Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Denville Division of Health, NJ

November 2008
Summary Statement

This collaborative consists of three municipal health departments in central Morris County, located in northern New Jersey and serving generally high income established suburban municipalities: (a) Randolph Township in the southern portion with a population in 2000 of 25,000; (b) Rockaway Township in the northwestern portion with a population of 23,000; (c) and Denville Township in the northeastern portion with a population of 16,000. The three, Denville, Randolph and Rockaway contract to provide public health services to an additional four municipalities. The six municipalities covered are geographically contiguous with a population served of over 88,000 persons. Licensed Health Officers with a total of 63 years public health experience manage the health departments. An increase in demand for public health services due to an expanding population and additional mandates by state and federal agencies has created a need to investigate cooperation between local health departments. In addition, the ability to comply with accreditation standards by pooling resources rather than hiring additional staff is an opportunity to increase the capabilities of the individual health department at a modest cost.

A significant weakness discovered during the project’s self-assessment activity was the ability of each of the three departments to evaluate the programs and projects they have undertaken. Programs of health education were selected as a topic common to the three to develop an evaluation technique.

The three municipalities created a formal Memorandum of Agreement specifying their terms to participate in a collaborative planning process to implement this project. The planning process was implemented to carry out the work.

The possibility to create collaborative plans by the health departments was approved by the three municipality’s managers and officers. Their implementation will require additional contracts to be executed that specify health department roles and responsibilities, particularly the expenditure of funds. This is not likely to take place unless private or non-municipal grant funds are available to sustain any major project costs that are required in addition to the normal health department budget.

Background

The municipalities in New Jersey operate under New Jersey “home rule” law that requires each municipality to provide a health department managed by a licensed Health Officer. Municipalities may join to contract with a Health Officer and share his or her services. Home rule law requires that each municipality sustain the costs of its public health operations as part of the local municipal budget.

Limited technical assistance and only very minor amounts of funds are provided to municipalities by the State. New Jersey is now undergoing a major budget crisis in consequence of which it may be expected to provide less such support than is now available. Municipal tax revenues are tending to decline owing to recent housing revaluations and in consequence of other aspects of an emerging state and national financial crisis and economic recession. In recent years many health departments have sustained budget cuts and staff decreases in the face of increasing demands for services. Health departments in more favored locations have had their budgets
“frozen” or have received only minor increases and provide their services with no increases in their staff resources.

The primary activities of the three health departments are environmental, restaurant and other inspections, and the provision of disease prevention, communicable disease control and health promotion activities including health education and screening activities. Collaborating municipal Health Officers are likely to be assigned differing administrative functions in each of their towns. For instance, the Randolph Township Health Officer is also in charge of the Township’s Office of Construction Codes, as well as the municipal housing, property maintenance, recycling and solid waste programs. Other municipalities may or may not assign such functions to their health department, and may assign others. These functions are not directly related to public health activities and the Health Officer’s time for public health activities is thereby reduced.

In 2000, Morris County’s population was 87 percent White and is known to be changing with the addition of new Hispanic Language and Asian residents. In 2006 the per cent of the White population had changed to 84 percent, with the remainder, 8.6 percent Asian, 3.1 percent Black10.2 and percent Hispanic 1. While Denville has experienced growth in its minority population, predominantly the population is Caucasian. According to the 2006 Profile of Health Indicators, Denville Township has a population with 92.6% white, 4.6% Asian, and 1.1% black, with the remainder being of mixed racial decent. The two sub-populations that experienced the most growth since the 2000 census is those of Asian or mixed racial heritage. This is pertinent to two of the Health Education weaknesses identified by this project’s assessments. Specifically, they are related to the provision of culturally appropriate health education. Our populations are changing faster than services can be adapted to provide culturally competent care. Adding bilingual staff and interpreters is greatly hampered by the increasingly limited municipal budgets.

No formal agreement is in place to implement the type of work planned by this project. However, the three municipalities have previously engaged with one another in a variety of cooperative activities. Rockaway and Denville have executed an Inter-local Agreement for nursing supervision. The collaborating municipalities have mutual aid agreements and participate in a countywide Public Health Preparedness Initiative.

The collaborating municipalities have also frequently communicated with one another as members of the Morris County Health Officers Association, and as members of the Morris Regional Public Health Partnership, Inc., a not-for-profit Governmental Public Health Partnership. Through the Partnership this collaborative has actively and regularly participated in public health planning and assessment activities on a region-wide basis. The governing bodies of each of the municipalities that comprise the collaborative have individually and formally authorized participation with that organization. The Partnership conducts research and planning activities on behalf of the county’s 39 municipal health departments, and has published a County Health Improvement Plan with the participation of the three health departments that have joined for this project. The health improvement plan has identified that among the county’s needs is the

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1 Figures do not total 100% since Hispanic language persons which may be of any racial background are not included in the total.
requirement to improve the public and private components of the regional health system with improved communication, sharing of information and more extensive collaboration when operating programs and projects.

While these three collaborating health departments have been part of the Partnership for a number of years and worked together to produce the County Health Improvement Plan, there is no formal mechanism for them to formally partner for a specific funded project. Given the nature of each municipality by virtue of their socio-economic, demographic, and municipal character, it made sense to formalize the working relationship of the collaborative for this project.

**Goals and Objectives**
Following the completion of the self-assessments the three Health Officers met to review their results in company with the assistance of a planner provided by the Partnership. The following evaluation goals and objectives were originated for the project, and it was recognized that these might change when the evaluation of a topic other than health education is selected.

I. **Purpose:**

   A. Develop an evaluation process that may be used collaboratively by municipal health departments to measure the outcomes of public health education projects.

II. **Evaluation Goals:**

   A. Determine if public health education goals are soundly established and are being achieved using information that is sufficient to measure outcomes and take corrective and improvement actions.

   B. Identify characteristics of the local public health system that affect the outcomes of public health education projects.

   C. Develop information for project participants and other interested parties that report the outcomes of public health education projects in terms of both qualitative and quantified criteria.

III. **Health Education Goal:**

   A. Generally: To enable persons to improve their health status with programs of health education provided by municipal health departments.

**Self Assessment**
As a small local health agency, the issues identified through the self-assessment are magnified owing to a lack alternative options. In Denville, there were only three licensed staff public health officials present during is project’s assessment phase, and two had a total of only two years experience in New Jersey’s public health system. The time required for this project’s compliance, and normal work demands, required that virtually all of its work be accomplished by the Health Officer. Additionally, a lack of guidance regarding the wording of project related
responses for its documentation led to different perceptions among the three health departments even though they shared similar situations.

It has been noted that many of our areas of need including health education and promotion, the evaluation of programs, and continuous quality improvement practices are commonly experienced. This is indicative of the level of resources dedicated to public health in New Jersey. Health departments are often tasked with performance standards that merely count numbers of service calls, inspections, etc. While the State’s Public Health Practice Standards regulation serves to change that, change is needed at our local governance level to enable Boards of Health, Town Administration, and Governing Bodies to focus on accreditation, broader performance and CQI, rather than how many complaints more or less we responded to this year over last. The simple fact that we, as local health officials, get involved in so many things other than public health in our daily professional lives, dilutes our ability to stay focused on public health.

The chart below is a list of indicators from the self-assessment where all three members of the collaborative scored a two or below as an average of all three scores. These scores indicate not only weaknesses in the current system or threats to the future of the system, but also opportunities to improve health department operations by collaborating with other departments.

**Listing of Indicators From NACCHO Self-Assessment**

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<thead>
<tr>
<th>Indicator #</th>
<th>Standard</th>
<th>QI/Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. B. 3</td>
<td>LHD uses QI process with providers to make reporting easy for providers to report</td>
<td>Q/I</td>
</tr>
<tr>
<td>III. D. 6</td>
<td>LHD assesses the target population for how they accept information</td>
<td>Evaluation</td>
</tr>
<tr>
<td>III. D. 8</td>
<td>LHD evaluates promotion efforts every 2 years and uses results to improve programs</td>
<td>Evaluation</td>
</tr>
<tr>
<td>III. D. 9</td>
<td>LHD develops and revises performance measures, goals &amp; objectives based on evaluation of health promotion activities</td>
<td>Evaluation</td>
</tr>
<tr>
<td>IX. A. 4</td>
<td>LHD uses internal policy to guide evaluation efforts, frequency and scope of evaluation, organization evaluation, use of health outcomes as benchmarks</td>
<td>Evaluation</td>
</tr>
<tr>
<td>IX. A. 5</td>
<td>LHD has evaluations with analysis of local data with goal, objectives &amp; performance measures with established community health goals, objectives &amp; performance measures</td>
<td>Evaluation</td>
</tr>
<tr>
<td>IX. A. 6</td>
<td>LHD uses community health target outcomes as evaluation benchmarks</td>
<td>Evaluation</td>
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<tr>
<td>IX. B. 1</td>
<td>LHD uses evaluation framework, connecting intervention to outcomes, based on evidence</td>
<td>Evaluation</td>
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<tr>
<td>IX. B. 2</td>
<td>LHD periodically evaluates key processes of service delivery for efficiency, effectiveness using established criteria</td>
<td>Evaluation</td>
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<tr>
<td>IX. B. 3</td>
<td>LHD works to identify best practices or benchmarks for evaluation purposes</td>
<td>Evaluation</td>
</tr>
<tr>
<td>IX. C. 2</td>
<td>LHD monitors program performance measures &amp; data to document progress toward goals &amp; requirements</td>
<td>Evaluation</td>
</tr>
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<thead>
<tr>
<th>Indicator #</th>
<th>Standard</th>
<th>Health Education/Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. B. 4</td>
<td>HCP’s and partners receive reports and feedback on disease trends and clusters</td>
<td>Communication</td>
</tr>
<tr>
<td>III. A. 4</td>
<td>LHD has media strategy, formal &amp; informal, and communicates w/media and responds to their requests; routine comm. to raise awareness of PH issues</td>
<td>Communication</td>
</tr>
<tr>
<td>III. B. 5</td>
<td>The public knows how to obtain health data and info from the LHD</td>
<td>Communication</td>
</tr>
<tr>
<td>III. C. 5</td>
<td>Target population helps develop and distribute health education materials</td>
<td>Culturally</td>
</tr>
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Following the completion of the self assessments it was agreed among the Health Officers that all three of the municipalities had a deficiency with its evaluation procedures. This was established by a formal review of each municipality’s self-assessment instrument and the preparation of an instrument that compared each of them. A copy of that review in the form of two memos that generally describe the collaborators approach is included in the Appendices to this report. One of the relevant issues of a self-assessment is disagreement on the grading of evaluation criteria. On the one hand, a self-assessment should be open to interpretation, however, those interpretations should follow a general guideline. Clear demonstrations of the grading of example situations would be helpful in avoiding creating artifacts in the data.

Subsequent discussion by the collaborators resulted in the adoption of the project’s priorities.

**Collaboration Mechanism**

The three health departments are known to one another and had a strong willingness to establish a formal working relationship. In consequence of their membership with the Partnership they believed that a pre-existing agreement for participation with that organization that had been approved by their mayors and councils would be sufficient to serve as the instrument that bound them to this project. The granting agency, NACCHO, required an agreement that was specific to its contacting elements, thereby requiring a new instrument to be originated.

The three health departments consulted with their municipal managers and identified the criteria required by each for a formal agreement. In some cases, Health Officers are given more autonomy to act without prior approval from their managers. In addition, differing levels of cooperation and latitude create opportunities for creative exchange of ideas, but can also reduce the exchange if additional approvals are needed for items such as: engaging in further activities, scope of the collaboration, and actual implementation of practices. In Denville, the Business Administrator and Township Attorney rigidly controlled the idea of the MOA with the other two municipalities, while the assessment of the functions and choice of area to work on were completely delegated to the Health Officer. Once the agreement was drafted by the Attorney, it was approved by the Denville Township Council, since the Health Officer has no authority to enter into a binding agreement with any other organization or agency.

Subsequently, the Health Officers met with the Partnership that is contracted to provide technical assistance to the project and produced a draft agreement. The agreement was reviewed by each municipality and after some minor word changes and additions, was approved. A copy of the agreement is made part of the Appendices to this report.

One of the barriers to collaboration was the need to preserve the individual rights and legal responsibilities of each municipality and health department. The municipal governing bodies do
occasionally communicate but rarely to discuss formal jointure of services. There was a concern that moving too quickly to consider formal co-location of resources would lead to a form of forced regionalization that was beyond individual municipal control. Assurances for the protection of municipal independence and the preservation of its rights became important. For example, the participation of a municipality would have to assure that each knew what the specific obligations of the other were, and that any agreement that specified that obligation did not improperly delegate the rights of one municipality to another, or to the funding source.

The planning process to be used for project implementation was developed simultaneously with the development of the collaboration agreement. A copy of the planning process that was agreed to is included in the Appendices of this report.

Any further grant funding or project would need additional legal review and approval since New Jersey Finance Law has specific criteria for grant funding streams that are added to a municipal budget.

**Results**

The planned evaluation project is intended to proceed but no implementation has been initiated to this time owing to time and resource constraints affecting the three health departments. In recent weeks the requirements for the preparation of annual municipal budgets, in addition to the regular duties of the health departments and their limited staff and fiscal resources requires that the project be initiated close to the beginning of the new year, and then at a moderate pace as its tasks are integrated with regular responsibilities.

The successes of the project to this point are:

- That the municipal managers who supervise the health departments are amenable to collaborative projects that require a formal agreement.
- That the health departments are sufficiently compatible to easily plan and agree to intended project terms and obligations;
- The establishment of a planning process based in theory and experience;
- That the services of the Morris Regional Public Health Partnership are useful for preparation of grants applications on behalf of more than one municipal health department and for project planning and design.
- Municipal Boards of Health appear to be interested in achieving national accreditation. The consensus of our boards is that if national accreditation is going to improve public health services at no additional cost to tax payers they will support the project.

**Lessons Learned**
• Health Departments may freely plan activities with one another under their current agreement with the Morris Regional Public Health Partnership.

• Some activities, particularly those that are coordinative, and low-cost or no-cost, are likely to proceed as a part of normal public health functions being delivered.

• It is likely that future projects requiring formal collaboration and the expenditure of new funds, or the commitment of larger amounts of municipal resources will each require a legally reviewed formal agreement approved by municipal managers that specifies roles, responsibilities and the resources that are to be committed to the effort by each participating health department.

• It may be possible to design a generic project collaborative agreement that will state basic understandings and require only the specific activities and resource commitment required by any project. The basic contract form used by NACCHO to establish agreements with the three collaborating municipalities may be such an instrument.

• Planning and assessment of projects such as this involve real costs and so long as organizations like NACCHO continue support through grants of this nature we are better off now than we were before this process began.

Next Steps and Conclusions

Any additional project work needs evaluation with regard to its priority in an age of additional regulatory mandates, reduced funding, contracting workforce, and restrictive tax environment. While this particular project was worthwhile as an exercise in forming a mechanism for collaboration that can be used as a model for other municipalities to follow, the burden on a Health Department with four and one half employees fell squarely on the supervisor. Unfortunately, the nature of time-management in public health is a zero sum game. Time spent on a grant project is time that cannot be spent performing other duties. The grant funds allow offsets for people to work, but what happens when staffs aren’t available to re-allocate? One fear with accreditation on a model that health care facilities use is that many hospitals have dedicated staff who work on accreditation. No such staff exists at the municipal and the cost for that dedicated staff is unacceptable. Denville Township will continue to work with the neighboring municipalities and the Public Health Partnership to improve public health capacity. Part of the evaluation for the next step is to engage the complete membership of the Partnership, which includes the 16 local health departments, county health department, as well as the three hospital systems in Morris County, and several not for profit corporate health interests to determine if these gaps in evaluation and CQI exist universally across the County. If so, using this collaborative as a model, an analysis of the available resources and alternative funding mechanisms to increase availability will be studied.

This is where the work of consultants such as the Morris Regional Public Health Partnership comes into play. The use of consultants to act as facilitators of information in all directions as well as a neutral but interested party to refine ideas is key in meeting additional mandates at a reduced cost. Since model agreements and much of the accreditation, work is similar across
different health departments, one agent can effectively assist in the creation of multiple documents that are easily tailored to the specifics of each health department. The other benefit is that the cost of these professional services can be diluted among numerous agencies and while receives full benefits of the work, they only receive a fraction of the total cost. One caveat is that a consultant must have experience working in the public health sector or at least the public sector to give that person the broad foundation of how government programs in general and public health programs in particular operate. Denville Township will continue to work with and as a member of the MRPHP to not only receive these benefits, but also contribute the skills, knowledge, and abilities of the Denville Division of Health.

Some specifics of the possible next steps are:

- Develop a generic agreement that may be used by municipal health departments to undertake collaborative activities and that need only to be complemented with the addition of the specific activities for the intended project.

- Evaluate current program requirements to develop evaluations for services that could be performed on a regional basis such as lead inspection, medical direction, noise investigation, health education and promotion. Determine if there are other examples using the work of other collaboratives in other parts of the country.

- Develop the evaluation criteria for health education and promotion programs in order to quantitatively evaluate the current status of such programs and act as a baseline for future evaluation

- Begin the process of educating policy and decision makers of the importance of national accreditation and how the areas of weakness defined in our assessment can be improved through the sharing of services with other regional entities.

- Specific to Denville, contracting with another municipal health agency to provide shared Health Education and Promotion services to meet a need that exists due to the departure of formerly qualified staff.