

# Quality Improvement Capacity in the Minnesota Department of Health: Results from 2011 Survey



*Minnesota Public Health Research to Action Network*

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A department-wide survey was fielded to all employees at the Minnesota Department of Health (MDH) in June 2011. This survey asked respondents to provide feedback on a variety of questions related to quality improvement (QI), employee empowerment, cultural competency and readiness for accreditation. This brief describes results related to MDH QI capacity and competencies.

## Methods

All MDH employees received a link to the online survey, which was fielded over three weeks in June 2011. Of 1,537 employees surveyed, 1,111 (73 percent) completed the survey with 1,108 having complete data (92 percent). Division-specific response rates ranged from 64 to 92 percent.

The MDH survey used questions from a modified tool developed by the University of Southern Maine for use in state and local health departments (Multi-State Learning Collaboration Version 3). Respondents were asked to indicate their level of agreement (strongly agree, agree, neutral, disagree, strongly disagree, I don't know) with statements related to QI capacity and competencies.

## Results

### Staffing, QI Training and Skills

Almost half of respondents did not know if their leaders or colleagues were trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act. Yet 59 percent of respondents did feel that individuals who were responsible for programs and services within their own divisions had the skills necessary to evaluate the quality of those programs and services. Only 37 percent of respondents agreed that staff have the authority to work within and across program boundaries to facilitate change (Figure 1). Also striking is that over 40 percent of respondents agreed that implementing methods for assessing and improving the quality of services can be quite challenging for individuals responsible for programs and services. Given the perceived difficulty of implementing QI methods, it is also notable that only 16 percent of respondents agreed that staff within MDH are given adequate time and support to use QI approaches before implementing them (Figure 1).

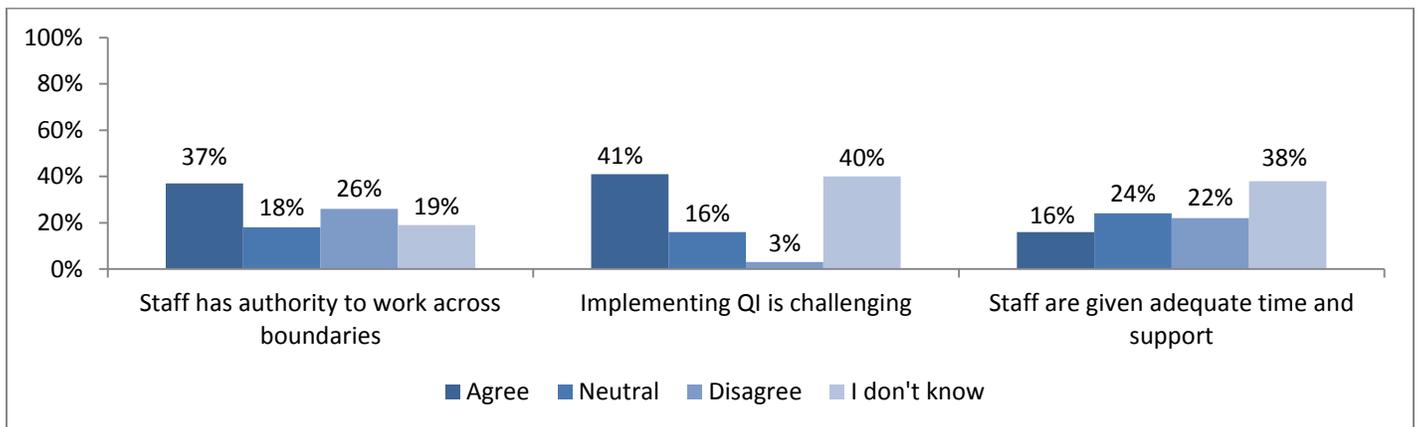
### At A Glance

Almost half of respondents were unsure as to whether leaders or staff in their division were trained in basic QI methods for evaluating and improving quality. However, almost 60 percent of respondents agreed that staff in their division had the skills needed to assess quality of their programs and services.

A high percent of respondents were not aware of formal QI efforts underway at MDH. Approximately 40 percent of respondents indicated that their division had objective measures and that programs were continuously monitored, however a much smaller percentage agreed that accurate and timely data was available to evaluate those services.

Overall, knowledge was quite low about formal QI activities within MDH. These findings suggest that the profile of QI could be raised within the agency.

**Figure 1. Staffing and QI Implementation**



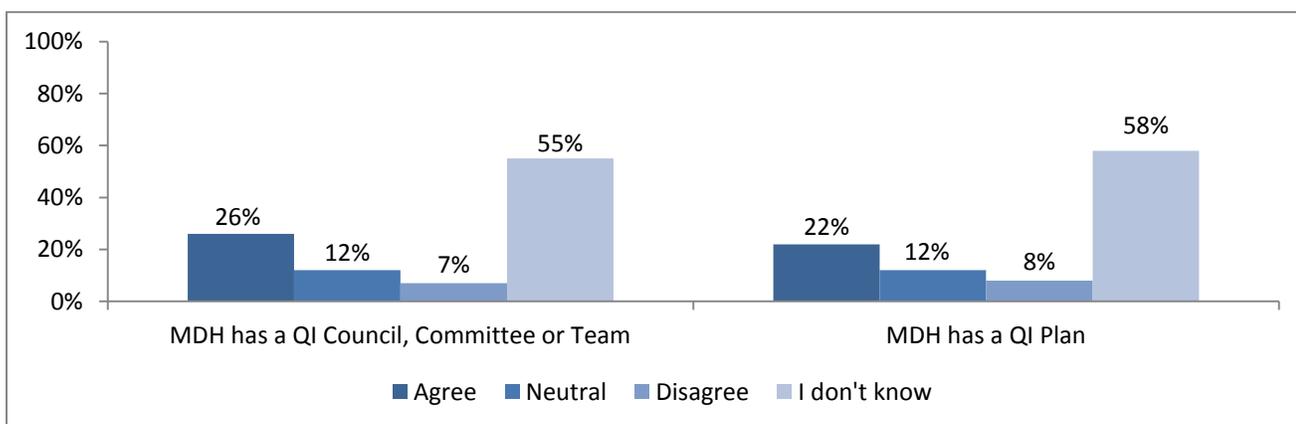
### Perceived Data Quality

Over 40 percent of respondents agreed that their division had objective measures for determining quality; that programs and services were continuously evaluated to determine whether they are working as intended and whether they are effective; and, that the quality of many programs and services are routinely monitored. However, only 25 percent of respondents agreed that accurate and timely data were available to evaluate those programs and services and a large percent of employees (36 percent) did not know if such data were available. Thus, while divisions may be working to monitor their programs and services, it is not apparent that they have the necessary data to do so effectively.

### Formal MDH Quality Improvement Capacity

A large percentage of employees were unaware of formal QI activities within the agency. Over 50 percent of respondents did not know whether MDH had a QI Council, committee or team or if it had a formal QI Plan. Also interesting, 26 percent of respondents did agree that MDH had a QI Council and 22 percent agreed that it had a QI Plan, yet those formal components were not in place at the time of the survey (Figure 2). While 36 percent of respondents agreed that there is an established process for identify QI priorities within many programs and services at MDH, 40 percent didn't know.

**Figure 2. Use of Data to Improve Quality**



## Conclusions

Overall, respondents displayed a general lack of knowledge around formal QI activities at MDH. This lack of knowledge extended to whether leaders and/or colleagues were trained or had specific skills in QI methods. Although, respondents did seem to have confidence that colleagues within their division had the necessary skills to evaluate the quality of programs and services. A strong message came through about the difficulty of implementing methods for assessing and improving the quality of services and that it can be challenging for staff. To add to that challenge, respondents did not feel that MDH staff are given adequate time and support to learn QI approaches before implementing them. While respondents did seem to agree that their division had objective measures for determining quality and programs and services were continuously evaluated, there was less agreement around the availability of accurate and timely data to evaluate such programs and services. It appears that there is agreement that QI activities occur within some divisions, there is less confidence in the data to support those activities and in the support given to staff to learn and implement them.

## Next Steps

1. Convene a MDH Quality Council
2. Create a MDH QI Plan
3. Implement the 2012-2015 QI Training Plan
4. Share results with divisions and offices
5. Facilitate Lean/Kaizen events
6. Provide technical assistance

To request assistance, please contact Chelsie Huntley at [chelsie.huntley@state.mn.us](mailto:chelsie.huntley@state.mn.us) or 651-201-3882.

## About the Research to Action Network

For more information on this issue brief or the Minnesota Public Health Research to Action Network, contact Kim Gearin at [kim.gearin@state.mn.us](mailto:kim.gearin@state.mn.us) or (651) 201-3884 or Beth Gyllstrom at [beth.gyllstrom@state.mn.us](mailto:beth.gyllstrom@state.mn.us) or 651-201-4072.

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