Region G Collaboration

Missouri
- Population: 5,842,713
- Land Area (sq. miles): 68,885.93
- Median Household Income, 2004: $40,885
- Persons below Poverty, 2004: 13%

Carter
- Population: 5,956
- Land Area (sq. miles): 507.58
- Median Household Income, 2004: $27,113
- Persons below Poverty, 2004: 20.7%

Douglas
- Population: 13,658
- Land Area (sq. miles): 814.53
- Median Household Income, 2004: $27,452
- Persons below Poverty, 2004: 18.8%

Howell
- Population: 38,734
- Land Area (sq. miles): 927.74
- Median Household Income, 2004: $28,864
- Persons below Poverty, 2004: 18.7%

Oregon
- Population: 10,407
- Land Area (sq. miles): 791.40
- Median Household Income, 2004: $26,551
- Persons below Poverty, 2004: 19.8%

Ozark
- Population: 9,393
- Land Area (sq. miles): 742.15
- Median Household Income, 2004: $26,952
- Persons below Poverty, 2004: 20.3%

Reynolds
- Population: 6,547
- Land Area (sq. miles): 811.20
- Median Household Income, 2004: $27,544
- Persons below Poverty, 2004: 18.3%

Shannon
- Population: 8,503
- Land Area (sq. miles): 1,003.83
- Median Household Income, 2004: $22,926
- Persons below Poverty, 2004: 23.2%

Texas
- Population: 23,566
- Land Area (sq. miles): 1,178.54
- Median Household Income, 2004: $27,193
- Persons below Poverty, 2004: 20.2%

Wright
- Population: 18,397
- Land Area (sq. miles): 682.13
- Median Household Income, 2004: $26,554
- Persons below Poverty, 2004: 20.3%

Source: U.S. Census Bureau
**Brief Summary Statement**
The State of Missouri is over 85% rural. The Region G Collaborative consists of Douglas, Ozark, Wright, Texas, Howell, Oregon, Shannon, Carter, and Reynolds County Health Departments. Our region covers 7,462 square miles and serves a total population of 135,669 citizens.

Carter County is located in the South Central region of the state, and one of two counties located on the eastern border of Region G. Counties that border Carter County are Reynolds to the north, Wayne and Butler to the east, Shannon to the west, and Ripley and Oregon to the south. According to the 2000 U.S. census, Carter County has a total population of 5956. The land area of Carter County is 508 square miles of rough to hilly wooded land and open pasture. It is a rural county with no hospital, only two healthcare providers, one dentist, one pharmacy, and no formal transportation system.

Upon completion of the NACCHO LHD Self-Assessment tool, it was determined that Carter County Health Center had many areas in which to grow and improve our processes. After collaboration with the other administrators of Region G, strategic planning was chosen as our combined project with each health department indicating this was an area that needed improvement.

The aggregate data from Region G Collaborative Self-Assessment Results identified several common gaps in our capacity to provide the ten essential services. From these gaps it was determined that the region would make the commitment to a formal 3-year regional strategic plan. Standard V-C, LHD Role in Implementing Community Health improvement Plan was selected as the focus area for the project. This standard focuses on strategic planning. However, to address implementing a community health improvement plan, the group identified that there were additional topics in the assessment that needed to be addressed prior to establishing a health improvement plan (strategic plan). One of these was to complete community health assessments in each county. Not all of the health departments in the region have completed a recent community health assessment and therefore in the planning process the collaborative determined that the topic areas of Community Health Assessment, Program and Health Outcome Evaluation, which is critical to creating a community health plan and Stakeholder Engagement and Partnering as the target areas to address over the next three years.

A planning process was utilized which first recognized the strengths of the LHDs in the region and the strength of the collaborative. The planning process focus on the three topic areas identified used a Force Field Analysis to identify the positive and negative forces and factors that would work for or against addressing the topic/issue. In addition, identification of potential stakeholders for each issue was identified. Part of the discussion of stakeholders included which ones would be advocates and be in favour of the project and support the efforts right away and which ones would need education to better understand the process and benefit to the health of the public.

Once the issues had been discussed, a goal statement was developed for each topic/issue area. Using the related indicators under the topics areas in the assessment, objectives were written to build the capacity to reach the selected goals. The group then used a brainstorming technique to identify strategies to move the process forward based on the goals, objectives, barriers and partners. A realistic timeline was created that would offer the best opportunity for the successful completion of the plan. For more detail on the activities to implement the strategic plan see Appendix III.

A discussion was held concerning the organizational structure that would be needed to move the plan forward and increase the capacity of the LHDs and collaborative. To formalize this process, a mission and vision were written for the collaborative. (They are included at the beginning of the strategic plan.)

It was determined that a Charter would be written that included the Goals, Boundaries, Expectations, Guiding Principles/Assumptions, Accountability and Reporting Structure for all projects that would be undertaken to attain the goals of this collaborative plan. This charter was signed by each health department administrator. This guiding document provides the framework for all collaborative activities/projects which will be entered into to build capacity based on the goals of this project.
In addition, for each specific activity/project, a collaborative agreement template was created that will be completed for each specific project when resources are found. This agreement will address the selection of the fiscal and administrative agency, staffing and budget, project specific goals, objectives, strategies and evaluation process.

The collaborative identified that there would be an opportunity to start working on the identification of existing process/protocols available for public health activities and program health outcomes evaluation through work that would be completed using the existing cluster group format. This could be worked into existing meetings and reduce travel and manpower resources.

Background
The Carter County Health Center was voted into operation with a mill tax in October 1954. Carter County Health Center envisions healthy Carter Countians living in an environment that is safe, supportive, and conducive to a healthy lifestyle. The board of directors and staff partner extensively with a local FQHC, faith based organizations, neighbouring county health departments, schools, daycares, businesses, and other organizations at the state and local levels to ensure a continuum of health services for underinsured, uninsured, and underserved residents.

The Board of Trustees and the staff continue to assess and identify health issues in the county and recognize that the Region G Collaboration is a great avenue to continue with our mission to assess and identify needs as well as increase our resources and funding capacities that enable us to continue our excellent service in the public health arena.

The LHDs of Region G recognized years ago that funding for public health programs was decreasing. We also were aware of the increase in the contract deliverables and the need to let go of the “silo mentality”. We identified the need to adopt a collaborative outlook for all our agencies. As small rural and remote LHDs we need our partners to survive this ever changing complex healthcare environment. As we move toward the future, LHDs must become leaders and embrace change. Accreditation is much more than a standard of quality. It is the foundation of our LHD’s structure, the commonality that will “unify” all LHDs with a solid base. Through our work as a collaborative, our goal is to identify the gaps and work collaboratively towards correcting these gaps so we will all have the capacity to provide the essential public health services.

This Region G team has worked together since 2003 as a regional public health emergency planning team forming a 501c3 to provide services and serve as the fiscal agent for regional grants. The team successfully brought over a million dollars to the region to improve public health services. Due to the efforts of this team Howell County voted in a mill tax in 2005 to establish their own health department. This corporation dissolved in 2007 when all the grants and contracts were completed. With this in mind, there was confirmation that all 9 LHDs have the ability to work collaboratively to bring projects to successful fruition.

On the eastern side of Region G, Reynolds County Health Center called a community meeting of leaders throughout the county to form a collaborative. After several meetings the Mark Twain Forest Regional Healthcare Alliance (MTFRHA) was formed in 2003. While the Region G collaborative already existed, it only included the 9 health departments as members. MTFRHA brought together 6 inaugural members which were Reynolds County Health Center, Carter County Health Center, Mo Highlands Healthcare Inc (our local Federally Qualified Health Center), Advanced Healthcare Medical Services (our local Critical Access Hospital), and 2 faith based organizations, Whole Health Outreach and Whole Kids Outreach. By bringing this multiagency collaborative together, it broadened the avenues to pursue grants from varied sources and enabled the two health departments to work closely with agencies that previously would have not been possible. This alliance now has a 501c3 and has been successful in receiving funding from HRSA and Missouri Foundation for Health for multiple projects. The Alliance has now grown to 10 members and is presently in its first year of a Missouri Foundation for Health funded proposal known as the Healthy and Active Rural Communities Model Best Practice Grant.
In September 2007 the Region G Collaboration held its first meeting to address accreditation through the Missouri Institute of Community Health (MICH). At this meeting we looked at the MICH accreditation program and extreme concern was expressed on our ability to accomplish accreditation using their tools.

All LHDs in Region G agreed it was essential that our LHD’s meet, communicate, and provide services through memorandums of agreement, jointly exercise our local emergency plans and implement a regional public health system. The Douglas County Health Department contracted with a local IT provider to develop an intranet that enables all team members to share information, data, documents, questions, etc. This intranet will be used to expedite evaluation of our areas of potential collaboration and successfully meet our deliverables.

In January 2008 the Region G Collaboration met with representatives from MICH to include Butler County, a successfully accredited Missouri Health Department. We reviewed fears and barriers about the accreditation process and reviewed the standards for accreditation through MICH. We then participated in an exercise to preview actual on-site review. MICH informed us at that meeting, they had travelled the state for LHD’s input and had taken seriously the information they were given. As a result of this information, MICH had meetings and discussed at great length the information and how best to proceed. As a result of those meetings they made improvements to the MICH guidelines for their Voluntary Accreditation Program for Local Public Health Agencies. These new guidelines became effective January 2008. All nine LHD’s agreed to pursue regional accreditation in order to:

- Strengthen our local health policies;
- Expand and strengthen our partnerships;
- Assist us in organizing;
- Obtain additional resources to run the vital programs that make a difference to everyone’s health.

It was recognized funding would be a barrier. Funding is necessary for:

- Staff time for assessment and to maintain a current and future competent public health workforce
- Data sharing with regional and community partners
- Systems development to include application of evidence based criteria to evaluation activities
- Sustainability

Due to the large geographic size of our region, we chose not to waste time and travel with unnecessary meetings. It is imperative that all feel equal and valued. Our 9 county region will form 3 Taskforce Teams of 3 LHD’s on each team across agency disciplines (administration, nursing, health education. etc) and identify a Project Coordinator for each individual LHD. These taskforce teams will begin work individually and collectively. Continuous interactive communication between teams by our regional intranet will keep us connected and moving forward on the journey.

Our Region G collaborative is continuing to work toward Missouri Accreditation, one small step at a time. The continuous interactive communication between the regional teams through our regional intranet will keep us connected and moving forward on the journey of Missouri Accreditation and eventually National Accreditation as a region.

LHD Coordinators were responsible for conducting the NACCHO Operational Definition Prototype Metrics Self Assessment with the agency taskforce team and staff. A meeting of all 9 LHD’s Taskforce Team members was held to analyze the aggregate data. Collectively, the LHD’s identified Standard V-C, Focus: LHD Role in Implementing Community Health Improvement Plan, from the Metrics, on which to collaborate. All LHD’s engaged in a planning process and established a formal mechanism to collaborate with the help of a NACCHO-sponsored consultant as a facilitator.

**Goals and Objectives**

**Goal I:** The same community health assessment tools and processes will be used by all Region G counties.
**Objective 1:** During first one and one half year after start of project, prepare for implementing a community health assessment in all the counties in Region G. A tool/process will be selected as well as data and data sources to be used in secondary data collection, surveys, and focus group topics/questions.

**Objective 2:** Two and one half years after start of project, counties complete Community Health Assessment and aggregate regional data and related information will be available for use in planning and distribution.

**Goal II:** Region G will have consistent Process and Protocols for public health activities and programmatic health outcome evaluation and revision.

**Objective 1:** One year after start of project, identify existing process/protocols available for programmatic health outcome evaluation.

**Objective 2:** By end of year three, have a regional protocol/process/procedure manual for core functions; create formalized process for common procedures. (Start right away sharing documents online)

**Goal III:** Region G will have increased local health department capacity through use of stakeholder engagement.

**Objective 1:** During all three years of implementation of this strategic plan, expand Region G local health department’s capacity through stakeholder engagement and partnering.

**Objective 2:** During all three years of implementation of this strategic plan, increase resources through stakeholder engagement by linking the issues to the stakeholders.

Initially after reviewing the aggregate data from the collaborative, it was decided to address Standard V-C Focus on LHD Role in Implementing Community Health Improvement Plan. Upon reviewing the indicators under this standard, it was realized that various components that were necessary for completing a strategic health improvement plan did not exist. For example, the LHDs did not have consistent assessment data to use in setting goals (V-C:5). Without this assessment data it would also be impossible to identify strategic opportunities to use in the planning process (V-5:6) and it would be necessary to build a relationship with stakeholders to not only plan appropriately, but also to have a venue for disseminating and implementing the plan. For this reason, the goals include activities for selecting and using a consistent community health assessment planning process, in each county, having the same process and protocols to evaluate health outcomes so there will be adequate data to determine what programs we need to target in a planning process, and the final goal of increasing our regional capacity through stakeholder engagement.

**Self-Assessment**

The Carter County Health Center chose to complete the individual assessment with input from key staff members of the agency. The staff were given a hard copy of the LDH Self-Assessment and asked to complete the self assessment on their own.

After completion of the individual assessments, a staff meeting was held, to review the entire self-assessment as a group. Each question was reviewed and discussed, and the group as a whole came to a consensus how to score each one. One deficit was realized, that although we provided many of the essential public health services, we lacked the documentation or specific and standardized processes to prove it.

Once our agency had finished our self-assessment and entered the information into the NACCHO’s online form, we were then able to get our aggregate results for the region. With these in hand, the region once again came together for a meeting of the minds. We broke off into our three separate task forces...
and made a decision on what priority we wanted to focus on. Then the three task forces came together as one group and voted on which priority area would prevail. The Region G Collaborative works extremely well together. We all have similar demographics and similar issues within our agencies. And the aggregate data really brought that to light for us. We all realized that assessing our communities with a standardized tool and then working on our strategic plans was something that would fit well into our agencies’ overall missions.

### Highlights from Self-Assessment Results

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<thead>
<tr>
<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
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<tbody>
<tr>
<td>V-C</td>
<td><strong>LHD Role in Implementing Community Health Improvement Plan</strong></td>
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<td>o Aggregated data demonstrated all indicators under this standard were below the 2.0 score</td>
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<td>V-C:5</td>
<td><strong>LHD uses assessment data to develop annual program goals to develop policy</strong> (1.67)</td>
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<td>o The community health assessment had not been completed by all LHDs leaving a gap in the data necessary for creating a health improvement plan and also for policy development.</td>
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<td>V-C:6</td>
<td><strong>LHD identified new strategic opportunities promoting public health activities</strong> (1.78)</td>
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<td>o Again, without a community assessment in each county, it would be impossible for the region to move forward with a total planning process</td>
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### Collaboration Mechanism

The collaborative selected a combination of mechanisms to direct their formal regional efforts. First a charter was completed that addressed the regions overall efforts to build capacity at the local and regional level through regional efforts. This charter addressed the purpose of the collaborative effort, boundaries, expectations, objectives to be accomplished, guiding principles/assumptions, accountability/reporting structure, listing of counties and contacts, possible sources of financial resources and a signature page.

The second mechanism was a template for a Collaborative Agreement. The group decided that for each funding stream or for agreed upon funding for a specific strategy/activity from their plan, that an agreement would be written. This agreement would include a work plan, with timeline and responsible parties, the fiscal and administrative agency would be selected and agreed upon by all health department administrators for each project. This appropriate fiscal and administrative agency will vary based on the capacity needed for a specific project and the capacity of the health departments. This agreement would also include staffing issues such as using existing staff or hiring new staff and determining which agency would house the staff.

There were no legal issues that came into play as authority has been established for the health directors to enter into contractual agreements that involve sharing of resources as long as each health department and the population served benefit from the efforts. The language that pertains to this is found in the Missouri Revised Statutes Section 205.042, Paragraph 9 which states, “The board of health center trustees may enter into contracts and agreements with federal, state, county, school and municipal governments and with private individuals, partnerships, firms, associations and corporations for the furtherance of health activities, except as hereafter prohibited.”

This statement is repeated in the Carter County Health Center bylaws revision of Section 13, from the October 2008 board meeting which now states: “The Board of Trustees and/or the Agency Administrator, can enter into contracts and agreements with federal, state, county, school and municipal governments and with private individuals, partnerships, firms, associations and corporations, for the furtherance of health activities, except as hereafter provide.,”
Although the Administrator has the authority to sign contracts, any type of new contract, grant, etc. is always discussed and approved by the Board of Trustees prior to implementation. This included the NACCHO project as well. The Board of Trustees not only approved of the project, but sent a letter of support along with the grant application. Once the formal mechanism of collaboration was finished by the Region G Collaborative, it was reviewed at the next meeting of the Board of Trustees to ensure that they approved of the scope of the project.

Results
There has not yet been an opportunity to implement the formal mechanism. The mechanism was just recently refined and resigned by the Region G Collaborative at our meeting on November 10, 2008. However, all involved have discussed the possibilities that this collaboration will give us. The idea that we will have a regional assessment in place and a strategic plan that will give us leverage when applying for grants and sign contracts. Our success at this point in time can only be defined in what we have accomplished, which by our standards has been highly successful and productive. To have a “Charter for Capacity Building Activities” in place which provides goals and objectives to be accomplished as a region is a first step to build upon. To have a formal mechanism for collaboration that gives us authority to implement our charter and work toward our goals is one step farther. The real success is to have a group of nine administrators who have come together, to collectively improve the efficiency of each of our agencies and overall to work toward improving the health of the 135,669 citizens we serve.

The Region G Collaborative has discussed different ways in which we will be able to utilize the mechanism for collaboration. We have talked about grants and contracts and purchasing power and personnel sharing and the list goes on and on. It is really only limited by our imaginations, which may be one of the hardest hurdles to overcome.

Lessons Learned
From the LHD self-assessment, we have identified many areas where we need improvement and better documentation. This realization has served to give the agency a working plan to accomplish these goals. Through our collaboration, the administrators of Region G applied and were chosen by Missouri Institute for Community Health (MICH) to work collectively and individually toward the state accreditation of all nine health departments. The MICH team has and is working with the health departments individually in specific areas that each agency felt they needed improvement. One of the lessons learned is the reinforcement that from this collaboration’s ability to accomplish much more together than anyone agency can do on their own. It also reinforced while we have similar goals for our agencies and programs, we are all vastly different but can still come together and function as one entity.

Next Steps
Our next step in this journey will likely be working on our Charter for Capacity Building Activities. It is a critical piece of our project in many ways, especially in attaining our ultimate goal of accreditation. Community assessments as well as strategic planning are both important aspects of the accreditation process and areas that we realized as a region we would need to improve upon. If we can follow through on our charter we will have a lot of the leg work out of the way in order to go through the accreditation process.

Region G has always been a close-knit group and with our current grants, projects and sharing of resources that is already underway, I foresee us continuing our relationships, meeting on a regular basis, and striving to complete the tasks that we have assigned to ourselves.

Conclusions
Through our work on the Accreditation Preparation Demonstration Preparation Sites Project has been beneficial to both our individual agencies and the region as a whole. The opportunity of working with one of NACCHO’s consultants was an added bonus in the process. Although our county is the smallest in the
region, we had an equal voice in the project. This effort has been one small step in our direction to both state and national accreditation. The self-assessment helped to identify areas of both strengths and areas of opportunities for improvement. From the staff and board of directors of Carter County Health Center we would like to say thank you for this unique opportunity.

Appendices
Appendix I: Charter for Capacity Building Activities
Appendix II: Collaborative Agreement
Appendix III: Strategic Plan