Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Rockaway Township Health Department, NJ

November 2008

ROCKAWAY TOWNSHIP

Summary Statement

This collaborative 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. Denville, Randolph and Rockaway Townships contract with additional municipalities to provide public health services. Rockaway Township Health Department contracts with Chester Township and the Town of Boonton for various public health services. Denville Township contracts with the Boonton Township; Randolph Township contracts with Rockaway Borough. The relationships among the contracting municipalities are stable and have endured over many years. Rockaway Township has contracted with Boonton and Chester Township for decades. Rockaway Township also contracts with Denville Township to provide public health nurse supervision and as of 2009 will be providing health education services, an outcome to which this collaborative may have contributed. See Table 1 below for details regarding the various populations of all municipalities involved which comprises approximately 18% of Morris County's population.

Table 1: Populations served by Collaborating Municipalities

Place	Total Population	% of Total Population	Urban Population	% urban	Rural population	% Rural
Morris County	470,212	100	432,880	92.1%	37,332	7.9
Rockaway Township	22,930	4.9	19,225	83.8	3,705	16.2
Town of Boonton	8,490	1.8	8,496	100	0	0
Chester Township	7,282	1.5	3516	48.3	3,766	51.7
Total	38,702	8.2	31,237	80.7	7,471	19.3
Randolph Township	24,847	5.3	24,552	98.8	295	1.2
Rockaway Borough	6,473	1.4	6,473	100	0	0
Total	31,320	5.7	31,025	99	295	1
Denville Township	15,824	3.4	15,824	100	0	0
Boonton Township	4,287	o.9	3,787	88.3	500	11.7
Total	20,111	4.3	19,611	97.5	500	2.5
Total for all	90,133	18.2	81,873	90.8	8,266	9.2

Data Source: U.S. Census 2000

Upon completing the self assessments and analyzing the aggregate results for mutual areas of weakness the collaborative chose to address Quality Improvement (QI) in the area of Communications/Health Education.

Background

An illustration of the uniqueness of each municipality is demonstrated by the fact that municipalities with which Rockaway Township contracts have various forms of government. Both Boonton Town and Chester Township have autonomous Boards of Health. Rockaway Township has the “Faulkner” form of government where the Township Council serves as the Board of Health. Additionally, the Town of Boonton has a lower socioeconomic status than the other two municipalities; it is more urban in character, and has a higher immigrant and non-English speaking population (Asian & Hispanic). Additionally, some municipalities operate within the Civil Service system while others do not. This also affects workforce and hiring practices including personnel requirements.

Despite our differences, Morris County’s local health departments (LHDs) have a long history of collaboration. There has been a county public health association and/or Health Officer’s organization, of some sort, for over

30 years. Collaborative practices have increased significantly and have become more formal over time. For example, one of the initial, more formal collaborations was the result of some "out of the box" thinking. Communities in Morris County were unable to apply for certain grant funds due to the fact that the county was generally upper middle to upper class with only a few pockets of populations meeting the socioeconomic criteria. The individual municipalities that met the socioeconomic criteria were too small and didn't meet the criteria for population size. At that time the Rockaway Township Health Officer proposed that the small communities of need combine forces and make a joint application. Rockaway Township was involved because we provided services to one of those areas of need, the Town of Boonton. Thus three municipalities joined forces and worked with a planner at a hospital in one of those communities. The grant application was made by the hospital in collaboration with the three communities. This was the beginning of the New Jersey Cancer Education and Early Detection (NJCEED) program in Morris County. As mentioned previously there has been a progression in the level and formality of collaboration in the county. Initially there were mutual aid agreements which are still in existence. Since its inception in 2002 municipalities have entered into formal contracts with the Morris Regional Public Health Partnership, Inc. (MRPHP). The MRPHP is a not-for-profit organization that was founded by the municipal health officers. The health officers of Morris County constitute the governing body of the partnership. Rockaway Township entered into a formal agreement with the MRPHP in May of 2004; which required approved by the governing body by resolution. The purpose of the relationship was to collaborate in the assessment, planning and implementation of public health services throughout the county. This opened doors and gave us a much greater ability to perform these tasks; "many hands make light work". No individual municipality in the county would be able to meet Public Health Practice Standards without the contributions of this organization.

More recent changes within an environment of strong "local rule" include a greater willingness and acceptance of reaching out of our jurisdictions and *across* our political borders. New Jersey is unique in the fact that the state provides very little funding to local health departments, therefore the brunt of the costs are being born by the local tax payer. State aid to municipalities, in general, was cut drastically in 2008 and in 2009 municipalities have a 4% cap on budget increases. The Health Department budget for 2009 is being cut (as are all departments within the Township). With the recent economic events, housing values have plummeted resulting in decreasing property tax revenue. The economic downturn has adversely affected businesses within township and property tax revenues. Recognition of the need to share services is greater than ever.

Goals and Objectives

1). Complete the self-assessment tool and analyze individual and aggregate scores to be completed by May 15, 2008.
2). Review and analyze aggregate data, jointly identify areas of potential collaboration, identify priority area(s) to address collaboratively and provide a summary of planning process to be completed by 7/25/2008.
3). Develop a formal mechanism of collaboration (i.e. MOA) by 8/30/2008.
4). Produce a final report submitted to NACCHO by 10/10/2008.

Self Assessment

Rockaway Township Health Department staff has previously, jointly, completed other assessment tools, such as APEX. In accordance with previous experience with the Department and being cognizant of the short timeframe in which to perform the assessment, this Health Officer solely performed the self-assessment. Each collaborating Health Department performed the self-assessments independently; results were discussed upon obtaining the individual and aggregate scores. Upon reviewing our results this Health Officer was struck by how similar our results were. These similarities made sharing individual results and the task of choosing priority areas to address a rather easy decision. On a personal level, this Health Officer found some solace in

the fact that others were struggling with the same issues and weaknesses; these were issues that were widespread within our public health system and not unique to Rockaway Township. Table 2 below illustrates the areas of weakness common to the three collaborative LHD's, organized by specific indicators and standards to demonstrate the relationship of standards to practice:

Table 2: Common Areas of Weakness Organized by Specific Indicators & Standards

Indicator #	Standard	QI/Evaluation
I. B. 3	LHD uses QI process with providers to make reporting easy for providers to report	Q/I
III. D. 6	LHD assesses the target population for how they accept information	Evaluation
III. D. 8	LHD evaluates promotion efforts every 2 years and uses results to improve programs	Evaluation
III. D. 9	LHD develops and revises performance measures, goals & objectives based on evaluation of health promotion activities	Evaluation
IX. A. 4	LHD uses internal policy to guide evaluation efforts, frequency and scope of evaluation, organization evaluation, use of health outcomes as benchmarks	Evaluation
IX. A. 5	LHD has evaluations with analysis of local data with goal, objectives & performance measures with established community health goals, objectives & performance measures	Evaluation
IX. A. 6	LHD uses community health target outcomes as evaluation benchmarks	Evaluation
IX. B. 1	LHD uses evaluation framework, connecting intervention to outcomes, based on evidence	Evaluation
IX. B. 2	LHD periodically evaluates key processes of service delivery for efficiency, effectiveness using established criteria	Evaluation

Table 2: Common Areas of Weakness Organized by Specific Indicators & Standards (continued)

Indicator #	Standard	QI/Evaluation
IX. B. 3	LHD works to identify best practices or benchmarks for evaluation purposes	Evaluation
IX. C. 2	LHD monitors program performance measures & data to document progress toward goals & requirements	Evaluation
Indicator #	**Standard**	**Health Education/ Communication**
I. B. 4	HCP's and partners receive reports and feedback on disease trends and clusters	Communication
III. A. 4	LHD has media strategy, formal & informal, and communicates w/media and responds to their requests; routine comm. to raise awareness of PH issues	Communication
III. B. 5	The public knows how to obtain health data and info from the LHD	Communication
III. C. 5	Target population helps develop and distribute health education materials	Culturally Appropriate Health Education
III. C. 6	Appropriate methods used for distributing culturally appropriate material	Culturally Appropriate Health Education

A review of the chart above illustrates that our common weaknesses reside in "QI" mainly in the area of "Evaluation". Using this basic common weakness we directed our attention to a secondary area of weakness; that being "Communication and Health Education" particularly in the area of "Culturally Appropriate Health Education". An analysis of our individual partners' resources and needs revealed that two of the Health Departments, Rockaway Township and Randolph Township, have staff resources that could be utilized to address these areas assisting the Denville Township Health Department that lacked the basic resource of having a Health Educator on staff. Denville Township contracts with a local hospital for health education services

which limits the ability to individualize and control programs to the extent necessary to accomplish public health goals.

Collaboration Mechanism

Our interest in participating in this grant project was an outgrowth of our membership in the MRPHP which enabled us to further evaluate our ability to execute a more formalized collaborative project. We meet at least monthly with our colleagues and the MRPHP. Therefore, we didn't lose time in becoming acquainted and developing working relationships. We began work immediately. Due to our busy schedules we availed ourselves of the opportunity to meet in person in conjunction with our routine monthly meetings of the Morris County Health Officers Association and the MRPHP. We, also, utilized email to share and comment on documents and, also, communicated via telephone. The three health departments have a long history of working together collaboratively and have entered into MOA's in the past. This was not a foreign concept to us. Morris County Health Departments have long recognized that collaboration is needed to produce outcomes that cannot be achieved by one LHD alone, mainly due to limited resources. As previously stated, the collaborating health departments are members of the MRPHP, Inc., which was founded to address the need for countywide collaboration, assessment, planning and practice. The Partnership Manager is a professional planner/project manager who functions, as well, as a member of the staff participated with the demonstration project to provide planning support to the collaborating municipalities.

Working under the terms of the NACCHO grant contract this individual served as our "project consultant". Historically this shared planner has facilitated collaborative projects that would otherwise be cost and time prohibitive for individual health departments to pursue. Without these services LHD's can become mired in the day-to-day operations and lose sight of the overarching goals. The consultant assisted in the preparation of the grant application, organization of data, facilitated meetings, assisted in the development of the planning process and the collaborative mechanism, developed agendas, and recorded the results of our meetings. The collaborating municipalities performed the self-assessments, analyzed the data, chose priority areas for collaboration, created the formal mechanism of agreement, interfaced with their governing bodies and developed a long-term planning process for the implementation of the project.

As a consequence of our membership with the Morris Regional Public Health Partnership we had a pre-existing agreement for collaboration with that organization that had previously been approved by our mayors and councils. We believed this agreement would be sufficient to serve as the instrument of agreement for this project. However, the granting agency, NACCHO, required an agreement that was more specific to its contracting elements, thereby requiring a the creation of a new instrument.

Each health department consulted with their municipal managers and identified the criteria required by each for a formal agreement. This Health Officer enjoys a very supportive relationship with the Business Manager and the governing body; having already received their support and approval via a resolution supporting applying for the grant. I approached our Business Manager who understood the need for this specific MOA and worked collaboratively with this Health Officer to ensure that the MOA would accurately reflect our level of commitment while not overstating it. Assurances were required that no one municipality was delegating its legal authority to another. Clarification was required that this reflected an agreement to plan and that the agreement would not require one health department to dedicate funds or in-kind services to another at this stage of the project.

In this environment of local rule and limited funds the wording of the agreement had to maintain the independence of each jurisdiction. Throughout New Jersey a number of government entities have been extremely interested in consolidation and have investigated changing regulations to remove protection of

positions within the workforce to facilitate same. The present climate has created and promoted the issue of consolidation of Health Departments making it very important that this project be viewed as collaboration and not a precursor of consolidation. This is a delicate issue with varying degrees of importance dependent on the value attributed to the LHD by the governing body and administration. There was a concern that a misunderstanding of intentions could, ultimately, lead to a form of forced regionalization.

The MRPHP planner/consultant facilitated and kept the process moving forward; the collaborating health departments were on equal standing with regard to input and planning. The atmosphere was one of mutual respect. Adjustments were made to accommodate individual health department needs. To achieve the required agreement the Health Officers communicated as described above. Subsequently, we met and produced a draft agreement. The agreement was reviewed by my municipal manager and after some minor changes and additions (reflecting the concerns as discussed above) and approved. Once all municipalities were totally satisfied the agreement was signed. A copy of the agreement is made part of the Appendices to this report.

Results

The approved MOA has been signed by the collaborating health departments and as such has been implemented; we have officially agreed to collaborate on our chosen project. The municipalities have agreed to "jointly evaluate the provision of health education and promotion activities on a regional basis and explore ways to utilize existing resources in an expeditious manner to improve capacity" and "to provide services in a manner both fiscally responsible and quantitatively measurable".

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. The collaborative has not taken the next step of implementing the planned activities as specified in our agreement. The MOA is very specific to the formation of a “Collaborative” with a formal mechanism of agreement; it does not include the implementation of the QI/Health Education project per se. However, given adequate funding and resources it is this Health Officer's opinion that we can proceed in our analysis, investigation and planning. However, implementation of the actual QI/Health Education project would require the approval of the governing body and be subject to another MOA that would require clear delineation of the project, desired outcomes, time period and specific financial and in-kind resources that would be required of each municipality.

The benefits 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;
- That the collaborative has had the opportunity to add to the body of research in promoting the accreditation of local health departments;
- That the LHD’s experienced growth and a better understanding of our status in the continuum of provision of public health services in accordance with national and state standards.
- That all parties involved in this project were able to strengthen their relationships and their ability to work collaboratively.

Lessons Learned

- 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 require a legally reviewed formal agreement approved by municipal managers and the Township Council that clearly specifies roles, responsibilities and the resources that are to be committed to the effort by each participating health department.
- Each municipality may have different political/governmental environments and systems that may require different approaches.
- It may be possible to utilize agreements and contracts developed in this project to design a generic project collaborative agreement that will state basic understandings and that can be customized to specify activities and resources committed required by each individual project.
- Local Health Departments have a greater ability to participate in projects and research when afforded the opportunity to collaborate with colleagues while having access to a consultant to assist in moving the project forward.

Next Steps

If time and resources permit this Health Officer would endeavor to take the following "next steps":

- Start the project by implementing the plan as described in the appendix;
- Expedite collaborative projects via the development of a generic agreement, with the ability to customize it to the specific project, that may be used by municipal health departments;
- Utilize knowledge gained from the self-assessment results to address additional weaknesses identified (beyond health education programs); while working collaboratively with other LHD's for mutual improvement; The MRHP is a substantial tool in the armamentarium, especially in this environment of inadequate workforce and funding levels.
- This Health Officer is particularly interested in pursuing TQI in numerous areas of public health practice.

Conclusions

It has been an honor to have had the opportunity to participate in a state-of-the-art project in the forefront of public health practice and accreditation. I would like to thank NACCHO, and in particular Penny Davis and Travis Lee, for making this possible. Accreditation is the future of public health practice and QI is an integral part of the process. The use of data and measurable outcomes is essential and often overlooked due to the limited availability of data supporting evidence based public health practices. In my opinion, many aspects of public health do not lend themselves to being quantified; but quantify we must if we want public health practices to be valued. In these economic times it's imperative to support public health programs with measurable outcomes to provide evidence that these programs need to be sustained.

The challenge is not in counting the number of inspections, immunizations or communicable disease cases; the challenge lies in quantifying the outcomes of programs requiring changes in behavior or health status which are prospective in nature and require years to show desired outcomes. The project our collaborative chose was Health Education/QI. The ultimate measure of effectiveness would demonstrate a change in health status outcomes as a result of a health education program, which requires long term study. The change in health outcomes relates to changes in behaviors which, in turn, relate to changes in knowledge and attitude. Initially, we must start with the more immediate measures and build upon them for the long term. We don't function in a vacuum and cannot control many of the variables that may impact results, thereby adding to the challenge of ascertaining the exact determinants of an outcome on which to base evidence-based practices.

Finally, I would like to thank my collaborative team, James Norgalis, HO, Mark Caputo, HO and our consultant, Robert Schermer. This was a true collaboration where all opinions were entertained and respected. We, as professionals, as well as our agencies have our strengths and weaknesses. Our alliance has a synergistic quality. It's reassuring to know that we share many of the same challenges and struggle with similar issues. We have developed a support group and together we work toward common goals. This experience has strengthened our ties fostering future sharing and problem solving. This work will continue, as it is necessitated by public health practice; however the rate of progress will be directly related to resources, such as staffing and funding levels, and our ability to have our work facilitated by the MRPHP. It is my sincere hope that we will be able to maintain the momentum on the work that we have started.