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

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.

Read the full report. Learn more about the program here.

CONTEXT
MLC evolved from a series of RJWF investments designed to strengthen the public health system. In particular, its Exploring Accreditation project concluded that voluntary national accreditation for state and local health departments could improve quality and developed a model for such an approach.

THE PROGRAM
MLC states worked to enhance their performance assessment programs and QI strategies, and to develop strategies to move towards voluntary accreditation. Each state formed partnerships that usually included state and local health departments, the state public
health institute, state associations representing public health professionals, and a university-based school of public health.

- In the first phase of the project (MLC-1), five grantee states informed the work of Exploring Accreditation, shared information with one another, and advanced their own QI efforts.

- During MLC-2, RWJF selected 10 states to focus on a variety of projects related to QI and accreditation.

For example, Illinois piloted voluntary accreditation tools and processes in seven local health departments, New Hampshire articulated workforce competencies and Ohio built a model for voluntary accreditation from its existing certification program.

- During MLC-3, 16 states established 38 mini-collaboratives involving 268 local health departments to test QI tools and techniques. They completed a total of 171 QI projects.

For example, seven states used QI to reduce preventable risk factors that predispose people to chronic disease, including three mini-collaboratives in New Hampshire that addressed childhood obesity. Mini-collaboratives in five other states worked on health improvement planning.

EVALUATION FINDINGS AND OVERALL RESULTS

The evaluation of MLC-1 and MLC-2 focused primarily on the process used to develop the program, and concluded it was well managed and had made considerable progress in achieving the desired goals.

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. Among the broad conclusions:

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

- Administrators and senior staff in public health departments supported QI, as seen by the scale of MLC and the number of departments that participated.

- 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.

- 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.
The recognized value of collaboration, shared resources, and common purpose is a lasting legacy of the program.

Staff at the national program office also reported these overall results from the three phases of MLC:

- MLC was instrumental in the evolution of public health accreditation.
- Participating states advanced policy, created infrastructure and found sustainable funding and related resources to institutionalize QI in public health.
- MLC provided a crucial foundation for the diffusion and spread of QI in public health.

**AFTERWARD**

To sustain the momentum from MLC, RWJF launched *Strengthening the Community of Practice: Accreditation and Quality Improvement in Public Health* 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. Read the Progress Report on the program.

On December 15, 2013, RWJF made an additional grant that provides two years of support to NNPHI for coalitions of public health stakeholders in up to seven states that have done little to date to implement quality improvement or prepare for accreditation.¹

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**Program Management**

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