

LEARNING TOGETHER: MLC I and II and III And Other Noble Efforts

Performance and Capacity Assessment or Accreditation of Public Health Agencies APHA 2007

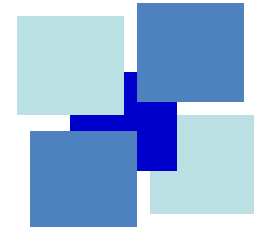
Lee Thielen



Multi-State Learning Collaborative II :Quality Improvement in the
Context of Assessment or Accreditation Programs (MLC-2)

Multi-State Learning Collaborative

Funded by:

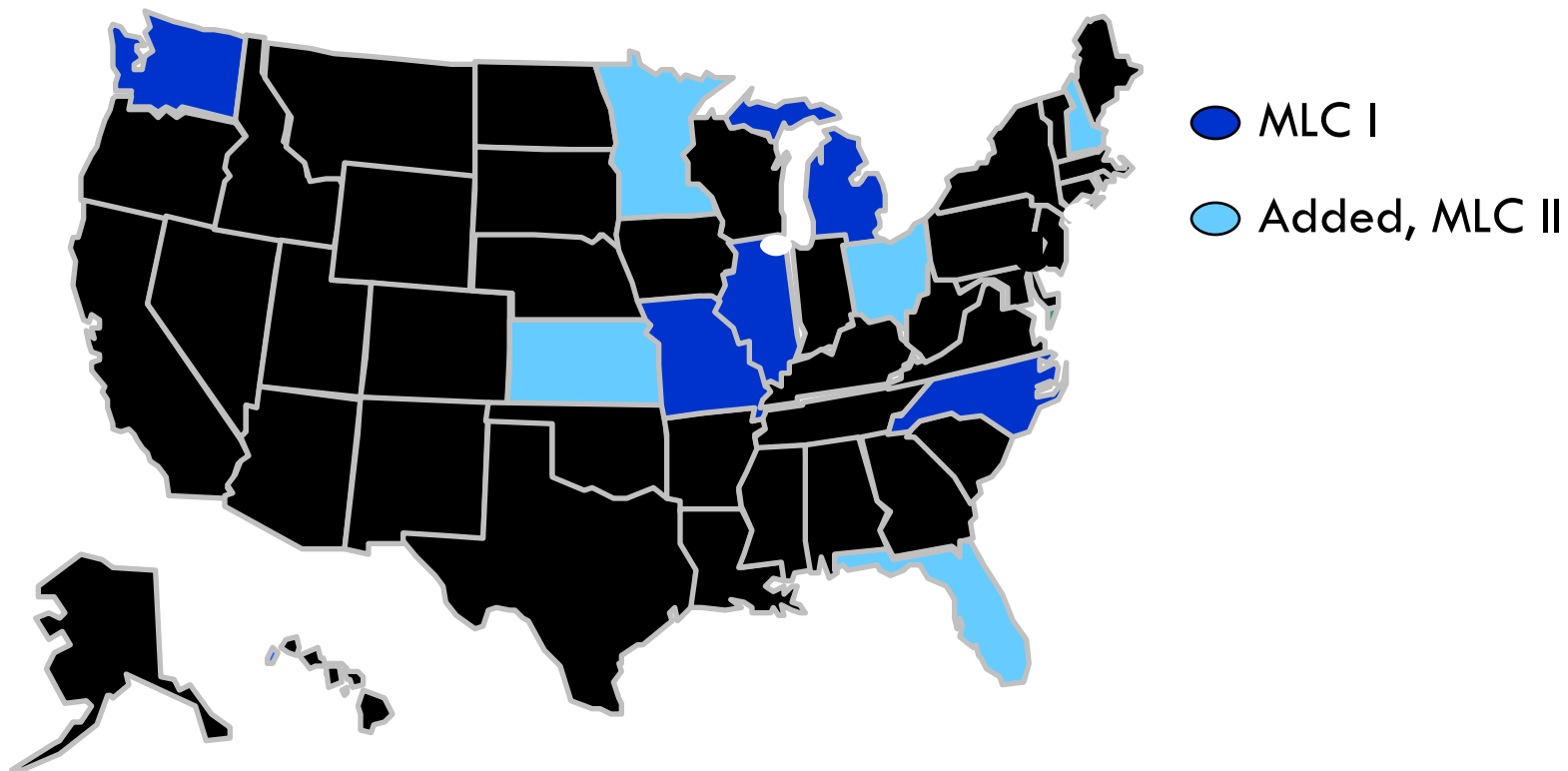
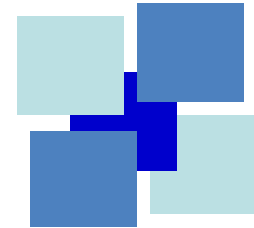


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Multi-State Learning Collaborative II :Quality Improvement in the
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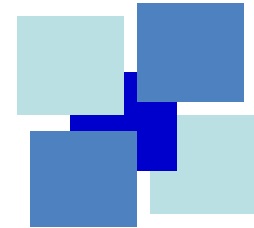
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Ten States as Laboratories for Accreditation/Assessment/QI



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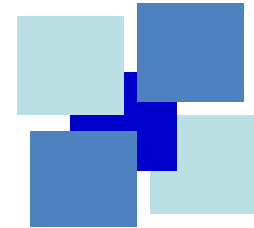
Multi-State Learning Collaborative managed by:



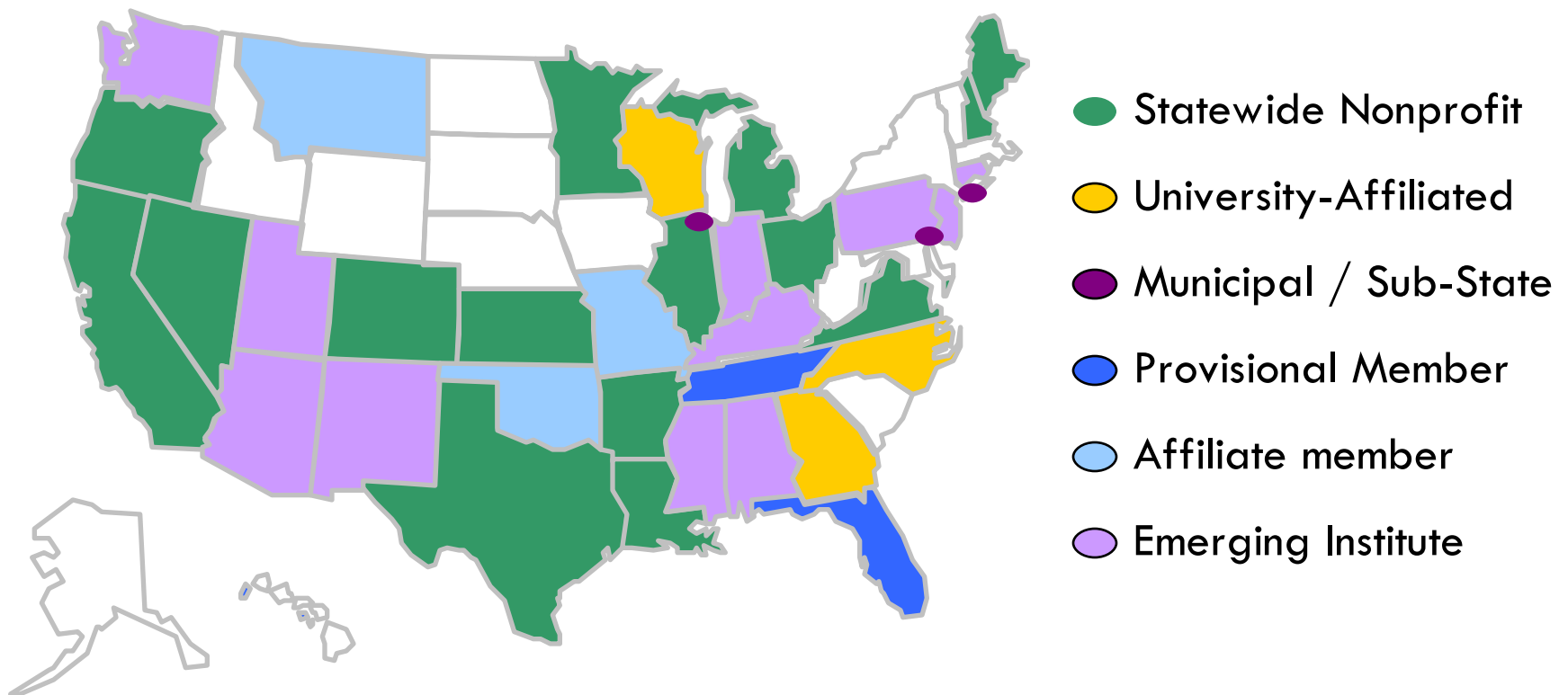
What is NNPHI?
Why are they involved in governmental public
health?

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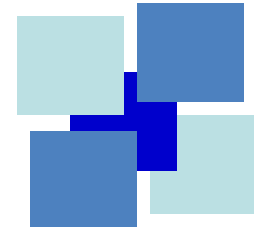


NNPHI Members and Emerging Institutes



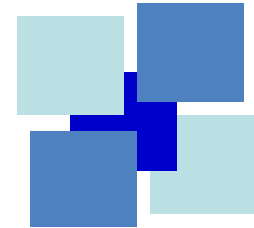
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What is a Public Health Institute?



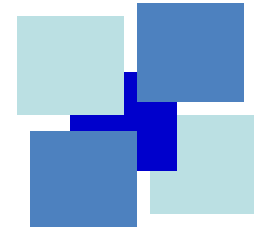
□ A multi-sector entity able to function as a convener to improve health status and foster innovations in health systems.

Purposes of the MLC



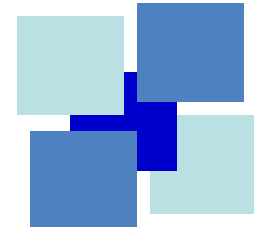
- Improve existing systems within the states
- Promote collaborative learning, learn from each other
- Inform the national project on accreditation
- Expand the knowledge base for the broader public health community

Lessons Learned: Year 1



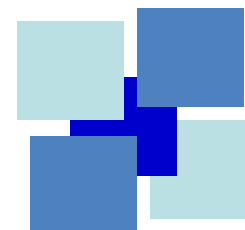
- Concern about consistency of public health services is impetus.
- Desire to show accountability.
- Each state system has evolved, often over a 10 year period.
- Third party institutes and academia have been involved.

More Lessons Learned: Attributes of the MLC I States

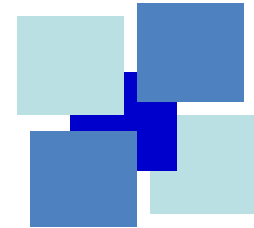


- State specific standards
- Strong local and state leadership
- Only one model is voluntary of the “Legacy” 5
- On-site reviews with external validation
- Self-assessment tools

Lessons Learned: Year I Outcomes



- ❑ Formation of a peer network
- ❑ Enhanced assessment and accreditation programs in the participating states
- ❑ Increased knowledge about assessment and accreditation
- ❑ Informed the development of the national model



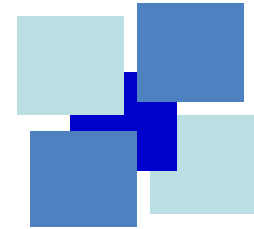
MLC and Accreditation

State to National Accreditation

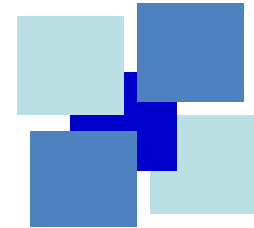
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Goal of a National Program for Voluntary Accreditation



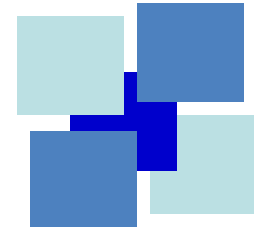
... to improve and protect
the health of the public by advancing
the quality and performance of
state and local public health
departments.



Multi-State Learning Collaborative II

- ❑ Assessment and accreditation programs provide a foundation for quality improvement
- ❑ MLC II focuses on quality improvement in the context of assessment and accreditation programs

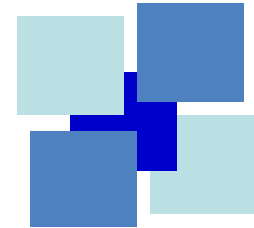
Why Quality Improvement?



- ❑ Public health often slow to adopt improvements.
- ❑ Cpt James Landcaster in 1601 proved Vitamin C prevented scurvy.
- ❑ British preventive policy on scurvy adopted 264 years later.

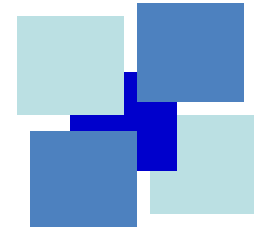


MLC II



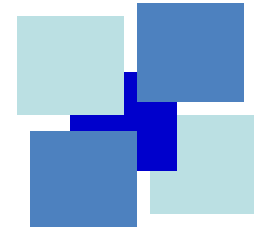
- ❑ MLC-2 includes 10 states
- ❑ Expands the learning community
- ❑ Builds on the success of MLC-1

Objectives of MLC II



- ❑ Support quality improvement techniques in assessment/accreditation programs.
- ❑ Learn from each other and experts.
- ❑ Produce documents and tools that will serve as resources.
- ❑ Inform the public health practice community.

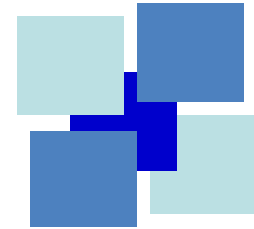
Activities



- Agency Level: Address challenges regarding individual agency's ability to meet particular standards

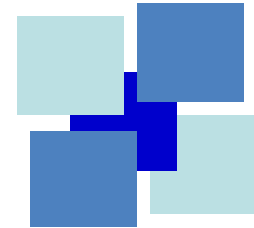


Activities



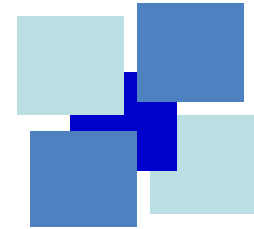
- ❑ Statewide Level: Address statewide challenges in meeting particular standards in the assessment/accreditation program

Activities



- ❑ QI: Incorporate quality improvement into the standards and processes of the assessment/ accreditation program.

MLC II is about:



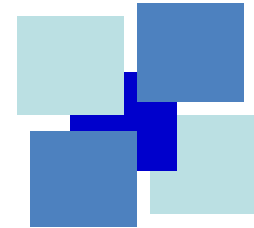
- Learning
- Improving
- Networking
- Influencing
- Change
- Leading the pack



Multi-State Learning Collaborative II :Quality Improvement in the Context of Assessment or Accreditation Programs (MLC-2)

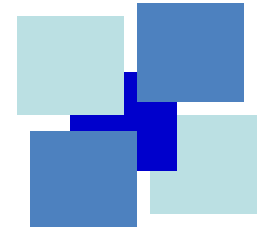
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MLC III?

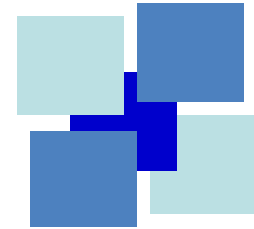


- Multi-year
- Expanding to a total of 15 states
- Focus on both preparing for accreditation and practicing quality improvement
- Parallel to the implementation of national accreditation in 2011
- Not yet funded, but stay tuned.

What Is Next?

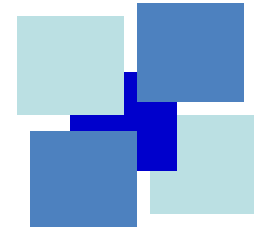


- National voluntary accreditation
- Additional states interested in state assessment
- State agency review more common
- Funders and partners interested in long-term structural improvement



The train is going down the tracks.
Are you getting on?

NORTH CAROLINA Lessons Learned through MLC2



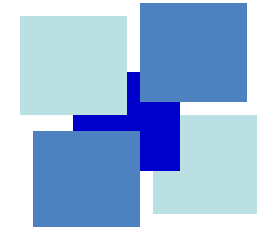
**APHA Annual Conference
November 5-7, 2007**

**North Carolina Division of Public Health
North Carolina Association of
Local Health Directors
North Carolina Institute for Public Health**

**Multi-State Learning Collaborative II :Quality Improvement in the
Context of Assessment or Accreditation Programs (MLC-2)**

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NC MLC 2 Projects



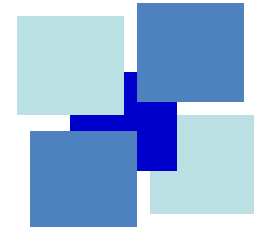
NCLHDA Improvements

- Adopting QI Innovations from other States
- Linking Accreditation to Quality Improvements in Local Health Departments

QI training to public health department staff and partners

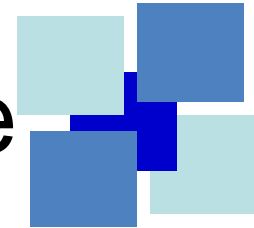
- Provide training to LHD staff and partners
- Incorporate training into accreditation training cycles
- Make training available thru videoconference, web

NC MLC 2 Projects



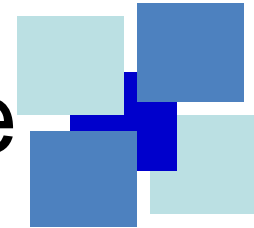
- ❑ Evaluation of the State Pilot Accreditation Process
- ❑ Technical Assistance through the Accreditation Road Map
- ❑ Networking with other MCL2 states

Local Accreditation Update



- Local Health Department Accreditation is Legislatively Mandated in the State of NC
- 30 Accredited Local Health Departments to date
- 16 Health Departments are currently undergoing the process in Fiscal Year 2008

Local Accreditation Update

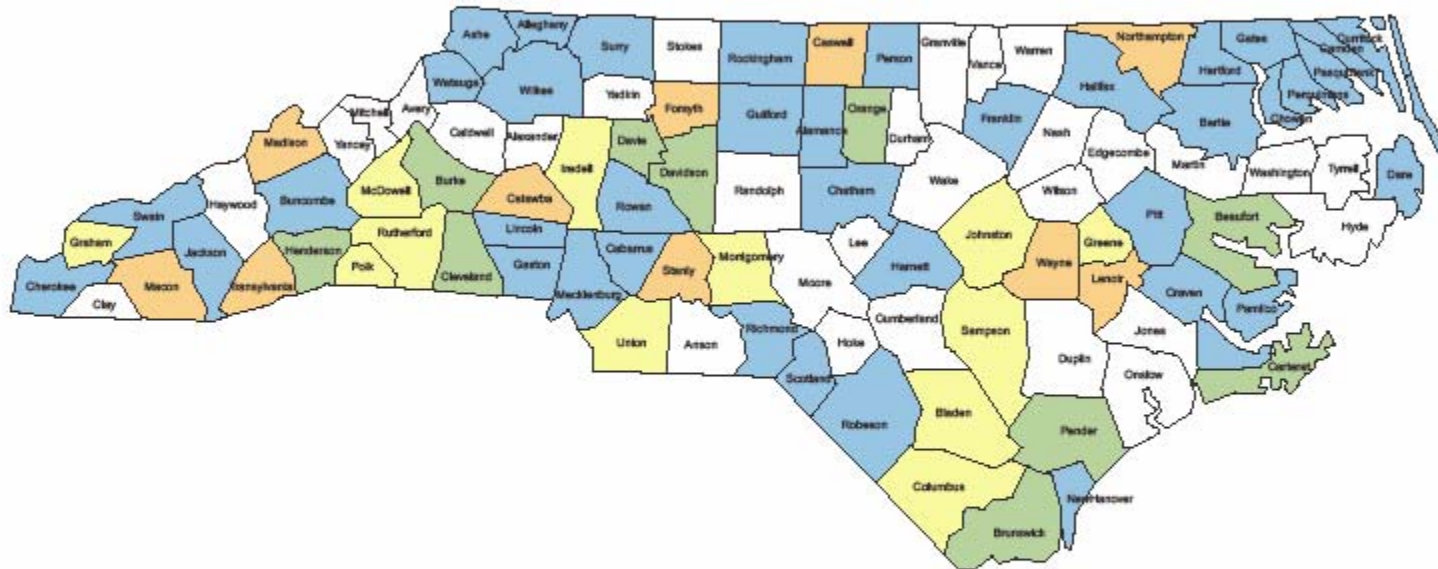


- ❑ 34 Additional Health Departments have volunteered to undergo the process between FY 2009 - 2010
- ❑ All 85 Health Departments will be Accredited by 2014
- ❑ Currently over 3.5 million NC citizens live in a county with an Accredited health department



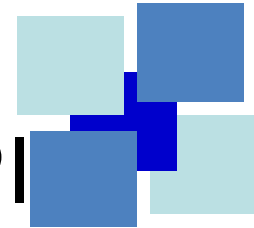
North Carolina

Local Health Department Accreditation Board



- Accredited Health Departments
- Health Departments participating in FY 2008 (July 2007-June 2008)
- Health Departments participating in FY 2009 (July 2008-June 2009)
- Health Departments participating in FY 2010 (July 2009-June 2010)

Local Health Department Accreditation Benchmark on PI

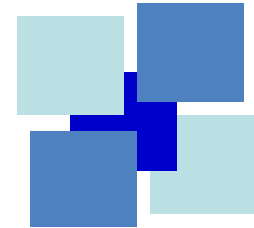


Benchmark 27, Activity 27.2:

The local health department shall employ a quality assurance and improvement process to assess the effectiveness of services and improve health outcomes.

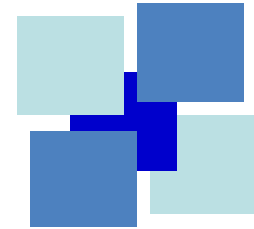
PI Training with PHF

October 16, 2007



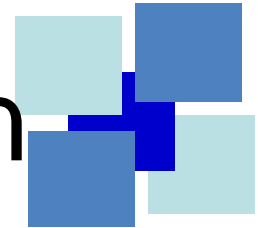
- ❑ Pre-training survey of all local health departments
- ❑ 65% response rate
- ❑ 18 questions on current PI activities

PI Training with PHF October 16, 2007



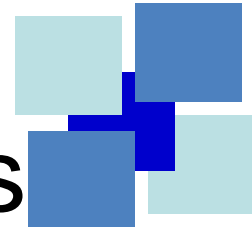
- 1/2 Day Training October 16th 2007 via videoconference
- 25 local health department sites
- 155 total participants

State Pilot Accreditation



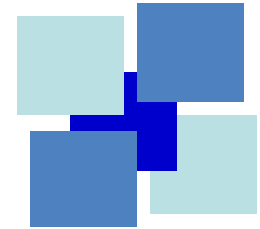
- ❑ Leadership support from both Division of Public Health and Division of Environmental Health
- ❑ Used modified National Performance Standards State Instrument (version 1.0)
- ❑ Self assessment, documentation collection September-November 2006
- ❑ Site visit February 27-March 1, 2007

Prioritization of Site Visit Team's Recommendations



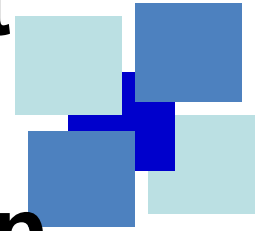
- 31 Recommendations
- Led by Dr. Devlin's Division Management Team
 - Essential Service #8: Assure Competent Public and Personal Health Care Workforce
 - Essential Service #3: Inform, Educate and Empower People about Health Issues
 - Essential Service #5: Develop policies and plans that support individual and statewide health efforts
 - Essential Service #10: Research for New Insights and Innovative Solutions to Health Problems

Prioritization of Operational Issues



- 8 operational issues identified
- Led by Administrative, Local Community Support Section Chief
 - Standardize PI Procedures for use by the state (develop a policy/procedure and toolkit)
 - Ensure grants, budget, and programs are better integrated

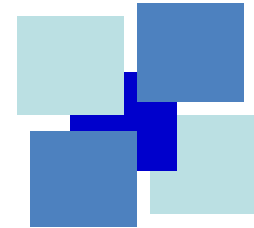
Performance Improvement Teams are called Division of Public Health On Target...DOT Teams



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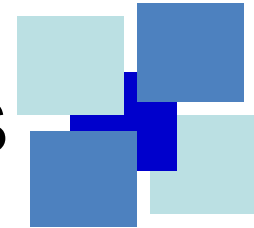
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Next Steps...



- ❑ NCIPH is finalizing a comprehensive evaluation of the State Pilot Accreditation
 - ❑ Process (State Preparation, Site Visit)
 - ❑ Appropriateness of tool as framework
 - ❑ DPH/DEH staff understanding of process
 - ❑ Implications for PHAB
- ❑ Performance Improvement “By-land” training
- ❑ Continue to work with Local Health Departments on Performance Improvement

NC Accreditation Resources



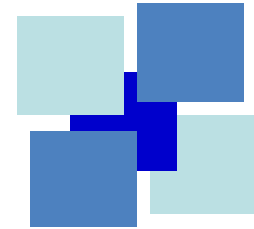
One stop shop: NCLHDA Website

<http://www2.sph.unc.edu/nciph/accred/index.htm>

A landscape photograph showing a wide, open field with a line of trees in the distance under a clear sky. The field is a mix of green and brown, suggesting a late summer or autumn setting. A large, dark tree stands on the left side of the field. The sky is a pale, clear blue.

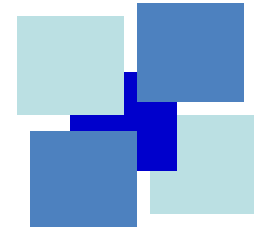
Illinois Accreditation Project

Goal



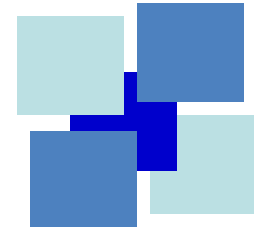
To create and test systems, tools and protocols of Illinois' proposed accreditation framework to ensure the quality improvement focus

Formed the Team



Multi-State Learning Collaborative II :Quality Improvement in the Context of Assessment or Accreditation Programs (MLC-2)

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Developed Performance Standards and Measures based on Illinois Standards and NACCHO Operational Definition

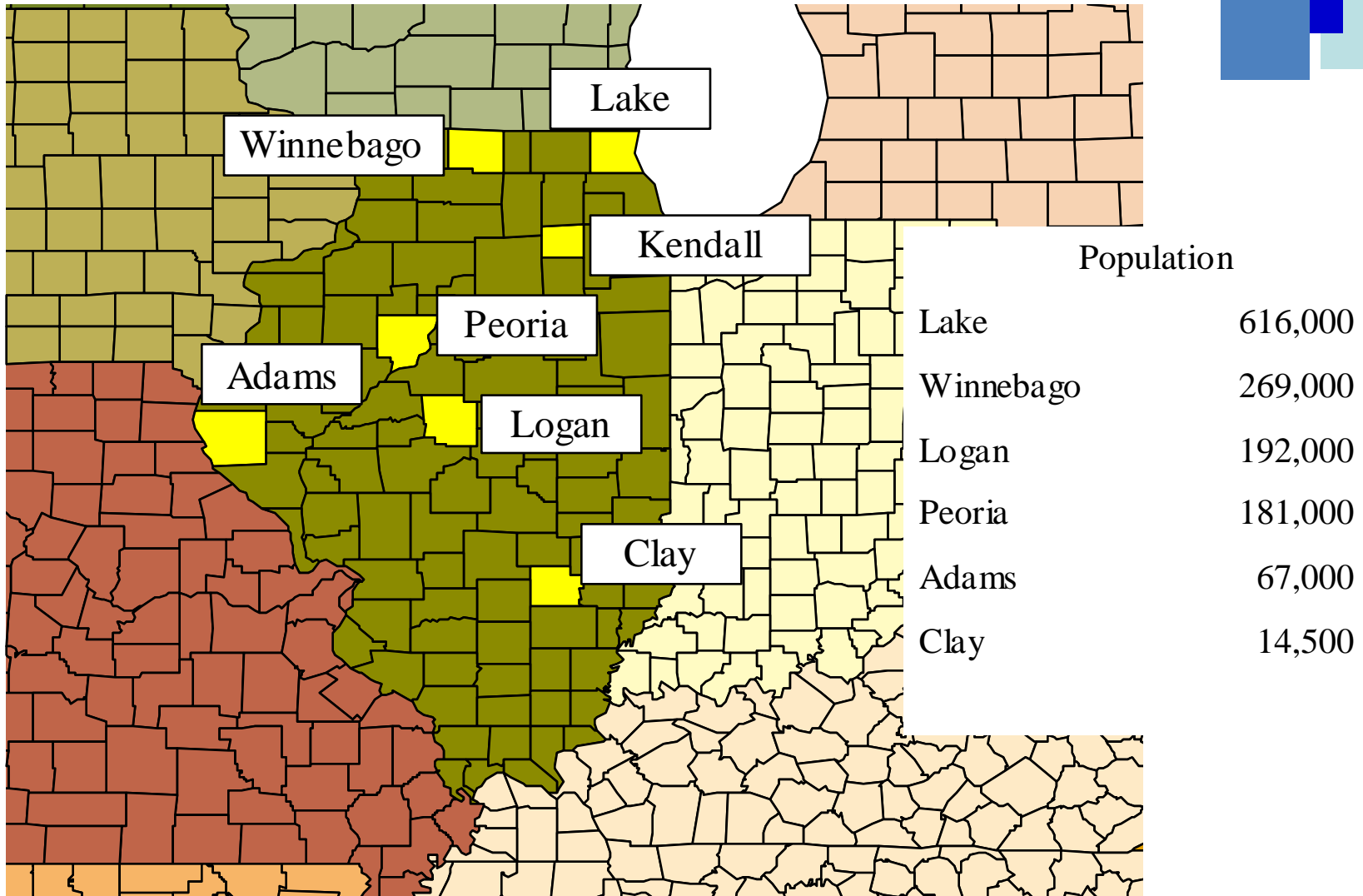
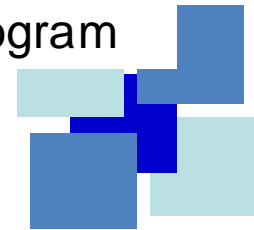


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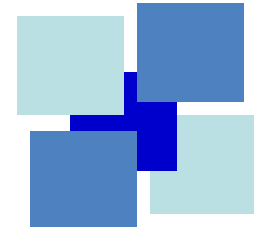
7 Pilot Sites



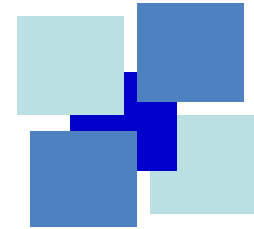
Seven Local Health Departments in 2007 Pilot of Accreditation Program



Survey Health Departments



What did we learn?

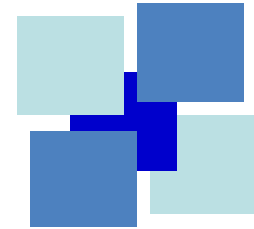


- Not everyone is in love
- Most everyone is curious
- Everyone wants to improve

A photograph of a sunset over the ocean. The sky is a gradient of orange and yellow, transitioning from a lighter yellow at the top to a darker orange near the horizon. The ocean is visible at the bottom, with a small sailboat on the left side. The text "Where do we go from here?" is overlaid in the center of the image.

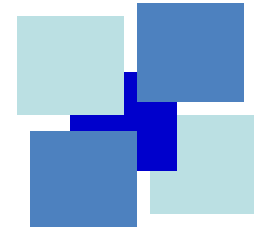
Where do we go
from here?

Next

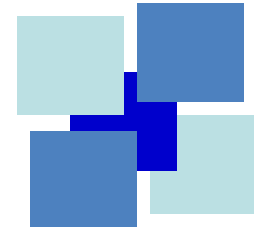


- ❑ Complete pilot site reviews
- ❑ Complete capacity survey of local health departments
- ❑ Evaluate the process

Then



On to MLC -3!



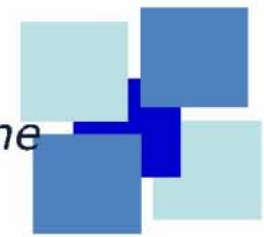
Improving the Public's Health in NH From Assessment to Quality Improvement

APHA Annual Meeting
November 6, 2007

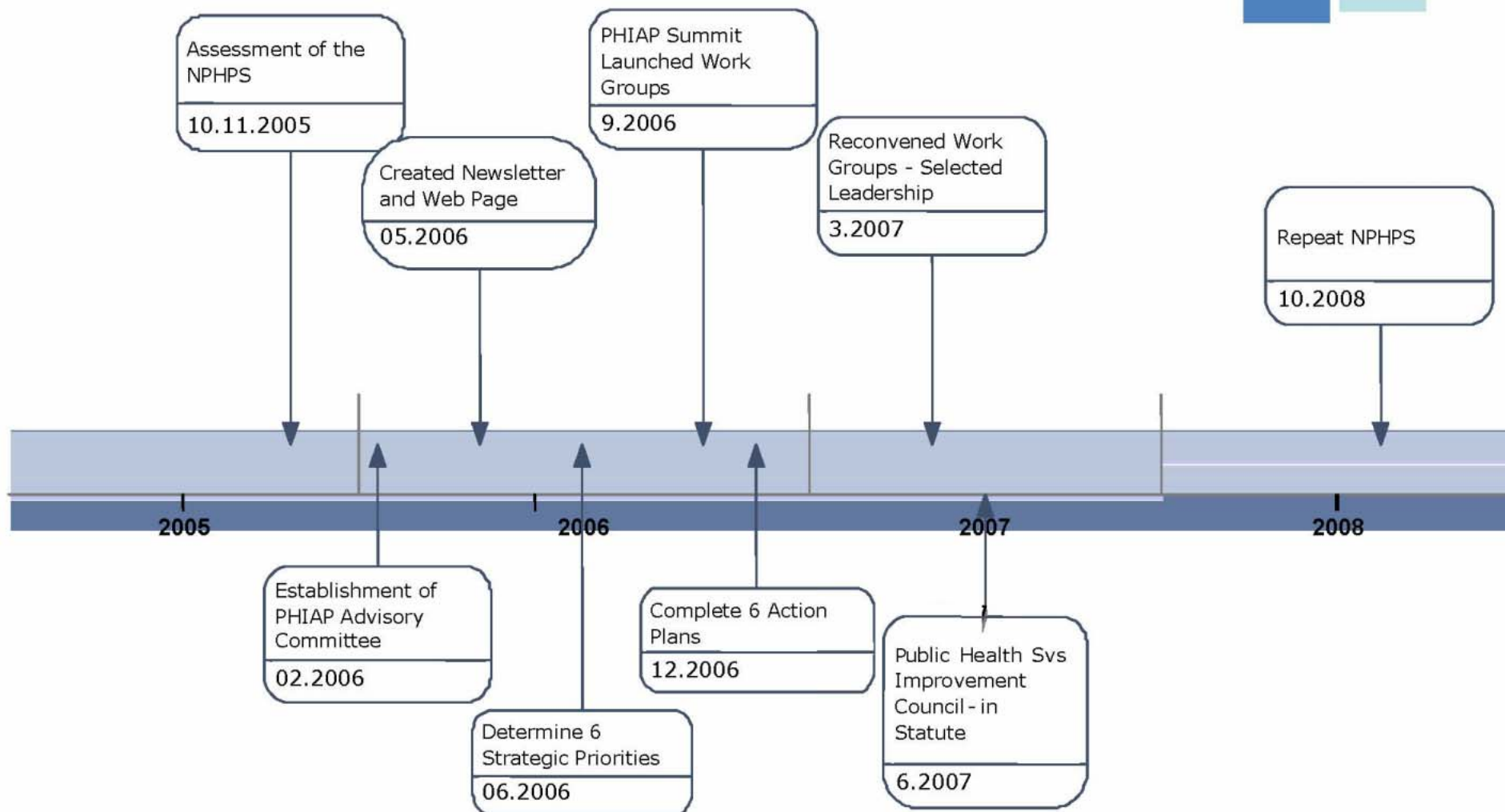
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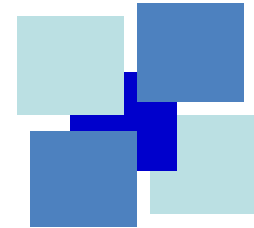
Public Health Improvement Action Plan Initiative (PHIAP) Timeline



Multi-State Learning Collaborative II :Quality Improvement in the Context of Assessment or Accreditation Programs (MLC-2)

Assessment of the National Public Health Performance Standards

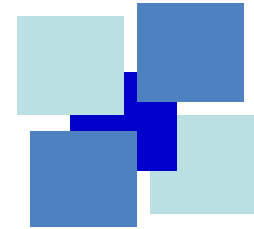
October 11th and 12th 2005



- 110 in attendance
- Highly engaged participants
- Strong commitment to continued participation
- Excellent networking opportunity
- Strong message to keep momentum
- Need for excellent communication
- Involve partners outside DPHS

PHIAP

Public Health Improvement Action Plan Advisory Committee



Purpose

To guide a process to *improve the New Hampshire public health system's capacity to provide essential services, with the fundamental purpose to improve the public's health*

Monthly meetings for 1 year

Staffed by DPHS

Membership

Co-chaired – DPHS, Foundation

Legislators

Insurers

Hospitals

Public Health Networks

Community Health Centers/organizations

Academic centers

Public Health Institute

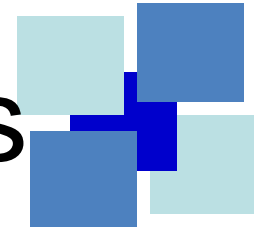
Health Departments

Coalitions

DES, DOE

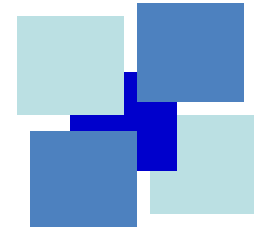
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Final Strategic Priorities



- 1) Inform, educate and empower people about health issues
- 2) Monitor health status to identify and solve community health problems
- ➔ 3) Mobilize community partnerships and actions to identify and solve health problems
- ➔ 4) Develop policies and plans that support individual and community health efforts
- 5) Communication plan
- 6) Workforce development

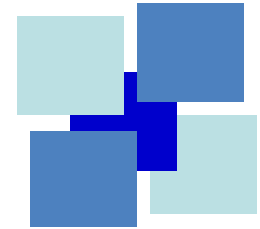
Charge to the 6 work groups at September 2006 Summit



6 strategic work groups of 20- 30 people

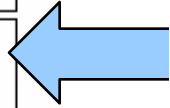
- Identify action steps
- Identify possible partners/leadership
- Determine time frames for completion
- Identify potential funding sources

Charge to the work groups



- ❑ Select priorities - reflecting PHIAP work
- ❑ Define the problem statement
- ❑ Determine root causes - why have we not accomplished this previously
- ❑ Complete PDSA work plans in 3 months

Mobilize Community Partnerships May 9, 2007		New Hampshire Division of Public Health Performance Improvement Workplan		Broad Aim of the Project or Performance Measure: To improve the effectiveness and collaboration of community coalitions/partnerships to deliver essential public health services Baseline: No coordinated effort to improve coalition effectiveness exists
1. Plan - the Change Based on problem identification, analysis and root causes	2. Do – Try the Change on a Small Scale Action Steps - What, Where, How?	Who? Potential partners to carry out the action or change	When? Target completion date	
*Note – these are the first 2 steps in the PDSA cycle. A follow-up work plan with the Study and Act components should be completed to evaluate the step taken.				
Problem statement defined: The system's ability to deliver essential services is limited by information gaps about coalition/partnerships, including: numbers, types, geographic distribution, effectiveness, strategies to evaluate effectiveness, and common terminology Performance measure(s) with baseline data:	1) Identify what coalitions currently exist <ul style="list-style-type: none"> Define common terminology for coalitions and other partnerships <ul style="list-style-type: none"> Taxonomy should not be exclusive #2. Conduct an inventory of the numbers and types of coalitions and partnerships <ul style="list-style-type: none"> Use existing maps and lists Determine the capacities/resources of coalitions/partnerships to carry out essential services 	DPHS, New Futures, NH National Guard, Public Health Networks, NH Hospital Association, NH Public Health Association, Bi-State Primary Care Assoc, United Ways, UNH Cooperative Extension, Community Coalitions	April 2007 June 2007 September 2007	



Mobilize Community Partnerships
 May 9, 2007

New Hampshire Division of Public Health
 Performance Improvement Workplan

Broad Aim of the Project or Performance Measure:
 To improve the effectiveness and collaboration of community coalitions/partnerships to deliver essential public health services
 Baseline: No coordinated effort to improve coalition effectiveness exists

1. Plan - the Change Based on problem identification, analysis and root causes	2. Do – Try the Change on a Small Scale Action Steps - What, Where, How?	Who? Potential partners to carry out the action or change	When? Target completion date	Study
	2) Gather from existing networks and previous plans info about partnerships, local community needs and priorities: #6 <ul style="list-style-type: none"> • PHNs • HP2010→ action steps • Turning Point→ Advisory group 	Policy and Planning Work Group CHI, DPHS Public Health Networks Community Coalitions	March 2007	2. Local needs and priorities documented from existing public health improvement plans
Too many different required "partnerships" with different "districts"	3) Create infrastructure that supports community partnerships. <ul style="list-style-type: none"> • Build policy agenda to maintain consistent focus over time not subject funding shifts, media influence #1 Issue call to action to the public health improvement services council to facilitate coordination among partnerships by: <ul style="list-style-type: none"> • Encouraging concordance between RFP's from DPHS that call for partnerships 	Department of Education, PHIAP/Council, Public Health Networks, DPHS, Dept of Safety, EMS, Community Coalitions, Advocacy Org, Citizens health Initiative DPHS, EMS,	June 2007 November 2007 December 2007	Policy agenda defined Call to action issued. RFPs from funders encourage building

Develop Policies and Plans that support individual and community health efforts

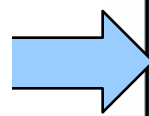
December 21, 2006

New Hampshire Division of Public Health Performance Improvement Work plan

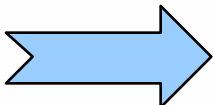
Broad Aim of the Project or Performance Measure:
 To institutionalize a public health improvement planning process
Current baseline: Current planning process tied to existing staff, not required



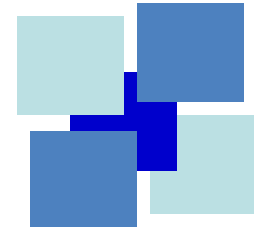
1. Plan - the Change Based on problem identification, analysis and root causes	2. Do – Try the Change on a Small Scale Action Steps - What, Where, How?	Who? Potential partners to carry out the action or change	When? Target completion date
*Note –these are the first 2 steps in the PDSA cycle. A follow-up work plan with the Study and Act components should be completed to evaluate the step taken.			



Problem statement defined: NH lacks a state public health system improvement planning process, which is sensitive to local priorities and strives to improve the health of all people in NH. The development of such a plan must incorporate a means of securing the resources needed for implementation	Information Gathering 1) Research what other states have done. Washington state and Illinois have improvement plans Explore: <ul style="list-style-type: none"> Are these processes in statute? Do they have a planning committee How is the plan related to the Governor's office/DHHS administration What level of detail is there? What kind of resources is available for planning and implementation? How do they address sustainability/support of the process? 2) Identify data to show variability in state communities and to identify disparities in health status 3) Inventory and/or visual map current local or regional public health planning processes/improvement planning processes <ul style="list-style-type: none"> Identify priorities and time tables 	DPHS Data Group/DPHS, UNH, EFH CHI, Local Planning partners	Done March 2007
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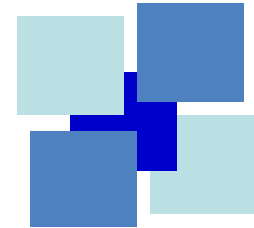
Develop Policies and Plans that support individual and community health efforts December 21, 2006		New Hampshire Division of Public Health Performance Improvement Work plan		Broad Aim of the Project or Performance Measure: To institutionalize a public health improvement planning process Current baseline: Current planning process tied to existing staff, not required	
1. Plan - the Change Based on problem identification, analysis and root causes	2. Do – Try the Change on a Small Scale Action Steps - What, Where, How?	Who? Potential partners to carry out the action or change	When? Target completion date		
		*Note –these are the first 2 steps in the PDSA cycle. A follow-up work plan with the Study and Act components should be completed to evaluate the step taken.			
		Legislation 1) Develop support for legislation for a planning process/council 2) Determine substance and timing of legislation to support ongoing performance improvement planning 3) Develop an LSR calling for the development of a plan/or council/task force. 4) Educate legislature on why we need an improvement process	Committee Members Stakeholders and other public health advocates, NHPHA	December 2006 January-June 2007	

Real Progress to Date



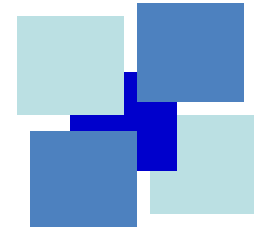
- ❑ HB 491 –establishing a public health improvement services council enacted
- ❑ A call to action issued to better coordinate and support community partnerships
- ❑ Survey drafted to create a data base on community partnerships

Real Progress to Date



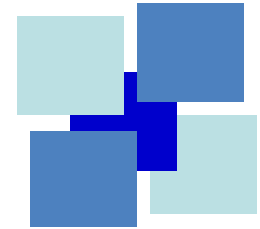
- ❑ *Develop a Communication Plan* - Grant obtained to retain a marketing firm develop a public health communication plan
- ❑ *Workforce Development* - Agreement to use TRAIN learning management system broadly
- ❑ *Inform and Educate* - Work groups convening with other initiatives on leading contributors to m&m – tobacco, alcohol, physical activity and nutrition

Charting our Progress



- Oversight by new Public Health Services Improvement Council
- Study cycle of PDSA
- Report to be published early 2008
- Reassess via NPHPS Fall 2008

Questions



[□Jascheim@dhhs.state.nh.us](mailto:Jascheim@dhhs.state.nh.us)

Joan Ascheim

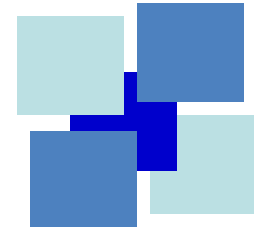
Bureau Chief

NH Division of Public Health Services

Bureau of Policy and Performance Management

603-271-4110

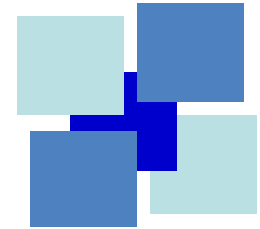
<http://www.dhhs.state.nh.us/DHHS/DPHS/iphnh.htm>



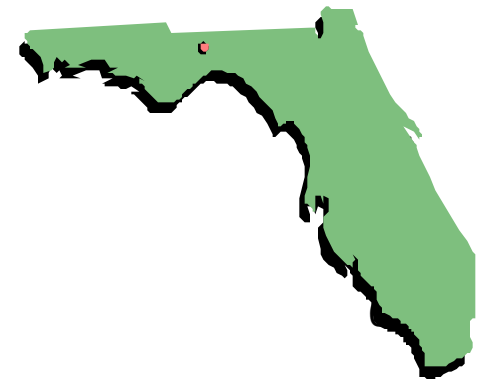
Lessons Learned: Florida's Quality Improvement Initiatives

Cathy Brewton, M.S., ASQ-CQIA
November 6, 2007

Structure of DOH

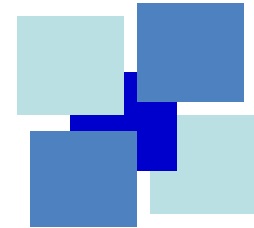


- ❑ State government agency
- ❑ 67 Public County Health Departments
- ❑ 17,000+ employees throughout the state of Florida
- ❑ 2006-2007 budget is approximately \$2,531,626,647



Multi-State Learning Collaborative II :Quality Improvement in the Context of Assessment or Accreditation Programs (MLC-2)

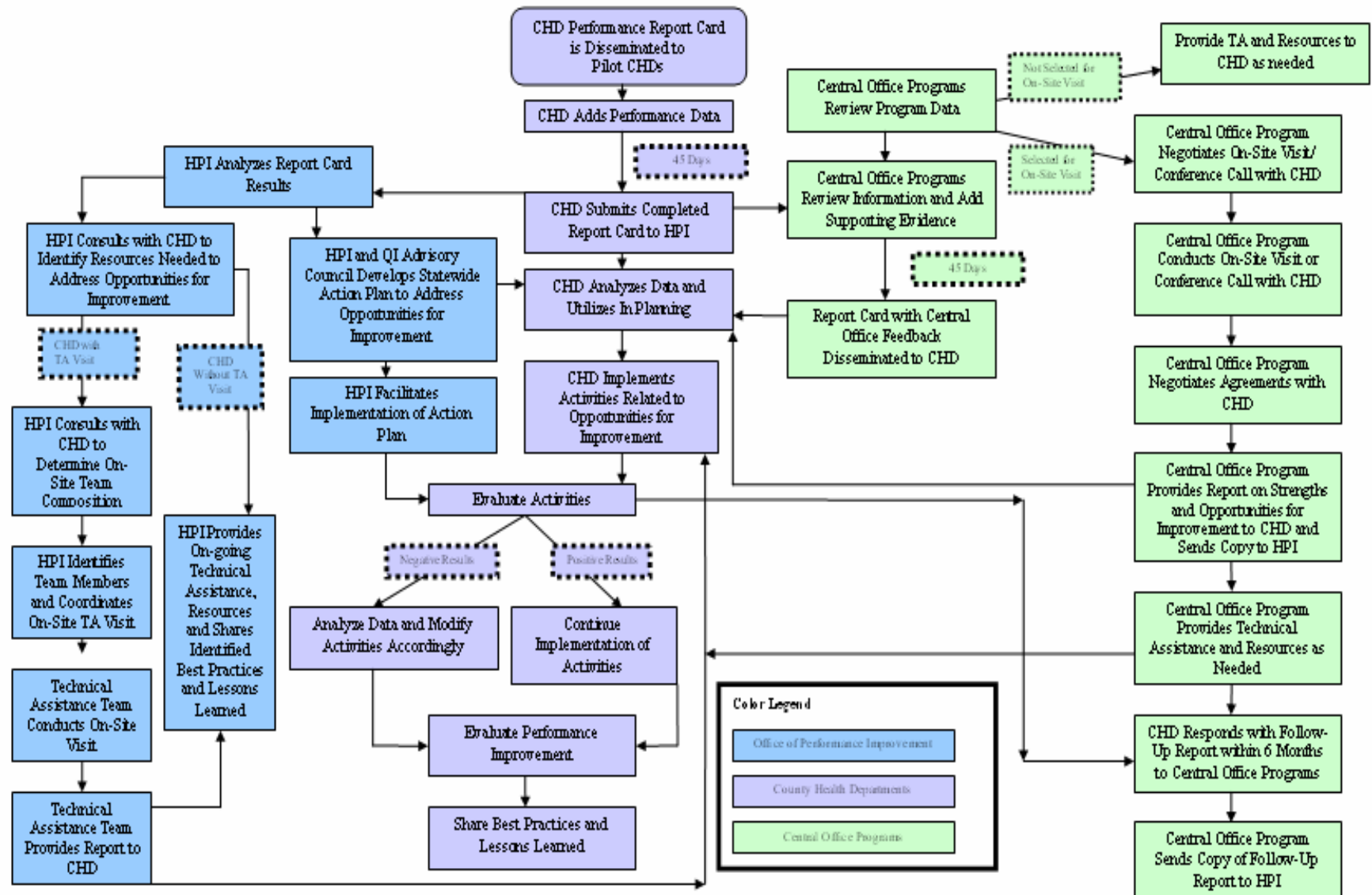
CHD Performance Improvement Process



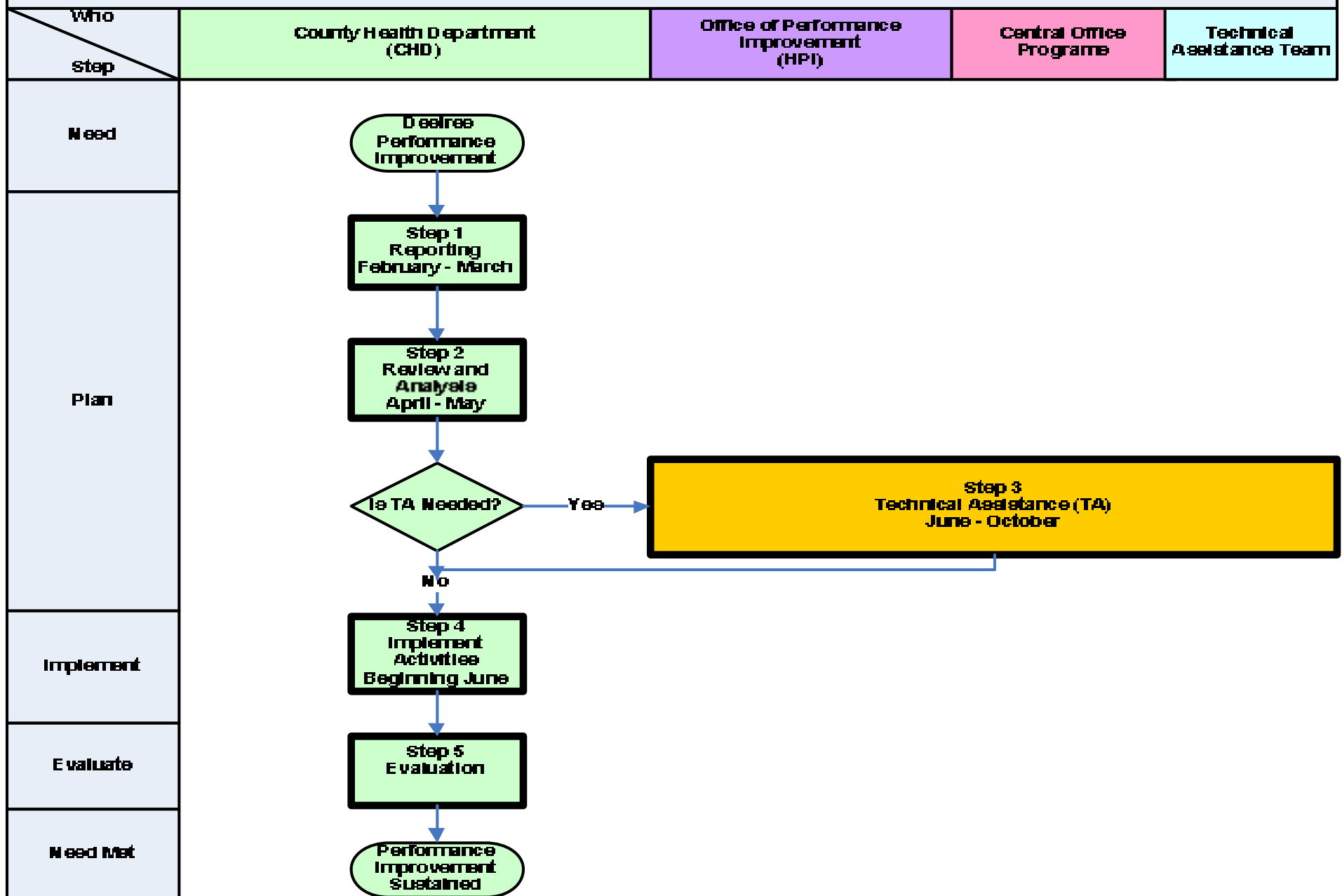
- ❑ Provides a process to sustain performance improvement
- ❑ Provides a set of key indicators for CHD's to measure, improve, and compare performance
- ❑ Provides statewide view of performance on an annual basis to drive statewide initiatives
- ❑ Ensures collaboration between CHDs, Central Office Programs and HPI

Pilot Performance Improvement Process

2005 Pilot CHD Performance Improvement Process



2007 County Health Department Performance Improvement Process Macro Process



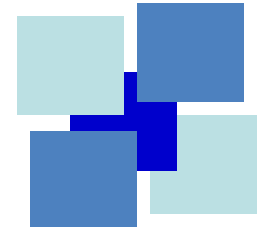
1.1 Product & Service Outcomes

Standard/Objective	Measure/Indicator	DOH Targets (5 year targets)	CHD Target	Data Point 1 Current month/ qtr./ year	Data Point 2 Previous month/ qtr./ year	Data Point 3 Prior to Data Point 2	CHD Performance (Trends)
Improve the community's health by utilizing evidence-based practice guidelines/initiatives							
	Age-Adjusted All Causes 3-Year Death Rate, 3-Year Rates for All Races All Sexes						RED
	All Causes Years of Potential Life Lost Under 75, 3-Year Rates for All Races All Sexes						RED
	Smoking Attributable Deaths Over Age 35, Rate Per 100,000 Population > 35, 3-Year Rates for All Races All Sexes						RED
	Age-Adjusted Coronary Heart Disease 3-Year Death Rate, 3-Year Rates for All Races All Sexes	166					RED
	Age-Adjusted Stroke 3-Year Death Rate, 3-Year Rates for All Races All Sexes	48					RED
	Age-Adjusted Diabetes 3-Year Death Rate, 3-Year Rates for All Races All Sexes	20					RED
	3-Year Age-Adjusted Hospitalization Rate From Amputation of a Lower Extremity Attributable to Diabetes, 3-Year Rates for All Races All Sexes	Not Established					RED
	Metastatic Breast Cancer at Diagnosis, Rate Per 100,000 Female Population, 3-Year Rates for All Races						RED
	Metastatic Cervical Cancer at Diagnosis, Rate Per 100,000 Female Population, 3-Year Rates for All Races						RED
	Colorectal Cancer 3-Year Age-Adjusted Incidence Rate, 3-Year Rates for All Races All Sexes	Not Established					RED
	Age-Adjusted Unintentional Injury (Accident) 3-Year Death Rate, 3-Year Rates for All Races All Sexes						RED
	Age-Adjusted Unintentional Poisoning 3-Year Death Rate, 3-Year Rates for All Races All Sexes						RED
	Age-Adjusted HIV/AIDS 3-Year Death Rate, 3-Year Rates for All Races All Sexes						RED
	AIDS Cases, Rate Per 100,000 Total Population, 3-Year Rates for All Races All Sexes	24					RED
	Chlamydia, Rate Per 100,000 Total Population, 3-Year Rates for All Races All Sexes	233					RED
	Gonorrhea Cases, Rate Per 100,000 Total Population, 3-Year Rates for All Races All Sexes						RED
	Infectious Syphilis Cases, Rate Per 100,000 Total Population, 3-Year Rates for All Races All Sexes						RED
	Tuberculosis Cases, Rate Per 100,000 Total Population, 3-Year Rates for All Races All Sexes	5.1					RED
	Tuberculosis Patients Completing Therapy, Percent of Patients in Therapy, Single-Year Percentage for All Races All Sexes	90%					RED
	Enteric Diseases Total, Rate Per 100,000 Population, 3-Year Rates for All Races All Sexes						RED
	Percent of Low Income Persons with access to Dental Care						RED
	Total Infant Mortality Rate, Rate Per 1,000 Total Live Births, 3-Year Rates for All Races All Sexes	4.5					RED
	Births With First Trimester Prenatal Care, Percent of Births With Known PNC Status, 3-Year Rates	90%					RED
	Live Births Under 2500 Grams to All Mothers, Percent of Total Births, 3-Year Rates for All Races	5					RED

SUNSHINE COUNTY PERFORMANCE SNAPSHOT

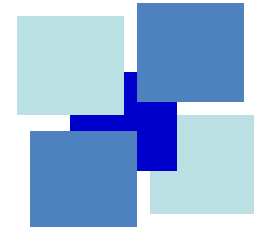
	Data Point 3	Data Point 2	Data Point 1	TREND	Target
(7.1) Products and Services Outcomes				Alert	
(7.1a) Assess, monitor and understand health issues facing the community					
(7.1a.1) Number of Births to Mothers Ages 15-17, Rate Per 1,000 Females, 3-Year Rate for All Races	57.3	55.8	42.9	+	21.0
(7.1a.2) Live Births Under 2500 Grams to All Mothers, Percent of Total Births, 3-Year Rates for All Races	10.3	9.2	7.9	+	5.0
(7.1a.3) % of WIC infants who are initially breastfed	62.8	68.6	60.0	ALERT	75.0
(7.1a.4) HIV cases per 100,000 population among non-Hispanic blacks	7.0	6.8	11.1	ALERT	120.0
(7.1a.5) % of active TB patients completing therapy within 12 months of initiation of treatment	0.0	50.0	66.7	+	90.0
(7.1a.6) Enteric Diseases Total, Rate Per 100,000 Population, 3-Year Rates for All Races All Sexes	49.9	55.5	54.8	ALERT	28.5
(7.1a.7) Chlamydia, Rate Per 100,000 Total Population, 3-Year Rates for All Races All Sexes	108.7	262.4	361.4	-	233.0

Evaluation of County Performance Snapshot



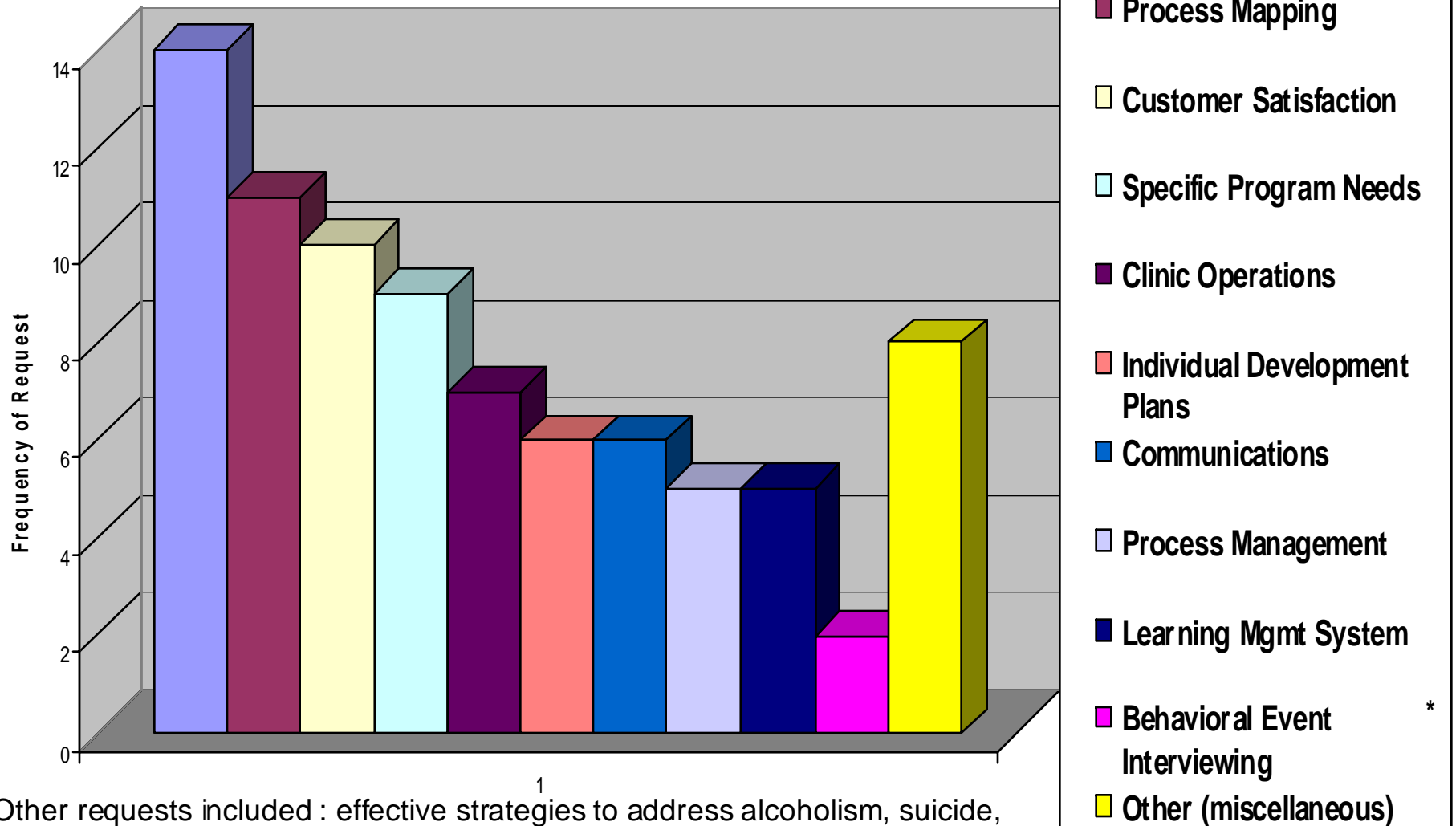
- CHDs have no control over a number of health status measures
- Collection of customer satisfaction data not standardized
- Interpretation of some measures is not consistent
- Targets for Employee Satisfaction are not realistic
- Central Office self-assessment tools change annually – difficult to make comparison

Review and Analysis



- ❑ Encourage use of multiple data sources
- ❑ Don't use tunnel vision – determine if data impacts other indicators
- ❑ Use quality tools
 - Root cause analysis
- ❑ Bring more than management team “to the table” when determining priorities

2007 Technical Assistance Requests

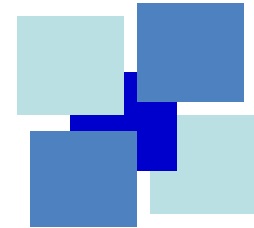


* Other requests included : effective strategies to address alcoholism, suicide, high rates of liver disease; preparation for Medicaid Reform; assistance with recruitment and retention of nurses and dietitians; employee reward and recognition, locating funds for community needs assessment; and GIS mapping.

Multi-State Learning Collaborative II :Quality Improvement in the Context of Assessment or Accreditation Programs (MLC-2)

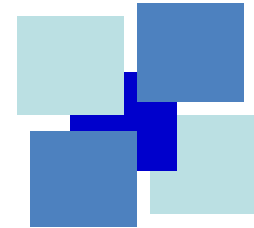
8/2/07

Technical Assistance Off-site



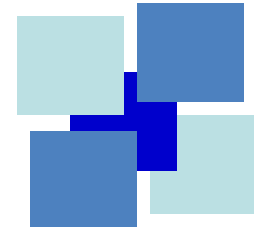
- Provide guidelines to help CHDs better prepare for conference calls
- Use technology
 - Live Meetings
 - Webcasts
- Recommendations for resources not affordable to small CHDs

Technical Assistance On-site



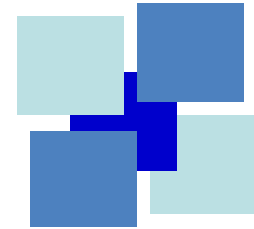
- ❑ Flexibility of timeframes – doesn't always fit in the process
- ❑ Locating subject matter experts to meet TA needs

Technical Assistance Statewide



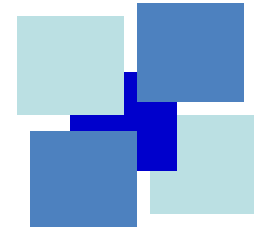
- Information not being disseminated throughout the CHD
- Hands-on training is beneficial

Implementation and Evaluation

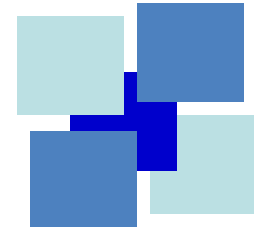


- Link quality improvement plan to strategic plan
- Evaluation of all steps in the process
 - Performance Consultants
 - Peer Advisors
 - MLC-2 States

Lessons Learned

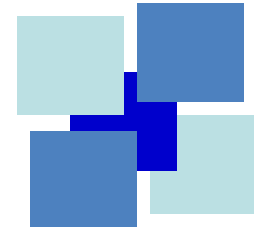


- ❑ Leadership buy-in required!
- ❑ Education and training are critical
- ❑ Be flexible
- ❑ Evolution of process takes time
- ❑ Follow through and follow up
- ❑ Keep partners updated throughout the process



Thank You

Florida Department of Health
Office of Performance Improvement
(850) 245-4007



For more information about these and other MLC projects please contact:

Liz Tagle at etagle@nnphi.org