TASK FORCE ON IMPLEMENTING EVIDENCE-BASED STRATEGIES IN PUBLIC HEALTH
May 17, 2012
North Carolina Institute of Medicine, Morrisville
10:00-3:00 pm
Meeting Summary

Attendees
Members: *Laura Gerald (co-chair), Gibbie Harris (co-chair), Monique Bethell, Battle Betts, Bob Blackburn, Megan Davies, Jeff Engel, Heather Gathes, Cameron Graham, Jacqueline Halladay, Eleanor Howell, Roxanne Leopper, Marilyn Pearson, Janice Petersen, Ruth Petersen, Rebecca Reeve, Kevin Ryan, Meka Sales, Anna Schenck, Anne Thomas, Melissa VanDyke, Battle Betts, Meka Sales*

Steering Committee and NCIOM Staff: *Krutika Amin, Libby Betts, Colleen Bridger, Laura Edwards, Lisa Harrison, Greg Randolph, Pam Silberman, Mike Steiner, Berkeley Yorkery*

Other Interested people: *Ann Absher, Nina Forestieri, Joy Reed, Jean Spratt, Mike Steiner, Joyce Swetlick, Jean Vukosan*

WELCOME AND INTRODUCTIONS

Laura Gerald, MD
State Health Director
North Carolina Division of Public Health
Co-Chair

Gibbie Harris
Health Director
Buncombe County Health Director
Co-Chair

IMPLEMENTING EVIDENCE-BASED CLINICAL STRATEGIES IN LOCAL HEALTH DEPARTMENTS
Implementing Clinical Evidence-based Strategy
Greg Randolph, MD, MPH,
Director, NC Center for Public Health Quality
North Carolina Division of Public Health

Dr. Randolph outlined the strategies involved in implementing clinical evidence-based strategies (EBS). Dr. Randolph discussed the advantages and challenges to EBS implementation in the clinical setting and provided a framework for the diffusion of innovation. Additionally, Dr. Randolph presented on the perceived attributes of change, methods to deal with challenges in the decision to adapt EBS, and currently available tools for EBS implementation (including US Preventive Services Task Force website, Institute for Healthcare Improvement maps and data clearinghouse opportunity in North Carolina).

Dr. Randolph's presentation is available here: Implementing Clinical EBS.

Selected Questions and Comments:

- Q: What is the difference between quality assurance and quality improvement?
  A: Quality assurance (QA) occurs when an external group or body (eg JCAHO) sets standards and the organization is measured against those standards. For QA, the organization tries to ensure that they are either at or above the level of the set standards. Quality improvement (QI) ensures changes to meet the patients' and customers' needs in a continuous improvement process.
- C: UNC faculty are working on updates to the US Preventive Services Task Force website (Bryan Weiner and Katherine E. Reeder-Hayes). This task force should get a better understanding of what the UNC faculty are doing to the USPSTF website, to ensure that North Carolina has access these resources and is not trying to duplicate the data.
- C: National Initiative for Children's Healthcare Quality (NICHQ) is aligning data clearinghouse tools between agencies; the national process model should be looked at as example. (Duke University and Wake Forest University are involved).
- Q: Is there any empirical research on predictors of success—eg, groups that will be vs those that will not be successful in implementing EBS?
  A: This is not well figured out; leadership, experience and culture of the organization have been brought up as critical factors.

Bright Futures Implementation in Local Departments
Jean Vukeson, RN, FNP
Child Health State Health Nurse Consultant
North Carolina Public Health

Ms. Vukeson gave an overview of the American Academy of Pediatrics Bright Futures quality improvement (QI) program implementation in the first eight pilot local health departments (LHDs) in North Carolina. Ms. Vukeson described the 3-day Kaizen event they used to start the statewide effort to implement Bright Futures clinical guidelines in LHDs. North Carolina State University Lean Quality Improvement experts led the effort. The initial Kaizen event included state staff, regional public health consultants, and frontline staff from LHDs to examine and evaluate their existing health care delivery processes, and to identify ways to implement Bright Futures. The group identified needed changes to the Bright Futures toolkit, as well as the need to translate some of the documents into Spanish. Ms. Vukeson described the improvement in wait times, improvement in client ratings of the LHDs as "excellent", implementation of the program in the rest of the North Carolina LHDs, and the lessons learned from the pilots. Ms. Vukeson discussed how the pilot LHD staff served as coaches or mentors to the rest of LHDs in implementing Bright Futures.

Ms. Vukeson's presentation is available here: Bright Futures Implementation in Local Health Departments.

Selected Questions and Comments:

- Q: What is a Kaizen event? A: Kaizen is a Japanese term taken from the Toyota production process, which means to take apart and put back together. The Kaizen event involves sitting back and looking at the work process to evaluate and improve the work process with involvement of frontline workers.

- Q: How long did the LHD staff meet with consultants? A: During the beginning phase, NCPH consultants communicated weekly with the pilots through the webinar training. Webinar based training allowed LHDs to work on the training at times that were convenient to the staff. Additionally, NCPH consultants made themselves available to the pilot LHDs for questions and problems.
- Q: Did all of the pilots have teams with quality improvement (QI) training? Could you tell differences between the teams with and without staff with QI training? A: Not all pilots had staff with QI training. LHD teams that went through QI 101 had an advantage.
- C: NCPH staff went through QI 101 training, which they provided to LHD staff that were not given direct training.
- Q: What was the process for rolling out the implementation of Bright Futures from the eight pilot LHDs to 85 LHDs? A: NCPH had regional webinar meetings to discuss: lessons learned from pilot LHDs and each local county need. NCPH worked with each local county to see how much tech support they would need. Webinars (20-30 minutes long) for local counties were useful as a starting point following which NCPH consultants provided direct support. The 8 first pilots also functioned as mentors for lessons learned.
- Q: How ready are you with readiness assessment tools and predictors of success? A: NCPH has not looked at that yet, it would be interesting to look at the experiences of NCPH consultants.

Local Health Department Experience
Ann Absher, RN, MPH
Health Director
Wilkes County Health Department

Ms. Absher presented on the implementation of the Bright Futures program in the Wilkes County Health Department, results of implementation, and reflections on the implementation process. Ms. Absher discussed the importance of communication between the North Carolina Public Health consultants and local health department (LHD) nurses, and the challenges faced by Wilkes County Health Department (difficulty allocating additional time to quality improvement and challenges with convincing the late adapters). Ms. Absher reflected on the importance of involving frontline staff and stakeholders, communicating both long-term and short-term goals, visions and tasks, and using smaller initiatives to gain organizational confidence in quality improvement process.

Ms. Absher's presentation is available here: Local Health Department Experience.

Selected Questions and Comments:

- C: Changing the focus of North Carolina Public Health (NCPH) consultants from regulatory managers to partners in quality improvement (QI) really helped this QI process succeed.
- C: Predicting success might involve seeing whether someone on staff had QI experience and JCAHO experience. However Wilson County did not have any QI experience and still were able to implement QI changes. The video itself with mapping process was educationally effective for them to move forward.
- Q: What was the burden, if any, for the initial readiness assessment for this QI program? A: There was a one-hour requirement to pull and gather individuals, but the webinars were not very intensive time commitments as they were available on the web and did not require scheduling.

- Q: Who are the primary payors at Wilkes County? A: Medicaid followed by uninsured.
- Q: What is the difference between those Medicaid children who visit private practices compared to those that visit LHDs? A: Most of the Hispanic population comes to the Wilkes County Health Department.
- C: Ultimately for quality improvement effort to be sustainable, NCPH should show that they are lowering costs. The challenge will be to show Medicaid savings. On other projects, NC state Lean QI experts have been able to provide groups with a cost-benefit analysis. Showing potential cost savings would be helpful for the state and LHDs in any quality improvement effort. .
- Q: Are there examples of using this QI process to non-clinical change like policy and environment change? A: Some have applied this QI process to messaging to see what the receivers of messaging want to obtain from the messaging. It is not as straightforward outside clinical settings. PDSA feedback and evaluation loops within policy are similar to this. However, it is sometimes difficult figuring out what to measure as indicators of improvement with policy change.
- C: Vocabulary between PDSA and lean QI is different but similar concepts. The more the vocabulary could be similar between programs, the easier for organizations to adapt and disseminate.

GROUP DISCUSSION
Pam Silberman, JD, DrPH

Dr. Silberman facilitated group discussion on the following questions:

- What do LHDs need to select evidence-based clinical strategies?
- How can the state help LHDs in selecting evidence-based clinical interventions?
- What resources do LHDs need to implement EBS clinical interventions?
- What resources do LHDs need to evaluate and sustain evidence-based clinical interventions?
- What resources can the state provide to help LHDs evaluate and sustain evidence-based clinical interventions?

Selected Discussion:

- What do LHDs need to select evidence-based clinical strategies
    - Identify priorities from HNC 2020
    - Look at existing sources of EB clinical screening and treatment
    - Involve customers
    - Look at level of coaching needed for the intervention
    - Leadership support for teams implementing strategies
    - Whether something can be “tailored” or adapted in context
    - Financial and staff resources to select the right program
    - Constraints of local health department, ex: still QA focused instead of QI focused; have the ability to prioritize requirements;
    - Community health assessment data
    - Engaging staff: tied back with leadership
- How can the state help LHDs in selecting evidence-based clinical interventions?
    - Help communities identify the EBS or where to go when trying to implement: Utilize ideas from HNC2020, a lot of HNC 2020 is clinical

    - Capacity building: leadership level, staff/resources level
    - Success stories clearinghouse
    - Change in focus of state consultants from regulatory to partners (QI not just QA)
    - Leveraging existing resources;
- What resources do LHDs need to implement EBS clinical interventions?
    - Implementation map
    - Key staff stakeholders in implementation process
    - Provide training in PDSA or QI
    - Identifying internal coaches
    - Celebrate success
    - Resources to be able to spend time on EBS (during implementation process)
    - Training of staff and coaching, not just internal, can also be regional (as with the champions); Flexibility in training schedules so that clinical services are not totally compromised;
    - Identifying local champions who are "early adapters" so that can continue efforts
    - Looking at technological that might be useful (Apps anyone?)
    - Leadership training and leadership capacity building to disseminate process goals and do change management
    - Partner agencies might be able to provide support
    - Monitoring past whether requirements accomplished but also include lessons/challenges
    - Could existing meetings be used to include EBS: LHD meetings, child health coordinator meetings? Working past just refocusing on meetings
    - Allow for flexibility from the state level for implementation
    - Would it be appropriate to specify one or two state level priorities? Should still permit some variation because communities will probably have different priorities from the community assessment
    - Communicating: with framing of the concept as well as over-communicating; using common language
- What resources do LHDs need to evaluate and sustain evidence-based clinical interventions?
    - Measure both process and outcomes
    - Local health departments do have access to the CCNC health portal. How to use this data to interact with clients and also to leverage to improve practice?
- What resources can the state provide to help LHDs evaluate and sustain evidence-based clinical interventions?
    - Training on QI 101
    - Work as a funnel for national resources
    - Monitoring tools
    - Determine cost-benefit/cost-effectiveness: need to connect CCNC , HIE, HIS
    - Need to sustain LHDs to keep EBS in LHDs

NEXT STEPS

The next meeting, June 8, will discuss priority areas outlined by the survey of various departments, and identify next step priorities. The next meeting will also discuss specific ways to implement EBS: enhance existing efforts and use EBS to better the efforts, shift existing resources to EBS, and provide new resources.