Minnesota Public Health
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Quality Improvement (QI) Practice in Minnesota Local Health Departments

February 2012

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 quality improvement (QI) practice, alignment and spread.

At a Glance

It appears that most MN LHDs have embraced QI activities as being compatible with their agency goals and also feel that QI will lead to improved program and service delivery. Quite telling is the high percent of respondents who agree that QI will translate into improved population health.

Yet even with high levels of buy-in, QI does not appear well-integrated in MN LHDs. There are opportunities for LHDs to incorporate QI into job responsibilities, involve staff at more levels into QI activities and provide more time and resources for staff to participate.

Currently, 40% of respondents agree that their agency has aligned their commitment to quality with most of their efforts, policies and plans. Thus it appears that respondents believe QI is compatible with their agency activities, but that it hasn't necessarily been formalized.

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.

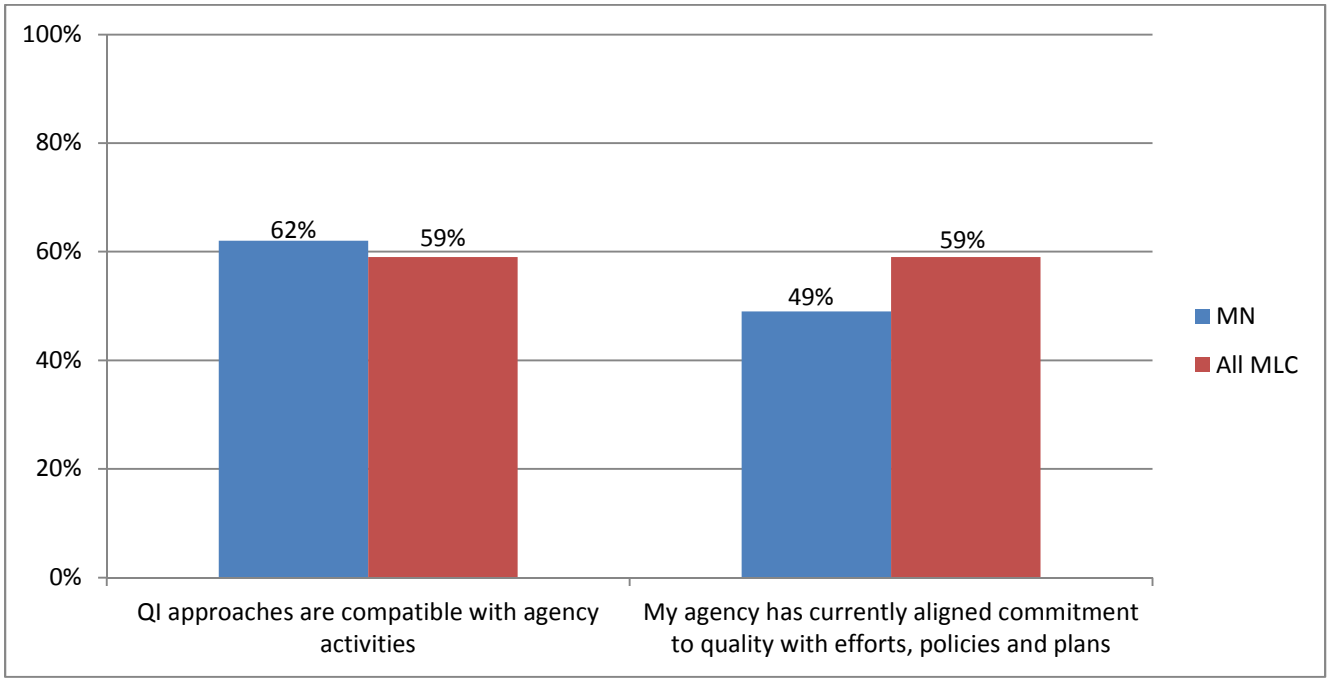
Results

Alignment with Agency Priorities and Goals

More respondents agreed that QI approaches are compatible with activities within their agency (62%). This is slightly higher than the national data provided by all MLC respondents (59%). Yet only 40% of respondents agreed that their public health agency has aligned their commitment to quality with most of their efforts,

policies and plans (Figure 1). This compares to almost 50% of all MLC-respondents. Thus it appears that respondents believe QI is compatible with their agency activities, but that it hasn't necessarily been formalized.

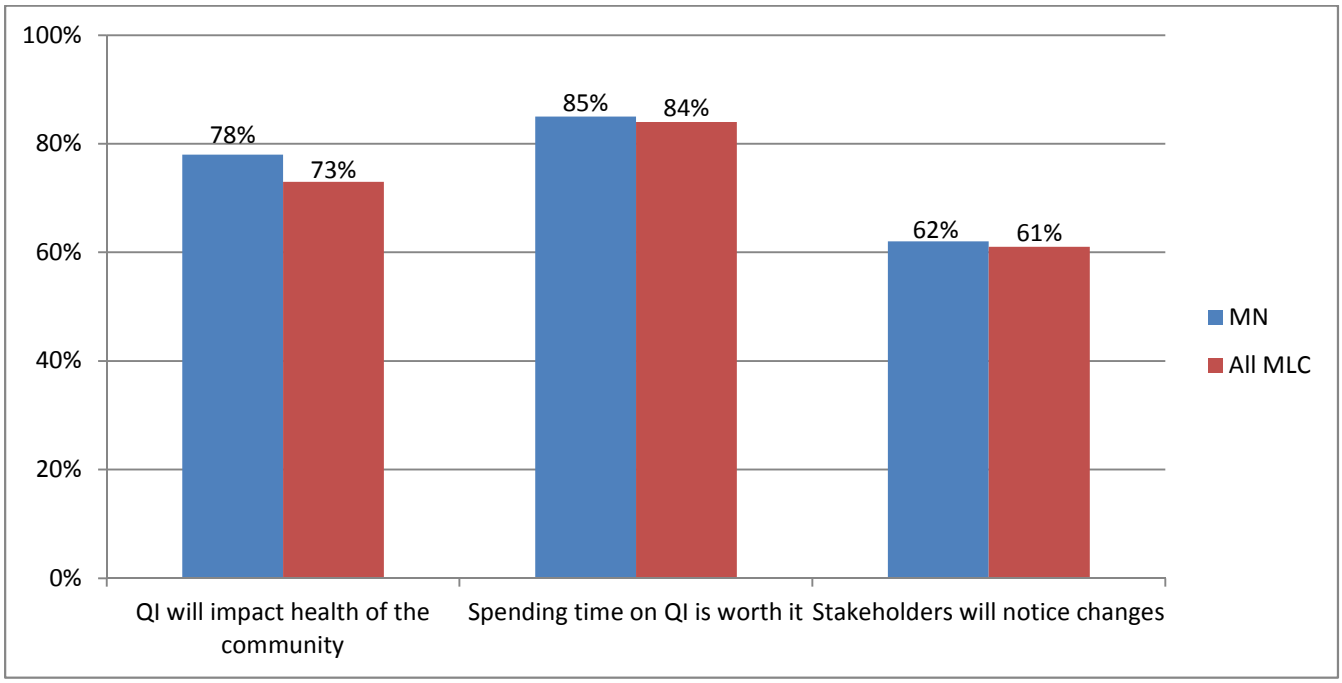
Figure 1. Alignment with Agency Activities, Policies and Plans



Employee Buy-In

An overwhelming percent of respondents agreed that spending time and resources on QI is worth the effort (85%). This is quite comparable to national results, with 84% agreeing. In addition, respondents agreed that using QI approaches will impact the health of their community (78%). This result is slightly higher than national numbers, with 73% of respondents agreeing. Finally, 62% of respondents agreed that agency staff and stakeholders will notice changes in programs and services as a result of QI efforts. These responses suggest that respondents see the value in QI as it pertains to the work of their agency and that those efforts will translate into better service to customers and stakeholders, as well as to improving population health.

Figure 2. Buy-In



QI Integration and Spread

Approximately 36% of respondents agreed that improving quality is well-integrated into the way many individuals responsible for programs and services work. In addition, only 18% of respondents agreed that job descriptions for many individuals include specific responsibilities related to measuring and improving quality. Slightly more respondents (42%) agreed that good ideas for measuring and improving quality in one program or service area usually are adopted by other programs or services within their agency. Forty-two percent also agreed that staff members at all levels participate in QI efforts. In terms of sustainability, only 20% of respondents agreed that their agency allocates sufficient time for staff to participate in QI efforts. These results indicate that QI hasn't been truly integrated within MN LHDs, even while the top officials within these agencies believe QI is important and will have an impact on population health.

Conclusions

MN LHDs agree that QI approaches are compatible with activities within their agency and also that spending resources on QI is worth it. An overwhelming percent of respondents felt that QI approaches would translate into improved population health in their communities. All questions related to employee buy-in or the value of QI were consistently supported by respondents. Yet it appears that fully integrating QI into MN LHDs hasn't

yet occurred. Only a low percent of respondents agreed that job descriptions include QI or that there are agency resources to sustain these activities. Less than half of the agencies reported that QI was spread across program areas within their agencies or that all of their staff were participating. Therefore, MN LHDs have an opportunity to build upon the enthusiasm and reported value of QI to more fully-integrate QI activities within their agencies.

About the Research to Action Network

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