

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

Final Report

**Prepared for NACCHO by the
Pomperaug Health District, CT**

November 2008



Brief Summary Statement

This collaborative consisted of the Pomperaug and Naugatuck Valley Health Districts located in western Connecticut. The Pomperaug District Department of Health (PDDH) covers the towns of Oxford, Southbury and Woodbury and serves a total population of 42,000. The Pomperaug Health District is the lead agency for this effort. These local health departments are adjacent to each other and have worked collaboratively on other initiatives, most notably regional emergency preparedness. As a result of the self-assessment, Standard 2A, Routine Outbreak Investigations, was identified as a common area for improvement. The districts established and executed a Mutual Aid Agreement that outlines a strategy for developing standard operating procedures and also commits to sharing resources when outbreak investigations exceed local capacities. The agreement was reviewed and approved by each Board of Health and represents several revisions/improvements to the original document. Furthermore, this agreement cements a long-standing informal arrangement and can serve as a template for other joint activities between the two districts.

Background

This initiative offered a unique portal into a state with rapidly changing communities and insight into how neighboring health districts with differing attributes of urban, suburban and rural life and distinct social, economic and demographic characteristics could effectively address common, regional weaknesses.

PDDH has operated since 1986 and traditionally has been strongly environmental health focused with some attention to community health efforts (i.e. flu clinics, screenings). The districts have a history of jointly implementing grant programs and regional emergency preparedness activities. Both are members of NACCHO, the CT Association of Directors of Health (CADH/SACCHO) and the CT Public Health Association. Each district has a user-friendly website offering health information to consumers and service providers and each has a strong staff infrastructure including long serving health directors and key personnel such as community health nurses and health educators.¹

While similar in many respects, there are differences between the two districts. PDDH does not have a local community hospital within its catchment area and has not completed a Public Health Performance Standards Program (NPHPSP) for the district. That process is beginning for PDDH and the Accreditation workup is an important part of an ongoing change in health district direction. Neither district has engaged in the MAPP process, although they have conducted strategic planning activities and expect that their efforts on this project will help inform and drive future quality improvement activities and joint efforts. A primary reason why the collaborative chose to undertake this work was to prepare for accreditation.

In the past two decades the region served by the districts has seen rapid change. Many towns have transformed from centers of manufacturing that were historically home to second and third generation European immigrants to bedroom communities with a more diverse population and employment base. A number of towns in the districts were among the fastest growing sub-region

¹ www.nvhd.org and www.pomperaughealthdistrict.org

in the state from the 1990s to 2000.² And yet, there are still distinct differences within the region and within the districts. Towns in the PDDH have an average median income of \$84,445, considerably above the state average of \$65,859; however, NVHD's communities' median incomes range from \$46,916 (almost 30% below the state average) to \$76,641.³ While PDDH serves a primarily white and somewhat aging population, one of its towns, Oxford, is one of the fastest growing communities for young families in the last five years. The NVHD meanwhile, is experiencing a rapid increase in the Latino population and an in-flux of young families from diverse cultures and races, while also serving an aging population that is still primarily white. Many of the residents served by NVHD still work and live in their communities; the PDDH is home to primarily white collar workers, many of whom work outside the health district.

Goals and Objectives

The overall goal of this initiative was to systematically identify an area(s) suitable for collaboration that was feasible, maximized resources and advanced the participating health departments' efforts to prepare for future accreditation. To achieve this goal, the participating health departments completed the Operational Definition self-assessment, established a process for sharing, comparing and prioritizing the data and ultimately selected a priority area for improvement and established a formal mechanism to advance the quality improvement efforts. The health departments completed the self-assessment by May 15th, met to review results and prioritize data on June 13th, selected a priority area in July, and signed a Mutual Aid Agreement outlining specific responsibilities and activities of each department in November. While identifying an area for collaboration was the overall goal, exploring and implementing the process to reach that end goal was a valuable experience in and of itself. The health departments gained important insights by completing the self-assessments and through the process of collaboration.

Self-Assessment

Both health districts assembled their leadership teams (program coordinators/managers) to complete the assessment. Health Directors from both districts choose this approach to ensure input from those closest to the specific program areas and complete an honest and thorough discussion among the program coordinators/managers. Both leadership teams were brought together for an orientation to the project and an introduction to the assessment tool. This was facilitated by the SACCHO, the Connecticut Association of Directors of Health, Inc. (CADH). Each member of the leadership team was provided a copy of the assessment tool and was asked to complete it independently prior to the leadership team assessment process.

Approximately two weeks after the project orientation meeting, each District brought their leadership teams together to complete the assessment. CADH facilitated half day sessions with each District for the scoring process. Each member of the leadership team was provided color coded cards that corresponded with the assessment scoring categories. By show of cards, CADH staff captured the results for each indicator. Only one score was recorded representing the overall consensus of the group. When there was considerable difference, CADH engaged the

² CT Economic Resource Center, 2007 Town Profiles

³ CT Economic Resource Center, 2007 Town Profiles

group in discussion regarding why they chose their score. CADH documented these discussions and following the discussion the group voted a second time.

Completing the assessment can be tedious and it is challenging keeping everyone focused and motivated. Some of the indicators were interpreted differently by different respondents. In some instances, engaging the group in discussion provided opportunity to standardize how each of them interpreted the indicator. In other instances suggestions for re-write were documented and submitted to NACCHO for consideration. Another challenge was in dealing with indicators for which the District had no direct involvement. In these cases there was considerable discussion regarding how much the District could or should rely on external systems for their specific score.

On June 13, 2008 the leadership teams from both the Pomperaug and Naugatuck Valley Health Districts met to review the summary reports from the individual department assessments and to begin the process of identifying the priority area for quality improvement focus. In addition to the NACCHO summary reports provided for each department with scores at the indicator and standard level and the collaborative score at the indicator level, CADH provided additional summary reports. (See Appendices A, B, and C)

They included:

- Standard Scores organized by Essential Service;
- Standard Scores organized by Capacity-lowest to highest based on the Collaborative Score;
- Graphs by Capacity-Lowest to Highest based on the Collaborative Score.

Each summary format included the collaborative scores as well as the individual health department scores. This was important because the collaborative score may or may not suggest the priority area. For example, a collaborative score of 2 could be the result of both departments scoring 2 or one department scoring 0 and the other scoring 4. A significant difference between the two departments may not be the best area to target for collaboration.

Highlights from Self-Assessment Results

Essential Service/ Standard	Standard and Significance
II. A	<p>Routine Outbreak Investigations</p> <ul style="list-style-type: none"> • This was an area of moderate capacity for both LHDs, as identified by both the collaborative score as well as the individual department scores. The group felt that this would be the best standard to address based on the high value they placed on it and their ability to advance a quality improvement effort through collaboration.

I. D	<p>Integrate data with health assessment and data collection efforts conducted by others in the public health system.</p> <ul style="list-style-type: none"> • This was an area where both LHDs scored lower, within the minimal capacity to moderate capacity level. This standard was initially considered by the group as an area to address but was not chosen because of the lower value placed on the standard as well as the perceived difficulty in advancing a quality improvement effort in this area.
VI. C	<p>Educate individuals and organizations on the meaning, purpose, and benefit of public health laws, regulations, and ordinances and how to comply.</p> <ul style="list-style-type: none"> • Noteworthy, this is a very high scoring area for both LHDs, as they scored optimal capacity for all indicators within this standard. The LHDs will continue to ensure that staff is competent to provide education to regulated entities, written policies and laws are accessible to the public, appropriate education to regulated entities is provided at inspection time, and that regulated entities are invited to education programs.

Essential Service/ Standard	Standard and Significance
I. B	<p>Develop relationships with local providers and others in the community who have information on reportable diseases and other conditions of public health interest and facilitate information exchange.</p> <ul style="list-style-type: none"> • This was an area of minimal capacity for both LHDs, as identified by both the collaborative score as well as the individual department scores. The group felt that this standard was of high value, but that it would be difficult to advance through a collaborative quality improvement effort.
VI.	<p>Enforce public health laws and regulations</p> <ul style="list-style-type: none"> • Of note, all of the standards within this Essential Service were high scoring areas for both LHDs. Both LHDs scored at a significant to optimal capacity level for all standards within this Essential Service.

In general, ES#2, Protect People from Health Problems and Health Hazards and #6, Enforce Public Health Laws and Regulations scored the highest both as a collaborative and by individual departments. Collaborative scores were lowest for ES#9, Evaluate and Improve Programs and #10 Contribute to and Apply the Evidence Base of Public Health. At the indicator level, five of the six indicators in ES#6 were at the “significant or optimal” capacity level as were six of the seven indicators in ES#2. At the indicator level there was a relatively equal distribution of scores across three categories of “no or minimal” capacity (scores 0-2), “moderate” capacity (scores 2-3) and “significant or optimal” capacity (scores 3-4).

After review of the data, the group developed criteria that were used to help identify priorities for quality improvement. The following themes emerged:

- SCORE
 - Focus on items with minimal or moderate capacity
 - Minimize the score differential between departments
 - Focus first at the standard level
- BENEFIT
 - Place greater emphasis on those items of greater value
 - Focus internally
 - Emphasize those items of benefit to both departments
- ACHIEVABLE
 - Focus on items that departments have capacity to advance
 - Focus on items that are reasonable based on time, resources, staffing, expertise
- SHARED WORKLOAD
 - Initiative should provide opportunity for shared tasks and effort

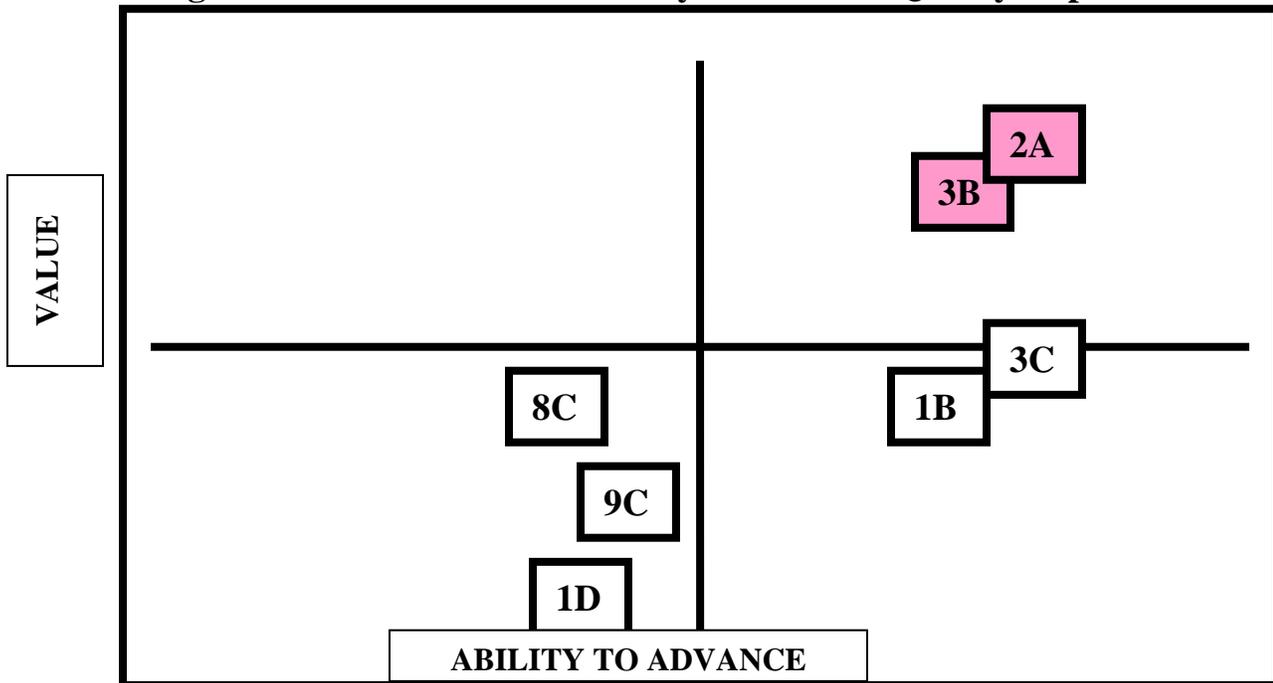
Members of the leadership team were asked to identify three priority areas using the established criteria as a first screen. This process resulted in a list of fourteen standards. They included:

- 3C Provide Health Information to Individuals for Behavior Change
- 2A Routine Outbreak Investigations
- 8C Developing the Future Workforce
- 9B Use of Evidence-based Methodology for Evaluation
- 9C Evaluate LHD Programs
- 1D Integrating and Sharing Data with Community Partners
- 7B Prevention and Personal Healthcare System Building
- 8D Effective Public Health Practices Used by Other Practitioners
- 1B Disease Reporting Relationships
- 6D Tracking and Understanding Compliance with Regulations
- 9A LHD Evaluation Strategy Focuses on Community Outcomes
- 7A Community-Oriented Program Planning
- 8A Overall Human Resources Function/Workforce Capacity
- 8B Public Health Competencies of Existing Workforce
- 3B Data and Information Exchange on Population Health Issues

The list of fourteen was further reduced to those standards that were identified by more than one member of the leadership team resulting in a final list of eight standards. Each leadership team

member was asked to score the eight items on a scale of 1-5 first on the value and benefit that they place on the specific standard and then on the ability to advance a quality improvement effort. The individual scores for each item were then tallied to get total group scores to reflect the leadership team’s perspective on value and ability to advance the standard. Those group scores are represented in the following graph:

**Prioritized Standards Mapped
Against Value/Benefit and Ability to Advance Quality Improvement**



Standard 2A, Routine Outbreak Investigations, and Standard 3B, Data and Information Exchange on Population Health Issues, were ranked highest in priority. 2A, Routine Outbreak Investigations had a collaborative score of 2.67 and the individual department scores were also 2.67. 3B, Data and Information Exchange on Population Health Issues received a collaborative score of 2.9, the departments scored 3 and 2.8 (See Appendix D). The following table summarizes the measures under each of these standards and the Capacity identified by each of the departments.

Following the prioritization process, CADH asked the leadership teams to fill out an evaluation form so that they could improve on their work in the future (See Appendix E).

Collaborative Mechanism

A Mutual Aid Agreement was developed to codify and formalize the collaboration to enhance Standard 2A, Routine Outbreak Investigations (See Appendix F). The districts met to discuss what elements should be included in the Mutual Aid Agreement and outline the available resources and strengths that each district could bring to the table. The Pomperaug and Naugatuck Valley Health Districts have worked collaboratively before and developing and

executing a Mutual Aid Agreement was not believed to be problematic. Both Health Districts have a fairly small organizational structure and a very similar underlying mode of operation. The District Operations are decision based, field level operations, with little time for more deliberative processes. That said, it was clear that collaborative mechanisms can work and in fact are necessary with the limited resources available.

The districts met to discuss the details of a joint Mutual Aid Agreement working from a rough template supplied by CADH. Modifications were then made to the MOU (MOA), and mutually agreed upon by the Director of each entity. One item of note from the PDDH side was the provision to allow for financial compensation for specific events that may go on for extended time periods. A Board of Health governs both districts, and the PDDH Board reviewed the MOA in October, 2008 and approved the document as presented. The NVHD approved the MOA in November, 2009.

As discussed above it was very clear that with limited budget resources and mandatory state programs, the small health districts in CT are stretched very thin in their total knowledge/skill resource base. It becomes impossible to know every thing in the community and environmental health areas, with staffs of 7 or 15 people. Therefore it behooves us to begin the collaborative process whereby strengths in one area can be shared with another entity and vice versa. This line of thinking, formalized in the MOA process, can apply for both routine and emergency situations.

Results

While the collaborative has not yet had the opportunity to advance work specific to the priority area, a number of significant outcomes have been achieved. The process of the self-assessment has provided each department, and their leadership teams, with insights into the strengths of their departments and programs. In addition, they have been able to identify areas for improvement against the operational definition and a standard that is likely going to be reflected in a national accreditation program. Through the collaborative process, staffs from each of the departments have begun to develop relationships that will support the joint efforts moving forward. Overall the departments were able to develop a process that can be used in the future to identify initiatives that would benefit from shared efforts, and a formal mechanism for articulating how those initiatives would be advanced.

Lessons Learned

Most importantly the Pomperaug Health District began the process toward eventual accreditation and the completion (spring, 2009) of the NPHPSP. A review of those standards and the associated Operational Definition Metrics will assist us in a gradual transformation to more capable health department. We found the SACCHO (CADH) to be most helpful in both completing the internal assessment and, most importantly, deciding which joint accreditation items to focus on. Without their assistance the PDDH may have bogged down in the vast “operational metrics” discussions. One of the early issues was the definition of the word “capacity”. It was a sort of, could you do it if you wanted to, and/or would you do it anyway. This may sound confusing but in the end we decided on capacity as “what you could do with existing staff (35 hrs /week), at the present time”. Once that was cleared up, CADH helped us to

stay on task and legitimately score the “standards”. The process itself was also beneficial in improving communication between the two districts, building relationships, and ultimately a collaborative partnership emerged. Additional items of note include 1) the general tendency for the Director to score higher than staff and 2) the critical nature, but honest scoring of key staff and 3) the realization of what we are “not” doing, but should be. One final thought involves the ultimate selection of the joint “standard” for the MOA. In the end we picked an area where both Health Districts had a reasonably good capacity, but we wished to improve that ability to a higher level. The primary lesson learned was that multiple health jurisdictions, working in good faith with responsible leadership, could proceed forward with the accreditation process. With the leadership (Director of Health) driving the efforts, the QI initiative process can gain traction. These efforts must include key staff directly involved in the effort and thereby gain a buy-in by those affected. This project, which in the end can only expand the capability of each health district, was greatly facilitated by an outside, neutral party. In our case the SACCHO, (CADH), provided the motivation and experience which prevented the process from getting “bogged” down in detail. The use of the outside facilitator helped to build a consensual agreement for both the local health district, and the joint effort.

Next Steps

The next steps in this process include an organized effort to carry out the intent and goal of the MOA. This would include the development of a special team, made up of members of each department, which would proceed to jointly develop the protocol. The protocol would detail the measures taken in regards to each type of disease outbreak occurrence, what measures the LHD would utilize, and when, if necessary, a call be made for outside assistance from the collaborative partner. Once the document is in place then a series of joint discussions, even a tabletop exercise conducted, in order to debug the process. During this development, key health department staff would kept in the loop, so as to ensure a buy in from each agency. Finally, the joint accreditation process lends itself to future efforts where shared expertise can be utilized.

Conclusions

The project enabled the staff of the Pomperaug Health District to gain an appreciation of what the future accreditation effort would look like. That process alone is helping the agency transform itself into a more complete public health entity. We also learned about a national benchmark standard and where the PDDH falls in relation to the “gold standard”. The accreditation project also helped the Board of Directors to become part of the formal process, and helps to educate these volunteer folks, of varying backgrounds, on what a fully functioning Health Department can do for the community they serve. Finally the two health districts, working together in a joint effort, demonstrated how, with limited resources, an important public health mission can be carried out. This effort can be a “model” for future joint endeavors.