

Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

**Prepared for NACCHO by the
Mercer County Health
Department, MO**

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Brief Summary Statement

The Mercer, Putnam, Sullivan Public Health Regional Collaborative consists of 3 rural counties in northern Missouri. Mercer County Health Department is the northwest county of the region. It serves a primarily rural population of about 3,900 people including a significant Amish population. Sullivan County Health Department is in the southern county of the region. It serves a primarily rural population of about 6,800 people with a Hispanic presence. Putnam County Health Department is in the northeast section of the region. It serves a rural population of about 5,100 people with very limited diversity. Mercer and Putnam's northern boundaries border the State of Iowa.

The common gap that was identified from the aggregate results from the three health departments NACCHO LHD Self-Assessment Tool for Accreditation Preparation was Standard V-C, The need to engage in LHD strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.

Prior to the NACCHO assessment, all three health departments had completed their own community health assessments, but had not used the information to create any form of health improvement plan. Using the results of the NACCHO assessment and the needs identified in their community assessments, a community health improvement plan was developed. This plan addresses the gap identified in Standard V-C. It also provides the capacity to communicate consistent messages about what public health is and health promotion and disease prevention education messages to the populations being served in each county. It will also help improve the health of the public as identified in the county community assessments. It includes efforts for policy development and advocacy activities which will be more effective coming from a joint effort than from three more fragmented efforts. The final effort included in the plan focuses on developing process and protocols to begin preparation for regional accreditation.

Project Summary

The project included each county completing the NACCHO capacity assessment.

The planning process was based on the initial goal of developing a regional community health improvement plan to address cross cutting issues. Six of the indicators under Standard V-C were discussed from a regional perspective using a Force Field Analysis. Positive forces (strengths) and negative forces (Challenges) were listed under each selected indicator. Following this exercise, the group used brainstorming technique to identify stakeholders that influence regional efforts.

The positive forces for completing a regional community health improvement plan far exceeded the negative. Facilitated discussion was held on the topics of social marketing (communication/education), evaluation and quality improvement, policy development and advocacy, regulatory, and education of public health partners. The participants identified that more consistent effective communication of what public health is and also of public health education messages would be a key to adding capacity in many area. The second focus area for the regional plan was public health policy and advocacy. The three participating counties are small and through joining efforts for public health policy and advocacy, they will have more impact at the policy level. And finally it was decided that the overarching area from the assessment that would add capacity for public health activity and prepare the region for future accreditation, would be the sharing or development of processes, procedures, and policies for public health programs and activities. A strategic plan was written with these three goal areas. Measurable objectives and strategies were selected.

Background

Mercer County has a small rural population of approximately 3600 that is 98.72% white, and 32.1% over the age of 55. 51.7% are employed in farming. We have a large hog CAFO employer in our county. The median household income is \$28,727 with a 12.5% poverty rate.

Mercer County has no local hospital. The closest hospital and ER is approximately 30 miles and is a small rural hospital. We have 2 clinics staffed with 1 full time physician, 1 part time physician, 1 full time physician assistant and 1 part time family nurse practitioner. We have an excellent paramedic level ambulance service for emergency transportation. Non-emergency transportation is sometimes an issue as we have no public transportation, other than scheduled OATS (Older American Transportation System) service. It does not run daily in Mercer County and must be scheduled usually 1 week in advance for transport to physician appointments, and etc.

Mercer County has 2 local weekly newspapers for communication and advertisements. We have no local TV or radio stations.

From our 2007 Community Health Assessment, chronic diseases are our major causes of mortality, with obesity, lack of physical exercise and emergency planning and education pinpointed as our public health priorities.

Mercer County Health Department provides Medicare reimbursed Home Health services for county residents through a contract with Serve Link HomeCare. The health department provides the nursing services for home health and the In-Home program and Serve Link provides physical therapy, speech therapy and aide services through their office. Mercer County Health Department also provides public health home visits for those individuals that do not qualify for Medicare or Insurance covered Home Health services, but have a skilled homebound need.

Other services we provide include: children and adult immunizations, Lead testing, WIC,TB screening/treatment, Maternal/child health services, Child Care Health Consultation, Child Care Sanitation Consultation, Environmental Services, Emergency Planning and Preparedness, Certified Car Seat Safety Inspection Station, pregnancy testing/Prenatal Case Management, Communicable Disease Surveillance, Diabetic Consultation and Education, Vital Records, homemaker assistance, and Community Health Promotion. The Health Department has six full-time employees and four part-time employees

The three counties have a long history of teamwork. The three participate in monthly administrator meetings in Grundy County with several other health departments. Additionally, the three health departments are members of the Mercer-Sullivan- Putnam Network, whose mission is to collaborate with community partners in all three counties to implement projects and obtain resources with the goal of making the counties a healthier place. The network is a 501(c) 3 non profit organization. Other collaborative efforts include Sullivan/Putman sharing a nurse and Sullivan and Mercer collaborating with Linn County for the provision of environmental services. It is imperative that resources be pooled to benefit the communities in the region due to the low multi-county household average income of only \$30,642 and low population numbers. With limited resources it is impossible for each county to provide the ten essential services for the entire population. In addition, the three counties feel that collaboration will provide the best opportunity for achieving the necessary capacity to attain future accreditation.

Goals and Objectives

Initially the collaborative selected the goal of developing a health improvement plan (Standard V-C). This remained the overall NACCHO project goal throughout the planning process. However, the project goal for inclusion in the first Charter was developed from the health improvement plan. The goal for the Charter was selected so the region would have a project that was manageable and attainable in a reasonable amount of time, The Charter goal is "To have a communication plan to educate the public, public health partners, governing bodies, and legislature about the role of public health."

Because the regional health departments are committed to an ongoing long term relationship, a long term goal for the collaborative was created. It is “to have a regional system that will help provide the capacity for each local health department in the collaborative to perform the Ten Essential Services of Public Health.”

Self-Assessment

To complete the individual self-assessment, Mercer County Health Department staff met together to discuss the self assessment process, review the questions and came to a verbal consensus on the answer. The majority ruled, and if there was a large difference in opinion, the Administrator answered the question. The Administrator then input the data in the online questionnaire. We encountered no difficulties in completing the self-assessment.

The results were provided in aggregate by NACCHO from the three separate health departments. The administrators of the three collaborating County health departments discussed the aggregate results via telephone conference and in person prior to discussing them with our consultant, Janan Wunsch-Smith. We had no difficulty selecting a priority area as we were all low in Standard VC, which was the community health improvement plan. Anonymity was not an issue as from past collaborative events, the three health departments have a very good working relationship, and were not opposed to disclosing individual results.

Highlights from Self-Assessment Results

| Standard/ Indicator # | Standard and Significance |
|----------------------------------|--|
| V-C | <i>LHD role in implementing community health improvement plan</i> <ul style="list-style-type: none">• <i>In the aggregate data for the three counties, this standard was one of the lowest. Even though each county had completed a community health assessment, they had not done any health improvement planning. Therefore they felt this was a good way to start filling the gaps as a region</i> |
| V-B. 3 & 4 | <i>3. LHD engages partners in policy development process and LHD legislative agenda</i> <i>4. LHD conducts advocacy at all levels that protect and promote the public's health</i> <ul style="list-style-type: none">• <i>These two indicators demonstrated the need for the collaborative to more proactive and engaged in policy and advocacy. This was one of the areas included in the regional community health improvement plan</i> |
| I.A | <i>Data Collection, Processing and Maintenance</i> <ul style="list-style-type: none">• <i>The collaborative demonstrated adequate capacity for all of the indicators under this standard. Capacity in this area provides a strong base for much of what public health does</i> |

Collaboration Mechanism

The three participating health departments have a long successful working relationship. There were no turf issues and everyone was cooperative and enthusiastic about working together on capacity building activities. It was therefore decided to create a generic Memorandum of Understanding for all activities that would build capacity across the region. The details of specific projects would be placed in a Charter. There were no other mechanisms considered as the collaboration had already been working under other Memorandums of Understanding for other projects and felt the Memorandum of Understanding and Charter combination was effective way to work through a variety of projects over time.

In Missouri each health director has the authority to sign interagency agreements such as the MOU and Charter, as long as it is promoting the health of the populations being served. The Boards of Trustees do not sign these agreements. The directors update the Trustees on what activities they are working on and collaborative efforts such as this project.

Because the directors have the authority to sign the agreements and work within the collaborative, there were no legal issues in developing the organizational structure.

All members of the collaborative work very well together and felt this collaborative effort was critical to filling gaps in their capacity and also preparing them for accreditation. There were no barriers to working together and the members understand they will have to access dollars for some of the activities. They are very willing to share resources when it is possible to get added benefit from a collaborative effort. It is understood that planning to accomplish goals using the efforts of three departments vs. each department working independently to accomplish the same goal is a win-win situation.

Accountability is addressed in the Charter with the following statement: "The activities undertaken through this charter and related Memorandum of Understanding will be reported to the participating Boards of Trustees, each local health department and the populations being served." Also, the MOU identifies the responsibility of the fiscal and administrative entity for projects.

The Memorandum of Understanding specifies the decision making structure. A committee consisting of all three health directors will determine the projects to be undertaken and which department will serve as fiscal and administrative agent. The committee will complete a budget, business, and work plan for each project. The work plan will include who will be responsible for the activities including coordination and oversight of the project.

Results

We have not yet had an opportunity to implement the formal mechanism of collaboration; however that does not minimize our success at this point. By having the MOU and charter in place, we now have the framework necessary to move forward. Previous MOU's were targeted only for personnel sharing and not really based on a coordinated plan to improve the regional Public Health Infrastructure. Design of the MOU is much broader so that we can work collaboratively in the future with a clear agreement already in place while the charter is more specific to separate projects. We have already outlined a charter: Communicating the Role of Public Health. By working on this regionally, we will be able to maximize our resources and outputs, with a standardized understanding of public health in our region. I can see using the MOU in the future to collaborate on policy development, marketing and personnel issues.

Unanticipated benefits as a result of undergoing the process, was that we realized we had many of the same strengths and weakness throughout the three counties. Through discussion, we were able to identify where one health department may already have a best practice that could be replicated. On an individual basis, our staff was able to identify some strengths and weaknesses we could address immediately and make improvements, such as in-house communication through a web conferencing and daily calendar.

Because of our collaboration on this process, we were selected by our state accreditation program to work on Quality Improvement and the state accreditation process as a collaborative.

Lessons Learned

The online tool through NACCHO made the self assessment process very easy and I would definitely recommend it to others. When choosing others to collaborate with, choose agencies with like populations and size, as well as similar public health priorities.

I would recommend setting aside one staff meeting to review the assessment questions with other personnel in the office. We found that some of our staff did not realize we addressed some of the measures, but when all the measures were explained, the office personnel had a better understanding of the process of the assessment and a new found understanding of things that happen in our office that because it was not in their department, they did not realize we were addressing at all.

Next Steps

The next steps, I think include, the collaborative meeting to review programs and issues and decide which programs would be good to work on together, which we choose to work on first. We are

continuing to work with MICH (the Mo. Accreditation Model) to progress to state accreditation in 2 years and hopefully this will prepare us also for national accreditation.

Conclusions

This has definitely been a beneficial process for our health department. This was the catalyst we needed to set up an official Quality Improvement plan for our agency and look at the accreditation process. Networking and discussion among the employees brought an increased awareness of program guidelines to our employees. Because of the grant, we made time to do what needed to be done, but it has been an educational process for all our employees, in quality improvement, but also in understanding Public Health Process and the 10 Essential Services. The consultant helped us go through the process in a more organized and targeted format, therefore speeding the process along. But with the tools provided, it is easy for any agency to duplicate this process on their own. The assessment tool, QI educational programs and consultant assistance have been a great asset in focusing on where to start for accreditation.

