



Multistate Learning Collaborative: A Mid-Course Report

An RWJF national program

SUMMARY

Beginning in 2005, the Robert Wood Johnson Foundation (RWJF) sponsored selected states with experience in public health assessment, accreditation and quality improvement to continue this work and share their experiences through three phases of the *Multistate Learning Collaborative* (MLC).

The first phase (MLC-1) also informed the *Exploring Accreditation* project, during which a national steering committee composed of public health practitioners and leaders concluded that a voluntary national accreditation program was desirable and feasible.

Five states were competitively selected to participate in MLC-1: Illinois, Michigan, Missouri, North Carolina and Washington. Ten states, the original five plus five additional states—Florida, Kansas, Minnesota, New Hampshire and Ohio—were competitively selected and participated in MLC-2. See the Project List in [Appendix 1](#) for additional information.

This report focuses on MLC-1 (ended October 2006) and MLC-2 (ended February 2008). MLC-3 (*Lead States in Public Health Quality Improvement*), which continues the focus on quality improvement and accreditation, began in April 2008 and is scheduled to run for three years.

Key Results

- MLC states provided empirical, practical information about what worked and what did not to the *Exploring Accreditation* steering committee—thus contributing to its decision to recommend that a national voluntary public health accreditation program for state and local health departments be implemented.

It also informed the work of the Public Health Accreditation Board (PHAB), established in 2007 by RWJF and the Centers for Disease Control and Prevention (CDC) according to the model and recommendations laid out in the *Exploring Accreditation* final report to manage and promote the national voluntary public health accreditation program. All phases of MLC have, and continue to inform PHAB.

- MLC raised the visibility of accreditation among public health departments in states that were not participating in the program. The National Network of Public Health Institutes (NNPHI), which has served as the national program office, worked with participants and partners to develop communication products to inform the public health community about accreditation.

Both the central office of NNPHI and the participating states produced reports, guides, e-newsletters, webinars, presentations at national meetings, and journal articles that were published in two issues of the *Journal of Public Health Management and Practice*. They also held an open forum each year, to which they invited all states who had applied to the program, with travel paid for one representative.

NNPHI posted these products on a section of its website dedicated to the *Multistate Learning Collaborative*.

Key Evaluation Findings

- Given its ambitious objectives and activities, the modest amount of funding, and the time frame for grants under the program, states participating in MLC-1 were able to make significant progress in their workplans.
- Participants perceived the collaborative approach as beneficial. The collaborative:
 - Helped participants foster relationships and develop a peer group
 - Provided a way to learn and share resources
 - Validated accreditation-related efforts among peers
 - Helped participants get more support and visibility for their state's public health assessment and accreditation efforts
 - Informed the national dialogue on public health accreditation by sharing many perspectives and state experiences.
- Overall, project and program staff, consultants and partners found MLC-2 to be successful and ranked their experiences very highly. "Most importantly, the MLC-2 was seen as a critical platform for advancing quality improvement infrastructure and capacity at the state and local public health levels," wrote the evaluators.
- The collaborative approach among the 10 states participating in MLC-2 flourished, with most project staff members indicating that the program offered a unique, safe and effective way to learn from both the experts and one another. A greater degree of collaboration also occurred within each state, resulting in more joint activities among existing partners and the creation of new partnerships.

Conclusions

- MLC-1 and MLC-2 accelerated the emphasis on quality improvement in public health and the move towards public health accreditation. "I don't think we'd be where we are with accreditation if we didn't have MLC-1 and MLC-2. I don't think we'd have the strength of the connections in quality improvement, and the stories and the messages we've been able to develop," said Pamela G. Russo, M.D., M.P.H., a senior program officer on RWJF's Public Health Team, who served as the original program officer for the program.

Program Management

NNPHI served as the national program office for the *Multistate Learning Collaborative*. Joseph Kimbrell, CEO of NNPHI, served as the initial program director. Sarah Gillen, M.P.H., who worked with Kimbrell during Phase 1, became program director in Phase 2 and has continued to direct MLC-3.

Based in New Orleans, NNPHI is a membership organization that fosters networking and collaboration among public health institutes and multi-sector partners to address critical and emerging public health issues.

Funding

Between July 2005 and October 2006, the RWJF Board of Trustees authorized the *Multistate Learning Collaborative* up to a total of \$3.76 million through 2008. MLC-3 continues with \$11.232 million through April 2011.

CONTEXT

In the early 2000s, interest in examining the performance of public health departments was growing. Public health practitioners and experts knew that better tools with external validation, not simply self assessment or grant compliance, were needed to measure performance.

Accreditation in Public Health

Accreditation is an accepted way to foster quality improvement and accountability in many fields. In 2002, the Institute of Medicine noted in *The Future of the Public's Health* that although health care organizations and other governmental agencies such as police, fire and schools had mechanisms for accreditation and quality assurance, public health did not. According to the report:

"Accreditation mechanisms may help to ensure the robustness and efficiency of the governmental public health infrastructure, assure the quality of public health services,

and transparently provide information to the public about the quality of the services delivered."

The report called for establishing a national steering committee to explore the potential benefits of accrediting public health departments and to determine how such a system should function.

Building on RWJF's Investments in Public Health

Improving the performance of the public health system so it can fulfill its important role in ensuring the safety and health of the public is one of the main strategies of RWJF's Public Health Program Management Team.

The concept of public health accreditation built on RWJF's other investments in programs and projects to improve the performance and impact of the public health system, most notably:

- *Turning Point: Collaborating for a New Century in Public Health*[®]
- The common operational definition for local public health departments developed by the National Association of County and City Health Officials (NACCHO)

Turning Point Performance Measurements

Turning Point, a collaboration between RWJF and the W.K. Kellogg Foundation from 1996 to 2006, sought to: "transform and strengthen the public health system in the United States to make the system more effective, more community-based and more collaborative." Some 22 states and 41 communities in those states worked together to strengthen their public health systems, including through five collaboratives focused on common challenges.

The program, through its Performance Management Collaborative, demonstrated the importance of performance management in driving public health improvements. This collaborative developed a model for performance management—composed of performance standards, performance measures, progress reports and quality improvement—which continues to provide an important framework for improving public health performance.

Read more about *Turning Point* in [Program Results](#).

Operational Definition of Local Health Departments

In 2004, RWJF began funding NACCHO to develop a common operational definition for local public health departments (Grant ID#s 050045, 052324, 052676 and 057248, February 2004 to July 2008).

Operational Definition of a Functional Local Health Department, (click on the title to get to the PDF) published in November 2005, described what public health practitioners and the communities they serve can reasonably expect from local health departments and set standards for accountability. This definition later became part of the foundation for the voluntary national accreditation standards developed for local and state public health departments.

RWJF and the Centers for Disease Control and Prevention (CDC) in Atlanta partnered in funding this work. Read more about this project in [Program Results](#).

Exploring Public Health Accreditation

In 2004, RWJF convened public health stakeholders to decide whether to explore a voluntary national accreditation program for state and local public health departments (Grant ID#s 051173 and 052159, July 2004 to April 2005, managed internally by RWJF). The consensus was to proceed.

That same year, RWJF began an initiative to learn from existing efforts and other sectors' experience to collaboratively develop a model and best practices and to foster the many efforts underway to consider public health department accreditation. Public health practitioners in health departments that would be eligible for accreditation drove the process. RWJF and the CDC were funding partners in this work.

A key part of this initiative was the *Exploring Accreditation* project, during which a 25-member steering committee considered whether it was desirable and feasible to implement a voluntary national accreditation program (June 2005 to December 2008; Grant ID#s 053182, 056262 and 058881). Members included representatives of public health agencies, departments and organizations at the local, state and federal levels.

The project used an open, consensus-building framework to consider whether and how a voluntary national accreditation program could advance the quality and performance of state, local, territorial and tribal public health departments, and developed a draft model for such a program.

Read more about the *Exploring Accreditation* project's process in [Appendix 2](#). For more details about *Exploring Accreditation*, see the separate [Program Results](#) report.

Multistate Learning Collaborative

As a parallel project that complemented the *Exploring Accreditation* project, RWJF created a collaborative of states that were implementing state-based performance assessment or accreditation of local public health departments—the *Multistate Learning Collaborative*—to share their experiences with each other and with agencies participating in *Exploring Accreditation*.

RWJF's Public Health Program Management Team conceived the collaborative after learning that some states had or were working on some type of accreditation programs and after a visit to North Carolina's pilot program. "After seeing the North Carolina program, we thought, wouldn't it be great if all the states that were doing this could have a forum for exchange and a small amount of flexible funding to advance their own programs," said RWJF's Russo.

The program was designed to meet two RWJF strategies for enhancing public health:

- To develop new tools for public health practitioners to use in measuring and improving performance
- To pursue changes in the environment that build a culture of accountability and greater public support for the work of public health

For more details about the impact of the *Multistate Learning Collaborative on Exploring Accreditation*, see the [Overall Program Results to Date](#) section of this report.

THE PROGRAM

Beginning in 2005, RWJF sponsored selected states to work on public health assessment, accreditation and quality improvement and share their experiences through three phases of the *Multistate Learning Collaborative* (MLC).

Each state formed a partnership that usually included:

- The state health, public health or community health department
- Local health departments, often represented by the state association for local public health departments
- The state public health institute—a independent nonprofit entity that functions as a convener to improve health status and foster innovations in health systems
- A state association representing public health professionals (such as nurses)
- Some states also partnered with a university-based school of public health
- The state public health association, the state version of the American Public Health Association.

This report focuses on MLC-1 and MLC-2, which ran from July 2005 to August 2008.

The third phase began in April 2008 and is scheduled to continue until April 2011. This phase focuses on advancing accreditation efforts and quality improvement strategies in public health departments. Read more about Phase 3 in [The Program Continues](#).

Program Implementation: Phase 1

In July 2005, RWJF launched a peer network of five innovator states with experience in systematic assessment of local public health department capacity and performance. The National Network of Public Health Institutes (NNPHI) served as the national program office. RWJF picked NNPHI to manage the programs because of their experience with collaborative in *Turning Point*.

The five states were among 18 that applied for grants:

- **Illinois**, with the Illinois Public Health Institute as the lead agency
- **Michigan**, with the Michigan Public Health Institute as the lead agency
- **Missouri**, with the Missouri Institute for Community Health as the lead agency
- **North Carolina**, with the North Carolina Institute for Public Health at the University of North Carolina at Chapel Hill Gillings School of Global Public Health as the lead agency
- **Washington**, with the State of Washington Department of Health as the lead agency

These states:

- Nominated people to attend the *Exploring Accreditation* meetings and provided the work groups with empirical evidence about existing public health accreditation practices
- Shared their experiences with one another through two meetings, seven conference calls, e-newsletters and briefs by Stacy Baker, consultant to MLC from the Public Health Foundation; all of this was organized by NNPHI
- Advanced their own efforts with projects related to public health performance and capacity assessment or accreditation

"The goal was to have them exchange with each other their best practices and also inform the *Exploring Accreditation* steering committee so instead of being theoretical, the committee was informed by real-world practice in public health," said RWJF's Russo, the program's original program officer.

The grants began in October 2005 and ended in October 2006. Each state received approximately \$150,000.

The State Projects

During Phase 1, Michigan, Missouri and North Carolina focused on enhancing their existing local public health accreditation programs while Illinois worked on transitioning

from certification to performance-based accreditation. Washington targeted its efforts at enhancing its assessment and improvement system for local and state health departments.

Examples of activities:

- **Missouri** integrated findings from an evaluation commissioned by the Institute for Community Health into its accreditation program. These included establishing staffing standards and mechanisms to boost productivity and clarifying documentation requirements.
- **Michigan** developed criteria for selecting accreditation site reviewers and other tools to enhance interactions between reviewers and local health department staff.
- **Washington** established a collaborative of four local health departments and the state department of health to establish and monitor performance measures.
- **North Carolina** produced the Road Map to Accreditation. It is available [online](#) at the North Carolina Accreditation Learning Collaborative website.

Program Implementation: Phase 2

RWJF had expected MLC to be "a one-year experiment," according to Russo. However, the program was effective beyond expectations, and some of the participating states had begun quality improvement work that RWJF was interested in supporting. "It was clear we needed to expand and continue to support the local and state health departments and their partners," said Russo.

MLC-2 was designed to integrate quality improvement into existing performance and capacity assessment or accreditation efforts. It enabled RWJF to "keep on incubating the states that were most likely to go earliest for national accreditation," said Russo.

Some 21 states applied for MLC-2 funding after RWJF launched this phase in December 2006. RWJF selected the five original states and five new ones:

- **Florida**, with the State of Florida Department of Health as the lead agency
- **Kansas**, with the Kansas Health Institute as the lead agency
- **Minnesota**, with the State of Minnesota Department of Health as the lead agency
- **New Hampshire**, with the Community Health Institute as the lead agency
- **Ohio**, with the State of Ohio Department of Health as the lead agency

See the Project List in [Appendix 1](#) for more information on the sites. Each state received approximately \$150,000 to explore and apply quality improvement techniques to improve capacity and performance. They also continued to work collaboratively, exchanging information through two meetings, five conference calls and site visits that NPPHI held.

MLC-2 ended in February 2008 for most states; a few continued their work with no-cost extensions to their grants up to August 2008.

The State Projects

The Continuing States. Michigan, Missouri and North Carolina implemented quality improvement initiatives to enhance their local public health accreditation programs. Illinois focused on quality improvement for the accreditation program the state began to develop during Phase 1. Washington used quality improvement methods to continue to improve capacity and performance.

Examples of activities:

- ***Illinois*** piloted voluntary accreditation tools and processes in seven local health departments.
- ***North Carolina*** incorporated quality improvement into accreditation standards training for local health department staff.

The New States. The five new states all worked on enhancing their performance assessment programs. Ohio also began to develop a model for voluntary accreditation, building from their existing certification program.

Examples of activities:

- ***Kansas*** trained staff from its 15 public health regions and selected local health department staff in performance monitoring and quality improvement.
- ***New Hampshire*** articulated workforce competencies to improve the quality of public health services.

Mini-Collaboratives. Several states formed mini-collaboratives among local health departments to enhance their public health services through quality improvement projects. The states adapted the Institute for Healthcare Improvement's "breakthrough series" model, designed for quality improvement in health care organizations. A breakthrough series collaborative is a short-term (6 to 15 month) learning system that brings together many teams from various sites that together seek improvement in a focused topic area.

Participating sites in the mini-collaboratives received modest financial support for their participation—from \$2,000 to \$10,500 apiece—as well as training and in-depth learning opportunities. Two examples of how the states proceeded:

- ***Minnesota*** established eight collaboratives involving 34 local health departments.
- ***Michigan*** formed a single collaborative of four local health departments to focus on quality improvement.

Site Visits. Each MLC state was permitted to participate in site visits to three other states to learn about best practices on particular topics. These visits also created opportunities for the sites to convene local stakeholders and leaders to gain buy-in for their new initiatives and showcase their quality improvement efforts. Staff and consultants from the national program office, RWJF staff and program partners—primarily representatives of national public health organizations—joined the visits.

MANAGEMENT AND PARTNERS

National Program Office

NNPHI has been serving as the national program office for the *Multistate Learning Collaborative*. Joseph Kimbrell, CEO of NNPHI, served as the initial program director. Sarah Gillen, M.P.H., who worked with Kimbrell during Phase 1, became program director in Phase 2 and has continued in this capacity.

Based in New Orleans, NNPHI is a membership organization that fosters networking and collaboration among public health institutes and multi-sector partners to address critical and emerging public health issues.

In its capacity as the national program office, NNPHI:

- Managed the application and selection process
- Convened the collaborative through meetings and teleconferences of the participating states
- Summarized and shared project findings, reports and quality improvement tools with the *Exploring Accreditation* project and the larger public health community through the program's eCatalog, a resource library on its [website](#) (select "The Multistate Learning Collaborative" under " Search by Program"), presentations, open forums and teleconferences
- Held grantee meetings, open forums and teleconferences to share the work of the MLC states with other states interested in enhancing health department performance and assessment or accreditation

Partners

In addition to RWJF, NNPHI collaborated with the Centers for Disease Control and Prevention (Atlanta) and these national public health organizations:

- Association of State and Territorial Health Officials (ASTHO), the national nonprofit organization representing state public health departments (Arlington, Va.)

- National Association of City and County Health Officials (NACCHO), the national organization representing local health departments (Washington)
- National Association of Local Boards of Health (NALBOH), the national organization representing local boards of health (Bowling Green, Ohio)
- Public Health Accreditation Board (PHAB), the accrediting body for national public health accreditation (Alexandria, Va.)
- Public Health Foundation (PHF), which provides research, training and technical assistance to public health departments and community health organizations (Washington)
- Public Health Leadership Society, a program of NNPHI, which is a membership organization comprised of the alumni from national, state and regional public health leadership institutes and the Robert Wood Johnson Foundation State Health Leadership Initiative (New Orleans)
- Public Health Informatics Institute (PHII) and another RWJF national program, *Common Ground: Transforming Public Health Information Systems*

These partners, most of which are involved in public health improvement, attended MLC meetings, joined site visits, provided consultants and shared what they learned through MLC with their own organizations.

"It's a collaborative process so all of us involved in these efforts are on the same page," said Jennifer McKeever, L.C.S.W., M.P.H., program manager for MLC-2. "We open the door to them to participate and learn as much as they can from the process."

Meeting on Quality Improvement in Public Health

In February 2007, in conjunction with an MLC meeting in Cincinnati, RWJF convened representatives of organizations involved in quality improvement to discuss adapting quality improvement to public health. The quality improvement meeting drew about 80 participants from:

- MLC states
- RAND Center for Public Health Preparedness, which convened a quality improvement learning collaborative that was initially funded by a Department of Health and Human Services contract, and then continued by RWJF
- The Public Health Informatics Institute's local public health business process framework project (the institute is the home of *Common Ground*)

OVERALL PROGRAM RESULTS TO DATE

Staff at NNPHI and RWJF reported the following results from the first two phases of the *Multistate Learning Collaborative* (MLC-1 and MLC-2).

Each site represented a coalition of local health departments, other organizations and the state agency—but this report often uses the term state to refer to that coalition.

- **The findings of MLC-1 contributed to the *Exploring Accreditation* steering committee's decision to recommend that a national voluntary public health accreditation program for state and local health departments be implemented, and to the development of the model for that program.**

Representatives of the states participating in MLC-1 provided the steering committee with empirical information on existing public health accreditation practices in many ways:

- A representative from each site or state-wide coalition served on the steering committee and made presentations about the state's work.
- The four steering committee workgroups (Governance and Implementation; Financial Incentives; Research and Evaluation; and Standards Development) each had at least one MLC representative.
- *Exploring Accreditation* participants visited each state to gather input.
- MLC developed a matrix of attributes of the five state's programs with the help of Glen Mays, M.P.H., Ph.D. Mays directs the *Robert Wood Johnson Foundation Practice-Based Research Network in Public Health*, a RWJF-funded program to support the development of research networks for studying public health practice.

The steering committee acknowledged the value of input from MLC participation in its report:

The opportunity to learn from operational accreditation and related programs for local health departments and one state health department allowed for more fully informed discussions to take place and for the pros and cons of each program to be reflected in the final recommendations put forth by the steering committee.

The Multistate Learning Collaborative served as a learning laboratory, and all of the information provided greatly assisted in informing decisions around the framework for the national program.

Exploring Accreditation: Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments (winter 2006–07) describes the steering committee's recommendations and model. Read more about the *Exploring Accreditation* project in [Program Results](#).

- **MLC raised the visibility of accreditation among public health departments.** The national program office at NNPHI worked with state participants and partners to inform the public health community about accreditation. Among other efforts, the national program office:

- Oversaw a special issue of the *Journal of Public Health Management and Practice* (July/August 2007) on public health accreditation. The issue featured 21 articles and is available [online](#). The articles are listed in [Appendix 3](#) of this report.
- Made presentations at national meetings of Academy Health, American Public Health Association, Association of State and Territorial Health Officials, National Association of City and County Health Officials and the National Association of Local Boards of Health.
- Disseminated its communications products through a section on its website dedicated to the *Multistate Learning Collaborative*. The website includes an overview of the program, information about the participating states, links to the journal supplement and a resource library.

The resource library, located in the [eCatalog](#), includes:

- A matrix of attributes of existing performance and capacity assessment or accreditation programs in the five Phase 1 states. NNPHI developed this matrix to inform the *Exploring Accreditation* project. See New Hampshire's [matrix](#). Others are available in the eCatalog, search term "matrix."
- Reports and other publications about the work of participating states.
- Conference, webinar and meeting materials.

The Public Health Accreditation Board has a link on its website to NNPHI's website section on the *Multistate Learning Collaborative*.

- **MLC created a learning community of more than 29 states sharing information on public health accreditation.**

The national program office held two open forums and an annual teleconference for states that were not participating in MLC but were interested in accreditation, including some MLC applicants that had not been selected. This fostered information sharing and networking among MLC and other states, and their public health partners. The states also networked informally. For example, states that were not funded to participate contacted the MLC states requesting more information or tools they could use.

"They could come to the open forum and learn from the experiences of the other states and get some confidence, knowing more about the models in the other states, as they went about development in their own states," said RWJF's Senior Program Officer, Pamela Russo.

"This learning community has become a community of practice that is building momentum toward accreditation and quality improvement," said McKeever, program manager for MLC-2. "It also provides a safe space for practitioners to come together and share both their successes and their struggles and to learn about accreditation."

- **The national program office at NNPHI worked with the participating states to develop and provide quality improvement resources for the public health community.** These resources, which are available through NNPHI's [eCatalog](#), help to maintain a focus on quality improvement. "Accreditation is important, but it should not happen in a vacuum without continuous quality improvement among practitioners and health departments," said McKeever.

Sample tools include:

- [Topical briefs](#) on sharing model practices, workforce training in quality improvement and supporting multisite quality improvement projects and collaboratives. The briefs describe approaches taken by participating states and their results, offer lessons learned and provide Web-based resources.
- [Storyboards](#), a way to document and showcase quality improvement or performance excellence using simple, clear statements and graphics to highlight key points and breakthroughs within the story of a project. Two examples:
 - One Kansas storyboard describes the steps taken to provide uniform testing and treatment services for sexually transmitted diseases. Another documents activities to and increase flu vaccination rates in children. See the [Kansas storyboards](#).
 - One Michigan storyboard documents the steps taken to build media awareness about a local health department's activities. Another documents efforts to educate people with hepatitis C about managing their disease. See the [Michigan storyboards](#).
- [Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook](#) provides models, strategies and tools that local public health practitioners can use to improve public health practice and improve outcomes.

The guidebook also offers instructions on using the Plan-Do-Study-Act cycle, a well-known management tool for testing a change and refining the approach based on observation:

- *Plan.* Plan the test or observation, including a plan for collecting data.
- *Do.* Try out the test on a small scale.
- *Study.* Set aside time to analyze the data and study the results.
- *Act.* Refine the change based on what was learned from the test.

- North Carolina's Accreditation Road Map, which provides a checklist of issues to consider in creating a new accreditation system for local or state public health departments, emphasizing partnership and communication.

The road map is available [online](#) at the North Carolina Accreditation Learning Collaborative website. The Public Health Accreditation Board and the National Association of County and City Health Officials also provide links to the road map.

- Florida's five-step [Performance Improvement Process](#), which Department of Health's employees use to plan, manage and improve the department's business outcomes and community health outcomes. The process enables the department to build a culture of continuous performance improvement by empowering employees with the knowledge, skills and tools to improve their processes and outcomes.

It is based on the "Plan-Do-Check-Act" (PDCA) model for continuous performance improvement, comprised of:

- *Plan.* Plan the test or observation, including a plan for collecting data.
- *Do.* Try out the test on a small scale.
- *Check.* Set aside time to analyze the data and study the results.
- *Act.* Refine the change, based on what was learned from the test.

The PDCA cycle should be repeated again and again for continuous improvement.

- **Four states participating in MLC-1 described their approaches to on-site reviews, which are a central feature of their accreditation programs, to help guide other states.** Michigan, Missouri, North Carolina and Washington described these reviews in an article published in an issue of *the Journal of Public Health Management Practice* devoted to accreditation (volume 13, issue 4, 2007), available [online](#).

The *Exploring Accreditation* project recommended on-site reviews as part of the accreditation process because first-hand examination of facilities and conversations with public health leaders and practitioners provides reviewers with a fuller picture of organizational capacity than relying solely on written material.

For a description of the on-site review process in these four states, see [Appendix 4](#). For recommendations in the journal article, see [Lessons Learned](#).

- **The MLC states informed the establishment of the Public Health Accreditation Board and its ongoing work.** In 2007, with funding from RWJF and the CDC, the Public Health Accreditation Board was established to manage and promote a national voluntary public health accreditation program. "Members of MLC participated in all of the Public Health Accreditation Board's workgroups

and continue to inform every aspect of the board's work," said Russo. "The Public Health Accreditation Board was directly modeled on the recommendations made in the *Exploring Accreditation* report."

From fall 2009 to the end of 2010, 30 public health departments nationwide, including local, state and tribal health departments, are participating in a test of the program, which is set to launch in 2011. Learn more about the Public Health Accreditation Board's [national voluntary public health accreditation program](#) for state and local health departments.

MLC-3, which began in April 2008 and is scheduled for three years, was ongoing as of the writing of this report (April 2010). It focuses on advancing accreditation efforts and quality improvement strategies in public health departments. For this phase, RWJF added "Lead States in Public Health Quality Improvement" to the program's name and it became known as *MLC: Lead States in Public Health Quality Improvement*.

Read more about MLC-3 in [The Program Continues](#).

KEY SITE RESULTS

The participating states and staff from the national program office and RWJF reported these results.

- **Michigan, Missouri and North Carolina enhanced their existing public health accreditation programs for local public health departments.** For example:
 - *Michigan* developed a framework for a voluntary continuous quality improvement process, based on the Plan-Do-Study-Act cycle combined with NACCHO's operational definition of a functional local health department (hereafter called operational definition).
 - *Missouri* revised its public health accreditation standards based on the operational definition and the Public Health Accreditation Board's work in developing a national public health accreditation program.
 - *North Carolina* created a Public Health Improvement Fund to provide a financial incentive for local health departments to conduct performance or quality improvement projects that address accreditation standards they did not meet during the accreditation review process. Eight local health departments received funding for projects such as developing a scorecard or assessing the community to determine health priorities and identify priority populations.
- **Florida, Illinois, Kansas, Minnesota, New Hampshire, Ohio and Washington enhanced their public health performance measurement programs as part of a move toward accreditation.** For example:

- *Illinois* designed a voluntary accreditation framework to enhance its local public health certification program and to develop a more performance-based approach.

During MLC-2, Illinois created and tested systems, tools and protocols for an accreditation program focused on quality improvement. Seven local health departments were selected to pilot test voluntary accreditation, which included evaluating 50 performance measures addressing eight public health practice standards. All seven health departments achieved pilot accreditation status.

- *Ohio* created performance standards and metrics associated with each standard for state and local public health departments. These standards are integrated with the operational definition of a functional local health department.
- *Minnesota* developed a comprehensive online Planning and Performance Measurement Reporting System allowing the Department of Health to analyze and present data about local public health department activities, staffing and finances. The local departments can then see how their data compare to regional and state data.
- *New Hampshire* began to create measures and approaches to improve state and local health department performance on six strategic priorities (e.g., monitoring health status and workforce development).

- **Participating states adopted best practices from one another.** Opportunities to exchange information through meetings, conference calls, the open forum, site visits, the MLC website and more informal mechanisms allowed states to learn about best practices and consider adopting them.

Among the practices of interest to other states were:

- Programs in *Michigan* and *North Carolina* to train site visitors, a system of provisional accreditation in Michigan and Washington's use of an external assessor who provided feedback to the health departments.
- *Missouri's* use of a tiered system of accreditation that could accommodate both small rural health departments and large metro health departments

- **Most states offered training and technical assistance to public health professionals to build their capacity to undertake quality improvement initiatives.** Collectively, the states trained more than 500 public health professionals in quality improvement methods.

For example:

- *Florida, North Carolina* and *Washington* showcased employees who achieved measurable quality improvement benefits to create enthusiasm for those efforts.

- *Kansas* held a three-day training session for participants from all 15 public health regions before releasing a request for proposals for mini-grants to undertake quality improvement projects.
- *Washington* developed an interactive, 40-minute Web-based course with information about the standards, measures and processes used to assess the state every three years. Staff in local health departments and the state Department of Health could take the course at their desk.

For more information, see the [topical brief](#) about preparing the public health workforce for quality improvement.

- **Some states demonstrated that public health teams can learn to apply quality improvement methods and achieve measurable improvement, sometimes in a relatively short time.** The states developed pilot quality improvement projects that engaged multiple local health departments or collaboratives of local health departments.

For example:

- A five-county team in rural *Kansas* increased influenza vaccination rates for babies and children ages 6 months to 59 months. The team analyzed the root causes of the region's low vaccination rates and found that education and awareness about the vaccine were the most important factors. The team increased efforts to raise awareness of the vaccine.
- *Washington* created a collaborative on establishing and monitoring performance measures. It was composed of the state health department and four local health departments. Each site selected a program area to work in (e.g., ensuring service to priority populations and increasing use of contraceptives in family planning).

The sites received on-site training, followed by individual coaching and group meetings. By the end of the collaborative, all of the sites had showed progress in developing goals, objectives and performance measures. Several sites had improved performance results.

- *Florida* created a childhood obesity collaborative, comprised of 10 local health departments and led by the state Department of Health. The collaborative focused on increasing the number of people who participated in moderate physical activity by sponsoring events such as walks or runs and facilitating employee wellness activities. The health departments participated in monthly Web ex/conference calls and two face-to-face meetings. They also received and shared information, resources and educational materials.

Collectively, the states:

- Leveraged modest funds to sponsor more than 35 quality improvement projects involving more than 75 local and state health departments.

- Engaged public health professionals directly as members of quality improvement project teams and showcased events and learning opportunities to others in public health.
- Found that similar quality improvement principles and tools can be applied to achieve results in a variety of areas important to public health.
- Increased capacity to support quality improvement projects through states' staff, partners and consultants.
- Generated enthusiasm for quality improvement by showcasing peers who found it doable, rewarding and relevant to public health goals.

For more information, see the [topical brief](#) about using pilot quality improvement projects and collaboratives.

- **A few states developed ways to share model practices for accreditation or performance improvement initiatives with their local health departments.** For example:
 - *Washington* relied on reviewers who were staff members or consultants to the Department of Health to identify exemplary practices and create a compendium of documents to assist local health departments in meeting the standards.
 - *Florida* and *Michigan* cultivated peer advisors and peer networks to expose local public health leaders to other practices, broaden expertise across the state and spread ideas. Peer advisors, for example, can spread model practices by sharing them with sites during on-site reviews and by bringing good ideas back to their health departments.

For more information, see the [topical brief](#) about sharing model practices for preparing for accreditation or performance improvement initiatives.

EVALUATION

Brenda M. Joly, Ph.D., M.P.H., was the lead evaluator. During MLC-1 she was employed by the Maine Center for Public Health. During MLC-2, she moved to the University of Southern Maine's Muskie School of Public Service in Portland, as an assistant research professor.

MLC Phase 1 Evaluation

During MLC-1, NNPHI contracted with the Muskie School for evaluation services. "It's part of our way of doing business to make sure we can learn from every project," said McKeever, program manager for MLC-2.

The Phase 1 evaluation focused on:

- MLC management, components and goals.
- Grantee efforts to enhance performance and capacity assessment or accreditation.
- The learning collaborative approach.

Evaluators gathered information through site visits, face-to-face group interviews, surveys, grantee reports and meeting evaluation forms. See [Appendix 5](#) for the evaluation questions and more information on the evaluation methodology.

Evaluation Findings: MLC Phase 1

Evaluators reported these key evaluation findings about MLC-1 in *Multistate Learning Collaborative: Evaluation Report* (November 2006):

- **MLC was well organized, facilitated and managed.**
- **All elements of the collaborative were relatively well received, and the kick-off meeting and site visits were particularly valuable.**
- **MLC made considerable progress in achieving the desired goals, despite a relatively short time frame.**
- **Given the ambitious objectives and activities, the modest amount of funding and the time frame for their grants, the MLC states were able to make significant progress in their work plans.** Moreover, despite some of the challenges they addressed, they made some important accomplishments in a relatively short time span.
- **Participants perceived the collaborative approach as beneficial.** The collaborative:
 - Helped participants foster relationships and develop a peer group
 - Provided a way to learn and share resources
 - Validated accreditation-related efforts among peers
 - Helped participants get more support and visibility for their state's public health assessment and accreditation efforts
 - Informed the national dialogue on public health accreditation by sharing many perspectives and state experiences.
- **The overall initiative was generally viewed positively.** While comments included suggestions for improvement, these generally involved minor "tweaking" to the initiative.

MLC Phase 2 Evaluation

RWJF supported the evaluation of MLC-2 and initially planned to use the evaluation findings to determine whether to fund a third phase of MLC. The evaluators assessed MLC-2's overall processes, structure and outcomes, including how well the participating states felt they met their goals.

Initially, the evaluators also planned to develop case studies of quality improvement initiatives in three states. However, partway through MLC-2, RWJF moved ahead on a decision to fund a third phase of MLC, and the evaluators decided to wait and develop more comprehensive case studies based on the experiences of both MLC-2 and MLC-3.

"Rather than try to arbitrarily differentiate between MLC-2 and MLC-3, it seemed better and more in depth to do them all at the same time and provide a fuller picture of what was really happening at the state level," said Maureen Booth, a member of the evaluation team. This also enabled the evaluators to work on case studies for all of the participating states.

"It was really about creating really good synergy and not duplicating effort," said Brenda L. Henry, Ph.D., M.P.H., a program officer at RWJF in Research and Evaluation.

Evaluators gathered information through participant questionnaires, key informant interviews, group grantee interviews, and a grantee status and exchange tool. See [Appendix 5](#) for the evaluation questions and more information on the evaluation methodology.

Evaluation Findings: MLC Phase 2

Evaluators reported these key evaluation findings in *Multistate Learning Collaborative-2: Evaluation Report: Component #1* (March 2008) and in a report to RWJF:

- **Overall, grantees, project staff, consultants and partners ranked their experiences with MLC-2 very highly and agreed that it successfully met its goals.** The participating sites identified site visits and face-to-face meetings as the most valuable components of MLC-2 and recognized the role of senior leaders and project teams in translating knowledge to create change at the local level.

"The MLC-2 was seen as a critical platform for advancing quality improvement infrastructure and capacity at the state and local public health levels," according to the report.

- **MLC-2 was well managed, stayed relevant to its grantees and goals and had strong leadership.** Both states and key informants identified the challenges of maintaining close and timely communications in a project as diverse as this one. More structured and frequent contact with states could help focus agendas and better target the use of available resources.

- **Grantees and key informants saw MLC-2 as offering a unique, safe and effective means for learning, both from the experts and one another.**

Collaboration has grown among the 10 participating states by fostering and strengthening relationships within the public health system. Most of the states also created new partnerships, saw greater collaboration among their existing partners and saw more collaboration at the regional or local level.

"The collaborative provided a forum for peers to learn and exchange resources and the resources helped to further the assessment or accreditation efforts in 10 states," according to the report.

Maureen Booth, a member of the evaluation team, added, "The states really benefit and take a great deal of value from these peer networking opportunities and being brought together in a way that allows shared learning and problem solving. It's one of the few times that this has happened on performance measurement in public health."

- **Given the relatively short time frame, modest resources, staffing issues and variation in capacity within and among the states, MLC-2 grantees made significant progress on their objectives and short-term outcomes.** In general, states that participated in both phases of MLC tackled more ambitious objectives and short-term outcomes than those that joined the initiative in the second phase. However, there were no major differences in accomplishing their stated objectives.

Many states committed to carry on the work begun during the program, regardless of future external funding.

- **By the end of MLC-2, the need for more structure to the program became apparent.** "We were really beginning to feel that some more structure through the grant solicitation would be advisable so there would be more commonality across states in terms of what they were working on," said Booth. More structure would have enabled the national program office at NNPHI to better serve the participating states.
- **Findings about quality improvement in public health need to be disseminated.** "In the absence of models for public health to develop and design their quality improvement systems, each state is sort of doing it for the first time alone," said Booth. The need to disseminate findings from these initiatives is really critical. By the end of MLC-2 there was really a call for more of a repository of learning and exchange across states so that they could document and learn what other states had done."

CONCLUSIONS

Staff at the national program office and RWJF drew these conclusions about the first two phases of the *Multistate Learning Collaborative*:

- **MLC has accelerated the pace of public health accreditation.** "I don't think we'd be where we are with accreditation if we didn't have MLC-1 and MLC-2. I don't think we'd have the strength of the connections in quality improvement, and the stories and the messages we've been able to develop," said RWJF's Russo.
- **States that participated in the first two phases of MLC have become the leaders in informing public health accreditation.** "Not just the Public Health Accreditation Board but many of the partner organizations, such as the National Association of County and City Health Officials and the Association of State and Territorial Health Officials, have really looked to these leaders to inform how the national accreditation program is rolled out, how to provide technical assistance and how to spread it to health departments outside of those states," said RWJF's Abbey Cofsky, a program officer on the Public Health Team.
- **MLC-2 established an early understanding of the need for quality improvement in public health.** "Quality improvement and accreditation are mutually supportive. We have a greater understanding now of the relationship between quality improvement and accreditation," said McKeever, program manager for MLC-2. MLC-2 also highlighted the need for additional training and capacity building in public health quality improvement.

LESSONS LEARNED

Lessons From the National Program Office

1. **Developing a communication plan at the beginning of a program is critically important, especially when many partners and participants are involved.** The NNPHI's national program office developed a plan that included strategies for communicating internally with project stakeholders and participants, as well as for external communications. (Program Director Sarah Gillen in a report to RWJF)
2. **Be prepared to spend more money and time, and to require more expertise, for extensive communication activities.** Sharing information about the *Multistate Learning Collaborative* with the public health field was a key component of the program, but that was costly. The national program office found that adding communications activities required additional expertise and staff time. (Program Director Sarah Gillen in a report to RWJF)
3. **Developing a system to manage Web-based products and information is a major undertaking, requiring considerable resources.** The NNPHI developed an electronic catalog (eCatalog) of communications products related to the program, but found that managing the system was a huge effort for which it had not allocated

sufficient funding or staff. Staff members were unable to update the eCatalog as often as they wished, or to adequately synthesize some of the information from each site. (Program Director Sarah Gillen in a report to RWJF)

4. **Consider hiring a librarian or an analyst for programs that involve sharing a large amount of information.** With 10 states preparing reports, presentations and other materials that would be useful to other states working on accreditation and performance assessment, the NNPHI could have used someone with experience to categorize the information and post it to the eCatalog. (Program Manager McKeever)
5. **Increasing the size of a program increases the complexity of preparing meaningful content for all participants.** As MLC increased from five to 10 states in Phase 2, the NNPHI national program office found that it was more difficult to prepare relevant content for meetings and teleconferences. Content that was relevant for the initial five states was sometimes too advanced for the newer states, which often required more background.

To accommodate the needs of new states, program staff provided orientation sessions at meetings. They also built cohesion by reminding participants that states were in different places in their accreditation or performance assessment processes. (Program Director Sarah Gillen in a report to RWJF)

6. **Achieving buy-in for continuous quality improvement in public health requires time, leadership and sometimes, political will.** Many MLC states made considerable investments of all three to gain widespread buy-in for quality improvement efforts among state and local public health practitioners. (Program Director Sarah Gillen in a report to Robert Wood Johnson Foundation)
7. **Quality improvement is relatively new to the field of public health and should be relevant and clearly defined.** The NNPHI found that quality improvement efforts needed to focus on the priorities of the public health practitioners involved and that common terminology is needed to define key principles. (Program Director Sarah Gillen in a report to RWJF)

Lessons About State Participation in MLC

Two overarching lessons about participating in MLC are offered in "[Lessons Learned from the Multistate Learning Collaborative](#)," *Journal of Public Health Management and Practice* (volume 13, issue 4, July/August 2007):

8. **Engage broad stakeholder and leadership (i.e., legislators and state and local health officials) support and participation in the accreditation or assessment process from the beginning.**
9. **Planning, implementing and evaluating an accreditation program for public health departments is an ongoing process that requires long-term commitment and a focus on the goals, benefits and anticipated outcome.**

Lessons described in reports from state participants to RWJF:

- 10. Developing a collaborative is hard work and requires the commitment of participants.** In creating a collaborative comprised of the state health department and four local health departments, Washington found that the participants needed to recognize the challenges of the collaborative's work and their participation, and understand the value of a collaborative.

"We learned to communicate the benefits and processes early on and to remind participants how to learn from each other's work," wrote Allene Mares, the Washington project director, to RWJF.

- 11. Understand current practices and needs and identify training resources when exploring ways to infuse quality improvement into public health departments.**

North Carolina surveyed local health departments to learn about their current performance improvement practices and performance improvement training needs. "This ensured that we targeted resources and tailored training content to the greatest need," wrote Edward L. Baker, M.D., M.P.H., M.S., the North Carolina project director, to RWJF.

- 12. Build toward accreditation by focusing on performance assessment first.** Ohio did not have a state accreditation program when it began participating in MLC. The state chose to focus on performance self-assessment as a way to advance continuous quality improvement (CQI) and prepare for national accreditation.

"Such a system creates the CQI framework, uncovers CQI training and technical assistance needs, and establishes a CQI culture within and between the states and localities. Without such a focus on self-assessment, national accreditation will be pursued in a piecemeal fashion," wrote John W. Francis, M.B.A., Ph.D., the Ohio project director, to RWJF.

- 13. Adopting quality improvement in public health requires a cultural shift.**

Participants in pilot projects in Kansas reported that it took a great deal of conscious effort to implement quality improvement and that they did not use quality improvement tools optimally. Health departments will need more "practice and reinforcement to become comfortable with quality improvement tools and utilize them routinely," wrote Gianfranco Pezzino, M.D., M.P.H., the Kansas project director to RWJF.

- 14. Provide many opportunities for collaborative partners to interact with each other and with project managers.** "In retrospect, it is apparent that more opportunities for collaboration and formal communication among the pilots and between the pilots and the management team would have led to better sharing of effective regional strategies and peer support," wrote Pezzino, the Kansas project director, to RWJF.

15. Comprehensive quality improvement in public health requires the state health department to be a partner in collaborative projects. Regional teams in Kansas often sought input from the state health department during the pilot project, but state staff members were not formally included.

"The formal involvement of state teams is an important step in comprehensive system-wide quality improvement. Involvement of local and state partners working together in learning collaborative projects will foster understanding of mutual roles, responsibilities and challenges," wrote Pezzino to RWJF.

A lesson from a [description of the on-site reviews](#) used by four MLC states as part of their accreditation process was published in the *Journal of Public Health Management and Practice* (2007, vol. 13):

16. On-site review and self-assessment are vital for states to assess the accountability and performance of local and state health departments. On-site review provides the venue to assess, observe, interview, review, evaluate or survey local and state health departments and programs about their ability to meet public health standards. The on-site review process should focus on continuous quality improvement of the review process itself, including the experiences of the reviewers and the local health departments during the review. Accreditation and performance assessment are living processes.

THE PROGRAM CONTINUES

In January 2008, the RWJF Board of Trustees authorized the third phase of the *Multistate Learning Collaborative* for up to \$11.75 million, expanding the program to 16 states. RWJF renamed the program *Lead States in Public Health Quality Improvement*. The program website calls it *MLC-3: Lead States in Public Health Quality Improvement*.

Building on the momentum of the two previous phases, MLC-3 is designed to:

- Contribute to the development of the national voluntary accreditation program.
- Prepare local and state health departments for national accreditation.
- Advance the use of quality improvement methods in health departments.

The program began in April 2008 and is scheduled to continue until April 2011.

States Participating in MLC-3

Sixteen states, out of 25 applicants, are participating in MLC-3. Participating states include nine of the 10 states from MLC-2 (Florida, Illinois, Kansas, Michigan, Minnesota, Missouri, New Hampshire, North Carolina and Washington). The tenth, Ohio, continued to develop its accreditation process and QI training with separate funding from RWJF.

The seven new states are:

- **Indiana**, with the State of Indiana Department of Health as the lead agency
- **Iowa**, with the State of Iowa Department of Public Health as the lead agency
- **Montana**, with the State of Montana Department of Public Health and Human Services as the lead agency
- **New Jersey**, with the New Jersey Health Officers Association as the lead agency
- **Oklahoma**, with the State of Oklahoma Department of Health as the lead agency
- **South Carolina**, with the Department of Health and Environmental Control as the lead agency
- **Wisconsin**, with the State of Wisconsin Department of Health Services as the lead agency

Each state is receiving up to \$150,000 per year.

The National Network of Public Health Institutes is also managing MLC-3. Researchers at the University of Southern Maine's Muskie School of Public Service are evaluating the program.

MLC-3 Emphasizes Quality Improvement

The participating states are applying quality improvement methods to improve public health services and the health of their communities in at least two of these 10 target areas. Five of the target areas were related to health department capacity/process and five were related to improving health outcomes:

Health department capacity/process target areas:

- Community health profile
- Culturally appropriate services
- Health improvement planning
- Assure competent workforce
- Customer service

Health outcome target areas:

- Reduce the incidence of vaccine-preventable disease
- Reduce preventable risk factors that predispose people to chronic disease
- Reduce infant mortality rates

- Reduce the burden of tobacco-related illness
- Reduce the burden of alcohol-related disease and injury

NNPHI, RWJF, states participating in MLC-2 and program partners worked together to identify these target areas.

Each state project is designed to achieve specific and measurable goals, such as:

- Increasing immunization rates
- Increasing the number of adults who engage in physical activity
- Implementing standard procedures to communicate efficiently with community members during disasters and health emergencies

RWJF's Russo noted that MLC-3 was purposefully designed to show the strong connection between accreditation and continual quality improvement—that accreditation drives quality improvement.

"In order to reach accreditation, agencies need to apply quality improvement in the areas where their performance will not satisfy the standards," states Russo. As the bar for accreditation rises over time, agencies will need to continue to do quality improvement to achieve accreditation. In addition, the national standards for accreditation require a QI plan in the agency and evidence of QI projects that have achieved improvement."

Mini-Collaboratives

In MLC-3, RWJF required participating states to form mini-collaboratives to spread quality improvement across health departments within their states. "Just as the national model had done this across state borders, we thought it would also work within the states," said Russo.

This approach builds on the mini-collaboratives three states had formed in MLC-2. "These states had been very successful. It was a way to concentrate technical assistance and training within the states," said Russo.

The MLC-3 mini-collaboratives can include any combination of state and local health departments and public health partners (e.g., public health associations, health care providers and universities). As few as two and as many as 60 local health departments are participating in each state, with most states involving five to 10 local health departments.

Prepared by: Lori De Milto

Reviewed by: Karyn Feiden and Molly McKaughan

Program officer: Pamela G. Russo and Abbey Cofsky

APPENDIX 1

Project List: Phase 1 and 2 of the *Multistate Learning Collaborative on Performance and Capacity Assessment or Accreditation of Public Health Departments*

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Phase 1 and 2

Illinois Multistate Learning Collaborative

Illinois Public Health Institute (Chicago)

ID# 053805, 059865 (October 2005 to February 2008): \$300,000

Project Director: Elissa J. Bassler, M.F.A.

(312) 850-4744

elissa.bassler@iphionline.org

Michigan Multistate Learning Collaborative

Michigan Public Health Institute (Okemos, Mich.)

ID# 053806, 059868 (October 2005 to February 2008): \$292,218

Project Director: Julia Heany, Ph.D.

(517) 324-7349

jheany@mphi.org

Missouri Multistate Learning Collaborative

Missouri Institute for Community Health (Jefferson City, Mo.)

ID# 053808, 059234, 059871 (October 2005 to February 2008): \$400,000

Project Director: Janet Canavese

(660) 343-3627

janet@michweb.org

North Carolina Multistate Learning Collaborative

University of North Carolina at Chapel Hill Gillings School of Public Health (Chapel Hill, N.C.)

ID# 053805, 059874 (October 2005 to June 2008): \$287,129

Project Director: Edward L. Baker, M.D., M.P.H., M.S.

(919) 966-1069

ed_baker@unc.edu

Washington Multistate Learning Collaborative

State of Washington Department of Health (Olympia, Wash.)

ID# 053809, 059876 (October 2005 to February 2008): \$300,000

Project Director: Allene Mares

(360) 236-4062

allene.mares@doh.wa.gov

States Added in Phase 2

Florida Multistate Learning Collaborative

State of Florida Department of Health (Tallahassee, Fla.)

ID# 059866 (December 2006 to March 2008): \$150,000

Project Director: Shannon Lease, M.S.

(850) 245-4007

shannon_lease@doh.state.fl.us

Kansas Multistate Learning Collaborative

Kansas Health Institute (Topeka, Kan.)

ID# 059866 (December 2006 to February 2008): \$147,963

Project Director: Gianfranco Pezzino, M.D., M.P.H.

(785) 233-5443

gpezzino@khi.org

Minnesota Multistate Learning Collaborative

State of Minnesota Department of Health (Saint Paul, Minn.)

ID# 059870 (December 2006 to May 2008): \$149,998

Project Director: Debra L. Burns, M.A.

(651) 201-3873

debra.burns@state.mn.us

New Hampshire Multistate Learning Collaborative

JSI Research and Training Institute, doing business as Community Health Institute
(Bow, N.H.)

ID# 059872 (December 2006 to May 2008): \$139,689

Project Director: Jonathan Stewart

(603) 573-3300

jstewart@jsi.com

Ohio Multistate Learning Collaborative

State of Ohio Department of Health (Columbus, Ohio)

ID# 059875 (December 2006 to August 2008): \$1490,586

Project Director: John W. Francis, M.B.A., Ph.D.

(614) 728-9173

john.francis@odh.ohio.gov

APPENDIX 2

The *Exploring Accreditation* Project

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The National Association of County and City Health Officials (NACCHO), in Washington, and the Association of State and Territorial Health Officers (ASTHO), in Arlington, Va., co-directed *Exploring Accreditation*.

The planning committee was comprised of the executive directors of:

- NACCHO
- ASTHO
- American Public Health Association (APHA) in Washington, which represents public health professionals across the country
- National Association of Local Boards of Health (NALBOH) in Bowling Green, Ohio

During *Exploring Accreditation*, RWJF funded the work done by NACCHO (ID#s 053182, 056262, 058881) and the CDC funded the work done by ASTHO.

The steering committee established four workgroups to inform its efforts:

- Governance and Implementation Workgroup, which developed governance recommendations
- Finance and Incentives Workgroup, which examined ways to finance the program
- Research and Evaluation Workgroup, which developed research principles and a framework for the program
- Standards Development Workgroup, which developed principles to guide standards development

More than 40 public health practitioners and academics participated in the workgroups, which developed recommendations and considered alternatives to accreditation.

The impact of the *Multistate Learning Collaboratives on Exploring Accreditation* is described in the [Overall Program Results to Date](#) section of this report. More details about *Exploring Accreditation* are available in a separate [Program Results](#) report.

APPENDIX 3

Journal of Public Health Management Practice (July/August 2007)

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

These articles were published in a special issue of the *Journal of Public Health Management Practice* and are available [online](#).

Editorials

- "Accreditation of Public Health Agencies: A Means, Not an End"
- "Accreditation as an Opportunity to Strengthen Public Health: CDC's Perspective"

Commentary

- "*Exploring Accreditation*: Striving for a Consensus Model"
- "History Will Be Kind"
- "Building a Bridge to Accreditation-the Role of the National Public Health Performance Standards Program"
- "Financing and Creating Incentives for a Voluntary National Accreditation System for Public Health"
- "The Role of Performance Management and Quality Improvement in a National Voluntary Public Health Accreditation System"

Articles

- "Final Recommendations for a Voluntary National Accreditation Program for State and Local Health Departments: Steering Committee Report"
- "Linking Accreditation and Public Health Outcomes: A Logic Model Approach"
- "The Operational Definition of a Functional Local Public Health Agency: The Next Strategic Step in the Quest for Identity and Relevance"
- "States Gathering Momentum: Promising Strategies for Accreditation and Assessment Activities in *Multistate Learning Collaborative* Applicant States"
- "Public Health Laws and Implications for a National Accreditation Program: Parallel Roadways Without Intersection?"

- "Lessons Learned from the *Multistate Learning Collaborative*"
- "Accreditation/Performance Assessment On-Site Reviews in Michigan, Missouri, North Carolina, and Washington: Implications for States and Evolving National Model
- "Evaluation as a Critical Factor of Success in Local Public Health Accreditation Programs"
- "Enhancing Michigan's Local Public Health Accreditation Program Through Participation in the *Multistate Learning Collaborative*"
- "Local Public Health Certification and Accreditation in Illinois: Blending the Old and the New"
- "The NC Accreditation Learning Collaborative: Partners Enhancing Local Health Department Accreditation"
- "Linking Agency Accreditation to Workforce Credentialing: A Few Steps Along a Difficult Path"
- "Accreditation: Time to Get Ready"

APPENDIX 4

How Four States Approached On-Site Review

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Michigan, Missouri, North Carolina and Washington described their procedures for conducting on-site reviews during the accreditation process and made recommendations to other states. These descriptions were published in "[Accreditation/Performance Assessment On-Site Review in Michigan, Missouri, North Carolina and Washington: Implications for States and an Evolving National Model](#)," in the *Journal of Public Health Management and Practice* (July/August 2007).

- **The states use different processes in their on-site reviews:**
 - Michigan, Missouri and North Carolina evaluate local health departments only; they do so on a rotating schedule across multiyear cycles. Washington evaluates local health departments, selected state programs and the state board of health; it conducts all reviews during a five-month period every three years to capture system performance.

The length of time on-site can vary from half a day to five days, and involve two to 15 reviewers. No state holds site visits more than every three years.

- All of the states emphasize assessing administrative capacity and adequacy of the public health infrastructure.
- **Most of the states use self-assessment to help the agency prepare for the on-site review.** Anecdotal reports and survey data suggest that the amount of time spent in the self-assessment and the seriousness with which the self-assessment is conducted may influence the accreditation or performance assessment outcome.
- **The on-site review is the springboard for quality improvement and provides the venue to evaluate conformity with standards and measures.** It is used to conduct interviews and examine agency documents and policies. It also provides a forum for discussion about conformance and best practices.
- **All states evaluate the on-site review process and provide ongoing training for reviewers and the agency undergoing review.** Ongoing evaluation activities demonstrate the critical importance of the face-to-face exchange between reviewers and participants.
- **Coordinating on-site review, including scheduling and logistical arrangements, is labor intensive.** Most states use a third party, such as a public health institute or non-governmental entity, to coordinate the review process.
- **Whether on-site review is a voluntary or mandatory part of the accreditation and performance assessment, it can result in the participation of all local public health departments, as well as the state entity.** All four states have, or expect to have, full participation.
- **Reviewer knowledge, experiences and skills, and organizational affiliation are important considerations for any accreditation or performance assessment program.**
- **Other important components of the on-site review process are the exit interview and the on-site review findings reports.** Exit interviews foster discussion of strengths and weaknesses. Written reports of findings are provided to all departments that are reviewed.

APPENDIX 5

Questions for and Methodology of the Evaluation of MLC-1

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Evaluation Questions

- Was MLC-1 effectively managed?
- What components of the initiative were valuable?

- Was MLC-1 successful in achieving the broad goals of the initiative?
- Were MLC-1 grantees successful in accomplishing their stated objectives?
- Was the collaborative approach a successful strategy?
- What are the lessons learned from the MLC-1 initiative?

Methodology

- Telephone interviews with state health department staff and initiative consultants
- Web-based survey of MLC-1 participants (grantees, consultants and partners)
- Group interviews with grantees at MLC-1 meetings
- A spreadsheet tracking tool completed by grantees
- Meeting evaluation forms

APPENDIX 6

Questions for and Methodology of the Evaluation of MLC-2

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Evaluation Questions

- Was MLC-2 effectively managed?
- What components of MLC-2 were valuable?
- Was the collaborative approach a successful strategy for the 10 states?
- What was the "reach" of MLC-2?
- Was MLC-2 successful in achieving the broad goals and anticipated outcomes of the initiatives?
- Were the MLC-2 grantees successful in accomplishing their stated objectives?
 - What were the barriers and facilitators?
- What were the lessons learned from the MLC-2 initiative?

Methodology

- Participant survey
- Key informant interviews with staff from the National Network of Public Health Institutes, project consultants and staff from RWJF

- Group interviews with grantees at MLC-2 meetings
- Grantee status and information exchange tool, used to gather information about short-term outcomes and interactions and resource exchange with other sites

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