Accreditation Preparation &
Quality Improvement
Demonstration Sites Project

Final Report

Prepared for NACCHO by the
Reynolds County Health Center,
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 .................... 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**

Reynolds County is 811 square miles and is located in the eastern part of Region G and in the Ozark Foothills. State and Federal land claims over 150,000 acres in forests and conservation land. Our population is approximately 6,547 averaging around 8 people per square mile. It is hilly and has narrow winding roads without shoulders contributing to MVA rate higher that the state rate. The 2006 census shows a fast growing senior population and a very subtle hint to a beginning exodus of small families with young children. This no doubt is connected to poor housing and a high rate of unemployment. The county is 97.6% Caucasian although there is a small minority population, including the beginning of a small migration of Hispanic people. The three branches of the Black River traverse and intersect the county dividing the population into small pockets of people. Over half of the population live outside the city limits. This small population can swell in the summer by several thousand tourists who come to our county to float the Black River, go to Johnson Shut Ins State Park or just enjoy the beautiful forest and hike, camp or bike the narrow roads.

Like many other Southeast Missouri counties we have generational poverty, high unemployment rates, and high rates of Medicaid and uninsured citizens. Our schools show a steady increase in students finishing high school but we still have a low rate of students getting their college degree. The majority of our employed citizens work at the lead mines, schools, in the timber logwoods, or governmental jobs. Doe Run Mine Corporation has five active lead mines all within our county lines. Depending on the market rate for lead ore there could possibly be 50 to 100 miners let go from their jobs at anytime. The wonderful people here live a simple life but unfortunately many are in a survival mode from day to day.

Again like most Southeast Missouri counties the lifestyle choices are not always the best when it comes to health and wellness. Reynolds County has a higher than state rate of chronic disease which includes heart disease, stroke, diabetes, COPD, and obesity in its citizens. The population has a high rate of tobacco use and that results in a higher than state rate of COPD, flu, pneumonia, and lung cancer. Historically fried foods are the choice for nutrition and little interest in exercise. We have seen a very subtle positive change in citizens asking questions about high dietary fat and cholesterol and an increase interest in walking and exercise. Just this year one restaurant has gone tobacco free. We are hopeful it is the beginning of a movement towards a healthier lifestyle for themselves and for the children. Alcohol and substance abuse are prevalent and this coincides with a high rate of mental illness and this has been difficult to make a positive impact.

Reynolds County is a designated HIPS A (Health Professional Shortage Area) with a local CAH (Critical Access Hospital) that is consistently plagued with financial problems and has in the past been on the verge of closing. We have two rural health clinics, one of which is our FQHC (Federally Qualified Health Center). The FQHC has another satellite clinic in the northern part of the county. Many of our citizens persist in using the emergency room as their primary medical provider.

Reynolds County Health Center (RCHC) sits in Centerville in the middle of the county. RCHC is very small with only five full time staff. The five part time staff are used to fill in the gaps for programs and services. It is become increasingly harder to do the ten essential public health services with so small a staff and that has caused us to make partnerships a primary focus. Friends of Reynolds County a non-profit organization was started in 2001 and has been able to bring in additional needed services and programs. The Mark Twain Forest Regional Health Alliance is a non-profit organization that was started in 2003. This group is diverse and has five Local Public Health Agencies (LPHA) one from Reynolds and the other four from surrounding counties. Also active in this group are two faith based organizations Whole Health Outreach and Whole Kids Outreach, two CAH’s Advanced HealthCare Medical Services in Reynolds and Iron County Hospital in Iron County. Our local FQHC is an active member and rounds out the membership. This organization has actively pursued and been awarded funding for programs and services.

As an active member of Region G we have tried to make ourselves available for any and all opportunities for working collaboratively to assist the RCHC do all it can do for the community. Region G jointly agreed to collectively investigate accreditation and travel the journey collaboratively. Region G was funded by NACCHO for this demonstration project to explore the feasibility of national accreditation. This has been
a several month project which ends the end of November 2008. It will end with the formalization of the Region G Public Health Collaborative a “first” for the state of Missouri. Because of the NACCHO award and our collaborative efforts MICH (Missouri Institute for Community Health) chose Region G to be one of two state “mini collaboratives”. The other mini collaborative is located in the northern part of the state and they too were awarded a NACCHO demonstration site project. Our work with MICH is with Quality Improvement and we will be learning the process to make our individual agencies the best they can be. This is in preparation to make an application to review our agency for Missouri State Accreditation. It has been a most rewarding and learning experience.

**Background**

Reynolds County Health Center (RCHC) belonged to Region G prior to this demonstration site project. We were a part of Region G and worked collaboratively on emergency/bioterrorism projects under the guidance of one regional planner and epidemiologist centrally housed in Texas County. All nine counties in this region are rural and face many of the same problems. This collaboration proved very successful. We met on a regular basis and participated in joint exercises and trainings. The meetings were moved from county to county so we had a visual experience of the different agencies and their staff. We shared ideas about staff, supplies and our learned experiences from the involvement in preparing for and doing these required emergency exercises.

I believe this experience allowed us to get to know one another, learn to share ideas and develop a give and take attitude. This brought out the best in each of us and ideas that we wanted to take back and implement in our own agencies. It is now much easier for us to all to work together and not fight over territorial issues. This sharing, compatibility, and workable attitude were a learned behaviour. We learned to share in kindergarten and in the following years this sharing attitude slowly slips away. Rural health centers must deal with deadlines to meet, deliverables that seem to never end, goals to accomplish, and funding streams that have quickly narrowed and have all but dried up. We all must accomplish this with limited staff and resources. We must learn to collaborate and be good partners or take the risk of becoming extinct. We have learned to talk with one another and help one another and this results in an improved ability to obtain all that each of us needs. The “silo mentality” has been changed to who can be our partners. RCHC is the smallest agency and has the smallest staff in the region. We openly look for partners for each project we consider.

Our Board of Trustees have full knowledge and approve of our agency participating in this project and see the value of partnerships and agreements between agencies. At our monthly board meetings an update of the project is given as well as interesting details of the remaining issues left to be completed. They are engaged in the process and ask questions and seem genuinely interested. At this months meeting we will be reviewing the assessment findings, the formal agreement, the strategic plan, and the final report. They will then have the full picture of the demonstration project and what has been accomplished. One of our board members has taken an active interest and volunteered as a member of MALBOH (Missouri Association of Local Boards of Health). This is a new organization that just came into existence this year. Our agency now has a membership in MALBOH as well as NALBOH (National Association of Local Boards of Health). This is an indicator that our Board’s perspective for our agency has grown greatly and our Board is looking at the big state wide picture. They are no longer limiting themselves to a small countywide perspective and this will no doubt spill over into their vision for our agency.

**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.

Self-Assessment
Reynolds County used the approach of the Administrator, Asst. to the Administrator & Quality Improvement Coordinator. This allowed a perspective from all angles from Administration to Bookkeeper to Nursing. This approach was selected because key individuals could bring all aspects of assessment knowledge to accomplish the task. The assessment took approximately 5-7 days at several sittings. It was enlightening as it brought us to the realization that we do most of the things being asked but we were unable to show documentation of it being done. Great discussion and analyzing was done to arrive at the final scoring. When disagreements were identified it allowed us to walk and talk through understandings to arrive at a consensus of score. Any difficulties that were experienced were mostly found within the wording of the assessment topic or the realization of lack of documentation or policy. We were able to recognize areas of tremendous strength and areas of great weakness. Those weaknesses seemed to be commonality among all the LHD’s.

After each individual agency put their assessment into the NACCHO tool that information was aggregated into a collaborative document which was available via the Team Intranet that allowed each agency to be able to print the results. We then met to discuss the aggregate results. We divided into 3 subgroups of three agencies to assess the data and decide on the Domain they felt was the most in need of work. When coming back together, we collaboratively and collectively voted upon the Domain identified as within our means and capability of making the most impact on all the agencies needs. Then we broke into the subgroups a second time to decide on the Standard number. What was amazing is that when we came back together as a large group, we had agreed on the same Standard. Discussion then was directed on if one or more of the Indicators.

A telephone call was made to Janan Wunsch-Smith, NACCHO Consultant chosen by the Reg G Collaboration, regarding the issue of choosing more than one Indicator. Through discussion with her, it was decided to address two. Strategic Planning within each agency was discussed with the understanding that you cannot plan strategically what direction the agency will go without a good and complete Community Assessment. The Core Public Health Contract requires a Community Assessment every three years. Some agencies have already completed their assessments while others have not. The idea of developing a standardized template for Strategic Planning could be used across the Region G area. This was an idea that was pleasing to decrease the need for each agency to develop their own.
This also led into the discussion of policies and procedures being shared across county lines. It was exciting to see the discovery of multiple ways that all 9 agencies could come together and create templates of necessary items from strategic planning to policies/procedures. This has opened the door to much discussion on other ways of sharing including staff during times of need.

### 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>LHD Role in Implementing Community Health Improvement Plan</td>
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<td>- 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>LHD uses assessment data to develop annual program goals to develop policy (1.67)</td>
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<td>- 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>V-C:6</td>
<td>LHD identified new strategic opportunities promoting public health activities (1.78)</td>
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<td></td>
<td>- 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

At one of our collaborative meetings our consultant assisted us through the process of developing our formal agreement. We were all familiar with a Memorandum of Agreement (MOA) since we had worked together under this type of document. We chose to do a MOA as we felt comfortable and familiar with the structure and verbiage of this document. Since we are so diverse we felt comfortable with the consultant’s suggestion of doing a charter for each individual project. The process went fairly quickly and in just a few hours we had the document finished. We met our first barrier just after it was submitted to NACCHO. They sent it back for a revision requesting a document that dealt with the specifics of legal issues, fiscal agent, and administrative issues. This revision of the agreement was the first challenge we had to face. Kathleen Zimmerman took the lead and immediately began to research the Missouri statutes and laws governing LHD’s. It proved to be a great learning experience. Upon investigation, the statutes validated that LHD’s are “political subdivisions” supported by tax levy funding. As “political subdivisions” LHD’s do have the authority to contract with each other, other entities, and even entities in another state. While this contractual authority was given to Boards of Trustees it was transferred to the administrator through the agency By Laws. Each of the nine LHD’s was asked to check in their individual agency by laws to verify that this was addressed and the authority was given to the administrators. It was then we met our second challenge as two of the nine agencies had by laws NOT validating the change of authority. Both of the two agency administrators took this to their board meetings and explained the problem. At their monthly board meeting the by laws were amended and then all nine agencies had the authority to enter into contractual agreements. The final agreement document clearly states that all nine agencies have equal value and will review each potential project. They will individually decide if they want to enter into a chapter agreement for a specific project or if they chose to pass and not to participate.

Those agencies that choose to participate will review the project and decide if it fits into the goals and objectives of their “Charter for Capacity Building Activities”, the potential funder, funding budget, and the appropriate agency size capacity and experience. They will collectively decide who can fulfill the role of fiscal agent. The chosen agency acting as the fiscal agent will take the lead in the project and carry out the administrative functions. This process will be used to make a decision for each individual project and will allow equity for all members of the collaborative.
Results
We have not had an opportunity to implement the formal agreement as of this date. We feel the ability to have accomplished creating and signing this formal agreement was a monumental success. It puts us ahead of many LHD’s that still struggle finding and working with partners. This will give us a terrific advantage when we decide to write for grant funding. Funders are always looking for partnerships and collaborative groups so they can get the very most for their funding dollar. Many RFP’s are specific and tell potential grantees not to even apply if they are not a member of an established collaborative. All of the nine LHD’s are actively looking for potential projects and we feel that being a member of this Region G collaborative expand our opportunities for funding.

The assessment process and reviewing the aggregate results proves we are more alike than we are different. We felt we were doing the services but we were unable to prove it. Documentation plays a huge part in successfully proving you are a quality agency. Even though we are rural and remote small agencies it is very important to connect with academia and be involved in cutting edge projects.

An unexpected benefit was the response of our own Missouri volunteer accreditation agency. Missouri Institute for Community Health (MICH) chose Region G Collaborative to be one of the two FIRST mini-collaboratives in the state. MICH is working with us to develop our Quality Improvement (QI) skills that will ultimately be a huge help in our pursuit of agency accreditation. This recognition has increased staff morale and given us positive feedback back from our own individual governing boards. Not only have we grown in knowledge we have better confidence and self esteem.

Lessons Learned
We would recommend to always first discus with your governing boards the intent to pursue a project of this nature. Make sure the governing board can see the value to the agency in participating in this type of project. Always engage them in the decision making process and keep them well informed on a regular basis. Think carefully when you chose your team. This is definitely a teamwork effort and all staff will have skills and will bring valuable information to the table. We now look at the connection with academia in a new light. Our partnership with them can greatly help both parties.

Never be afraid to step out and actively seek opportunities to find partners and take any opportunity to collaborate in any agency appropriate project that presents itself. If no one is forming partnerships be the FIRST to recommend the idea of collaboration. When you belong to a collaborative each member’s partners now become your partners! The funding opportunities will greatly increase when you are part of a collaborative. Remember most funders seek funding opportunities to impact the most for their money. Think “out of the box” and don’t be fearful of trying something new. Challenges are not to be avoided, they are opportunities to grow.

Next Steps
Completion of this project is only the beginning. We are all actively seeking opportunities to find fundable projects that relate to the need in our communities. We seek to keep the momentum going forward. As we continue our work towards accreditation our newly learned QI skills will be a terrific benefit. We are able to see the “big picture” and realize that regardless of our individual size, as a Region G collaborative we are stronger than we were before. We plan to continue to use our team intranet connection and sharing of documents, ideas, successes and failures. We know now we do not have to do this alone and together we can get the job done. We do not have to create each needed item we can share with our partners and all will benefit.

As we move towards building the standard structure of our agencies we can now share staff. They will be able to cross county lines and work in other agencies with ease as we will all be alike in thought and policy and procedures. We all will have a greater ability to perform the 10 essential services.

We are considering funding opportunities that will enable us to make plans for a regional health assessment that will allow us to compile data cross county lines. We then will be able to say for example poverty, unemployment, and the growing population of underinsured and uninsured are a huge problem
REGIONALLY and not just in one or two counties. We believe that we will garner greater funding and more importantly a REGIONAL problem will get more attention and carry “more clout” with Missouri legislators. We will see positive changes come to fruition from a REGIONAL out cry of the people.

Conclusions
This has been an enormous learning experience. We have gained knowledge but also a greater appreciation of each other and what each of us has to offer. This would have been almost impossible without NACCHO giving us the opportunity and funding to hire a consultant and take the time to come together and work on this project. Thank you NACCHO for believing in us and helping us to believe in ourselves and each other!

We live in an era of high technology. Communication, sharing ideas and information is faster than ever imagined. We have less opportunity for face to face encounters and experiencing the emotional responses of each other. While this speed is good in many ways it can allow separation and can promote “silo” thinking and responses. We run the risk of polarizing ourselves and stifling partnerships and an emotional bond of caring for one another. We must find ways to keep this face to face approach in all facets of our lives. In addition to the accreditation journey whatever we will face in the future we must remember that we are people searching for the best answers for all and not just for ourselves.

We must be not afraid to look at a regional approach. There are friends out there suffering the same trials and experiencing the same problems. The burden is lighter when share with many people. No one agency is an island unto its self. It can be difficult to loose the “individual” approach but the future begins NOW and it begins with one step.

As we go forward towards attaining our goal of agency accreditation we can be the beacon of light for our agency friends. Local Public Health Agencies can be the “trail blazers” for building a better future! We can be the slow and steady shift for the world to once again value working together for the betterment for all people. I am excited and optimistic about this work and our time in history!

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