

Quality Improvement Capacity in Minnesota Local Health Departments



Minnesota Public Health Research to Action Network

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The Multi-State Learning Collaborative Survey (MLC) was administered annually to state and local health departments (LHDs) in 16 states from 2009-2011. Minnesota participated each year, yet had the highest response rates for the February 2011 administration. The MLC-3 survey asked respondents to provide feedback on a variety of questions related to quality improvement, organizational culture and readiness for accreditation. This brief describes results related to Minnesota LHD quality improvement (QI) capacity.

Methods

The University of Southern Maine (USM) administered the MLC-3 survey. The Public Health Director or Community Health Services Administrator completed the survey for his/her health department. In 2011, the Minnesota-specific MLC response rate was 78 percent (n=56 LHDs). Of those, 55 (98 percent) provided written consent to the USM to provide the Minnesota Department of Health (MDH) with the Minnesota results. There was some regional variation in response, with response rates ranging from 58 to 100 percent by region. Also, response rates appeared to vary slightly by whether the LHD was governed by a single-county Community Health Board (CHB) (75 percent response), a multi-county CHB (79 percent) or by a Human Services Board (HSB) (63 percent). Respondents were asked to indicate their level of agreement (strongly agree, agree, neutral, disagree, strongly disagree, I don't know). For the purposes of this report, strongly agree/agree and disagree/strongly disagree have been combined.

Results

Staffing, QI Training and Skills

More respondents agreed that leaders were trained in basic QI methods, such as Plan-Do-Study-Act as compared to staff (63 percent vs. 45 percent). When asked whether individuals responsible for programs and services within the public health agency had the skills needed to assess quality, 48 percent of respondents agreed. Thus, close to half of staff do not have the training or skills needed to assess quality (Figure 1). In addition, only 27 percent of respondents agreed that agency staff is aware of external quality improvement expertise to help measure and improve quality. A very low percentage of respondents (18 percent) agreed that staff at their agency are given adequate time and support to learn QI approaches before implementing them.

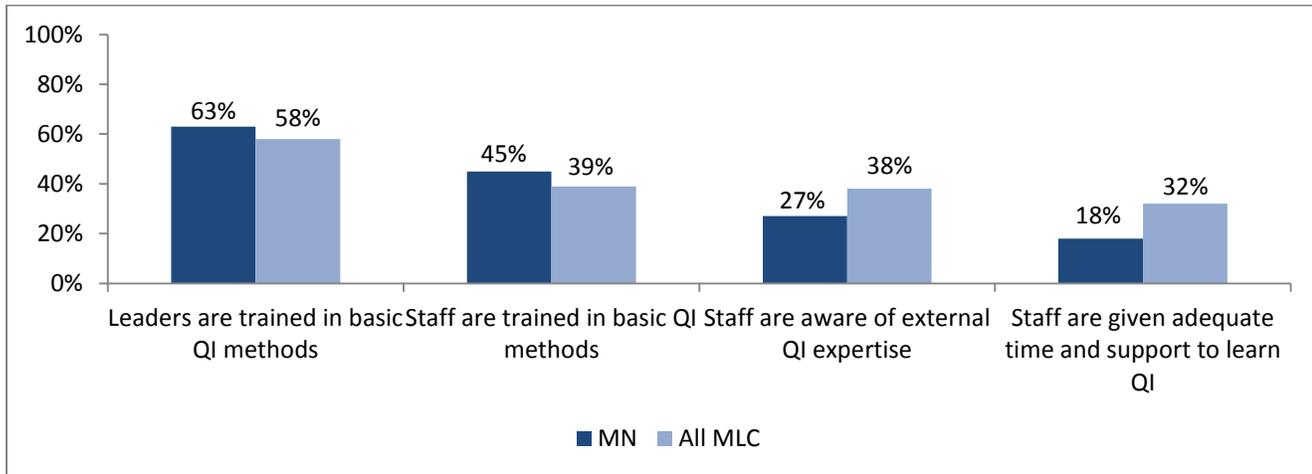
At A Glance

Minnesota's local health departments (LHDs) show a high level of knowledge about QI capacity within their agencies. It appears that while there has been some training, particularly at the leadership level, staff do not have high levels of training and skills related to QI activities.

A low percentage of respondents agreed that their public health agency had objective measures for determining the quality of many programs and services. In addition, accurate and timely data for program managers to evaluate the quality of their services on an ongoing basis appears lacking. A higher percentage of respondents agreed that customer satisfaction information is routinely used by many individuals responsible for programs and services within their public health agency.

While knowledge about QI infrastructure was high among respondents, most LHDs represented had not yet formalized QI activities within their agency.

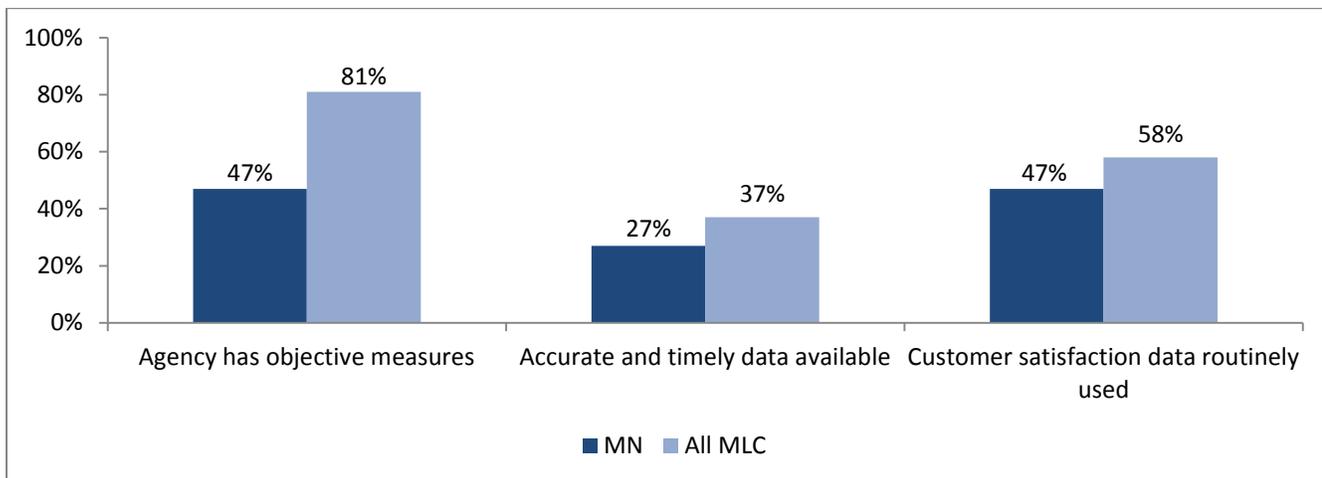
Figure 1. QI Skills and Training



Perceived Data Quality

Less than 40 percent of respondents agreed that their public health agency had objective measures for determining the quality of many programs and services. This compares to 55 percent of respondents nationally (Figure 2). In addition, only 27 percent of respondents agreed that accurate and timely data were available for program managers to evaluate the quality of their services on an ongoing basis. A higher percentage of respondents agreed that customer satisfaction information is routinely used by many individuals responsible for programs and services within their public health agency (47 percent). This is lower than the national percent agreement which was almost 60 percent. Also telling, almost one-third of Minnesota respondents disagreed that customer satisfaction information is routinely used. This suggests that while a majority of LHDs have focused on customer satisfaction, it is not yet universal in Minnesota’s public health system. Thus, this could be an opportunity for the system to learn from those LHDs that are using and incorporating customer satisfaction information into their routine work.

Figure 2. Data Quality



Formal MDH Quality Improvement Capacity

While knowledge about QI infrastructure was high among respondents, most LHDs represented had not yet formalized QI activities within their agency. Only 25 percent had a QI council, committee or team and 16 percent reported having a QI plan.

Over 21 percent reported having a designated QI Officer. Approximately 16 percent of respondents agreed that there was an established process for identifying QI priorities. A small percentage of respondents (11 percent) agreed that their public health agency currently has a high level of capacity to engage in QI efforts. This question had over two-thirds of respondents disagree with that statement. Yet, even though current QI capacity may not be as high as respondents might hope, there are indications that Minnesota LHDs are prioritizing QI within their agencies. For example, over 46 percent of respondents agreed that their public health agency has specific plans to expand QI efforts.

Conclusions

Minnesota LHDs show a high level of knowledge about QI capacity within their agencies. It appears that while there has been some training, particularly at the leadership level, staff do not have high levels of training and skills related to QI activities. Overall, LHDs within Minnesota appear to be doing a good job using customer satisfaction information. Yet other data indicators are less developed. Respondents indicate a general lack of accurate and timely data, as well as objective measures for evaluating quality. Also, formal QI activities do not appear widespread at the time of this survey. These indicators will likely change in Minnesota, particularly given the high interest among LHD leadership and staff. In addition, the Minnesota Department of Health (MDH) provided resources around development of a QI Plan to 10 LHDs who applied to be part of a leadership collaborative. These LHDs all submitted completed QI Plans in December 2011.

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 or (651) 201-3884 or Beth Gyllstrom at beth.gyllstrom@state.mn.us or 651-201-4072.

For more information about the MLC Annual Survey, please contact Brenda Joly, USM, at bjoly@usm.maine.edu or 207-228-8456.

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