Lead States in Public Health Quality Improvement (originally called the Multistate Learning Collaborative)

A collaborative of states that were implementing performance assessment or accreditation of local public health departments

SUMMARY

From 2005 to 2011, the Robert Wood Johnson Foundation (RWJF) sponsored 17 states to work on public health assessment and quality improvement (QI), with an eye towards pursuing the accreditation of local health departments, and to share their experiences with one another through three phases of the Multistate Learning Collaborative (MLC), later renamed Lead States in Public Health Quality Improvement. This report refers to it as the Multistate Learning Collaborative/Lead States Program, or simply MLC.

The National Network of Public Health Institutes (NNPHI) served as the MLC national program office; the program was evaluated by researchers at the University of Southern Maine's Muskie School of Public Service.

CONTEXT

In the early 2000s, interest in examining the performance of public health departments was growing. Public health practitioners and experts knew that better, externally validated tools, 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 (QI) 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.

**RWJF’s Interest in This Area**

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*®
- Operational Definition of a Functional Local Public Health Department

**Turning Point Performance Measurements**

*Turning Point: Collaborating for a New Century in Public Health*, 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. For more information, read the Program Results Report.
**Operational Definition of Local Health Departments**

The National Association of City and County Health Officials (NACCHO) published the *Operational Definition of a Functional Local Health Department* in November 2005. The definition 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, which RWJF managed internally.¹ Read more about this project in the Program Results Report.

**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.² The consensus was to proceed.

So, that same year, RWJF began an initiative to learn from existing efforts and the experience in other sectors to collaboratively develop a model and best practices—and to support 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.³ 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.

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¹ RWJF provided four grants for this project: ID# 50045 ($200,000, February 1, 2004 to January 31, 2005); ID# 52324 ($60,000, December 1, 2004 to July 15, 2005); ID# 52676 ($200,000, March 1, 2005 to May 31, 2008); and ID#E 57248 ($400,000, August 1, 2006 to July 31, 2008)
² RWJF Grant ID# 51173 ($50,000, July 1, 2004 to December 31, 2004); and ID# 52159 ($85,000, November 1, 2004 to February 28, 2006)
³ RWJF Grant ID# 53182 ($742,377, June 15, 2005 to Mary 31, 2007); ID# 56262 ($35,743, December 1, 2005 to February 28, 2006); and ID# 58881 ($749,528, December 1, 2006 to December 31, 2008)
Read more about the Exploring Accreditation project's process in Appendix 1. For more details about Exploring Accreditation, see the separate Special Report.

THE MULTISTATE LEARNING COLLABORATIVE/LEAD STATES PROGRAM

RWJF complemented Exploring Accreditation by creating a collaborative of states that were implementing performance assessment or accreditation of local public health departments. Originally called the Multistate Learning Collaborative, the program brought the states together to share their experiences with each other and with agencies participating in Exploring Accreditation.

In 2008, the name was changed to Lead States in Public Health Quality Improvement.

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 can build a culture of accountability and greater public support for the work of public health. From 2005 to 2011, RWJF sponsored 17 states to work on public health assessment, accreditation, and quality improvement (QI) and share their experiences through three phases of the Multistate Learning Collaborative/Lead States Program.

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—an 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)
- The state public health association, the state version of the American Public Health Association
- A university-based school of public health (which some states partnered with)
Public health institutes served as the lead organizations for seven of the participating states. State health departments and other public health agencies and nonprofits filled that role in other states.

See the Project List in Appendix 2 for more information on the participating states, including their lead organizations, during all three phases of MLC.

Researchers at the University of Southern Maine's Muskie School of Public Service evaluated the program. For more information about the evaluation and its findings, see the section Evaluation.

**Management: National Program Office**

The National Network of Public Health Institutes (NNPHI) served as the MLC national program office. RWJF picked NNPHI to manage the program because of its experience with collaboratives in *Turning Point*. Joseph Kimbrell, then chief executive officer of NNPHI, served as the initial program director. Sarah Gillen, MPH, who worked with Kimbrell during Phase 1, became program director in Phase 2. Jennifer McKeever, LCSW, MPH, worked with Gillen as program manager. During Phase 3, Gillen and McKeever co-directed the program.

With offices in Washington and New Orleans, NNPHI is a membership organization that fosters networking and collaboration among public health institutes and multisector partners to address critical and emerging public health issues. Read the Progress Report on its work.

**Partners**

In addition to RWJF and the CDC, NNPHI collaborated with other national public health organizations on the *Multistate Learning Collaborative/Lead States Program*. These included the Association of State and Territorial Health Officials (ASTHO), NACCHO, the Public Health Informatics Institute, and others. For a list and descriptions of the partners, see Appendix 3.

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.

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4 Public health institutes are nonprofit organizations that foster innovation, leverage resources, and build partnerships across sectors, including government agencies, communities, the health care delivery system, media, and academia, in order to improve the public’s health. See the Progress Report on RWJF’s efforts to build the capacity of these institutes, online at [www.rwjf.org/en/research-publications/find-rwjf-research/2010/10/helping-public-health-institutes-become-a-key-player-in-the--new.html](http://www.rwjf.org/en/research-publications/find-rwjf-research/2010/10/helping-public-health-institutes-become-a-key-player-in-the--new.html).

“It's a collaborative process so all of us involved in these efforts are on the same page. We open the door to our partners to participate and learn as much as they can from this work.”—NNPHI’s Jennifer McKeever, program manager MLC-3

MLC – Phase 1 (MLC-1)


In work organized by NNPHI, 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
- 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.”—Pamela G. Russo, MD, MPH, senior program officer

RWJF chose these five states from 18 that applied for grants. The grants began in October 2005 and ended in October 2006. Each state received approximately $150,000.

The State Projects

During MLC-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.

- **North Carolina** produced the Road Map to Accreditation. It is available online at the North Carolina Accreditation Learning Collaborative website.

- **Washington** established a collaborative of four local health departments and the state department of health to establish and monitor performance measures.

**MLC-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 QI 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, launched in December 2006, explored what QI means in public health, how it could be done, and its potential impact. It was designed to integrate QI into existing performance and capacity assessment or accreditation efforts and 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. RWJF selected the five original states and five new ones: Florida, Kansas, Minnesota, New Hampshire, and Ohio.

Each state received approximately $150,000 to explore and apply QI techniques to improve capacity and performance. They also continued to work collaboratively, exchanging information through two meetings, five conference calls, and site visits.

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 QI initiatives to enhance their existing local public health accreditation programs. Illinois focused on QI for the accreditation program it had begun to develop during MLC-1. Washington used QI 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 on its existing certification program.

Examples of activities:

- **Kansas** trained staff from its 15 public health regions and some staff from local health departments in performance monitoring and QI.

- **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 QI projects. The states adapted the Institute for Healthcare Improvement’s “breakthrough series” model, designed for QI in health care organizations. A breakthrough series collaborative is a short-term (6- to 15-month) learning system that brings many teams from various sites together to seek improvement in a focused topic area.

Sites participating 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 QI.

**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 QI efforts. Staff and consultants from the national program office, RWJF staff, and program partners—primarily representatives of national public health organizations—joined the visits.
**Accreditation Link**

The idea that public health accreditation would be a platform for QI became more firmly established during MLC-2.

“In order to reach accreditation, agencies need to apply QI in the areas where their performance will not satisfy the standards,” states RWJF’s Russo. “As the bar for accreditation rises over time, agencies will need to continue to do QI to achieve accreditation.”

The need for more work in public health QI also became apparent during MLC-2. States needed evidence of what worked, and they needed to build their QI capacity.

**MLC-3**

In April 2008, RWJF launched MLC-3, renaming the program *Lead States in Public Health Quality Improvement*, and focusing on:

- Helping local and state public health departments expand their QI capacity and practice
- Contributing to the development of and preparation for public health accreditation

Some 25 states applied for MLC-3 funding and NNPHI and RWJF selected 16 of them. Participating states included 10 states from MLC-2 (Florida, Illinois, Kansas, Michigan, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, and Washington). The seven new states were: Indiana, Iowa, Montana, New Jersey, Oklahoma, South Carolina, and Wisconsin.

Each state received about $450,000, except for Ohio, which received two grants totaling $169,524 starting in September 2008 and ending in January 2011. All the other grants began in April 2008 and ended between April and August 2011. See Appendix 2 for a list of all the grants each state received in their phase of the program.

**Mini-Collaboratives and Target Areas**

RWJF required participating states to form mini-collaboratives to test QI tools and techniques in target areas where change could be documented and measured. NNPHI, RWJF, states participating in MLC-2, and program partners worked together to identify these target areas.

This approach built on the mini-collaboratives several states had formed in MLC-2. “These states had been very successful. [We built this as] a way to concentrate technical assistance and training within the states,” said Russo.
RWJF and NNPHI designed the mini-collaboratives to be flexible. Each state could include any combination of local and state public health departments or public health partners that were focused on improving public health performance in the selected target areas. As few as two and as many as 60 local health departments participated in each state, with most states involving 5 to 10 local health departments.

The participating states applied QI methods in at least 2 of 10 target areas, related to either health department capacity/process or improving health outcomes (five target areas each):

**Health department capacity/process target areas:**
- Community health profile
- Culturally appropriate services
- Health improvement planning
- Assurance of competent workforce
- Customer service

**Health outcome target areas:**
- Reduction of the incidence of vaccine-preventable disease
- Reduction of preventable risk factors that predispose people to chronic disease
- Reduction of infant mortality rates
- Reduction of the burden of tobacco-related illness
- Reduction of the burden of alcohol-related disease and injury

Each state project was 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

**The State Projects**

Examples of activities:
- Seven states—*Florida, Illinois, Michigan, Minnesota, New Hampshire, Oklahoma,* and *Washington*—used QI to reduce preventable risk factors that predispose people to chronic disease.
— In New Hampshire, for example, three mini-collaboratives implemented strategies to address childhood obesity, such as a campaign by the Lakes Regional Partnership for Public Health to encourage second-grade students at one school to bring fruit and/or vegetables for snacks at least 60 percent of the time.

- Five states—Illinois, Iowa, Michigan, Minnesota, and New Hampshire—worked on health improvement planning.
  - In Minnesota, for example, one of four mini-collaboratives focused on enhancing leadership and engaging community members in the health improvement planning process.

- Other examples of mini-collaborative efforts include efforts to:
  - Improve birth outcomes and work on two prerequisites for national voluntary accreditation: a community health assessment and an improvement plan (Kansas)
  - Increase the immunization rate and develop a mentoring program to improve nurse retention rates (North Carolina)
  - Reduce tobacco risk factors and infant mortality (South Carolina)

**Public Health Accreditation Moves Forward**

In September 2011, a few months after the participating states completed MLC-3, the Public Health Accreditation Board launched the voluntary national public health accreditation program. RWJF and CDC supported the board’s establishment in 2007 and have continued to support its work to develop the voluntary national public health accreditation program.6

**EVALUATION**

Brenda M. Joly, PhD, MPH, was the lead evaluator for the program. Initially employed by the Maine Center for Public Health, she moved to the University of Southern Maine's Muskie School of Public Service in Portland, as an assistant research professor during MLC-2.

The evaluation of MLC-1 and MLC-2 focused on the process used. During MLC-1, evaluators also studied grantee efforts to enhance performance and capacity assessment or accreditation. During MLC-2, they also studied the structure and outcomes, including how well the participating states felt they met their goals.

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6 RWJF’s support runs through May 2016, and as of October 2013 has totaled $11.5 million.
The MLC-3 evaluation focused on determining the effectiveness of the initiative and understanding the factors influencing the adoption, application, and spread of QI in public health departments.

The evaluators also prepared and disseminated 55 reports to the participating states and the NNPHI. More than half of the reports included state-specific findings to guide programming in the states.

Evaluators gathered information during the three phases of the *Multistate Learning Collaborative/Lead States Program* through:

- Site visits
- Key informant interviews
- Face-to-face group interviews
- Annual surveys, which included the QI Maturity Tool developed by the evaluators. This is the first validated tool to identify and quantify factors believed to influence the adoption and use of QI in public health; it looks at QI practice, organizational culture, capacity and competency, and alignment and spread.
- Mini-collaborative participant survey (MLC-3 only)
- Grantee reports
- Meeting evaluation forms
- Grantee status and an information exchange tool, used to gather information about short-term outcomes, as well as interactions and resource exchanges with other sites
- Case studies

See Appendix 4 for the evaluation methodology and questions explored.

**Evaluation Findings: MLC-1 and MLC-2**

In *Multistate Learning Collaborative: Evaluation Report* (November 2006), *Multistate Learning Collaborative-2: Evaluation Report: Component #1* (March 2008), and a report to RWJF, evaluators reported that MLC-1 and MLC-2:

- Was well managed
- Made considerable progress in achieving the desired goals, despite a relatively short time frame
- Was highly rated by participating states, consultants, and partners, who cited the site visits and face-to-face meetings as the most valuable parts of the collaborative
• Gave participants a way to learn from experts and one another and to share resources. The program increased collaboration among and within the participating states.

• Informed public health accreditation, and helped participants validate and obtain support for their accreditation efforts.

For more detailed findings from MLC-1 and MLC-2, see Appendix 5.

Evaluation Findings: MLC-3

The evaluators reported on five areas of MLC-3: program reach, perceived impact and implications, changes in QI, QI collaborations in public health, and accreditation.

Program Reach

The evaluators reported to RWJF that:

• The 16 participating states established 38 mini-collaboratives that involved 268 local health departments. Approximately 27 local health departments participated in more than one QI project or focused on more than one target area.

• The health departments completed 171 QI projects, according to the national program office. Between 2009 and 2011, the number of health departments that implemented at least one QI project increased 27 percent.

• The 16 states exchanged information with one another and with 14 other states and the District of Columbia. The participating states received 257 requests for information.

• Overall, the states provided more than 2,000 hours of technical assistance and delivered approximately 774 trainings on the target areas. Most trainings involved multiple health departments, and occasionally included some that did not participate in a mini-collaborative.

Perceived Impact and Implications

Also in a report to RWJF, evaluators offered these broad conclusions about the legacy and implications of the overall program for public health leaders, practitioners, researchers, and funders.

• MLC had substantial impact on local public health departments in general, including their attitudes and readiness for accreditation, as well as QI practice and maturity.

• Public health administrators and senior staff supported QI, as seen by the scale of MLC and the number of public health departments that participated.
However, there was no strong evidence that public health leaders will advance QI going forward.

The program largely focused on health department staff and not program leaders. The evaluators recommended that further efforts should target public health leaders whose decisions influence budgets, staff responsibilities, and strategic planning—all of which are essential to building QI capacity.

- **Public health practitioners made major strides in QI, including the increased use of formal QI processes, tools, and techniques and the implementation of QI projects.** More program managers assumed accountability for improving services and programs. More administrators designated a QI officer or coordinator. Public health departments reached out to universities and other partners to enhance their QI efforts.

  The most significant across-the-board progress occurred among health departments in the lowest quartile of QI maturity in 2009. This suggests that small but sustained efforts to raise awareness and introduce concepts can have major impact on QI practice.

- **Although MLC trained a cadre of QI practitioners, the longer term impact on integrating QI into everyday practice, spreading QI skills beyond a small circle of staff, and demonstrating sustainable improvements in services and outcomes is less clear.**

  “MLC provided an important wake-up call and introduction to the fundamentals of QI but it has yet to transform practice, services or outcomes,” according to the evaluators’ report to RWJF. More training and technical assistance are needed to progress, but resource constraints will impede the ability to pursue further training or engage outside technical assistance.

- **The recognized value of collaboration, shared resources, and common purpose is a lasting legacy of the program.** There is a ready audience and significant merit in building networks to support QI in public health and help health departments develop more focused and evidence-based strategies.

- **RWJF’s sponsorship of an evaluation of MLC demonstrates the importance of building a research base for QI in public health.** The development of the QI Maturity Tool was a major contribution of the evaluation.

  Results from its use have important implications for measuring and tracking the adoption of QI, supporting QI efforts, and assessing long-term impact on services and outcomes. But further work is needed to refine the tool and to standardize language and definitions.

- **Public health funders are well positioned to lead the charge for QI and to build an evidence base of effective strategies.** Their participation and guidance provides a structure for action and a vehicle for support.
Requirements specifying performance indicators and benchmarks or participation in collaborative projects were extremely helpful in focusing program objectives and cultivating a practice community. This also allows the small numbers from any one health department to be combined with similar projects so that outcomes can be realistically measured.

**Changes in QI**

The evaluators reported on changes in QI in an article in the *Journal of Public Health Management and Practice*\(^7\)

- After three years, the number of local health departments that had implemented a formal process to improve the performance of a service, program, process, or outcome increased significantly. Local health departments that participated in mini-collaboratives were more likely to implement a formal QI process than those that did not participate.

- Local health departments gained QI skills and learned about methods and increased QI investments. There was a statistically significant change among all local health departments in three domains of capacity and competency: QI skills, methods, and investment.

- QI alignment and spread within local health departments significantly improved. Local health departments were better able to integrate QI into programs and services, allocate staff time for QI, and engage more staff in QI efforts.

- “Mini-collaboratives hold particular promise for lower-performing agencies, which showed remarkable progress.” These local health departments saw “significant changes in organizational culture during the project period,” while other participants in the mini-collaboratives did not.

**QI Collaboratives in Public Health**

The evaluators reported on the results of the collaboratives in an article in the *Journal of Public Health Management and Practice*\(^8\)

- Key drivers of effective mini-collaboratives are:

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— Advanced planning to detail the process, expectations, and measures of success
— Selection of qualified faculty
— Timely and skill-based training and technical assistance
— Engagement of and commitment from senior leaders in participating local health departments
— Use of evidence-based practices to achieve change
— Use of a credible improvement model
— Evaluation of QI efforts and outcomes
— Communication about roles, responsibilities, and goals
— Resources to implement small-scale change
— Selection of target areas that were relevant to accreditation or their areas of interest
— Prior experience with and application of QI

- A majority of local health departments endorsed the mini-collaboratives as a learning and engagement tool. The variability of the mini-collaboratives across the states, however, made it difficult to develop conclusions about ideal structure and length.

- Although there was limited evidence of QI sustainability and broad spread within participating states, mini-collaboratives appear to have had a major impact and will likely influence the future work of participating local health departments.

**Accreditation**

In a report to RWJF, the evaluators presented their findings on accreditation.

- The percentage of health departments that intended to apply for accreditation remained stable over three years (63% in 2009 and 62% in 2011). There was a decrease in the percentage of health departments that intended to apply within the first two years after the accreditation program started (from 48% in 2009 to 34% in 2011).

- By 2011, many health departments had completed or were working on the three prerequisites for accreditation: a strategic plan, a health assessment, and an improvement plan:
  — Strategic plan: 58 percent of health departments
  — Health assessment: 75 percent
— Improvement plan: 64 percent

Other health departments intended to develop these documents “in the next few years”:

- Strategic plan: 28 percent
- Health assessment: 16 percent
- Improvement plan: 21 percent

- At least two-thirds of health departments consistently believed that accreditation would strengthen their department and enhance their credibility. There was an increase in the percentage of health department staffs that also believed that accreditation would improve the quality of services they provided (48% in 2009 compared to 57% in 2011).

OVERALL PROGRAM RESULTS

Staff at NNPHI and RWJF reported the following results from the three phases of the Multistate Learning Collaborative/Lead States Program. For details about results of the program’s sites, see Topical Brief: The Story of Progress, The Hope of Sustainability: The Work of the MLC Will Endure (September 2011) and Appendix 6.

- MLC was instrumental in the evolution of public health accreditation. The program contributed to the recommendation that national voluntary public health accreditation be established, to the development of the Public Health Accreditation Board, and to the design of the QI skills domain.

  “Members of MLC participated in all of the Public Health Accreditation Board’s workgroups and informed every aspect of the board’s work.”—RWJF’s Pamela Russo.

  Learn more about the accreditation process for state, local, tribal, and territorial health departments on the accreditation board’s website.

- Participating states advanced policy, created infrastructure, and found sustainable funding and related resources to institutionalize QI in public health.

  — Policies. Examples of laws, regulatory measures, actions, and priorities:

  - Iowa passed voluntary accreditation legislation through the Iowa Public Health Modernization Act and other changes to state laws.

  - Montana passed legislation that funded seven competitively selected local health departments to prepare for accreditation.
— **Infrastructure.** In several states, the MLC grants created an incentive to establish infrastructure support for offices of QI or performance management. Examples of infrastructure:

- **North Carolina** established a new nonprofit agency, the North Carolina Center for Public Health Quality, to continue QI training and initiatives at the state and local levels. BlueCross BlueShield Foundation of North Carolina, The Duke Endowment, and the Kate B. Reynolds Charitable Trust invested $4.7 million in the center.

- The **Indiana** State Department of Health hired an accreditation coordinator to support state and local accreditation efforts.

— **Resources.** Several MLC states participated in RWJF’s national Public Health Practice Based Research Networks Program. (Read the Progress Report for more information about this program.⁹) These networks are groups of public health practitioners and researchers that conduct research to improve the performance and capacity of local and state public health agencies and systems, and ultimately of public health.

Studies by the Wisconsin’s Practice-Based Research Network, for example, include:

- The impact of economic recession on health department funding
- A method for coding population health services by community nurses
- Measuring the quality of community health improvement plans and processes

Wisconsin also developed a draft inventory of the public health services and systems in the state.

- **MLC provided a crucial foundation for the diffusion and spread of QI in public health.**

  *“It shifted the focus from sustaining performance to improving performance through QI.”*—NNPHI’s Jennifer McKeever

The 171 QI projects that were completed established ways to incorporate QI into the processes, functions, and outcomes of health departments. The program also helped develop a stable pool of content experts in public health QI. Several states used mini-collaboratives and training available via MLC-3 to disseminate knowledge of QI and basic tools.

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— **Kansas, Minnesota, and Wisconsin**, for example, worked on increasing QI capacity statewide. Kansas reached over 60 health departments; Minnesota reached more than 80; and Wisconsin reached more than 45.

This showed that QI could be widely disseminated with a relatively modest investment, and that making training available statewide is likely to have a lasting impact on QI uptake.

— The MLC mini-collaborative model inspired others to use similar approaches in providing QI technical assistance and training. For example:

- **NACCHO** sponsored several rounds of short-term QI projects for local health departments.

- **ASTHO** provided technical assistance on QI and the use of QI tools such as Kaizen for state health departments. Kaizen, or rapid improvement processes, focuses on eliminating waste, improving productivity, and achieving sustained continual improvement in targeted activities and processes. It is often considered the building block of all lean production methods, which focus on continual improvement.10

— MLC helped develop a stable pool of QI public health content experts—some came with background and knowledge about QI, and learned more about public health; others were public health practitioners who gained expertise in QI through the program.

The MLC states and other public health organizations, including ASTHO, NACCHO, and the CDC, continue to use these experts for training, presentations, and webinars.

- **The CDC implemented the National Public Health Improvement Initiative to support public health infrastructure.** RWJF’s collaboration with the CDC on the *Multistate Learning Collaborative/Lead States Program* contributed to the CDC’s decision to implement this initiative, says Russo.

The National Public Health Improvement Initiative is supporting 73 state, tribal, local, and territorial health agencies to make fundamental changes and enhancements in their organizations and to implement practices that improve the delivery and impact of public health services. The initiative began in 2010 and is supported by funding from the Affordable Care Act.

The CDC grants will help sustain MLC goals by enabling state agencies to hire new personnel to support QI and accreditation.

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10 Kaizen is Japanese for "improvement" or "change for the better." Its practices have been used in manufacturing, engineering, and business management. It has been applied in health care, psychotherapy, life-coaching, government, banking, and other industries.
Examples of uses of funding among the MLC states:

- **Iowa** is implementing performance management at the state level.
- **Washington** state is establishing three Performance Management Centers of Excellence in Public Health.
- **Wisconsin** is expanding its MLC statewide approach to QI by working with more local and tribal health departments.

**Communication Results**

The national program office at NNPHI shared resources, results, and lessons learned from the *Multistate Learning Collaborative/Lead States Program* with the participating states, other public health practitioners, national public health partner organizations, funders, and others in many ways.

Working with the participating states, the national program office helped develop many resources, available through NNPHI's eCatalog (search under the Multi-State Learning Collaborative section). Examples include:

- A **Public Health Performance Improvement Toolkit**, an online collection of tools, such as archived trainings, sample QI products, templates, and related resources developed by public health practitioners preparing for public health accreditation.

- **Topical briefs** on sharing model practices, workforce training in QI and supporting multisite QI projects and collaboratives.

The national program office shared results and lessons learned in a special issue of the *Journal of Public Health Management and Practice*, as well as individual articles, and through its website, presentations at national meetings, webinars, and elsewhere. Staff members also 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.

See the **Bibliography** for details.

**SIGNIFICANCE OF THE PROGRAM**

The *Multistate Learning Collaborative/Lead States Program* accelerated public health accreditation, helped make QI a key part of public health, and contributed to building a “community of practice” among public health practitioners, according to RWJF program officers and national program office leadership.
Accelerating Public Health Accreditation

When MLC began in 2005, public health accreditation was just an idea and many states were skeptical about its value. The program generated momentum for public health accreditation, and accelerated the pace at which it moved forward.

“When we came out of MLC-3, broadly across the country there was a sense that the public health accreditation program will improve public health infrastructure and public health outcomes.”—NNPHI’s Jennifer McKeever

“I don’t think we would be where we are with the success of applications to the Public Health Accreditation Board if it hadn’t been for MLC,” adds RWJF’s Russo. “It was the place for people to encourage each other, help each other, share best practices, and create enthusiasm and momentum.”

Most Accredited Health Departments Are in MLC States

From the time the Public Health Accreditation Board launched the accreditation program in September 2011 through September 2013, 19 state and local health departments have been accredited. Thirteen of these are from eight MLC states, according to McKeever. An additional 140 state and local health departments had applied for accreditation as of September 2013—41 percent of which are from MLC states.

These health departments cover nearly 160 million people, or 51 percent of the population of the United States. That means RWJF’s Public Health team is well on its way to meeting its goal of ensuring that 60 percent of Americans are served by an accredited health department by the end of 2015.

Spreading QI in Public Health

By increasing the visibility of accreditation and QI in public health, MLC increased the recognition of the need for QI among public health practitioners and laid a foundation for its spread.

“MLC helped the participating states create a culture that supports QI.”—NNPHI’s Sarah Gillen, Program Director, MLC

Since accreditation involves the health department as an organization, many public health practitioners involved with health department programs—such as those involving chronic diseases—did not understand its relevance to them. “It was through QI that they were drawn in and began to understand that an organization that was efficient and effective and
had a strategic plan would be able to deliver better chronic disease programming,” says Russo.

The 171 QI projects completed by the participating states helped build evidence about how to do QI in public health. And the program showed the multiple uses of QI in public health: “to support administrative processes and programmatic processes, and to demonstrate continuous improvement of a program towards improving health outcomes,” says Gillen.

“Having multiple ways to incorporate QI into public health practice has had an impact on the field.”—NNPHI’s Sarah Gillen

One striking example of this spread is the National Public Health Improvement Initiative, designed by the CDC’s Office for State, Tribal, Local and Territorial Support. MLC was “hugely influential” in its development, according to RWJF’s Russo, both by increasing the visibility of accreditation and QI and by collaborating closely with leaders and staff in that CDC office.

**Peer Network of Public Health Practitioners**

The peer network of public health practitioners, or “community of practice,” developed through the *Multistate Learning Collaborative/Lead States Program* is facilitating the spread of QI in public health and promoting consistency and quality.

“If you want diffusion of an activity or program in public health, it’s key to develop a network where people can exchange knowledge. People learn better from their peers than from anyone else. This generates enthusiasm, confidence, and leadership, as well as knowledge and skills.”—RWJF’s Pamela Russo

Public health practitioners are now more willing to adapt things that have worked for other health departments and adapt them for their use than they were before. The old mantra “if you’ve seen one health department you’ve seen one health department,” has been replaced by expectations for a certain level of quality and consistency across all health departments, as indicated by accreditation, says Russo.

The MLC community of practice “is continuing to grow, and to advance and shape national and state policy, and support sustainable change,” adds McKeever. See *Afterward* for more about how RWJF is maintaining the MLC momentum through a new program, *Strengthening the Community of Practice for Public Health Improvement*.
LESSONS LEARNED

Lessons From the National Program Office

1. **Synthesizing results of QI projects across health departments is difficult.** The national program office had expected to be able to synthesize results of similar QI projects (e.g., projects to increase immunization rates in children) and provide evidence on what worked. But the projects were so varied that they were unable to do that. (Program Director Gillen)

2. **Tap into, and show respect for, the expertise of project participants.** NNPHI provided resources to all participating states and to the field by having project participants present at webinars and meetings, and co-author articles and other documents. This helped to engage them in the collaborative learning model and build sustainable capacity. Also, peers appreciate learning from each other. (Report to RWJF)

3. **Developing a system to manage Web-based products and information is a major undertaking, requiring considerable resources.** The national program office 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 national program office could have used someone with experience to categorize the information and post it to the eCatalog. (Program Manager McKeever)

5. **Achieving buy-in for continuous QI 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 QI efforts among state and local public health practitioners. (Program Director Sarah Gillen in a report to RWJF)

6. **QI is relatively new to the field of public health and should be clearly defined.** The national program office 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 an article in the Journal of Public Health Management and Practice.11

7. 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.

8. 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.

For more lessons about states participating in Multistate Learning Collaborative/Lead States Program, see Appendix 7.

AFTERWARD

To sustain the momentum from the Multistate Learning Collaborative/Lead States Program, RWJF launched Strengthening the Community of Practice for Public Health Improvement in August 2011, as MLC was approaching its December close. This program builds capacity among the nation’s public health departments to meet national standards for accreditation and conduct QI activities, and is another tool for meeting RWJF’s goal of covering 60 percent of the nation’s population by an accredited health department by 2015.

Strengthening the Community of Practice for Public Health Improvement is a 32-month, $3.7 million program led by NNPHI that facilitates the exchange of best practices and builds capacity among the nation’s public health departments to become accredited and conduct QI. It runs to mid-June 2016.

The program promotes shared learning through:

- **Open Forums**: Twice a year, NNPHI hosts a national meeting with accreditation and QI experts and public health practitioners. RWJF supports 125 public health practitioners to attend. Recent meetings have had about 300 attendees, with most paying their own way, an indication of how useful the meetings are, says Russo.

- **QI Award Program**: To date (September 2013), 60 health departments have received small grants and virtual coaches to conduct a QI project that results in measureable change:

Thirty-five of the health departments were from MLC states.

One-third of the virtual coaches are leaders from the MLC states.

With its emphasis on smaller health departments, *Strengthening the Community of Practice for Public Health Improvement* complements the CDC’s National Public Health Improvement Initiative, which focuses on state and large local health departments. NNPHI is evaluating the CDC effort, which creates many opportunities for shared learning.

NNPHI also promotes use of the Public Health Quality Improvement Exchange, an online hub for public health professionals interested in learning and sharing information about QI in public health. RWJF contracted with North Carolina-based Research Triangle Institute (also known as RTI International) to develop the exchange.

In December 2013, RWJF made its latest grant in the program: to NNPHI for it to support coalitions of public health stakeholders in up to seven states to be selected from those with minimal activity regarding readiness for accreditation and implementation of quality improvement projects. NNPHI in turn is re-granting funds to the state coalitions and providing technical assistance through dedicated consultants. NNPHI also plans to continue to expand the reach of the Community of Practice for Public Health Improvement by convening two annual Open Forum meetings in 2015 and 2016.

Read the Progress Report on *Strengthening the Community of Practice for Public Health Improvement*.

**Measuring QI in Public Health**

The QI Maturity Tool developed by the MLC evaluators is now being used beyond the program, and cited in the literature, to measure the capacity and QI work of public health departments.

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12 ID# 71449 ($2,082,453, December 15, 2013 to June 14, 2016)
APPENDIX 1

The Exploring Accreditation Project

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\(^\text{13}\) 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 section of this report. More details about Exploring Accreditation are available in a separate Special Report.

\(^{13}\) RWJF Grant ID# 53182 ($742,377, June 15, 2005 to March 31, 2007); ID# 56262 ($35,743, December 1, 2005 to February 28, 2006); and ID# 58881 ($749,528, December 1, 2006 to December 31, 2008)
APPENDIX 2

States Participating in the Multistate Learning Collaborative/Lead States in Public Health Quality Improvement

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

States That Participated in Phases 1, 2, and 3

Illinois Multistate Learning Collaborative
Illinois Public Health Institute (Chicago, Ill.)
ID#s 53805, 59865 (October 2005 to February 2008): $300,000
ID# 64213 (April 2008 to July 2009): $164,502
ID# 66484 (April 2008 to April 2011): $285,498
    Project Director: Elissa J. Bassler, MFA
    (312) 850-4744
    elissa.bassler@iphionline.org

Michigan Multistate Learning Collaborative
Michigan Public Health Institute (Okemos, Mich.)
ID#s 53806, 59868 (October 2005 to February 2008): $292,218
ID# 64228 (April 2008 to April 2011): $449,896
    Project Director: Angela Martin, PhD
    (517) 324-8381
    amartin@mphi.org

Missouri Multistate Learning Collaborative
Missouri Institute for Community Health (Jefferson City, Mo.)
ID#s 53808, 059234, 059871 (October 2005 to February 2008): $400,000
ID# 64186 (April 2008 to April 2011): $450,000
    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#s 53805, 059874 (October 2005 to June 2008): $287,129
ID# 64233 (April 2008 to April 2011): $449,590
Project Director: Edward L. Baker, MD, MPH, MS  
(919) 966-1069  
ed_baker@unc.edu

Washington Multistate Learning Collaborative  
State of Washington Department of Health (Olympia, Wash.)  
ID#s 53809, 59876 (October 2005 to February 2008): $300,000  
ID# 64230 (April 2008 to April 2011): $450,000  
Project Director: Allene Mares  
(360) 236-4062  
allene.mares@doh.wa.gov

**States That Participated in Phases 2 and 3**

Florida Multistate Learning Collaborative  
State of Florida Department of Health (Tallahassee, Fla.)  
ID# 59866 (December 2006 to March 2008): $150,000  
ID# 64225 (April 2008 to April 2011): $450,000  
Project Director: Shannon Lease, MS  
(850) 245-4007  
shannon_lease@doh.state.fl.us

Kansas Multistate Learning Collaborative  
Kansas Health Institute (Topeka, Kan.)  
ID# 59866 (December 2006 to February 2008): $147,963  
ID# 64227 (April 2008 to April 2011): $448,213  
Project Director: Gianfranco Pezzino, MD, MPH  
(785) 233-5443  
gpezzino@khi.org

Minnesota Multistate Learning Collaborative  
State of Minnesota Department of Health (St. Paul, Minn.)  
ID# 59870 (December 2006 to May 2008): $149,998  
ID# 64185 (April 2008 to April 2011): $450,000  
Project Director: Debra L. Burns, MA  
(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# 59872 (December 2006 to May 2008): $139,689
ID# 64188 (April 2008 to April 2011): $446,639
  Project Director: Jonathan Stewart
  (603) 573-3300
  jstewart@jsi.com

Ohio Multistate Learning Collaborative

State of Ohio Department of Health (Columbus, Ohio)
ID# 59875 (December 2006 to August 2008): $490,586
  Project Director: John W. Francis, MBA, PhD
  (614) 728-9173
  john.francis@odh.ohio.gov

Ohio Public Health Partnership (Columbus, Ohio)
ID# 64812 (September 2008 to September 2009): $100,000
ID# 67311 (February 2010 to February 2011): $78,480
  Project Director: Susan A. Tilgne, MS, RD, LD
  (614) 462-5766
  satilgne@franklincountyohio.gov

States That Participated in Phase 3

Iowa Multistate Learning Collaborative

State of Iowa Department of Public Health (Des Moines, Iowa)
ID# 64223 (April 2008 to April 2011): $450,000
  Project Director: Julie McMahon
  (515) 281-3104
  jmcmahon@idph.state.ia.us

Indiana Multistate Learning Collaborative

State of Indiana Department of Health (Indianapolis, Ind.)
ID# 64223 (April 2008 to April 2011): $450,000
  Project Director: Kristin Adams, PhD, CHES
  (317) 233-9250
  kadams@isdh.in.gov
Montana Multistate Learning Collaborative
State of Montana Department of Public Health and Human Services (Helena, Mont.)
ID# 64223 (April 2008 to April 2011): $450,000
  **Project Director:** Jane Smilie, MPH
  (406) 444-4141
  jsmilie@mt.gov

New Jersey Multistate Learning Collaborative
New Jersey Health Officers Association (Toms River, N.J.)
ID# 64223 (April 2008 to April 2011): $450,000
  **Project Director:** Peter Tabbot
  (973) 226-2303
  ptabbot@aol.com

Oklahoma Multistate Learning Collaborative
State of Oklahoma Department of Health (Oklahoma City, Okla.)
ID# 64223 (April 2008 to April 2011): $450,000
  **Project Director:** Joyce Marshall, MPH
  (405) 271-4200
  joycem@health.ok.gov

South Carolina Multistate Learning Collaborative
State of South Carolina Department of Health and Environmental Control (Columbia, S.C.)
ID# 64223 (April 2008 to April 2011): $450,000
  **Project Director:** Joseph Kyle, MPH
  (803) 898-0777
  kyleja@dhec.sc.gov

Wisconsin Multistate Learning Collaborative
State of Wisconsin Department of Health Services (Madison, Wis.)
ID# 64223 (April 2008 to April 2011): $450,000
  **Project Director:** Elizabeth Lieske Giese, RN, MSPH
  (715) 836-2871
  elizabeth.giese@dhfs.wisconsin.gov
APPENDIX 3

(Current as of the time of the program; provided by the national program office; not verified by RWJF.)

National Public Health Organization Partners

- 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

APPENDIX 4

Evaluation Methodology

MLC-1

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 were 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

**MLC-2**

**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 NNPHI, 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

**MCL-3**

The MLC-3 evaluation focused on the:

- Extent to which grantees met their goals
- Adoption, reach, and impact of QI efforts within and across the participating states
• Resources, support, and capacity needed to achieve success within the participating states
• Spread of QI efforts to non-participating states

APPENDIX 5

Evaluation Findings for MLC-1 and MLC-2

Evaluation Findings: MLC-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.
• 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.
**Evaluation Findings: MLC-2**

Evaluators reported these 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 QI 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, given the diversity of the project. 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.

  “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.”—Maureen Booth, evaluation team member

- **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 the first and second 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 QI in public health need to be disseminated.** “In the absence of models for public health to develop and design their QI 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.”—Maureen Booth, evaluation team member

**APPENDIX 6**

**Key Site Results**

The national program office reported the following results in the *Topical Brief: The Story of Progress, The Hope of Sustainability: The Work of the MLC Will Endure* (September 2011) and in reports to RWJF. Participating states also reported some of these results.

- **Participating states prepared for accreditation.** Examples of work to prepare for accreditation during MLC-3:
  - In **Kansas**, 65 local health departments and the state health agency committed to a nine-month process of developing health profiles and action plans.
  - **Oklahoma** recognized that the state agency met all three accreditation prerequisites (strategic plan, health assessment, and improvement plan) but county health departments did not and focused on improving community engagement and health improvement planning processes at the county level.
  - States with existing accreditation or certification programs moved toward aligning state standards more closely with national standards. For example:
    - **Michigan** added a Quality Improvement Supplement to the Michigan Local Public Health Accreditation Program.
• The state of Washington incorporated PHAB standards along with state standards into its long-standing local health department performance assessment system.

  — During MLC-1 and MLC-2, Michigan, Missouri, and North Carolina enhanced their public health accreditation programs for local public health departments.

  • **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.

  • **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.

• **Other states**—Florida, Illinois, Kansas, Minnesota, New Hampshire, Ohio, and Washington—enhanced their public health performance measurement programs as part of a move toward accreditation during MLC-1 and MLC-2. 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 QI. Seven local health departments pilot tested voluntary accreditation, which included evaluating 50 performance measures addressing eight public health practice standards. All achieved pilot accreditation status.

  — **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 now 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).
— **Ohio** created performance standards and associated metrics for state and local public health departments. These standards are integrated with the operational definition of a functional local health department.

- **Participating states built workforce capacity through training and learning communities.** Staff members at hundreds of local and state health departments received training in QI, community engagement, community health assessments, and other related topics through MLC. Some states also established learning communities.

Examples of building workforce capacity during MLC-3:

— The **Florida** Department of Health created a collaborative of health departments that are actively taking steps to prepare for accreditation (players) and those that are not yet doing so but want to learn from others (fans).

— The **Illinois** Public Health Institute started a learning community that enables local health departments to share their experiences via teleconferences and webinars.

— **Minnesota** trained 12 local and state teams to build a culture of quality and develop quality improvement plans.

— **Missouri** brought QI training to 12 rural health departments and worked with the St. Louis University Heartland Center to create online QI training modules.

During MLC-1 and MLC-2, collectively, the states trained more than 500 public health professionals in QI methods. Examples:

— **Florida, North Carolina,** and **Washington** showcased employees who achieved measurable quality improvement benefits to create enthusiasm for their 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 desks.

For more information, see the topical brief about preparing the public health workforce for quality improvement.

- **Participating states strengthened or developed enduring partnerships and relationships.** New partners include quality institutes and centers and health care-related organizations. MLC states also strengthened their relationships with national associations and organizations, one another, and experts in public health QI.

Examples of partnerships and relationships during MLC-3:
In Kansas, the Kansas Health Institute (lead agency), the Kansas Association of Local Health Departments, the Kansas Department of Health and Environment, and the Area Health Education Center worked together to manage and implement the state’s MLC project. The Kansas Health Foundation provided matching support for the project.

In North Carolina, the Association of Local Health Directors provided practical input on how QI and accreditation could be implemented locally.

Participating states strengthened and developed relationships within their local and state health departments and across the MLC states.

During MLC-1 and MLC-2, participating states used these relationships to exchange information and learn about best practices through meetings, conference calls, the open forum, site visits, the MLC website, as well as through more informal interactions. 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

“The relationships of staff across the 16 states as they have learned together will continue to provide a viable network of peer communication and help when needed.”—the topical brief

These connections are a no-cost way for program participants to continue to connect with their peers and experts and to share tools and training materials.

• During MLC-1 and MLC-2, some states demonstrated that public health teams can learn to apply QI methods and achieve measurable improvement, sometimes in a relatively short time. The states developed pilot QI 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 children from 6 months to 59 months of age. 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 state 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-based 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 QI projects involving more than 75 local and state health departments.

— Engaged public health professionals directly as members of QI project teams and showcased events and learning opportunities to others in public health.

— Found that similar QI principles and tools can be applied to achieve results in a variety of areas important to public health.

— Increased capacity to support QI projects through states' staff, partners and consultants.

— Generated enthusiasm for QI 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.

• During MLC-1 and MLC-2, 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 state 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 advisers and peer networks to expose local public health leaders to other practices, broaden expertise across the state, and spread ideas. Peer advisers, 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.

**APPENDIX 7**

**More Lessons Learned About State Participation in Multistate Learning Collaborative/Lead States in Public Health Quality Improvement**

Lessons described in reports from state participants to RWJF:

1. **Collaboration is key in QI work.** Many public health partners throughout *Iowa*, including local public health departments, academia, and state health department staff, contributed to the accomplishments of Iowa’s QI work. Team members also learned a great deal from other MLC states, national QI experts, and national partner organizations. (Report to RWJF)

2. **Develop materials and resources that are truly helpful to people working in the field.** Many areas of *Washington* state are very rural and under-resourced, so the state health department developed technical assistance and resources that are simple and quick to use. (Report to RWJF)

3. **Help public health practitioners understand and appropriately apply QI principles by providing technical assistance and expertise.** *South Carolina* provided QI expertise/coaching on site through the QI adviser of the Arnold School of Public Health and the QI coordinator of the state Office of Performance Management in Health Services. (Report to RWJF)

   The *Kansas* Health Institute scheduled monthly conference calls with the project management team and each regional/state team, made multiple visits to each site, and provided timely feedback specific to work of teams. (Report to RWJF)

4. **Conduct comprehensive training for leaders of QI teams and provide logistical support.** In *Kansas*, QI team leaders experienced many challenges, such as finding peer counties within the region, dealing with busy schedules of team members, and maintaining enthusiasm for the project. The state health department provided a one-day training session for team leaders, invited them to share their insights at subsequent training sessions, and exposed them to QI tools early.

   To help QI team members in Kansas who were working from multiple sites and on multiple projects, the Kansas Health Institute offered training on the dynamics of leading discussions and team efforts from remote locations via conference calls, posted online virtual storyboards on the Kansas Association of Local Health Departments website, and used an online whiteboard. (Report to RWJF)
5. **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.

6. **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, MD, MPH, MS, the North Carolina project director, to RWJF.

7. **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, MBA, PhD, the Ohio project director, to RWJF.

8. **Adopting QI 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 QI tools optimally. Health departments will need more “practice and reinforcement to become comfortable with quality improvement tools and utilize them routinely,” wrote Gianfranco Pezzino, MD, MPH, the Kansas project director, to RWJF.

9. **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.

10. **Comprehensive QI 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,”—Gianfranco Pezzino, Kansas project director, in a report 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):

11. **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 QI 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.
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**Newsletters**

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**Toolkits**

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**Webinars**

All webinars from the *Multistate Learning Collaborative/Lead States* program and other NNPHI work are archived online. Sample webinars from the *Multistate Learning Collaborative/Lead States* program:

- **The MLC: A Story of Progress with Hopes of Sustainability (Part 2).** April 8, 2011. Available online.
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