



Evaluation of the
Multi-State Learning Collaborative (MLC) and Future
Directions for the Missouri Institute for Community Health
(MICH) 2011

prepared by



Public Health
Consulting, LLC

Research, Evaluation, and Quality
Improvement Services for Public Health

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Executive Summary

The Missouri Institute for Community Health (MICH) is a broad-based entity that facilitates dialogue among health care providers, the private sector, community colleges, universities, health and human service associations, and state and local government. The mission is to facilitate and promote excellence in community systems for health and quality of life. MICH's major product is the administration of the accreditation program. A Board of Directors leads this organization with representatives from local health departments (LHD), public health agencies, community organizations, professional associations, state agencies, and colleges and universities. In 2008, MICH, in partnership with the Missouri Department of Health and Senior Services, St. Louis University's Heartland Centers for Workforce Preparedness and Missouri Association for Local Public Health Agencies, established mini-collaboratives (MLC) of LHDs focusing on institutionalizing quality improvement and establishing a supportive climate for these agencies to go through the accreditation process. Formative and impact evaluation was used for all MLC as appropriate. A main focus of the project was to institutionalize quality improvement. To prepare Missouri's local health departments for state and national accreditation, Missouri's MLC-3 project focused its efforts on workforce development, specifically in the area of quality improvement. Target areas were selected for each LHD under assure a competent workforce and develop a community health profile. Results showed that at the 18-month mark, 92% had a QI plan in place, 58% have QI responsibilities in job descriptions, and 67% have a QI plan in performance evaluations. Readiness for QI was measured historically, before MLC-3, just after MLC-3 began, and at the end of the project (3 years later). There were changes in the readiness of the organizations to use and integrate QI into daily practice with internal staff and their governing entities. At least seven LHD will apply for accreditation with MICH in the next year and 5 will apply for PHAB Accreditation in the next 5 years. Recommendations are providing as a starting point after the MLC-3. They are based on the findings and recent discussions with MICH staff about how the last three years in the MLC has prepared MICH to take the next step and become a higher-functioning organization.

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Section 1. Mission of the Missouri Institute for Community Health and Purpose of the Multi-State Learning Collaborative (MLC-3)

The Missouri Institute for Community Health (MICH) is a broad-based entity that facilitates dialogue among health care providers, the private sector, community colleges, universities, health and human service associations, and state and local government. The mission is to facilitate and promote excellence in community systems for health and quality of life. MICH's major product is the administration of the accreditation program. . A Board of Directors leads this organization with representatives from local health departments (LHD), public health agencies, community organizations, professional associations, state agencies, and colleges and universities. The Accreditation Council under the auspices of MICH includes local public health agency representatives: 1 MICH Board Member, 1 Academician, 2 MICH members at large, and 1 State Health Department Representative. This body further defined accreditation standards and refined the accreditation tools and process.

In 2008, MICH, in partnership with the Missouri Department of Health and Senior Services, St. Louis University's Heartland Centers for Workforce Preparedness and Missouri Association for Local Public Health Agencies, established mini-collaboratives (MLC) of LHDs focusing on institutionalizing quality improvement and establishing a supportive climate for these agencies to go through the accreditation process. These LHDs shared their quality tools and projects with other LHDs in their geographic region and provided a foundation for system change in Missouri. The evaluation of the 12 MLC participants includes a description of Quality Improvement activities of the LHDs, change in level of readiness for QI at four time points, experiences during the project by the LHDs, and lessons learned from the MICH staff, and recommendations.

Three agencies are in the north near the Iowa border and 9 agencies are in the south next to the Arkansas border. The 12 MLC (Figure 1) participants remained together for three years and held their last meeting in Willow Springs, Missouri on March 25, 2011.

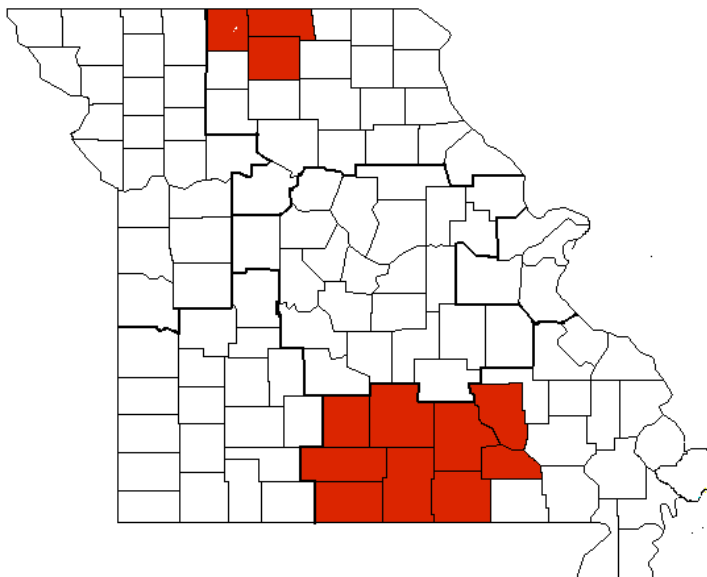


Figure 1.

Section 2: Final MICH Staff Survey

Formative and impact evaluation was used for all MLC as appropriate. At the end of the MLC-3 (April 2011), two staff members who most closely directed the activities and worked with the LHD were asked to complete a short survey about the strengths, weaknesses, opportunities, and threats of the mini-collaborative approach.

On a scale of 1 to 5, how well did the MLC-3 project conclude overall according to stated goals and objectives? A "1" indicates the project had nothing but challenges and did not progress according to stated goals and objectives; A "5" indicates the project was everything it was planned to be and more.

This was rated successful and very successful. Region G was everything we could have hoped for. They responded well to training, were engaged and almost all of them institutionalized qi into their everyday practices. 2. The northern group was disappointing apart from one LHD. Not engaged, appeared not to be interested and was a waste of our time. However that one LHD was way worth the effort. 3. Overall very pleased with results.

Several agencies were self-starters and just took up QI and made it work in their agencies. 2. Region G was an established and motivated group; they were successful from Day 1. 3. The northern group was more of a typical random group except the administrators had an established relationship. One agency excelled; one agency responded well to a QI pilot and the third agency never matured. 4. Two of the agencies already went through a successful accreditation application. The project leaders rethought their approach and started where staff were and brought them forward.

In the first stakeholders survey, you mentioned the capacity issues with the LHD were a challenge (staffing, technology, etc.). How did you work past that?

Kept working with them, continued to ask about progress. Peer pressure helped, too.

Technology was addressed by MDHSS installing DSL lines. Staff were able to participate in webinars and Region G developed uniform on-line nutrition education for their WIC clients. I think agency staff in the more successful agencies just adopted QI and made it part of their day. They came to realize it didn't have to add to their work load. I'm not sure that we had a particular technique that helped that except Marty developed some shortened forms "pigs" for capturing projects. Those were widely used.

Engaged leadership, open attitude, willingness to just jump in regardless if project doesn't work out as planned, you learn a lot by mistakes. Commitment to improving, to be the best you can be.

Predictors include staff that are willing to take risks, think out of the box, and willing to start over if it doesn't work. First thing out of the mouth is not "we've done it this way so"

Knowing what you know now, how would you design the MLC-3 differently with that information?

Never assume people know what you are talking about. Start the training at the beginning. Ask for a written commitment before you begin, to ensure you have their attention and willingness to engage.

Initially our project was structured around the MLC3 requirements of addressing a health risk. That was not feasible with this group. They needed coaching on the basic QI principles and then needed to apply in everyday situations. We needed to focus on institutionalizing QI into the culture, so the emphasis changed to workforce competency. Agencies were encouraged to incorporate QI requirements into job descriptions and evaluations and to develop and use an agency QI plan. This is where we needed to start. We lost 4-6 months trying to follow the original MLC3 model. All the agencies agreed to apply for accreditation, and we did not give them a time-line. We probably needed to have them sign up and go through the accreditation process.

Considering the entire MLC-3 Project, what stands out most in your mind about the strengths of the project?

How region g institutionalized qi into their everyday work load. We saw evidence of their commitment by their storyboards and willingness to share their work, failures and all.

Marty was a good choice as the project leader. She comes from a local health department and shared some of the same experiences. Using Heartland's webinar line had the potential of being a real strength but we lacked the experience to maximize its use. Having a group meeting in conjunction with the MICH annual meeting was strength. People got to travel and share experiences with others. Having participants attend the MLC-3 annual meetings was strength because people got to see how they were part of a large project. Frequent sharing sessions were learning sessions. Staff from one agency sometimes coached those at other agencies.

What do you see MICH doing in 5 years?

Working closely with PHAB. Providing QI training and other TA as required by LHD. Working with the Practice Based Research Network (PBRN) and multiple partners to improve the system of community health.

MICH is perched on a precipice. In 5 years we will be either a regional accreditor or a regional trainer for PHAB. I also see an educational arm of MICH developing. The PBRN will definitely be a part and MICH will have contractors working with local health department, providing TA or coaching in areas such as quality improvement, performance management, evaluation, etc. What is not answered is what will happen to small agencies seeking accreditation. OK and KS already indicated they would like to see MICH do regional accreditation for small agencies using the MICH standards. This is something the Board of Directors will have to study and make some decisions.

Section 3. Purpose and Focus of the Mini-Collaboratives (MLC)

A main focus of the project was to institutionalize quality improvement. To prepare Missouri’s local health departments for state and national accreditation, Missouri’s MLC-3 project focused its efforts on workforce development, specifically in the area of quality improvement. Initially, during the first year of MLC, MICH focused on basic QI training, introduction of simple QI tools and the use of the Institute for Health Care Improvement’s Model for Improvement. To gain buy-in, trust and commitment of agency staff to focus on quality, MICH allowed the directors of participating MLC to work with their staff to identify an agency wide process, program or initiative that needed improvement. The QI projects initially selected, documented via storyboards, were quick and successful. The topics for the QI projects ranged from: simple communication processes, patient confidentiality, immunizations, moving to a new building, to CD Investigations.

The target areas and goals for each of the 12 LHDs are in Table 1.

Table 1. Targets and Goals of the 12 Mini-Collaboratives	
Targets	Goals
1. Assure a competent workforce (specifically related to quality improvement competencies)	a. incorporate specific quality improvement competencies into personnel systems
	b. develop a departmental quality improvement plan
	c. develop and provide a quality improvement module available on St. Louis University’s School of Public Health’s Heartland Centers Learning Management System available for just in time training for new staff and those staff requiring a refresher course on quality improvement principles
2. Develop a community health profile	a. Develop a comprehensive community health profile by geographic area (north and south-central)
	b. Develop regional balanced scorecards focusing on health status indicators and disseminated to the public

Activities to carry out the targets and goals are described as follows. Supporting documents, such as handouts are included in the attachments.

Assure a competent workforce (specifically related to quality improvement competencies)

Incorporate specific quality improvement competencies into personnel systems and develop a departmental quality improvement plan

The agencies were given guidance on institutionalizing QI through board involvement, job descriptions, and annual employee performance appraisals. A first step was to create a written description of QI activities that was approved by the governing entity and includes an annual plan that describes with timelines, the specific planned activities to be carried out. The Quality Improvement Plan identifies specific areas of current operational performance for improvement within the agency. Examples of QI responsibilities used in job descriptions are:

Agencies were challenged to create a way to “document QI on the Fly” and find ways to incorporate the documentation of QI into the practice of the agency.

- Participates in appropriate agency Quality Improvement projects.
- Participates in Continuous Quality Improvement Planning for the Health Department.
- Participate in improving agency performance, processes, programs, and interventions through quality improvement which will be demonstrated in at least one specific instance prior to [insert date]
- Serve as member of the QI advisory team. Review, identify and make recommendations to QI plan as needed.

Incorporating QI language into annual employee performance appraisals could be addressed using the following question or statements:

- As part of our On-going Quality Improvement Program: What one issue, Program or Process do you feel needs to be “fixed” in our agency and list one recommendation for improvement to assist in the fix.
- Participate in improving agency performance, processes, programs, and interventions through quality improvement which will be demonstrated in at least one specific instance prior to [insert date].
- Keeps abreast of current trends and developments in public health and nursing by reviewing professional literature and/or attending available training and seminars, within budget constraints
- Takes part in continuing education relevant to duties and responsibilities at least once every 24 months
- Participate in appropriate agency Quality Improvement projects.

Develop a Learning Management System (LMS)

Missouri, like many other states, is losing many of its senior public health workers and the new workforce is constantly changing. In addition, budget cuts are forcing agencies to do their business a different way. Gone are the days of closing down the agency, and everyone going to

training. Time and distance do make a difference, so staff are turning to on-line services for updating their skills. Learning quality improvement principles is no different. MICH provided technical assistance on quality improvement to 12 rural local health departments, and time and distance were barriers to the success of the project. MICH started doing monthly webinars, but more was needed to help with the institutionalization of quality improvement into the cultures of the agencies.

The MLC worked toward a competent workforce, related specifically to quality improvement competencies by incorporating specific quality improvement competencies into personnel systems and developing a departmental quality improvement plan. St. Louis University School of Public Health, Heartland Center for Public Health and Community Capacity Development (Heartland) offered to partner with MICH to develop a quality improvement learning module for Heartland's on-line Learning Management System as one way to help address institutionalization.¹ The Kansas Health Department contributed a video about a regional quality improvement project, and Oklahoma Department of Health provided information about performance management. The audience is the beginning public health worker or anyone wanting a refresher course in quality improvement. The goals are to introduce quality improvement tools and demonstrate how the principles of quality improvement are part of performance management, or in other words, "little qi and Big QI". There are six segments:

1. An Introduction to Performance Management
2. Quality Improvement Plan Components
3. Quality Improvement 101 (focusing on the voice of the customer and basic tools to use in the workplace)
4. The Role of Evaluation in Big QI
5. Balanced Scorecard and Agency Accountability
6. Accreditation and Institutionalizing Quality Improvement

Develop a community health profile

Develop a comprehensive community health profile by geographic area (north and south-central)

The southern cohort developed a regional health profile using data from MDHSS' MICA and MICA Intervention data systems and OSEDA. A public health intern from Missouri State University assisted in the data gathering. All the counties have similar characteristics, and the regional approach helped them decide on what problems to address. The first one they chose was to regionalize their WIC system, with the first project being the development of on-line nutritional programs for clients to access regardless of their entry point into the system.

The northern cohort gathered data using MDHSS' sources and OSEDA, then compiling the information by county so that the boards of trustees for each county agency could use the information for planning purposes. In addition, the three agencies did a region-wide customer satisfaction project based on the community health profile.

¹ Learning Mangement System at St. Louis University. Retrieved from <http://www.heartlandcenters.slu.edu/lms.htm> on April 6, 2011.

Develop regional balanced scorecards focusing on health status indicators and disseminate to the public

Part of the activity was completing a balanced scorecard. This was done as a group activity in the North and South. The common goals to each were to protect, prevent and promote healthy communities. Each group then developed objectives and activities to address these overarching public. The scorecards were then presented to the DHSS. A state representative was asked the value of these cards for their work. They stated that “some DHSS programs have used balanced scorecards in tracking of outcomes. It seems that the balanced scorecard project assisted agencies in collaborating and in the case of Region G doing some strategic planning on a regional basis and preparing for accreditation.” In the south, individual agencies used them for agency planning and to decide to regionalize their approach to WIC; in the northern counties, the agencies determined from the scorecard that they did not have enough visibility in their communities, so they did a region-wide customer satisfaction survey.

Table 2 provides a list of the activities for each MLC.

Table 2. List of Quality Improvement Projects Completed by Agency

County	Activities
Carter County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions • WIC Vouchers and Current Immunization • Staff working on workforce development, education and training requirements for accreditation
Douglas County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions • WIC Outreach at Lion’s Club Walk/Run and other similar events • Tdap Outreach clinics increasing the number of 7th graders who are vaccinated • Collaboration with Douglas County Elementary Schools to increase ATV Safety Awareness. • Designed survey to measure changes in knowledge/compliance with ATV Safe Practices and Laws
Howell County	<ul style="list-style-type: none"> • QI Plan QI Responsibilities in Job Descriptions
Mercer County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions • QI Responsibilities incorporated into Performance Evaluations • Consistent Communication with full time and part time staff • Consistent Count of Vaccines • Working on joint accreditation with Putnam and Sullivan Counties • County wide customer survey in conjunction with Putnam and Sullivan Counties
Oregon County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions
Ozark County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions • Modified Immunization screening questionnaire to capture allergies to vaccine • Training back up staff on guidelines for lead screening, utilizing new form for parents head start • Reviewed job descriptions & added QI responsibilities to all job descriptions
Putnam County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions • County wide customer satisfaction survey in conjunction with Mercer and Sullivan Counties • Initiated Professional Development Days with the permission of her Board • Workforce Development requirements for Accreditation and has arranged for LMS training for staff • Working on Joint Accreditation with Mercer & Sullivan Counties
Reynolds County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions • Coordinated Sexual Assault Education and Prevention with Violence against Women presentations resulting in improved time management and decreased mileage cost • Monthly waiting room education bulletin board & reorganization of educational pamphlets result in timely educational updates on current health issues • Installed doorbells in several areas to notify staff of client arrival
Shannon County	<ul style="list-style-type: none"> • QI Plan Presented to the Board of Trustees and if approved will be inserted into the Policy Manual • QI Responsibilities in Job Descriptions • Data collection forms were initiated in April and will be turned in monthly.
Sullivan County	<ul style="list-style-type: none"> • QI Plan • Working on joint accreditation with Putnam and Sullivan Counties • County wide customer satisfaction survey in conjunction with Putnam and Sullivan Counties
Texas County	<ul style="list-style-type: none"> • QI Plan • QI Responsibilities in Job Descriptions • Staff training on QI • Reviewing immunization process
Wright County	<ul style="list-style-type: none"> • Staff (2) received their BSN last week (honors). Independent study on Accreditation

Section 4. Process and Impact Evaluation at Specific Timepoints during MLC-3

Process Evaluation Findings

During the MLC, staff members documented process evaluation findings. In February 2010, these process targets were noted.

- All 12 agencies completed a QI project and documented it on a Story Board.
- All 12 agencies participated in a balanced scorecard training and developed either their own Balanced Scorecard or a regional Balanced Scorecard.
- The southern MLC have joined forces and have completed a regional community assessment together.
- One of the strategic objectives identified on the balanced scorecard was to develop a regional health education/communication plan to promote regional awareness about selected health topics. They are working on this now.
- One agency has been accredited through the Missouri Voluntary Accreditation Program.

In August 2010, additional lessons learned were noted.

- Tools that include public health examples are essential. The Public Health Memory Jogger was a start, but the Michigan Handbook was even better. All examples and samples were from health departments.
- Group size does matter in order to improve the group dynamics. Five to nine agencies in a collaborative works best. Three is too few, and more than nine doesn't allow for enough individual input. Individual agency projects worked best with the small group, and each agency reported on its progress to the group.
- Projects worked best that the group devised rather than being told an issue to address. We often had to revise the chosen projects and change to better suit the needs of the group. An example was health literacy. Identified as an important topic on the region's balanced scorecard, they didn't want to address unless they got funding. They had the opportunity to self-administer the region's WIC program, so this emerged as a QI opportunity.
- The balanced scorecard exercise gave agencies something they could share with their boards and the public which was easy to understand and made the agency more visible. It also was a great tool that was incorporated into agency grant applications and presentations.
- Institutionalization of QI requires time. Attempting new collaboratives every year was not going to work if the agencies were to incorporate QI principles and tools into their work. Each agency developed a QI plan and made knowledge of QI principles part of individual job expectations. This not only takes time to develop but also to evaluate to see if the plan and the job expectations are working. MICH did one collaborative with 12 agencies during MLC-3.
- Webinars are needed to address time and distance issues, but they create their own set of problems. Presenters and audience have to be comfortable with the format. Silences need to be turned into learning opportunities. Lots of pre-planning is required to make sure there will be individual presentations and group discussions during the call.
- Sometimes to further encourage agency staff, special projects with individual visits was required. Both staff and MICH contractors profited because staff were helped in making QI

individual, and MICH contractors were able to pilot the approach to see if would be suitable for a module on the Learning Management System.

- Developing Quality Improvement modules for the Learning Management System was needed to help with institutionalization. MICH did an introductory quality improvement module so that new staff could gain a basic understanding of QI, and trained staff was able to return for a refresher course.

As shown in Table 3, at the 18-month mark, 92% have a QI plan in place, 58% have QI responsibilities integrated in job descriptions, and 67% have QI responsibilities integrated into performance evaluations.

Table 3. Institutionalization of QI for Agencies in August 2010			
Agency	QI Plan In Place	QI responsibilities integrated in Job Descriptions	QI responsibilities integrated in Performance evaluations
Mercer	X	X	X
Putnam	X	X	X
Sullivan	X		
Douglas	X	X	X
Ozark	X	X	X
Wright			
Carter	X		
Howell	X		X
Oregon	X	X	
Reynolds	X	X	X
Shannon	X		X
Texas	X	X	x
Total	11/12	7/12	8/12
Percent	92%	58%	67%

An online survey was sent to all MLC. The first three questions were rated on a scale of 1 (less) to 5 (more) with various semantic differentials (Table 4).

Table 4. Experienced Benefits of MLC-3 Quality Improvement Activities (N = 10)					
On a scale of 1 to 5, how much did the MLC-3...	1	2	3	4	5
	Less				more
a. help the staff at your department understand that QI does not take a lot of time to implement compared to its benefit?	0	0	1	4	5
b. help the staff at your department understand that QI can be an effective way to understand your programs and outcomes better?	0	0	1	3	6
c. help increase the QI capacity at your department through webinars (scheduled the 4th Wednesday of every month)	0	0	1	4	5

The LHD were asked if they have performed specific tasks that would increase the culture of QI in their department (Table 5).

Table 5. Specific Actions taken in LHD related to QI Culture (N = 10)				
Question	yes	not sure	no	future
1. incorporated QI language into all or most job descriptions	7	0	1	2
2. talked about QI concepts and activities at most staff meetings	9	0	1	0
3. talked with our governing board about QI concepts	8	0	1	1
4. incorporated QI into our annual performance evaluation for staff	7	0	1	2
5. created a quality improvement plan	9	0	1	0

We introduced the PDSA (Plan, Do, Study, Act Cycle) Worksheet that had steps for planning QI (e.g., getting started, assembling a team, examining current approaches, identifying solutions, developing the theory, etc.). The respondents were asked how useful this tool was during the MLC-3 and if they used it within other programs of the department. Seven of the respondents said it was “very useful” for the MLC-3 and seven expanded the PDSA cycle to other programs in the department. One respondent said the PDSA was “somewhat useful” for the project and one said it was “somewhat useful” when they expanded it to other programs in the department. Two respondents were “neutral” about the use of PDS for the MLC-3 and for other departments, respectively.

One LHD has used the quality improvement module available on St. Louis University’s School of Public Health’s Heartland Centers Learning Management System, one was “not sure”, and two plan to use it in the future. Five LHD did not use the LMS.

Considering the LHD intent to apply for accreditation now and in the future and to MICH and/or the national program through the Public Health Accreditation Board (PHAB), results are shown in Table 6.

Table 6. Intent to Apply for Accreditation through MICH and/or PHAB		
Statement	Response	
	MICH	PHAB
1. will not apply for accreditation	1	3
2. will apply, but within the next 3 to 5 years	2	1
3. will apply, but within the next 1 to 2 years	4	1
4. will apply, but within the next year	0	0
5. we've made the decision to apply and are getting staff buy-in and planning for the process (early stages)		0
6. we've designated an accreditation manager and formed a committee	1	0
7. conducting the self-assessment now	1	0
8. completed the self-assessment and waiting on the site review	0	0

Impact Evaluation Findings

Impact of the MLC-3 was measured by LHD reported readiness at four different time periods. To understand the readiness for a quality improvement cultural change, the 12 MLC were interviewed in August 2008 and again in April 2011. The purpose of the instrument was to (a) understand how LHDs in the MLC are progressing and (b) collect information on QI and how that diffuses across the LHD through time, specifically to the end of the project. The tool used for this interview is based on the Community Readiness Model² (Appendix A). Terms used in the instrument and in the interview are:

- Quality Improvement can be defined as "a multidisciplinary, systems-focused, data-driven method of understanding and improving the efficiency, effectiveness, and reliability of public health processes and practices."³ Readiness for QI is ranked on a scale (stages) from 1 (no awareness) to 9 (complete department ownership).
- Community in this case is the Local Health Department (“department”) and to some extent the public they serve (e.g., physical environment, culture, policies, financial health,

² Colorado State University. Community Readiness Model. Available path: <http://www.triethniccenter.colostate.edu/communityreadiness.shtml>. Retrieved July 21, 2009.

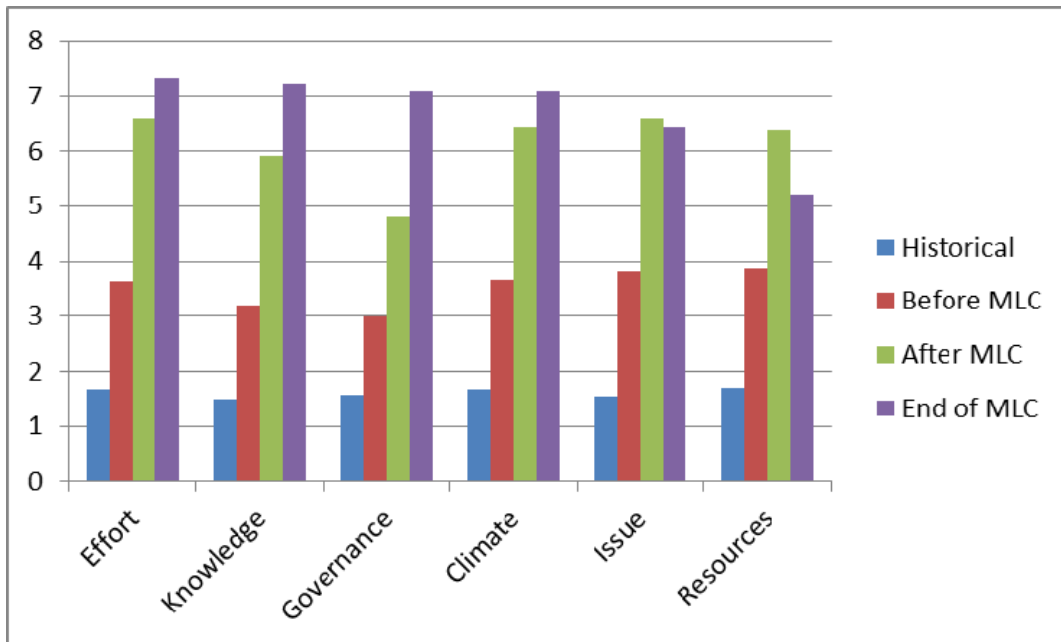
³ Rand Corporation. Quality Improvement: Implications for Public Health Preparedness. Available path: http://www.naccho.org/topics/infrastructure/accreditation/resources/upload/RAND_TR316.pdf. Retrieved on July 21, 2009.

norms, history, personnel, etc.).

- Dimensions of readiness (e.g., effort, leadership, knowledge, etc.) are key factors that influence department and community's preparedness to take action on an issue. In this case, QI. The six dimensions identified and measured in the Community Readiness Model are very comprehensive in nature. They are an excellent tool for diagnosing community's needs and for developing strategies that meet those needs.

In the first survey (in 2008), each interviewee was asked to select one stage under each time period. Ratings were collected on three time periods: (a) historically (creation of the LHD in the community until about 10 years prior); (b) before MLC-3 (10 years in the past, but before MLC-3); and (c) after (after beginning MLC-3 project). In April 2011 (Time 4), the MLC were asked to complete the survey a last time to understand how their readiness for QI changed through the project. For both data collection points (2008 and 2011), each LHD administrator was asked a series of questions to understand their level of readiness for each dimension. The figure shows a consistent increase in readiness through time.

Figure 2. Historical, Before, and after MLC-3 Scores for Dimensions of Readiness.



Additional comments provided by the participants are as follows:

- *This has been a continuous learning project for our whole staff and leadership. We have steadily advanced and are doing quality improvement as part of everyday business. The actual documentation of the process will take constant reminders as we are very busy.*
- *We all feel this has been a tremendous and positive learning experience. Staff are aware of the benefits and they recognize the need for QI and when things are not going smoothly they often bring up the idea to do a RCI and get the situation "taken care of". It has just been great and we all hate to see the experience end. I do feel the staff have internalized the process and our Board of Trustees enjoy hearing updates at monthly Board of trustee meetings. QI is an agenda item every month and we almost always have something to report. It has been a wonderful benefit and professional growth for our staff. Our annual employee evaluations are coming up and QI will be addressed on the review and I have included QI participation on job descriptions so this will continue and never be lost to the agency.*
- *Thank you for allowing us to participate in the mini collaborative it has been an excellent learning experience for us. The tools, projects and webinars that were provided were very useful in helping us with our quality improvement techniques. We feel this was a wonderful tool that helped us to achieve Accreditation. One of the outcomes is that staff sees the importance of using the templates given to them to help with QI improvements and how to evaluate the project. Thanks again.*

Section 5. Lessons Learned by MICH Staff About Achieving Institutionalization of Quality Improvement in 12 Local Health Departments

Lessons learned about institutionalizing QI with LHD are as follows:

- Customers of the LHD understand a balanced scorecard related to the function of the LHD. Institutionalizing QI takes time.
- Webinars are needed to address time and distance – but be careful with the lack of contact you have with a webinar.
- Using on-line QI training gets new employees in the loop and provides refresher courses.
- Institutionalizing QI capacity into the workforce requires strong commitment and leadership
- Agencies initial understanding, perceptions of quality, and anxiety levels about QI/Evaluation influence adoption.
- Agency size does matter. It is easier to introduce QI in a larger agency because there can be a QI team rather than everyone ending up involved in all the projects.
- QI training and implementation must co-exist with LHD work (e.g., H1N1).
H1N1
- Mini-collaboratives chosen were already active and had established relationships. MICH had to gain entry to the group by coming up with something that would be of value to the group. MICH originally thought it would be working on health indicators using quality

improvement tools, but the group said this wouldn't be useful. Instead, by developing an introduction to quality improvement, MICH created what was useful and of value to the group. It was an interesting lesson in group dynamics.

Staff identified certain solutions that helped QI adoption easier for the agencies. One of the solutions was to demystify the concept of QI and incorporate the MLC-3 into the goals of the agency instead of approaching it as additional work or a project. The team constantly re-evaluated their approach, direction and speed of instruction. Additional solutions are:

- Customized training is valuable, group work is contagious & celebrating success begets success
- Chose size of agency carefully
- Focus on big QI & small QI
- Take QI off the shelf
- Build on existing synergy
- Use existing structure in department (e.g., intranet, face to face meetings, work with all staff not just QI team)
- Each employee selected one process to improve

The staff was asked if they were to plan another collaborative approach, how they would plan this differently. When the collaborative was initiated, we thought we would be working with larger agencies. However, the State Health Department suggested working with a group of high performing small agencies that had been a part of a NACCHO strategic planning project. The focus on small agencies fit in nicely, because when we initially piloted volunteer accreditation and evaluated accredited agencies the data identified the quality standards as the most challenging area agencies struggled with, particularly the small agencies. Being that the majority of LHD's in the state are small, rural agencies we decided to target them for the collaborative.

One staff member said, "When we chose small agencies not familiar with QI use we also chose to start with a group with limited resources, time and knowledge. These challenges meant we had to start from the very beginning, which slowed the process down. The good news is lack of resources did not mean a lack of enthusiasm. The rural agencies are becoming accredited, yet if we had focused on the larger agencies a larger percentage of our state would be served by an accredited agency."

Section 6: Recommendations from this Report

The recommendations are based on the above stated findings in this report and on recent discussions with MICH staff about how the last three years in the MLC has prepared MICH to take the next step and become a higher-functioning organization. Therefore, we present these recommendations as not an end point, but as a catalyst for future board discussions and staff internal goals and work.

1. Seek more visibility out of state for the organization. The website is updated and very sophisticated looking. Work more with national stakeholders we already have a relationship with, such as RWJ Foundation, National Network of Public Health Institutes. Bring in additional resources to MICH with communications and marketing expertise. Present at a specified number of conferences each year. Establish early in the year which public venues are appropriate. All activity should have a clear purpose and outlined strategy for dissemination.
2. Use our current expertise and past experiences as a foundation for additional lines of work, such as research technical assistance, education, training, and vendor for accreditation. Seek funding and opportunities that allow us to build upon recent successes (e.g., Quick Strike Funding).
3. With limited resources, we need to be creative about human capital within the organization. Use the resources readily available in our academic institution partners. Employ the use of research assistants on a regular basis to assist with planning of events, attending meetings, coordination of partner work, newsletter writing, database maintenance, literature reviews. This could be a win-win situation for both and MICH could play a role in the pipeline of workers for public health. When seeking new partners, be clear about expectations for their work and how it will benefit them and MICH.
4. Establish an arm of MICH awards or recognitions. Consider a research award or excellent practice in the field award. Create an award or internship placement for students every year, rotating between all the public health institutions.
5. Create a special technical assistance role for MICH every month. This improves our visibility and allows us to fill a gap needed in public health capacity in the state. Consider social networking, use of software products (Microsoft office, Visio). Ask public health workers what capacity training events they need (e.g., policy writing, working with social media, database design, designing a survey, etc.).
6. Reach out to new and existing stakeholders and be clear about what they need to do and how the collaboration will benefit them.
7. Apply for a Practice Based Research Network, if and when available. This will lend legitimacy to our efforts.

8. Take a more active role with NNPHI. We are now a regular member, but need to attend more of the meetings, webinars and present at their conferences.

Attachment A
Building and Sustaining Momentum for QI
When Staff is Doing More With Less

Given the results of NACCHO's surveys measuring the impact of the economic recession on local health departments (LHDs)⁴ during the past 2 years where LHDs lost 23,000 jobs to layoffs and attrition and an additional 25,000 employees were subjected to reduced hours or mandatory furloughs and with more than half of LHDs making cuts to important population-based primary prevention programs, we were not surprised to receive the following question from a local health director on the front line of the economic recession.

Question: Any ideas on morale boosters that doesn't cost us money? Some of my staff are getting really negative. I'm trying to look for something that will get them all involved in quality improvement activities and cut the bickering about whose job is it. I want the message to be "it's everyone's job".

Answer: Here are a few ideas to encourage and motivate quality improvement activities and boost morale at the same time:

- ❖ Give staff a Hershey Kiss or Kudo bar when you want to acknowledge employees who have gone above and beyond, and or encourage staff to acknowledge one another with a Kiss or Kudo bar when they want to acknowledge a fellow employee who has gone out of their way to make a difference or has implemented a quality improvement activity/initiative. A national Baldrige quality award winning organization implemented a "Caught in the Act" program where staff wrote down what was caught (helping a customer, improving a process, helping a fellow employee, etc), i.e. "I caught Phyllis answering the phones when we short of staff". Each employee was given a stack of "Caught in the Act" cards/forms. Then when something was caught and written down it was posted in the lunch room. Through out the month the number of cards grew in number and the staff was surrounded by positive comments. At the end of each month all the comments were taken down, put in a box, the director then asked someone to draw a Caught in the Act card. The employee who performed the "act" on the selected card had lunch with the Director or got the coveted front door parking spot.
- ❖ Implement a "Quality is Personal" program. This program could involve all agency employees in three to four sessions spread out over a ten to twelve week period. Have employees identify items for improvement from three categories: personal, professional, and or academic. In the first session employees would be introduced to the principles of quality and asked to identify 3-7 items they want to improve. During the second session the lists would be reviewed, employees would learn how to establish standards for measurement, and create a data collection process. Over the next two weeks employees would collect data. During session three staff would share their experiences in collecting the data and how it has changed their performance, learn how to analyze, chart the data

⁴ National Association of County & City Health Officials web site, LHD Job Loses and Budget Cuts at <http://www.naccho.org/topics/infrastructure/lhdbudget/index.cfm>

and conduct a root cause analysis. Between sessions three and four staff would continue to collect data on the personal, professional and or academic items they selected for improvement. During session four data would be reviewed and additional quality tools will be introduced. The sessions should provide staff with a hands on learning experience, and an opportunity to share and discuss personal improvement efforts with each other allowing them an opportunity to encourage one another and celebrate successes. As employees are successful in making improvements in areas of their life they want to change, moral should improve and they should become more energized as a group. As a side benefit agency efficiency and effectiveness should also improve.

- ❖ Create an agency newsletter to increase internal spirit. Ask each staff member to contribute an article describing their area(s) of responsibility or activities they are involved in or are trying to improve. The newsletter could be a monthly or quarterly production that could be shared internally or with customers and/or Board. Excerpts of the newsletter could be submitted to the local paper to promote agency services, activities and initiatives.
- ❖ Jumbo Comment Card: Post a flip chart or large piece of paper with markers stationed close the employee entrance or the customer exit. At the top of the piece of paper/flip chart, write, "Tell us how we did, or Tell us how your visit was today, or if you're daring, ask, "What can we do to improve our service?" (surprisingly you will get positive comments from this question). If you post a comment board by the employee entrance, ask, "Who or what made a difference in your day today?", or "I appreciated....." The comments left on a comment board are often very positive, and uplifting for staff. You can share/show off the comments to your Board.

Attachment B
Quality Improvement Readiness Instrument

1 - Dimension	2 – Stage (1-9)	3 - Historical	4 - Before	5 -Post
A. Department Efforts: To what extent were there efforts, programs, and policies that address QI in the department?	1. No Awareness QI or lack thereof was not generally recognized by the department or leaders as a problem (or it truly was not an issue).			
B. Department Knowledge of the Efforts: To what extent did department members know about QI efforts and their effectiveness, and were the efforts accessible to all segments of the department?	2. Denial / Resistance At least some department members recognized the absence of QI, but there is little recognition that it was lacking in our department. 3. Vague Awareness Most felt that there is a local problem, but there was no immediate motivation to do anything about it.			
C. Leadership: To what extent were governing board members and internal management influential department members supportive of the QI?	4. Preplanning There was clear recognition that something must be done, and there may have even been a committee. However, efforts were not focused or detailed.			
D. Department Climate: What was the prevailing attitude of the department toward QI? Was it one of helplessness or one of responsibility and empowerment?	5. Preparation Active leaders began planning in earnest. Department offered modest support of efforts. 6. Initiation Enough information was available to justify efforts. Activities were underway. 7. Stabilization Activities were supported by administrators or community decision makers. Staff were trained and experienced.			
E. Department Knowledge about the Issue: To what extent do staff know about QI concepts and how it can affect the department?	8. Confirmation/ Expansion Standard efforts were in place. The community felt comfortable using services, and they support expansions. Local data were regularly obtained. 9. High Level of Department Ownership Detailed and sophisticated knowledge existed about prevalence, causes, and consequences. Effective evaluation guided new directions. Model was applied to other issues.			
F. Resources: To what extent were resources – people, time, money, space – available to support QI efforts?				

Attachment C CQI Vocabulary

Quality:

Improving how we do, what we do together, to meet the needs and expectations of our customers

NACCHO adopted the following definition of Quality:

“Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health.

It refers to a continuous and ongoing effort to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.

PDCA:

Plan-Do-Check-Act was the original term used to describe a quality improvement cycle. Dr. W. Edwards Deming considered by many to be the father of modern quality control felt people were jumping through the “check” phase too fast by not analyzing the effect of the intervention. To encourage the STUDY of the data the model was renamed’ Plan, Do study, Act.

PDSA:

This term refers to refers to Plan-Do-Study-Act, with emphases on studying the data from the “Do” phase to identify what the data is telling you and to see or check if you are getting the results you want.

The Model for Improvement:

The Model for Improvement is used for learning, to develop changes, test changes, and implement changes. It is based on three fundamental questions- What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?-and a “cycle” for learning and improvement – PDSA

Customer

Refers to actual and potential users of you agency’s services or programs. Customers are the heart of QI as they define quality

Voice of the Customer

This term refers to your process for capturing client- and stakeholder-related information. Voice-of-the-customer processes are intended to be proactive and continuously innovative to capture stated, unstated, and anticipated patient and stakeholder requirements, expectations and desires.

Quality Improvement Plan:

A written description of QI activities that has been approved by the governing entity and includes an annual plan that describes with timelines, the specific planned activities to be carried out. It should be broad in scope, reflecting a range of health and service issues relevant to the population served.

The Quality Improvement Plan identifies specific areas of current operational performance for improvement within the agency. These plans can and should cross-reference one another, so a quality improvement initiative that is in the QIP may also be in the Strategic Plan

The Model for Improvement:

The Model for Improvement is used for learning, to develop changes, test changes, and implement changes. It is based on three fundamental questions- What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?-and a “cycle” for learning and improvement – PDSA