

Quality in Public Health

CDC Performance Improvement Managers Network Call

February 23, 2012

Today's Presenters: Peggy Honoré and Amishi Shah, Public Health System, Finance & Quality Program, Office of Healthcare Quality, U.S. Department of Health and Human Services
Greg Randolph, North Carolina Center for Public Health Quality & UNC-Chapel Hill
Lisa Harrison, North Carolina Center for Public Health & North Carolina Division of Public Health

Moderator: Teresa Daub, CDC/OSTLTS

Operator: Welcome and thank you for standing by. Today's conference all lines will be open and interactive. To eliminate background noise if you could please use your mute feature when not speaking. If you do not have a mute feature you may press star 6 to mute and un-mute your lines. Today's conference is being recorded; if you have any objections you may disconnect at this time. I would like to turn the call over your first speaker Ms. Teresa Daub. Ma'am you may begin.

Teresa Daub: Thank you, and welcome everyone to the January Performance Improvement Managers Network Call – I'm sorry – the February Performance Improvement Managers Network Call. I'm Teresa Daub with the Office for State, Tribal, Local and Territorial Support, I'm joined here today by my colleagues from OSTLTS, including Liza Corso, whose voice just isn't quite up to the task of being on the line with us, but she is here. We are delighted that you all could join us as well for today's call. This is our second call of the year, and our monthly webinar series, Performance Improvement Managers from throughout the country. The PIM Network is our forum intended to support all performance improvement managers in learning from each other as well as from partners and experts in the field. 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.

On today's call, we are looking forward to hearing from Peggy Honoré and Amishi Shah of the U.S. Department of Health and Human Services about the work that they've been doing to promote quality in public health. Joining Dr. Honoré and Amishi will be Dr. Greg Randolph and Lisa Harrison of North



Carolina, both of whom will discuss how they have used this quality work in the state of North Carolina and through their NPHII activities. But before we introduce our speakers I want to review the technological features of today's call. For those of you who are not able to access the web portion of the call, you may refer to the slides that were emailed to you yesterday. For those of you on the Live Meeting site, you will see the slides on your screen. These slides can also be downloaded via the icon on the top right of your screen – this is the icon that looks like three sheets of paper. If you are on the web, you will also be able to see the other sites participating in the call by looking under the attendee's link at the top left of your screen. There will be two ways for us to take your questions today. First, you may type in your questions and comments at any time by using the Q & A box and by clicking on the Q & A in the toolbar at the top of your screen. Second, we will open the lines for discussion after our presenters have finished. So please mute your line now. You can do so by using your mute button or pressing star six on your phone's keypad. That will help us be prepared for when the lines go live after the presentations. Please note that we will announce the identity of those submitting questions via the Q & A feature on Live Meeting, so if you want your question to be anonymous, please type 'anon' either before or after your question. Today's call will last approximately one hour, and as you heard from our operator it is being recorded so that the full presentation can be archived on the OSTLTS PIM Network web page. We have a few polls on today's call beginning with our first poll right now. So our first question will give us some idea of who's participating on the call today. Please indicate your affiliation by responding to the poll.

All right, we'll move now to our second poll. And this question will give us some idea of how many people are on the line today and we'd like to know how many people are in the room with you. Okay. Again, thank you for responding to the polls. We will have a couple of more at the end of the call so we can gather your thoughts about the call today.

So I would now like to introduce our speakers, beginning with Dr. Peggy Honoré, Director of the Public Health System Finance and Quality Program in the Office of Health Care Quality, Office of the Assistant Secretary for Health, and Amishi Shah of the same office. Dr. Honoré is leading national efforts to develop fundamental concepts for quality in the public health system, develop the field of public health finance, and promote public health systems research. Ms. Shah works as a policy analyst and is the lead person in the program. She promotes the implementation of the concept into the practice of public health. An emerging priority for her is to also identify quality measures aligned with the public health quality concept. So we'll hear from Dr. Honoré and Ms. Shah first, and they will be followed by Dr. Greg Randolph and Lisa Harrison of North Carolina. Dr. Randolph is the Director of the North Carolina Center for Public Health Quality and is an Associate Professor of Pediatrics and Adjunct Associate Professor of Public Health at UNC Chapel Hill. He has 15 years of experience in quality improvement, including leadership, implementation, and research. He has also advised the New York City Department of Health on its QI initiatives, and the RAND Corporation with planning for the Pandemic Influenza Learning Collaborative.



Lisa Macon Harrison of the North Carolina Center for Public Health Quality and the North Carolina Division of Public Health has worked at the intersection of public health research and practice since 1995, directing projects in workforce development, public health leadership, management and administration, epidemiology, preparedness, and health promotion and disease prevention. Mrs. Harrison now serves as the senior program director for performance improvement at the North Carolina Division of Public Health, where she has a formal role leading a CDC grant for performance improvement, as do many of you on the line today. So I will now turn it over to you, Peggy. Thanks to all of our speakers for joining us today.

Peggy Honoré: And thank you so much for inviting us here today. I want to start by just giving a brief history on how this work evolved, and it actually started in 2008 when the Office of the Assistant Secretary for Health was asked by the Office of the Secretary to begin working on quality as a macro level concept in public health. And the reasons for this were primarily gaps that were identified in national guidelines for public health quality. When the Institute of Medicine developed Crossing the Quality Chasm in 2001, it was a very good report for outlining characteristics or aims for quality in health care, and they acknowledged the important role of public health but they didn't address issues of quality in public health at the time. That 2001 IOM work was actually driven by a 1998 Commission – President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. In 1998 they said that all sectors of health needed to have aims, they needed to have priority areas, they needed to have definitions, and they also needed to share common goals. And that's why in 2008 the Public Health Quality Forum at HHS was convened to begin to address quality as a macro level concept for public health. What was developed in 2008, if you'll go to the next slide, was the consensus statement on quality in the public health system and there's a link there where you can access that. The purpose of the consensus statement was to provide principles to enhance and guide quality improvement goals of existing and future programs that promote quality. And notice I said to enhance and guide quality improvement and not to replace but actually to complement existing quality improvement efforts. It was also to articulate a commitment to providing leadership at the HHS level. In steering a course of action where quality management systems are routine and woven into all components of the public health system and we stress quality management *systems* because that not only includes quality improvement, but it includes quality assessment and quality assurance as well. One of the first things that we did in the forum was to provide a definition of public health quality. There was no definition of public health quality prior to that. So that's what we did in 2008. The definition was framed, somewhat by the Institute of Medicine definition of health care quality, but it was tailored specifically for public health. Later in 2010, and Amishi will talk more about what happened in 2010, but Dr. Howard Koh, the Assistant Secretary for Health under the Obama administration, went a step further and actually provided a vision statement for quality in public health. If we could go to the next slide please. Oh, I'm sorry. One more slide. Okay. One of the important things that emerged from the work of the forum was to identify characteristics of quality in the public health system. And this concept of characteristics actually comes straight from the International Organization of Standards and how it



defines quality. So what exactly do we mean by quality? How do we know when something does have quality? They define it as a set of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs. So to break this down into very easy to illustrate examples, for instance, how do you know when you have quality drinking water? Well, there's characteristics of quality drinking water – its color, taste, and smell. So if you have those three things, then you know that you have quality drinking water. I'll skip over software and go directly to the six characteristics of patient care. And this is what the Institute of Medicine identified for the characteristics of good patient care – safe, timely, efficient, patient-centered, equitable, and effective. So if we could go to the next slide, we did a comparable thing in identifying aims or characteristics of quality in public health. So what this framework shows is exactly the process that we went through in order to identify the nine aims for quality in public health. and we started out if you look on the left side of the slide you see it says "The Role of Public Health Described As," "The Definitions of Public Health," "The Public Health Vision," "The 3 Core Functions," "The 10 Essential Services," and also the operational definition of a local public health. So that's where we started. We said this is what public health is attempting to do. We're attempting to fulfill this definition. These three core functions. These ten essential services. So knowing that, the question is what optimal improvement in population health is the ultimate goal. What characteristics describe the fundamental tactics to fulfilling the role of public health and then also the expected outcome. And that's where we came up with the nine aims, or characteristics, and they are population-centered, equitable, proactive, health-promoting, risk-reducing, vigilant, transparent, effective, and efficient. For purposes of time limitations, we didn't include the definitions of each of those in the slides, but you can go to the links that we've provided on both sets of slides and you can get the definitions of those. So what those nine things are saying is the public health system should have these characteristics, and when these characteristics are present in the public health system, then we know that we have quality in the system. It doesn't replace processes that you may go through to improve quality, or improve quality in specific processes within the agency; it doesn't replace that at all. These are macro level characteristics, and I'll walk through a slide a little bit later to kind of demonstrate this to you, and Amishi will also. And if we can go to the next slide, we show here a macro level framework to assure characteristics of quality in the public health system. As you can see at the top of the diagram, you can see Public Health Aims for Improvement of Quality and that's where the nine characteristics would be so they serve kind of like as an umbrella overarching the entire system. And then below that you have all of the activity going on within the system at the goal setting stage, at the practice level, at the research level, and at the performance level. So a lot of or most of the quality improvement activities that most people are most familiar with will be going on at those lower levels, but at the umbrella or the macro level would be the characteristics in the system. Can we go to the next slide, please.

What we show here is just a very early pilot that we did to test whether or not a state Office of Minority Health, whether or not they conformed to the nine aims and the activities that are done within that office. Now we looked at this from a global perspective of the entire office. You could in fact do this within specific programs within an office, obviously, but this was one of the early pilots that we did, so we did a series of interviews with people in the office, primarily the Medical Director, to determine, do



they in fact do population-centered activities? And yes, in fact most of their programs were population-centered. Could they demonstrate that they were equitable, defined as moving toward health equity, and yes, they were targeting vulnerable populations, doing cultural competency training, and those kind of things. Could they demonstrate that they were being proactive in some respects? Yes, they could. Health promoting, risk reducing. When it came to vigilant, transparent, and effective and efficient, quality gaps were identified. And basically a lot of this was due to the lack of available statewide data broken down in appropriate minority, ethnic, and rural populations. So they were not able to be transparent because of the lack of data. They also had no established processes to measure effectiveness and efficiency as well. So it was really a tool for them to identify where some quality gaps did exist. And I will turn it over to Amishi now who will talk about the priority areas.

Amishi Shah: Thank you, Peggy. As you see on the next slide that Peggy initially mentioned the framework that was done to create the aims. This is a slide to show how the priority areas were treated. Now priority areas were identified as areas of great need and priority where public health should improve quality to help facilitate better population health outcomes. They also advance quality and achieve health outcomes. On the extreme left are the Four Functions of Public Health which is Assessment, Policy Development, Assurance, and Systems, and in the middle is the criteria which were used to select the priority areas. Impact is the extent to which the changes could result in improvement and how the results are documented. Improvability is how it could document the possibility of change in a given area. And practice variability helps identify gaps and also if they're going to need non-standardized processes that are being used that influence impacts and improvements to be examined. The priority areas are population health metrics and information technology; evidence-based practices, research, and evaluation; systems thinking; sustainability and stewardship; policy; and workforce and education. They all are quite critical and work is being done on them; in fact, a recent paper was published in *Health Care Management Science* on systems thinking, and it highlights how it is an emerging area that is in need for how it can help the public health system, so they are critical, and work is being done on them. We can go to the next slide. This is how, it shows, it's a diagram to show how population health improvements can be achieved through the priority areas which are also known as primary drivers, and then our secondary drivers where the public health quality characteristics can be seen as secondary drivers as they help the priority areas. I will explain that in detail in the next slide. Can we go on the next slide? This is where it reaches closer home. Based on what we studied about the PIM Network managers, Reduction in Tobacco Use and Healthy Weight was one of the things that is being worked on, so we have given some examples of how there are certain steps like population-centered, proactive, health-promoting, and risk-reducing and vigilant – steps that can be taken in order to reduce tobacco use, like conducting social marketing and PSA campaigns. If you increase the excise tax, that is also a policy that can be implemented. This also shows that it helps identify gaps that if one year all of these are being considered, then maybe the next time around you want to achieve quality say by being efficient, vigilant, having effectiveness. So this is what we're trying to show, if you can go on the next slide. And similarly this is for maintaining healthy weight because we also saw that obesity prevention was a big thing, and there are similar things of how the quality characteristics can be used to improve



healthy weight in the people. So this is what we were trying to say. I am going to give it on to Greg and Lisa from here.

Greg Randolph: Thanks Amishi and Peggy. This is Greg Randolph and it's a pleasure to be able to share with you all some of the ways that we're applying some of these concepts and frameworks that you've heard here in North Carolina. So let's go to the next slide. And just to tell you a little bit about our Center here, the Center for Public Health Quality, our mission and vision is really all about helping our local health departments as well as our state vision of public health really embed the culture and infrastructure for continuous quality improvement so that we can be continuously improving every day in our work, but the ultimate outcome that we're really looking for is that this work contributes to the best possible health for our populations. And that's kind of the segue into what we're talking about today. Let's go to the next slide. And I wanted to say a few words about the nine quality aims, the foundational work that Peggy and many others have done under her leadership. First of all, I am at heart a practitioner, but I do recognize and I've learned over the years it's really important for practice to be guided by theory. So I look at the nine quality aims as a really great framework or theoretical framework to guide our practice. Some people will call this your true north. But as you look at the quality aims as Peggy so well described them, they're really characteristics of what quality in public health is. It's really hard to argue that there's something missing there; I think it's very comprehensive. And in our thinking about the work we do in trying to improve quality and improve health outcomes, that framework, I think, would be a really good way to help us think broadly and think more inclusively when we're planning projects and things like that. And we've also found it to be very helpful to use as a checklist with our work and sometimes at kind of at the micro level when we're working with teams and projects they're doing, a lot of times as a coach you can use these aims to really help teams select the projects. In other words, asking those questions – are their projects affecting one of these nine aims – they should be affecting at least one, probably, to really be making a difference. Sometimes it may be that if you're choosing between projects – one that's going to go deeper into one of those areas or maybe one that's going to cover multiple areas at the same time but more broadly, that can be a checklist that sort of says this project looks like it's going to have more of an outcome or impact than another. We've also found, and I think this might be helpful for the PIMs on the call today, we've found it helpful to look at our work, our portfolio of work here in North Carolina. We've been at this now for, we're about to enter our third year of work. In the beginning, probably like a lot of you, we were just happy to get anyone to do quality improvement, and give it a try. So we've been very flexible and accommodating in trying to get people to try quality improvement projects and methods and tools and things like that. And so we've sort of let our groups that we work with – our health departments, our programs – select the areas that they work on, but we really started to look at as the demand has increased for our work, we're really now looking at how can we have the most impact with our work. And I think that's where these quality aims can be a really good way to kind of look at the portfolio of work that you're supporting as a PIM in your state or city or territory, and are we hitting a lot of these, a lot of these aims. I look at as a nice way to do that is – what we've found, and probably what some of you may find is, really we were hitting a lot of projects dealing with efficiency, and given the times we're in, that's quite appropriate. But we did see some gaps that, some areas we felt like we wanted to encourage more work in, for example, more



population health-focused projects. A lot of our additional projects were focused more on clinical settings, for example. And projects that are more along the lines of health promotion and also dealing with equity issues. So we made, by looking at our portfolio and kind of using these aims as a checklist, we've sort of prioritized our work going forward on trying to promote some of those areas that we were not addressing in our early work. Let's go to the next slide. And then I just want to say a few words about the priority areas. Our work thus far, probably like many of you, has included a number of the priority areas – public health, population health metrics, promoting systems thinking, evidence-based practice, sustainability – but none compares to these that we've found in terms of building our workforce capacity to do quality improvement. So that's them and I'm sort of copying from the Institute of Medicine. When they did their initial report on Quality in Health Care, they talked about it not being just a gap, but a chasm, and I sort of feel that's the way it is with our workforce right now. There's just a huge need to help our workforce develop the capacity to do quality improvement, and that's been a big focus of our work in our first years, and I think it's going to continue to be. So we've used experiential training to do that, and I've included a link here for those of you who have not had a chance to look at the quality improvement journals, at the journal *Public Health Management Practice*, just released at the beginning of this year. But some of our programs are described in there, so if you want to look at a little more detail, you can go to that link and look at that issue; regardless, I would really take a look at that issue, there are some really good articles and papers in there on a variety of topics about quality improvement, including an article by Peggy, who's on the call today with us. She did an editorial. But anyway, I'm sort of doing the boring part. I'm going to turn it over to Lisa now, who gets to talk in more detail about some of our programs, and I think you'll find that quite interesting.

Lisa Harrison: The next slide, please. What are we doing here in North Carolina, specifically? In addition to the training that Greg was just talking about with our workforce and addressing that priority, we do have a number of other projects going on. So, continue to the next slide. We have something we call QI 101, and we have that both at the local health department level and also at our Division of Public Health level. We're getting ready to begin a new task force with our North Carolina Institute of Medicine to make sure that we're paying attention not only to what evidence-based strategies exist to help us move forward with measuring our health outcomes in North Carolina, but that we also know how to implement them, and that we work with the practitioners at the local level to tell us what else they need for us to help implement evidence-based strategies. So that actually gets started next week. We're working on a dashboard for state and local public health, just like many of you are. I've seen a lot of conversation on the PIM Network about different tools that you all are using for dashboards, and we're trying to work on that here as well with our local health departments, our communities, and our own Center. We're trying to practice what we preach here and come up with our own dashboard for the work that we're doing internally. We're doing a project called Retooling the Business Office, because a lot of those levels of efficiency and effectiveness that many of us run up against at the state level or the local level deal with things like contracts, with things like budgets and reviewing things that are administrative in nature, so we're trying to address that. We're also doing some strategic planning and are already involved in preparation for PHAB accreditation to make sure we are looking at all of that readiness. And our components here in North Carolina, we have birth and death certificate automation



taking place and also working on an online system with data to do something called HealthStat. It's similar to the IBIS system, a lot of states are looking at or using to make sure we can share data on our North Carolina 2020 Objectives across the state, and we also have something called an aligning and streamlining partnership between states – State Department of Health programs and our local health departments working together with our local health directors and having a lot of good progress made on local accreditation, how we can help align and streamline some of the work that goes on. In addition we have a lot of agreement addenda and we have administrative data that we collect between the state health department and local health departments, and different programs may collect a lot of the same data. So we're trying to work together with nurse consultants across our state and other programs that collect data that are similar to streamline that and align it. That's where that name comes from. So that's more of a practical, hands-on, making small changes that are dictated by our local health directors that are most helpful to them. Next slide.

So we're going to focus just for a second on the DPH QI 101 Program in particular, the thing that we're doing for our workforce. We try to use QI methods in schools and so with the groups – the QI teams – that go through our training, a way to incorporate those QI tools in their daily activities. So we use coaching with each of our quality improvement teams that come through the training to make sure that they have assistance in addition to helping provide examples and opportunities to hear about how to use QI tools and methods. We also help them develop a plan and a project that over time they can practice the way to do business and the culture that they become more quality improvement oriented. And then the two main methods that we apply throughout our program, both at the local level and here at the state, are Lean and the Model for Improvement so that we can best connect to our health care world who really most often use those two models as well. Next.

So this is just an overview of our program timeline on what our quality improvement program looks like at the Division of Public Health level. We have a six month program that has this information we share, a kickoff meeting that introduces them more to the concepts and the QI methods we try to train in. We offer them pre-work sessions and help guide them on making aim statements, charters, and doing stakeholder analysis, those sorts of things. We also make sure they have action period opportunities and coaching opportunities, face-to-face when we're with them, and we have different workshops, too, so that they have more intense times to work together as a team on their projects. So I'm going to share with you on the next slide one example, and it's interesting, it certainly follows one of Peggy and Amishi's example on tobacco prevention and control. One of the teams that we had in our training group last year was the North Carolina Tobacco Prevention and Control Branch. This is a picture of their team here. They're called the Five A's. And the Five A's are an evidence-based strategy for tobacco prevention that stand for ask, advise, assess, assist, and arrange, so that folks who are in the clinic trying to help other people stop are advised to do the Five A's. So their project aim for this particular team was to make sure that in one clinic, a clinic that had a high Medicaid population and a high non-insured population, had access to clinicians who were always prompting their patients to use the five major components of this tobacco cessation intervention. So they found a provider and wanted to work with them to do a Kaizen event or a rapid improvement event to figure out the best way to incorporate the



five A's in the clinic setting. So just briefly I can share with you some of the results of this team. They had a good return on investment from their efforts. And next slide. They had some clinic benefits by proving that they could save time. It was approximately five minutes per clinician saved time by establishing a standard process protocol in their system. They were able to increase clinic staff knowledge of tobacco cessation – why it's important and what they should do about it. They increased the number of patients referred to a quit line via fax referral to about 60 per year. They are projected to increase their clinic Medicaid revenue by over 15,000 dollars because of the embedded tobacco electronic health records that they improved. They made a template to document the counseling across their clinic. So you can see there are some of the savings that are projected and that for every dollar invested in QI this particular clinic and projected community savings received in return about fifteen dollars. So fifteen times return on investment on their dollars spent.

Greg Randolph: Lisa, I was just going to add, this is Greg. A lot of that savings came from a variety of places, but a lot of it came from the increased referral to the QuitLine, which is another safe approach to helping folks quit. In North Carolina we know that about 38 to 33 percent of our referrals end up actually successfully quitting smoking, and so a lot of those cost savings they had were generated from their QuitLine.

Lisa Harrison: And in South Carolina – I remember from our PIM Network meeting last year that South Carolina had some really impressive results on this too. So kudos for that example for us. So one of the things we also try to focus in on in this training is the return on investment calculation, and we have a Lean trainer on staff, contracted with our group to help our teams calculate return on investment. Next slide. The baseline of that particular example and that team's success in their intervention and making sure that the electronic health record in that clinic had a prompt for clinicians to do this evidence-based practice of Five A's. What aims do you all think were characteristics of quality that that team incorporated? You can think about that for a minute and I just have them up here, I think we'll have an official poll on the next slide, if I'm right. There we go. So please select the quality aim that was most impacted by the North Carolina Tobacco Branch Project. All right. Thank you. So it looks like we had a lot of health promotion, a lot of risk reducing, still having some votes come in – efficient, worked on populations, tried to make things a little bit more effective, a little bit – I'm seeing three percent in proactive. There goes some more efficient. Uh-oh – went down again. Excellent. While I'm – and you just got the two slide overview. So you definitely got the most concise overview of what that project was about and what was involved in their rapid cycle improvement, too. I do think that they've provided a really good example for other electronic health record users of that particular kind because they worked very hard to incorporate this prompt in that electronic health record and that sort of had implications for other types of health promoting projects or interventions.

Greg Randolph: Yeah, and we were limited by the technology – we were going to have you do multiple, check all that apply, because I do think this project as we both kind of show do affect a lot of the different aims, not just one of them. And I figured if you were only-unfortunately, we could only let you vote for one, and I figured it would come out that you would be voting for a lot of the ones that we



thought applied as well across the board. So I had just flagged, if I could have voted for multiple votes I think definitely equitable, although that didn't get any votes because we were asking for the top, but equitable was one because they really did focus on a provider that was taking care of a very vulnerable population, so in a way you could say it was equitable. Definitely health promoting, and I think that was the one that got the most votes, certainly was aligned with that aim, clearly. And I think also effective, which I think got a few votes, through use of the evidence-based Five A approach as well as the Tobacco QuitLine in North Carolina and that other states have as well. That's definitely in there with the state's practice. And then I think a number of you also voted for efficiency as well. Where is that in there. I think – Yeah, yeah. A number of you voted there. Certainly they did some things to streamline their processes, too, to do that. I also probably – I had a question mark, but I also probably would have checked population-centered, too, which is another, quite a few people selected, there I was thinking more along the lines of folks who quit smoking, they're actually exposing tons of people in the population to their cigarette smoke when they're out in public or in their homes smoking; it's exposing a large proportion of the population. So if they quit, that, that stops. So anyway, we just wanted to give you a concrete example of how these aims might apply to a particular project.

Lisa Harrison: So yes, there's a story from the field here. I know you all have some similar stories that you could tell and ways you could apply the nine aims. I think I'm going to turn it back over to CDC now.

Teresa Daub: Thank you very much, Lisa and Greg. And Peggy, you and Amishi as well. It was great to hear about the quality framework from the macro level all the way to the practice level, and thank you so much for providing us with the great example there. I think what we'll do now is open the lines for questions. This is a great opportunity, having the four presenters on the line, to interact and ask them questions directly. So Lee, if you're standing by, we will open the lines now. Thanks.

Lee (Operator): All lines are open.

Teresa Daub: And a reminder to all of our participants on the line – if you don't have a question, please remember to mute your line by using star six or using your mute feature. However, if you have a question, star six will un-mute and you may pose your question or comment now. We'd love to hear your comments, your stories, your questions in these last few minutes of the call.

Questioner: This is Dave Palm from Nebraska. Could you explain a little more about the – I understand Lean fairly well, but your Model for Improvement. Is that a – could you talk a little bit more about that?

Greg Randolph: Yes, thank you. This is Greg Randolph and I'll say a little bit about that. The Model for Improvement was developed by a group called Associates in Process Improvement, and they wrote a book called *The Improvement Guide*. That's probably the best, I guess, resource to use – *The Improvement Guide* – and we have, we'll leave author Langley to describe that, but the reason we have selected as a model is and a framework for improvement is because, a couple things: one is it's very, very flexible. It can be adapted to many different situations. It's a fairly simple model. It's answering three basic questions: What are we trying to accomplish? How will we know if the changes were an improvement? [unintelligible] And they also use, it also uses a very powerful tool that probably a lot of



you.... [No audio] rapid test change, as you're testing and implementing things. So that's sort of an overview of the model.

Dave Palm: Okay. Thank you very much.

Greg Randolph: The other reason we like that [no audio] for health care improvement [no audio] they're very [no audio]

Teresa Daub: Greg, pardon the interruption. This is Teresa. We're having a little bit of trouble hearing you, and there's also some background noise on the line. So maybe if you could move closer to your phone line and everybody else on the line in the meantime if you would mute your line; star six. Sorry Greg; please continue.

Greg Randolph: Thanks. The other reason is I said because the Institute for Health Care Improvement has been very influential in health care settings. They sort of adopted that I guess as their primary method for improvement. They worked closely with the Associates. When you go around at least in North Carolina and probably other places as well you'll see a lot of your health care and public health system partners using the Model for Improvement. Our health departments here to be able to kind of speak the same language, so that's another reason we selected that method. But I think also –

Dave Palm: Thank you very much. I appreciate it. I didn't catch the author's name of the, of the book. Could you repeat that please?

Greg Randolph: Yes, it's Langley. And Nolan. L-A-N-G-L-E-Y and Nolan, N-O-L-A-N.

Dave Palm: Very good. Thank you very much.

Greg Randolph: You're welcome.

Teresa Daub: And thank you for the question, David. Are there any other questions or comments on the line? Okay, if so, please break in, but in the meantime, we do continue to have some questions from North Carolina that have come in via LiveMeeting. Magaly from Rhode Island and Tamara from San Diego have questions about some of your resources, Greg and Lisa. First, do you provide training beyond North Carolina?

Greg Randolph: We have not thus far, but we have actually started exploring that in the last few months, so we are considering doing that. So yes.

Teresa Daub: That sounds like welcome news. And second question: Do you have a written QI plan, and, if so, is it something you could share in part or in whole with the network?

Greg Randolph: I'm not sure, I'm not quite sure if that's being asked, you might be able to explain this more from the question and how it's worded. Was that being asked for ourselves, or is that really for like an example of how a local health department might have a QI plan?



Teresa Daub: I'll read the question exactly as it's written. "Does North Carolina have a written QI plan; if so, is it available to share?"

Greg Randolph: I think probably the best answer is we don't – I don't know that we have like an overall, overarching QI plan for North Carolina, but what we do have, is we do have some health departments who have been doing quality improvement work for quite some time and have done very well with it. One of them we actually wrote about in the *Journal of Public Health Management Practice* in Cabarrus County, North Carolina. But some of those health departments have very nice QI plans, and we'd be happy to share those with permission from the local health departments, if that's helpful.

Lisa Harrison: We also have established charters for each of our projects, so on the slide where I was telling you the different things that we have going on as activities related to our performance improvement efforts. We have individual charters, plans, and include measures for each of those projects separately. So I'm glad to share charters for anything that you would be interested in.

Teresa Daub: That sounds, that sounds great. Thank you for your willingness to share, and I know they're eager, folks eager to take advantage of that. We do have another question from Nancy in Maine, who says that staff are very stretched for time. I know that's true in most health departments. How does, how do you use this framework to recruit program staff to participate in QI projects? And I think we'd love to hear probably both from you Peggy, but also from Greg and Lisa.

Peggy Honoré: Well if I could just go first for a second. When you read the consensus statement where we detail the aims and the definitions, one of the things we say in opening up the document is that these concepts were developed to promote and embed a culture for quality within public health so that it becomes embedded into the daily practices of everything that you do. The macro level concepts, that is. So it's not like you have to actually stop and do an improvement project. But they should be top of mind and woven across what you do in your daily activities of public health and carried over to quality improvement projects. So we've really had changing to a culture for quality in public health when we developed these.

Greg Randolph: This is Greg. I'll just add on to what Peggy has mentioned. I agree. We really do promote that. To look at this is not – the tendency is to look at this as extra work, as added on to everything else you do, but we really try to stress, and it takes some time, but we really do try to stress that this should be part of everyone's work. You know we come to work every day to deliver, you know, excellent services – that's part of our job, and the other part is to continuously improve those services. So that's sort of the mantra we preach a lot, I guess, but the other thing that we have found is we actually do use that as a motivator or incentive and we have found that to be an incentive for getting interested in quality improvement is that, and often it's kind of obvious when funding has been cut and the mission is still the same, there's a lot of work to do, but you have fewer people and resources. A lot of our health departments are exploring quality improvement as a way to deal with this kind of funding crisis and tight resources that we have now. And that's another reason we took care of some return on investment data – that's another reason we started collecting return on investment data on every project we do, because



in the end you need to be able to show that this is actually allowing you, by doing this work, you're able to do more work with fewer resources.

Lisa Harrison: Well, we also sort of do the return on investment approach at the beginning, when we're recruiting people. In the information sessions we let them know what the program is worth to them individually for professional development opportunities, and that it's typically pretty expensive to go to these kinds of intense training and coaching opportunities at the health care improvement or other organizations that offer team, networking, and coaching the way that we do. And with our NPHII funds we're able to share that kind of investment that's been made here at the Division of Public Health to say look, we're able to offer this for you and help coach you with a program that or a project that you select and it's worth at least 1500 dollars a person to be able to do that, we tell them. So we hope you'll take advantage of that opportunity and these resources. It helps a little. Telling those stories of the local health departments and the state teams of quality improvement that have already gone through, they help a lot, too, so we sort of use their testimony to help recruit others. I think once they've been through it, seen the light, experienced the project, pieces and parts – they are the best sales pitch we can offer.

Teresa Daub: Yes. Thank you for answering that question with all the detail. And I can see a lot of what you use to recruit participants would be used – can be also used to gain leadership support, for quality improvement. But I want to offer you the opportunity to comment further on how you've used the framework or other techniques to gain leadership support as well, if you have anything to add on that.

Greg Randolph: This is Greg. I'll take a crack. And that – I'm glad you said that because that was starting to come to my mind that we didn't say anything about the leadership. That is so critical to get – to kind of get the leader because as the questioner mentioned, you know, the staff are very, very stressed, and very, very stretched, and the leader's got to kind of make the case for why the organization is going to invest in this while there's so much other work to be done. So we do try to work very carefully and I guess one – I like sayings, and one of my favorite sayings is eight times, eight different ways, in terms of communication, but we do spend a lot of time in North Carolina on communicating success stories, and especially targeting our leaders so we have a monthly newsletter that we send out to all of our public health workforce across the state, both local and state level, we have, another thing we've found and learned and it's no surprise is that leaders like to hear from other leaders, so we have in our newsletter every month, now we have a sort of a message from a leader type of column where they talk about this is why I invest in quality improvement and have successful leaders who have kind of gone through our program and had success share with their colleagues across the state "why should you invest in this." And then you know there are a variety of other ways in terms of in person, presenting at conferences, and things like that. But in the end, I guess at the end of the day, you've got to have the results. You've got to be able to show improvement. You've got to be able to show the efficiencies that help us get through these very difficult times with funding and resources. Anything you want to add?

Lisa Harrison: We were having a conversation on leaders about this today when someone brought up in our advisory board meeting that these are such interesting times and challenging for a lot of our



workforce at every level and instead of looking at this as the hardest time to implement quality improvement, you have to also talk about how quality improvement is a morale booster when it's done well and when the front line staff has the opportunity to create new ideas and make changes and have a sense of control, it can be, you know, really a helpful shot in the arm. So, we like to try to remember that and talk about that too.

Peggy Honoré: This is Peggy. I want to add just one thing real quick about leadership. This was a deliberate attempt on the part of HHS beginning in 2008 to begin to demonstrate that HHS was taking a leadership role in quality in the system with the intent that it would drive leadership at the lower levels for this, because one of the things we noted in the consensus statement was actually I think some research that was done by NACCHO, I believe, that it showed, the research findings indicated that public health quality improvement practices were most prevalent when driven by strong national leadership. So we felt like by us taking a leadership position, that it would filter down throughout all levels of the system.

Teresa Daub: Thank you, and another thing, our time. I want to thank everyone for participating on the call today; our presenters for their presentation and their leadership on quality improvement is helpful to us all. Before we leave, we do have a couple of more polls. The first poll we did conduct in January, but we need to conduct it again because the results were lost in our system. So, the first question: When we do webinars that feature sharing sessions, as we did in January, and hearing from other PIMs, how many PIMs would you like to hear in a single call? So this is for our PIM Network sharing calls. And our options are two, three, four, and five, realizing the more people we have speaking, the less time per speaker. Melody, if you'll let us know when we have results from all, we'll move to our next poll. Okay, we'll move now to our poll about today's call: How would you rate this webinar overall? This poll is open, and we appreciate your votes. Again, thank you for participating today. We hope you'll join us again in March, on March 22, and that call will explore the culture of QI with the Public Health Foundation and the South Carolina Office of Performance Management. In the meantime, don't forget that you can view and download these calls and materials from the PIM Network web conference call series on the OSTLTS PIM Network page. Thank you for joining us today, and we'll be with you again in March. Good bye.

