Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Montgomery Township Health Department, NJ

November 2008
**Brief Summary Statement**

Montgomery Township Health Department (MTHD) is located in central New Jersey, serving a suburban population of 24,000. MTHD used the NACCHO LHD Self-Assessment Tool for Accreditation Preparation to identify areas for improvement, and a Quality Improvement process to address our top priorities for improvement. MTHD worked with its community partners to improve data collection in order to begin to do outcome-based evaluation. The community partners’ task was to improve data collection on utilization of low-cost clinical services, in order to assure at-risk residents had access to these services. As a result, MTHD is developing expanded partnerships and outreach programs to assure that residents know how to access services offered by our clinical partners.

**Background**

MTHD employs 4 FTEs to provide environmental health services and administration. Primary focus has been on septic systems, private wells, and retail foods. Clinical services, preventive health services, and health education are provided by community partners through a series of service agreements or contracts. These contracts include:

- STD testing and treatment
- Cancer Screenings
- CVD risk factor screening
- Adolescent health services
- Childhood immunizations/well baby visits

The clinical and preventive health services have experienced low utilization and tend to be fragmented by nature of the service agreements. Montgomery has benefited from high socioeconomic status and, until recently, has not needed to commit resources to assure provision of these services. Recent reports of increased economic need in the community have pointed to a need to strengthen our existing partnerships.

MTHD has benefitted from the support of an active and involved governing Board of Health, which has the authority to approve budget requests and health-related ordinances. MTHD was inspired to participate in this initiative by the advocacy of peers and the support of our Board of Health. Members of our Governmental Public Health Partnership, Health Officers from 10 local health agencies, have been strong advocates of accreditation to demonstrate the need to strengthen the public health system. At the same time, the New Jersey Public Health Practice Standards are setting new criteria for Local Health Departments to assure provision of the Ten Essential Services.

MTHD previously participated in a self-assessment process (New Jersey Enhanced APEX, 2004). While the earlier self-assessment process began to improve communication, and created a comfort level with the process, there was no mechanism (or incentive) to change existing practices. The QI initiative allowed us to focus with our partners on identified areas of weakness (i.e. program evaluation) to both improve service delivery and meet the requirements of Public Health Practice Standards. Since the goals of both accreditation and the Public Health Practice Standards (PHPS) are similar, this Preparation for Accreditation initiative has helped us meet the PHPS requirements while letting our department serve as a role model for other LHDs in the state.

**Goals and Objectives**

The goal of the project was to improve community partnerships with our clinical service providers to assure the provision of needed health services. Within the broader goal were nested data collection objectives:

1. Improve data collection in order evaluate program effectiveness
2. Identify who is in-need in our community
3. Identify what their unmet needs are; and
4. Expand partnerships to meet identified needs
Self-Assessment

The Self-Assessment process was performed using a focus group format. Montgomery Health Department had successfully used a focus group format to complete an "New Jersey Enhanced APEX" assessment in 2004 as well as the National Public Health Performance Standards Local Public Health Governance Assessment Instrument in 2005. The focus group format is effective in generating feedback, coming to consensus on meaning of complex terminology, and developing consistent rating standards. Three focus group meetings were targeted toward contract service providers, environmental health staff, and governing body members. Each focus group took about a half a work day, with compilation of data taking an additional two days. A total of 10 stakeholders participated in parts of this assessment.

The chart below highlights results from the self-assessment that were noteworthy, including those we chose to focus on for the QI process.

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<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
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| VII-C-3              | LHD engages local lay health advocates for outreach to special populations in need of healthcare.  
  - This was an area of weakness for MTHD, as identified through the self-assessment. MTHD determined that this related access issues were a priority because of individuals losing their health insurance in the economic downturn |
| VII-A-4              | LHD, in partnership with community partners, interprets qualitative and quantitative information on program gaps, developed through surveys, focus groups, interviews, or other means of primary data collection  
  - This was also an area of weakness, as MTHD had not participated in this type of evaluation previously. |
| IX-A-4               | LHD has an internal policy to guide its overall evaluation, including frequency and scope of program evaluations, organizational evaluations, and use of Health outcomes as benchmarks for evaluation.  
  - MTHD has not had a formal system of program evaluation, nor used outcomes as a measure of program effectiveness. We chose to try to improve data collection to enable meaningful evaluation, and apply this system to evaluating whether our clinical service providers are reaching our population who needs services. |
| VII-A                | Recruit, train, develop and retain a diverse staff  
  - MTHD has a highly trained staff, with a strong program of continuing education to ensure that their skills are current. This pool of talent, as well as access to a diverse set of community partners, is one of MTHD’s greatest strengths. |

Quality Improvement Process

AIM Statement: The purpose of this program was to improve community partnerships with our clinical service providers to 1) improve data collection to evaluate program effectiveness, 2) expand partnerships to respond to identified needs in the community, and 3) develop a baseline of data that can be used to identify emerging trends.

PLAN: We began by gathering our community partners together to form self-assessment focus groups. We used the self-assessment process to identify, with our partners, top priority areas of weakness to address as a team. We agreed that Montgomery Health Department has not been collecting or using health outcome or health status data in a systematic way (Essential Services #7 and #9).

The Quality Improvement process started by convening a meeting of community service providers, especially outside agencies that serve our residents. We included representatives from our community’s food pantry, women’s health center, Visiting Nurse Association, adolescent health center, school nursing, and elected officials. We provided the representatives with an overview of our project goals and training in QI processes. This seminar, developed by our QI consultant (Jack Moran of the Public Health Foundation), consisted of a half-day of orientation and training, followed by a half-day working group to develop the project timeline and task assignments.
The Working Group used brainstorming to identify the consequences of weak data collection, and the benefits of improving data collection. Consequences included:

- Without data, our planning to address the needs of underserved populations was based on an educated guess.
- We could potentially qualify for grants, but lack data to support a grant request.
- We routinely request funding as a budget line item, but lack data to justify expansion of programs, or document program effectiveness.
- We have been shifting the cost of providing services to our residents to other service providers that we don’t fully acknowledge.
- We are under-reporting what is being provided by others and under-“assuring” that the services are being provided.

The Working Group developed a Force Field Analysis diagram to identify opportunities and barriers to improve data collection. We then brainstormed measures to determine how to measure changes and improvement:

- Increase in people getting services by improving awareness of available programs
- New programs developed through Gap Analysis
- Current programs revised to focus on population needs
- Create a sustainable data-gathering mechanism
- Improved awareness of data needs by all partners to identify data gaps and address those gaps in the next data collection cycle.

**DO:** First, the Group developed a survey tool for community service providers in order to quantify numbers of people in need and the types of services most needed. Each group member was assigned specific organizations that they had previously worked with to interview for the survey. This personal approach was considered essential to generate willingness to participate and to improve the quality of data collected (including soft data). We also used the interview conversation to educate the partners/providers on the benefits to their organization to provide us the data:

- Develop New Partnerships
- Improve Funding Potential based on evidence
- Help implement “best practices”
- Cover Gaps in services by expanding partnerships
- Improve understanding of the range of services available in the community among all partners.

**Obstacles**

It is very difficult to get municipal level data for this community. We cover several zip codes, but we also share zip codes (Princeton) with other municipalities in other counties (so even the county data doesn’t hold). We are halfway between two hospital catchment areas, so our population uses both hospitals and their associated VNAs. Thus, we made more use of “soft” data/ experiences of providers rather than hard numerical data.

**CHECK:** Our next task was to compile the data gathered and create a matrix to identify gaps in the data (to improve the second iteration of data collection). We then used the data collected to develop a program gap analysis. The program gap analysis was used to drive the develop the 2009 program plan to address the identified gaps.

The data collection process by definition is an improvement, since there previously was no process. The process has identified areas where improved data-gathering is needed in 2009 (e.g. Spanish language population). Most importantly, the Quality Improvement process has sparked conversations about new and expanded partnership opportunities (Healthy Youth, Women’s Health & Counseling Center, and HiTops Adolescent Health Services). Specifically, many of our partners provide a broader
range of services than the contract language specifies, and therefore had access to blocks of data that were not previously reported. The reports traditionally generated under the contract were limited to the services specified in the contract. Identifying this data gap revealed a need to renegotiate the contracts, to improve reporting and to support an expanded scope of services.

**ACT:** MTHD and its community partners are working together to close the gaps in available data and improve program evaluation. Additional utilization data on services outside the contract scope is starting to be included in provider reports. This data is developing evidence to justify a rewrite contracts to broaden scope of services (and provide additional financial support where indicated).

As much as these conversations are broadening the Health Department’s approach to its partners, the partners are also becoming more familiar with the Health Department and its mission under the Operational Definition and the PHPS. It introduces the health department as a helping agency in a community that thinks of us primarily as an environmental enforcement agency.

The following QI tools were used to develop our process:

- **Brainstorming** – opportunities, barriers, and benefits of collecting data, as well as identifying possible sources of data.
- **Forces of Change (Force Field Analysis)** – to determine areas where the team needed to focus its efforts to ensure success
- **Flow Charting** – The team developed a high level flow chart of the future state to understand what the external steps were to collect the data from community partners and the internal steps to process the collected data, develop reports, analyze the reports for trends, publicize the data both internally and externally to initiate actions to respond to trends, and sustain the process over time.
- **Matrix Diagrams** – utilized an L-shaped matrix to identify Community Partners and Data requirements. The matrix was used to analyze what data was available and what was missing. A gap analysis was made to pinpoint data needs that were not currently being recorded by Community Partners.
- **Gantt Chart** – utilized the Gantt chart as a project planning tool to develop a time line of actions to be completed, the timeline for completion, and who was responsible. This was used a tracking mechanism to keep the project on track.

**Results**

Only a few organizations were able to give us numerical data specific to Montgomery Township. The results showed (fortunately), Montgomery residents are not overwhelming the available services. Montgomery residents in need tend to have more short-term needs for interim periods, rather than chronic needs of the underserved. Major obstacles to seeking assistance include embarrassment (“I never thought I would have to ask for help”), lack of familiarity with the services that may be available, and lack of knowledge about how to navigate the system of service. There is also a small Spanish-speaking population that is accessing services through agencies outside the community. The results provide reassurance that the scope of the problems associated with the economic downturn is manageable (in this community at this time)

**Lessons Learned**

- Some team members were intimidated by a 52-page package of questions in the Self-assessment tool. The team addressed this by reading and discussing the questions one at a time. The insight generated by the discussion often went well beyond the question itself.
- We focused on involving lots of stakeholders in the discussion from different support functions to get their buy-in. This will ultimately improve the quality and applicability of the assessment
- A major concern was how to keep the process simple and sustainable. QI efforts have to be scaled the size of the organization.
- Initially, the team chose to think small and get comfortable with the process. Success with one small project creates a template for the next project.
- Health Departments should also not be afraid to “flunk” a standard if resources have not been allocated for that task. It provides justification for putting additional resources into that function.
**Next Steps**
We intend to use the survey tool and re-contact our community partners to do follow-up data collection in fall, 2009. The data collected at that time can be compared with 2008 data to help evaluate outreach effectiveness, and to identify priorities for 2010.

Based on our gap analysis, the QI team concluded that the primary barrier in this community to utilization of health services was a lack of knowledge of those services, and not a capacity issue. An effective response to this knowledge gap would have to acknowledge the reluctance of residents to admit need. A targeted response is planned for 2009 implementation, described in Appendix C.

We are developing a “Peer Outreach” program to take advantage of a known community strength. Our community has a strong spirit of volunteerism and a willingness to help their neighbors. Volunteers from a cross-section of community groups will receive peer-to-peer training in what health and social services are available for those in need, as well as how to share such information in an environment of confidentiality and trust. The availability of these peer outreach counselors would be announced throughout the community (through venues such as PTAs or faith-based groups), under the branding of “Do you have a friend that needs help?”, or similar. Launch of this program will be in early 2009.

Measures of success would include: number of peer outreach counselors trained; number of contacts made with the peer counselors (without identifying information); and utilization rates of the service providers compared with baseline.

The improved data collection is already enhancing partnerships:
- The Health Department will be assisting with a community needs assessment with the Healthy Youth program in 2009.
- We are in discussion with clinical partners on ways to broaden the scope of services offered, and increase to quality of data reporting.

By targeting our QI process directly at an identified area of weakness, our organization is better prepared to meet the requirements of voluntary accreditation. This process further enabled us to successfully participate in early evaluation for NJ PHPS compliance. The process generated a comfort level with Quality Improvement practices among our service providers. Since these providers also serve a number of nearby local health agencies, their experience helps spread the word and speed the adoption of QI practices throughout the region.

The immediate task at hand is to implement the action items identified as top priorities during the data collection and gap analysis:
1. Implement a peer outreach program to improve community awareness of available services and how to locate them.
2. Initiate a dialog with Spanish-language service providers in nearby communities to assure needs of Montgomery residents are being adequately addressed.
3. Re-survey service providers in fall, 2009 to evaluate impact of outreach efforts, and identify emerging needs to prioritize for 2010.

Serendipitously, the proposed peer outreach program will help us in our emergency response capacity. In 2007, resident stakeholders on our Pandemic Preparedness Coordinating Committee recommended development of volunteer “Neighborhood Help Centers” to meet non-medical community needs during an influenza pandemic or other public health emergency. Training a corps of Peer Outreach volunteers will create a framework which can be adapted for use in a community emergency, helping to locate vulnerable populations and create a trusted information source.

**Conclusions**
Our organization has become an advocate of voluntary accreditation and self-assessment as a result of this initiative. Going through the self-assessment tool with our stakeholders has helped us take a serious look at our operations, and ask, “How does this activity improve the health status of this community?”, and why we do the things we do.

In a tough fiscal environment, Local Health needs to be able to demonstrate evidence-based, measurable results. This evidence base will help prove the value of public health, and show decision-makers why we need to protect public health infrastructure. Public Health must increase its visibility or will be identified as “low-hanging fruit” when the budget axe is wielded.
Appendices

Appendix A: Storyboard of QI Process
Appendix B: Survey Instrument for Community and Health Service providers
Appendix C: Proposed Peer Outreach Program