

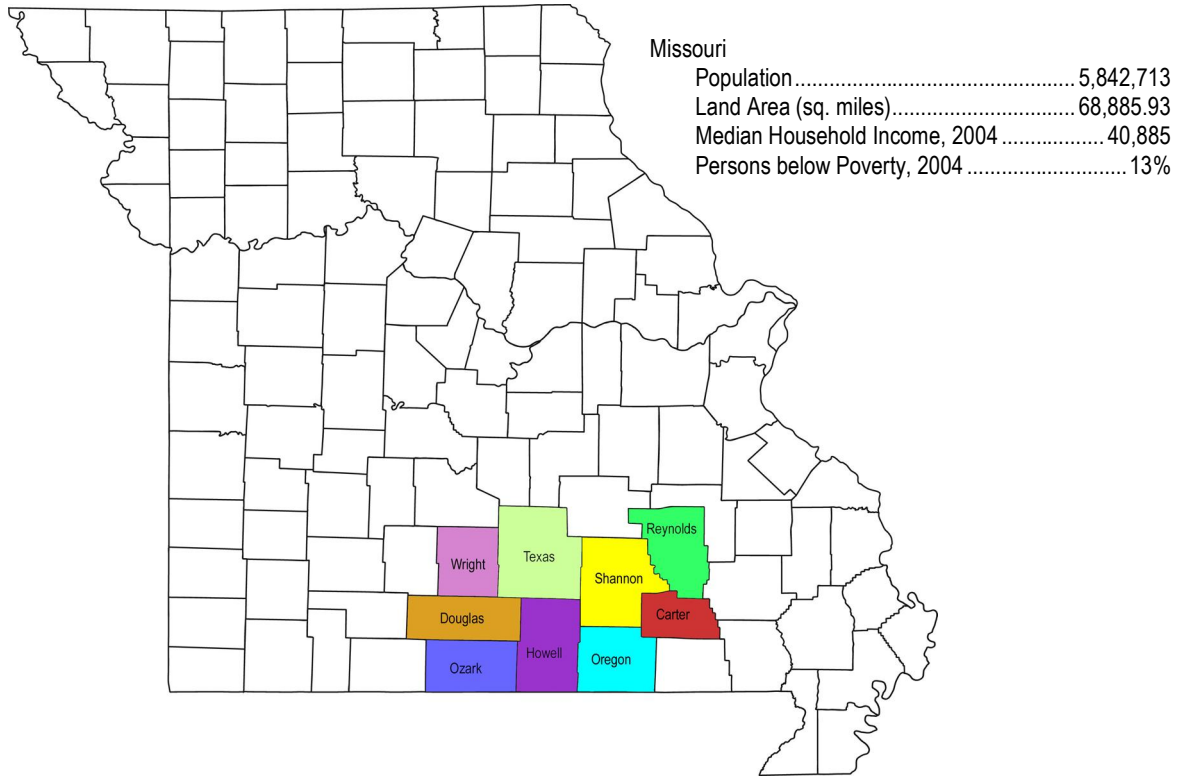
**Accreditation Preparation &
Quality Improvement
Demonstration Sites Project**

Final Report

**Prepared for NACCHO by the
Texas County Health Department,
MO**

November 2008

Region G Collaboration



Carter

Population	5,956
Land Area (sq. miles)	507.58
Median Household Income, 2004	27,113
Persons below Poverty, 2004	20.7%

Reynolds

Population	6,547
Land Area (sq. miles)	811.20
Median Household Income, 2004	27,544
Persons below Poverty, 2004	18.3%

Douglas

Population	13,658
Land Area (sq. miles)	814.53
Median Household Income, 2004	27,452
Persons below Poverty, 2004	18.8%

Shannon

Population	8,503
Land Area (sq. miles)	1,003.83
Median Household Income, 2004	22,926
Persons below Poverty, 2004	23.2%

Howell

Population	38,734
Land Area (sq. miles)	927.74
Median Household Income, 2004	28,864
Persons below Poverty, 2004	18.7%

Texas

Population	23,566
Land Area (sq. miles)	1,178.54
Median Household Income, 2004	27,193
Persons below Poverty, 2004	20.2%

Oregon

Population	10,407
Land Area (sq. miles)	791.40
Median Household Income, 2004	25,551
Persons below Poverty, 2004	19.8%

Wright

Population	18,397
Land Area (sq. miles)	682.13
Median Household Income, 2004	26,554
Persons below Poverty, 2004	20.3%

Ozark

Population	9,393
Land Area (sq. miles)	742.15
Median Household Income, 2004	26,952
Persons below Poverty, 2004	20%

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 in the south central portion of Region G, Texas County contains 1,178.54 square miles, ranking it the largest county geographically in the state of Missouri. According to the 2000 U.S. census, Texas County has a total population of 23,566 with 99% living in rural areas. The 2004 census data reveals 20.2% of the persons live below poverty level. It is a rural county with one hospital and seven physician clinics providing the medical needs to the community.

After completion of the NACCHO LHD Self-Assessment tool, it was evident that the Texas County Health Department fell short in several areas of the ten essential services. After the aggregate data for the region was available and collaboration with the other administrators in Region G, it appeared that strategic planning was a recurring weakness and this was an area that needed improvement.

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. Each health department administrator signed this charter. 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 Texas County Health Department was started in August 1986, when the residents of the county passed a mill tax to support a health department. An administrator was hired in December 1986 and the health department officially opened January 1, 1987.

In 2007 the Texas County Health Department moved from the building it had occupied since opening to its present location, a 7,000 square foot building, ½ mile north highway 63, Houston. The new facility not only gave the staff more space, it also enabled them to serve the citizens more efficiently and gave the citizens a new health center they could be proud of. The majority of the services provided to the community are performed at this primary location. In order to provide convenience to the community and have public health services accessible satellite offices are in place in Summersville, Cabool, and Licking.

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.

As a first step in pursuing state accreditation the Region G Collaboration held its first meeting in September 2007 to discuss accreditation through the Missouri Institute of Community Health (MICH). At this meeting we looked at the MICH accreditation program and concern was expressed on our ability to accomplish accreditation using their tools and meeting requirements outlined in the program for individual health departments.

In order to be able to fulfill requirements for accreditation individual LPHAs weren’t able to accomplish it was decided working as a collaborative to share resources and/or staff would meet requirements. 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 to accreditation.

LHD Coordinators were responsible for conducting the NACCHO Operational Definition Prototype Metrics Self Assessment with the agency taskforce team and staff. A meeting of all 9 LHD's Taskforce Team members was held to analyze the aggregate data. Collectively, the LHD's identified Standard V-C, Focus: LHD Role in Implementing Community Health Improvement Plan, from the Metrics, on which to collaborate. All LHD's engaged in a planning process and established a formal mechanism to collaborate with the help of a NACCHO-sponsored consultant as a facilitator.

Goals and Objectives

Goal I: The same community health assessment tools and processes will be used by all Region G counties.

Objective 1: During first one and one half year after start of project, prepare for implementing a community health assessment in all the counties in Region G. A tool/process will be selected as well as data and data sources to be used in secondary data collection, surveys, and focus group topics/questions.

Objective 2: Two and one half years after start of project, counties complete Community Health Assessment and aggregate regional data and related information will be available for use in planning and distribution.

Goal II: Region G will have consistent Process and Protocols for public health activities and programmatic health outcome evaluation and revision.

Objective 1: One year after start of project, identify existing process/protocols available for programmatic health outcome evaluation.

Objective 2: By end of year three, have a regional protocol/process/procedure manual for core functions; create formalized process for common procedures. (Start right away sharing documents on line)

Goal III: Region G will have increased local health department capacity through use of stakeholder engagement.

Objective 1: During all three years of implementation of this strategic plan, expand Region G local health department's capacity through stakeholder engagement and partnering.

Objective 2: During all three years of implementation of this strategic plan, increase resources through stakeholder engagement by linking the issues to the stakeholders.

Initially after reviewing the aggregate data from the collaborative, it was decided to address Standard V-C Focus on LHD Role in Implementing Community Health Improvement Plan. Upon reviewing the indicators under this standard, it was realized that various components that were necessary for completing a strategic health improvement plan did not exist. For example, the LHDs did not have consistent assessment data to use in setting goals (V-C:5). Without this assessment data it would also be impossible to identify strategic opportunities to use in the planning process (V-5:6) and it would be necessary to build a relationship with stakeholders to not only plan appropriately, but also to have a venue for disseminating and implementing the plan. For this reason, the goals include activities for selecting and using a consistent community health assessment planning process, in each county, having the same process and protocols to evaluate health outcomes so there will be adequate data to determine what programs we need to target in a planning process, and the final goal of increasing our regional capacity through stakeholder engagement.

Self-Assessment

The Texas County Health Department decided to complete the individual assessment with input from key staff members. As we are a small agency with only ten office staff and many different programs, we felt it was necessary to include employees from the different programs in the assessment process. The team was given a hard copy of the LHD Self-Assessment and asked to complete the self-assessment pertaining to their job duties on their own and at their own pace.

After completing our own individual assessments, we discussed the results. One deficit was realized, that although we provided many of the essential public health services, we lacked the documentation or specific and standardized processes to prove it.

Once our agency had finished our self-assessment and entered the information into the NACCHO's online form, we were then able to get our aggregate results for the region. With these 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 meeting did not take as long as we had thought it would. Amazingly, 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. 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 really wasn't an issue. When the priority was chosen, there was no dissension among the group. We all realized that assessing our communities with a standardized tool and then working on our strategic plans was something that would fit well into our agencies' overall missions.

Highlights from Self-Assessment Results

Standard/ Indicator #	Standard and Significance
V-C	<i>LHD Role in Implementing Community Health Improvement Plan</i> <ul style="list-style-type: none"> ○ <i>Aggregated data demonstrated all indicators under this standard were below the 2.0 score</i>
V-C:5	<i>LHD uses assessment data to develop annual program goals to develop policy (1.67)</i> <ul style="list-style-type: none"> ○ <i>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.</i>

V-C:6	<p><i>LHD identified new strategic opportunities promoting public health activities (1.78)</i></p> <ul style="list-style-type: none"> ○ <i>Again, without a community assessment in each county, it would be impossible for the region to move forward with a total planning process</i>
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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 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 Texas County Health Department’s bylaws, along with Article 9m, which then passes authority down to the Administrator by stating, “Administrator has responsibility and authority to sign contracts representing Texas 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 also 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. In fact, 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. The idea that we will have a regional assessment in place and a strategic plan that will give us leverage when applying for grants and signing into contracts is almost beyond our collective comprehension. Our success at this point in time can only be defined in what we have accomplished, which by our standards has been tremendous. 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 people from nine different agencies come together and in a short matter of time agree on what direction we all want to go as one unit is absolutely amazing. I believe that we can consider ourselves successful.

The Region G Collaborative has discussed different ways in which we will be able to utilize the mechanism for collaboration. We have talked about grants and contracts and purchasing power and personnel sharing and the list goes on and on. It is really only limited by our imaginations, which may be one of the hardest hurdles to overcome. We may ask ourselves, “Can we really do this?” or “Do you think this is going to work?”. We will have to really force ourselves to read what’s already been written and say, “Yeah, we have a document that says this is okay so let’s go for it!”

Lessons Learned

From the LHD self-assessment, we have identified many areas where we need improvement and better documentation. This realization has served to give the agency a working plan to accomplish these goals. Through our collaboration, the administrators in Region G applied and were chosen by Missouri Institute for Community Health (MICH) to work collectively and individually toward the state accreditation of all nine health departments. The MICH team has and is working with the health departments individually in specific areas that each agency felt they needed improvement. One of the lessons learned is the reinforcement that from this collaboration’s ability to accomplish much more together than anyone agency can do on their own. It also reinforced while we have similar goals for our agencies and programs, we are all vastly different but can still come together and function as one entity.

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 are 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 legwork 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, projects 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

Through our work on the Accreditation Preparation Demonstration Preparation Sites Project has been beneficial to both our individual agencies and the region as a whole. This effort has been one small step in our direction to both state and national accreditation. The self-assessment helped to identify areas of both strengths and areas of opportunities for improvement. The Board of Trustees, Administration, and staff of Texas County Health Department would like to say “thank you” for this opportunity and for providing the tools and knowledge to put us on the road to bigger and better things!

Appendices

Appendix I: Charter for Capacity Building Activities

Appendix II: Collaborative Agreement

Appendix III: Strategic Plan