Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Douglas County Health Department, MO

November 2008
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: 26,952
- Persons below Poverty, 2004: 19.8%

Ozark
- Population: 9,393
- Land Area (sq. miles): 742.15
- Median Household Income, 2004: 26,554
- Persons below Poverty, 2004: 20.0%

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.

Douglas County is located on the western side of the collaboration. We have 13,658 residents living in 815 square miles. Our county is unique in that it has only one incorporated city, Ava, with a population of 3,021, no hospitals, and one major employer. The remaining residents reside on farms and small acreages surrounding Ava. After completion of the NACCHO LHD Self-Assessment tool, it was evident that the Douglas County Health Department could improve performance by engaging the community, evaluating and improving programs using QI processes, and partnering with academia. The aggregate data for the region indicated that strategic planning was essential for the nine counties. By taking a strategic approach through sharing resources and enhancing communication, our collaboration will improve essential services and meet the challenges of accreditation.

The aggregate data from Region G Collaborative Self-Assessment Results identified several common gaps in their capacity to provide the ten essential services. From these gaps it was determined that the region would make a formal commitment to a 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, 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. Force Field Analysis was used to identify the positive and negative forces, and factors that would work for or against addressing the three identified topic areas. 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 identified 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. (See Appendix III)

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. (See Appendix I)
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. (See Appendix II)

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, thereby reducing travel and manpower resources.

Background
The Douglas County Health Department was established in 1974 with one nurse and one clerk. In 1976 residents voted a mill tax to support the health department. The health department is governed by a five member elected board who meet monthly or as indicated to conduct business.

This Region G team has worked together since 2003 as a regional public health emergency planning team. Region G existed but not all nine health departments were active partners. NACCHO funding gave us the opportunity to further unite and solidified our relationship. 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.

Region G has a history of collaborating among themselves and others with the below as examples:

Seven of these health departments formed the South Central Public Health Services Group, Inc which was founded in 1993. The SCPHSG was a 501c3, which was founded to provide local public health services to Howell County and to be 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.

On the eastern side of Region G, Reynolds County Health Center called a community meeting of leaders throughout the county to form the Mark Twain Forest Regional Healthcare Alliance (MTFRHA) in 2003. The 6 inaugural members were Reynolds County Health Center, Carter County Health Center, Mo Highlands Healthcare Inc (our local FQHC), Advanced Healthcare Medical Services (our local CAH), and 2 faith based organizations, Whole Health Outreach and Whole Kids Outreach. This multi-agency collaborative 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. With this in mind, there was confirmation that all 9 LHDs have the ability to work collaboratively to bring projects to successful fruition.

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 LHDs 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.

While working on the Missouri voluntary accreditation standards we learned of the opportunity to apply to NACCHO for funding to complete the self-assessment and to formalize our collaboration. All nine LHDs agreed to pursue national 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

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 formed 3 Taskforce Teams of 3 LHDs on each team across agency disciplines (administration, nursing, health education etc.) and identified a Project Coordinator for each individual LHD. These taskforce teams worked individually and collectively. Continuous interactive communication between teams by our regional intranet will keep us connected and moving forward on the journey.

LHDs’ 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 LHDs’ Taskforce Team members was held to analyze the aggregate data. Collectively, the LHDs identified Standard V-C, Focus: LHD Role in Implementing Community Health Improvement Plan, from the Metrics, on which to collaborate. All LHDs engaged in a planning process and established a formal mechanism to collaborate with the help of a NACCHO-sponsored consultant as a facilitator.

The NACCHO funding has allowed us to take the self-assessment, and realistically assess our status and what we needed to accomplish to achieve national accreditation individually and as a region. We hired a consultant, who met with us regionally allowing us to strengthen and formalize our collaboration. NACCHO gave us the capacity to build our quality assurance tools, resources and processes.

Goals and Objectives

Goal I: The same community health assessment tools and processes will be used by all Region G counties.

Objective 1: During the first one and one half years 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 on line.

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 departments’ 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.

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 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 need to be targeted in a planning process; and the final goal of increasing their regional capacity through stakeholder engagement.

**Self-Assessment**

The Douglas County Health Department Administrator, Nursing Supervisor/Assistant Administrator, and Program Manager met to review the self-assessment tool. It was decided the tool could not be completed online because of all the steps to score each indicator. We printed hard copies and individually scored each indicator. We then met to discuss our scoring and reach consensus. This took approximately twelve hours. It took this long because lengthy discussions resulted on what documentation met or was needed for each indicator. If there was not a consensus other staff members were consulted. Once consensus was reached the Program Manager entered the data into the on-line self-assessment tool.

After our aggregate data was available on the scoreboard the Region G Collaborative Partners met to review results and select areas to address as a collaborative. The Douglas County Health Department, as the lead agency, decided to use an affinity diagram process to reach consensus. Anonymity was not an issue because of our strong working relationship and mutual respect.

### Highlights from Self-Assessment Results

<table>
<thead>
<tr>
<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
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<tbody>
<tr>
<td><strong>V-C</strong></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><strong>V-C:5</strong></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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<tr>
<td><strong>V-C:6</strong></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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<tr>
<td><strong>I-A:2</strong></td>
<td><strong>LHD uses appropriate equipment and technology.</strong> (3.44)</td>
</tr>
<tr>
<td><strong>I-A:3</strong></td>
<td><strong>LHD maintains and uses information system(s).</strong> (3.44)</td>
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<td></td>
<td>o In a rural community where technology is not the standard our health departments have put resources toward appropriate equipment, technology and using information systems.</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 region's 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 and the selection of a fiscal and administrative agency 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 (both new and existing), identification of employing agency/agencies for the project, and staff reporting guidelines.

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 individual agency by-laws and the Missouri state statutes which reflect that LHDs are recognized as political subdivisions with authority to contract with each other, other entities, and other states. The health directors continually update their Board of Trustees as to collaborative projects that build the capacity for their health departments. The governing boards of all nine health departments support our efforts to work collaboratively to enhance individual agency capacity, fulfill the essential public health functions, better serve the citizens and attempt to be more cost effective.

**Results**

The formal mechanism has not yet been implemented.

Our definition of success at this point includes:

- Improved communication to include regular regional meetings
- Intranet in place and being used to share resources and information such as policy and procedures manuals
- Planning a regional webpage to standardize chronic disease prevention marketing, provide access to a resource directory, promote activities from all nine health departments, conduct surveys
- Inclusion in the Delta learning collaborative, which gave us the opportunity to get Management and Leadership certification from Rockhurst University and has funded our IT projects
- Developed a three year strategic plan for the region
- Capacity building through sharing resources

Unanticipated benefits include:

- Availability of tools from state and national organizations
- Having the opportunity to hear from health departments all over the nation that are working on similar projects through webcasts and teleconferences
- MICHI mini collaborative
- Missouri Department of Health is exploring the possibilities of helping us partner with academia
- *Live Like Your Life Depends On It* social marketing campaign to prevent chronic disease adopted by multiple partners
- Adopting the NACCHO public health logo regionally
- Individual interest in updating technology
- Our staff’s support of the accreditation process and the quality improvement processes
- Recognition on a state level regarding the regional collaboration.
Expected benefits in the future:

- Leverage for funding and legislation.
- The opportunity to share the MICH QI education with other local health departments
- A more cohesive and competent health department workforce
- Increased sense of pride in our health department
- Selection as a Model Practice
- Accreditation

Lessons Learned

Over the past ten years Douglas County Health Department administrative staff have attended various meetings conducted by the Missouri Department of Health and MICH on voluntary accreditation. While we realized the importance of accreditation it appeared to be out of our reach and we left these meetings feeling discouraged. With the MICH voluntary accreditation program evolving to what it has become today we realize we can reach our goal by sharing resources with our neighbouring health departments.

After conducting the self assessment and meeting with MICH we concluded:

- At the onset the governing board must be an active part of this process. The project has been discussed with our Board of Trustees at every board meeting as to progress, needs, and plans. The administrative staff must encourage participation by all employees.
- You must stay objective when conducting the self assessment. You must keep a positive attitude and look at the big picture rather than focus on individual indicator deficiencies.
- You can easily get mired down in trying to determine what documents will prove each indicator. Our health department has assigned a file cabinet for documentation on accreditation standards. Meetings were held with entire staff for planning purposes. Individual staff members were asked to provide documentation on the indicators within their programs and were given a timeline for completion. They were encouraged to ask questions, give suggestions and in general take part in the process. They were informed that this is an ongoing process that would need to be maintained. Staff members were also given a copy of their MICH workforce qualification standards and were asked to provide documentation of same. On a quarterly basis employees have been asked to complete learning assignments through the online learning management system and provide documentation for same.
- It would be hard to start a collaboration with regional accreditation in mind without any past history. You have to have a level of trust because you have to discuss your short comings. We are not all going to see things from the same perspective because we are at different stages in our health departments, workforce experience, education, and in setting priorities.
- Participation in the collaborative meetings by ancillary staff from several health departments has increased the comfort level and willingness to call on each other for resources.

Next Steps

Although the requirement to submit a Model Practice application has been eliminated for collaboratives, our intention is to follow through with our plans to submit one. Our health department is moving forward on accreditation with MICH with a goal to be accredited by the end of 2009. We will keep apprised of the progress made by the Public Health Accreditation Board. As a collaborative we hope to expand usage of the team intranet and have a regional website up and running in 2009. Our collaborative will implement our strategic plan, will continue to work together on accreditation and search for funds to continue our efforts.

Conclusions

Accreditation is one of the goals in the Douglas County Health Department strategic plan. Our Board of Trustees and staff are collaborating within our agency to build capacity to achieve our accreditation goals:

- To achieve Missouri Institute for Community Health Accreditation by 2009
- To achieve national accreditation by 2011
We will continue to work with the Region G partners to build capacity, share resources, exchange information and regionalize activities.

The NACCHO funding has given us the opportunity to assess where we are, to look at past learning experiences and put them into context. Employees are saying, “Oh that’s what they meant when I attended that workshop” or “Now I understand why we need to do that”. Our staff is becoming more aware of the role of public health and what they accomplish on a daily basis. Instead of looking at quality improvement as another load to carry, we are for the first time looking at it as a useful way to do better in providing our public health services and collaborating with our partners.

We have always felt that academia would not want to partner with us because of our low population base. This opportunity has shown us that we can look at strategies to improve on this area. As a result the Missouri Department of Health and MICH are both looking at avenues to address this issue.

The Douglas County Health Department staff and board are taking a positive outlook on all that we have accomplished since we have started working with NACCHO on this project. We are energized and looking at new ways to accomplish our goals.

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