Accreditation Preparation &
Quality Improvement
Demonstration Sites Project

Final Report

Prepared for NACCHO by the
Ozark 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 .............................. 19.8%

Oregon
Population ...................................................... 10,407
Land Area (sq. miles) .......................................... 791.40
Median Household Income, 2004 .......................... 25,551
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.

Ozark County Department is located in Gainesville which is the county seat for the county, and serves a very rural population of about 9,393 within 742 square miles. However, Ozark County represents only 7% of the region’s rural population. Ozark County is located on the south western side of Region G which also borders the state of Arkansas. After completion of the NACCHO LHD Self-Assessment tool, it was evident that the Ozark County Health Department fell short in many areas of the ten essential services. After the aggregate data for the region was available a common/theme gap that emerged was that strategic planning was a recurring weakness and something that could possibly be address as a regional collaboration.

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 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.)

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 Ozark County Health Department has provided services to the citizens of Ozark County for 46 years. We were established as a local public unit in 1962 when voters passed a tax levy. The Ozark County Health Department is governed by a five member Board of Trustees that are elected on a rotating basis to serve 4-year terms and staffed by 14 employees and 12 volunteers. The Board of Trustees has always had a good relationship with the elected officials, staff and the community. Services have diversified over the years to meet the needs of the community.

The Ozark County Health Department serves all county residents; the population is 9,393. The main sources of economy consist of agricultural operations, small businesses, tourism and the 5 rural schools being the largest employers of the county. Due to the nature of rural communities having a predominately agricultural economy and lack of major employers to provide comprehensive health insurance plans, many of the Ozark County residents are either uninsured, under insured, or have Medicaid.

The Ozark County Health Department has been a partner in securing a Federally Qualified Health Clinic for the community. The Federally Qualified Clinic was housed in the Ozark County Health Department building for three years at no charge until a separate facility could be established.

The Ozark County Health Department was one of the seven counties in Region G that formed South Central Public Health Services Group, Inc to provide services to Howell County until their voters elected to have a Public Health Department for that county. The Ozark County was the lead county that allowed their funding to pass through our county.

The Board of Trustees and the staff continue to assess and identify health issues in the county and recognize that the Region G Collaboration could be a great tool 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 great 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. 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.

In September 2007 the Region G Collaboration held a meeting to address accreditation through the Missouri Institute of Community Health (MICH).
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 edu. 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.

LHD’s 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 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 Ozark County Health Department staff came together in April 2008 to complete the Local Health Department Self-Assessment Tool.

The staff started the process by going over the purpose of using the self-assessment tool which allows us to measure ourselves against the Operational Definition and subsequently identify areas of strength and areas for improvement an assess our capacity to fulfil the functions outlined in the Operational Definition and engage in quality improvement activities as needed to enhance our capacity.

Our staff dedicated the whole day to conduct the self-assessment. Each staff member was given a hard copy of the LHD Self-Assessment. We read each question on the assessment and discussed as a team which score to give to the question. It was a good learning tool for the staff to look at everyone’s job duties and realized all the services that are provided at our agency and where we stand at meeting the ten essential public health services. This brought our attention that we are meeting most of the standards, but not always providing documentation to prove it.

The information we gathered from our self-assessment was entered online to NACCHO’s form, we were then able to get our aggregate results for the region. With this 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.

All of the Region G counties realized that assessing our communities with a standardized tool and working on our strategic plans was something that would fit 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 (1.67)</strong></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 (1.78)</strong></td>
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<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 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 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 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 Ozark County Health Department bylaws, along with Article 9b which passes authority down to the Administrator to sign contracts representing Ozark County Health Department.

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. However, all involved have discussed the possibilities that this collaboration will give us. We will have a regional assessment in place and a strategic plan that will give us leverage when applying for grants and signing 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 great. To have a formal mechanism for collaboration that gives us authority to implement our charter and work toward our goals is fantastic. 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 our county residents we serve is a real success.

The Region G Collaborative has discussed different opportunities in which we will be able to utilize the mechanism for collaboration. Some of the discussions have been about sharing of personnel, grants, contracts and other doors that could be opened for us as a region. We will continue to look at opportunities as a region.

**Lessons Learned**

From our perspective as a Local Health Department the self-assessment was a useful tool that help us to identify the areas we needed improvement in. an overwhelm you. Getting staff involved from day one was very important, their input was essential to achieve a scoring on each question and after the data was entered online to NACCHO’s form and aggregated for the region to find that we all basically scored low or high in the same areas. The self-assessment has been one of the most beneficial aspects of the entire project. Working on this project as a collaboration between nine counties has definitely been a plus for our local agency.
**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 assessment as well as strategic planning is 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, project 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**

Participating in the Accreditation Preparation Demonstration Sites Project has been a positive experience for us. We have discussed in the past few years about looking into the process of accreditation, but I think we were always overwhelmed at just getting started and getting staff involved. But as we learned about NACCHO and looked at how we could start this project as a Region it appeared to be more feasible for us to do. We have also worked with MICH, our state accreditation board and that we are working on this project. It is very important that small, rural health departments have an input on the whole accreditation process, because we cannot compete with the larger departments. It has been very exciting for us as a very small health department to be involved in an accreditation process for this industry. I hope that what we contributed will help in the finalizing of the final documents.

To all those rural health departments who choose accreditation, I hope that we have taken a few bumps out of the road for you.

**Appendices**

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