



2012

Governor's Sterling Award Application



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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

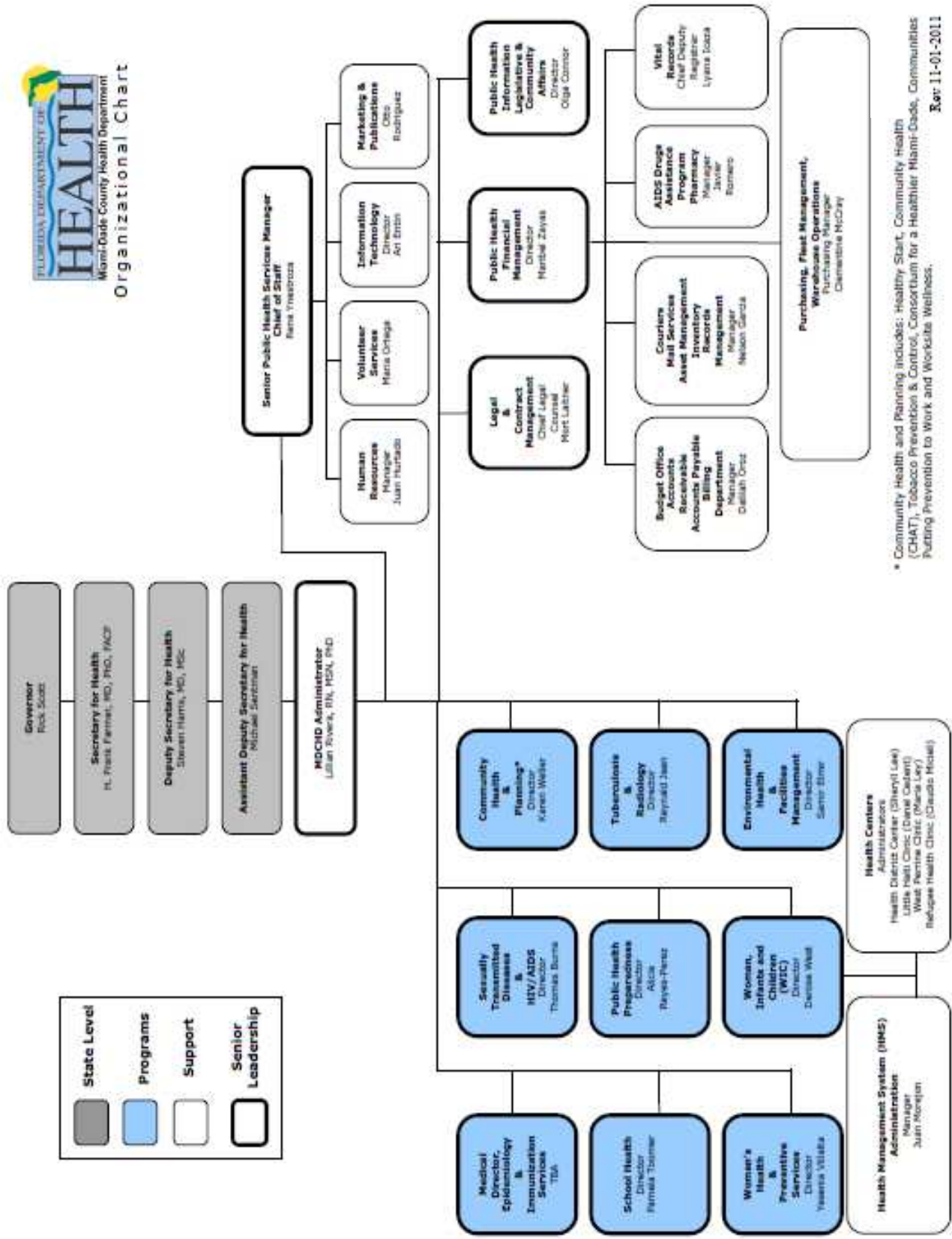
Date: 11/1/11

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.



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 as 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)	36	C, F
6. Enforce PH laws and regulations	School Health (1,2,3,7,9,10)	189	C, P
7. Help people receive health services	WIC (3,7,9,10)	77	C
8. Maintain a competent PH workforce	Refugee Health (1,2,3,7,9,10)	49	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)	69	F, I
10. Contribute to and apply the evidence base of PH	Environmental Health (1,3,5,6,9,10)	18	O, F, I
11. Maintain administrative and management capacity	Public Health Preparedness/ Emergency/ Disaster Response (1,2,4,5,8,9,10)	22	O, I
12. Maintain capacity to engage the PH governing entity	Vital Records (birth/ death certificates) (9,11)	19	O, F
	Community Health and Planning (1,2,3,4,5,7,9,10)	51	O, P
	Administration (1,,2,3,4,5,6,7,8,9,10,11,12)		
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: Regulates 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	<ul style="list-style-type: none"> • Official Memorandums • Two-way communication • Meetings/Conference calls/emails • Customer Service Survey • BOCC Official Meetings • Grant applications 	<ul style="list-style-type: none"> • Satisfaction • Timely delivery of service and information • Accuracy • Legal/Policy Compliance • Team work 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Supplier Customer Service Survey • Quotes • Contract Management • Two-way Communication • Meetings/conference calls/emails • RFP/ITB/ITN Process • Counseling • MFMP integration 	<ul style="list-style-type: none"> • Timely delivery of services • Satisfaction • Fair and competitive pricing • Customer Support • Billing accuracy • Contractual compliance • Prompt Payment of Services 	<ul style="list-style-type: none"> • 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 Community	-Funding Limitations -Unfunded mandates -Travel Restrictions - Brand awareness -Healthcare Reform -Political changes	-Strong partnerships -Expertise in PH epidemiology, EH, PH preparedness
Operational	-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 will be developed to assume higher level positions as anticipated turnover occurs.

In 2010 four of our top managerial positions were 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
<ul style="list-style-type: none"> • Mission, Vision, Values • Purpose • Fundamental Principles • Strategic Priorities • Legal/Ethical Compliance 	<ul style="list-style-type: none"> • Strategic Planning • Direct Input From Customers, Partners And Stakeholders • Environmental Scan 	<ul style="list-style-type: none"> • Direct Communications • Role Modeling • Mission, Vision On IDs • Quality Plan • Strategic Plan • Leadership Meetings • State of Organization Address 	<ul style="list-style-type: none"> • Employee Orientation • Customer Service Training • Supervisor Training • Newsletter/Website/Intranet • Annual Employee Conference/Retreats
<ul style="list-style-type: none"> • Performance Expectations 	<ul style="list-style-type: none"> • Strategic Planning • Performance Standards Linked To Objectives • Individual Development Plans • Competency Based Performance Expectation 	<ul style="list-style-type: none"> • Champion For Each Strategic Priority • Performance Measures Tracked • Team Improvement Projects • Results-based Accountability Framework 	<ul style="list-style-type: none"> • Business Results • Performance Appraisals • Annual Employee Conference/Retreats • Newsletters • Business Review Minutes And Action Plans
<ul style="list-style-type: none"> • Creating Value for Customers & Stakeholders 	<ul style="list-style-type: none"> • Employee Surveys • Customer Surveys • Strategic Priorities • Benchmarking • Legislative Contact 	<ul style="list-style-type: none"> • Annual Employee Conference/Retreat • Strategic Objectives • Survey Results 	<ul style="list-style-type: none"> • Employee Workgroups/Teams • Customer Service Training • Quality Training • Role Modeling
<ul style="list-style-type: none"> • Establish & Reinforce Environment For Empowerment 	<ul style="list-style-type: none"> • Use Of Sterling Management Model • Cross Organization SWOT • Open Door Policy 	<ul style="list-style-type: none"> • Program Strategic Plans • Employee Opinion Survey • Employee Involvement Showcases 	<ul style="list-style-type: none"> • Team Showcasing • Quality Training At All Levels • SL Accessibility • Programmatic Employee team/workgroups
<ul style="list-style-type: none"> • Organizational Agility 	<ul style="list-style-type: none"> • Strategic Planning • Employee Empowerment & Training • Employee Involvement Presentations 	<ul style="list-style-type: none"> • Strategic Priorities And Key Objectives • Annual Employee Conference/Retreats • Meeting Summaries 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 managers 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	<ul style="list-style-type: none"> Opportunities For Improvement 	<ul style="list-style-type: none"> Quality Initiatives Results and Succession Planning
180 Degree Evaluation And Leadership Development Opportunities	<ul style="list-style-type: none"> Direct Feedback From Staff Self-Evaluation 	<ul style="list-style-type: none"> IDPs To Improve Performance Individual Coaching
Robert-Wood Johnson Nursing Leadership Fellows Program	<ul style="list-style-type: none"> Feedback From Peers, Pre And Post Surveys For IDPs 	<ul style="list-style-type: none"> Development Of IDPs And ID Of Coaching Opportunities
SHO Quality Improvement Peer Review Visit	<ul style="list-style-type: none"> Feedback From QI Team With Opportunities For Improvement 	<ul style="list-style-type: none"> Development Of Formalized Agreements And Action Plans
Employee Opinion Survey	<ul style="list-style-type: none"> Direct Feedback From Employees 	<ul style="list-style-type: none"> Used To Establish Employee team/workgroups/Workgroups Incorporated Into The SP Process Development Of IDP For SL
Annual Employee Conference/Retreats/Recognition Ceremony	<ul style="list-style-type: none"> Direct Feedback From Employees 	<ul style="list-style-type: none"> Feedback Used To Improve Next Year’s Conference
Business Review Process	<ul style="list-style-type: none"> Information Shared At Meetings 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Monitoring And Surveillance Partnering With The Community Statewide Database 	<ul style="list-style-type: none"> Monitoring At Address Level Stratification Of Data 	<ul style="list-style-type: none"> Respond To Individuals and the Community
Emergency Planning	<ul style="list-style-type: none"> Emergency Plans Ongoing Communication and Updates from EOC 	<ul style="list-style-type: none"> Emergency Logs Debriefings Facilities Form Address Level Mapping Of Impact Surveillance System 	<ul style="list-style-type: none"> Staff posted at EOC SNEC and Medical Management Staffing HAZMAT Team Bioterrorism Plan Incident Command Structure Staff Training Event Exercises
Environmental Health Threats	<ul style="list-style-type: none"> Feedback From Stakeholders Risk Associated With Population Served 	<ul style="list-style-type: none"> Surveys Audits Performance Measures Records Review 	<ul style="list-style-type: none"> Strategic Objectives Communication With Service Providers
Refugee/Migrant Health	<ul style="list-style-type: none"> INS Meetings Communication With Public Officials 	<ul style="list-style-type: none"> Trend Analysis Benchmarking 	<ul style="list-style-type: none"> Partnerships Innovative Programs
Healthy Community	<ul style="list-style-type: none"> Public Communication Efforts Community Education Working with Other Agencies 	<ul style="list-style-type: none"> Public Health Advisories / Press Releases Surveys / Assessments MAPP Client Complaints/Inquiries Health Status Indicators 	<ul style="list-style-type: none"> 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	How Improved
		Measures	
Organizational	<ul style="list-style-type: none"> Consortium for a Healthier Miami-Dade Health Fairs/Outreach 	<ul style="list-style-type: none"> # Of Members # of Health Fairs 	<ul style="list-style-type: none"> Direct Feedback Health Improvement Plan
Senior Leaders	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> # Board/Task Force Memberships # of Courses Taught 	<ul style="list-style-type: none"> Implement Changes To Impact Community Educate Future Public Health Workforce
Employees	<ul style="list-style-type: none"> Florida State Employees Charitable Campaign Toy Drive 	<ul style="list-style-type: none"> \$ Donated # of toys donated 	<ul style="list-style-type: none"> 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	May
8. Develop Strategic Objectives, Indicators, Targets	
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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

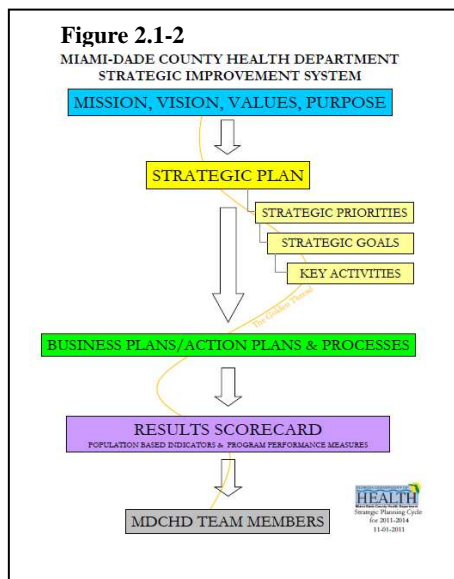
2.2 Strategy Implementation

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.

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.

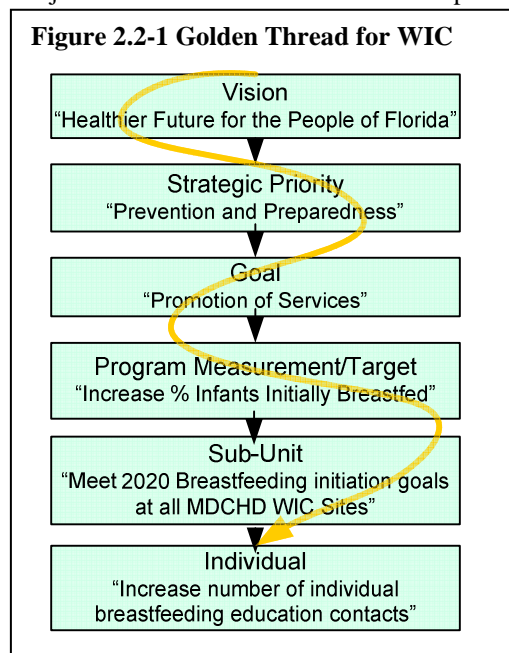


2.2a(2) Action Plan Implementation

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.

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 activities and identifying value-added and non-value-added activities.

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ▪ 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
2.0 Return on Investment Addressed: <ul style="list-style-type: none"> ▪ Central office (C) ▪ Requests (A) 		County Rankings	Meet state target	▪ Benchmark key industry indicators
		% Indicators meeting target	70% Meet Targets	▪ Improve health indicators
	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
3.0 Service Excellence Addressed: <ul style="list-style-type: none"> ▪ Cultures (C) ▪ Tourists (C) ▪ Salaries (C) ▪ Rewards (C) ▪ Training funds (C) ▪ Partnerships (A) ▪ Media (A) ▪ Staff (A) ▪ Competencies (A) ▪ Diverse (A) 	2.3 Capital improvement plan	% of project completed by 2013	100%	▪ Complete Phase 2 HDC and Little Haiti Clinic
	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	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Customer Inquiry Telephone Line Customer Satisfaction Survey Website Community Partners Health Assessments Data Analyses Direct Contact with MDCHD Staff
Indirect Service Customers	<ul style="list-style-type: none"> Emergency Preparedness Planning Water, Food and Environmental Monitoring/Regulation Health and Nutrition Education 	<ul style="list-style-type: none"> Customer Inquiry Telephone Line Website Community Partners Health Assessments Data Analyses Outreach Events State Corrfow

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 as 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 route 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 Corrfow. 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

<i>Year</i>	<i>Improvements</i>
'97-'01	<ul style="list-style-type: none"> • Indicators For Strategic Processes Established • PDCA Improvement Teams Began • Core And Support Process Indicators Identified • Process Management Training Initiated
'02-'05	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Employee Assistance (EAP) • Vaccines (Hepatitis, Flu.) • TB/PPD Screening • Health Fairs • Drug Testing • Stress Reduction • Walking Clubs • Wellness Program 	<ul style="list-style-type: none"> • Participation in Wellness Activities • % screened & referred for BP/Cholesterol
Safety/Ergonomics	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • # Needlestick Injuries • % Employees Fit Tested with N95 Respirators • % Employees trained in CPR & First Aid • # Workers Comp Cases Resulting in Lost Days
Security	<ul style="list-style-type: none"> • Security Staff • Restricted Access • Employment Identification • Alarm/Surveillance Systems 	<ul style="list-style-type: none"> • Number of Incident Reports
Preparedness	<ul style="list-style-type: none"> • COOP Plan • NIMS Training Initiative 	<ul style="list-style-type: none"> • % 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

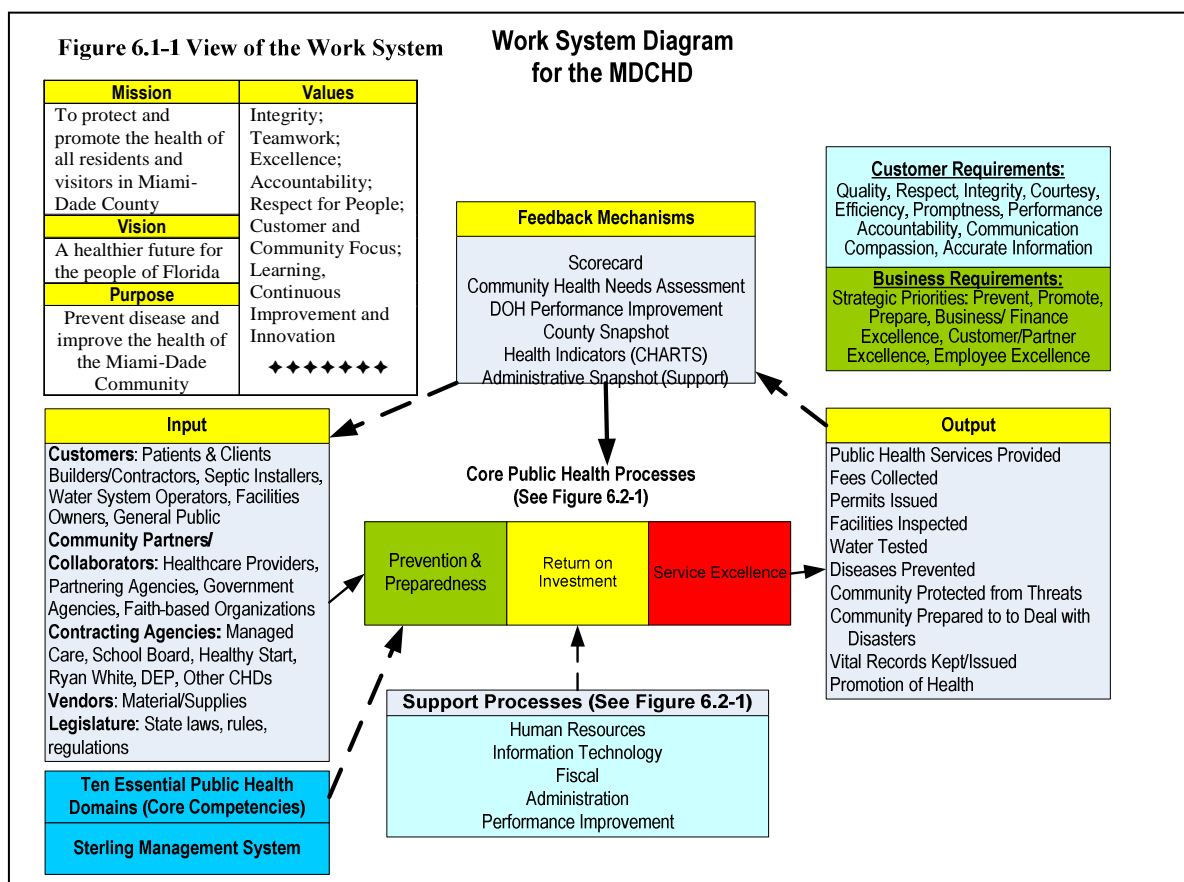
Most key work system requirements are pre-determined for us through the various mandates that come from local, state and federal agencies that provide us with the funding for these programs. For example, there are numerous federal requirements for the Women, Infants and Children (WIC) program and partner 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.

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, cashing 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 through 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 Statutes, 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 managers 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	<ul style="list-style-type: none"> Detect, Treat and Prevent Transmission and Provide Partner Services 	<ul style="list-style-type: none"> Reduce STD Incidence 	<ul style="list-style-type: none"> Infectious Syphilis incidence per 100K 	7.1a
			<ul style="list-style-type: none"> % High Titer Syphilis Records Disposition w/in 14 days 	7.1b(1)
			<ul style="list-style-type: none"> % of Infectious Syphilis Cases Treated w/in 14 Days 	7.1b(1)
2.0 TB	<ul style="list-style-type: none"> Identify, Treat and Prevent Transmission 	<ul style="list-style-type: none"> Reduce TB Incidence 	<ul style="list-style-type: none"> TB Incidence per 100,000 Population 	7.1a
3.0 School Health	<ul style="list-style-type: none"> Refer/ follow-up abnormal student vision screenings 	<ul style="list-style-type: none"> Increase vision referral completion rate 	<ul style="list-style-type: none"> % of TB Patients Completing Therapy W/in 12 months 	7.1b(1)
	<ul style="list-style-type: none"> Education and Eligibility Determination 	<ul style="list-style-type: none"> Increase prenatal clients certified for WIC 	<ul style="list-style-type: none"> Percent of completed vision referrals with confirmed additional evaluation and/or treatment. 	7.1b(1)
4.0 WIC	<ul style="list-style-type: none"> Education 	<ul style="list-style-type: none"> Increase WIC Breastfeeding 	<ul style="list-style-type: none"> % First Trimester Entry into WIC 	7.1b(1)
5.0 Special Immunization	<ul style="list-style-type: none"> Provide Childhood Immunizations 	<ul style="list-style-type: none"> Increase Childhood Immunization Rates 	<ul style="list-style-type: none"> % Of WIC Infants Initially Breastfed 	7.1b(1)
	<ul style="list-style-type: none"> Permitting process for new OSTDS application 	<ul style="list-style-type: none"> Increase Under Two Fully Immunized (HIGH) 	<ul style="list-style-type: none"> % Children Under Two Fully Immunized (HIGH) 	7.1b(1)
6.0 Environmental Health	<ul style="list-style-type: none"> Community Hygiene Compliance inspection s 	<ul style="list-style-type: none"> Timely issuance of New Permits 	<ul style="list-style-type: none"> % of New OSTDS Permits Issued in 8 days or less 	7.1b(1)
	<ul style="list-style-type: none"> Monitor /Investigate and Prevent Communicable Diseases 	<ul style="list-style-type: none"> Timely Completion of Inspections 	<ul style="list-style-type: none"> % of Required Inspections Completed within the Required Timeframe. 	7.1b(1)
7.0 Epidemiology	<ul style="list-style-type: none"> HIV Prevention 	<ul style="list-style-type: none"> Improve Prenatal/ Infant/Child Health Reduce Communicable & Vaccine Preventable Diseases 	<ul style="list-style-type: none"> Health Status Outcomes (All) 	7.1a (All)
			<ul style="list-style-type: none"> % Surveillance cases reported from the CHD to BOE within (21 days before 2011, 14 days starting 2011 	7.1b(1)
8.0 HIV Surveillance	<ul style="list-style-type: none"> HIV Prevention 	<ul style="list-style-type: none"> Reduce NIR Rate 	<ul style="list-style-type: none"> % of HIV Cases Classified as NIR 	7.1b(1)
9.0 HIV/AIDS	<ul style="list-style-type: none"> HIV Prevention 	<ul style="list-style-type: none"> Reduce NIR Rate Increase Access to HIV Testing 	<ul style="list-style-type: none"> % of AIDS Cases Classified as NIR 	7.1b(1)
			<ul style="list-style-type: none"> Number of tests performed by our testing sites per basis 	7.2a(1)
10.0 Women's Health	<ul style="list-style-type: none"> Provide access to birth control, preconception and interconception counseling. 	<ul style="list-style-type: none"> Prevent unplanned pregnancies Reduce/Prevent repeat births to teens 	<ul style="list-style-type: none"> Number of testing sites registered per year 	7.2a(1)
			<ul style="list-style-type: none"> % of Repeat Births to Teens (Age 15-19) % Women's Health record review compliance 	7.1b(1)
11.0 Vital Records	<ul style="list-style-type: none"> Issues Birth and Death Certificates 	<ul style="list-style-type: none"> Timely and Accurate Records Reporting 	<ul style="list-style-type: none"> Number of Birth and Death Certificates Issued. 	7.1b(1)
12.0 Refugee Health	<ul style="list-style-type: none"> Health Assessment to newly arriving refugees in Miami-Dade County 	<ul style="list-style-type: none"> Increase % of newly arriving refugees completing assessments Decrease average days for refugee health assessments 	<ul style="list-style-type: none"> % of Newly Arrived Refugees with Access to Health Assessment Services 	7.1b(1)
			<ul style="list-style-type: none"> Average days of Refugees Screened within 90 Days 	7.1b(1)
13.0 Preparedness	<ul style="list-style-type: none"> All Hazards Plans (AHP) 	<ul style="list-style-type: none"> AHP developed, reviewed and revised 	<ul style="list-style-type: none"> CHD Public Health Preparedness score (% of all hazards preparedness plans that meet state and national standards) 	7.1b(2)
	<ul style="list-style-type: none"> Mass Prophylaxis Plan 	<ul style="list-style-type: none"> MPP strategies implemented 	<ul style="list-style-type: none"> % 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)
		• Chronic Disease Prevention and Control	• Consortium strategies implemented • Community Assessments Performed.	• # Activities performed by Consortium overall	7.2a(2)
14. Community Health					
Support		Key Processes	Key Process Requirements	Key Performance Indicators	Cat. 7
15.0 Financial Management			Manage Operating Budgets:	• % Compliant P-Card Payments (Current)	7.4a(3)
		• Budget		• % Prompt Payment (Current)	7.4a(3)
		• Accounts Payable	• Revenue Collections	• Medicaid denial rate by month	7.5a(1)
		• Accounts Receivable	• Actual Expenditures	• Revenue to Expense Ratio	7.5a(1)
		• Billing	• Outstanding Receivables	• Fee Collections as % of total revenue	7.5a(1)
16.0 Clinic Admin Services			• TF Balance 7-9.5%	• 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)
		• 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				• % of Employees who completed the mandatory training	7.3a(10)
		• Human Resource Administration	• Improve HR Policy Administration • Improve Employee Satisfaction/Engagement	• % of Performance Appraisal Compliance	7.3a(1)
		• Workforce Development	• Improve Workforce Development	• % 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	• Increase favorable resolutions	• % of Cases Resolved Favorably	7.1b(1)
		• Supplier Contract Management	• Reduce settlement agreements	• # of Settlement Agreements	7.1b(1)
		• Information Security Management	• 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	• Timely IT services	• % of Help Desk Calls Abandoned	7.1b(1)
		• IT Availability	• Increase availability of network and applications	• % 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)

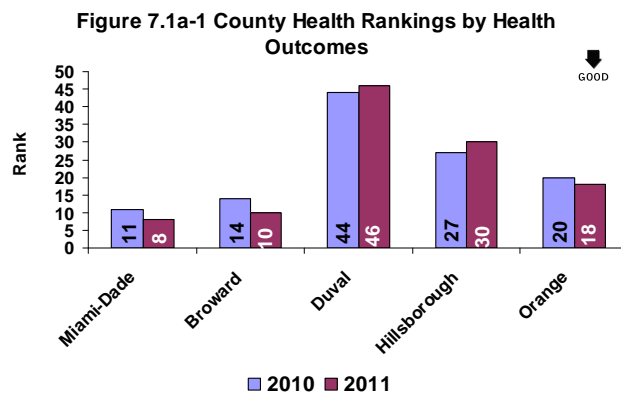


Figure 7.1a-2 shows the Years of Potential Life Lost (YPLL) per 100,000 population under 75 years of age in MDC compared to FL-State and the FL-Best Peer. YPLL is an estimate of the average years a person would have lived if he or she had not died prematurely. The YPLL for MDC was better than both FL-State 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)

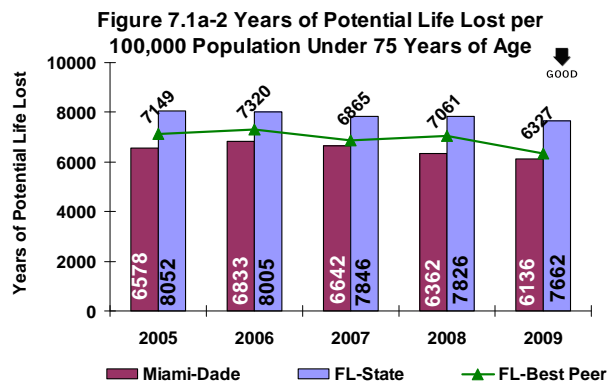


Figure 7.1a-3 shows the percent of adults who were reported overweight with a body mass index (BMI) of 25 to 30 based on the BRFSS survey. MDC has steadily decreased the percentage of overweight adults from 2002 to 2010. (Data source: FL Charts and US Peer County/State web)

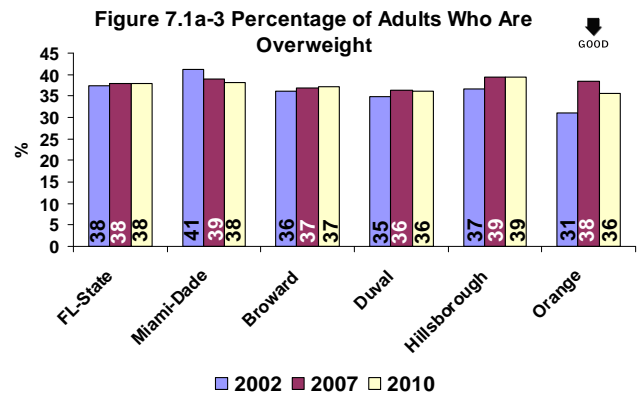


Figure 7.1a-4 represents the age-adjusted mortality rate per 100,000 population for MDC compared to FL-State, FL-Best Peer and US-Best Peer. The age-adjustment rate allows communities with different age structures to be compared. MDC has continually decreased its age-adjusted mortality rate from 2005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

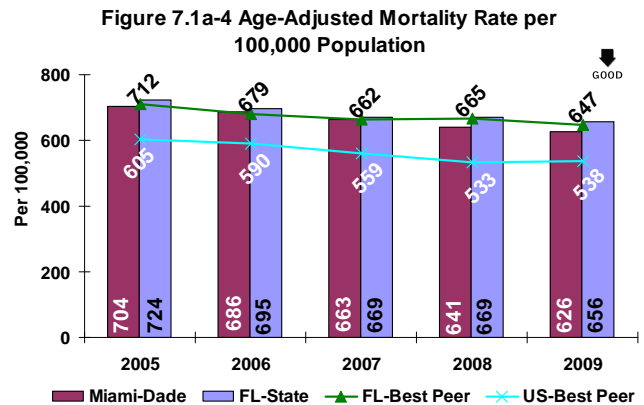


Figure 7.1a-5 shows the infant mortality rate per 1,000 live births for MDC compared to FL-State, FL-Best and US-Best Peer. This indicator is used to compare the health and well-being of a community. The infant mortality rates for MDC were better than FL-State from 2005 to 2010. MDC ranked better than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

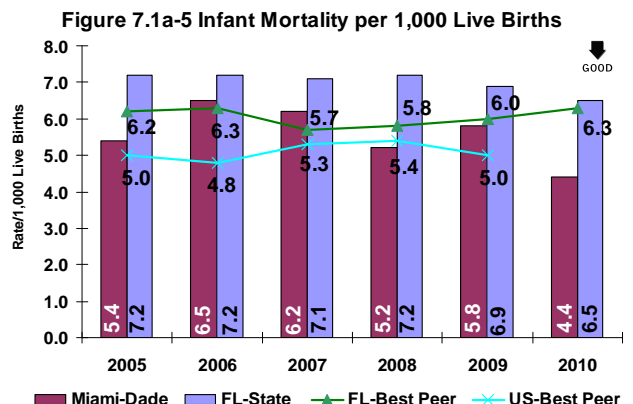


Figure 7.1a-6 shows the infant mortality rates by race and ethnicity for MDC. During the 20th century, U.S. infant mortality rates improved by 90%. However, Black infants are much more likely to die than White infants. The Black infant mortality rate has declined from 32 in 1970 to 11.5 in 2010. (Data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

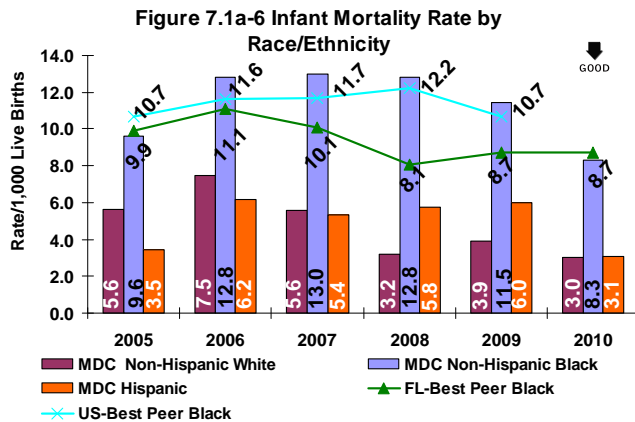


Figure 7.1a-7 represents the percent of live births to mothers aged 10 to 17 years in MDC from 2005 to 2009. The percent of live births to mothers aged 10 to 17 years has decreased since 2007. MDC overall was lower than FL-State. (Data source: FL Charts and US Peer County/State web)

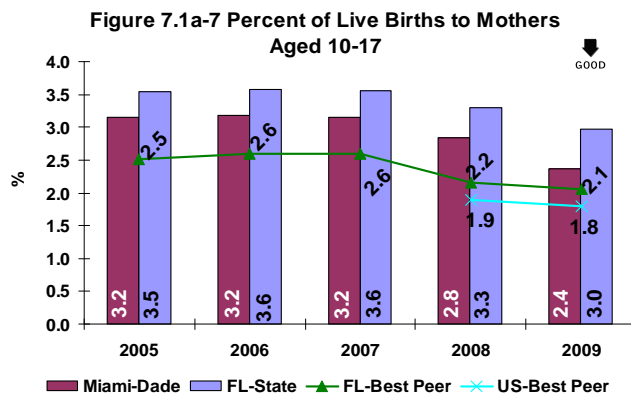


Figure 7.1a-8 represents the percent of repeat live births to mothers aged 15 to 19 years in MDC compared to FL-State, FL-Best and US-Best Peer from 2005 to 2009. In 2009, the percentage was comparable to FL-State. (Data source: FL Charts and US Peer County/State web)

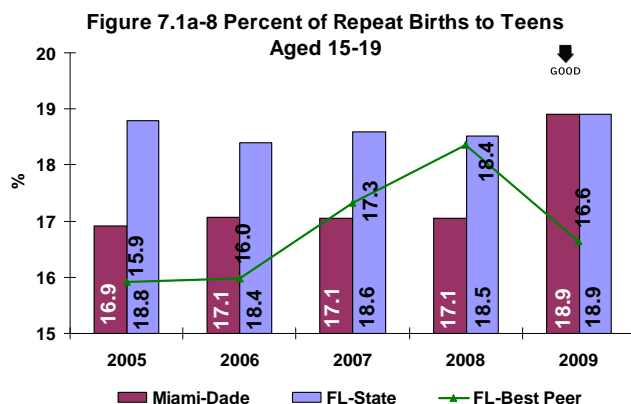


Figure 7.1a-9 shows the percentage of low birth weight (< 2,500 grams) infants for MDC from 2005 to 2009. The Healthy People (HP) 2020 target is $\leq 7.8\%$. (Data source: FL Charts and US Peer County/State web)

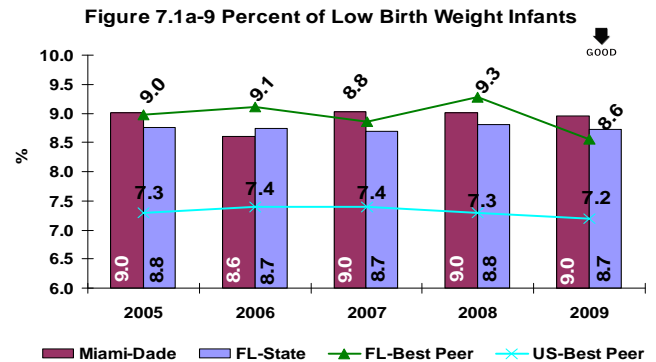


Figure 7.1a-10 shows the rate of reported primary and secondary syphilis cases per 100,000 population compared to FL-State, FL-Best and US-Best Peer. Although the rate in the US declined to 89.7% during 1990–2000, it increased during 2001–2010. Syphilis remains a major health problem in the South and 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)

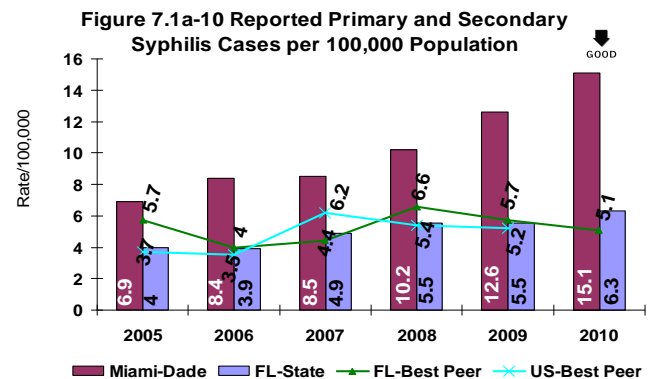


Figure 7.1a-11 represents the AIDS rate per 100,000 population in MDC compared to FL-State, FL-Best and US-Best Peer. Since 2008, the AIDS rate has decreased in MDC. The results indicate the success of our HIV/AIDS program. (Data source: FL Charts and US Peer County/State web)

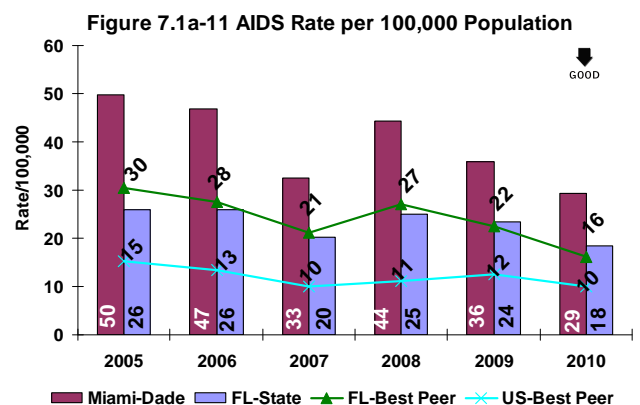
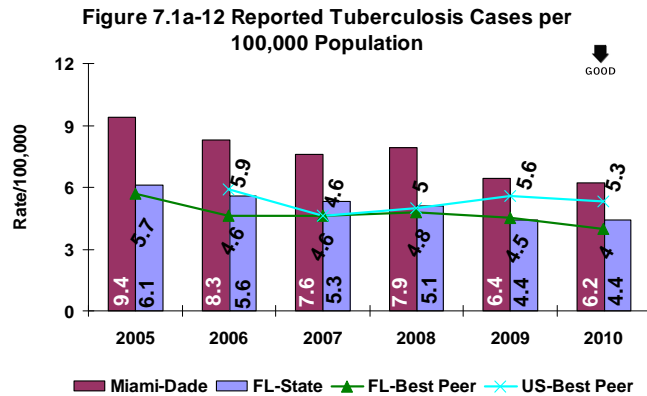


Figure 7.1a-12 represents the rate of reported tuberculosis (TB) cases per 100,000 population in MDC compared to FL-State, FL-Best and US-Best Peer. The rate of reported TB cases per 100,000 has declined from 2005 to 2010 in MDC. The decline is attributed to the outreach efforts of the MDCHD TB program.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



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.

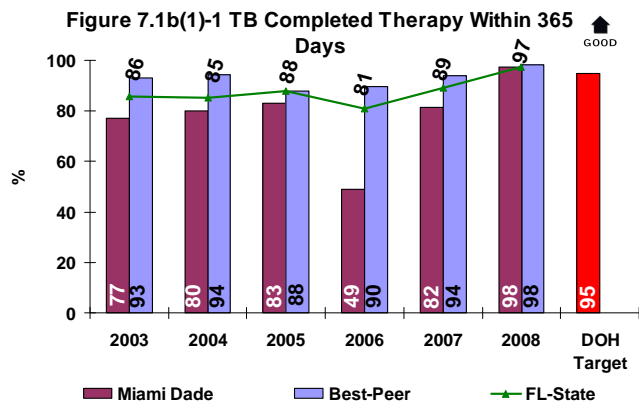


Figure 7.1b(1)-2 compares the average client cycle time among MDCHD clinics from 2008 to 2010. Patient flow and cycle time is crucial to our clinic practice efficiency and capacity. This in turn affects revenue and patient satisfaction. An employee workgroup was initiated in June 2010 to reduce client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

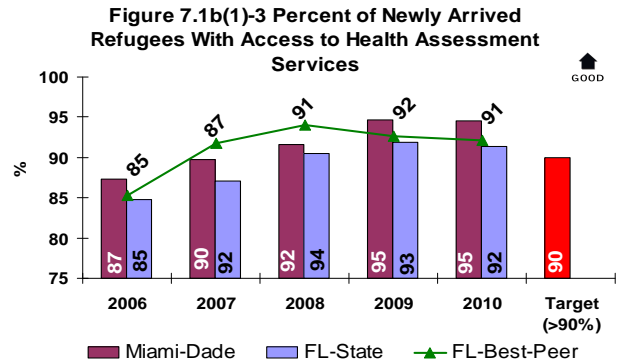


Figure 7.1b(1)-4 Average Days for Refugee Screening Between Day of Arrival and Day of Health Assessment

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.

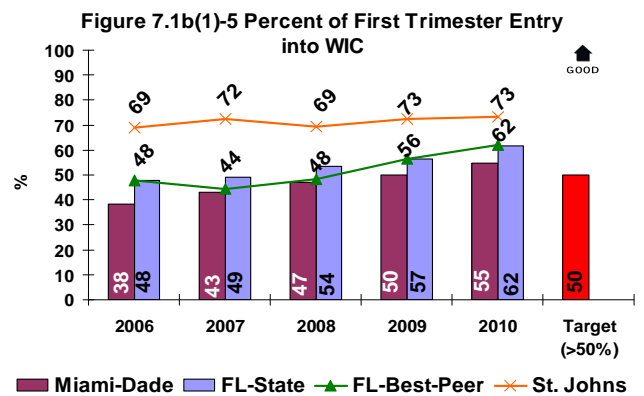


Figure 7.1b(1)-6 represents the percent of infants initially breastfed. Breastfeeding protects babies from a multitude of illnesses. In MDC, the percent of infants initially breastfed increased from 71% in 2006 to 75.4% in 2010. In the last two years the program has added peer counselors and increased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

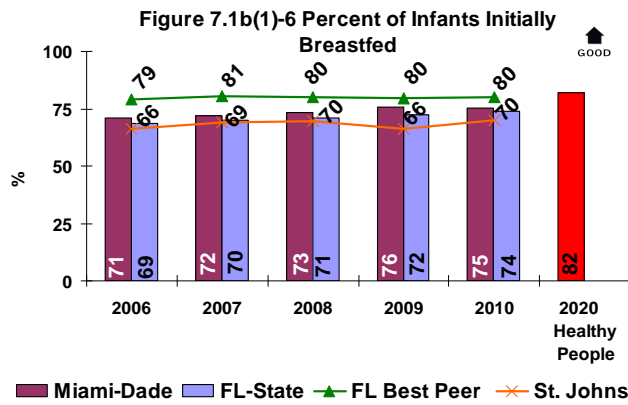


Figure 7.1b(1)-7 shows the percentage of vision referrals by school health providers with confirmed additional evaluation and/or treatment in MDC compared to FL-State and the FL-Best Peer. The percent of vision referrals in MDC increased by almost half in 2010 compared to 2009. The implementation of 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)

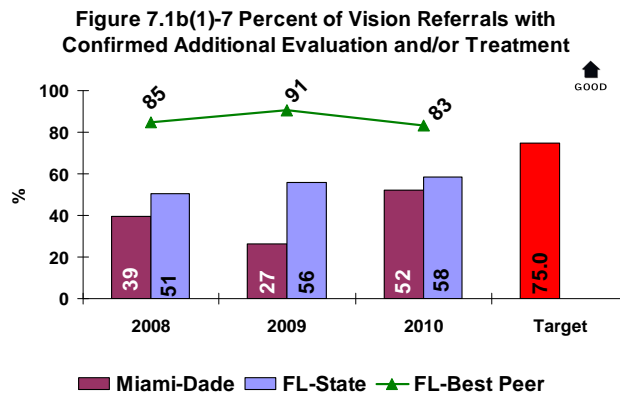


Figure 7.1b(1)-8 represents the percent of two-year-old children immunized in MDC compared to FL-State and the FL-Best Peer. MDC had a higher percentage of two-year-olds immunized compared to FL-State from 2005 to 2010. This is a key indicator of the effectiveness of our Immunization Program. High immunization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

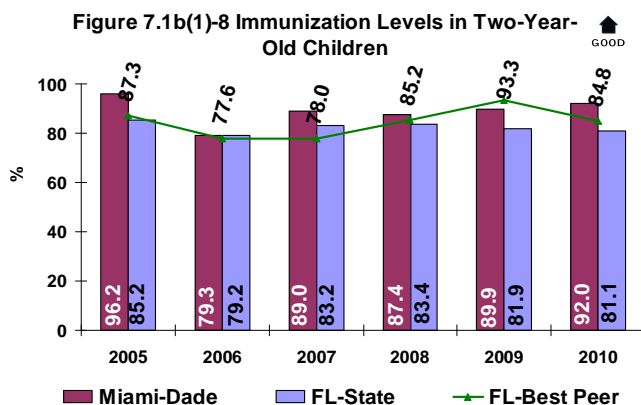


Figure 7.1b(1)-9 represents the vaccine preventable disease rate per 100,000 population in MDC compared to FL-State and the FL-Best Peer. MDC had a lower vaccine preventable disease rate compared to FL-State from 2005 to 2010. (Data source: FL Charts).

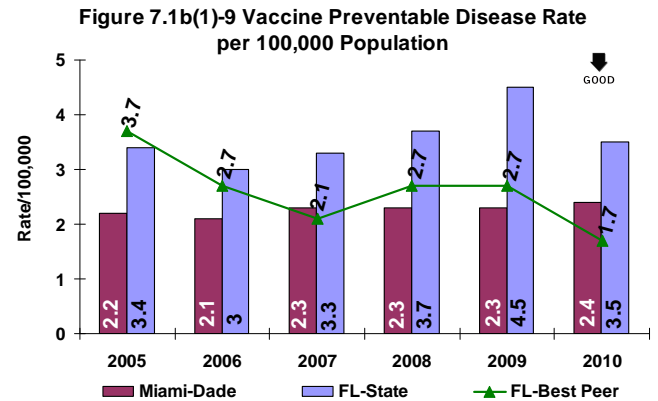


Figure 7.1b(1)-10 and **Figure 7.1b(1)-11** shows the percent of HIV/AIDS cases classified as non-identified risk in MDC compared to FL-State, FL-Best Peer and St. Johns County. The percent of HIV and AIDS cases classified as non-identified risk was lower than FL-State from 2006 to 2010. MDC met its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

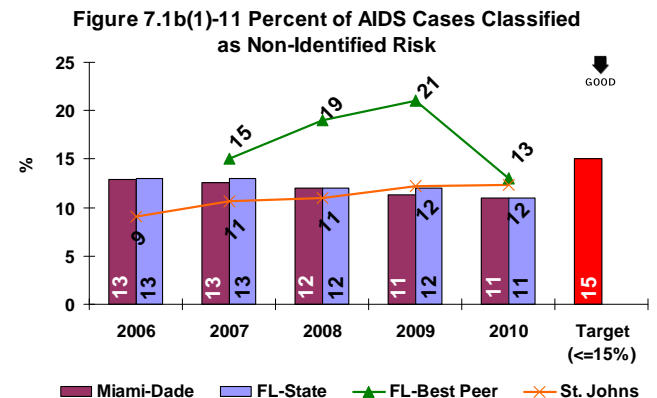
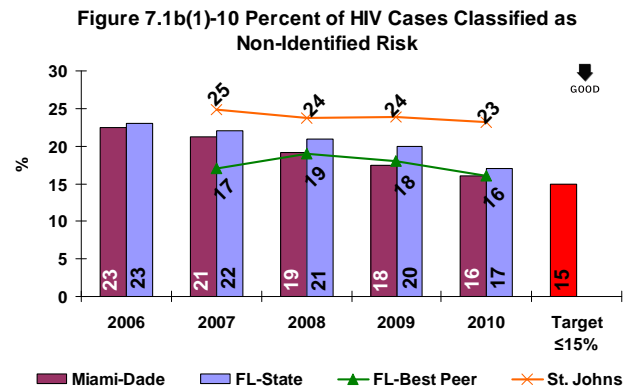


Figure 7.1b(1)-12 shows the percent of new Onsite Sewage Treatment Disposal Systems (OSTDS) permits issued ≤ 8

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

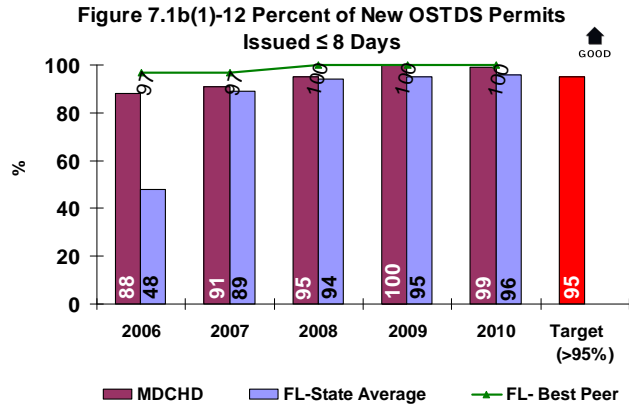


Figure 7.1b(1)-13 represents the percent of required Environmental Health inspections completed within the required timeframe. The target is > 95%.

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.

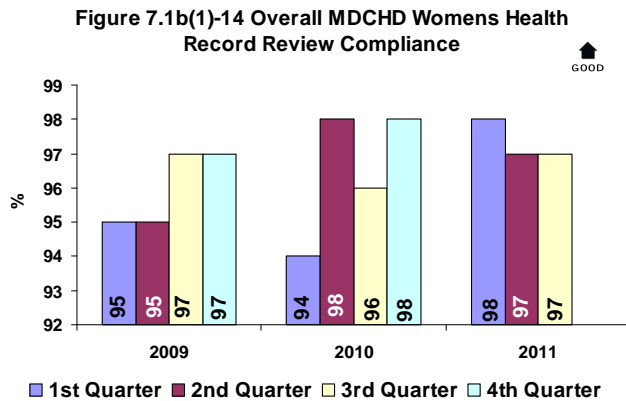


Figure 7.1b(1)-15 shows the percent of cases resolved favorably for the MDCHD by the Legal Department. The target is 100%.

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).

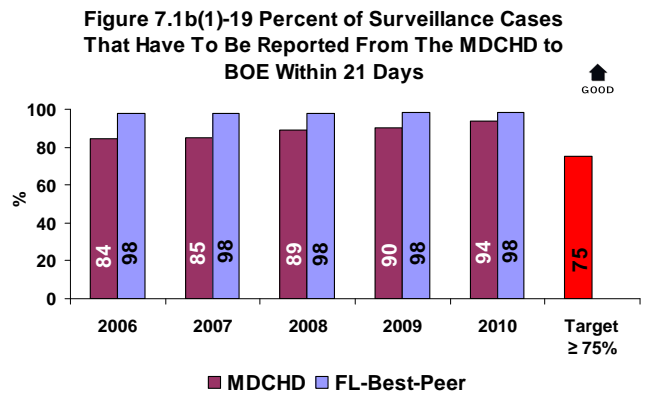


Figure 7.1b(1)-20 shows the percent of high titer syphilis field records disposition within 14 days from 2008 to 2010.

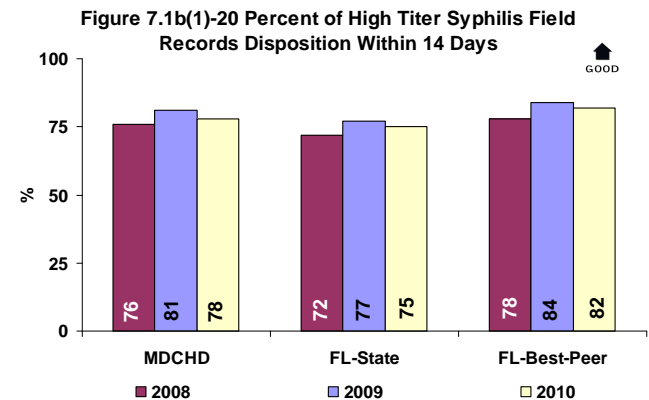


Figure 7.1b(1)-21 represents the percent of infectious syphilis cases treated within 14 days from 2007 to 2010.

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

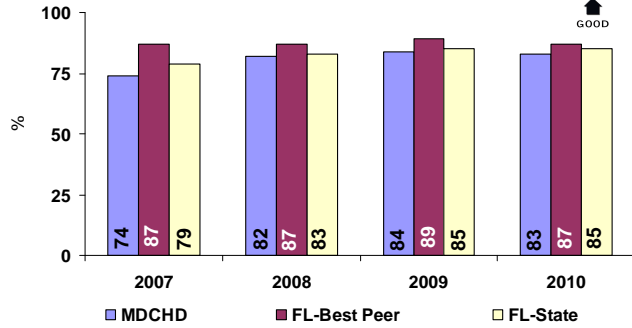


Figure 7.1b(1)-22 represents the number of new HIV/AIDS testing sites that register annually in MDC compared to Broward and Palm Beach County. The goal is to increase the number of sites registered in order to increase testing.

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 The CDC and State Reviews of SNS Plan (Mass Dispensing)

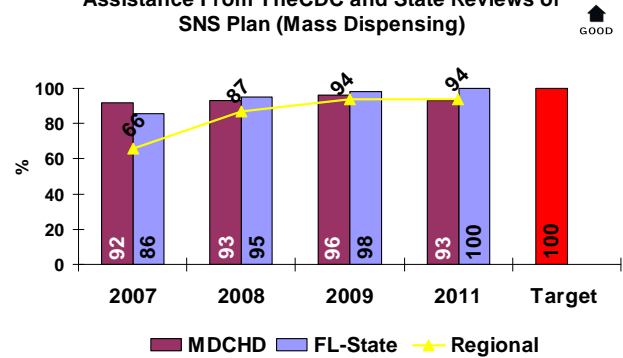


Figure 7.1b(2)-3 represents the percent of MDCHD FDENS users alerted who confirmed alert during tests and real events within 60 minutes. Florida Department of Health's Emergency Notification System (FDENS) is a CDC mandated web-based emergency notification system. The target is 100%.

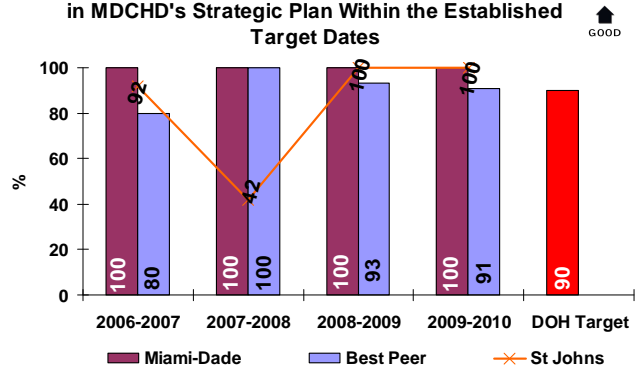
Figure 7.1b(2)-3 Percent FDENS Users Alerted Who Confirmed Alert Within 60 Minutes

	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

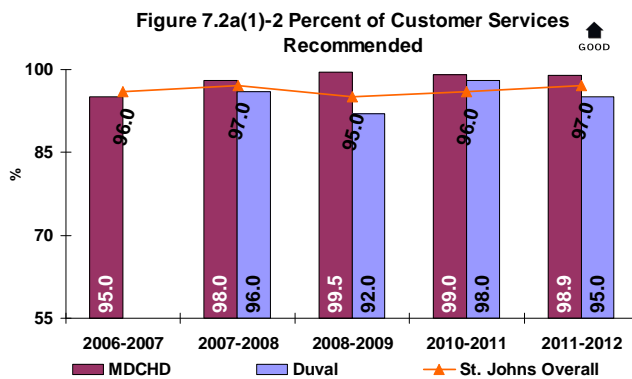
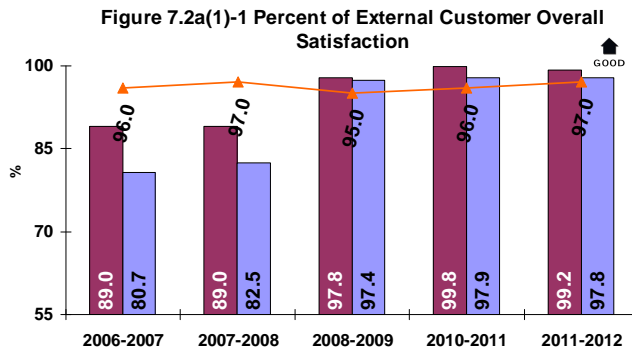


7.2 Customer-Focused Outcomes

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.



*: 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

*:provisional data

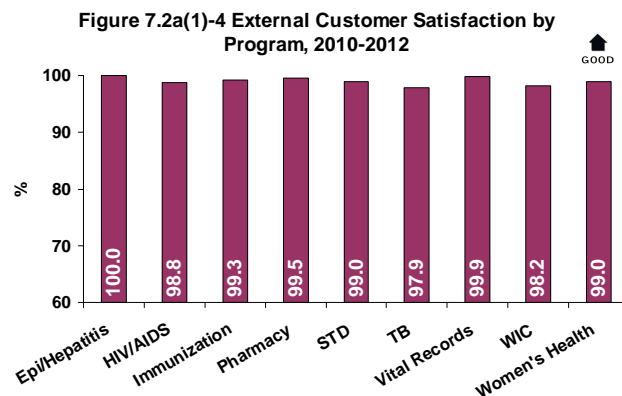


Figure 7.2a(1)-5 represents the percent of clients dissatisfied with MDCHD services.

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.

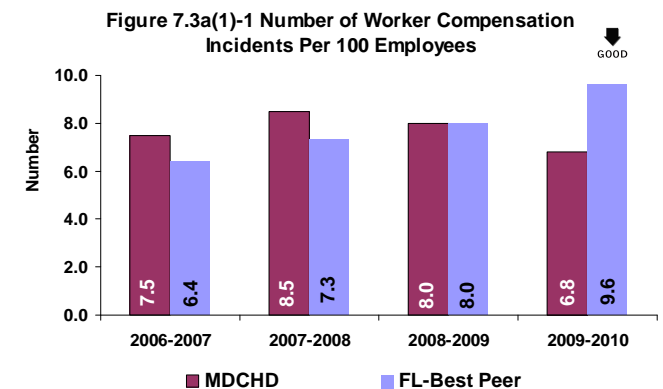


Figure 7.3a(1)-2 represents the number of Full Time Equivalent (FTEs) that are career service and other personnel services (OPS) for MDC from 2006 to 2011.

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

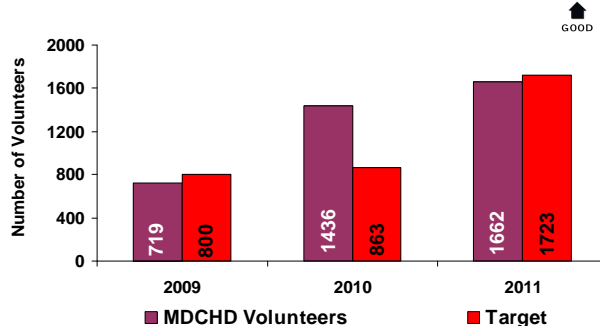
Figure 7.3a(1)-4 represents the percent of MDCHD staff that completed mandatory public health preparedness (PHP) training courses as per training policy DOHP 310-01-11 from 2008-2010. The target is 100%.

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

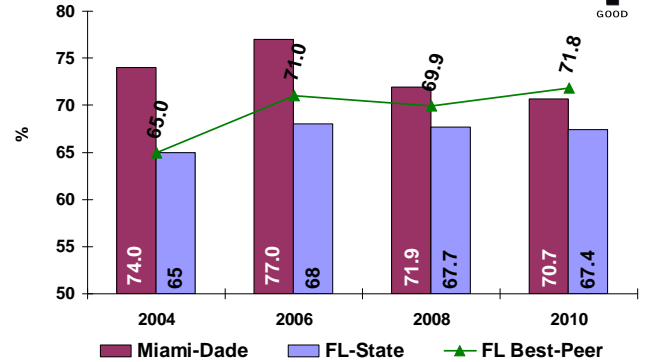


Figure 7.3a(3)-2 represents the employee survey response rate for MDCHD compared to FL-State and the FL Best-Peer from 2004 to 2010. High response rates show that employees trust that their concerns will be addressed by management. Since 2004, the employee survey response rate has steadily improved.

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

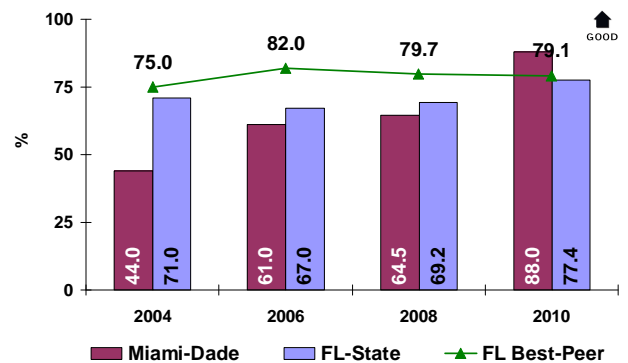


Figure 7.3a(3)-3 shows the results of the 2010 Employee Satisfaction Survey by six climate dimensions that are essential to employee engagement. This is on a 5-point Likert scale.

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

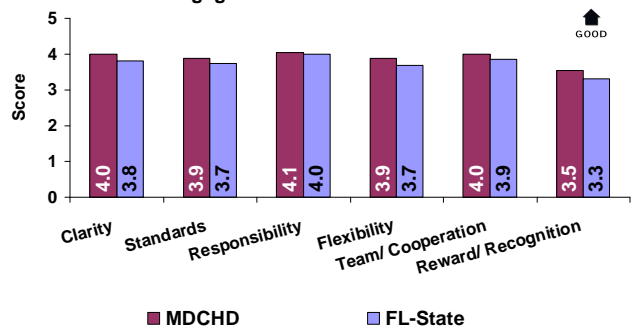


Figure 7.3a(3)-4 shows the results of the 2010 Employee Satisfaction Survey segmented by key question and compared to the FL-State FL Best-Peer and St. Johns County Health Department, GSA recipient.

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.

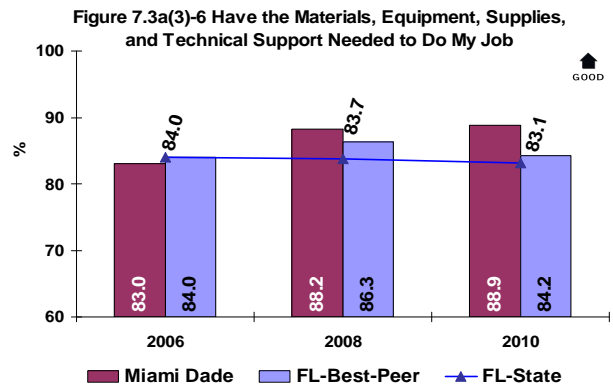


Figure 7.3a(3)-7 shows the percent of MDCHD employees that feel their work contributes to the DOH Mission from 2006 to 2010.

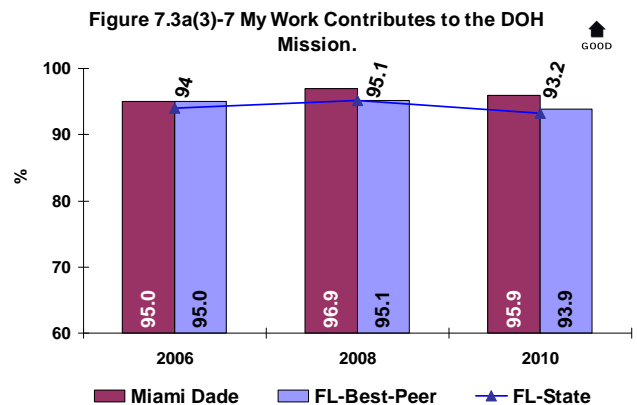


Figure 7.3a(3)-8 shows the percent of MDCHD employees that feel their work climate supports them in sharing their opinion from 2006 to 2010.

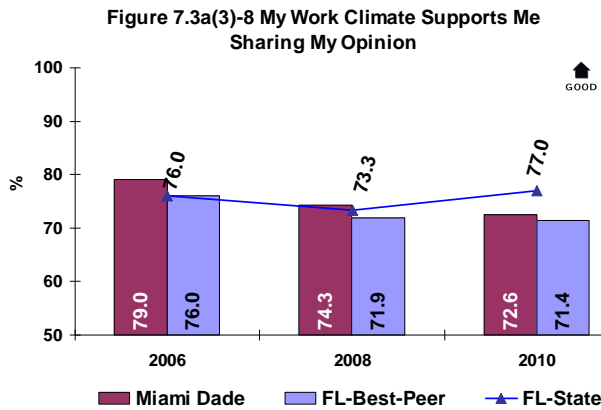


Figure 7.3a(3)-9 shows the percent of MDCHD employees involved in teams, workgroups, committees and councils from 2006 to 2011.

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 $\geq 95\%$.

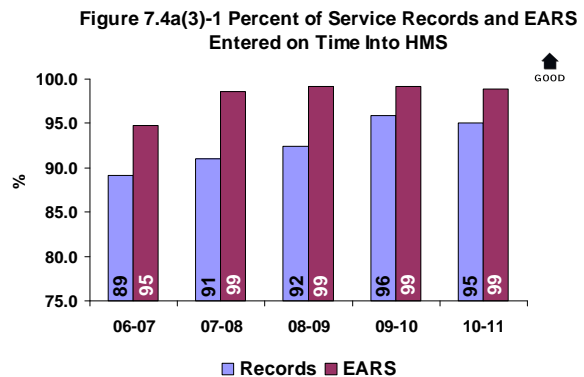


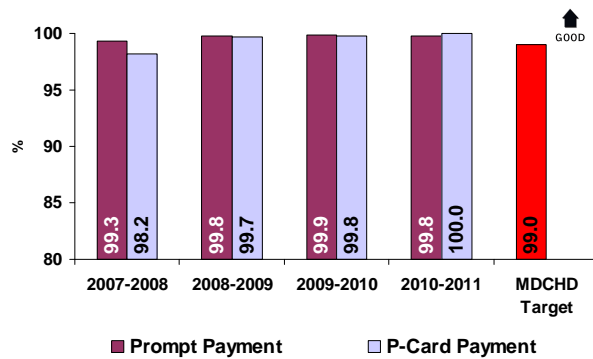
Figure 7.4a(3)-2 represents the water, sewage and community programs from 2006 to 2011 for MDCHD compared to FL-Best Peer and FL-State. The review for SHO for cycle 2009 - 2011 is not available.

Figure 7.4a(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

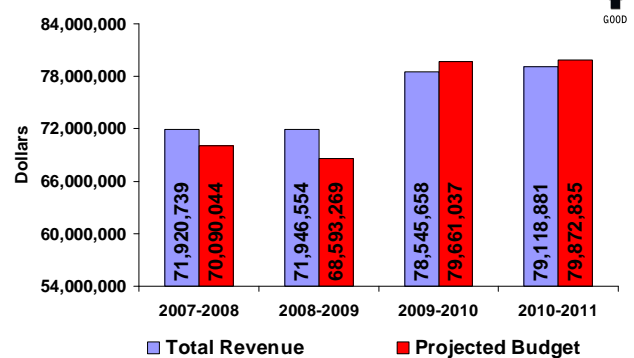


Figure 7.5a(1)-2 shows MDCHD's revenue-to-expense ratio for fiscal years 2007 to 2011. Since 2008, we have maintained a revenue-to-expense ratio above that of the FL-Best Peer and St. Johns County. The revenue-to-expense ratio measures performance in terms of profitability and asset utilization.

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

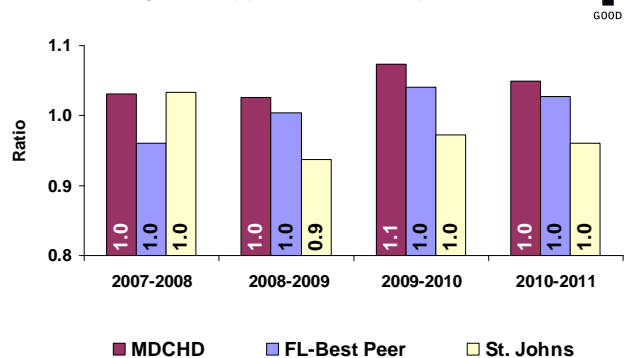


Figure 7.5a(1)-3 represents the total revenue per capita for MDCHD compared to FL-Best Peer for fiscal years 2007 to 2011. Despite low total revenue per capita, MDCHD consistently attains successful outcomes.

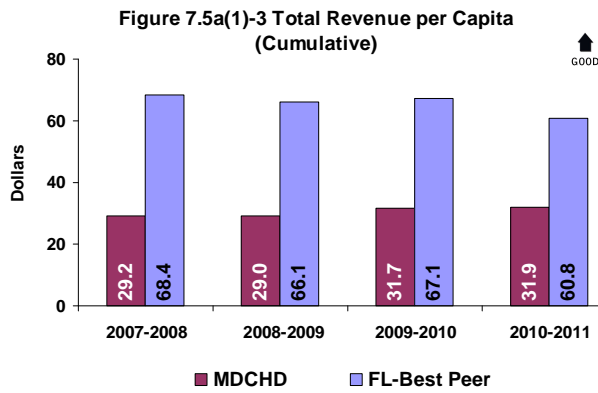


Figure 7.5a(1)-4 represents the Medicaid denial rate by month for MDCHD County for fiscal year 2008-2011. We have significantly improved our billing quality through workgroup implementation.

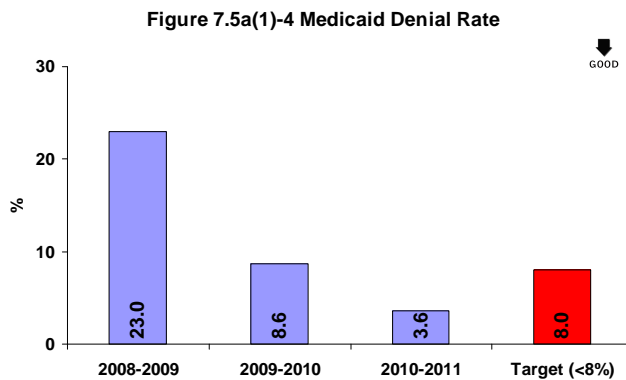


Figure 7.5a(1)-5 represents fee collections as percent of total revenue for MDCHD for fiscal years 2007 to 2011.

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 $\leq 10\%$.

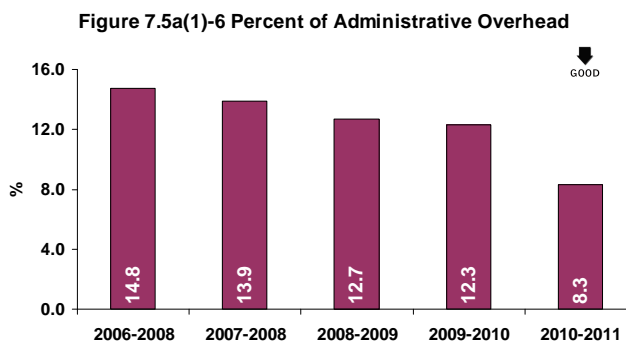


Figure 7.5a(1)-7 represents the trust fund balance at year end for MDCHD compared to FL-Best Peer.

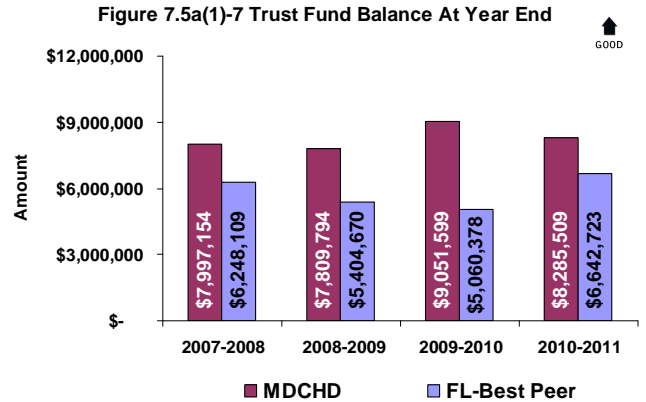


Figure 7.5a(1)-8 shows accounts receivable greater than 365 days for MDCHD segregated by type. Target is 0%.

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