Accreditation Preparation &
Quality Improvement
Demonstration Sites Project

Final Report

Prepared for NACCHO by the
Wright County Health Department,
MO

November 2008
<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>
<td>13%</td>
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<td>Carter</td>
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<td>507.58</td>
<td>27,113</td>
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<td>Howell</td>
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<tr>
<td>Oregon</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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<tr>
<td>Ozark</td>
<td>9,393</td>
<td>742.15</td>
<td>26,952</td>
<td>18.7%</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 north western corner of Region G, Wright County contains 682 square miles making it the second smallest county in the region. The population of Wright County is 18,397 ranking it third in the region which accounts for 13.6% of the total population for the region. Wright County is also ranked third for its poverty level in Region G. The NACCHO LHD Self-Assessment tool identified several areas of weakness and concern in the ten essential services for Wright County Health Department. Once the aggregate data was compiled for the region, an overall weakness of strategic planning was identified for Region G counties.

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 Wright County Health Department was voted into existence on November 1, 1948, located in the county seat of Hartville. The Health Department operates multiple health related programs out of two offices totalling over $500,000 in state contracts, county tax money and donations. The Health Department has built an active and thriving working relationship with area schools, businesses, other state agencies and surrounding Health Departments. This expansion in capacity has increased the programs offered and services received by our clients. The county is made up of seven towns with a combined population of approximately 18,397 residents. Wright County is an industrially diversified and rural county. The main sources of economy consist of agricultural operations, industries, schools and small businesses.

The Health Department has grown from one office and 5 employees in 1995 to 2 offices and 11 employees currently. The expansion in growth came in 1997 when we identified a need to have a full time office in the largest city of the county which staffs 6 of our employees. Wright County Health Department is one of the few counties that operate 2 full time offices.

The staff and Board of Trustees of the Wright County Health Department understand the diverse health concerns of the rural population that we serve and are committed to providing excellent public health services to our community. The Region G collaboration is the logical next step to increasing resources and securing potential funding to enable us to continue to provide these essential and valuable public health services.

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, forming a 501c3 to provide services and serve as 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 its first 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 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 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 Wright County Health Department chose to complete the individual agency assessment using input from the Administrator and key nursing, environmental and clerical staff members. The identified key staff and the Administrator met together and went over each item of the assessment and then scored it.

Upon completion of the assessment it was evident to us that we were providing most of the essential services but that our documentation to prove that we were providing those services was lacking or simply not there. The lack of documentation to prove what services we were providing and how we were providing them was a reoccurring theme throughout the assessment process.

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

Once our group had completed the team review we identified 3 priority areas based on our collective assessment results.

After the small group discussion and identification of the priority areas we met again as a region and voted on the priority area to address collectively. This was a time consuming but relatively easy process since our counties work well together and can see the need to be leaders in our state. We all have similar demographics and health issues within our respective counties and we find it much easier to help each other out to accomplish our region and county goals.
<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**  
|                     |   - 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)**  
|                     |   - 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)**  
|                     |   - 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 Wright County Health Department’s bylaws, Article 5 of Section IV which then passes authority down to the Administrator by stating, “The Authority of and responsibility of the Administrator shall include the following: Responsible for entering into contracts and agreements with federal, state, county, school and municipal governments and with private individuals, partnerships, firms, associations and corporations for the furtherance of health activities”

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 at the November 10, 2008 meeting. 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. Ultimately the success has been that a group of people from nine different agencies can come together and in a short matter of time and agree on a direction and vision for our future as a group.

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.

Lessons Learned
At first this assessment looked like a monster. The staff of our agency was a little overwhelmed at the idea of evaluating every aspect of what we do on a daily basis. I think we were afraid of finding out just how good or bad our performance was. In the end we found that we are in the same situation as several other counties and that we struggle with the same issues as they do. As an individual Health Department, we have identified several areas where improvement and better documentation is needed. We have an awesome opportunity to improve our agencies with the help and support of each of us in this collaboration. We can do this together and not reinvent the wheel 9 times over.

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, 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
This project has been a great experience for all involved. I have learned the importance and value of common people working together for the greater cause and how beneficial and rewarding that is. I think that accreditation process itself is a great tool for agencies to identify where they are lacking and how they can improve their services. What is even greater in our area is that we have 9 counties working towards the same goal. We can support each other and share resources to help each other along the way.

Each of our counties had an equal voice in the assessment process and we are very proud of ourselves for having the courage to take this leap of faith. I feel that accreditation for the smaller counties are much different than that of the larger ones in our state. We do not have the staffing and resources to compete with them. Ultimately I hope that this project will be a stepping stone to identifying these differences as the accreditation process continues.
Appendices
Appendix I: Charter for Capacity Building Activities
Appendix II: Collaborative Agreement
Appendix III: Strategic Plan