Accreditation Preparation &
Quality Improvement
Demonstration Sites Project

Final Report

Prepared for NACCHO by the
Oregon County Health
Department, MO

November 2008
## Region G Collaboration

<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>Missouri</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td>Howell</td>
<td>38,734</td>
<td>927.74</td>
<td>28,864</td>
<td>18.7%</td>
</tr>
<tr>
<td>Oregon</td>
<td>10,407</td>
<td>791.40</td>
<td>25,551</td>
<td>19.8%</td>
</tr>
<tr>
<td>Ozark</td>
<td>9,393</td>
<td>742.15</td>
<td>26,952</td>
<td>20.0%</td>
</tr>
<tr>
<td>Reynolds</td>
<td>6,547</td>
<td>811.20</td>
<td>27,544</td>
<td>18.3%</td>
</tr>
<tr>
<td>Shannon</td>
<td>8,503</td>
<td>1,003.83</td>
<td>22,926</td>
<td>23.2%</td>
</tr>
<tr>
<td>Texas</td>
<td>23,566</td>
<td>1,178.54</td>
<td>27,193</td>
<td>20.2%</td>
</tr>
<tr>
<td>Wright</td>
<td>18,397</td>
<td>682.13</td>
<td>26,554</td>
<td>20.3%</td>
</tr>
</tbody>
</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.

Oregon County is located in the U.S. state of Missouri. Oregon County contains 791 square miles, with 13 people per square mile. The county was organized in 1845 and named for the Oregon Territory in the northwestern United States. As of 2007, the population is 10,304. Its county seat is Alton. Home to a large area of the Mark Twain National Forest, Oregon County contains more National Forest land than any other county in Missouri. It also contains the largest federally protected wilderness area in the state, the Irish Wilderness. Oregon County is adjacent to the following counties, Shannon County (north), Carter County (northeast), Ripley County (east), Randolph County, Arkansas (southeast), Sharp County, Arkansas (south), Fulton County, Arkansas (southwest), Howell County (west).

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 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 were 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.)

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 Oregon County Health Department was voted into operation with a mill tax in June of 1949. The County Commission appointed a 5-member Board of Trustees to govern over the agency and this Board continues today with members being elected on a rotating basis to serve 4-year terms. The Board of Trustees has always had a good relationship with elected officials, the staff and the community and has strived to provide the best working conditions for employees of the agency.

The Oregon County Health Department, Board of Trustees recognized the great need for public health services from the beginning. In 1949 Oregon County was one of the first counties in our district to establish a county health department. Our health department has always put community first. We have collaborated with the area schools, senior centers, and state agencies within the county, to improve the immunization rates and overall health status of our county.

In August of 1994 The Board Of Trustees made the unanimous decision to expand public health services within our county by opening an satellite office in Thayer, MO, initially at one day a week (Wednesday) and later two days a week (Tuesday and Wednesday). This expansion made it easier for children and parents to obtain local public health services such as immunizations and WIC service. The health department began to provide home health services during this time to cover the expense of the satellite office. The health department no longer provides home health services but, has continued to provide the satellite office services. Maintaining and staffing two offices have been difficult at times, due to decreased state contract funding and increased budget expenses but, the Oregon County Board of Trustees understand the importance of providing local public health services and have endeavored to provide this service to our county with no increase in property tax revenue.

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. 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.

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 used 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 targeting in a planning process, and the final goal of increasing their regional capacity through stakeholder engagement.

**Self-Assessment**

The Self-Assessment was completed by the Oregon County Health Department in a team approach method. Each staff member was given a hard copy of the assessment to be completed within a week. At the end of the week we met in our staff meeting and discussed the assessment. We then went through the assessment data and discussed the individual results. It was evident to the entire staff that we were providing most of the essential services but that our documentation to prove that we were providing those services was lacking. There were several areas that we were all in agreement that were completely nonexistent. These low scoring areas were identified as areas we have seen utilized to set our own objectives and goals within our local public health agency.

Our region met as a group and we divided into 3 groups of 3 counties to work on the assessment for the region in teams. Once each county completed their individual assessments and entered the assessment results into the NACCHO online form we met in our small groups to review each of the assessment items. Our group consisted of Oregon, Texas and Wright Counties. We reviewed each item and how we had
individually scored them for our respective counties and discussed the rationale for why we scored each item as we did and what documentation did we have or not have to support the item. We found as a group that most items we scored alike but those that we didn’t score alike were because of how we each viewed the supporting documentation for that item. This was a great way to identify what type of documentation that each of our counties were using to support our work and we came away with great ideas and strategies for improving our documentation.

Once our group had completed the team review we identified 3 priority areas based on our collective assessment results. After the small group discussion and identification of the priority areas we met again as a region and voted on the priority area to address collectively. We all have similar demographics and health issues within our respective counties and we find it much easier to help each other out to accomplish our region and county goals.

### Highlights from Self-Assessment Results

<table>
<thead>
<tr>
<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
</tr>
</thead>
<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>
</tr>
</tbody>
</table>

### 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 administrator 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 and who that staff would belong to and report to.

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 Oregon County Health Department Policy Manual; SECTION IV, ARTICLE 5. states: The Authority and responsibility of the Administrator shall include, the following: Responsible for entering into contracts and agreements with federal, state, county, school and municipal governments and with private individuals, partnerships, firms, associations, corporations for the furtherance of health activities. (RSMO 205.042.9)

The health directors continually update their Board of Trustees as to collaborative projects that build the capacity for their health departments.
Results
The mechanism was just recently refined and resigned by the Region G Collaborative at the November 10, 2008 meeting. Our success at this point in time can only be defined in what we have accomplished. To have a "Charter for Capacity Building Activities" in place which provides goals and objectives to be accomplished as a region is astonishing. To have a formal mechanism for collaboration that gives us authority to implement our charter and work toward our goals is extraordinary. Ultimately the success has been that a group of people from nine different agencies can come together and accomplish a task such as this says a lot about the determination of this Collaborative Group.

Lessons Learned
I cannot speak for the others in our collaborative group but, I was a little overwhelmed by the self-assessment. It covered areas that I really had never taken the time to think about or to address. Our agency is very small and we tend to get involved with the programs we work with day to day. The assessment gave us all a chance to assess all of the areas of public health. So, even though we were somewhat hesitant it was worth the time and effort to see our strengths as well as our weaknesses. Missouri local public health agencies are not like other states such as Arkansas. We are not state, county or city employees, we are a local non-profit agencies. So what that means to me is we have work extra hard for every dollar that our agency receives. My staff are all very hard working individuals, we are cross-trained in many areas and that means they are always busy. But, they took the time to complete the assessment and I feel have learned so much from the experience.

Next Steps
Our next step will be working on our Charter for Capacity Building Activities, in an effort of attaining our ultimate goal of National Accreditation. We focused on strategic planning as an aspect of the accreditation process and which was an area that we realized as a region we would need to improve upon.

The Region G Collaborative Group, is a very strong group. We have successfully worked together on many projects in the past. I feel that we can only move forward because this group is so strong and motivated to accomplish the objectives and goals we have set for the group. I think together we can accomplish the National Accreditation.

Conclusions
I have concluded that nothing is impossible if you work together. I was very overwhelmed by the accreditation process and by working in the Region G Collaborative group I have seen we can accomplish the impossible. The self-assessment gave me the tools I need to set goals and objectives within my own local public health agency. By working with NACCHO you have given my agency the funding to take that first step towards accreditation. The Oregon County Health Department has a very small budget and as with all agencies funding sources are an issue. With all of the serious economic issues our country is facing we must all work together to provide unity in care and services. Thank you for providing us with an enjoyable experience and the funding that made it possible.

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