean areas that have been contaminated by dangerous materials; monitoring and preventing pesticide-related illness; and helping communities minimize or eliminate exposure to contaminants in the environment.

Shellfish and Food Safety

We make sure that food served in restaurants and other businesses is safe to eat. The department ensures that shellfish harvested from Washington waters is also safe to eat. Activities include monitoring local waters and beaches where shellfish grow for pollution and harmful toxins; developing public health standards for the safe sale and service of food; educating food service workers and the public on proper food safety; inspecting commercial shellfish companies; and investigating and controlling outbreaks of foodborne illnesses.

Strengthening the Public Health Systems

Washington's governmental public health system is decentralized, relying heavily on the day-to-day work of 35 local public health jurisdictions (county and multi-county agencies) and many additional partners such as emergency response teams, trauma response units, hospitals, community clinics, and tribal health services. The department maintains an active partnership and continuous communication with a range of public health decision-makers at all levels local, state and federal.

Family and Child Health and Safety

The department promotes regular health checkups for everyone and prenatal care for pregnant women. The department develops and disseminates educational materials that provide valuable information throughout the life span. Some of the most notable work is to distribute vaccines for children and investigate and control vaccine-preventable disease. We provide health promotion materials and consultation on the best strategies; provide nutrition and health education for pregnant women; and help thousands of state residents by providing healthy food through the Women, Infants, and Children (WIC) program. The department supports family planning and reproductive health services for women, men, and teens; linking children and families to health services; and providing programs to prevent injuries.

Public Health Laboratories

The department's Public Health Laboratories (PHL) serves the people of our state by providing accurate and timely laboratory results. The laboratories' around-the-clock, cutting-edge services are used by LHJ, DOH programs, and the state's health care and emergency response systems. The laboratories provide a broad range of tests including identifying communicable diseases, shellfish poisoning, foodborne illnesses, health issues in newborn babies, and contamination of air, water, and food that may endanger human health.

Access to Quality Health Care Services

All people in Washington deserve to be able to access quality health care, including pre-hospital emergency services. The department works with local health care professionals and services, and law enforcement and fire agencies to design, build, manage and improve systems to provide health care and emergency or trauma care. Examples include recruitment of doctors and nurses to underserved areas of the state; recruitment, training and certification of emergency medical personnel and trauma centers; and provide trauma quality improvement

programs to ensure best practices in emergency trauma care. Programs also work with providers, institutions and associations to integrate systems to increase access. A few programs pay for screening, referral and treatment services for specific conditions.

Patient and Consumer Safety

Patient and consumer safety are among the department's top priorities. The department works to ensure that more than 300,000 health care providers comply with health, safety, and professional standards through licensing, investigation and disciplinary activities. We provide information to health care facilities, health care professionals, consumers, and purchasers that allows them to make informed choices when delivering or receiving services. Other activities range from providing safe housing for farm and agricultural workers and their families to assuring laboratories meet standards.

Prevent and Respond to the Transmission of Communicable and Infectious Disease

The department works with many partners to protect people from communicable and infectious disease, including HIV/AIDS, sexually transmitted diseases, hepatitis, and tuberculosis. We educate the public on ways to stay healthy and avoid contracting and spreading disease. We monitor and track health trends as well as the rate and frequency of infectious disease. State health programs pay for drugs and limited medical care for eligible HIV clients and work with local health agencies to investigate disease outbreaks. The department also works with partners to prevent and reduce the effects of communicable diseases.

P.1.a (2) Organizational Culture

Vision, mission, values and leadership drive the organizational culture.

The department's **Vision** is reflected in the following:

- When people in our state need important health information, they will think of our agency first.
- We are public health leaders and innovators; we set the standard.
- Everyone in the department will share information and talents across programs and divisions with a common goal to better serve our customers.
- The public will better understand the important work of public health and its positive impact on their lives.
- We will be a department where the best people want to work, and once they are here they will not want to leave.

Mission: The Department of Health works to protect and improve the health of the people of Washington State.

These department **Values** guide our actions:

- Employees – We recognize that department employees are our most valuable resource; we encourage them to be innovative in their work to protect and improve the public's health.
- Cultural Competency – We seek diversity in our employees and recognize the value diversity brings in understanding and serving all people.
- Respect – We respect and value our employees, partners and the people of our state.
- Trust – We honor the public's trust and believe in working hard to maintain and improve that relationship.
- Communication – We strive for effective, responsive and timely communications in our role as a trusted source of health information.
- Collaboration – We encourage collaborative relationships between employees, partners and our communities working for a safer and healthier Washington State.

P.1.a (3) Workforce Profile

The following is a breakdown of our workforce of 1,493 staff. The majority of our employees work at the Tumwater campus comprised of four buildings. The 2006 consolidation of several different locations into one campus marked a major milestone for the department. Several programs and regional offices are also located in Kent, Shoreline, Richland and Spokane. We have two unions representing our employees. The Washington Federation of State Employees represents 1,098 and the Service Employees International Union District 1199 NW represents 36 staff. The department offers employee tuition assistance for continuing education, sick leave, annual leave, shared leave, long-term disability insurance, dependent care assistance program, deferred compensation, and tuition waivers. Employees expect a living wage, respect and a safe environment where there are opportunities for advancement.

The special health and safety requirements for employees vary depending on the area of work and their job responsibilities. We provide training for:

- respirator use;
- confined space;
- fall protection and ladder safety and
- bloodborne pathogens.

Our employee diversity is broad. Eighty-five percent of employees are non-minority, 43 percent of staff is over 50 years of age, 52 percent of staff has college or advanced degrees and 64 percent of staff are in the key job class of Professionals.

P.1.a (4) Major Facilities, Technologies and Equipment

Our main campus is located in Tumwater. We have a public health laboratory located in Shoreline and satellite offices in Richland, Kent, and Spokane.

The department's information technology environment consists of an infrastructure that connects all sites in a dual loop network to ensure network reliability and redundancy. We manage a main data center located in Tumwater that houses over 200 servers. A second data center is located at the Public Health Laboratories in Shoreline, Washington.

The department currently supports 30 internet applications for its business partners and the general public. We host an additional 30 internal web applications and support over 120 client server applications and databases. We also purchase hosting services from the Department of Information Services (DIS) for the Vital Statistics application, which provides birth, death and marriage records, and the CHILD Profile application, which collects immunization records.

P.1.a (5) Regulatory Environment

There are very strict state laws that protect health care information. The department complies with all of them, including the federal Health Insurance Portability and Accountability Act (HIPAA). Several state laws enable the department to do its work.

- *Title 43* establishes the Department of Health and defines its roles in health promotion, prevention, and general oversight over health planning and managing vital records.
- *Title 18* provides regulatory authority, rule making and discipline for over 62 health professions.
- *Title 41* addresses access to health care in rural and underserved areas of the state, and prescription drugs.
- *Title 69* allows control of pharmaceuticals, food and shellfish safety programs and medicines that could be used to make illegal drugs.
- *Title 70* covers licensing of health care facilities, control of communicable diseases and health promotion.

We also comply with Generally Accepted Accounting Principles (GAAP), as well as standards established by the Governmental Accounting Standards Board (GASB).

Two offices within the department are accredited by external organizations. The PHL has been accredited by the American College of Pathology for 35 years. The Food and Drug Administration (FDA), the Environmental Protection Agency (EPA), and the Centers for Disease Control Select Agent program (CDC) also accredit the PHL.

In its capacity as an employer, the department is also regulated by the Occupational Safety and Health Administration (OSHA), the Washington Industrial Safety and Health Administration (WISHA), the Washington State Department of Labor and Industries (L&I), the Internal Revenue Service (IRS), the Equal Employment Opportunity Commission (EEOC), and other employer regulatory agencies.

P.1.b Organizational Relationships

P.1.b (1) Organizational structure and governance system: As public health administrators, the department is at the center of a complex network of organizational relationships that impact the health of the public.

State

- ***Governor's Office*** – Establishes executive policy. Appoints the Secretary of the Washington State Department of Health.
- ***Legislature*** – Establishes policy in conjunction with the Governor through laws and budgets.
- ***Governor's Blue Ribbon Commission on Health*** – Studies health issues, develops policy proposals and makes recommendations to the Legislature. The Secretary of Health is a member of this Commission.
- ***State Board of Health*** – Studies health issues, develops policy proposals, develops rules, and makes policy recommendations to the Governor and the Legislature.
- ***Puget Sound Partnership*** – Representatives of the department are part of state agency advisory committee advising the Partnership on issues such as: toxic pollutants entering Puget Sound, storm water runoff, and nutrient and pathogen pollution.

Local

- ***Public Health Improvement Partnership (PHIP)*** – has an ongoing role to continuously improve public health services. Its leadership is shared by LHJ directors and the department's Secretary.
- ***Local Health Jurisdictions*** – Provide population-based services to the broader community (assessment, policy development, assurance through the enforcement of state and local rules, direct services, and referral of community members to medical care).
- ***Community agencies and providers –*** Provide direct services to residents in a variety of specific areas.

Federal

- ***Federal Agencies*** – Provide direction and funding for public health programs and services in Washington State (key federal agencies are Health and Human Services, Agriculture, and Department of Energy).

P.1.b (2) Key customers and stakeholder groups
P.1.b (3) Suppliers, partners and collaborators
P.1.b (4) Partnering relationships and communication mechanisms

The department has many customer, supplier, and partner groups that expect access to information to make effective decisions about public health. *(see Figure P.1, Department Key Customers, Suppliers, and Partners With Needs and Primary Communication Methods)*

Department staff meet as needed with these and other suppliers and partners to improve communication and discuss issues. Several conferences are convened annually to network. Moreover, the department maintains internet-based resources for these groups. This includes the main site at *www.doh.wa.gov* and popular applications such as the provider look-up, which allows anyone to view the disciplinary record of a health provider.

Each stakeholder, partner, supplier or advocate has a unique role and connection to the department's mission. Working together makes the systems stronger and the mission workable.

The department holds focus groups on varying topics, bringing in a wide array of participants for input. The Secretary meets with all local health jurisdictions and each of the Assistant Secretaries host open meetings with partners.

Management and program staff meet on a consistent basis with service providers and advocacy groups. Meetings occur frequently with individuals or groups to discuss changes to state law or rules.

P.2. ORGANIZATIONAL CHALLENGES

P.2.a Competitive Environment

P.2.a (1) Competitive Position

Funding – The public health budget increasingly depends on federal funds, where many health and social issues compete for money. *(see Figure 7.3b, PHEPR Funding Example)*

Human Resources – Approximately 5,400 people were estimated to work for state and local public health agencies in Washington in 2004. We compete for clinical staff against Washington State's health industry employers who are experiencing critical shortages of qualified, competent health care workers. Our annual turnover rate is 13%, which is low for an agency of this size.

P.2.a (2) Factors That Determine Success

How well the department performs public health responsibilities depends on how good we are at planning ahead, implementing new programs, operating our existing programs, openness to new ideas and continuous improvement. Prevention is the primary goal of the department. In order to remain competitive as a prevention organization, we must identify and respond to potential risks far in advance to prevent public health threats.

As an example, data is gathered and analyzed to support preventative approaches. Surveys are used to determine how many youth did not start smoking because of an anti-smoking campaign *(see Figure 7.1a, Smoking by 10th Graders)* or radiation is checked frequently to prevent illness *(see Figure 7.5b Percent of Radiation Inspections Completed With No Critical Violations)*. The department focuses on performance. For example, it reviews the number of children immunized each year and identifies ways to improve the rate. *(see Figure 7.1b, Immunization Coverage Rates 15 Dose Series [%])* Factors that determine success include qualified and competent staff, effective partnerships, proper advanced strategizing, planning and implementation, and appropriate funding.

During the past five years, public health agencies across the nation have been asked to make emergency preparedness a top priority.

The department has taken a comprehensive partnership approach to preparing for disasters. Planning goes beyond working with traditional first-responders and includes tribes, schools, businesses, border states, British Columbia and others. These partnerships will lead to more efficient and effective responses in disasters with significant public health consequences.

P.2.a. (3) Comparative Information

There are several ways the department and Washington residents can compare themselves against national benchmarks, other state agencies or other states.

The Healthy People 2010 is a set of health objectives for the nation to achieve over the first decade of this century. It was developed through a broad consultation process, built on the best scientific knowledge and designed to measure programs over time. There are ten leading health indictors that have one or more objectives associated with it. The leading health indicators were selected on the basis of their ability to motivate action, the availability of data to measure progress, and their importance as public health issues. The leading health indicators that we use to compare ourselves to are:

- physical activity;
- overweight and obesity;
- tobacco use *(see Figure 7.1a);*
- substance abuse;
- responsible sexual behavior *(see Figure 7.1d);*
- mental health;
- injury and violence;
- environmental quality *(see Figures 7.5a, b, and c);*
- immunization *(see Figure 7.1b)* and
- access to health care *(see Figure 7.2c)*

The department also compares our employee diversity with other state agencies in five major diverse categories. *(see Figure 7.4a, Diversity)*

P.2.b Strategic Context, Strategic Challenges and Advantages for Accomplishing our Mission

Department Challenges

1. ***Improving the health status of people in Washington***
   - Washington's childhood immunization rates are below the national average.
   - Diabetes is increasing among children and adults.
2. ***Improve public health system accountability and responsiveness***
   - Unethical or incompetent health practitioners continue to pose a danger to patient safety.
   - Increasing global travel means that diseases such as drug resistant strains of tuberculosis, Severe Acute Respiratory Syndrome (SARS), or avian flu can spread rapidly to Washington State from other parts of the world.
3. ***Fiscal accountability***
   - Getting the most out of technology continues to be a challenge.
   - Unstable funding. (*see Figure 7.3b, PHEPR Funding Example*)
4. ***Hire, develop and retain a competent and diverse workforce***
   - The graying of the workforce with 43 percent of employees over the age of 50. *(see Figure 7.4a, Diversity)*
   - The demand for services is increasing and the greater workload is demanding more from employees.
5. ***Improve department performance by increasing the use of performance management tools***
   - There is a growing movement to increase accountability in the public sector through performance measures. Wherever inefficiency is found, there is a demand to resolve it through quality improvement initiatives. The benefits of increased accountability include demonstrated performance, identification of opportunities and increased public confidence.

The above challenges are compounded by unstable funding and increased competition for funding. They are also exacerbated by the need for clarity of roles as three entities make up the public health system: the department (DOH), the State Board of Health and LHJ. Responsibilities are diffused and accountability decentralized.

Department Advantages

The department also has some important assets. These advantages include its senior leadership. Both the Secretary and State Health Officer are well-respected statewide and nationally.

The department has a national reputation for quality programs. The Public Health Improvement Plan is described by the Centers for Disease Control and Prevention as a national trendsetter. Affiliations with the 35 local health jurisdictions, 16 boards/ commissions, numerous advisory bodies, and professional associations add to the department's resource base. The highly educated and trained workforce is also an asset as the public health employees are both committed to and passionate about their mission.

P.2.c Performance Improvement Systems

The department has several systems in place to track performance of operations, initiatives and employees. These include:

- The Senior Management Team (SMT) has chartered a Quality Improvement Committee to review quality improvement proposals and provide guidance to project leads. This committee tracks projects and reports to the SMT quarterly.
- Public Health Improvement Partnership – This initiative is a joint venture with Local Health Jurisdictions (LHJs) to periodically assess public health program performance against established standards.
- Government Management Accountability and Performance (GMAP) and Health Management Accountability and Performance (HealthMAP) sessions use data to drill deeply into chronic management problems, fully understand processes, showcase improvements, lessons learned and determine the best course of action quarterly.
- Performance Accountability Liaisons (PALs) – This workgroup is the collaborative effort, with representation from all divisions within the department, to provide a link to employees within each division communicating changes in policy, strategic direction, and performance management.
- The department and each of the divisions develop strategic plans. Quarterly results are expected for agency, divisional and Office of Financial Management (OFM) reporting.

Figure P.1 Department Key Customers, Suppliers, and Partners, With Needs and Primary Communication Methods

Type of Groups	Customer/Supplier/Partner Group Examples	Respective Needs	Communication Methods
Private Sector	Hospitals, health care providers, laboratories, public water suppliers, shellfish industry, restaurant industry, septic installers, agriculture industry	***Theirs:*** Provide technical assistance, funding, training ***Ours:*** Provide technical assistance, develop policies and practices to improve health outcomes	Public hearings, DOH Web site, meetings, written correspondence, surveys, seminars, teleconferences, survey feedback, site visits
Advocacy	People for Puget Sound, Washington Toxics Coalition, Children's Alliance, Disease Associations, Washington Federation State Employees, Service Employees International Union District 1199 NW, Washington Health Institute, Washington Environmental Council	***Theirs:*** Provide support community-based efforts in disease areas for awareness, screening and control; DOH employee support ***Ours:*** Identify perspectives of customer specific issues, develop strategies and health promotion messages, create positive working relationships in a full collective bargaining environment that further management rights and responsibilities to meet the agency's mission and goals	Focus groups, telephone, written correspondence, publications, meetings Telephonic, and Union Management Communication Committee meetings, formal collective bargaining sessions we participate in every two years
State	State Board of Health, Department of Ecology, Attorney General, Department of Social Health Services, Department of Fish and Wildlife, Department of Information Services, Office Superintendent of Public Instruction, State Auditors Office, Emergency Management Division, General Administration, University of Washington	***Theirs:*** Provide technical assistance, coordinate issues, share best practices, develop state-level plans to provide comprehensive services ***Ours:*** Provide technical assistance, communicate issues, share best practices	Focus groups, teleconferences, written correspondence, meetings, DOH Web site, publications, workgroups
Local/County	35 LHJs, local boards of health, county/city governments, public utility districts, water and sewer districts, mosquito control districts, law enforcement, fire protection, schools	***Theirs:*** Provide technical assistance and funding, shape public health policy ***Ours:*** Provide technical assistance, accountability, communicate issues about local county needs and unique demographics	Site visits, surveys, teleconferences interviews, listservs, committee work-groups, e-mail, meetings, forums, publications
Tribal	29 tribes, Indian Health Commission, NW Portland Indian Health Board, NW Indian Fisheries Commission	***Theirs:*** Provide technical assistance, consult at policy level ***Ours:*** Provide technical assistance, communicate issues and be effective partners by supporting joint efforts related to tribes	E-mail, listserv, written correspondence, telephone interviews, surveys, forums, publications
Professional Associations	WA State Hospital Association, Healthcare Provider Associations, National/Washington State Association of Counties, WA State Association of Local Public Health Officials, Public Health Executive Leadership Forum	***Theirs:*** Communicate public health issues, consult at policy level ***Ours:*** Provide share members' positions, share information with members, negotiate on behalf of members	E-mail, listserv, written correspondence, telephone interviews, surveys, forums, meetings, publications
National/Federal	Centers for Disease Control, Health and Human Services, Food and Drug Agency, Environment Protection Agency, U.S. Department of Agriculture, Nuclear Regulatory Commission	***Theirs:*** Communicate state issues, request assistance, support federal activities ***Ours:*** Communicate regulations, requirements of programs, federal issues that have local impacts, and provide technical assistance	E-mail, listserv, written correspondence, telephone interviews, surveys, forums, meetings

1. LEADERSHIP

Our Secretary leads and oversees the department with the assistance of the SMT. In turn, the SMT leads and oversees with the assistance of our Chief Administrators' Group (CAG) and the Program Management Team (PMT). The SMT serves as a catalyst for results and change and sets department strategic direction; the CAG directs business and operational functions; the PMT leads the work of major programs and is held accountable for our strategic plan through specific public health standards, goals, objectives, performance measures, and action plans *(see Figure 2.1, Key Strategic Objectives and Action Plans).* With these defined roles, all three leadership teams translate our strategic plan into an agency working plan.

1 a. Our senior leaders set and deploy vision and values throughout the organization, workforce and stakeholders

The SMT revisits, reaffirms and refreshes the department's vision, mission and values during our biennial strategic planning process (most recently, November 2007). Senior leaders crosswalk our strategic plan with the vision, values and expectations of our Governor, customers, stakeholders, partners and employees. Our senior leaders take an enterprise, holistic, approach to strategic planning that considers the multiple intersections of public health, emerging issues, and the specific needs and expectations of our varied customers *(see Figure P.1, Department Key Customers, Suppliers, and Partners and 2.c. Development and Deployment of Action Plans to Achieve Key Strategic Objectives).*

PMT members work to leverage the potential of every office manager, program director and front-line employee through department and division-linked strategic plans with the day-to-day demands of "working for a safer and healthier Washington" *(see Figure 6.1, Key Work Processes).* Division leaders strive to create an accountable, performance-based culture that demonstrates progress toward achievement of our mission and strategic objectives. Throughout the department, individual performance expectations are tied to our strategic plan and evaluated yearly.

Department leaders personally communicate organizational mission, vision and values to staff, key customers and partners to align and implement our strategic plan through:

- quarterly PMT training sessions;
- quarterly dialogues with the Governor's senior staff and Cabinet (GMAP) *(GMAP, HealthMAP, see P.2.c, Performance Improvement Systems);*
- quarterly internal interactive discussions with the SMT, PMT and front-line staff (HealthMAP); and
- monthly, weekly and daily meetings, and communications between program staff, key stakeholders and program partners.

Our leaders model the department's mission, vision and values, and their behaviors set the standard across the department.

Our leaders model the department's mission, vision and values, *(see P.1a (2) Organizational Culture)* and their behavior sets the standard across the department. Leaders' performance and development is driven by a set of core leadership competencies linked to the department's mission and referenced during hiring, evaluation (by management, peers, employees), and advancement *(see Figure 1.1,* DOH *Leadership Core Competencies).*

Figure 1.1 DOH Leadership Core Competencies

Washington State Department of Health Leadership Core Competencies

Leaders coach, inspire and motivate staff and others to accomplish our agency mission. A quality leader:

- delegates responsibility with associated authority.
- promotes a cooperative work environment.
- sets clear, reasonable expectations and follows through.
- determines and models when and how to include risk taking in strategic actions.
- facilitates development of shared mission, vision, and key values and uses those principles to guide actions.
- creates a culture of ethical standards.
- empowers others to take action.

Our mission, vision and values are an integral part of the selection process for staff members, partners, and potential joint ventures. They also serve as the foundation for new staff orientation *(see 5.2.a Workforce Capability and Capacity).*

1 b. Our senior leaders employ a governance system to ensure regulatory and legal compliance and to ensure ethical behavior

Senior leaders are held accountable for the department's actions and performance through:

- Quarterly internal (HealthMAP) and external (GMAP) reviews. These discussions intersect the department's strategic plan with emerging concerns such as patient safety issues among department-licensed health professionals. HealthMAP and GMAP discussions include learning through the identification of gaps and changes that need to be made to achieve our desired results.
- Policy development, such as federal communications in accordance with the Office of the Governor (Policy #05-001).
- Independent financial, operational, and performance audits performed by the State Auditor's Office.
- Internal audits such as monitoring the use of IT equipment, software and state vehicles.
- Quality initiatives, such as working to improve our contract and procurement process.

- Additional performance improvement systems and learning cycles as noted in *P.2.c Performance Improvement Systems and Category 2.c Development and Deployment of Actions Plans to Achieve Key Strategic Objectives, "we identify gaps and changes that need to be made."*

Department senior leaders recognize they must be trustworthy and ethical individuals to engender trust in others. The department has a strict zero-tolerance policy for unethical or illegal activities by any employee. This policy, in concert with state and federal laws, and guided by the state Executive Ethics Board, drives department ethic standards. Based on the nature of their work, employees attend mandatory, targeted training such as technology use, HIPPA, and the rights of public health research subjects as required by the Washington State Institutional Review Board (WSIRB). Annually, staff members review and (re)certify their understanding of ethics and confidentiality standards. The department maintains a system of internal controls to protect department assets that includes routine physical inventories and documented procedures to safeguard property. If violations occur at any level, formal procedures (as outlined in Ethics Policy 07.015) are followed to correct the behavior and apply appropriate disciplinary action.

2 . STRATEGIC PLANNING

Strategy Development and Deployment

2 a. Key Strategic Objectives and Action Plans

Figure 2.1, *Key Strategic Objectives and Action Plans* describes our key strategic objectives and action plans. The strategic objectives are directly linked to the mission of the department to protect and improve the health of the people of Washington and are linked to the challenges identified in our organizational profile *(see P.2.b, Strategic Objectives, Challenges & Advantages).* We use our strategic planning process to identify the key objectives. The balanced score card approach was integrated in 2003, and accountability was strengthened through the implementation and evaluation processes added in 2005 *(see 2.c, Development and Deployment of Action Plans to Achieve Key Strategic Objectives).*

2 b. Strategic Objectives, Challenges and Advantages

Our strategic advantages and challenges are identified through the strategic planning process. The objectives and strategies in our plan are selected to address key challenges and to take advantage of our significant role in the public health system for policy development and implementation. Our plan is reviewed and updated every two years as part of the state budget process. *Figure 2.1, Key Strategic Objectives and Action Plans* shows the linkages to our strategic challenges and references to Category 7 for our results.

2 c. Development and Deployment of Action Plans to Achieve Key Strategic Objectives

The process for identifying and implementing action plans has evolved during the last year. In prior biennia, we developed a strategic plan but fell short in implementing action plans and reporting on the results. That process changed in 2006 as we increased our emphasis in the areas of management accountability and performance.

In 2006, as part of the implementation process for our strategic plan, the SMT and program management teams reviewed the action plans for each objective and designated a leader for each plan at the division level. The leader worked with program staff to integrate the strategic plan into day-to-day work. They identified the tasks, established the timelines and developed an implementation plan.

Performance measures were developed as part of the strategic planning process. However, as part of our recent emphasis on accountability, results are now reported quarterly to SMT through the HealthMAP process. As part of the results reporting, we identify gaps and changes that need to be made. Timelines for implementing changes are developed and results are reported at the following HealthMAP session.

Figure 2.1 Key Strategic Objectives and Action Plans

Goals and Key Strategic Objectives	Strategies (Action Plans)	Development & Deployment Through Strategic Measures (see Category 7)
1. Improve the health status of people in Washington State		
People have information they need to prevent disease and injury, manage chronic conditions, increase healthy behaviors, and make healthy choices.	• Increase healthy behaviors. • Reduce communicable diseases and the impact of chronic disease by targeting interventions that work.	**Tobacco Use:** Reduce the rate of smoking by 10th graders. *(see Figure 7.1a)* and tobacco quit line calls *(see Figure 7.2a)* **Immunizations:** Proportion of children who receive all recommended vaccines 15 dose series *(see Figure 7.1b)* **Chlamydia:** Chlamydia rates in Washington *(see*
All people have an equal opportunity to	Increase the number and type of	

Goals and Key Strategic Objectives	Strategies (Action Plans)	Development & Deployment Through Strategic Measures (see Category 7)
be healthy.	interventions designed to improve equal opportunity to health.	*Figure 7.1d)* **Shellfish Operations:** Inspections of shellfish operations with no critical deficiencies *(see Figure 7.5c).* Reopen acres closed to recreational and commercial shellfishing *(see Figure 7.5c)* **Radiation:** Radiation inspections completed with no critical violations *(see Figure 7.5b)*
2. Improve public health system accountability and responsiveness		
Create access to Quality Health Care Services.	• Recruitment of practitioners for Medicaid and underserved rural areas • Improve average wait time in call center.	**Medicaid and Underserved Populations:** Providers serving Medicaid and underserved populations *(see Figure 7.2c)* **Call Center:** Annual average wait time HSQA call center *(see Figure 7.2b)*
Public health standards are used to make the system more efficient and effective.	Assess state and local performance against the public health standards every three years.	
3. Make every dollar count		
Focus agency resources on public health priorities.	Contain costs: Dollars are maximized through cost containment strategies and activities that reduce the cost to the health care system.	**HIV:** Increase the number of HIV clients accessing private insurance *(see Figure 7.3a)*
Improve the quality, availability and use of data to inform the public and design public health programs.	Provide the public, public health partners and other organization information and data as it becomes available.	
Assure that public health interventions are designed using best available evidence.	Maintain surveillance and reporting systems to identify health threats.	
4. Hire, develop and retain a competent and diverse workforce		
Employees reflect the diversity of Washington.	Develop recruitment strategies to ensure diverse workforce.	**Diversity:** Percentage increase in diversity of applicant pool *(see Figure 7.4b)*
5. Improve agency performance by increasing the use of performance management tools		
Develop and execute an annual agency wide quality improvement program.	• Each division will have at least one element within the quality improvement plan. • The agency will review and establish quality improvement priorities at least twice per year.	**HealthMAP:** The Senior Management Team tracks changes in performance measure for key areas at least quarterly and uses the information provided to drive improvement in those measures. *(see charts in Category 7)*
Increase the use of GMAP and other data driven management tools throughout the agency.	• Each division will use GMAP or other tools to identify and drive improvements. • The senior management team uses GMAP and other data driven management tools to track and improve performance.	

3. CUSTOMER AND MARKET FOCUS

Customer and Market Knowledge

The department is home to approximately 200 programs. Each program has specific requirements based on federal and state mandates and are aligned to our strategic plan. Due to the nature of health related programs and our vision and mission, key customers and customer groups vary greatly (*see Figure P.1, Department Key Customers, Suppliers, and Partners*). Often a relationship will rotate between roles – customer, stakeholder, partner – depending on an issue or need. Customers are considered partners in the work that DOH conducts. These relationships are collaborative and mutually beneficial to support our mission, "The Department of Health works to protect and improve the health of people in Washington State".

3 a. Our Key Customers and Customer Groups

In the majority of our programs, a list of customers is prescriptive, based on federal and state requirements *(see Figure P.1, Department Key Customers, Suppliers, and Partners* for segmentation*)*. However, programs have the freedom and are encouraged to go beyond the recommended lists and include appropriate customers/partners based on the demographics of intended impact. This process includes but is not limited to full analysis of health data, public forums, targeted publications, surveys and partner recommendations. Nationally and state sponsored surveys such as the Behavioral Risk Factor Surveillance System (BRFSS) and Pregnancy Risk Assessment Monitoring System (PRAMS) are examples of evidence based reports that we use to determine significant health concerns in the population and determine appropriate target audiences for interventions. Often times, presumed unrelated interested parties express expectations or needs of programs and thus, are added for a more comprehensive approach to the programs' work and missions.

3 b. Requirements, Needs and Expectations of Our Customers

Gaining a solid understanding of our customer needs is determined through a variety of methods *(see Figure P.1, Department Key Customers, Suppliers, and Partners* for communication methods*)*. Depending on the type of program and target customers, certain methods are more appropriate than others. The best way to understand a customer's needs and expectations is to ask the right questions and take the time to listen. We engage with our customers on the telephone, in person, through correspondence and via the Web. A customer always has the option to quickly reach an actual person, not a recording. For example, two programs use call centers to address customer needs: the Tobacco Quit Line and the Health Services Quality Assurance (HSQA) centralized call center. They both illustrate the cycle of determining customer needs and resulting quality improvement to develop an efficient and useful tool for customers *(see Figure 7.2a, Tobacco Program Quit Line and Figure 7.2b, HSQA Call Center Progress to Meet One-Minute maximum Wait Time Target).*

The best way to understand a customer's needs and expectations is to ask the right questions and take the time to listen.

After determining the target audience for the tobacco quit line to be insured, uninsured and underinsured smokers, the program developed a counseling approach that would work for all groups. Based on market analysis to determine audience needs, the counseling approaches for the two audiences are slightly different. The uninsured and underinsured callers receive more counseling calls and a four-week supply of nicotine therapy. The insured callers receive one counseling call, a smaller therapy package, and are connected to their insurance provider for further counseling. This two-pronged strategy is consistent with our mission and values to provide services to the people of Washington.

To make the HSQA call center more efficient, the department hired a consultant in 2002 to conduct market research and evaluate the existing call centers within the division. Each individual professional program had a call center that served the same functions, such as license renewal and updated education credits. Upon completion of the analysis, the program followed the recommendations to centralize these redundant functions into one call center. Now all health care professionals licensed by the department can access one number to accomplish these functions. Not only was the system simplified but caller confusion regarding which number to call was drastically reduced. This improvement was noted by callers, and the system is continually evaluated for further improvement opportunities. Recently the phone announcements were shortened and re-ordered based on customer feedback. This simple solution resulted in quicker navigation of the call system and shorter calls.

3 c. Building and Maintaining Relationships with Our Customers

One of our primary customers are LHJs; maintaining these relationships is vital in carrying out our mission and vision. We have identified local health liaisons within the agency. These liaisons are tasked with maintaining the relationship with LHJs and further developing the knowledge base about this customer group and the various subsets. Liaisons serve as well-known and easy-to-locate points of contact for the LHJs when they have questions or concerns. These individuals maintain a steady and helpful presence through continued communication via email, conference calls, meeting attendance and site visits. Liaisons often consult, coordinate, edit and triage communication from the department. Department liaisons meet internally to share information and identify and address broader system issues such as customer needs and program gaps to be addressed. They are seen as trustworthy brokers and problem solvers. The LHJs find the liaison network to be a successful and useful tool in conducting everyday public health work.

Recent emphasis on preparedness activities has challenged us to develop and maintain relationships with customers that are not traditionally considered health customers. Based on federal requirements and the state's need for subject matter experts, first responders and emergency preparedness planners (inside and outside of Washington) are now our customers. This successful effort with new customers is best described in our annual Cross-Border workshops with our Canadian partners. Workshop workgroups are an ongoing priority to determine the coming year's objectives for the workshop. This is done through feedback, careful observation and agreed upon gaps and needs. These workgroups consist of all the customers who meet regularly prior, during and after each workshop. This attention to planning based on needs and gaps has led to an increased awareness of the public health preparedness work, increased numbers of participants and increased satisfaction in partner development and workgroup objectives (*see Figure 7.2a, Tobacco Program Quit Line and Figure 7.2b, HSQA Call Center Progress to Meet One-Minute maximum Wait Time Target*). Our workshops are considered national best practices by the U.S. Centers for Disease Control and Prevention (CDC).

4. MEASUREMENT, ANALYSIS AND KNOWLEDGE MANAGEMENT

Since 2001, the department has used a strategic planning process to identify key challenges and to measure those challenges in order to drive organizational performance. The department's HealthMAP process identifies additional challenges, objectives and measures. We measure and analyze data quarterly; compiling the results so senior leaders can revisit organizational challenges and improve performance.

4 a. How do you measure, analyze and then improve organizational performance?

The department uses the strategic planning process described in Category 2; Strategic Planning, to identify key strategic objectives and challenges. We have established specific intermediate objectives for 2007-2009, which are designed to help meet long-term goals *(see Figure 2.1, Key Strategic Objectives and Action Plans).* These objectives are interim markers toward reaching our goals and are supported by efforts described in the accompanying actions and measures. The strategic plan reaches into the variety of programs throughout the department and includes measures of organizational performance from them. Staff update measures quarterly with current data and analyze results. Senior management reviews the trends and determines if a change in implementation is required. Depending on the measure, they may use a multi-team approach, external evaluation or enhanced management oversight to institute change. The current measures reflect the refinement and learning from previous strategic planning efforts. Since 2001, we have reduced the number of measures and changed them to more closely align with desired outcomes for public health priorities.

We use the HealthMAP process to supplement our performance improvement activities. We first used the Governor's GMAP in 2005 to measure the performance of the health care disciplinary system. Since then, we have refined our own version in HealthMAP and deployed the practice throughout the department. The process identifies organizational priorities, sets a culture of accountability, resolves barriers to action, and through relentless follow up, drives performance improvement. Measuring performance is an integral part of HealthMAP. Offices throughout the department give the SMT quarterly updates which are placed on the agency intranet and available to all staff.

The department also serves as a major source of public health data used at the local and state level to make data-based decisions and determine health priorities for the state. Through publications like the Health of Washington (a statewide assessment of health status and health risks), the Vital Statistics report, the Communicable Disease report and programs like the Cancer Registry, and the Childhood Lead Registry, we use statistical methods to identify health concerns and make data available to health policy makers, local and state government, researchers, the media and other interested people. Data collected by the department is invaluable to agency senior management in determining public health priorities.

4 b. What are your key organizational performance measures?

(see Category 2, Strategic Planning, Figure 2.1, Key Strategic Objectives and Action Plans)

4 c. What comparative data do you use to support decision-making and evaluate organizational performance?

The department has contributed to the development of statewide standards for the delivery of public health since 1995, through the PHIP. The revised 2006 PHIP includes standards on measuring health, public health system capacity and public health indicators. The department assesses its compliance against these standards every three years: 2002, 2005 and 2008.

Business needs are aligned with program, division and agency organizational purposes.

The department also compares public health in Washington to national standards through the Healthy People 2010. Healthy People 2010 builds on initiatives pursued over the past two decades. The Healthy People 2010 has been adapted to reflect improvements in methodology and changes in the focus of public health policy.

5. HUMAN RESOURCE FOCUS

5 a. How do you determine key factors that affect your workforce's commitment to accomplishing your organization's mission and how do you assess workforce engagement?

The department engages our workforce through committed leadership and focus on our public health mission.

We begin with Human Resource (HR) professionals working with supervisors to identify key skills sets for each position that fit the business function(s) needs. Business needs are aligned with program, division and agency organizational purposes. All of this is in the context of continuing to refine our implementation of Civil Service Reform since the passage of the Personnel System Reform Act in 2002. This reform significantly changed how state government manages its workforce.

Once identified in the position description form, key skill sets are used in the recruitment process. Recruitment announcements include the key skills sets and a short description of how this position fits within the agency organizational structure. They are also integrated into the screening and hiring process. We take care to identify the variety of outreach sources to create diverse and competent candidate pools. Once finalists are identified, reference checks based on the key skill sets and experience unique to the individual help the hiring authority make an informed hiring decision.

Supervisors orient new employees in the department's mission and how their position fits within that mission. A key element of orientation is a collaborative process between the supervisor and employee to identify performance expectations and a supportive training and development plan for the new employee. Using this base throughout the performance timeframe results in an annual assessment of performance for all department employees. This process allows for two-way communication and sharing of meaningful feedback on performance, achievement, and career goals.

We use HR data and demographics to identify the influences on our workforce. Particularly, we track turnover statistics, termination trends, and diversity demographics to identify what our workforce looks like *(see Figure 7.4a, Diversity)*. We use exit interviews and a biannual employee survey to gauge the 'temperature' of our workforce.

The data we track shows retention trends, retirement eligibility and actual reasons for leaving the agency. We use this information to identify the 'graying' or 'youthfulness' of the department. The information is used to train supervisors and managers about interacting effectively with staff. It points out 'hot spots' that require specific attention and intervention.

The response from exit interviews and the employee survey provides general reactions about how engaged staff feel with their current work environment. The feedback includes snapshots in time about how staff feels about their relationship with their supervisor, whether they receive the training or support they need to do their job duties, whether they know how their work fits within the organizational purpose or mission and do they receive recognition for the work they do. All are indicators of workforce engagement.

The department has been organized in a union environment since 2003 with two separate unions representing about 85% of the staff. We have few grievances filed (five filed in 2007). The data is used to identify problems that could impact workforce engagement. So far, the only identifiable pattern is that all were resolved within the department with none going forward to arbitration. Our successful use of this process to identify and then influence change shows the department's commitment to workforce enrichment.

In reviewing these key factors we noted that turnover averaged 9.64% over the past three years, from an annual high of 10.23% to a low of 8.72% as of December 1, 2007. Turnover does not appear to be an overall issue for the department, although we are working to identify challenges in specific job groups and any projected retirement impacts. In the past, retirement eligibility has not been an indicator of workforce turnover. With the Baby Boomer's coming of age in the next five years, we may see increasing retirements, depending on a variety of influences: high medical coverage costs, better health, Social Security changes, Medicare/Medicaid changes, etc. Termination trends, on an average for the past five years, show that of those leaving the agency, 18.85% moved to positions within state government, 69.33% moved outside of state government and 11.82% retired. This information helps us determine that our primary 'competitor' is outside of state government, probably local health jurisdictions and other public health entities.

The statewide employee survey was started in 2006 and is given every two years. We participate in the statewide survey, which has 13 standard questions that rate the level of employee satisfaction, commitment, and performance and accountability. The survey was conducted during October/November 2007 and the results were shared with agency management in February 2008.

Divisions use this feedback as they develop their strategic plans and performance measures.

Our department executive leadership works with each of our diverse organizational entities to develop meaningful staff recognition, performance development and planning. This approach is intended to foster a positive environment in the context of cohesive workforce management tailored to each specific work place culture. For instance, HSQA with their regulatory mission is much more task and results oriented. The division of Community and Family Health (CFH) with their work building healthy families is much more

relationship oriented. Recognizing those culture differences is key to building effective work environments.

At the agency level, we have established performance and development planning (PDP) and assessment tools and guidelines for how to use the tools effectively. This is a statewide focus that the department shares. Discussions have centered on how to use the tools and making the process more effective. The Office of Financial Services will pilot an annual approach, preparing all expectations and training plans for their staff by January 1, 2008, and then assessing performance during November 2008.

Creating our Health and Productivity Program shows the broad approach the department has taken to create a healthy workplace. Executive leadership actively sponsors three focus areas: Assessment & Evaluation; Policy, Systems & Environmental Practice; and Health Promotion & Programs. We have a sustainable structure and system to engage staff at all levels so that the different focus areas are responsive to staff needs.

Our Return to Work program has eliminated the backlog of worker's compensation claims and is working so well that there are no time loss claims submitted to date in 2007 *(see Figure 7.4c, Time Loss Claims*). Working with Safety staff, we have also achieved a significant reduction in time loss payout. The 2007 payout is less than $10,000, compared to nearly $300,000 during 2006 by working to keep employees in their jobs, with or without temporary adjustments *(see Figure 7.3c, Worker's Compensation Claim Costs)*. This effort clearly shows commitment to staff safety and providing a safe and healthy work environment.

5 b. How do you assess your workforce capability and capacity needs, including skills, competencies and staffing levels and how do you manage your workforce capability and capacity to accomplish your performance objectives?

The Civil Service System framework uses job classifications that have identified requirements. The department details job duties and responsibilities in the Position Description Form (PDF) and essential functions are identified in the Job Assessment (JA). We use these documents to assess staff resources for program business needs that are aligned with our division and department strategic plans. This alignment is critical to building decision packages to request staff and funding resources. All materials are used to help us effectively recruit, screen and hire competent staff. Skills such as critical thinking and analytical problem solving are emphasized so that staff can promote a learning environment of continual improvement to be responsive to changing business needs.

The organizational profile *(see Figure P.2, Department Organizational Chart)* shows the department is structured to meet the diverse program and business needs to support public health in the State of Washington. Divisions address specific public health program areas and are led by an Assistant Secretary or Office Director.

6. PROCESS MANAGEMENT

6 a. How do you design your work systems? What are your organization's key work processes, and how do you determine the key work process requirements for each process?

The SMT, CAG and HR identify and design many of the key business and support processes. Because much of the key work is funded through grants, there are also many processes that are developed by managers and staff through conversations with grant officials or advisory committees.

Since 2006, quarterly GMAP sessions with the Governor and internal HealthMAP presentations have occurred. The focus is internal and external key issues, and processes may be reviewed, revised and introduced.

Consumers and clients are queried about the services they receive and that information is used to make improvements. The SMT receives reports and feedback from financial and performance audits, from site visits of granting agencies and from contractors regarding the services the department provides. The Public Health Standards review is another major source of input into the department's performance. The review is conducted at both the state and local level every three years. This information is used to analyze the key processes and identify opportunities for improvement.

Another strategy for monitoring processes is with cross-agency workgroups. They provide monitoring and oversight of processes on a regular schedule and make recommendations to the SMT. These groups also communicate adjustments and revisions to the deployment throughout the department. An example is the production of "The Health of Washington State" report. It is produced through a cross-agency workgroup that identifies the issues, data and analysis. This work is monitored by assessment staff and the department Assessment Operations Group (AOG) that assures the quality of the final product.

6 b. How do you implement, manage, and improve your key requirements and to achieve better performance and meet key requirements? What are your key performance measures or indicators and in-process measures used for control and improvement of your processes?

The key work categories are continually reviewed in conjunction with the budget processes, grant applications and the strategic plan. A ranking system has been used in the past to identify the priority of each of the key work categories; this is done with the PMT of the organization. Figure 6.1 shows the measures used to monitor the key work processes, and identifies areas for improvement. Individual management teams meet regularly and are responsible to identify improvement strategies. They manage the day-to-day operations as well as progress toward stated goals.

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Figure 6.1Key Work Processes

Key Work Categories	Key Work Processes	Measures Used to Manage Work Processes
Chronic Disease Prevention	• Identify diseases causing death	• Percent of 10th graders who reported smoking in the last 30 days *(see Figure 7.1a)* • Number of calls to the Tobacco Quit Line *(see Figure 7.2a)*
Shellfish and Food Safety	• Food served in restaurants and other businesses is safe to eat • Shellfish harvested from Washington waters is safe to eat	• % of shellfish inspections completed with no critical violations *(see Figure 7.5c)* • Number of acres of shellfish beds currently closed to commercial and recreational harvests that are reopened *(see Figure 7.5a)*
Drinking Water Protection	• Monitoring water quality tests and conducting inspections of water systems	• Percent of drinking water sanitary surveys completed with no critical violations *(see Figure 7.5b)*
Hire, develop and retain a competent and diverse workforce	• Core competencies, skills and abilities are used in hiring • DOH employees reflect the diversity of Washington State	• Percentage increase in diversity of new hires *(see Figure 7.4b)*
Family and Child Health Promotion and Safety	• Infants and children and mothers healthy • Childhood immunizations given	• Percent of women who receive prenatal care in first trimester *(see Figure 7.1e* • Proportion of children who receive all recommended vaccines (15 dose series) *(see Figure 7.1b)*
Public Health Laboratory Services	• Laboratory tests conducted and reported accurately	• Percent of infants born in the state who have a New Born Screening (NBS) specimen received and analyzed by the NBS program *(see Figure 7.1c)*
Creating access to Quality Health Care Services	• Recruitment of practitioners for rural areas • Fund Community clinics	• Number of health care providers recruited to serve Medicaid and underserved populations *(see Figure 7.2c)* • HSQA call center wait time *(see Figure 7.2b)*
Prevent and Respond to the Transmission of Communicable and Infectious Disease	• Prevent spread of TB, STD, AIDS • Provide HIV Drugs	• Chlamydia rates *(see Figure 7.1d)* • HIV patients accessing private insurance *(see Figure 7.3a)*

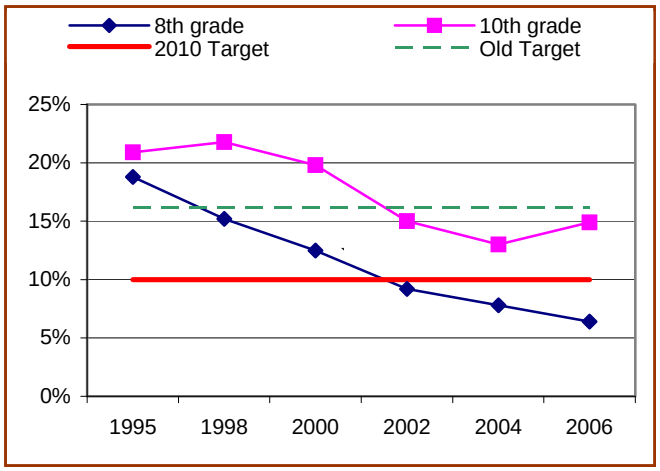
7. RESULTS

7.1 PRODUCT AND SERVICE OUTCOMES

SMOKING

Cigarette smoking among all youth is down by about half – 65,000 fewer smokers in Washington since 1999. We achieved our original 10th grade goal and set a new goal in 2007. Declines continue among middle school youth but have stalled among high school youth.

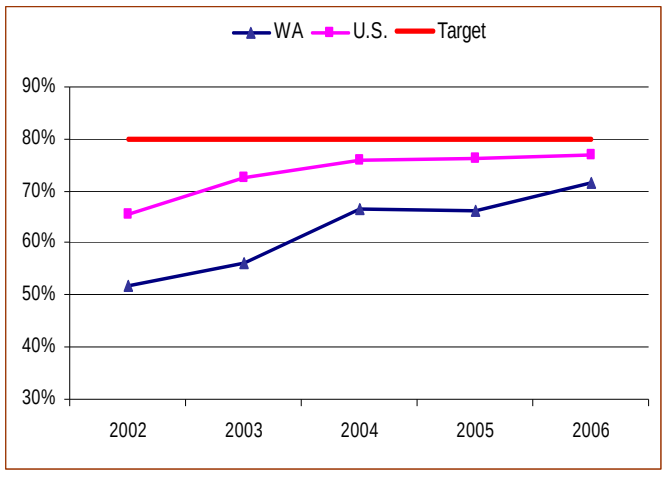
Figure 7.1a Smoking by 10th Graders



IMMUNIZATIONS

Immunization is the single most important method to protect children against serious and sometimes deadly infectious diseases. Between birth and age two, your child should receive immunizations to protect against 15 potentially deadly and disabling diseases. The chart measures the proportion of children who receive all recommended vaccines (15 dose series). Washington rates improved 5.1% from 2005 to 2006, moving the state from 45th to 41st in the nation.

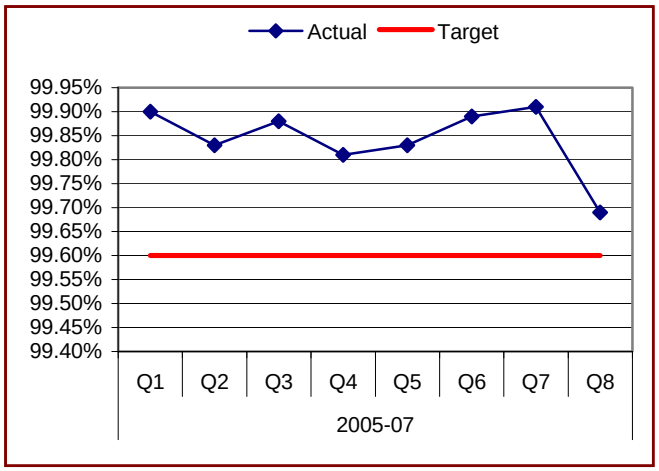
Figure 7.1b Immunization Coverage Rates 15 Dose Series (%)



LABORATORY TESTS CONDUCTED

The department tests each newborn in order to screen them for genetic disorders that can be treated. We have been consistent in reaching our 99.6% target for screening in the 05-07 biennium.

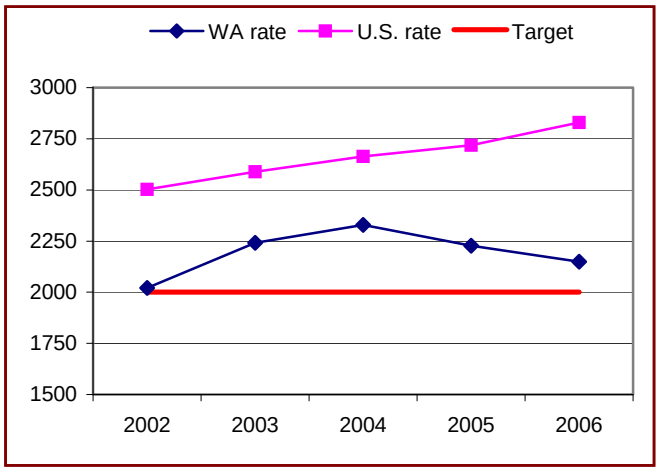
Figure 7.1c Newborn Screening (NBS) Specimens Analyzed



CHLAMYDIA

Screening for Chlamydia started in Washington in 1988. Rates decreased steadily from 1988 to 1996 and increased from 1997 to 2004. Case rates decreased slightly in 2005 and 2006.

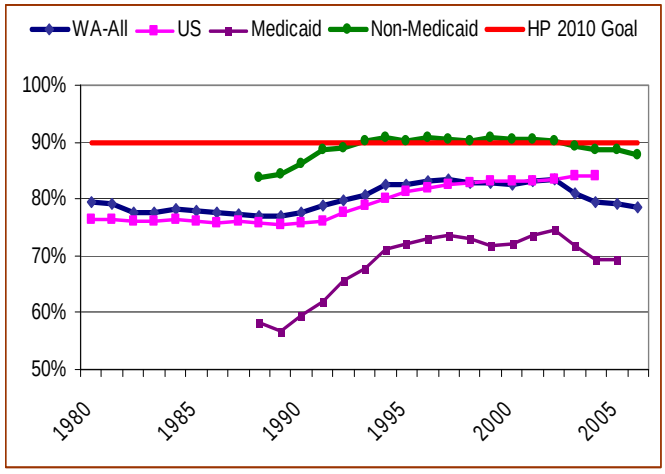
Figure 7.1d Chlamydia Rates



PRE-NATAL CARE

There is a significant disparity in Medicaid versus nonMedicaid-covered women receiving pre-natal care. While Washington is near the national goal of 90% for women with nonMedicaid coverage, first trimester prenatal care for Medicaid-paid births is much lower (68.4%) Forty-seven percent of all births are to women with Medicaid coverage.

Figure 7.1e Pre-Natal Care, First Trimester Entry into Prenatal Care (%)

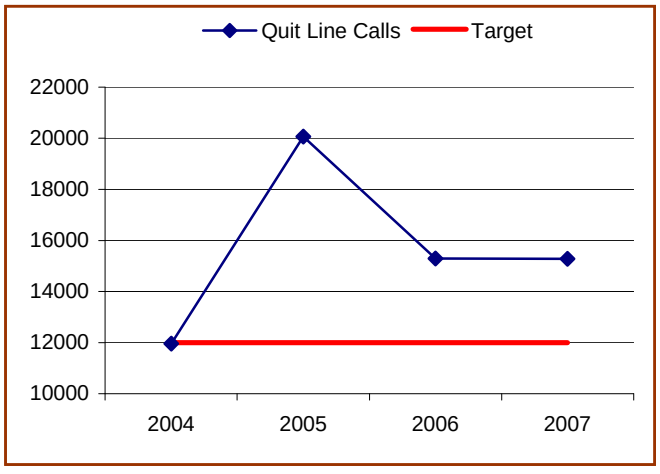


7.2 CUSTOMER-FOCUSED OUTCOMES

TOBACCO QUIT LINE

In 2005, Washington became the 10th state to ban smoking in all work and public places. The department's Tobacco Quit Line has been accessed more frequently over the last three years due to ongoing analysis of customer needs and targeted advertising of the program. The spike in 2005 was due to the marketing push to young adults. The quit line maintains a call level higher than our target.

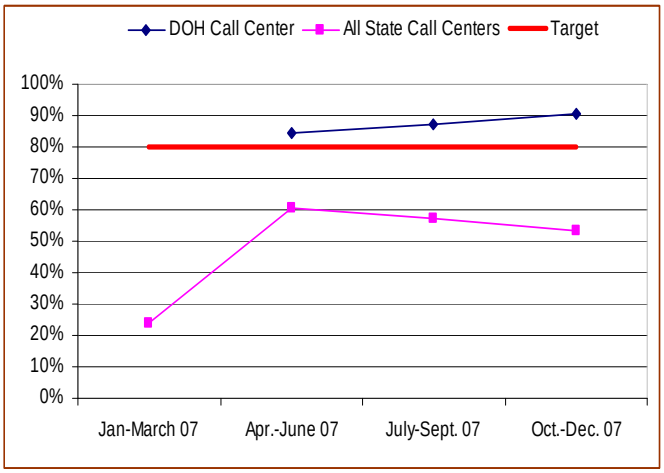
Figure 7.2 a Tobacco Program Quit Line Calls



HSQA CALL CENTER

Based on the 2002 market analysis and customer feedback of our HSQA call centers (using the plan-do-check-act cycle), improvements were made to consolidate call functions and reorder navigational elements in the system. These improvements resulted in significantly shorter calls and customer satisfaction.

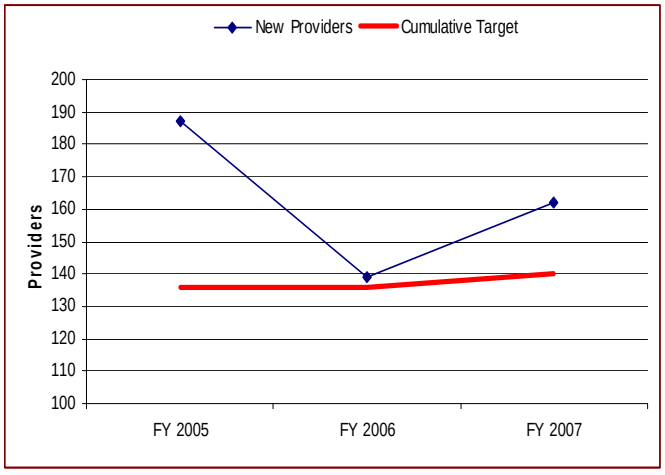
Figure 7.2b HSQA Call Center Progress to Meet One-Minute Maximum Wait Time Target



HEALTH CARE PROVIDERS

Rural and underserved communities need more primary care providers. Incentives to get providers to work in rural and underserved communities include: paying back student loans, paying malpractice insurance, sponsoring foreign providers and increasing reimbursement rates. The department rural provider recruitment target was exceeded every year. As a result, the target was increased from 140 to 170 providers a year for 2008.

Figure 7.2c Number of Additional Providers Serving Medicaid and Underserved Populations

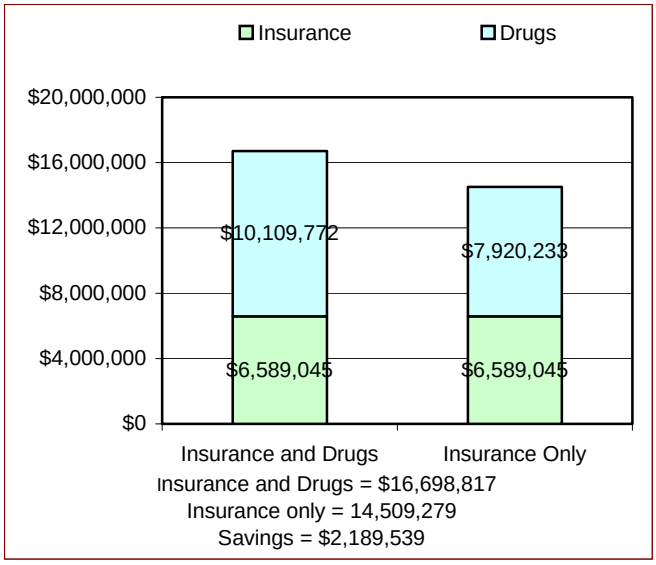


7.3 FINANCIAL AND MARKET OUTCOMES

HIV

Evidence shows that access to health care improves after an uninsured person obtains health insurance. The Early Intervention Program for HIV has 74.39% of enrollees with health coverage. Having insurance improves health overall and could reduce mortality rates by 10-15%. I.

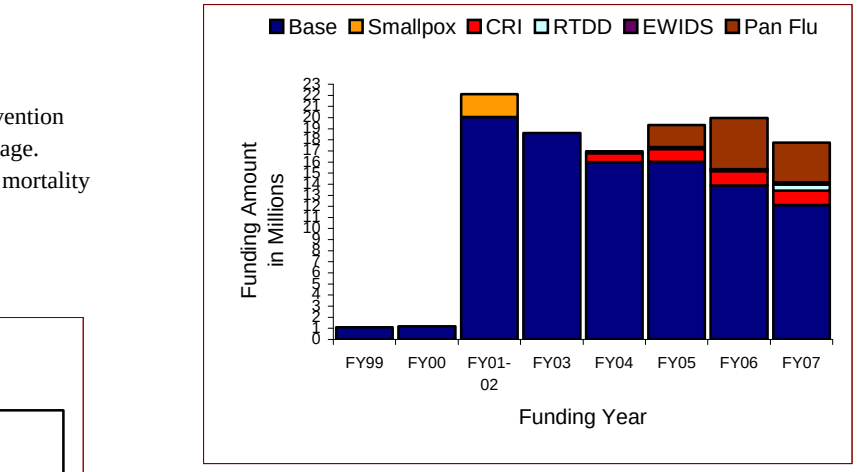
Figure 7.3a HIV Clients Accessing Private Insurance



FEDERAL FUNDING

CDC Base federal funding for the department has decreased. As an example, in the PHEPR program it has decreased over the last five years. The funding that was taken from the base was reallocated to categorical projects leading to a more inflexible program and moving away from the All-Hazard Preparedness approach. Not only is the money tied to individual projects, but the projects themselves are not funded enough. If the money were to continue to come in as a lump sum, the program would be more efficient and effective with its funds and resources. Unstable funding and an increase in competition for funding is a challenge for the department.

Figure 7.3b PHEPR Funding Example



WORKERS COMPENSATION

By taking a coordinated and aggressive approach to claims management, the costs for claims is reduced to less than $10,000 in 2007, compared to nearly $400,000 in 2005.

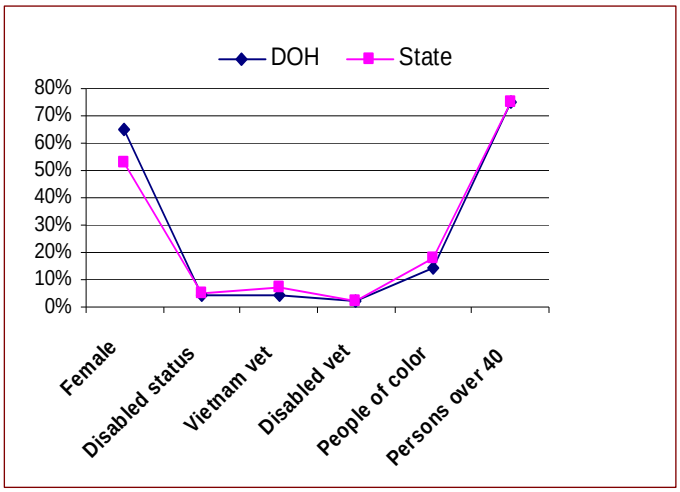
Figure 7.3c Worker's Compensation Claim Costs

7.4 WORKFORCE-FOCUSED OUTCOMES

DIVERSITY

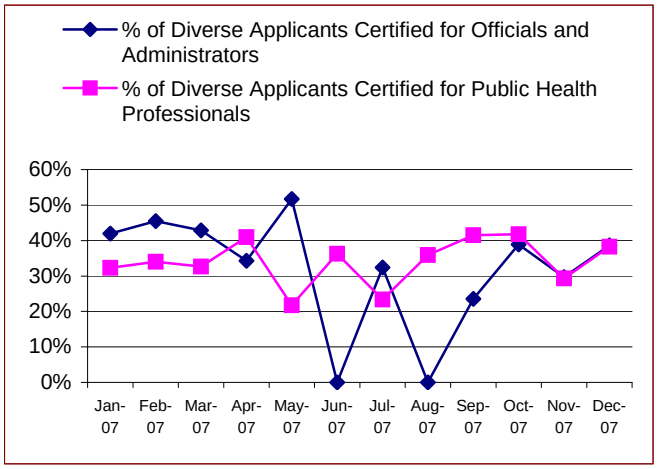
Our focus on outreach and recruitment has improved the applicant pools so that managers have more diverse representation from which to match to their position and program needs. The diversity includes broader educational and experiential backgrounds, and improved diversity category representation. The agency demographics show we are reflective of the state profile.

Figure 7.4a Diversity



For example, in 2007 we tracked the level of diversity for candidates referred to hiring authorities filling positions in two job categories: Officials and Administrators, and Public Health Professionals. The data sets a baseline and shows about one third of the candidates referred for hiring consideration were identified as diverse. For the first half of 2007 about 66.6% of the Officials and Administrators, and 22.92% of the Public Health Professionals' positions were filled with diverse candidates.

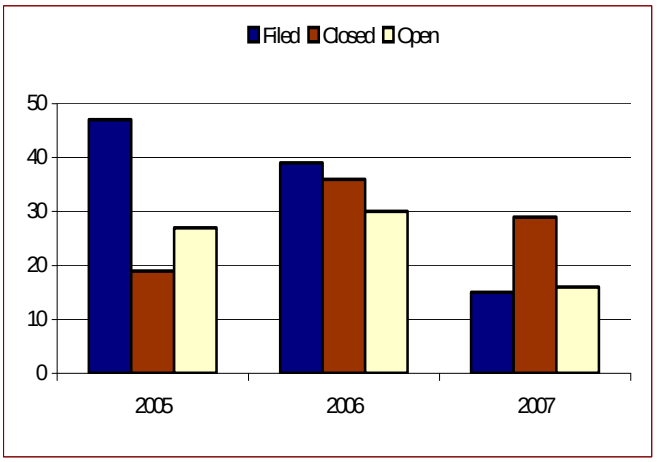
Figure 7.4b Hiring Pool on Diversity



TIME LOSS CLAIMS

In 2005, the department took an aggressive approach to reducing time loss claims. By contacting injured staff and medical providers as soon as a claim was filed, we either kept staff working or returned them to work more quickly. Staff benefited by partnering with HR staff that coordinated their claim, found light duty work or adjusted their work environment so they could support themselves.

Figure 7.4c Time Loss Claims



7.5 PROCESS EFFECTIVENESS OUTCOMES

SHELLFISH OPERATIONS

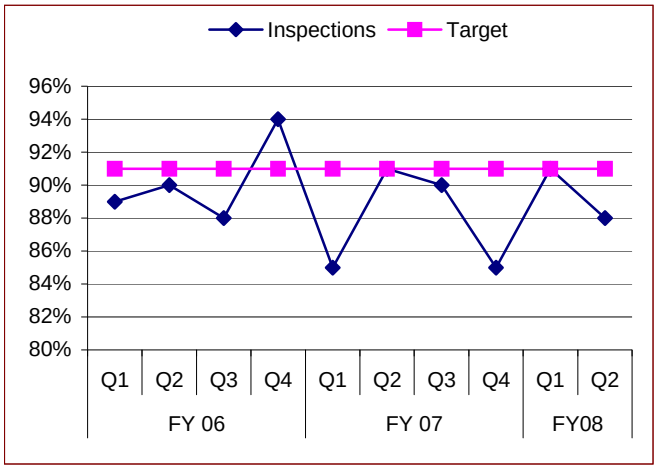
The department ensures shellfish harvested from Washington waters is safe to eat. Our target of 96% of shellfish operations with no critical deficiencies has been met all but two quarters.

Figure 7.5a Inspections of Shellfish Operations With No Critical Deficiencies

RADIATION INSPECTIONS

The department inspects x-ray facilities to protect patients and workers. We are not consistently meeting our target and are working on strategies to improve performance of the x-ray facility operators.

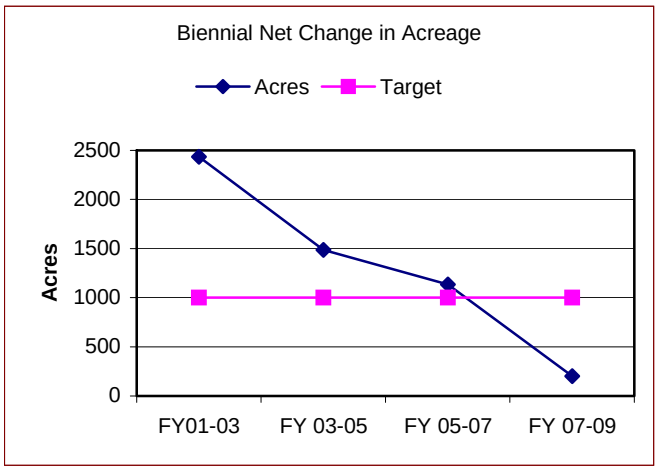
Figure 7.5b Percent of Radiation Inspections Completed With No Critical Violations



RECREATIONAL AND COMMERCIAL SHELLFISHING

In an effort to help clean up Puget Sound, one of our goals is to reopen 1,000 acres per biennia currently closed to recreational and commercial shellfishing. We far exceeded this target last biennia, reopening 3,697 acres.

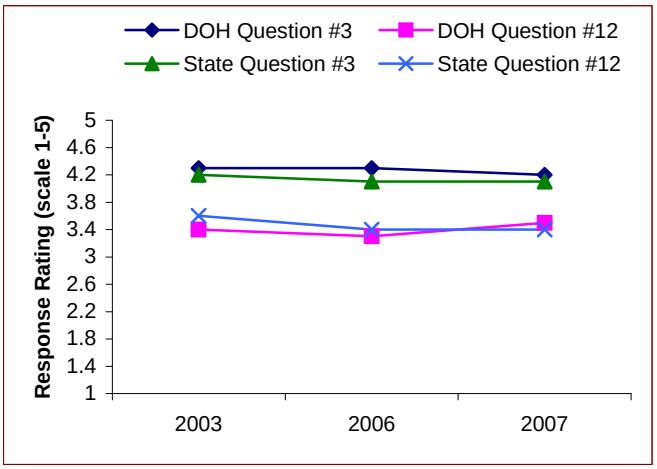
Figure 7.5c Reopen 1,000 Acres per Biennium Currently Closed To Recreational and Commercial Shellfishing



7.6 LEADERSHIP OUTCOMES

The department senior leaders set and deploy vision and values throughout the organization as evidenced by consistent employee survey results. The two questions in the employee survey that relates to these activities are question #3 “I know how my work contributes to the goals of my agency” and question #12 “I know how my agency measures its success”.

Figure 7.6a Employee Survey Results



WSQA
Washington State Quality Award
Path To Performance Excellence

2007 Lite (Assessment) Criteria

The Assessment level is the starting point for many organizations that are beginning to adopt and apply quality principles as defined by the WSQA and Baldrige Criteria. This assessment provides your organization with the ability to begin the journey with an abbreviated set of criteria questions. These questions are a direct subset of the full Criteria for Performance Excellence and references to the 2007 *Criteria for Performance Excellence* booklet are listed.

Requirements

1. Obtain complete Assessment guidelines and Eligibility Determination Form from the WSQA Web page at www.wsqa.net/apply.htm. This set of guidelines will provide time frames of submittal, information required for submittal, application length, and much more.
2. Complete the *entire Organizational Profile* as described in Section P Preface: Organizational Profile, P.1 Organizational Description and P.2 Organizational Challenges in the *Criteria for Performance Excellence* booklet (available for free download at www.wsqa.net/apply.htm). Limit your response to 5 pages. In addition, include a copy of your organizational chart.
3. Describe your organization by answering the following questions for each category. See the full Criteria booklet for definitions of terms and further explanations to help you understand the questions. Please focus your response on the questions in this document only, not on the full set of Criteria questions. Limit your response to no more than 15 pages. The following page guideline is suggested, but not required: up to 1½ pages each for Categories 1-6 and 6 pages for Category 7. Please note that Category 7 results should be linked to and be the result of your processes described in Categories 1-6. Results demonstrate the effectiveness of your processes.
4. Please note that your responses will be evaluated using the Scoring Guidelines from the Criteria booklet.
5. Refer to the *italics notes in parenthesis* after each criteria reference number for the equivalent Education or Healthcare criteria terminology.

Assessment Criteria

1. **Leadership: How do your senior leaders lead? How do you govern and address your social responsibilities?**
   a. How do your senior leaders set and deploy your organizations vision and values throughout the organization, workforce, and stakeholders? (ref 1.1a1) *(stakeholders should include students for education and patients for healthcare)*
   b. How do senior leaders employ a governance system to assure regulatory and legal compliance and ensure ethical behavior? (ref 1.2a and b)
2. **Strategic Planning: How do you develop and deploy your strategy?**
   a. What are your key strategic objectives and action plans? (ref 2.1b1 and 2.2a1)
   b. How do your strategic objectives address strategic challenges and strategic advantages? (ref P.2b and 2.1b2)
   c. How do you develop and deploy action plans through out the organization to achieve your key strategic objectives? (ref 2.2a1)
3. **Customer and Market Focus: How do you use customer and market knowledge? How do you build relationships and grow customer satisfaction and loyalty?**
   a. Who are your key customers or key customer groups? (ref P.1b2 and 3.1a1) *(Education include student and market segments, Healthcare include patients and other customer groups)*
   b. How do you determine key customer requirements, needs, and changing expectations? (ref P.1b2 and 3.1a2) *(Education include students and Healthcare include patients)*
   c. How do you build relationships to acquire customers, to meet and exceed their expectations, to increase loyalty and repeat business, and to gain positive referrals? (ref 3.2a1) *(Education include students, Healthcare include patients)*

4. **Measurement, Analysis, and Knowledge Management: How do you measure, analyze, and then improve organizational performance?**
   a. How do your senior leaders and your organization measure, review and improve its performance? (ref 4.1)
   b. What are your key organizational performance measures? (ref 4.1a1)
   c. What comparative data do you use to support decision making and evaluate organizational performance? (ref 4.1a2)

5. **Human Resource Focus: How do you engage your workforce to achieve organizational and personal success? How do you build an effective and supportive work environment?**
   a. How do you determine key factors that affect your workforce's commitment to accomplishing your organization's mission and how do you assess workforce engagement? (ref 5.1a2 and 5.1 c1)
   b. How do you assess workforce capability and capacity needs, including skills, competencies, and staffing levels and how do you manage your workforce capability and capacity to accomplish your performance objectives? (ref 5.2a1 and 3)

6. **Process Management: How do you design your work systems? How do you manage and improve your key organizational work processes?**
   a. What are your organization's key work processes, and how do you determine the key work process requirements for each process? (ref 6.1b1 and 2)
   b. How do you implement, manage, and improve your key work processes to meet key process requirements and to achieve better performance and meet key requirements? (ref 6.2a1 and 6.2b) What are your key performance measures or indicators and in-process measures used for control and improvement of your processes?

7. **Business Results: What are your product and service, customer-focused performance, financial and market, workforce-focused performance, organizational effectiveness, performance, process effectiveness and leadership results?**
   a. What are your organization's key performance and improvement results in key business areas for:
   - product and service performance (ref 7.1a)
     (Education: Student Learning Results, Healthcare: Healthcare results)
   - customer satisfaction (ref 7.2a1)
     (Education: Student and Stakeholder-focused results, Healthcare: Patient and other customer satisfaction)
   - financial and marketplace performance (ref 7.3a1 and 2)
     (Education: Budgetary, Financial and Market Results)
   - workforce engagement, satisfaction and development (ref 7.4a1)
   - operational performance, process effectiveness results (ref 7.5a1)
   - accomplishment of strategy and action plans (ref 7.6a1)

   Please provide results by segments if applicable. (ref 7)
   b. How do your key performance results compare to competitors or others in your industry? (ref 7)

Within 12 weeks of the submission date, applicants will receive a feedback report written at the category level. Feedback will include comments on the strengths of the organization as well as opportunities for improvement and a scoring range for each category. All applicants will also be offered the opportunity for a meeting with a representative of WSQA (Executive Director or Board member) and a member of the Examination team (member of the Judges Panel or Board of Examiners).

Glossary of Acronyms, Terms & Definitions

A

AOG: Assessment Operations Group – An executive group made up of the Assistant Secretaries from CFH, EHP, EHSPHL and HSQA or their designees assigned staff with health assessment responsibilities to represent their Divisions or specific units within their Divisions. Additional members include the Community Assessment Liaison and representatives from DIRM and OS. The AOG works to facilitate high quality health-related assessment for DOH and partner agencies and organizations.

Arbitration - A process that is external and with a binding decision.

B

BRFSS: Behavioral Risk Factor Surveillance System - is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.

C

CAG: Chief Administrators' Group – Membership on the CAG consists of the Deputy Secretary, the Chief Administrators for divisions and a representative(s) for Central Administration units. Team membership crosses department boundaries. The group oversees, coordinates and administers agency-wide business and preparation for/in response to emerging issues; supports and contributes to meeting strategic goals and improving services while maintaining ongoing operations; and, focuses agency resources to ensure successful results in major agency activities.

CDC: Centers for Disease Control - Federal agency managing the cooperative agreement for Public Health Preparedness and Response to Terrorism.

CHILD Profile application - Collects immunization records.

Civil Service Reform - The Civil Service Reform Act of 1978 (CSRA) applies to labor organizations which represents employees in most agencies of the executive branch of the Federal Government. On June 2, 2006 OLMS published a final rule that requires Federal sector labor organizations to inform members of their democratic rights including, among other things, the right to inspect collective bargaining agreements, to participate in officer elections and other union activities, and to exercise free speech rights without fear of retaliation. Notice must be given by hand delivery, U.S. mail, e-mail, or any combination as long as the method is reasonably calculated to reach all members.

CFH: Community and Family Health - A division within DOH. Their mission is to enhance the health of communities through culturally sensitive programs that promote a healthy start, healthy choices, and access to services.

D

DOH: Department of Health

DIS: Department of Information Services – An agency that manages the state Information Technology infrastructure.

E

EPA: Environmental Protection Agency

EEOC: Equal Employment Opportunity Commission

F

FDA: Food and Drug Administration

G

GAAP: Generally Accepted Accounting Principles

GASB: Governmental Accounting Standards Board

GMAP: Government Management Accountability and Performance - A reporting mechanism for the state agencies to report directly to the governor and staff on agency performance. It gives the public a clear, concise view of how government programs are working and whether citizens are receiving value for their dollars. GMAP gives citizens a way to judge the effectiveness of government programs. It allows agency leaders to shine a spotlight on problems and make decisions with greater clarity and accuracy. At the same time, it gives agency managers new tools to solve problems and improve services.

H

HIPAA: Health Insurance Portability and Accountability Act - A Privacy Rule to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

HealthMAP - Health Management Accountability and Performance – an internal GMAP reporting mechanism within the Department of Health. It provides a forum for divisions to report on progress, solve problems and provide current department information to the Senior Management Team.

Healthy People 2010 - Healthy People 2010 is a set of health objectives for the Nation to achieve over the first decade of the new century. It was developed through a broad consultation process, built on the best scientific knowledge, and designed to measure programs over time.

HSQA: Health Systems and Quality Assurance - A division within DOH that works to assure access to safe, appropriate and continuously improving health care.

HR: Human Resources - The Office of Human Resources provides professional HR consultation to build and maintain a diverse and competent workforce within the DOH.

I

IRS: Internal Revenue Service

J

JA: Job Assessment

Job Analysis: A detailed analysis of the essential functions, competencies, skills and abilities inherent in a position.

L

L&I: State Department of Labor and Industries – a state agency that manages workers' compensation, injury claims, and training.

LHJs: Local Health Jurisdictions - Washington's public health services are delivered through 35 local health jurisdictions.

O

OSHA: Occupational Safety and Health Administration

OFM: Office of Financial Management - The Office of Financial Management provides vital information, fiscal services and policy support that the Governor, legislature and state agencies need to serve the people of Washington State.

P

PALs: Performance Accountability Liaisons – an internal group representing DOH's divisions and programs that meet regularly to monitor, track and report performance measures. They serve as critical communication liaisons between management, the divisions and programs.

PDP: Performance Development Plan - A form that is used as a tool to support effective employee performance management. It is formatted to facilitate both performance planning and feedback at the end of the performance period.

Personnel System Reform Act - The Personnel System Reform Act of 2002 ties together the interests of state managers, labor and business in changing the existing state employment system to make it more effective and more fair, while providing new opportunities for improving the way the states does business

PRAMS: Pregnancy Risk Assessment Monitoring System – A system of data collection through surveys and telephone contact that supplements birth certificate data to generate information for planning and evaluating perinatal health programs.

PDF: Position Description Form - A foundational piece of managing performance within Washington state civil service that; links the position to the mission or goals of the agency and its specific organization with DOH; lists the officially assigned duties of the position; identifies the essential functions or duties that must be performed by the employee, with or without reasonable accommodation; outlines the key work activities of the position; describes the general working conditions of the position; and describes the required and desired qualifications and competencies required by the employee to successfully perform the assigned duties of the position.

PMT: Program Management Team - A team of core managers responsible for influencing, motivating, and leading staff and others to achieve the vision, mission, and goals of DOH.

PHIP: Public Health Improvement Plan – A plan that guides the development of Washington's public health system, based on a shared vision of what we would like for the future. By doing the work through committees, we can share the workload and ensure that many people's perspectives are incorporated.

PHL: Public Health Laboratories - The laboratories provide; a wide range of diagnostic and analytical services for the assessment and surveillance of infectious, communicable, genetic, chronic diseases and environmental health concerns for state residents; serve to coordinate and promote quality assurance programs for private clinical & environmental laboratories through training, consultation, certification and quality assurance sample programs; and provide scientific and managerial leadership for the development of Public Health Policy.

R

RCW: Revised Code of Washington - The laws of Washington State

S

SMT: Senior Management Team - The executive leadership body that supports and implements decisions made by the Secretary, (DOH).

V

Vital Statistics Application: Provides birth, death and marriage records for Washington State.

W

WISHA: Washington Industrial Safety and Health Administration - WHISHA is Washington State's occupational safety and health program, designed to assure, so far as reasonable possible, safe and healthful working conditions for all workers in our state. Established in 1973 when the

Legislature passed the Washington Industrial Safety and Health Act, WISHA is administered by the state's Department of Labor and Industries.

WSIRB: Washington State Institutional Review Board - is responsible for reviewing and approving human subjects research in the jurisdiction of three Washington State Agencies: the Department of Social and Health Services, the Department of Health, and the Department of Labor and Industries (L&I).

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