

The Multi-State Learning Collaborative Survey (MLC) was administered annually to state and local health departments (LHDs) in 16 states from 2009-2011. Minnesota (MN) 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 MN LHD organizational culture, particularly in the context of quality improvement (QI).

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 MN-specific MLC response rate was 78% (n=56 LHDs). Of those, 55 (98%) provided written consent to the USM to provide the Minnesota Department of Health (MDH) with the MN results. There was some regional variation in response, with response rates ranging from 58-100% by region. Also, response rates appeared to vary slightly by whether the LHD was governed by a single-county Community Health Board (CHB) (75% response), a multi-county CHB (79%) or by a Human Services Board (HSB) (63%). 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

Leadership

A high percent of respondents agreed that leaders in their LHD were receptive to new ideas for improving agency programs, services and outcomes (85%). This is the same as results reported nationally. Similarly, a high percentage of respondents agreed that key decision-makers in their

At a Glance

Minnesota Local Health Directors and CHS administrators provided a self-assessment of their agency's level of QI organizational culture. Most respondents agreed that leadership was both receptive to new ideas for improving programs, services and outcomes and that key decision-makers within their agencies believe QI is important. These results were similar to those reported nationally. However, a slightly lower percentage of respondents felt that the board and/or management team worked together for common goals.

In general, respondents reported a high level of consultation among staff as well as a respectful environment where problems were handled without blame and reprisal. However, a lower percent of MN respondents agreed that agency data are shared with staff for performance improvement, particularly as compared to national estimates.

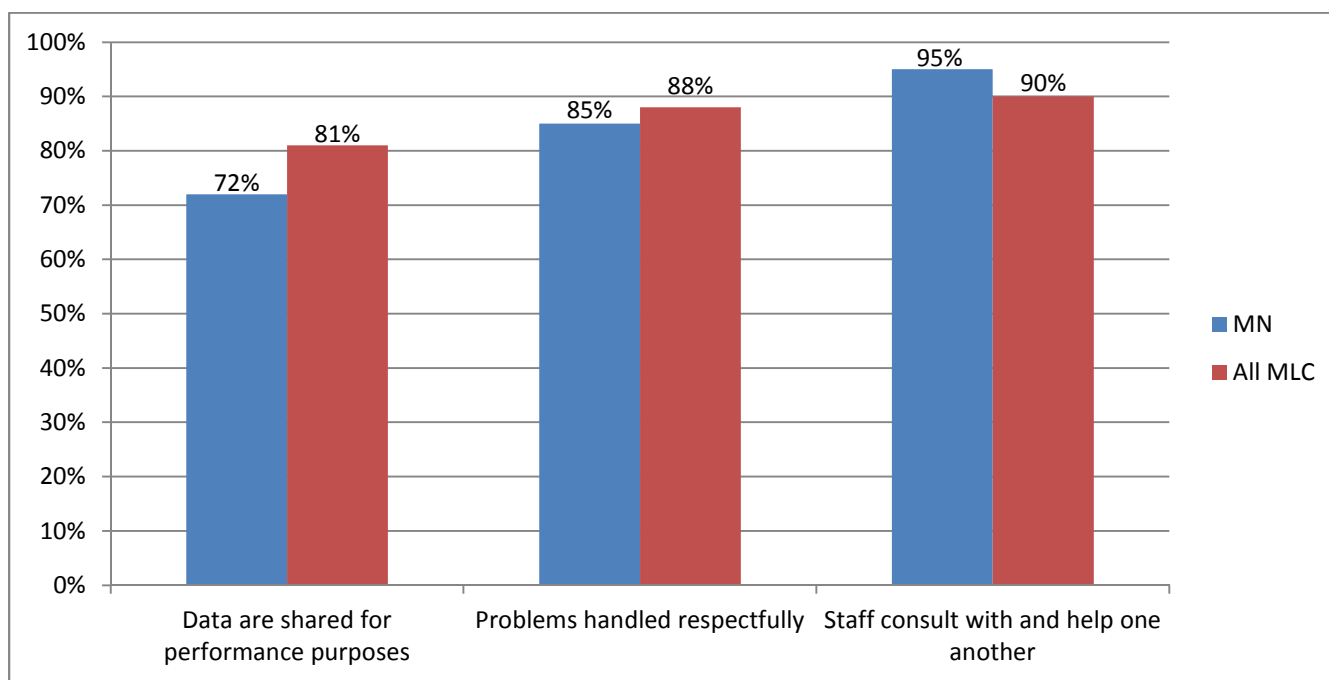
In general, while responses were fairly high to individual culture questions, when asked about whether their agency had a *pervasive culture* of quality, the level of agreement dropped dramatically.

agency believe QI is very important (85%). Slightly less respondents agreed that the board and/or management team worked together for common goals (74%), which is lower than national estimates at 83%. Thus it appears that while LHD leaders are poised to embrace new ideas for improving quality or changing their approach to service provision, there is less confidence that the governing board(s) share common goals.

Collaborative Learning Culture

A majority of respondents agreed that agency data are shared with staff for performance improvement purposes (72%), which is slightly lower than the national results (83%) (Figure 1). In addition, a high percentage of respondents agreed that when things go wrong, their agency looks at matters in a respectful way without blaming others (85%). An overwhelming percent of respondents agreed that staff consult with, and help one another to solve problems (95%).

Figure 1. Agency Learning Culture

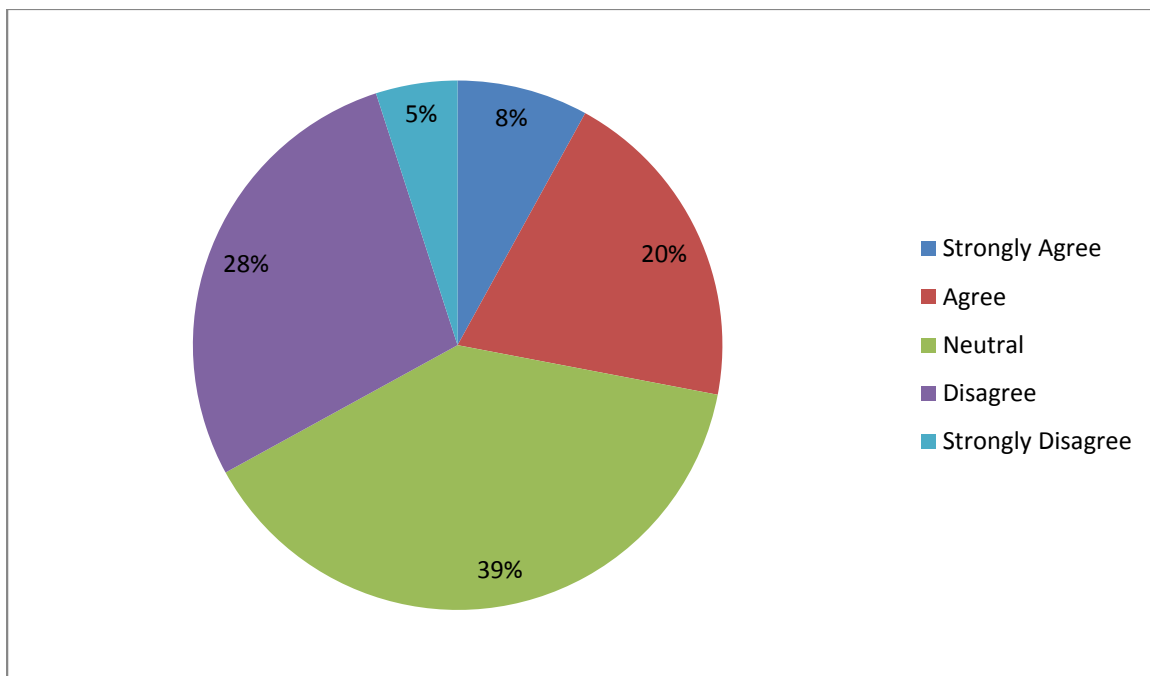


Pervasive Culture of Quality

Respondents were asked whether their agency currently had a pervasive culture that focuses on continuous quality improvement. This question reflected a broader distribution of responses in comparison to other questions related to agency culture. In this instance, only 28% of respondents agreed or strongly agreed with that statement. A high percentage were neutral (39%) and over 33% disagreed. None of the respondents

replied “I don’t know.” (Figure 2). Nationally, 36% of respondents agreed or strongly agreed that their agency had a pervasive culture of continuous quality improvement. Thus, while individual questions within the domain of organizational culture seemingly reflect high levels of items that are believed to contribute to culture, yet when asked directly, respondent were less likely to agree that they have a culture of continuous QI. It may be that the previous questions address factors that are necessary to create a culture of continuous QI, but that there is something additional needed to truly create a continuous QI environment.

Figure 2. Pervasive Culture of Continuous Quality Improvement



Conclusions

Local public health departments in MN appear to be on the forefront, as a system, in moving towards a culture that supports quality efforts and improvement. Leaders are receptive to change and see value in QI activities. In addition, there appears to be a strong sense of working together and handling issues respectfully. Yet, this knowledge of QI and the steps needed to get there may make MN respondents more stringent in their self-evaluation as to whether a continuous QI culture has become pervasive within their agencies. Thus, as they learn more about truly embracing continuous QI, they see room for improvement. In addition, these LHD leaders will need to continue to work with their boards and management teams to come together around a common set of goals related to enhancing quality within their organizations.



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About the Research to Action Network

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