

# Sharing, Helping, Growing

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## CDC Performance Improvement Managers Network Call

**July 28, 2011**

**Moderators:** Liza Corso, CDC/OSTLTS

Teresa Daub, CDC/OSTLTS

**Jody (Operator):** Welcome and thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session please press star 1 to ask your question. Today's conference is being recorded. If you have any objections you may disconnect at this time. Now I'll turn the meeting over to Ms. Liza Corso. Ma'am you may begin.

**Liza Corso:** Thank you very much. Welcome everyone to the July Performance Improvement Managers Network call. I am Liza Corso with the Office for State, Tribal, Local and Territorial Support and I'm joined here today by colleagues from OSTLTS. Teresa Daub and I will be co-moderating this call.

This is our sixth call in the monthly webinar series for Performance Improvement Managers. The PIM Network is intended to be a forum to support all Performance Improvement Managers in learning from each other as well as from partners and experts in the field.

We're hoping that these calls are a way for members of the network to get to know each other better, learn about best practices and quality improvement and performance management and share information about resources and training opportunities.

We've heard from many of you that you want to hear a little bit more about what the rest of your Performance Improvement Manager colleagues are doing. So on today's call we're going to try and do something a little new and different. And we're going to have - a bit of round robin sharing from five sites each of which will highlight some of their NPHII efforts.

I'll introduce our speakers as we go through the call but before I do, Teresa Daub is going to review some of the technological features of today's call.



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**Teresa Daub:** Thanks Liza and welcome to the PIM network call everyone. For those of you who are not able to join on the Web portion of the call - the LiveMeeting site- please refer to the slides that were emailed to you yesterday, just follow along. And for those of you on the LiveMeeting site you will see the slides on your screen but if you're interested in downloading them you can do so via the icon at the top right of your screen. It's the one that looks like three sheets of paper. So you can click on that and download the slides if you want to reference them later.

Also if you're on the LiveMeeting site you'll be able to see the other sites participating by looking under the attendee tab, top left. It's just a way to notice your peers who are joining on the line. We're going to have two ways to take your questions today. You can use the Q&A box at any time. That box is at the bottom right of your screen and you can type in your questions there. Those of you who've joined us in the recent months know that we get quite a few questions that way and we do our very best to get answers to them by the end of the call. We're not always able to do that. So what we've done for the last call and we'll continue to do is to record those questions, document them, get answers from our speakers later and post them on the phConnect site. We'll be doing that in the next few days for last month's call and we'll do it again for this call if necessary but, please do put your questions in, use the Q&A box at any time.

You may also ask live questions via the phone line and to do that you'll need to press star 1 and our operator, Jody will queue you up to ask your question live. One final note about asking questions, if you want to do so anonymously via the Q&A box on the LiveMeeting site please type 'anon' either before or after your question so that we know you want to be in an anonymous position. Today's call will last about one hour. It's being recorded and will also be posted on the phConnect site as well as the PIM Network Web page.

And if you haven't joined the phConnect site we certainly hope you'll do so and we can provide you with assistance if needed. Just give us an email at [pimnetwork@cdc.gov](mailto:pimnetwork@cdc.gov) and we'll give you help in joining that community. We have a few polls on today's call as usual and we'll go to our first poll right now. And this is our poll where we ask you to indicate your affiliation.

So we can see today that we have good representation from different organizations for our territorial health department colleagues. But other than that we have good representation on today's call.

So we'll go to the next poll and in this poll please indicate how many folks are in the room with you today. This will give us an idea of how many total participants we have on the call. All right, thank you for participating in the polls today. We have one final poll at the end of the call that's where we want to hear your thoughts about the call so we hope you'll participate in that. But for now I'll turn it back to Liza to introduce our speakers.

**LC:** Thank you so much Teresa. I'm pleased to introduce to you today five people who will share highlights from their NPHII efforts. We'll hear from all the speakers before we take questions. But as a



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reminder you may type in the questions anytime during the presentation and if there are any brief or burning questions that can be clarified very quickly after a presentation we may queue those up.

Our first presenter today is Jessie Baker of the Vermont Department of Health. Jessie was hired as Vermont's performance improvement manager in February of 2011. Before joining the health department Jessie did some performance management work for the City of Somerville, Massachusetts as well as program evaluation for the Massachusetts Society for the Prevention of Cruelty to Children. She has a bachelor's degree from Columbia University and a Master's degree in policy and planning from Tufts University. Jessie, welcome and take it away.

**Jessie Baker:** Great, thank you very much and thank you for having me. Good afternoon, my name is Jessie Baker and I'm PIM from Vermont. This afternoon I'm going to give you a very brief overview of our NPHII component I supported efforts in Vermont with a specific focus on our PHIT QI activity. Next slide please. So when I joined the health department upon consultation with leaders in the health department and an assessment of current performance management activities, we developed a performance management framework oriented around the components you see here on this slide.

We start with a population health status including both our strategic plans and our Healthy Vermonters 2020 identified priorities. By reviewing our health surveillance data and coming to agreement on our department wide priorities we then asked managers to identify, track and report on key performance measures for each population objective we are trying to influence. These performance measures tracked quarterly and to be reported on a public facing dashboard illustrates the department's activities to address population level change.

So once we know where we're going and how we're getting there we use our Public Health Stat process to manage for results. And I'll talk more about that process in the next few slides. From there we have our quality improvement activities oriented around a QI model promulgated by our Agency of Human Services. Using this model each division addresses system improvements identified by leadership. Population health objectives and performance measures are then incorporated into our performance based contracts and grants with our community partners and stakeholders as well as linked to staff performance evaluations.

Through this framework we insure that our efforts are aligned and our services are delivered effectively and efficiently. Next slide please. So Public Health Stat. Our Public Health Stat process is modeled after City Stat, a performance management practice implemented first in the New York City police department, then by the City of Baltimore and then the State of Maryland, Somerville, Massachusetts and other governmental entities. Through Public Health Stat we facilitate monthly cross divisional content these meetings with key decision makers.

At these meetings we review the data, the evidence base and priorities of a specific area and make recommendations about program planning and resource allocations. Next slide please. In advance of each monthly Public Health Stat meeting I meet with key programmatic staff to collect, review and



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analyze data. Through this review and discussion we identify recommendations for program improvements and resource allocations. At the first Public Health Stat meeting the panel which is made up of the Commissioner of Public Health, the Deputy Commissioners and the Division Directors review the data analysis and the recommendations of program stats.

Decisions are made in the room, tasks and next steps and responsible parties are identified at the meeting and then distributed to staff after the meeting. Between Public Health Stat meetings these tasks are tracked and regularly reviewed by me as the PIM, the Commissioner's office staff and program managers. Then at the second Public Health Stat meeting the panel reviews progress to date and decides on redirection as needed. This cycle then repeats as prioritized by the Commissioner and senior management. Additionally on this slide you'll see the year one priorities.

These priorities are in line with our strategic plan; they help us address key accreditation standards where we need to more fully flush out processes and our focus on issues where we're trying to "bend the curve" of a population measure. So a population measure we're not completely satisfied with our results on and wanted to make a difference. Next slide please. So what are the results of the Public Health Stat process we hope to achieve? One, we hope program planning and resource allocations decisions are made based on data with key stakeholder input and aligned to strategicals and performance measures.

We help a systematic processes provided to that recommendation and make quick decisions therefore saving staff time to pull together decision makers in an ad hoc manner. And third, we hope that all levels of managers are engaged in developing and owning solutions that are data driven with an eye towards achieving efficiencies. It's our belief that not only do we need to identify population objectives and performance measures and report out on our activities but we need a system in place to manage to this data. Public Health Stat is our effort to make data driven decisions and hold each other accountable.

Thank you and I'm happy to answer any questions you may have later on.

**LC:** Thank you so much Jessie. It's amazing the work you're doing in Vermont and I'm sure folks have been very impressed to see that and in such a short period of time. Our next speaker and of course we'll be able to answer questions at the end, so now we'll move on to hear our next speaker, Laura Holmes from the New Hampshire Department of Health and Human Services. Laura has been the PIM since February, 2011 and she's located in the Division of Public Health Services, Bureau of Public Health Systems, Policy and Performance.

She was previously the Healthy Communities coordinator and worked with the Environmental Public Health Tracking program from 2004 to 2010. Laura has a Master's in public administration, is a certified public manager and holds a bachelor of science in communications. Thanks Laura.

**Laura Holmes:** Hi, so today I'm going to talk a little bit about just our cultural - the cultural piece that we want to achieve. Colleen asked me to focus on that but I also wanted to talk about why kind of context



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of that, I think we all want to create a culture of quality improvement but it's not in a silo or in a vacuum and for us it's related to training and also the work we're doing around creating a supportive environment for learning and doing. So those are kind of the three highlights that I'll talk about today. Next slide please.

The first thing we did to kind of get an idea of what we wanted to do around training and which led to kind of the culture because we asked around the culture, how did you create a culture of quality improvement? We asked six Multi-Learning Collaborative states to talk to us about what they did for training and the successes and challenges they had. So I pulled out these kind of top highlights related to the concept of the cultural change and this building this culture of quality improvement. And the most important thing they said was engagement of leadership and training of leadership.

And within the engagement of leadership was the most critical part and the most tricky part. As you can see, you need to have it or you lose momentum, things will basically not be successful without that engagement and support. Some of the highlights were make them champions, some states said make them sponsors of projects to get them not to just to get the buy in you needed more than that, you needed their participation in some respects. Leadership has to make it a priority they kind of have to model this, walk the talk. If they do it then everybody else will follow.

Managers must respect the outcome of the process and not micromanage. The data will speak to what needs to be done and they need to respect that. They need to respect the process of quality improvement. Buy in, very important and it's the leadership that have to get the laggards involved some of the states said they 'voluntold' versus volunteer and we found that kind of is a cultural thing in itself and needs to be decided, you know, each state agency does it differently. One state suggested that the leadership be the ones that identified the strategic QI projects. So those high level QI projects because they found a lot of the success hinged on that.

If the right project wasn't selected and leadership didn't put the, you know, to allocate the time and the resources it wasn't successful. Training of leadership was a must. Make sure managers are trained and leaders are trained and they become champions. Start with those who are supportive. In some cases you might have to exclude those who aren't brought in from the beginning and work on them over time because you need to have success up front really quickly. Next slide.

We talked with the Public Health Foundation and we decided that a cultural assessment would be really important for us to do, to get a sense of what our leadership knows and understands around quality improvement. We also discussed at length who would be part of that, how do we define leadership, what level of management? We felt strongly with the work that we're doing with our public health improvement team, I'll talk about that a little bit later, that we want to hear from everybody. We also did a lot of work previously on a survey through the PHIT team, through our strategic planning initiative that identified training needs and also attitudes and beliefs.



It was anonymous so we don't have names with the answers so we want to go back and glean information from that, we want a survey program managers with these three simple questions. What went well in the QI work you're doing? What didn't and why? And we want to use information from those assessments to - and the cultural assessments that the Public Health Foundation does through this workshop. So we want this kind of pre-information to inform the workshop because we feel strongly that it's highly likely we're going to get different perceptions of what quality improvement is. How well we're doing, is there some of the components that you'll see in this list, is there trust, is there the ability to have constructive conflict, is there accountability? We're likely going to get different perspectives from senior management, middle management and program level management and program staff. So, some of the pieces that the public health foundation want to achieve through this assessment workshop, you can see them there.

Focus on how effective leaders build trust and commitment for change, understand the need for constructive conflict, develop reason for accountability, focus the entire agency on delivering results, understand the leadership traits that need to be addressed, understand the gaps that need to be closed to insure culture of quality, understand the inhibitors and identify next steps for developing an action plan. We're talking at length about this.

We don't want to just jump in. We want to do this right and I think it's - when you're dealing with people and perceptions and previous history and some successes and some failures it's kind of a tricky like they said at the MLC stage tricky, a little bit touchy. So we want to do this right and we've been talking a lot through the PHIT team and management team getting people ready so that's not a surprise, that it's not coming out of the blue. We'll talk about that. So the next slide please.

We have a little plan for our training that the cultural assessment and the cultural change we feel strongly that the training will really help move that along. We're also building a system like a lot of other states and that will also help push this along. So they're really, really integrated and I don't think you can separate them out. When we talked to the MLC states, basically they said these four things: You really need a kick-off event, you need to have everybody on board and excited and enthusiastic and really understand why we're doing this.

And we looked at what the MLC states said and we looked at our self and our own people, our own culture and what we've already done and we said, well we need leadership training to help support the QI teams and to really push it along, institutionalize it, we want to do a train the trainer program where we'll have as select staff learn how to do QI they will be learning how to teach other staff and work with them through their projects so that we have that capacity in house because currently we don't.

And component three, the basic training, we want everybody to get training and a basic understanding of the terminology and the methodology and the basic tools so that we can build these QI teams and move this work forward. And next slide, last slide. Our public health improvement team, I'm really proud of this group, they've come a long way and we've put them through a lot of iterations and evolutions of



what we want to do around quality improvement and they're just a great voice and they're a great feedback mechanism.

The purpose of this team to help establish a culture continues quality improvement within the division, they really are my team. I don't have staff, they're my staff and they're really going to help me move this initiative forward, develop a framework. So we kind of have three things that this group wants to achieve, develop a framework to assist the division in developing this support and empowerment around quality - continuous quality improvement. So communication, big, big, big component, really important. How do we talk up to management and say we want to do these good works, we need your blessing, we need your support.

Talk, you know, from management down to staff and the sideways from program to program, section to section, bureau to bureau, a lot of communication going on across - serve as a learning laboratory. This is really important. We want people to feel free to come to the PHIT team, to get some suggestions, some help, to bounce ideas off of. We're not going to hand hold them through the process of, you know, PDSA but we'll get them going, we'll keep them going and be there for them to work with in a completely supportive environment.

Develop a system to plan, document and check QI efforts. I think we heard that a lot from the MLC states, this is really important to have your - to document the work you're doing and make it available to everybody else. So we're going to put in a system to do that so that people can access the information. And develop a system to promote and communicate our efforts. I think public health is notorious for not tooting our own horn and not being our own PR agents and we need to do a better job of that. So, this team is dedicated and determined to really tell our story and keep everybody informed so we don't hear, well we didn't know that. That's going to end. So that's basically it in a nutshell.

**LC:** Thank you so much Laura. It's amazing to see what's going on in New Hampshire and how you're building on previous efforts. So moving along quickly so that we can make sure we do hear from all speakers. You're now going to be hearing from Joshua Czarda of the Virginia Department of Public Health.

Mr. Czarda is the performance improvement manager for Virginia and prior to joining the Virginia Department of Health Mr. Czarda served as the Director of Operations for Mid Atlantic Evercare and before that as Assistant Director for evaluation and quality at the United Network for Organ Sharing. Josh.

**Joshua Czarda:** Great, thanks. Much like all of you we really started from scratch building the foundation here. So, like Jessie and Laura, we started with a couple of different areas from sitting down with our commissioners, the deputies to establish a basic methodology, doing one on one assessments with all the directors for various offices just to see where they felt their gaps were, what we needed to work on.



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We then set up a performance improvement council that was comprised of the commissioner, deputy, some of our local health district directors, external private subject matter experts and some representatives from the CDC as well.

And then we developed teams to go out-cross agency teams- to go out and work on some of the initial performance improvement projects. And those specific projects are the ones I'm going to talk about today just as we go through. So four big projects that we did. We implemented a dashboard system so we can capture and show and work on those specific metrics and put them before our council on an ongoing basis so they can take some action on them. We identified some very significant potential of savings in our IT system which I'll talk about just momentarily. We streamlined something that's called a RAP process which is really a procurement process for us that had been driving everybody nuts. It takes about 20 days just to complete it but I'll go into that in just a minute.

And then we worked in our - to increase enrollment in our Plan First Medicaid family program which is, you know, we had classically very historically low enrollment and already just within six months we've increased it by 91%. So next slide. Okay, so here we - you see this big fancy radial. This is basically just a snapshot of what our agency looks like.

We're a centralized agency and so when we came in we really did an assessment with every one of these folks to try to get at, you know, what are the metrics we need to look at, what do we need to focus on and how do we pull it all together in a way that is intuitive, that a council could take a peek at it and be effective and efficient and all that good stuff.

One of the problems that we face, which probably everybody faces, that we have 119 different databases, some are internal, some are external, some are homegrown Access databases and absolutely none of them talk to each other. So for us to create a dashboard system, we bought an off the shelf product, it's very expensive, very expensive licensing but it takes a heck of a lot of programming and a dedicated programmer to make it work because they basically have to pull data from all these different databases to make it work.

As an interim staff as we started to identify metrics that are important and that's always an ongoing process we ended up setting up basically templates for our individual offices and then a centralized file. And we did all of this in Excel and it's kind of a supped up version of it.

But basically the centralized file goes out to the templates we set up for the office which they can manipulate and control as much as they want. They dump in the data and the centralized file pulls it all together into a dashboard system which puts the most critical metrics up front and allows you to drill down every which way from Sunday. So you can see the performance at a local health district level or at an office level or whatever you want and we're also using it to track all of our PIPs. Next slide.

Okay, so IT. In Virginia we have a unique situation where IT - all IT for every state agency is run through an institution called VITA, so basically they're a third party vendor. We rent all our computers and all the



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service from these folks and is extraordinarily expensive so in the last year alone our IT costs have gone up about 30%. This is identified in kind of these one on ones with the directors where they said this is really going to impact our capacity because the costs are just enormous.

Now as you can see we're spending about \$18.5 million a year just for our computers and printers and land lines and all that stuff. So this is a project we approach. We formed across agency team a different, you know, power business users if you will, and we looked at everything from how we control the inventory to begin with before we even purchase it to once we have it, how we're actually conducting oversight and looking at our utilization to kind of the more periodic annual audits of our inventory.

And as we went through this we found a number of areas where we could implement some measures to give us savings. So, in terms of how we go about buying IT there's some ways we could tighten it up and reduce some of the extreme purchases that we've seen. More importantly in our overall utilization we found at least a potential of \$1.5 million in savings just from better kind of control of the assets. We had a bunch of computers - we had more computers than we had people was one of the things to boil it down simply.

And in terms of how we stored data which gets a little bit technical, we have SANs and we have DASDs, those are kind of the same thing but we get charged different rates. So we figured out if we actually switched everything to a different type of server we could realize almost upwards of a million dollars just from that action. Now actually making those savings real takes a lot of follow up and that's what we're working on now but it's all been validated and we're pretty sure we can move forward with it. All right, next slide.

Okay, the procurement process I'm sure everybody has very unique and interesting procurement process. They're all probably fairly tedious. We have this extra step in Virginia for our procurement process where you actually have to go out and basically get permission from your - from all types of folks, your immediate director, your supervisor, the deputy director, all the way up to the commissioner and then your purchasing folks. If you can kind of click I think there's some arrows that come in here - great.

And what we noticed as we went through it is that the process was really non-standardized, we had a ton of redundancy where the commissioner herself even would sign off, basically permission to buy the same thing multiple times throughout the process. So, you know, there are a couple of instances and this is at a very high level overview where we had directors or we had deputy directors or we had the commissioner taking so much time that they're actually signing off on basically the same purchase four or five times which was really interesting to visualize for them.

And ultimately we calculated all their actions and it really cut the value of what they were doing in half just from the time and effort. We were calculating it took them about 80,000 bucks worth of effort to review \$150,000 of stuff that they potentially denied. So we went through this, we found all types of areas we can improve upon. One of the first things we did however was automate the process. This is all



a paper based process, right now it's averaging about 20 days to complete and we think we can cut it down to about ten. Next slide.

Okay, here our Plan First is a family planning program through Medicaid. In here, if you can click once again, we have all types of barriers from knowledge of the program itself to actually how the enrollment process works to how we work with department of social services to Medicaid services. So this has been an ongoing project. But interestingly enough just kicking the tires, getting a group of cross agency representatives together we've already bumped up the enrollment from 4,500 to about 8,000 enrollees. And our goal is to take it up to about 16,000 over the course of the next year.

And here we're taking all types of actions. So we've had a cross agency group, we're working with DMAS and DSS, we're finding the enrollment process, launching some education initiatives and really working on some of the data management so we can hold peoples feet to the fire. And that's it.

**LC:** Thank you so much Josh. I do hope everyone was ultimately able to see the slides. I'm actually quite in awe of your PowerPointing or someone's PowerPointing skills. It was a really fantastic visual way to see and understand some of the things you're trying to do in Virginia. If anyone out there wasn't able to see the full slides of course these will be posted and of course were sent yesterday. But we'll be making sure that they're up with no glitches when they do get posted.

Next we're going to move on and hear from Christine Abarca, the Performance and Improvement Manager for the Florida Department of Health. She started her public health career as a health educator in the Florida County Health Department and then moved to the state health department seven years ago to serve as the community health improvement manager in the Office of Health, Statistics and Assessment. Chris holds an MPH from the University of South Florida and is a master certified health education specialist. Welcome Chris.

**Christine Abarca:** Thank you Liza and I appreciate the opportunity to talk about our work here in Florida. And just wanted to mention that I do represent a large team of folks who are working on this particular project. For a bit of background information I'll mention that two of our major focus areas for the NPHII grants are first, state and local health improvement planning and secondly to create the performance management data system through which we'll monitor and report on the progress of our state health improvement planning. And both of these processes are supported by workforce development activities and public health policy and law analysis.

In envisioning and developing our performance management system we've used the Turning Point framework which you'll see a little bit later and I'm sure most of you will recognize. I'm going to talk a little bit about one aspect of our project and then some of the ups and downs that we've experienced along the way. Next slide please. Being a NPHII grantee in both component I and II has had its ups and downs. The up side has been that we've had an unprecedented opportunity here in Florida to bring together our existing pieces of performance management work that we do.



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For example, we have a very strong quality improvement department and resources. We have isolated data elements, perhaps not 100 plus as Joshua mentioned in Virginia, but we have many that don't talk to each other. And we have pockets throughout the department of measurement activity. But now we have the resources, the technical assistance and a plan to create a comprehensive system.

Another part of the up side is that we have the attention and support of leadership. And that leadership is even above and beyond the department of health. So much so has been the interest in performance management at the department of health that just this very week some colleagues and I have been working on crafting language for legislation to put state health improvement planning into statute in Florida.

I mentioned that legislation as I talk about the down side you could look at that as a good thing or a bad thing. We have garnered much attention around this work and we're doing it -as we say in Florida- in the sunshine with many eyes upon us which means, we get lots of input, good and bad, along the way. So, again it's an unprecedented opportunity to bridge and build and align very publically. And oh, did I mention, it does include lots of work, not necessarily a downside but all hands on deck is the M.O. here in Florida. Next slide please.

One of the target areas that we're working on besides in the upper left hand quadrant of the Turning Point framework and you'll recognize the Turning Point framework model that we've co-opted and populated with our Florida project. Included in our goal for performance standards is work around developing state and local goals and targets for improving health outcomes. In order to improve those goals and targets we'll need to monitor health indicators and regularly assess our capacity along the way.

In Florida, many of our county health departments, a matter of fact I think almost all of them have been using the Mobilizing for Action through Planning and Partnerships process for doing local health improvement activities. As part of our performance standards project the state health office will align our work towards state health improvement planning using a modified MAPP process. Among the assessments that not only our state health office but our local health office, our local county health departments will be engaging in are using the National Public Health Performance Standards to do capacity assessments.

We feel like we get a trifecta from using the National Public Health Performance Standards integrated into a MAPP process at state and local levels because the resulting data will get us closer to system improvement, we'll get closer to our community health improvement planning goals and it also helps with accreditation preparation for our local agencies that are looking towards becoming nationally accredited. Next slide please. Our strategy towards state and local health improvement projects has been to give many grants to our county health departments. We spent a majority of our funds that we received through the component II grant to help this work at the local level.



And we have a number of deliverables from which our local health departments were able to choose among them, of course were the results from their National Public Health Performance Standards assessment, some MAPP based products or some of them have been working on PACE EH. Other products are related to the accreditation prerequisites which we know are strategic plans, community health improvement plans and community health assessments. For our many grants we supply support for technical assistance and training along the way.

And as I mentioned this work will help us align the state and local health improvement activities, building capacity for our workforce across the multiple disciplines that are touched by community health improvement planning and then to reinforce the interrelationships of assessment processes, planning processes, quality improvement, accreditation preparations, strategic planning, all those processes that you may think you do in isolation but they definitely provide information for one another.

Among those interrelationships are teaching folks about using data to prioritize and make decisions whether it's in your work at your desk and program, whether it's across bureaus and offices or the entire state health department. And then also working towards creating that culture of quality improvement in a similar fashion and perhaps we can learn from New Hampshire where you're doing it so robustly. The next slide please. And I'll just leave you with some thoughts about the up and down side of what we've learned along the way in just that one small area.

On the downside it has been labor intensive and I won't lie, we've had some challenges with hiring folks but we've been able to recruit and very happily move forward according to our timeframe. So, although it's a downside it hasn't been a barrier. We've had some timing issues in that it's been recently an election year so we've had some changes in leadership at the highest level that does have impact for organization things here at the Department of Health.

Another challenge has been aligning the existing work and I'm sure you can appreciate that if you're in one of the bureaus or offices that have dedicated a lot of time to develop your data system, it's not always good news to hear that someone else is developing a different vision for you data system. So that can be a downside but it's just relationship building and we look forward to incorporating everyone in the department of health along the way.

And lastly on the downside just-in-time training may not be the most optimal way. I think we've had to do quite a bit on the fly and we haven't had the opportunity to be as proactive as we'd like to be but that will come next year in our and in our next work plan that we do. And on the upside of course, for the first time ever we've had money to invest in local projects. This has been a learning and sharing opportunity and we've built capacity along the way. And lastly we are beginning to see evidence already of our progress towards improvement and we look forward to sharing that with our PIM Network and others in the future. Thank you Liza.

**LC:** And thank you Chris. That was great although with all those up and downsides I feel like I'm a little bit on a seesaw now.



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**CA:** Welcome to Florida.

**LC:** So we are going to wrap up now with our last speaker but before I introduce Bernita Frazier I want to remind folks that we will have just a little bit of time at the end for questions. Please post them via LiveMeeting so that we can queue up those questions and of course anything that doesn't end up getting answered we'll make sure it gets answered subsequent to the call. So finally, we'll now hear from Bernita or Bee Frazier from the Georgia Department of Community Health. Bee is the Performance Improvement Manager in Georgia and has over 15 years of experience in quality improvement in private, public, nonprofit and academic arenas. Welcome Bee.

**Bernita Frazier:** Good afternoon everyone and greetings from Hotlanta. Next slide please. What I wanted to start with you all today in getting the Office of Performance and Improvement up and running, one of the things that my staff and I sat down and did was come up with a vision statement. How did we see ourselves existing within the department of public health? So our vision statement piggy backs off of the vision statement of the Georgia department of public health.

And so our vision for the office of performance improvement was that all departments of public health entities will consistently participate in continuous quality improvement initiatives that drive performance and help create a safe and healthy Georgia for all citizens where they live, work and play. This was important to us as we started to - we wanted to build a culture of quality and performance improvement.

Some of the earlier presenters talked about the importance of building a culture and building a buy in for quality and performance improvement and we felt that when we all came on board there had been several quality and performance improvement initiatives but they were short lived. They were six months or three months. Things like rapid process improvement, lead measures and they were just put upon to people as we had quotes from feedback that things were thrown at them and they didn't really understand the foundational information or the foundational value of quality and performance improvement.

So we started out with a vision statement as to how we see ourselves contributing to improving public health. Next slide please. And then after, you know, we went through this whole process because we're all about quality and performance improvement, we came up with our mission. What is the mission of the office of performance improvement? And we wanted to create an infrastructure that enables sustainable continuous quality improvement and performance management capacity or capabilities around DPH. And we wanted to do this by creating learning organizations.

And learning organizations was a term that really wasn't used around the department of public health. So we started using learning organizations and I came on in February and now we're just getting people to start talking about learning organizations and understanding what a learning organization is and the impact that a learning organization can have on our ability to deliver our services. So, we wanted the



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learning organizations - the knowledge of best practices to drive optimal decision making and effective and efficient outcomes.

As you see the vision, mission, all of these things we were trying to - we are, not were, we're currently in the process of trying to bring all of these things together. Next slide, thank you.

So, how do we go about doing it? One of the first things that we try to do in building a culture around quality performance improvement is for us to collaborate with offices, sections, programs and districts to encourage quality improvement practices. And how we did that was my quality improvement consultants, my performance - I'm sorry, public health informatics specialist and myself, we basically knocked on doors and we said hey, this is who we are, these are the services that we offer, what are you interested in? What do you need?

So we did kind of an ad hoc needs assessment trying to figure out where people were, you know, did they understand quality and performance improvement, were they even interested in quality and performance improvement activities? And if they were where did they want to go, where did they see themselves going? The next thing that we are doing - are in the process of doing is providing QI PI training and technical assistance services. And I'll talk a little bit about those in a couple of minutes. Next slide please.

So, some major activities. I mentioned that we wanted to do needs assessment - quality and performance needs assessment. And we did a rudimentary where we knocked on doors and we just asked them, it was qualitative piece, what do you need, where are you on quality, do you even understand quality? And the feedback that we received is people have ideas of quality but there was not one definition of what quality and performance improvement was. Quality seemed to be very specific to what they were doing or particular projects they were working on.

So, we recognized that there was a need a common nomenclature around what is quality, what is performance improvement. So after we did the qualitative piece where we actually knocked on doors and talked to them, we came up with just a basic survey and we sent it out to all programs. And we had about a 70% return rate on the survey. We asked them to give us a little bit of information about what they were doing around quality. Once again we asked them because we wanted to validate our findings on understanding the terminology of quality and what quality is to them.

So we did that survey and we found out that it validated our findings from our qualitative piece where we had knocked on doors that there was a need for some common understanding around what is quality, what is quality and performance improvement, what does it mean for department of public health, what does it mean for our programs? And we also found that they were really interested in building their capacity for quality and performance improvement.

So the biggest thing that we have done is we have established what we call a QI PI Network, quality improvement, performance improvement network and it's a forum of experts and we identified from



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our survey that we did and from our qualitative piece where we did interviews, we identified people in different programs who had some background or particular expertise with quality whether it was HIV/AIDS, whether it was epidemiology, whether it was maternal and child health, we asked them to come together and let's start talking about quality and performance improvement.

I didn't hear anyone mention the fact that there were lots of silos operating within the division of public health. There's not a lot of dialogue - at least from our department of public health where programs are talking to each other and sharing lessons learned and best practices.

So we conceptualized if we brought a forum of experts together where they could talk and share lessons learned and best practices around quality and performance improvement that it would be a way to break down those silos' information and it would also go towards building that culture of quality because it would help with understanding what quality is, where you go with quality and performance improvement and that type of thing.

So, I'm proud to say that today was our second biggest meeting of our quality and performance improvement network. We had about 13 participants. We've had as many as 20 participants. We're still trying to get that number up but we're bringing through the QI PI network, we have them to identify issues that impact their programs ability to deliver goods and services. And when they bring it to us we try to bring them training or other information to help them to get over those humps.

The next thing that we are doing is we're offering training and technical assistance. We have come up with a training curriculum, we've come up with a QI PI glossary and the glossary is just - it was a meta-analysis of several tools that were out there around several tools that were glossaries. And we put together common terms around quality and performance improvement so that we could get people talking the same language.

The next thing that we have been participating in is we're actually helping programs design logic models, we're helping them to design SMART goals and objectives, we're working with them to create action plans around those logic models, understanding performance indicators and measures, we're helping them with their data collection analysis. And one of the quality improvement methodologies that they are interested in is plan, do, check or study act. And we will be offering that as a part of our TA curriculum. So we're really excited here in Georgia because we're putting together a formal curriculum around quality and performance improvement and we are also working with the QI PI network to have open discussions about quality and performance improvement. Someone earlier had mentioned the role of leadership and we have had a hard time getting leadership buy in from the top down.

So we're now, we're a new department, we have new leadership and it seems that we're getting more buy in these past few weeks that we've become a department. So, hopefully we will be able to continue to express our added value or what value we bring to the department of public health and the services that we can provide to programs to help them be more efficient and effective.



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But we definitely know and we recognize that there's a need for leadership buy in, it has to come from a top down approach but we also are building from the bottoms up by looking at our QI PI network and building from the program.

So hopefully we'll meet in the middle and we will see more as we go about. But our first six months has really been about building a culture and building an infrastructure to even support quality and performance improvement efforts. Thank you.

**TD:** Thanks Bee, that was really great and I'm in awe of how quickly you can speak being from Atlanta. That's really impressive.

**BF:** Did I speak too fast? I'm sorry.

**TD:** No, you did great, thank you so much. We have about five minutes for questions so I do want to go directly to questions after thanking each of you for your presentations. I think one thing that really stood out for me as each of you spoke is how consistent you've been in applying your work across the agency and making sure that there's a systematic approach and there are benefits to the agency as well as the system.

And then the other thing that I really noticed too is that you've each had to face keeping the work going, keeping the momentum going in the face of reorganization and political changes and some challenges. So I think there are a lot of opportunities to learn from that.

For our first question, Laura, I want to turn to you. There's a question from Kim McCoy in Minnesota about the three tier training approach that you described. Kim is interested in trying something similar in Minnesota and is wondering if you have a training plan or curriculum that you could describe or share?

**LH:** What we are planning on doing is we have a plan but it's very general. It's a little bit more detailed than this and I can share that. But I - we didn't - what we discovered is we didn't want - we're doing this in a contract so we're going to put out an RFP and contract the training to come here. So I didn't want to be too descriptive. I wanted to see what kind of proposals I'll get back.

We have minimum requirements so we definitely want everybody to know the seven basic tools, we want everybody to know the terminology like Georgia said, it there's a lot of language that needs to be developed around QI, PI and PM and da ta da, so we haven't done it yet. We're putting together the scope of services now but we really put in a lot of thought around what we want to have and we really felt it was important that everybody get the basic that we have the train the trainer approach so that we build in capacity.

Here we don't have separate staff trainers. And that leadership gets training because we really heard it loud and clear from the MLC states is that's the critical piece. Because the bottom really wants to do this



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work, there's no doubt about that, they're raring to go and really excited to get going but, you know, there's a lot of, you know, we need a lot of buy in and support and participation by leadership.

**LC:** Thank you, thank you Laura for making that point and for being willing to share. We'll look forward to doing that on phConnect.

**LH:** You're welcome.

**LC:** We're going to do one more question at this point and as we mentioned earlier we'll document the additional questions we have and get responses to those from our speakers posted. So the final question for today, Chris actually it's going to go to you and it's from Laverne Snow in Utah. She's noting that Florida is a centralized state in terms of the way public health is organized so there may be some overlap in health improvement planning efforts between state and local.

So do you have any recommendations for a process of coordinating community engagement and communication around health improvement planning so as, and I'm going to quote Laverne so as not to create friction with local health officials and local communities?

**CA:** Well thank you Laverne for that question. As I alluded to in the presentation we've been using MAPP, the NACCHO framework for about the past seven years in a more or less coordinated systematic way and encouraging our local folks to follow that model. And in my observation by following those steps in each of our - because we're centralized we do them in counties, each process - I haven't seen a lot of those kinds of problems crop up.

There are things to consider in that there are regional assets so you'll have three or four counties that will perhaps have the same area health education network or work at the same universities and they have to coordinate in a certain way there. But I really, I think trusting the process and by following the steps it tends to work itself out. And I may have missed the mark in interpreting the question.

**LC:** Hi Chris, this is Liza, I think also perhaps there will be something to learn as you move forward with how the community health improvement plans end up synergizing with the work you're doing at the state level. So perhaps there's probably more there for the future to be sharing once you get to some upcoming points in the processes.

**CA:** And you're right Liza, the piece that has been missing recently has been the state health improvement plan so there really hasn't been anything for the locals to align to.

**LC:** Right. Well I want to thank again, Bee, Chris, Josh, Laura and Jessie, all of you and all of the performance improvement managers and others on today's call for participating. Before we leave today we have one more poll and just a few quick announcements. First the poll, the question is how would you rate this webinar overall. Sorry, and now hopefully you all see the poll. So the poll's open and cast your vote. And while you're all doing that let me mention if you'd like to give us additional feedback on this call or suggest topics for future calls please email us at [pimnetwork@cdc.gov](mailto:pimnetwork@cdc.gov).



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We also of course hope you'll plan to join us on August 25 for our next call where we plan on sharing information from the baseline assessment about NPHII grantees, so it's that baseline evaluation that you all responded to. We're also as part of that going to be sharing some ideas, resources and more information about workforce development and continuing education. On the subsequent call on September 22, we'll hear from Kaye Bender of Public Health Accreditation Board and you'll have an opportunity to ask her questions about the launch of accreditation which will have just occurred at that time.

Don't forget that you'll be able to view and download all calls from the PIM network web conference call series over at the OSTLTS Web site and the phConnect virtual community. Thanks again to everyone for participating and have a good evening. Bye, bye.

**Jody:** Thank you, this concludes today's conference. You may disconnect at this time.



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