

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

Final Report

**Prepared for NACCHO by the
Naugatuck Valley Health District,
CT**

November 2008

Brief Summary Statement

This collaborative consisted of the Naugatuck Valley and Pomperaug Health Districts located in western Connecticut. The Naugatuck Valley Health District (NVHD) covers the towns of Ansonia, Beacon Falls, Derby, Naugatuck, Seymour, and Shelton and serves a total population of 125,241 with a staff of 18 public health professionals. The Pomperaug District Department of Health (PDDH) covers the towns of Oxford, Southbury and Woodbury and serves a total population of 42,000 with a staff of seven. The Pomperaug Health District was the lead agency and initiator of the project. These local health districts are adjacent to each other and have worked collaboratively on other initiatives, most notably regional emergency preparedness. This was the first time the two districts collaborated on a grant together. The Connecticut Association of Directors of Health (CADH), a state-based association of county and city health officials (SACCHO), facilitated the process. As a result of the self-assessment and the facilitated process, Standard 2A, Routine Outbreak Investigations, was identified as a common area for improvement. With the approval of the respective governing bodies of the two districts, a Mutual Aid Agreement was established and executed that outlines a strategy for developing standard operating procedures and also commits to sharing resources when outbreak investigations exceed local capacities. This agreement formalized a long-standing informal relationship that can be used by the districts for other activities beyond outbreak investigations.

Background

Connecticut is a state of contrasts. Wealthy communities are often adjacent to socially distressed communities and resources to address public health problems vary from municipality to municipality, not necessarily corresponding to the wealth and/or needs of the residents. This initiative offered 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.

NVHD, located in the Lower Naugatuck Valley in western Connecticut, has operated since 1972. PDDH has operated since 1986. Both health districts offer a range of environmental health and community health programs. The districts have a history of working on 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. The Naugatuck Valley Health District has considerably more experience with assessments, community partnerships, strategic planning and related activities. PDDH does not have a local community hospital within its catchment area while Griffin Hospital, a strong community resource, is in the NVHD public health system. Through a partnership with the Yale-Griffin Prevention Center, the NVHD benefits from a community health profile updated regularly with trend data extending beyond a decade. The director of NVHD recently completed a two-year term as chair of the Valley Council for Health and Human Services, an organization of more than 40 agency

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

dedicated to identifying community needs and developing culturally responsive solutions. NVHD completed the National Public Health Performance Standards Program's (NPHPSP) Local Public Health System Performance Assessment in 2004; Pomperaug will seek technical assistance from CADH to conduct the NPHPSP survey in late 2008. Neither district has engaged in the Mobilizing for Action through Planning and Partnership (MAPP) process, although they have conducted strategic planning activities and expects 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. A number of towns in the districts were among the fastest growing sub-region in the state from the 1990s to 2000.² And yet, there are still distinct differences within the region and within the districts. Overall, the residents of PDDH are more affluent, highly educated and less diverse than those of NVHD. 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 aging population, one of its towns, Oxford, is one of the fastest growing communities for young families in the last five years. The NVHD is experiencing an in-flux of families from diverse cultures and races with approximately 70 languages documented by Adult Education Classes, while also serving an aging population that is still primarily white. Many of its towns have transformed from centers of manufacturing that were historically home to European immigrants to a more diverse population and economic base.

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 chose this approach to ensure input from those closest to the specific program areas and to provide "cross fertilization" and discussion among the program coordinators/managers. Both leadership teams were brought

² CT Economic Resource Center, 2007 Town Profiles

³ CT Economic Resource Center, 2007 Town Profiles

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 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

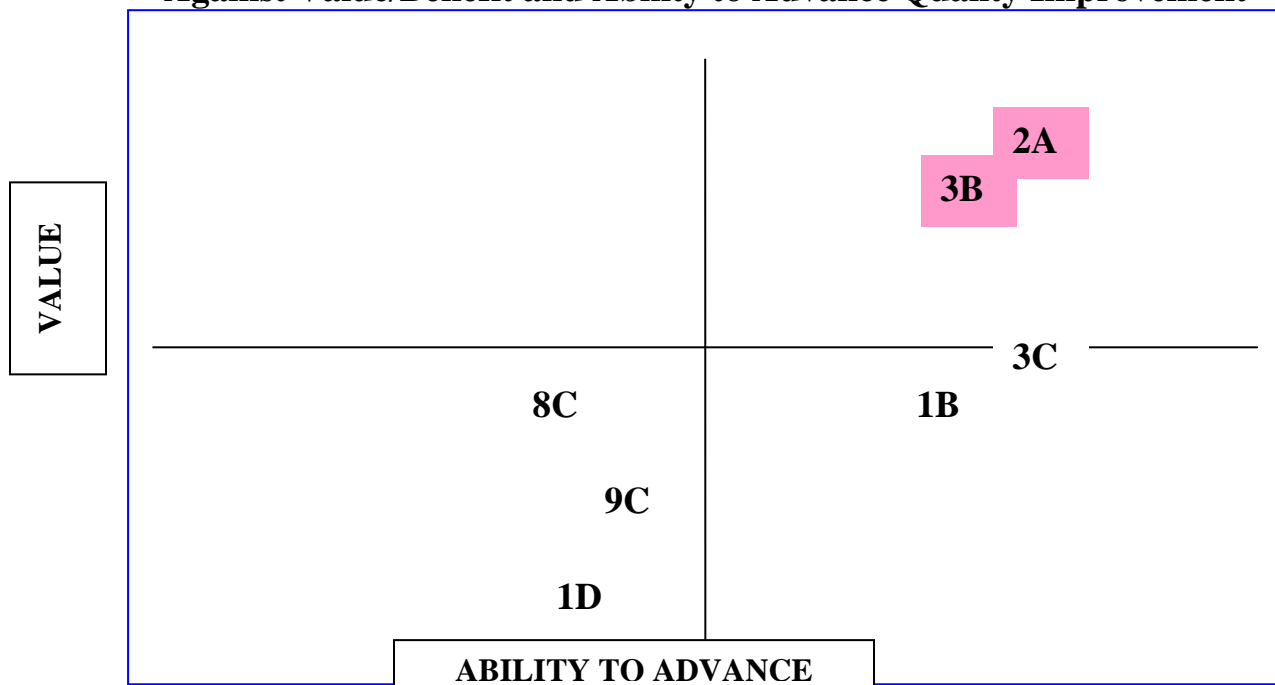
Members of the leadership team were asked to identify three priority areas using the established criteria as a first screen. This process resulted in a list of fourteen standards. They included:

- 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).

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

The districts chose to develop a Mutual Aid Agreement to codify and formalize the collaboration to enhance Standard 2A, Routine Outbreak Investigations (See Appendix F). Although the districts have collaborated in the past on emergency preparedness, staffing for community health programs and coverage in the absence of Directors of Health, those relationships were always informal verbal agreements without a defined process for collaboration. As the districts had a long history of assisting each other, it was thought that a more formal Mutual Aid Agreement would not be problematic to execute.

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. Each of the districts is governed by a Board of Health scheduled to meet monthly. Through the month of September and into early October, the Mutual Aid Agreement was drafted and reviewed by the Directors. In October each district presented the Mutual Aid Agreement to their respective Boards for approval. The Pomperaug Health District approved the Mutual Aid Agreement at the October meeting. The Mutual Aid Agreement was distributed and discussed with the Naugatuck Valley Health District Board of Directors in October for passage at its November meeting. This is consistent with Board procedures to provide adequate time for review and comment when scheduling allows.

At its November meeting, the NVHD Board passed the Mutual Aid Agreement as written with strong support and very little discussion. Several years previous to this project, the Board of Directors reviewed in detail the issue of Mutual Aid Agreements in relationship to regional emergency preparedness. The Corporation Counsel for the district determined that the decision to enter into an agreement was a policy decision for the Board of Directors to make. After considerable deliberation on the matter, the Board of Directors agreed that the district had limited resources and Mutual Aid Agreements provided mechanisms for expanding resources through collaboration. That earlier process was instrumental in removing barriers to the development of a Mutual Aid Agreement for this project.

Although the focus of this Mutual Aid Agreement was on Routine Outbreak Investigations, there were discussions between the two health districts that the mechanism for collaboration can be expanded beyond the scope of the project into other areas such as the sharing of staff and supplies for community health, environmental health, health education and public health emergencies when events require additional resources. Also, it is recognized that both districts combined may become overwhelmed quickly in an emergency and the Mutual Aid Agreement can be adapted quickly for use with other health districts or departments.

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 to be reflected in a national accreditation program. Through the collaborative process, staff members from each of the departments have begun to develop relationships that will support the collaborative efforts moving forward. Overall the districts 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

The most important lesson learned is that working collaboratively with multiple agencies to meet specific grant deliverables requires that all roles and responsibilities are clearly defined and ground rules are established from the onset so that all are in agreement how the project is to progress in a timely basis. The lead agency should identify an individual that ensures that all the partners are coordinated with the requirements of the funding agency because working across districts is more challenging than one district carrying out deliverables.

It was beneficial to develop leadership teams in each of the health districts to address the self-assessments. Members were introduced to the Operational Definition Metrics and the move toward accreditation. The participants were focused on their respective health districts and the need to compete was minimized. Also, it was beneficial to engage NVHD staff across disciplines in an open discussion regarding each of the standards as awareness was increased about program areas and activities within the department.

Prior collaborations between the two health districts (e.g., flu clinics, emergency preparedness planning) enhanced and contributed to the success of this project. Involving the management team of each district in the collaborative process promoted relationship building and partnerships. Their involvement enhanced staff buy-in moving forward. Also, the participation of the two directors throughout the process sent the message that the project was a priority for the districts.

The use of a facilitator from outside the two districts helped to build consensus and provide mediation when there were differences of opinions. Scoring cards ensured assessments were completed in a timely manner as the assessment was a lengthy process and often subjective. The facilitator kept the health districts on track and minimized digressions.

Next Steps

The focus of the next steps is to prepare the staff of the two health districts to implement the Mutual Aid Agreement in the event that a response to a disease outbreak should occur in either district and assistance is required. A working team comprised of key management and program staff from each district should be created to advance the QI initiative around the priority area.

The team should be provided with an orientation to continuous QI concepts and tools that can be applied to this initiative. The team should establish specific goals, objectives and timelines related to the advancement of the priority area focused on outbreak investigations. Quality Improvement processes and tools should be applied.

Unique to a collaborative, the required skill sets of the various public health professionals and the existing protocols in each district should be identified, strengths and gaps addressed, and training provided to meet those gaps in the priority area. Roles should be clearly defined. Mutually acceptable protocols should be developed so that all are in agreement how to proceed during an investigation. The remaining staff and Board members of the two districts should become aware of the processes. Training should be provided as needed to all relevant staff so that if the Mutual Aid Agreement is implemented, all should be prepared to support the outbreak investigation. A mutual process for evaluation should be built into the process.

The formal mechanism for collaboration can be applied during future initiatives either between the two participating health districts or adopted with our neighboring health districts or departments. The team can explore other ways to share staff expertise between the districts as the model can also be applied to other public health initiatives beyond disease outbreaks.

Conclusions

The project enabled the staff of Naugatuck Valley Health District to get its first glimpse of what accreditation standards might look like by completing the self-assessment tool that addressed essential public health services. The district was provided with a benchmark against a national standard for health departments. It is able to see where its strengths are and identify areas for improvement. Staff awareness of accreditation standards was increased considerably. Also, the project provided an opportunity to further familiarize the Board of Directors with the standards and accreditation beginning a dialogue that will continue on as we enter into the next strategic planning cycle that will incorporate some of these quality improvements into the process.

Participating in self-assessments as part of a collaborative helped identify areas where each department could learn from each other as well as identify areas where collaborative efforts would serve to benefit both. The process allowed staff from the two departments to learn from their colleagues regarding other program areas. They were able to build relationships that should strengthen as the project continues over time.

Finally, the two health districts developed a formal mechanism for collaboration providing an even stronger foundation for a partnership that has existed informally into its second decade. The collaboration demonstrates that two very different districts in size, resources and demographics can work together effectively. That mechanism for collaboration can be expanded into other areas and should serve both districts well in the event of a disease outbreak.