Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Shannon County Health Center, 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>
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<tr>
<td>Missouri</td>
<td>5,842,713</td>
<td>68,885.93</td>
<td>40,885</td>
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<td>Carter</td>
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<td>Howell</td>
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<td>Shannon</td>
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<td>Wright</td>
<td>18,397</td>
<td>682.13</td>
<td>26,554</td>
<td>20.3%</td>
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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.

Located on the eastern side of Region G, Shannon County contains 1003 square miles, ranking it the second largest county in the state of Missouri, and accounts for 13% of the land mass in Region G. However, with a population of approximately 8,500, the county represents only 6% of the region’s rural population.

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.

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 favor 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 identify 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 Shannon County Health Center was voted into operation with a mill tax in April of 1961 with a 5-member Board of Trustees appointed to govern over the agency. These members serve 4-year terms and receive no compensation for their dedication to service.

Until taxes could start being collected in 1962, the center’s financing came from the State Division of Health and money borrowed locally. The District Health Office in Poplar Bluff furnished the office with a desk, some filing cabinets, an exam table and other minor equipment. The first annual report stated “As in all new businesses, we must begin our activities slowly and build gradually in both equipment for the Health Center as well as programs in which we will be able to participate.”

Little did they know then that the agency would flourish and someday offer a smorgasbord of programs that not only included public health services such as immunizations, health inspections, the WIC program and communicable disease testing and follow-up, but also a whole new component providing home health care and in-home services for the elderly and disabled residents of the community. It was in 1967 that the Shannon County Home Health Agency was added to the menu and it is these services that account for more than half of the revenues of the entire agency today.

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. In 1976, they recognized that the staff had outgrown the small four-room house that was serving as an office and they managed to fund the construction of a new 4000 square-foot facility, giving a more professional appearance for the agency.

In the mid-1990’s the agency administrator, with support from the Board of Trustees, applied for and received a PRIMO grant which brought a primary care physician into the county, a joint-collaboration with the Big Springs Medical Clinic, now known as Missouri Highlands Health Care. The basement of the Shannon County Health Center was remodeled and housed the new clinic until they were able to get on their feet and move into their own facility. This was just another example of the priorities of the Board of Trustees and the administration. Identifying needs in the community and seeking out ways to meet those needs has always been of utmost importance.

It is because of their community-mindedness that our Board of Trustees and staff realized that the Region G Collaboration was right in line with our mission as an agency to “protect, promote, and assure the health of our citizens” in a new and broader arena. We feel that this new venture will increase our capacity to assess health status and needs, develop policies and priorities, provide services efficiently, and utilize all available resources to attain our goals.

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. The Shannon County Health Center was one of the seven health departments in the region to help form 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). At this meeting we looked at the MICH accreditation program and extreme concern was expressed on our ability to accomplish accreditation using their tools.

All LHDs in Region G agreed it was essential that our LHD’s meet, communicate, and provide services through memorandums of agreement, jointly exercise our local emergency plans and implement a regional public health system. The Douglas County Health Department contracted with a local IT provider to develop an intranet that enables all team members to share information, data, documents, questions, etc. This intranet will be used to expedite evaluation of our areas of potential collaboration and successfully meet our deliverables.

In January 2008 the Region G Collaboration met with representatives from MICH to include Butler County, a successfully accredited Missouri Health Department. We reviewed fears and barriers about the accreditation process and reviewed the standards for accreditation through MICH. We then participated in an exercise to preview actual on-site review. MICH informed us at that meeting, they had traveled the state for LHD’s input and had taken seriously the information they were given. As a result of this information, MICH had meetings and discussed at great length the information and how best to proceed. As a result of those meetings they made improvements to the MICH guidelines for their Voluntary Accreditation Program for Local Public Health Agencies. These new guidelines became effective January 2008. All nine LHD’s agreed to pursue regional accreditation in order to:

- Strengthen our local health policies;
- Expand and strengthen our partnerships;
- Assist us in organizing;
- Obtain additional resources to run the vital programs that make a difference to everyone’s health.

It was recognized funding would be a barrier. Funding is necessary for:

- Staff time for assessment and to maintain a current and future competent public health workforce
- Data sharing with regional and community partners
- Systems development to include application of evidence based criteria to evaluation activities
- Sustainability

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 education, 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 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 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 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 Shannon County Health Center decided to complete the individual assessment from a team approach. As we are a small agency with only ten office staff and many different programs, we felt it was necessary to include everyone in the assessment process. The LHD Self-Assessment was distributed to staff members a week ahead of the scheduled meeting date to be completed on their own and at their own pace.

After completing the individual assessments, we held a staff meeting on April 25, 2008 to review the entire self-assessment as a group. We read each question on the assessment and discussed everyone’s individual scoring before coming to a consensus about which score to give to the question. We learned a great deal about everyone else’s job duties and discovered that we do indeed perform a great amount of services at our agency and come closer to meeting the ten essential public health services than previously thought. We realized that we are meeting most of the standards, but not always providing the documentation to prove it.
After all nine counties in the region had entered the self-assessments into the NACCHO online form, we were able to retrieve the regional aggregate results from the website. We then met in three separate task forces to choose a priority area to focus on. Those three task forces then came together as one group to vote on the final priority for the region. Since all nine counties have similar demographics and similar issues within our agencies it didn’t take long to come to a consensus on our priority issue. As far as anonymity, we really were not concerned about it. We have always shared our troubles with each other, admitted our downfalls and reached out to help one another. It simply wasn’t an issue. When the priority was chosen, there was no dissension among the group. We all had the same vision to create a common assessment process and focus on strategic planning.

### Highlights from Self-Assessment Results

<table>
<thead>
<tr>
<th>Standard/Indicator #</th>
<th>Standard and Significance</th>
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| V-C                  | **LHD Role in Implementing Community Health Improvement Plan**  
  o Aggregated data demonstrated all indicators under this standard were below the 2.0 score |
| V-C:5                | **LHD uses assessment data to develop annual program goals to develop policy**  
  (1.67)  
  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. |
| V-C:6                | **LHD identified new strategic opportunities promoting public health activities**  
  (1.78)  
  o Again, without a community assessment in each county, it would be impossible for the region to move forward with a total planning process |

### 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 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 the Shannon County Health Center's bylaws, along with Article 9m which then passes authority down to the Administrator by stating, “Administrator has authority to sign contracts representing Shannon County Health Center/Home Health Agency.”
As with all new programs and contracts, the Board of Trustees has the final say in whether or not the agency will proceed. When presented with the NACCHO project, they gave their blessing in the form of a signed letter of support that was submitted with the original application. They were updated when the priority area was chosen and again after the formal mechanism of collaboration was signed. They are wholeheartedly committed to the project and agree that it will lead to a positive and effective change for the agency.

Results
The formal mechanism of collaboration was only recently completed and signed by all of the nine county administrators. Our hope is that opportunities will surface in which we will be able to put the agreement to the test. We feel that we have been successful as an individual agency in being able to work together as a team and complete the deliverables of the project. We have been successful as a region in coming together and completing our Charter for Capacity Building Activities as well as our formal agreement. We should be most proud of the fact that such a large group was able to come together and make a united decision on the path that we will all travel down together. As we reflect back on what has been accomplished we also look forward to what we have yet to achieve.

Lessons Learned
From our local agency perspective, I would have to say that the biggest lesson learned is to try not to look at the project as one huge undertaking. You really have to break it down into smaller pieces that you can work on a little at a time. Even the self-assessment can be an overwhelming task. By letting everyone complete it individually and then discussing it as a group, it took the heavy burden off of the one person who was responsible for reporting back to the region.

Getting everyone’s input is also vitally important. Many staff members learned about programs at our agency and job tasks that they didn’t realize existed. The scoring process really brought this to light as we saw the vast spread in our own agency results. Our agency meeting was an enlightening experience for many of the staff (especially the newer members) as they realized the broad range of job functions that are performed by everyone. The self-assessment was one of the most beneficial aspects of the entire project and possibly the greatest lesson learned.

Next Steps
It is imperative that we continue our relationships with each other and keep the lines of communication open. The Region G internet forum created by the Douglas County Health Department will be an invaluable tool in the continuation of our project. We must also implement our Charter for Capacity Building Activities in order to complete the goals and objectives that we have set for ourselves, since much of what we lack in our individual agencies is encompassed in this. Once we have jumped that hurdle, we will be well on our way in the accreditation process.

Conclusions
Participating in the Accreditation Preparation Demonstration Sites Project has been quite an experience. As this project has moved along and we have learned more about NACCHO, our state accreditation board and the other agencies involved in the public health accreditation process, the more we have realized the need for this project. The importance of small, rural health agencies having input on this process is so important. We cannot compete with large agencies when it comes to staffing and resources and this really needs to be taken into account when considering smaller agencies for accreditation. This was truly a once in a lifetime opportunity for us. We hope that our feedback and survey questions on the self-assessment have helped in some way and will be taken into account as the final decisions are made.

In reality, not only was this a journey as an individual agency, helping us to realize our strengths and our weaknesses, but hopefully it has helped to pave the way for other small, rural agencies across the
country who will someday be travelling down the same road. We are thankful to NACCHO for providing us with this opportunity.

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