Accreditation Quality Improvement Focus: Michigan Tackles Local Health Department Organizational Capacity by Debra Scamarcia Tews, MA

What is organizational capacity and how does it fit with accreditation? How can quality improvement efforts positively affect organizational capacity? How can public health practitioners measure improvements and make connections to improved health status in the community?

Michigan, within the context of its accreditation program for local public health, is seeking answers to these questions and many more. You may not know the Michigan Local Public Health Accreditation Program was piloted in 1997 and implemented statewide in 1998; it was the first of its kind in the nation. Using 122 standards and 202 measures, it improves local public health by reviewing local health department (LHD) organizational capacity and 12 programs. Partners in the process are the Michigan Departments of Community Health, Agriculture, and Environmental Quality; Michigan Public Health Institute; Michigan Association for Local Public Health; and Michigan's 45 LHDs.

Accreditation Cycles 1 and 2 are complete. All 45 Michigan LHDs have been accredited twice. Cycle 3 is well underway with a renewed focus on quality improvement.

Early Accreditation Quality Improvement Efforts

Michigan is no stranger to quality improvement (QI) efforts within the context of accreditation. The mission of its Accreditation Program is to assure and enhance the quality of local public health by identifying and promoting the implementation of public health standards for LHDs and evaluating and accrediting LHDs on their ability to meet the standards. That mission relates directly to a familiar definition of QI—*the establishment of a program or process to manage change and achieve quality improvement in public health policies, programs or infrastructure based on performance standards, measures and reports*. Using this definition, structured improvement activities were underway in Michigan upon program inception. Moreover, a related mechanism was implemented via the 2003 Accreditation Quality Improvement Process (AQIP). The AQIP Committee (a standing committee, which reports to the Michigan Local Public Health Accreditation Program Commission) provides QI oversight.

One of the AQIP Committee's accomplishments in 2003 was conducting a comprehensive survey of LHDs and on-site reviewers regarding their experiences with and perceptions of the Accreditation Program. With an 81% rate of response, Michigan learned that over 90% of respondents believe the purpose of Accreditation should be ongoing QI; over 70% believe that Accreditation has improved LHD performance. Using survey data, the AQIP Committee identified 44 opportunities for program and process improvement—all of which have been implemented.

Current Accreditation Quality Improvement Efforts

As mentioned above, Michigan has conducted QI relative to LHD satisfaction with Accreditation. That effort is congruent with what the *Public Health Memory Jogger II: A Pocket Guide of Tools for Continuous Improvement and Effective Planning* lists as four basic principles of QI:

1) Develop a strong customer focus
2) Continually improve all processes
3) Involve employees
4) Mobilize both data and team knowledge to improve decision making

Michigan, to continue integration of these four principles into ongoing QI initiatives, has chosen to focus its current efforts on strengthening LHD organizational capacity within the context of the Michigan Local Public Health Accreditation Program. Michigan's participation in the Multi-State Learning Collaborative I (2006) and II (2007) is spurring these efforts. The Multi-State Learning Collaborative (MLC) is funded by the Robert Wood Johnson Foundation (RWJF) and managed by the National Network of Public Health Institutes (NNPHI).

During MLC-I, Michigan developed a model for voluntary QI related to strengthening LHD organizational capacity. In Michigan's work, ***organizational capacity*** is defined as ***the ability of an organization to carry out the essential public health services, and in particular, to provide specific services; for example, disease surveillance, community education, or clinical screening. This ability is made possible by specific program resources as well as by maintenance of the basic infrastructure of the public health system. Capacity means, for example, that you have sufficient staff, training, facilities, and finances, among other things.***

The MLC-1 model Michigan developed calls for a LHD self-assessment of organizational capacity using the NACCHO Operational Definition of a Functional Local Health Department. The LHD, once opportunities for improvement are identified, uses the Shewhart Cycle of Plan-Do-Check-Act (PDCA) to test hypotheses, implement improvements, and seek further refinement and/or opportunities. PDCA provides a repeatable set of steps any organization can use for making improvements.

In MLC-II, Michigan is testing its MLC-I model with four pilot LHDs. The four pilots were asked to select improvement projects related to the *LHD Powers & Duties* section of the Accreditation Program, which pertains to a LHD's organizational capacity to provide services and otherwise carry out its legal obligations required by the Michigan Public Health Code.

Four Michigan LHDs are Silo Busting with QI

Thinking about QI as it relates to organizational capacity presents some challenges in the public health arena. We are accustomed to working with a strong "program focus." We fund and operate immunization programs, communicable disease programs, environmental health programs, and many others. Some students of public health have observed that much of our work is conducted in silos. Not surprisingly, in Michigan, as in many other states, much of our public health QI work has also occurred in our programs—in silos!

Accreditation is not easy. QI is not easy. Silo busting is not easy. And improving organizational capacity is definitely not easy. However, the four pilot LHDs in Michigan are living proof that with leadership support, training, commitment, and financial and technical assistance these undertakings are attainable.

During the recent MLC-II site visit to Michigan, representatives from the RWJF, NNPHI, NACCHO, NALBOH, ASTHO, CDC, PHF, PHII, Florida, Washington state, Missouri, Kansas, and others saw firsthand the progress that Michigan LHDs are making in terms of strengthening their organizational capacity through the use of QI tools. Using aim statements, root cause analyses, flow charts, process maps, fishbone diagrams, Pareto charts, histograms, run charts, rapid cycle improvement, and PDCA the LHDs are becoming increasingly versed in QI. The Berrien County Health Department is building media capacity; Genesee County Health Department is improving their capacity for surveillance and communication; Kent County Health Department is building organizational capacity in the areas of outreach and education; and Ottawa County Health Department is addressing leadership, planning, and communication issues spanning their entire organization. During the site visit, these LHDs presented vivid snapshots of their evolving QI efforts using Quality Improvement Story Boards. Organizations in other fields frequently use story boards as methods of reporting on QI or performance excellence. By highlighting key points and breakthroughs within a project, the viewer of a story board can quickly gain an idea on the scope, plan, and results of that effort.

In planning for their QI projects, some of the questions the LHD teams have asked are, "How do we evaluate our success and measure our results?" "How will QI positively impact our community residents?" What does improved organizational capacity look like?"

One of the ways Michigan is looking at these questions relates to outcomes. Outcomes, such as changes or benefits resulting from activities, processes, and programs are typically divided into short-term, intermediate, and long-term outcomes. We are probably most familiar with thinking about program outcomes as they relate to long-term outcomes, such as changes in morbidity or mortality of a population. The ultimate public health outcome for accreditation and/or QI in Michigan would be

improved population-based health outcomes and a strengthened public health system. But such long-term outcomes may not be immediately appropriate measures of improvement in the context of QI efforts targeted at organizational capacity. It may be more productive to ascertain whether the LHD teams have acquired the necessary skills to apply and evaluate QI throughout the organization, increased their capacity to function as a team, fostered a culture of quality, bolstered their infrastructure, improved their ability to inform their peers about QI, or otherwise improved any other element of their capacity to carry out essential public health services.

The four Michigan LHD teams will continue their QI work within the context of Accreditation. They will help shape a Collaborative Learning Module (CLM), which is under development for use by additional Michigan LHDs and the broader public health practice community. The CLM will contain a comprehensive set of QI tools, processes, resources, and guidance. Its purpose is to support growth, increase knowledge, and foster acceptance of QI as an approach for making data-driven decisions that lead to true improvement. The AQIP Committee will provide ongoing oversight and support of the living CLM.

Initial work by the LHDs as part of MLC-II will be completed by January 2008. Will they be successful in using QI to improve organizational capacity? Michigan believes the arrows are pointing upward. Nevertheless, they and you, as part of the larger public health practice community, will be engaged to help answer that question.