Accreditation Preparation & Quality Improvement Demonstration Sites Project

Final Report

Prepared for NACCHO by the Putnam County Health Department, MO

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Public Health
Prevent. Promote. Protect.
Putnam County Health Department

Brief Summary Statement

The Mercer, Putnam, Sullivan Public Health Regional Collaborative consists of 3 rural counties in northern Missouri. Mercer County Health Department is the northwest county of the region. It serves a primarily rural population of about 3,900 people including a significant Amish population. Sullivan County Health Department is in the southern county of the region. It serves a primarily rural population of about 6,800 people with a Hispanic presence. Putnam County Health Department is in the northeast section of the region. It serves a rural population of about 5,100 people with very limited diversity. Mercer and Putnam's northern boundaries border the State of Iowa.

The common gap that was identified from the aggregate results from the three health departments NACCHO LHD Self-Assessment Tool for Accreditation Preparation was Standard V-C, The need to engage in LHD strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.

Prior to the NACCHO assessment, all three health departments had completed their own community health assessments, but had not used the information to create any form of health improvement plan. Using the results of the NACCHO assessment and the needs identified in their community assessments, a community health improvement plan was developed. This plan addresses the gap identified in Standard V-C. It also provides the capacity to communicate consistent messages about what public health is and health promotion and disease prevention education messages to the populations being served in each county. It will also help improve the health of the public as identified in the county community assessments. It includes efforts for policy development and advocacy activities which will be more effective coming from a joint effort than from three more fragmented efforts. The final effort included in the plan focuses on developing process and protocols to begin preparation for regional accreditation.

Project Summary

The project included each county completing the NACCHO capacity assessment.

The planning process was based on the initial goal of developing a regional community health improvement plan to address cross cutting issues. Six of the indicators under Standard V-C were discussed from a regional perspective using a Force Field Analysis. Positive forces (strengths) and negative forces (Challenges) were listed under each selected indicator. Following this exercise, the group used brainstorming technique to identify stakeholders that influence regional efforts.

The positive forces for completing a regional community health improvement plan far exceeded the negative. Facilitated discussion was held on the topics of social marketing (communication/education), evaluation and quality improvement, policy development and advocacy, regulatory, and education of public health partners. The participants identified that more consistent effective communication of what public health is and also of public health education messages would be a key to adding capacity in many areas. The second focus area for the regional plan was public health policy and advocacy. The three participating counties are small and through joining efforts for public health policy and advocacy, they will have more impact at the policy level. And finally it was decided that the overarching area from the assessment that would add capacity for public health activity and

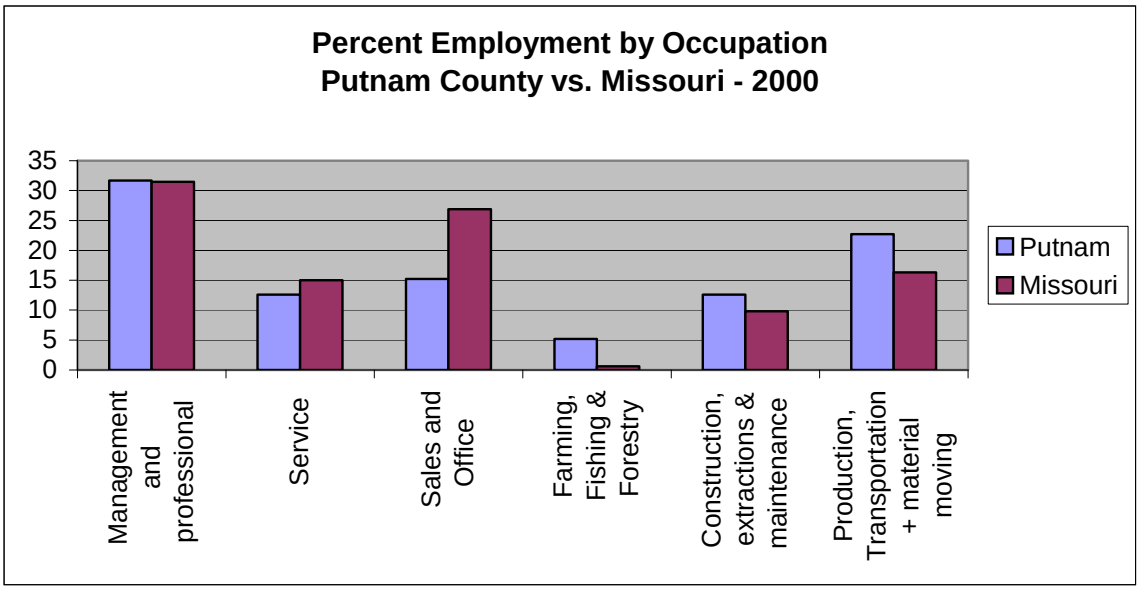
prepare the region for future accreditation, would be the sharing or development of processes, procedures, and policies for public health programs and activities. A strategic plan was written with these three goal areas. Measurable objectives and strategies were selected.

Background

The ethnic and racial composition of Putnam County has remained rather consistent over the last three decades. In 2000, whites represented 98.7% of the population, with only 1.3% of other racial and ethnic groups present. Putnam County has notably fewer young people and a very high population over 65 years of age in comparison to the state rates. The aging community will undoubtedly pose challenges for the county. Services for health care, transportation, assisted living will need to expand to assist the elderly.

While the high school graduation rate for Putnam County residents over the age of 25 was similar to the state rate in 2000 at 80% and 81.3% respectively, there were significantly fewer college graduates in Putnam County compared to the state. In 2000, the percentage of people over 25 with a Bachelor's degree was only 11.2% in Putnam County while the state of Missouri rate was 21.6%. According to the Kids Count data, the percentage of students enrolled in the free and reduced lunch program for Putnam County in 2005 was 45.5% while the state average in Missouri is 41.7%. Twenty point six percent of children in Putnam County were in poverty in the year 2000 while the state rate was lower at 15.3%. Similarly, the average annual wage or salary in Putnam County during 2004 was $19,366 while the state average was $34,356. All of these statistics indicate that Putnam County is a poor county.

While there is not a significant difference in types of employment by industry between Putnam County and the state of Missouri, there are substantial differences when comparing the state rate to our county when looking at workforce by occupation (see below).



The Health and Preventative Practice Status Report from Missouri County-level Study conducted by DHSS provides an overview of the chronic disease trends in Putnam County in comparison to the regional and state percentages. Some of the highlights from that survey can be found in the table below. Those rows that are highlighted indicate when the

Putnam County rate was above the state rate. With majority of the factors showing higher rates than the state, chronic disease in Putnam County is a concern.

Behavioral Risk Factor Survey - Putnam County, 2003			
	Percent		
	Putnam	NE Region	State
Health Status Reported Fair or Poor	22.9	20.7	16.9
No Health Coverage	17.4	15.4	12.3
Physical Inactivity	29.8	25.2	23
Current Smoker	30.3	28.2	26.5
Overweight (BMI 25-29.9)	31.8	34.9	35.3
Obese (BMI greater than 30)	24.8	25.7	23.4
High Blood Pressure	31.6	29	28.5
High Cholesterol (35 yrs +)	42.1	39.1	37.3
Asthma	10.1	10.4	10.7
Diabetes	7	6.3	7.2
Activity Limitation	12.3	17.8	17.8
Never had a Mammogram	26.5	17.4	13.4

The Putnam County Health Department offers a variety of services including: blood pressure screening, cancer screenings and education, case management, child safety seat inspections, cholesterol screening, communicable disease surveillance/investigation, diabetes screening, environmental services, food safety education and inspections, health education and services to day cares, home health and public health visits, immunizations for children and adults, lead testing for children, maternal and child health, pregnancy testing, school and community health programs, HIV testing, TB screening/treatment and WIC. The health department has five full-time staff one of which is wholly dedicated to home health, and five part-time staff. The relationship between the local health department and their Board of Trustees, which is their governing body, is strong.
Barriers to accessing health care in Putnam County include:

- Limited transportation resources
- Lack of insurance/affordable health insurance (17.4% do not have health coverage)
- Absence of mental health services
- Lack of dentists accepting Mo Health Net

The three most significant problems affecting the health status of the population within the jurisdiction of the local public health agency are (public health priorities):

- **Issues of Obesity/Nutrition: (**Physical inactivity, diabetes, stroke, heart disease)
- **Tobacco Use/Cessation:** (COPD, heart disease, asthma, cancer, stroke, public policy)
- **Unintentional Injuries:** (Motor vehicle accidents, falls, poisonings)

The three counties in the collaborative have a long history of teamwork. The three participate in monthly administrator meetings in Grundy County with several other health departments. Additionally, the three health departments are members of the Mercer-Sullivan- Putnam Rural Health Network, whose mission is to collaborate with community partners in all three counties to implement projects and obtain resources with the goal of making the counties a healthier place. The network is a 501(c) 3 non profit organization. Other collaborative efforts include Sullivan/Putman sharing a nurse and Sullivan and Mercer collaborating with Linn County for the provision of environmental services. It is imperative that resources pooled to benefit the communities in the region due to the low

multi-county household average income of only $30,642 and low population numbers. With limited resources it is impossible for each county to provide the ten essential services for the entire population. In addition, the three counties feel that collaboration will provide the best opportunity for achieving the necessary capacity to attain future accreditation.

Goals and Objectives

Initially the collaborative selected the goal of developing a health improvement plan (Standard V-C). This remained the overall NACCHO project goal throughout the planning process. However, the project goal for inclusion in the first Charter was developed from the health improvement plan. The goal for the Charter was selected so the region would have a project that was manageable and attainable in a reasonable amount of time, The Charter goal is "To have a communication plan to educate the public, public health partners, governing bodies, and legislature about the role of public health."

Because the regional health departments are committed to an ongoing long term relationship, a long-term goal for the collaborative was created. It is "to have a regional system that will help provide the capacity for each local health department in the collaborative to perform the Ten Essential Services of Public Health."

Self-Assessment

To complete the individual self-assessment tool, the administrator at the Putnam County Health Department spearheaded the process. The tool was shared with two of the other health department staff for input, but the administrator entered one set of results into the self-assessment tool online. The other two staff who were involved were the bookkeeper and the WIC/Immunization Clerk. The nurses were not involved because they did not have enough time to complete it. One master copy of the tool was completed by hand with input from the three staff and then entered into the computer. There was not an instance when a consensus on a score could not be reached, however there were times when one staff person may suggest something to alter the original answer. There were not any difficulties in completing the tool other than the administrator had printed off an earlier version which was subsequently changed by NACCHO.

The results were provided in aggregate by NACCHO from the three separate health departments. The administrators of the three health departments discussed those aggregate results via telephone and in-person before also discussing them with our consultant, Janan Wunsch-Smith. We did not have any difficulty in selecting a priority area as we were all low in Standard VC which was the community health improvement plan. There were other areas which we were all low as well, but felt that we must first have a framework or plan in place before moving to a correcting or improving those other areas. Anonymity was not an issue as all three of the health departments have a very good, open working relationship and were not opposed to disclosing individual results. The consensus was reached by simply reviewing all of the standards and through several discussions.

Highlights from Self-Assessment Results

Standard/ Indicator #	**Standard and Significance**
V-C	*LHD role in implementing community health improvement plan* • *In the aggregate data for the three counties, this standard was one of the lowest. Even though each county had completed a community health assessment, they had not done any health improvement planning. Therefore they felt this was a good way to start filling the gaps as a region*
V-B. 3 & 4	*3. LHD engages partners in policy development process and LHD legislative*

	agenda *4. LHD conducts advocacy at all levels that protect and promote the public's health* • *These two indicators demonstrated the need for the collaborative to more proactive and engaged in policy and advocacy. This was one of the areas included in the regional community health improvement plan*
I.A	*Ata Collection, Processing and Maintenance* • *The collaborative demonstrated adequate capacity for all of the indicators under this standard. Capacity in this area provides a strong base for much of what pubic health does*

Collaboration Mechanism

The three participating health departments have a long successful working relationship. There were no turf issues and everyone was cooperative and enthusiastic about working together on capacity building activities. It was therefore decided to create a generic Memorandum or Understanding for all activities that would build capacity across the region. The details of specific projects would be placed in a Charter. There were no other mechanisms considered as the collaboration had already been working under other Memorandums of Understanding for other projects and felt the Memorandum of Understanding and Charter combination was effective way to work through a variety of projects over time.

In Missouri each health director has the authority to sign interagency agreements such as the MOU and Charter, as long as it is promoting the health of the populations being served. The Boards of Trustees do not sign these agreements. The directors update the Trustees on what activities they are working on and collaborative efforts such at this project. Because the directors have the authority to sign the agreements and work within the collaborative, there were no legal issues in developing the organizational structure.

All members of the collaborative work very well together and felt this collaborative effort was critical to filling gaps in their capacity and also preparing them for accreditation. There were no barriers to working together and the members understand they will have to access dollars for some of the activities. They are very willing to share resources when it is possible to get added benefit from a collaborative effort. It is understood that planning to accomplish goals using the efforts of three departments vs. each department working independently to accomplish the same goal is a win-win situation.

Accountability is addressed in the Charter with the following statement. "The activities undertaken through this charter and related Memorandum of Understanding will be reported to the participating Boards of Trustees, each local health department and the populations being served." Also, the MOU identifies the responsibility of the fiscal and administrative entity for projects.

The Memorandum of Understanding specifies the decision making structure. A committee consisting of all three health directors will determine the projects to be undertaken and which department will serve as fiscal and administrative agent. The committee will complete a budget, business, and work plan for each project. The work plan will include who will be responsible for the activities including coordination and oversight of the project.

Results

We have not yet had an opportunity to implement the formal mechanism of collaboration; however that does not minimize our success at this point. By having the MOU and charter in place we now have the framework necessary to move forward. This MOU is much different than others that were already in existence because instead of being specific to just

fulfilling a staffing need, this MOU enables us to utilize our coordinated plan to improve our infrastructure. By design, the MOU is much broader so that we can continue to work collaboratively in the future with a clear agreement already in place while the charter is more specific to separate projects. We have already outlined a specific charter: Communicating the Role of Public Health. By working on this regionally we will be able to maximize outputs and not reinvent the wheel. By using consistent messages across our county we will be able to standardize the understanding of public health across our three counties. This is also very beneficial with the minimal media coverage in our areas. Newspapers in each of the counties are only disseminated once weekly, television coverage is minimal, and radio coverage does not come directly from any of the three counties in which our health departments reside. The charter format can then easily continue to be adapted to additional specific projects in the future. The charter has improved our efforts by outlining the expectations and tasks and is agreed upon by all members of the collaborative.

The unanticipated benefits from the individual and aggregate assessment were many. On an individual basis it prompted our staff to consider strengths and weaknesses as we had not before. We were able to identify some improvements which we could initiate immediately such as developing a website but also see where some of the standards were going to require a long-term commitment. It helped us to get in the necessary mindset to begin preparing for accreditation, something that we had not made the time to do prior to this funding. The same held true for the collaborative. While in several of the areas our strengths and weakness were similar we were able to identify where one health department may already have a best practice that could be replicated, hence a resource that it free and relevant.

Lessons Learned

The self-assessment was a wonderful tool that I would recommend to any health department. It was easy to digest and as I said before highlighted some immediate improvements that could be made as well as some long-term. I do think that the more people an agency can dedicate to filling it out will result in more input which will invariably change perspectives on the answers. I hope the tool will continue to be offered online for free. In our health department's experience, printing off the tool for staff to review and then setting aside time to share answers and go through the entire assessment was an effective process. Utilizing the "Illustrative Evidence" examples that were provided with the assessment for indicators was very beneficial. Another practice that was beneficial was that as the assessment tool was completed, we created a list of areas for improvement that the assessment highlighted for our agency.

Collaboration in this process has only strengthened what we have done. Just like internally, when we started thinking regionally with three different administrators some fresh perspectives were offered that had not considered when completing the tool independently. In a rural area I think collaboration is especially important because the resources are so sparse as it is, it only makes it that much more imperative to join forces with others in the field. I have found as an administrator that often I gain much from networking meetings by simply learning from others. The same was true for this project with the bonus of having a structure around which to think (the self-assessment tool) and a consultant to guide the process. When considering partners for accreditation preparation we found it helpful to have similar agencies with regard to size and county demographics.

Next Steps
Because of the MOU and Charter we have tools in place to build on what we have done and expand it. Specifically, we'll be able to begin on our first project outlined in the attached Charter, "Communicating the Role of Public Health" with relative ease. Once we have accomplished the goal for that project we can focus on other areas of improvement and create a new charter to begin a subsequent project.

Similarly, as an independent health department we will be able to use the Community Health Improvement Plan as a template to create our own strategic plan for our agency. We have not utilized a workable comprehensive strategic plan and this experience helped prompt that improvement as well.

Additionally, as a result of our involvement with the NACCHO project, our collaborative was also chosen by the Missouri Institute of Community Health to be a mini-collaborative to work toward accreditation in the state of Missouri. We have already begun this project, attending a few different meetings and focusing on quality improvement. One of the goals of the mini-collaborative is to achieve state accreditation in the next two years. If this is accomplished, we will only be that much closer to achieving national accreditation.

Conclusions
Participating in the accreditation preparation demonstration sites project has been the catalyst we needed to start working toward state and national accreditation. Having a consultant we would have not otherwise been able to afford to guide this process was instrumental. Our consultant helped us digest our area of improvement in a more tangible way and expedite our discussions toward real results.

If others are unable to fund a consultant a recommendation would be to appoint a facilitator who is charged with keeping all parties on task and moving forward during meetings. Some useful tools that the consultant used which could be prepared by someone internal to a local health department includes: agendas for meetings, recording "strengths and challenges" as they relate to specific priority topic areas or indicators, and recording stakeholders from brainstorming sessions that will have an influence on efforts. Our consultant also prepared a "Crosswalk of Issues" which highlighted issues from the assessment and the presented individual issues from each participating county in a table format.

Networking and discussion among the administrators was extremely important as was in the increased awareness of accreditation and quality improvement by our governing body. I would recommend the tools used by NACCHO during this project to any health department.