

**Accreditation Preparation &
Quality Improvement
Demonstration Sites Project**

Final Report

**Prepared for NACCHO by the
Randolph Township Health
Department, NJ**

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Executive Summary

New Jersey requires in its Performance Standards of Local Boards of Health, that each county create a Governmental Public Health Partnership GPHP. (See generally, New Jersey Administrative Code (NJAC) 8:52-1 et seq.). Morris County has been in compliance with this requirement since its inception in 2002 with the establishment of the Morris Regional public Health Partnership, Inc, and a not-for-profit entity. Although the services authorized by the GPHP are limited in scope, Morris County local health agencies have come to recognize the GPHP as a planning and assessment entity as contemplated under the local health performance standards.

The success enjoyed by the GPHP has given rise to the hope of expanding its scope of service; however, such expansion is not yet authorized under the current empowering legislation. With accreditation, local health agencies may be forced to petition the State to broaden the empowering statute so that the scope of GPHP activities may include services such as health education planning, assessment and delivery; this however is speculation.

In an effort to move toward accreditation, this collaborative was been formed. It consists of three municipal health departments in central Morris County, located in northern New Jersey 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 are contracted to provide public health services to an additional three municipalities. The six are geographically contiguous with a population served of over 88,000 persons. The health departments are managed by licensed health officers with a total of 63 years public health experience.

Demand for public health services is increasing with population growth and increasing requirements of state law and regulation.

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 that specified their agreement to participate in a collaborative planning process to implement this project. A planning process was originated 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 major project costs.

Background

The municipalities in New Jersey operate under a system of “home rule”. The concept of Home Rule is derived partly by statutory requirement and local preference to control local governmental activities, due to the fact that local services are primarily financed by property tax revenue. Property taxes are assessed and collected at the municipal level. Municipal services are viewed in a manner similar to local public education. It appears that the consensus of public opinion is that “I want my property tax dollar to finance my local board of education and I do not want my property tax dollars subsidizing an educational system of another lesser perceived municipality”.

In New Jersey, the Home Rule mind set tends to influence the decision made on other municipal services such as police, fire, public works, health, code enforcement and recreation. Home Rule requires each town to provide a health department managed by a licensed health officer. (See NJSA 26:3A-1 et seq). Municipalities may join to contract with a health officer and share his or her services. At the end of the day, Home Rule 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. 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. Tax revenues are declining owing to recent housing revaluations and in consequence of other aspects of an emerging state and national financial crisis and economic recession.

The primary activities of the three health departments are environmental, restaurant and other inspections, and the provision of disease prevention and health promotion activities including health education and screening activities, and communicable disease prevention and control. Each local health officer may be involved with different municipal administrative functions. 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. Although these functions are not directly related to public health activities, the health officer’s administrative time that may be otherwise allocated to public health activities, is reduced. In 2000 the county’s population was 87 percent White and is changing with the addition of new Hispanic Language and Asian residents. In 2006 the per cent of the White population had declined to 84 percent, with the remainder 10.2 percent Hispanic, 8.6 percent Asian and 3.1 percent Black. This is pertinent with regard to two of our Health Education weaknesses identified through this assessment. Specifically, they are related to the provision of culturally appropriate health education. Our populations are changing faster than we can adapt our services to provide culturally competent care. Our ability to add staff (bilingual) and hire interpreters is greatly hampered by our increasingly limited budgets.

The three municipalities have previously engaged with one another in a variety of cooperative activities. The municipalities have mutual aid agreements and participate in a countywide Public Health Preparedness Initiative. Through the Morris Regional Public Health 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 GPHP participation.

No formal agreement is in place to implement the type of work specific to this grant. Randolph Township has also frequently communicated with the other collaborating municipalities as members of the Morris County Health Officers Association, and as members of the Morris Regional Public Health Partnership, Inc. The Partnership conducts research and planning activities on behalf of the 39 municipal health departments in the county, 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 one of the county's needs is the need 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 Randolph Township has been part of the Partnership for a number of years and worked together to produce the County Health Improvement Plan, there was 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 a collaborative.

Goals and Objectives

Following the completion of the self-assessments Randolph Township met with the other health administrators to review the results in company with the assistance of a planner provided by the Morris Regional Public Health 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.

A. Purpose:

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

B. Evaluation Goals:

1. 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.
2. Identify characteristics of the local public health system that affect the outcomes of public health education projects.
3. Develop information for project participants and other interested parties that report the outcomes of public health education projects in terms of quantified criteria.

C. Health Education Goal:

1. To enable persons to improve their health status with programs of health education provided by Morris County municipal health departments.

Self Assessment

Each health department conducted its own self assessment in a manner that was determined by its health officer. The following practices were brought to bear In Randolph Township.

One of the main objectives in conducting Randolph Township's self assessment was to fully understand what was asked under each metric. Objective and true assessments of each metric necessitated some research. This health officer tried to limit the amount of research for any one assessment to one hour. Contact with other collaborative health officers was not an option as it was important to compile the assessment without influence from the other municipalities. Research was limited to the review and examination of office records, some of which were archived and difficult to retrieve.

The order in which the assessment was complete was not a factor. This health officer found the organization of the assessment instrument to be crafted in a fluid manner that made sense. The ten main indicators seemed to mirror New Jersey's Public Health Practice Standards "Ten Essential Services" and each standard under the indicators had a logical sequence. Moreover, answering the metrics in the prearranged order appeared to have been contemplated at the design level.

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

In sum, the authors of the instrument appeared to get it right, as evidenced by the findings of the collaborative. By using the assessment we were able to conclude that an area of common weakness was the assessment of health educational programming. Through the use of the self-assessment tool the collaborative can move toward implementation of an effective health education assessment tool which we are sure will be an integral part of national accreditation.

Collaboration Mechanism

The Randolph Township Health Department is familiar with both the Denville Department of Health and Rockaway Township Department of Health. The three departments had a strong willingness to establish a formal working relationship. In consequence of their membership with the Morris Regional Public Health 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. Subsequently, the health officers met with the Morris Regional Public Health 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 character 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.

Randolph Township, in particular is a council/manager form of government. In New Jersey, this form of government is chosen when the people desire its local governance to mimic how the private sector operates. The council/manager form of government closely resembles the CEO/Board of Director business model and is considered by many to be the closest to how affairs are handled in the private sector. In Randolph, consolidating services for the sake of consolidation alone is looked upon with a somewhat jaundiced eye. The concern is that joining with a municipality having baggage occasioned by its adoption of a more political and less efficient form of government will result in Randolph Township subsidizing the joining municipality. This explains, in part the hesitancy of one municipality joining the other without comprehensive analysis.

However, with regard to the project's substantive content, the collaborative decided the planning process to be used for project implementation was to be 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.

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 and other barriers as described above. In recent weeks the municipal requirements for the preparation of 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 have been the following:

- That the municipal managers who supervise the health departments are amenable to collaborative projects that require a formal agreement so long as the appropriate level of analysis is placed on the project to answer criticism of subsidizing joining municipalities.
- That the health departments are sufficiently compatible to easily plan and agree to intended project terms and obligations through participation in the GPHP.

- 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.
- Boards of health appear to be interested in achieving national accreditation. The consensus of the Randolph Board of Health is that if national accreditation is going to improve public health services at no additional cost to tax payers they will support this 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 advance as a part of normal public health functions being carried out.
- 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

- Start the project in an environment that is restricted financially and by staff limitations.
- 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.
- Develop health education programs with measurable outcomes to support evidence-based practice.

- Assess the outcomes of the programs and whether we were able to measure the targeted outcomes.
- Implement the program with the changes.
- Collect and contribute to data supporting evidence based health education programs/practices.
- 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 thru the sharing of services with other regional entities.

Conclusions

In summation, local health accreditation has compelling public health significance. Agencies which value accreditation will be better positioned to move public health forward in the approaching decades. Agencies which fail to look at accreditation as means by which to grow, will be stunted and be in a disadvantageous position to withstand the rigors of organizational justification. I would liken the concept of local health accreditation by example. If you were an organization formed in 1970 and chose to ignore the value of the computer you are probably not around today. Today, if you are a local health organization that fails to see the value in accreditation, it is likely the next generation will know of you only in an academic context when discussing archaic forms of public health agencies.