



# MLC TOPICAL BRIEF: **SUPPORTING MULTI-SITE QUALITY IMPROVEMENT PROJECTS AND COLLABORATIVES**

February 29, 2008

*“The way to get started is to quit talking and begin doing.”*

—Walt Disney

That’s the simple but powerful idea behind the decision of six states to make hands-on quality improvement (QI) projects a cornerstone of their efforts in the [Multi-state Learning Collaborative II](#) (MLC-2). To these states—Florida, Kansas, Illinois, Michigan, Minnesota, and Washington—the best way to introduce public health professionals to the benefits of QI is to get people doing it. At the policy level, MLC-2 states have focused on accreditation and other longer-term and systematic efforts to raise public health performance. Yet, grounding these efforts is a decidedly more personal, immediate, and small-scale strategy to involve front line public health teams in QI. By sponsoring three to 13 QI pilot projects each, these MLC-2 states set out to:

- Learn what it takes to spark and support QI around public health issues or capacity standards.
- Road test various QI methods and ideas to see what works and resonates with public health teams.
- Demonstrate measurable results & compelling stories to show the practical relevance of QI to public health.
- Create enthusiasm and “buzz” about QI among both leaders and employees.
- Begin to build informal networks of public health professionals with skill and experience in QI.

As a result of their collective efforts, MLC-2 states have demonstrated that public health teams can learn to apply QI methods and achieve measurable improvement in a short time – often just a few months. Collectively, the MLC-2 states have:

- Leveraged modest funds to sponsor over 35 QI projects, involving more than 75 local and state health departments.
- Engaged public health professionals directly as QI project team members and/or by opening many project showcase 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—including media or surveillance capacities, public health services, and even community health outcomes.
- 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 achieving public health goals



*Berrien County, MI Quality Improvement Team, see page 5 for description of the QI project.*

On the following pages, find out what the MLC participants and their collaborative partners have learned about conducting pilot QI projects including recruiting participants, motivating pilot sites, providing training and technical assistance, the benefits of a collaborative approach, and much more. At the end of this document, you will find resources and links to help you learn more about collaborative approaches to implementing QI projects.

*"Initially, I was skeptical about the application of quality improvement methodologies developed for the hospital and medical care sector to the day-to-day practice in our governmental public health setting. To challenge my own skepticism, I agreed to select a few Department staff to participate in a project which trained them to use some of these formal tools and methods and then apply them to scrutinize and improve one area of the Department's work.. Delightfully, process and outcomes improved. Staff were pleased with the work they did. We've since looked for other opportunities to have more staff trained and to apply these tools in additional settings so that a culture of quality improvement can become a hallmark of our work."*

—Robert “Bobby” Pestronk, Health Official, Genessee County Health Department, a Michigan project site

*The MLC-2 is funded by the Robert Wood Johnson Foundation and managed by the National Network of Public Health Institutes.*



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## How Did MLC Participants Recruit and Motivate QI Project Teams?

- **Request for Proposals (RFP)** : Issuing brief RFPs helped states publicize the opportunity and select motivated sites that were ready to apply QI to specific issues.

### Tips for RFPs

- **Create contingency plans for a “too successful” RFP.** Because local interest exceeded expectations, states such as Washington came up with additional dollars to enable more sites to participate. In Illinois, seven counties applied for four spots and agreed to further divide the limited funds so all could participate. Others opened up project trainings or found other ways to engage interested sites.
  - **Help applicants understand QI project purposes,** including the emphasis on learning QI methods and tools by using them to solve a problem. Before issuing its RFP, Kansas organized a training to create interest and help regions design a QI project.
  - **Keep proposals simple, flexible, and focused on how applicants will manage the QI project.** Requests for detailed work plans may inadvertently send signals to identify the solution to the problem right away. This contradicts the QI principle that it is the team’s analysis of the problem that should dictate the solution. This required efforts to “pull back” and begin by gaining a full understanding of the root causes of the problem.
- **A mix of financial & non-financial incentives motivated participation and provided support,** such as:

- **Mini-grants, ranging from \$2,000 - \$10,500 each:** “The grant got people talking and was a catalyst to start or advance QI efforts. Funding is very important even if it doesn’t fully cover all costs. It creates a sense of commitment to stick with the project,” said one Michigan official. Participating Michigan sites received \$10,500, and estimated they contributed over \$25,000 each in-kind. In Minnesota, where each QI project (some involving as many as 29 sites) received a modest \$2,000 grant, “People thought the money was nice, but it doesn’t cover most costs,” said coordinator Kim McCoy.



Representatives from each of 15 Kansas public health regions attended a 2-day training to learn QI methods and prepare them to respond to an RFP for regional QI pilot projects

- **Training from QI experts:** All MLC states with pilot projects offered sites training and in-depth learning opportunities, generally through a combination of face-to-face and web or phone meetings. Sites typically wanted more opportunities for interaction and face-to-face time with each other. Michigan contracted with two Public Health QI consultants to assist in training development and for expert oversight and critique of project activities.
- **Recognition and Opportunities to Learn from Peers:** Some states reported that the opportunity for sites to be recognized for their QI projects and have the opportunity to learn from their peers was a motivator. “Excitement is building for the Michigan QI Showcase; it will provide an excellent venue to highlight the local health departments’ QI accomplishments”, said Angela Martin of the Michigan Public Health Institute. *Continued on page 3.*



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*“People raved about the training. They loved it because it was practical. After learning basic QI concepts, our team went right into planning how we would collect data for our project, asking, ‘What might our first rapid cycle look like?’”*

— Cindan Gizzi, Tacoma-Pierce County

- **Technical support:** Most states provided a mix of support from consultants and staff, many of whom were trained in QI as part of the MLC project. Academic-practice linkages boosted state capacity to support projects in Minnesota, where state leaders pooled resources from the MLC-2 and a related project at the University of Minnesota School of Public Health. By linking with the university, Minnesota was able to augment their staff support and offer their eight QI projects hands-on assistance from faculty and graduate students who were trained in QI methods.

## **What were the Responsibilities of Sites Participating in the Collaborative?**

Most MLC-2 states that sponsored collaborative pilot projects established clear responsibilities of participating sites through the initial request for proposals (RFP), individual agreements, or other communications. Listed below are some examples of responsibilities that were defined. For state-specific documents outlining responsibilities, see p. 6.

### ■ **Typical Participation Responsibilities of the QI Team:**

- Assemble and regularly convene a project team with relevant knowledge and responsibilities (from local, state, or multiple organizations)
- Participate in a kick-off learning session at the beginning of the project, and mid-project learning sessions via webcast or in person
- Attend Collaborative teleconferences (at least one representative) to share progress, discuss successes and challenges, and receive feedback
- Communicate frequently with Collaborative staff about their progress
- Attend and present the project’s processes and results at a showcase meeting at the end of the grant cycle.

### ■ **Additionally, Sites May be Asked to:**

- Contribute in-kind staff time to the project
- Provide top leadership support with team oversight or participation
- Use technical assistance provided by staff, consultants, or students
- Develop a project plan that incorporates QI principles
- Collect and report data to measure progress
- Revise project aims or plans as needed based on QI findings
- Submit brief written report(s) during the project with copies of QI tools used or developed by the team
- Prepare a summary report or storyboard at the end of the project showing results

**A National Model for Collaboratives:** *The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement.* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (on [www.IHI.org](http://www.IHI.org))

For links to successful collaboratives relevant to public health and spreading change, refer to the IHI Public Health Page, developed with the Public Health Foundation



[www.ihl.org/IHcs/Improvement/ResourcesforPublicHealth.htm](http://www.ihl.org/IHcs/Improvement/ResourcesforPublicHealth.htm)



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## **What Did MLC Sites Learn About Managing QI Projects or Collaboratives?**

MLC states' QI pilot projects and collaboratives generated a number of valuable insights that can help others learn from their successes and challenges.

- ✓ **Start by training sites to follow similar QI steps, such as “Plan-Do-Check-Act,” and a short set of QI tools.** Covering too many tools or concepts can be overwhelming to QI novices, who often seek a recipe or a few simple steps to get them going, noted Angela Martin of the Michigan Public Health Institute. Use follow-up sessions to gradually introduce more concepts and tools, when sites' practical experience will make them ready to learn. In response to project sites' requests for step-by-step guidance, Minnesota created a Tool Selection Guide and Michigan created their own QI guidebook that includes a 'checklist' tailored to state needs. (See Resources, p. 6.)
- ✓ **Most QI project sites needed more support than anticipated.** In Florida, for example, state health department staff learned that clearer understanding of expectations, anticipation and adjustment for potential turnover among County Health Department staff, and more individual coaching for collaborative participants may have yielded better results for the state's cardiovascular collaborative. Additionally, Florida leaders thought that fewer sites may have been more manageable. Similarly, even with the resources of the University of Minnesota, the Minnesota team similarly said of the state's 8 projects in 38 counties, “It was a very ambitious project.”
- ✓ **Guide sites on their aim statements, but let them decide their own.** One of the most important areas where technical assistance can prime QI project teams for success is in creating a

*“This project helped us learn how to take one bite at a time.”*

— Peggy Grigg,  
Grant County  
(Washington)

well-defined aim or problem statement. However, buy-in may be more important than a perfect aim statement. In Minnesota, for example, when some of the teams proposed project aims that really were solutions or management issues, staff guided the teams to better identify the actual problem that was to be addressed and often found some 'middle ground.' Given the opportunity again, Minnesota staff indicated that they would spend more time up front with sites, helping to define the problem and aim statements. When developing their aim statement, Florida's cardiovascular collaborative used evidence-based strategies, but found the aim to be unachievable. One lesson learned from the state health department and evaluators is to obtain more input from collaborative participants' when selecting the aim, strategies and activities.

- ✓ **Give people permission to fail.** “Not all changes people make are going to work,” advised Jim Butler of the Michigan Department of Community Health. When the proposed change does not work as expected, that experience is a learning moment to review to process used and to look for another way to improve. The iterative process WILL lead to improvements.
- ✓ **Develop simple methods of collecting data from sites.** Florida developed an easy-to-use, integrated data collection method, and Minnesota used a two-page form to report site progress and request assistance if needed. See page 6.
- ✓ **Provide the flexibility to change course.** In Kansas, one of the teams began by proposing an MCH project, but after analyzing their data realized they had greater problems with the consistent quality of STD services throughout the region. “The team hesitated to request the change, thinking normally it's not good to shift gears,” said Gianfranco Pezzino, of the Kansas Health Institute. “But we responded by saying, ‘You're doing exactly what we want —making decisions based on your data.’”



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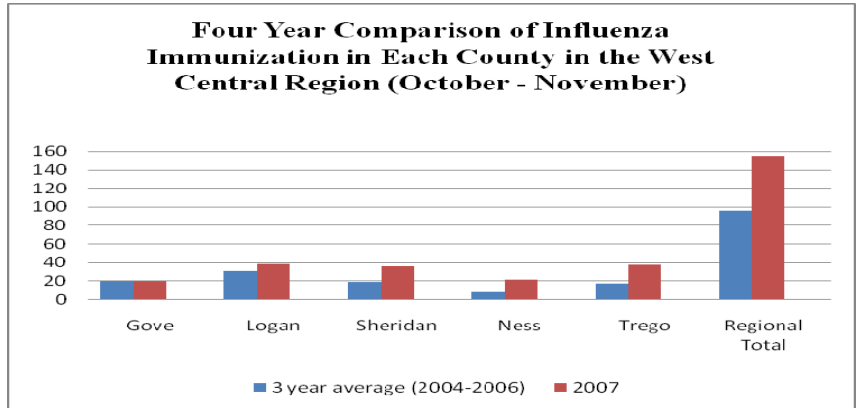
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## Two QI Project Success Stories

To make QI projects achievable within their project periods, most MLC sites focused on improving public health capacities, services, or health outcomes that respond more quickly to changes, such as sexually transmitted disease or vaccine-preventable conditions. Two success stories come from Kansas and Michigan.

### INFLUENZA IMMUNIZATIONS PROVIDED TO CHILDREN AGES 6-59 MONTHS

In rural Kansas, a five-county team used QI methods to address the region's problem of low influenza vaccination rates for children ages 6 – 59 months. The team's analysis of root causes led them to conclude that, rather than clinic access, education and awareness about the influenza vaccine was the most important factor in their region. As a result of the team's efforts, each county increased vaccination in the target age group (see data at right), and they learned to collect data from multiple sources for closer to real-time monitoring of regional goals.



Project Teams: Gove-Cheryl Goetz & Maxine Litson, Logan-Georgetta Schoenfeld & Rhonda Sperber, Ness: Sharon Anderson & Arlene Langer, Sheridan-Melanie Cooper & Heather Bracht, Trego- Diana Parke & Nicole Mattheyer, Regional Coordinator: Cindy Mullen

### A Project Team's Improvement Storyboard: Berrien County, Michigan — Media Capacity

Project Team: Theresa Green, John Nelson, Rebecka Weberg, Vita Polasek, Princella Tobias, Benton Spirit, Erin Edinger

#### Focused on two related improvement opportunities:

- Health department media capacity
- Community awareness of services provided LHD

#### Used the "Plan-Do-Check-Act" model to:

- Set measurable aim to have 30 County Health Department service-related articles appear in a local newspaper during the grant period.
- Analyzed the current frequency, processes, and reasons for difficulties generating media articles
- Piloted strategies to address time and article quality factors, such as creating author guidelines and providing more lead time to staff
- Measured effects of changes, which reduced time needed to edit staff-written articles and increased deadlines met
- Make changes based on data; standardize improvements

#### Results:

- ✓ Increased frequency of articles
- ✓ Raised awareness of health department services, and began tracking service impact (increased phone calls, visits, etc.)
- ✓ Post survey data showed that most residents surveyed had to read at least on health article
- ✓ Editing time decreased to less than 2 hours down from 3
- ✓ Other larger newspapers began to carry public health articles

See Resources, p. 6, to download the Berrien County storyboard and other Michigan QI project storyboards.



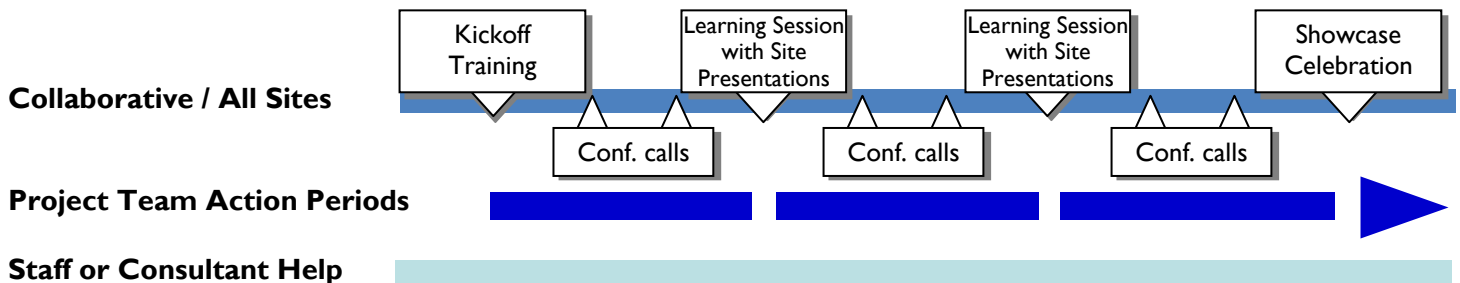
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## What Questions should we Consider when Planning a QI Collaborative?

The following questions are meant to provide a starting point from which to think through the process of managing a QI collaborative:

1. **What incentives will motivate jurisdictions to participate in these QI projects?** Without deep pockets to pay the full cost of projects, states needed feasible and sustainable alternatives. Would micro-grants, recognition, or other non-financial incentives be enough to get sites to participate?
2. **What training and assistance would pilot sites need to apply QI concepts and achieve results?** Considering the newness of QI to many public health agencies, how would they quickly ramp up their expertise and capacity to help project sites? Who can provide initial training and ongoing coaching? Where should we invest most of our assistance for the greatest impact?
3. **How should the projects be organized to maximize the benefits and fit with the time and resources available?** Should we regularly bring together teams from across the state? Could the “collaborative” model used in healthcare to support improvement in multiple sites be adapted for beginners in public health?
4. **What are the collaborative components?** Kick off meeting? Teleconferences? Face-to-Face meetings? Reporting?
5. **What are the responsibilities or requirements of sites who are participating?** Should we ask the sites to submit regular reports on their progress? How detailed? Should they be willing and able to demonstrate leadership support of their project? Do they then become mentors as other sites participate?
6. **What methods can be used to maximize peer sharing and learning?** Teleconferences? Face to face meetings? Web resources? Mentoring? Showcase presentation, etc?
7. **How can we best capture and disseminate the project methods and results?** It can be helpful to define who within and outside of the state should be informed of the project’s progress. Who are our “key stakeholders and/or audiences?” With that in mind, it is necessary to then consider how to best disseminate the information: Should we make a press release? Are there electronic newsletters or other forms of media (e.g., storyboards) we can use? Who will be responsible for this?
8. **How will results be displayed for different audiences?** Board of Health members? Policymakers? Health Department staff? Funders? Others defined as “key stakeholders?”
9. **How long will the collaborative projects need to last in order to be able to demonstrate measurable change?** What is the best way to address the need for measurable data to be defined and captured for pre and post survey analysis?
10. **What is the best way to build in an evaluation component up front in the planning process?**
11. **How will the efforts of the project(s) be sustained?**

## Common Milestone Events in a QI Collaborative





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## For More Information...

### MLC-2 State Resources:

Visit the MLC File Library at [www.nnphi.org/eCatalog](http://www.nnphi.org/eCatalog) to access more examples of work from all of the MLC states. Select “MLC”, then click search to browse publicly available documents including many of the following:

#### ☐ MLC QI Projects: Overviews

- Regional QI Pilot Projects (Kansas), [www.kalhd.org/en/cms/?633](http://www.kalhd.org/en/cms/?633)
- Michigan Accreditation Continuous Quality Improvement Collaborative, [www.accreditation.localhealth.net/mlc2.htm](http://www.accreditation.localhealth.net/mlc2.htm)
- Minnesota Public Health Collaborative for QI, [www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/index.html](http://www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/index.html)
- Washington, Quality Improvement Projects Summary, [www.nnphi.org/CMSuploads/SummaryQIProjects-65448.pdf](http://www.nnphi.org/CMSuploads/SummaryQIProjects-65448.pdf)

#### ☐ Organizing a Public Health QI Collaborative

- Sample Collaborative RFP (Minnesota): [http://www.nnphi.org/CMSuploads/QI\\_Project\\_Application-93084.doc](http://www.nnphi.org/CMSuploads/QI_Project_Application-93084.doc)
- Time Line (Minnesota): [www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/docs/learningsession3-timeline.pdf](http://www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/docs/learningsession3-timeline.pdf)
- Roles and Responsibilities: (Michigan): <http://www.accreditation.localhealth.net/MLC-2%20website/MACQIC%20Resources/PDF/MACQIC%20Roles%20and%20Responsibilities.pdf>
- Roles and Responsibilities: Graduate Students and Faculty Advisors (Minnesota), [http://www.nnphi.org/CMSuploads/MN\\_PH\\_Collab\\_QI%20Roles-Responsibilities\\_Aug\\_17\\_2007-92257.doc](http://www.nnphi.org/CMSuploads/MN_PH_Collab_QI%20Roles-Responsibilities_Aug_17_2007-92257.doc)
- Learning Session Schedule (Minnesota): [www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/training.html](http://www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/training.html)
- Learning Congress Agenda (Washington): <http://www.nnphi.org/CMSuploads/Agenda-07575.doc>
- Simple report form for QI project (Minnesota): [www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/docs/monthlyteamreport-blank.doc](http://www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/docs/monthlyteamreport-blank.doc)

#### ☐ Examples of storyboards and presentations from QI project teams

- “Plan-Do-Study-Act” Storyboards: [http://www.nnphi.org/CMSuploads/Michigan\\_QI\\_Story\\_Boards-11699.pdf](http://www.nnphi.org/CMSuploads/Michigan_QI_Story_Boards-11699.pdf)
- Chlamydia Quality Improvement Team Presentation (Washington): <http://www.nnphi.org/CMSuploads/chlamydia-44726.ppt>
- Immunization Reminder Recall Project: (Washington): [http://www.nnphi.org/CMSuploads/WA\\_Immunizations-45204.ppt](http://www.nnphi.org/CMSuploads/WA_Immunizations-45204.ppt)
- Kansas QI Storyboards <http://www.khi.org/s/index.cfm?aid=1172> (Link will be active March 7<sup>th</sup>, 2008)
- Visit the NNPHI eCatalog for the additional links

#### ☐ QI Technical Assistance Resources for Project Sites

- Michigan’s Quality Improvement Guidebook: [http://www.nnphi.org/CMSuploads/Michigans\\_QI\\_Guidebook-47434.pdf](http://www.nnphi.org/CMSuploads/Michigans_QI_Guidebook-47434.pdf)
- Tool Selection Guide (Minnesota): [www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/docs/chaap-qitools.pdf](http://www.health.state.mn.us/divs/cfh/ophp/consultation/mlc2/docs/chaap-qitools.pdf)

## National Resources

- **A National Model for Collaboratives: Institute for Healthcare Improvement**—*The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement*. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on [www.IHI.org](http://www.IHI.org))
- PREPARE for PI Collaborative (RAND), [www.rand.org/pubs/working\\_papers/WR491/](http://www.rand.org/pubs/working_papers/WR491/)
- Common Ground (Public Health Informatics Institute), [www.phii.org/programs/CommonGround.asp](http://www.phii.org/programs/CommonGround.asp)
- Public Health Foundation, [www.phf.org/infrastructure/performance](http://www.phf.org/infrastructure/performance)
- NACCHO, Accreditation & Quality Improvement, [www.naccho.org/topics/infrastructure/accreditation.cfm](http://www.naccho.org/topics/infrastructure/accreditation.cfm)
- For links to successful collaboratives relevant to public health and spreading change, refer to the IHI Public Health Page, developed with the Public Health Foundation [www.ihf.org/IHI/Topics/Improvement/ResourcesforPublicHealth.htm](http://www.ihf.org/IHI/Topics/Improvement/ResourcesforPublicHealth.htm)