Accreditation Preparation &
Quality Improvement
Demonstration Sites Project

Final Report

Prepared for NACCHO by the
Howell County Health Department, MO

November 2008
<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Land Area (sq. miles)</th>
<th>Median Household Income, 2004</th>
<th>Persons below Poverty, 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carter</td>
<td>5,956</td>
<td>507.58</td>
<td>27,113</td>
<td>20.7%</td>
</tr>
<tr>
<td>Douglas</td>
<td>13,658</td>
<td>814.53</td>
<td>27,452</td>
<td>18.8%</td>
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<tr>
<td>Howell</td>
<td>38,734</td>
<td>927.74</td>
<td>28,864</td>
<td>18.7%</td>
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<td>Oregon</td>
<td>10,407</td>
<td>927.74</td>
<td>25,551</td>
<td>19.8%</td>
</tr>
<tr>
<td>Ozark</td>
<td>8,993</td>
<td>742.15</td>
<td>26,952</td>
<td>20.0%</td>
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<td>Reynolds</td>
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<td>811.20</td>
<td>27,544</td>
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<td>Shannon</td>
<td>8,503</td>
<td>1,003.83</td>
<td>22,926</td>
<td>23.2%</td>
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<tr>
<td>Texas</td>
<td>23,566</td>
<td>1,178.54</td>
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<tr>
<td>Wright</td>
<td>18,397</td>
<td>682.13</td>
<td>26,554</td>
<td>20.3%</td>
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</table>

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.

Howell County is located in the South Central Region of Missouri. Located in the center of Region G, a nine county region. Howell County contains approximately 928 square miles of land area, made up mostly by wooded areas broken up by open pastures. As a rural county, the economy is based largely upon agriculture and small industry. The county’s population is currently around 38,734, with a large percentage of the populous centered in the vicinity of the county seat, West Plains.

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.

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
A mill-tax to fund Howell County Health Center was not approved by Howell County voters until April of 2003. Fortunately, in 1981 a group of area citizens formed a 501 c (3) not for Profit Corporation under the name of Southern Missouri Association of Public Health Administrators. SMCHA was governed by a board, whose members were comprised of local health department administrators from six surrounding counties in Region G, including: Douglas, Oregon, Ozark, Shannon, Texas, and Wright Counties. As the result of this group’s efforts an umbrella for the WIC program was established in Howell County. This action helped establish the groundwork of collaboration between the health departments within Region G, which continues on through today.

In August of 1995 the Howell County Commission and SCPHSG Inc. board reached an agreement to appoint a health officer in Howell County and to designate SCPHSG Inc. as the local public health agency for the residents of Howell County.
On July 1, 2003 in accordance with state statute 205.031 a Board of Trustees was appointed by the County Commission, to establish a County Health Center for Howell County.

Since its inception only five years ago, Howell County Health Center’s staff and board have strived to meet the identified public health needs of Howell County. In addition to efforts to expand services in both nature and scope, concerted efforts have been underway to establish a building capital fund, with the purpose of purchasing a another facility. This investment of funding paid off in July of 2008, when Howell County Health Center purchased a considerably larger facility in West Plains. The purchase of this facility will make it possible to expand the agency’s scope and depth of public health services in 2009.

Ozarks Medical Center, a 113 bed community hospital located in West Plains administers an extensive home health program, offered throughout the county. As this is an area where no identified gaps in services exist, the Howell County Health Center has opted out of providing this service. One area of service the agency continues to strive to meet the need is in the area of family planning. Howell County Health Center continues to compete for grants and contracts to help us financially meet this need.

The board and staff of Howell County Health Center continue to partner with other organizations in the area in an effort to maintain an environment that safe, supportive and conducive to a healthy lifestyle. In addition the Board of Trustees and staff continue to assess and identify health issues within the county and strive to ensure that health services are available to all in our area, including our uninsured, underinsured and underserved population.

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.

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 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 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 Howell County Health Center chose to only include key personnel, mostly department heads, to participate in the individual assessment. This decision was made more out of necessity than choice. Demands on staff time agency-wide have increased considerably in the past several months. Each staff participating in this portion of the project was provided a copy of the LDH self-assessment tool, and was instructed to complete the assessment based upon their own knowledge and experience.

Upon completion of the individual assessments staff met to discuss their individual responses, as well as to come to a consensus on how to score each question included on the tool. In most areas identified within the tool the group agreed that we were really doing better than they initially thought when they completed the self-assessment tool by themselves. However, when it came to a number of issues, documentation of our practices and processes were found to be deficient.

After the Self-Assessment was completed and entered online we were provided a report that reflected the aggregate results as a region. With this data now available the coalition convened once more to discuss and determine the priority area on which we would be focusing. The decision was made that we would break into our smaller identified groups to help determine the group’s priority. The group then met as a whole for the final determination. The group identified that we have more in common than we would have
initially thought. This provided an impetus for working toward developing a standardized tool for the group in conducting our individual strategic plans.

<table>
<thead>
<tr>
<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
</tr>
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<tbody>
<tr>
<td>V-C</td>
<td>LHD Role in Implementing Community Health Improvement Plan</td>
</tr>
<tr>
<td></td>
<td>o Aggregated data demonstrated all indicators under this standard were below the 2.0 score</td>
</tr>
<tr>
<td>V-C:5</td>
<td>LHD uses assessment data to develop annual program goals to develop policy (1.67)</td>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td>V-C:6</td>
<td>LHD identified new strategic opportunities promoting public health activities (1.78)</td>
</tr>
<tr>
<td></td>
<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 a 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 again in Section IV, Article 4 of the Howell County Health Center’s bylaws, which states “**The authority, responsibility and limitations of the Administrator shall include the following: Responsibility for entering 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. (RSMO 205.042.9).**

In spite of the fact that Article 4 of the Howell County Health Center’s bylaws provide the Administrator the needed authority to enter into contracts and agreements, as well as apply for grants, the commonly accepted practice has been that the Administrator will inform the Board of Trustees of any such agreement prior to taking action. This was the case with the NACCHO project as well. Once the formal
mechanism of collaboration was finished by the Region G Collaborative, it was reviewed by the Board of Trustees at the following meeting, to ensure we had approval with the scope of the project.

Results
We have not yet had the opportunity to implement the formal mechanism, as it was recently redesigned by the collaborative at our November 10th 2008 meeting. The group has processed the potential possibilities the collaboration will provide. The fact that as a region we have completed a regional assessment and a strategic plan should give the Region G Collaborative a “foot up” when it comes to applying for grant funds and entering into contracts. The evaluation of the group’s success at this point can only be defined by our current accomplishments. The members of the collaborative at this point appear to be in agreement that our successes have been substantial. To have a “Charter for Capacity Building Activities in place which provides goals and objectives to be accomplished as a region, will be the group’s first step. To have a mechanism for collaboration that gives us the authority to implement our charter and to work toward common goals is another. The Region G Coalition’s demonstrated ability to work together and come to unified decisions without dissention is a good indicator of the projects success to this point.

The group has identified that much more can be accomplished when efforts are combined. The coalition’s participation in this project further ensures the likelihood of further partnerships in the future. The group has identified a need and desire to explore additional grants. In addition, discussions have included the feasibility of staff sharing and group purchasing or cost sharing as a potential means for individual health centers to save money. Finally, we are currently in the process of looking into the potential of standardizing policy and procedures across the board, at least to the fullest degree possible.

Lessons Learned
Participation in this project has truly been an educational experience for staff and administration alike. One recommendation I would have for any LHD taking on the self-assessment piece is to have staff complete the assessment individually, prior to processing the document as a group. By doing so, you will benefit from input from a variety of different perspectives. Many staff will likely come into this meeting thinking their agency is woefully deficient in a number of areas, based on their individual perspective. However, when assessed by the group as a whole, many of your participants will determine that you are actually doing better than was initially believed. Had our group not done the activity initially as a solo effort, I seriously doubt we would have had the same positive outcomes.

For some health centers the act of turning a critical eye to current processes and policies and identifying internal deficiencies can be an intimidating experience. However, through a collaborative effort LHD’s can process with one another how they measure up in the different identified areas of the assessment, as well as share how their individual agency is meeting requirements. In addition, once involved in the assessment process the group’s focus will change from “what we are failing to do” to “how we are successfully meeting these criteria”

In spite of the fact that each LHD will have their own unique issues or situations, benefits of working as a group can be experienced as a result of a more universally identified set of overriding objectives or goals. The assistance I have received as a result of taking this project on as a part of a regional collaboration can not be overstated. It is difficult to comprehend attempting to complete this process without the support and assistance of my partners within the Region G collaborative.

Next Steps
Our next anticipated step will be to work on our Charter for Capacity, in an effort toward achieving our ultimate goal of accreditation. Two other areas of importance that have been identified include strategic planning and completing an up to date and thorough community assessment.
With the ongoing history of the Region G group I would expect a continued collaboration amongst the team. My expectation is that the Region G Collaborative will continue to work together toward accreditation as well as other endeavors.

Conclusions
The benefits received as a result of participation in the Accreditation Preparation Demonstration Sites Project apply to both individual LHD’s and Region G as a whole. Participation is in this project is merely the first step in a long journey for each participating LDH. Benefits resulting from the project will positively impact the quality and scope of services offered by the Howell County Health Center from this point forward. By providing Region G LHDs with the needed funding, tools and assistance, NACCHO has played an instrumental role in providing an avenue to accreditation that would likely not have been possible for a number of us, otherwise. Thank you.

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