Five State Health Departments Worked to Improve Quality

Linking quality improvement in state public health programs to national accreditation for state health departments

SUMMARY

From 2011 to 2013, the Association of State and Territorial Health Officials (ASTHO) led a demonstration initiative with five state public health agencies to promote quality improvement (QI) across three key program areas—environmental health, chronic disease and prevention, and maternal and child health. A key aim of the initiative was to link QI to the departments’ efforts to achieve accreditation from the Public Health Accreditation Board (PHAB).

Key Results

- State health agency staffs worked across program area lines, in some cases for the first time.
- Four of the five states showed improvement in their project area; the fifth state completed its tests of change after the initiative concluded.
- Each state submitted five examples of documentation demonstrating compliance with the PHAB standards and measures.
- All five states submitted their QI projects to the RWJF-funded Public Health Quality Improvement Exchange (PHQIX), a searchable online database that organizes information from public health quality improvement projects.

Funding

RWJF supported this project from June 2011 through November 2013 with two grants to ASTHO totaling $937,869.¹

¹ ID# 69098 ($121,026, June 15, 2011 through June 30, 2012) and ID# 69394 ($816,843, November 15, 2011 through November 14, 2013)
CONTEXT

QI in public health is a fast-growing enterprise. However, despite the growing emphasis, it is not widespread in state health agencies. According to the *ASTHO Profile of State Public Health, Volume 2* (September 2011):

- A third of state health agencies reported having no quality improvement framework or approach.
- More than 40 percent have no staff dedicated to quality improvement efforts.
- About 85 percent reported that less than a quarter of their staff members had received formal training in quality improvement.

National Accreditation

Beginning in late 2011, state (as well as local and tribal) health agencies have been able to apply for accreditation through PHAB, an organization established and co-funded by RWJF and the Centers for Disease Control and Prevention (CDC) in 2007 as a result of the Exploring Accreditation project (see the Special Report for more information). PHAB serves as the nonprofit entity to implement and oversee national public health department accreditation. RWJF funding runs through May 2017, and PHAB is working to be self-sustaining through accreditation fees.

To achieve accreditation, an agency must present documentation that it meets prescribed measures, particularly for core public health programs that require interdepartmental collaboration.

Before this project was funded, little was known about the extent of linkages between efforts to achieve accreditation and progress on adopting quality improvement methods.

“Until the project started, not a lot of states were doing quality improvement projects that were cross programmatic,” said Denise Pavletic, MPH. “Our goal was to get state programs working together.”

THE PROJECT

A key aim of this project was to link quality improvement in several public health programs to state health agency efforts to achieve accreditation. It focused on three core public health programs:

- Maternal and child health programs
- Chronic disease and prevention programs
• Environmental public health programs

ASTHO held four organizational meetings in the summer of 2011 to review current research and best practices in quality improvement in each of the three fields in order to develop a framework for the national demonstration initiative.

State public health programs were chosen to participate in the demonstration based on their previous quality improvement experience, the feasibility of their proposed projects and how well they were engaging internal staff and external partners. Fourteen states responded to a request for proposals, and in February 2012, the following five were selected:

• Arizona
• Connecticut
• Maryland
• Minnesota
• Oregon

Project Director, and director of public health systems improvement at ASTHO, Denise Pavletic and two quality improvement coaches visited each of the five states several times during the project. In addition to helping with the projects, Pavletic said, they coached state health officials on telling their stories more effectively.

“We need to be able to tell our stories to the political leadership and we need to be able to show our value. When you talk about saving money their ears are going to perk up.”—Denise Pavletic

RESULTS

Pavletic reported the following results to RWJF:

• **State health agency staff in four of the five states worked across program area lines, in some cases for the first time.** The exception was Oregon, which did three separate quality improvement projects.

• **Four of the five states showed improvement in their chosen area.** The fifth state completed its tests of change after the initiative concluded.

• **Each state submitted five examples of documentation complying with specific requirements of PHAB.** For example:

  — A Confidentiality Pledge regarding health data
— An example of a report from a data portal in which a user can select various demographic fields to generate a report of records

— Minutes of an ASTHO Quality Improvement Meeting, demonstrating staff participation in QI activities

- All five states submitted their projects to the RWJF-funded Public Health Quality Improvement Exchange (PHQIX), a searchable online database that organizes information from public health QI projects.

**Individual State Projects**

**Arizona**

The state team integrated environmental health and chronic disease assessment elements into state-funded child and maternal health home visiting programs. The goal was to address all three areas (i.e., environmental health, chronic disease and maternal and child health) during the home health visit to ensure a coordinated approach and address all concerns at the same visit. The long-term goal was to address health and safety concerns in more families in Arizona.

The team developed a standardized home safety assessment with environmental health and chronic disease components. The trained home visitors were provided with the assessment tool and a complete packet of Arizona Home Safety and Family Wellness Assessment educational materials and sources for any necessary referrals. Results of the combined home visiting project showed:

- The home visitors demonstrated greater knowledge of environmental health and chronic disease resources.
- Families received more educational materials.
- More families were referred for home visits.

**Connecticut**

The state team focused on improving data accessibility among hospital emergency departments, the state Department of Public Health, and local health departments and reducing the number of defects in incoming and outgoing data; and creating a data ownership process through developing a combined data portal.

Although the project was not completed by the end of the grant period due to difficulties involving data confidentiality, the team discovered several important issues such as the need for standardization of calculated variables and for an automated process to cleanse the data in a standardized way.
Once the project is completed, the goal is to increase the number of state health department staff who can access the data, increase the number of local health departments that can access the data, and decrease the time that staff spend preparing the data for use.

**Maryland**

The state team focused on streamlining the referral process for WIC clients (a program that provides supplemental nutritional assistance to women, infants, and children) to immunizations, lead testing, comprehensive women’s health services, and smoking cessation services in order to improve the chances of the client receiving those services.

The team identified and addressed the cause of the limited follow-up in each area. For example:

- A lack of training for WIC staff in comprehensive women’s health was a major reason for low referral rates to family planning services. The project trained all 74 members of the pilot WIC clinic staff in that area.

- Immunization coordinators were not receiving the correct report, including the head of household contact information, from the WIC coordinators. The team required that WIC staff provide a full report to the Immunization team.

- WIC clinics were not included in the MD Quitline database and therefore not captured in the data. The team implemented their “fax to assist” process, by which staff faxes client referral forms directly to another program. They subsequently saw an increase in the number of WIC clients referred to the smoking cessation service as well as an increase in clients accepting the service.

**Minnesota**

The state team used quality improvement tools to increase coordination of smoking cessation outreach programs. Initially they thought there was duplication of services; however; after completing an inventory, collection, and analysis of tobacco cessation materials, the team concluded that there was minimal overlap/duplication across divisions.

Instead, Pavletic said, “They found that the real issue was that employees didn’t know whom to go to.” A staff survey revealed that state health department staff members did not know who to contact for internal resources.

The team shifted the project’s emphasis to developing both a mechanism for staff to meet and collaborate to foster relationships and a staff directory that could identify people with specific types of expertise.
Oregon
The state team worked on three separate projects:

- Streamlining data entry in the Oregon MothersCare prenatal program (which provides needs assessments to pregnant women) by moving from a paper-based to a Web-based process. This project reduced the error rate from 13 percent to 6 percent.

- Increasing the number of providers, hospitals, and pathology labs submitting data electronically to the Oregon State Cancer Registry. The project reduced the time to enroll pathology labs in the electronic data submission process from 27.5 days to 2.5 days.

- Streamlining the process by which the state health department contracts with local health departments to conduct health and safety inspections of local water companies. The project reduced the time spent processing invoices at the state and local level from 100 hours per month to 10–20 hours per month.

Communications Results
Project staff made presentations at national conferences, including:

- Two Community of Practice in Public Health Improvement open forums, December 5, 2012, Charlotte, N.C., and June 12–13, 2013, Milwaukee. (Also see RWJF Progress Report on the Strengthening the Community of Practice program).

- American Public Health Association annual conference, November 2–6, 2013, Boston

- Association of Maternal & Child Health Programs annual meeting, February 9–12, 2013, Washington

LESSONS LEARNED
There were many lessons learned from this initiative, but, according to Pavletic, above all, the biggest lessons learned were:

- Require that all projects be cross programmatic

- Get the right people at the table at each project early on

AFTERWARD
Oregon and Minnesota were among 26 states to submit applications for accreditation to the Public Health Accreditation Board. The other three states in the project were preparing their applications at the time the grant closed.