COMMUNITY HEALTH RESOURCE CENTERS: A TOOLKIT

ACKNOWLEDGMENTS

The Center for Community Health Development extends special thanks to the following individuals. Without them, the development and sustainability of the Brazos Valley Community Health Resource Centers and this Case Study would have not been possible.

- Ms. Angela Alaniz, former Associate Director, Center for Community Health Development
- Dr. James Alexander, former Professor, Texas A&M University School of Public Health and member Burleson County Health Commission
- Mr. Britt Allen, former Board Member, Brazos Valley Health Partnership
- Honorable John Brieden, County Judge, Washington County
- Mr. Jack Buckley, former CEO St. Joseph Health System
- Ms. Donna Danford, Executive Director, Leon County Health Resource Center
- Dr. Nancy Dickey, former President, Texas A&M Health Science Center
- Ms. Heather Dillard, former Graduate Assistant, Center for Community Health Development
- Mr. Reed Edmondson, former Regional Hospitals and Rural Clinics Administrator, St. Joseph Health System
- Mr. Michael R J. Felix, consultant
- Mr. Tom Jackson, former Chief Executive Officer, The College Station Medical Center
- Ms. Vicky Jackson, former Board Member, Brazos Valley Health Partnership
- Mr. Jay Jezierski, former Graduate Assistant, Center for Community Health Development
- Ms. Kathy Jones, Office Manager, Burleson County Health Resource Center (Caldwell)
- Ms. Faith Keller, former Public Health Nurse, Region Seven, Texas Department of State Health Services
- Ms. Ella McGruder, Program Director, Project Unity
- Ms. Jeannie McGuire, President, Project Unity
- Ms. Lara Meece, Executive Director, Grimes and Madison County Health Resource Centers
- Honorable Bert Miller, County Judge, Grimes County
- Honorable Dorothy Morgan, former County Judge, Washington County
- Mr. Dean Player, former Leon County Health Resource Commission Board Member
- Mr. Albert Ramirez, Executive Director, Burleson County Health Resource Centers (Caldwell and Somerville)
- Honorable Byron Ryder, County Judge, Leon County
- Mr. Robert Shaw, former Executive Director, Madison County Health Resource Center
- Ms. Erin Schneider, former Graduate Assistant, Center for Community Health Development

- Ms. Amber Schnickendanz, former Graduate Assistant, Center for Community Health Development
- Mr. Don Strickland, former Chair, Brazos Valley Health Partnership
- Honorable Mike Sutherland, County Judge, Burleson County
- Mr. Eric Todd, CEO, Brazos Valley Community Action Agency
- Ms. Camilla Viator, former Executive Director, Madison County Health Resource Center
- Col. James Wallace, former Executive Director, Leon County Health Resource Center
- Ms. Towanda Webber, Office Manager, Madison County Health Resource Center
- Mr. Randy Wells, Executive Director, Faith Mission and Help Center
- Ms. Monica Wendel, former Director, Center for Community Health Development
- Mr. Tom Wilkinson, Executive Director, Brazos Valley Council of Governments
- Ms. Laura Windwehen, former Staff, Center for Community Health Development

PREFACE

The Episcopal Health Foundation commissioned the Center for Community Health Development at the Texas A&M School of Public Health to prepare a case study and a companion toolkit to help communities understand the value of and process for creating Community Health Resource Centers to serve their populations.

The case study documents the process through which six Community Health Resource Centers (CHRC) were created in five counties in the Brazos Valley Region of Central Texas. Starting in 2002 with a regional community health status assessment which established a need, the health resource centers have matured from nearly 15 years of evolution into locally sustained facilities offering a wide variety of medical and health and human services to help meet the needs of their communities.

This document, the Toolkit, focuses on the "how to," whereas the "what and why" is emphasized in the case study. Because they were designed to be independent of each other, there is some duplication between the two documents. We strongly suggest reading both documents to get a thorough understanding of how, historically, the CHRCs were developed, as well as details to guide your community in the planning and implementation of a CHRC.

What the reader will find in this document is a description of the process, detailed instructions for the various key components of previous CHRC development, and sample materials. Many drivers and facilitators paved the way for the success of the Brazos Valley CHRCs, but each one evolved in a unique manner, dictated in large part to the local community's readiness, available resources, and experience from previous CHRC establishment in other communities. No two communities are identical; therefore, this toolkit or how-to manual outlines the "how" of Brazos Valley CHRC development, the steps and tools provided herein may need to occur in a different order, be skipped completely, or may not work. That is the uniqueness of your community and one of the most important reasons why Step One – community assessment and reconnaissance – is critical to understanding local community issues and determining if a CCHRC is the right solution for your community. It is our firm belief that community organizing for HRC development, using the process

outlined in this document, Community Health Development, *should* improve the probability of successful planning and implementation of a locally sustainable and managed CHRC in your community.

The information contained in this toolkit is largely based on our own experience in the Brazos Valley CHRC development process, but also presents a thematic analysis from interviews with key Brazos Valley community leaders and other stakeholders involved through the nearly 15-year evolution of the BV CHRCs. Other information contained in this document came from an archival review of historical documents including, but not limited to, meeting minutes, documents, reports, and grant proposals from/on/about health resource centers. The toolkit presents the key elements of HRC development. Throughout the document recommendations and thoughts from community members' interviews are highlighted to support major points of discussion.

This report was developed by the Center for Community Health Development

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TABLE OF CONTENTS

COMMUNITY HEALTH RESOURCE CENTERS: A TOOLKIT

Introduction

This toolkit was designed as a "how-to" manual for communities interested in impacting the health status of their population through a process that simultaneously enhances their capacity as a community to solve subsequent problems. As the reader will discover in the companion case study document, each community health resource center's process is slightly different. Organic in nature the unique process in each community was determined by each community's driving factors impacting health status (their "needs") and their assets and resources. These driving factors, assets, and resources are either present at the outset or are developed through the Community Health Development model via the Partnership Approach.

What is a Community Health Resource Center?

A community health resource center (CHRC) was described in nearly every interview as a "one-stop-shop" – a physical location, where rural county residents (in the case of the Brazos Valley) can gain access to multiple health and wellness resources because service providers co-locate in one facility to provide care for rural residents. With a CHRC, rural residents can travel a relatively short distance within their community to obtain care and services instead of traveling long distances to the closest urban hub where regional service providers' offices are typically located. As a result, CHRCs increase access to health care, wellness and human services for rural residents. In the Brazos Valley, community assessment continually revealed frustrations from rural residents that health care and health and human service organizations were primarily located in the region's urban hub, Brazos County. As such, in order to receive services, they had to travel long distances (in the case of Leon County, the county seat is 64 miles from Bryan, the county seat of Brazos County. To reach services located in Brazos County, a rural resident's decision to go (or not to) were potentially impacted by car access/dependability, affordability of gas for a round trip, taking time off work (compensated or not), finding childcare for half a day or longer to travel, and unease driving in the more urban hub.

The background and process of developing CHRCs in the Brazos Valley, Texas, are described in depth in the accompanying Case Study, including an outline of services offered, by CHRC. Fifteen years following the doors opening in the first Brazos Valley CHRC – the Madison County Health Resource Center - all six CHRCs are still currently active and locally sustained in five Brazos Valley counties.

Establishing a Community Health Resource Center in Your Community

The following steps in establishing a community health resource center align with the Partnership Approach as the practical implementation of the Community Health Development process, as they occurred in the development of the Brazos Valley Health Resource Centers (Wendel, Burdine, & McLeroy, 2007; Felix, Burdine, Wendel, & Alaniz, 2010; Felix & Burdine, 1995; Burdine & Felix, 2017). An important piece of information about these steps as you consider using this process in your community – sometimes they may overlap or occur simultaneously. It is not a perfectly linear process. Remember, every community is different and some steps as outlined here may go over smoothly, others may not, and in some cases, steps are co-occurring or overlapping.

STEP 1: ASSESSMENT

While the Case Study companion document presents the background, theory, and general philosophy for conducting a community health status assessment, this Toolkit provides insight into conducting the ideal or optimal community health assessment. This discussion assumes the reader is familiar with the description of the social reconnaissance methodology described in the Case Study document and understands the sections below are likely to be occurring simultaneously or in a different order as a result of local factors.

The ideal community health status assessment consists of three components: a household survey, community discussion groups, and an examination of existing data (secondary data) from a variety of other reliable sources. Ideally, the assessment is comprehensive and optimally matches results with available resources. While planning for a community assessment, an assessment steering committee

should be established to include community stakeholders, assessment sponsors, and an experienced survey developer (e.g., academic partner, survey design expert, etc.).

Determine Components of Your Health Assessment

The steering committee, in true community-based participatory research fashion, is the body that identifies the purpose of the assessment, chooses the various data collection topics, and provides valuable feedback on methods to be included in the assessment. Often available resources and funding are the determining factors in how population health data ends up being collected.

The following is a description of each of the components suggested in an ideal community health status assessment – household survey, community discussion groups, and secondary data analysis. It is up to your community to decide what components would best fit your assessment's purpose. Again, all this assumes a social reconnaissance has been conducted to provide some critical information guiding the development and implementation of the assessment process.

COMMUNITY HEALTH STATUS ASSESSMENTS ARE A CRITICAL COMPONENT FOR THE INFORMATION THEY PROVIDE, AND PERHAPS EVEN MORE IMPORTANTLY, AS A COMMUNITY ORGANIZING TOOL

A number of key leaders suggested that the community health assessments (particularly the initial assessment conducted in 2002) were essential not only to establish key problems and priorities, but also to help manage the political aspects of this kind of community process. Too often, the "disease" or "problem" *de jour* can distract from larger goals. There is the need to be sensitive to changing priorities and opportunities that may develop along the way, but without the rigorous assessments that could be pointed to when the process began to drift off course, community leaders felt we would not attained the sustainability and stability seen in the health resource centers.

What is a Household Survey?
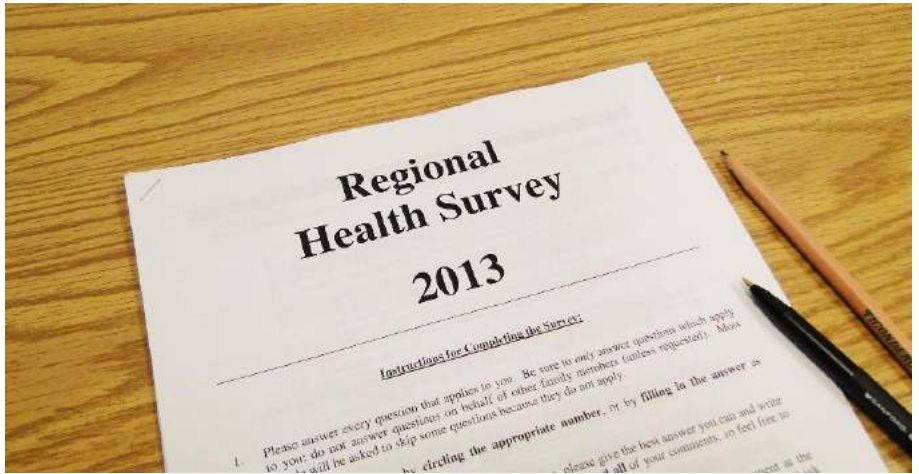
Household surveys are a standard method for collecting all types of data, including health related data. In the case of a community health status assessment, a household survey is conducted in a local community with a defined area such as a county, city, neighborhood, county, hospital service area, or any combination of these. Household surveys have the advantage of allowing a respondent to

complete a survey in the comfort of their own home at their convenience and have the potential to yield large amounts of data. Limitations of household surveys include willingness to complete the survey, knowledge of personal health information, and an inability to ask for clarification about the questions, as well as they take a substantial amount of time. Designing a household survey should include someone with expertise in the health survey field, as should the design of the sampling frame for how many responses are needed, and how to analyze data. Often, because of the need for expertise in distributing and collecting the responses, a survey research firm is contracted with to distribute and collect the household surveys, although college students have been used successfully on occasion.

In the Brazos Valley, the first of a series of household surveys (2002, 2006, 2010, and 2013) was conducted in the spring of 2002. It consisted of a random sample of 1,500 households and was comprised of a 75-question "paper and pencil" survey. With a response rate of nearly 60%, analysts at the School of Public Health were very comfortable providing the community with a clear snapshot of factors impacting population health status.

Complimenting Quantitative Data through Community Discussion Groups

Besides the primary quantitative data collected through the household survey, qualitative primary data is equally important. A useful tool for this purpose is found in Community Discussion Groups (CDGs). CDGs are critical to the assessment process when using the guiding principles of CHD and community capacity building.

Community discussion groups, similar to "town hall meetings" or "focus groups" and are held in each community to capture rich data that is difficult to obtain in a survey format. Discussions are generally

organized to meet with various audiences including health and human service providers, community leaders, and the general public. The involvement of community members through the CDG process ultimately assists in the identification of community stakeholders and encourages community involvement in the CHD process, all of which position the community favorable towards improving their health status.

An outcome of the community discussion groups will be enhanced relationships between and among community groups and members and the organizations sponsoring the community assessment/community health development process. The product from this assessment component will glean information about the issues, challenges, resources, history, and advice about implementation from the perspectives of a variety of community members.

Secondary Data for Comparison Purposes

Secondary data are data that have been previously collected by other researchers, which are often available in the public domain or for purchase. Secondary data can be helpful as a supplement to primary data collection and used for comparing local data to the other populations. Or, it can be the principal type of data used for an assessment when a household survey is not feasible. Secondary data sources often come from the Centers for Disease Control and Prevention, Robert Wood Johnson Foundation, the United States Census Bureau, the Substance Abuse Mental Health Services Administration, among many others. Typically used secondary data in health assessments include:

- demographic data (census and vital statistics),
- disease registries,
- service utilization data,
- hospital data (discharge data, Healthcare Cost and Utilization Project, State Emergency Department Database, etc.), and/or
- health surveillance data (Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, National Health and Nutrition Examination Survey, County Health Rankings, etc.).

Although secondary data is readily available in most cases, it is important to remember that these data were gathered for a purpose other than your assessment. Therefore, careful attention must be paid to how the data were collected, analyzed, and reported. However, it is useful in providing a broader context and using as a basis for comparison to how the selected community's health status compares to that of the state and the nation overall.

Planning the Assessment – Personnel, Sampling, Costs, and Sponsors

Before continuing this section, it is appropriate to ask the question – "Do you need to hire a consultant or can you do this yourselves?" As much as we advocate for community capacity building, there are times and situations in which having professional expertise as part of that capacity building process is needed. For example, in the assessment step critical decisions need to be made that impact the integrity of a data driven health assessment, such as, "how many surveys do we need to collect?" As mentioned previously, some communities have the necessary skills and resources locally and simply need to develop a mechanism for coordinating those resources. Others will have to hire essential services to conduct their assessment. The only way to reach this conclusion is to understand what skills are locally present and what you might need to acquire from outside the community.

HAVING AN EXPERIENCED AND TECHNICALLY COMPETENT FACILITATOR IN THIS PROCESS IS ESSENTIAL

Essentially every interviewee made the observation that the participation of the staff from the Center for Community Health Development in the process was a most critical element. While great for our egos, this raises the question of "Can you implement an HRC strategy in a place that doesn't have access to a CCHD?" We believe that answer is definitely "yes" for several reasons. First, we had good success in training students and faculty in community health development strategies and techniques. The first HRC managers were doctoral and master's students, a former student was hired to work as an executive director of an HRC, and several faculty who conducted small projects at/through the HRCs have gone on to replicate those projects on a much larger scale. Second, community health development is not "owned" by CCHD, historically it grew out of the work of Dr. Guy Steuart at the University of North Carolina at Chapel Hill and a number of prominent researchers/practitioners spread across the country today apply his methods. However, it is apparent from the interviews conducted that having an facilitator throughout the planning, development and implementation process was very helpful to the local community efforts in opening and sustaining the CHRCs.

Quality household surveys are expensive, so designing an assessment that requires the smallest number of respondents while still being able to generalize the findings to the entire community is beneficial. In our experience, for averaged sized communities/regions with an aggregate population up to 300,000, somewhere between 1,000 and 2,000 surveys is the balance point where budget and methodology needs can be agreed to. However, in smaller communities that cannot be aggregated into a region, this may not be realistic. Additionally, the needed number of surveys may be much smaller, especially if there is a desire to break down results by certain demographics. Of course, larger samples (the 2013 Brazos Valley Health Survey included more than 3,000 respondents) can be very helpful in focusing on the impact of social and behavioral determinants of health and the impact of potential interventions. This is, again, why it is important to involve an experienced researcher. Therefore, it is also why the area to be included in the assessment should be defined and clearly communicated throughout the entire process.

CDGs and secondary data are less expensive than a household survey. CDG costs include personnel time for the discussion group facilitator and note taker, mileage and travel costs to the meeting locations, and food to be provided to discussion group participants. On average, one community discussion group costs $375, which includes personnel time (facilitator and note taker), mileage up to 100 miles roundtrip, and food for approximately 20 people. Secondary data analysis costs only include personnel time for an individual or team to collect, clean, and analyze existing data sources.

As mentioned earlier, household surveys are expensive. In the most recent Brazos Valley household survey (2013), using a survey firm for distribution and collection, the cost per completed survey was approximately $50. That did not include data analysis, but did include a basic summary report (e. g., item frequencies, response rates, etc.) from the survey firm with which we contracted for data collection.

When split among a number of co-sponsors, the cost becomes more feasible for many communities. Through the social reconnaissance, key resource holders should have been identified and their self-

interests which might be incorporated into an overall assessment strategy can be developed into an effective organizing tool. Rural communities generally discover that working collaboratively is the most cost-effective way to approach a household survey, as this cost is often beyond the scope of small rural communities. Through this collaboration organizations can be identified that have periodic health assessments required. For example, federally qualified health centers (FQHCs), funded through the Health Resources and Services Administration, are required to demonstrate local need for services in order to obtain funding to operate in a particular community. State offices of rural health, which differ from state to state, also must document rural health needs and disparities to access federal funding. Similarly, United Way agencies and municipalities receiving Federal Block Grant funds must also document community needs via health assessments, making them another potential partners.

Non-profit hospitals are required to conduct a Community Health Needs Assessment (CHNA) every three years under the Affordable Care Act. Finally, the move to accredit public health departments includes a requirement to conduct a community health status assessment and community health improvement planning every five years. Because of this requirement, much of the funding for the assessments have been provided by these organizations. There are also occasions when other groups – Chambers of Commerce, Councils of Government, School Districts, and even major employers can be convinced to co-sponsor (co-fund) a community assessment, and potentially, a CHRC.

Conducting the Assessment

Once the steering committee has determined the assessment components, the time has come to conduct the assessment. This timeline looks different for everyone, but on average takes between eight to ten months from pulling together the steering committee through presenting data to the community. Some communities chose to only use one or two components of the assessment, such as only secondary data and community discussion groups. Effective community health status assessments can be based on qualitative and secondary data. The following sections describe the processes as if your community has chosen to conduct the ideal assessment including the household survey, conducting the CDGs, and gathering and analyzing secondary data.

A thorough explanation of all the factors involved in conducting a proper community health survey includes sampling methodology, survey design, data analysis, etc. and is too extensive for this toolkit. Suffice it to say instrument design and sampling methodology are their own fields of study! What we have included here is a detailed overview of the process involved in conducting a community assessment. As stated earlier, involvement from an experienced survey design and administrator throughout the process is vital to ensure *usable data* are gathered. Often local colleges, universities, or state agencies will have personnel with this expertise and are familiar with existing tools and resources will allow for the development of a household survey that incorporates standardized, validated measures.

Ideal Community Health Assessment Question Topics

- Overall health status
- Medical history
- Health habits
- Physical activity
- Preventive screening
- Local health care/services resources used
- Perceptions around access to and quality of health care/services

- Transportation
- Food and nutrition
- Health insurance coverage
- Community perceptions of key local issues
- Social capital
- Human services needed and used
- Demographic information

Standard in any survey design process, following the survey instrument's completion, it is necessary to conduct a pilot test on the survey. This can be completed in a number of ways, including working with the assessment's steering committee or reaching out through partners for community members to participate and provide feedback.

Use of a survey research firm is highly recommended for the household survey component for survey distribution and data collection/entry. In this role, depending on the survey recruitment strategy, the firm utilizes a telephone number database for local residences to randomly select community residents who receive a phone call to determine their willingness to participate in the comprehensive health survey. Using the Total Design Method (Dillman, Smyth, & Christian, 2014) for survey distribution to increase survey response rates, those who agree are mailed a survey with introduction letter and a self-addressed, stamped envelope to return the survey followed by reminder postcards after the initial mailing.

Engage the Community in the Assessment Development Process

As survey development nears completion, the next step is to disseminate information to the community to promote the upcoming assessment. This can occur in a variety of ways, including, but not limited to, radio, newspaper, local television news programs, social media, and advertising. Information covered should include:

- Components of the health status assessment;
- Communities that will be included in the assessment;
- A timeline for the assessment; and
- How the assessment is useful to local organizations and the community.

The purposes of this step are to increase community awareness regarding the importance of the survey to local providers as a tool to allow them to better serve the local community needs, as well as encourage participation in the survey by notifying residents they may receive a phone call asking them to take a survey – and this one is not a telemarketer!

Conduct the Community Discussion Groups

During the household survey data collection time frame, the assessment's facilitator also plans and conducts the local CDGs. To boost participation, working with local intermediaries and community

identified leaders to organize and host discussion groups provides the assessment process with legitimacy in the eyes of the leaders' affiliated groups and community residents. This process also encourages participation from community segments which might otherwise be missed. For example, a pastor in a local church could provide the venue for a CDG in the church hall and assist in recruiting CDG participants through the church bulletin or newsletter. Utilizing local key leaders and already existing organized groups of residents can be very helpful in accessing underrepresented populations.

How do you know how many CDGs to do? The number of planned community discussion groups should reflect both the goals and context of the assessment. First, target three community groups - providers, community leaders, and general public. General public groups should be organized to include a variety of age groups, ethnic and cultural backgrounds, and rural populations. Under any circumstance, a *minimum* of three CDGs would be required for each unit of analysis (county, city, etc.). To gather quality information, it is preferable to conduct at least six CDGs in each unit of analysis. For instance, if the community assessment is targeting three counties, then a minimum of nine CDGs is recommended – for each county, one with providers, one with leaders, and one with the general public. However, it would be preferred to have at least 18 – six in each county with at least two in each type of community group. A good measure of when "enough" information has been collected is called data saturation, or when similar responses (thematically the same, but specifics may vary) are being heard repeatedly with no new information appearing across all groups.

Meetings should be held in locations to encourage participation of all segments of the population (recognizing the importance of public safety, cultural and social significance of locations – both positive and negative). These sites may be geographically disbursed or centrally located depending upon community characteristics. The following "rules of thumb" have been found to be useful when scheduling community discussions:

- Community leaders are typically interviewed (part of a discussion) over *breakfast* or *lunch*;
- Health and human services providers can typically meet at *late morning* or *mid-afternoon*;

- General public participants are easiest to recruit for an *early evening* meeting after the workday has concluded.

As you may have noticed, the times of day above all include a meal time. Supplying participants with a small meal or snack is a suitable thank you for the time they are taking from their day to provide their perspectives on the local community. When planning to provide food, ensure no group appears to be more special than others, and, support the local economy by using local food options. If unsure of the best options for a local bakery, for instance, ask the local community member assisting in the discussion group. In the Brazos Valley assessment process, it has been a long standing standard that all discussion groups at lunch or evening had Subway® sandwich platters, chips, cookies, and bottled water. Breakfast and mid-morning discussion groups purchased pastries, donuts, kolaches, and coffee from local bakeries. Afternoon CDGs usually provided cookie platters and bottled water. Remember, if your organization is tax exempt, the restaurant/bakery will need your organization's tax identification number!

When facilitating CDGs it is preferable for project staff persons to serve as note takers. It is preferable to have one facilitator, one recorder documenting paraphrased responses on a flip chart for the whole group to see, and one recorder taking detailed notes on a laptop computer. (It is also easier to capture more of the discussion on the laptop than on the flip charts.) Flip charts are used as a visual cue for the facilitator and as a tool to evidence that participants' comments are being documented.

Open-ended questions are asked to generate rich information from participants. The question set we generally recommend solicits input from participants by asking them to do the following:

- Describe their community [this is both an "icebreaker" as well as a source of useful information about the perceived characteristics of an environment];
- Identify key issues in their community [we specifically do not ask about "health problems" to elicit responses that include environmental, social, economic and other factors knowing that health problems will emerge into the conversation eventually];
- List resources present in their community [an effective cue might be "looking at the list of issues you identified, what are some resources in your community that might be able to address any of these issues?"];
- Describe the history of collaboration among organizations working together to solve problems locally; and
- Give their advice on how to most effectively work with their community if attempting to improve the community's health.

Someone with experience in qualitative data analysis should complete analysis of qualitative data that is collected in the CDG process. In general, notes from the CDGs are reviewed by several reviewers and examined for themes that emerged across all data. We employ word-repetition and key-word in-context techniques in our analysis. Results are incorporated into the final assessment report.

Conduct Secondary Data Collection and Analysis

There is a great deal of information available through secondary data sources. It is called secondary data because it was collected for another "primary" purpose and now is being used secondarily to that original purpose. Census data, for example, is collected to apportion representatives in Congress. Any use beyond that, such as describing the residents of a community for estimating hospital bed-needs, is "secondary." Beyond data from the U.S. Census, many other federal, state and local governmental agencies collect and disseminate data that can be used for describing and

understanding factors related to population health. Resources such as the County Health Rankings project, make secondary data from numerous sources available to anyone. Clustered at the county level, this single resource might be adequate for some communities to use in determining priorities for population health initiative planning.

Like all data, secondary data has limitations. Foremost is understanding what were/are the limits imposed by the nature of the primary purpose. If, as is the case with Census data, counting residents to determine representation in Congress does not require collecting much of the data we might want have to understand the factors impacting the health status of residents of a particular community. There may be adequate demographic data and some economic/employment information, but little in terms of risk factors, access to health care services or other more pertinent data.

The levels at which secondary data were collected and are available is another limitation. The County Health Rankings previously mentioned is a powerful resource if the "unit of analysis" is one or more counties. However, if a target community occupies less than an entire county, parts of multiple counties or even crosses state lines, there are significant challenges in aggregating that data. The city of Augusta, GA, for example, occupies parts of three counties in two states. Further, data is updated periodically and must be reviewed in repeated years or assessment to ensure the latest, most up to date information is available.

Secondary data tends to be relatively "clean" – that is requiring little additional work before it can be directly applied, but even there, one needs to understand the data as it was collected. Some state Behavioral Risk Factor Surveillance System (BRFSS) data from the Centers for Disease Control and Prevention (CDC) is collected at the state level but reported at the county level. In 2010, for example, the BRFSS data for Brazos County reported an unusually low cigarette smoking rate. Before celebrating, we looked more carefully and discovered that only 57 adults were sampled in Brazos County – far too few responses to reliably generate a *population* smoking rate.

Working with community partners and the steering committee, many secondary data sources can be identified as useful in your assessment process, especially to use in comparing locally collected primary data from the survey and CDGs as a point of data triangulation and comparison. Once sources are identified it is usually helpful to compile all secondary data relevant to the assessment process at the local, state, and national level into one electronic document for easy reference. Importantly, be sure to save the data source point (i.e., website's URL), in order to easily find it again. However, previously "good" URLs may no longer work due to the ever-changing world on the internet.

The final step in the data analysis process is to prioritize health issues. Tools such as the Hanlon Method for prioritizing among possible health issues to address, is one such tool. This method allows for decision makers to identify explicit major factors to be included in the priority setting process, to organize the factors into groups that are weighted relative to each other, and to allow the factors to be modified as needed and scored individually.

The Hanlon Method groups the criteria into three components each of which is assigned a value on a predetermined scale. The component scores are inserted into a formula that reflects the relative weight of each component in the decision making process. Values derived from these formulas can be compared and used to rank order each of the issues included in the process.

The Hanlon Method has been modified by practitioners to fit varying contexts and the evolution of health issues from acute to chronic disease to social concerns (what are called the broader determinants of health - education, employment, housing, etc.). We have added a dimension to the process which introduces community values into the process. Our experience has been that when this dimension is included the probability for community "buy-in" is substantially increased and the likelihood of intervention success is greatly increased. A whitepaper on the modified Hanlon Method can be found in the appendix.

Disseminate the Assessment Findings

Once the assessment has concluded and data collection and analysis is complete, the assessment facilitator summarizes the findings in an assessment report prepared for distribution to assessment partners, community stakeholders, and community organizations, among others.

The assessment report should include an acknowledgment to the assessment sponsors, assessment methodology, narrative summary of the assessment findings, as well as tables and charts to display data. Final reports are distributed to sponsors and are made available to the communities involved in the assessment. Additionally, presentations of the findings can be completed throughout the geographic region and/or a "Health Summit" can be held to present the findings to a larger audience. CCHD has held a Health Summit at the culmination of all of the Brazos Valley Health Status Assessments. The value of the community meeting process is realized in using the information gathered to do any of the following:

- Reconvene community leaders, providers and members to share results and continue community dialogue;
- Use report/results as part of a team building exercise for your organization;
- Build relationships between external agencies and organizations;
- Incorporate information into an already existing community health status improvement initiative;
- Organize a community coalition to address issues raised in the report; and/or
- Increase awareness of community health issues and community health status improvement activities.

STEP 2: PLANNING

Determining that a CHRC is an appropriate tool to address specific factors impacting the health status of a particular population begins with a social reconnaissance/community health status assessment or similar activity that has identified key stakeholders, their "enlightened self-interests", pertinent community resources, and health status improvement intervention points. All this information is required to plan a successful population health improvement program such as the community health resource centers. Once acquired, that information influences how "standard" components of any intervention, such as a CHRC, must be modified to fit with a local community.

A CHRC requires time, volunteers, and funding to operate, and tool kits are necessary to get things started. The initial stages require a health assessment to fully understand the social determinants and health needs of the community. A town hall or community planning meeting is also required to gather all key players: county and city officials, church leaders, school officials, hospital officials and providers, patient/consumer advocate, non-profit organizations, and all residents and volunteers who want to help. This meeting helps identify people who are influential within the community, as well as assess if there is interest in having a CHRC and potential to sustain it. The secondary stages are finding a location (space), health care providers, social services providers, vehicle(s) and volunteers to provide transportation, funding, and hiring an office manager and/or executive director. The final stages, outreach and marketing, are related to increasing available

> **RURAL COMMUNITIES ARE WEARY OF OUTSIDERS. IT'S IMPORTANT THAT YOU TAKE TIME TO BUILD TRUST.**
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> Residents of the Brazos Valley are not strangers to the research project concept, being the surrounding environment of one of the top research institutions in the nation. It is an easy option for Texas A&M University researchers to conduct research in these communities because of the close proximity, however, community members are often left no better off as programs reported to "come and go" as funding came and went. Additionally, rural communities pride themselves on their close-knit, familial-like community, and outsiders must build trust to become trustworthy members within the community. Important to the success of CHRCs, facilitators must show a commitment to the long-term project and provide assurances that the efforts will not be abandoned. Working in and with rural communities requires patience and great deal of self-awareness about how one is being perceived both personally and institutionally. Finding a local intermediary that can extend the mantel of legitimacy to you, is critical.

information in the community about the CHRC opening, hours, and services available, and planning for sustainability. The planning process for a CHRC can happen organically or can include a detailed plan, depending on community readiness and resources available. It may also go quickly or slowly, sometimes even starting over multiple times in the same community, albeit with a different group of community members/organizations. We know this from experience!

Identify Local Champion(s)

Similar to Brazos Valley Health Partnership (BVHP), local community champions typically emerge during the assessment process. The BVHP emerged during and after the 2002 Brazos Valley Health Status Assessment as a group of individuals who were passionate and motivated to address health disparities in the Brazos Valley rural communities. These community champions are a crucial part of the CHRC development process because they garner community support for the CHRC concept and drive progress. Local champions do not necessarily need to be local governmental representatives; however, it is imperative that the local champion be well known and respected amongst residents. The champions may not be known across the entire city or county, but are an influential link in their specific community (i.e., physicians, service providers, African-American community, religious community, etc.)

Host a Community Informational Meeting

Once the local champion(s) has/have emerged, the next step is to host a community informational meeting to educate the community on the CHRC concept in hopes of increasing community support. The local champion should host the informational meeting and invite local government officials, business owners, leaders of faith-based organizations, social service organizations, and the general public. During the meeting, the community champion should introduce the CHRC concept, discuss how the CHRC concept could provide a solution to community needs, provide an overview of the development process, and determine community interest and commitment. The meeting should focus on how the CHRC can directly address concerns from different organizations, such as poverty,

healthcare, and transportation, and how the CHRC can be the "umbrella" to address multiple community concerns.

Establish Health Resource Center Advisory Board

An advisory board should be established to support, promote, and govern the CHRC. After the community informational meeting, additional local champions may emerge and offer their support of the CHRC concept. These individuals are a great place to begin recruiting for the CHRC advisory board. The advisory board should meet regularly, select leadership, institute guiding principles (bylaws) of the CHRC, and determine a governance plan. If additional local leaders are needed for the Advisory Board, recruitment should occur during this time. Planning tasks of the advisory board include: strategic planning, writing of bylaws, securing a facility, determining staff needs, determining and maintaining the CHRC budget, determining services to be provided, recruiting service providers, and planning for sustainability.

> **YOU HAVE TO ENGAGE THE COMMUNITY THROUGHOUT THE ENTIRE PROCESS SO THAT THE HEALTH RESOURCE CENTER IS COMMUNITY DRIVEN AND COMMUNITY OWNED**
> ---------------------------------
> To foster success of the CHRCs, they should be community driven and community owned. In order to ensure that the resource centers are community owned, local community members should be engaged from the community assessment to implementation. It is extremely important that the individuals who will be managing the daily operations of the CHRC have ownership of the development of the CHRC, since they will be charged with long-term sustainability of the CHRC in their community. Therefore, the facilitator (or any other outside entity), should not force its own ideas, goals, or plans on the CHRC, or the CHRC will not be sustainable beyond facilitator support.

Advisory boards should be invested in participation in future community assessments to continue addressing the most pressing needs of the community. Additionally, both formative and outcome evaluation of the CHRC should be of interest to the advisory board as it presents opportunities for continuous quality improvement and ability to document impact in their community. In the Brazos Valley these groups evolved from advisory boards into Health Resource Commissions appointed by the local county judge in four of the five counties. In the case of the fifth county, rather than create a new organization, community leaders felt it more effective and efficient to incorporate the CHRC

functions into an existing, well-respected, local nonprofit organization. A template for commission policies and procedures is included in the appendix.

Strategic Planning

One of the responsibilities of the advisory board is establishing a strategic plan to support the on-going development and management of the CHRC. Strategic planning is an organizational management activity that helps an organization define its mission, goals, and activities towards achieving those goals. Many planning models for health improvement exist, including, but not limited to models such as the Mobilizing for Action through Planning and Partnerships (MAPP), a Planned Approach to Community Health (PATCH), and the PRECEDE/PROCEED model (National Association of County and City Health Official, 2018; U. S. Department of Health & Human Services, n.d.; Green & Kreuter, 2005). An example of a strategic plan is included in the appendix.

The approach used by the Brazos Valley Health Resource Centers included goal setting and the development of a logic model and action plan. A logic model tells a story of the planned work and intended results with the following components: inputs, activities, outputs, outcomes, and impact (W. K. Kellogg Foundation, 2006). Consideration of each component reminds the advisory board of the efforts needed to ensure success. CCHD utilizes an interactive approach when conducting logic modeling workshops where participants and facilitators work collaboratively to brainstorm proposed inputs, activities, outputs, etc. The discussion is an organic process that begins with no specific "correct" answers as to what each component should contain, instead the discussion plays through various scenarios and discussions that end with a completed logic model, minus a few details such as producing it in an electronic document and any additional discussions needed for items still in question.   CCHD logic model discussions employ a blank wall and large post-it notes which can be easily moved, removed, and added to eventually display with a finished logic model on the wall. Once finalized, the logic model is then reproduced using Microsoft Word, Excel, or other computer program. An example CHRC logic model is included in the Appendix.

Example Logic Model Components

Inputs	Activities	Outputs	Outcomes	Impact
What are the required resources and/or other factors that are needed which will enable or limit program effectiveness. Examples: Funding, existing organizations, collaborating partners, staff, volunteers, time, facilities, community support.	**The planned program will incorporate what type of processes, techniques, tool development, events, and/or actions.** Examples: Hire staff, services provided at the HRC (counseling, health screenings, transportation, etc.), products (promotional materials), infrastructure building.	**When program activities are implemented outputs are the direct results of program activities.** Examples: Number of sessions provided in a health education program, number of clients seen, number of rides provided, process measures such as client satisfaction.	**Given the activities are implemented, outcomes are the expected changes in health status, knowledge, behaviors, and skills.** Examples: Increased access to health care; increased medication adherence; reduced unnecessary emergency room visits.	**Collective outcomes result in impacts of large-scale organizational, community, or system level changes.** Examples: Improved quality of life, reduced cancer rates.

Once the logic model is completed, it is a framework for developing action and evaluation plans, as the outputs and outcomes within the logic model easily translate into goals and objectives to be achieved through the listed activities. An action plan assists the program in creating a work plan for implementation of the overall project, including, but not limited to, a detailed listing of activities, timelines, responsible parties, and how the completion/outcome of the activity is measured. A completed action plan include goals, objectives, and activities, while also assigning responsible parties and due dates for each activity.

Typical goals and objectives of a CHRC include:

1. Overseeing the planning, operations, and evaluation of the CHRC,

2. Providing updates to stakeholders on a regular basis,

3. Developing a budget for the CHRC and secure funding,

4. Collaborating with service providers to address community needs,

5. Expanding existing CHRC programs and services, and

6. Focusing CHRC efforts on promoting the CHRC to the community through sponsorship of education activities.

Bylaws

Bylaws are rules and regulations written by the advisory board to establish procedures for the structure and essential operations of the CHRC. Additionally, if the advisory board intends to incorporate as a nonprofit, bylaws are a requirement of the nonprofit application process, although this is not a decision that must be made prior to opening a CHRC. As the CHRC and advisory board evolve over time (increase services provided, changes in advisory board membership), bylaws should be reviewed periodically and amended to match the mission and vision. Template advisory board/commission bylaws are included in the appendix. Common items covered in organizational bylaws include:

- Mission and Vision

- Membership

- Governance Structure

- Functions of the Advisory Board/Commission

- Officers and Duties of Officers

- Committees (standing or ad hoc)

- Meetings and Attendance Policy

- Amendments

Budgeting for the CHRC

Approximations for CHRC costs are difficult to estimate because of varying programmatic costs, which largely depend on the services the CHRC intends to provide. Additionally, it is strongly encouraged that CHRCs secure donated personnel and facility space to decrease the expenses related to CHRC operations and management. Financial and/or operational support can be requested from the local county government, hospital district, or even school district. Often times, the CHRC will aid these agencies in achieving their own mission and goals, creating a mutually beneficial relationship and long standing partnership. For example, all of the Brazos Valley Health Resource Centers either co-locate with another entity or are housed in donated space, so there is no facility cost. The base operating costs below are calculated as costs solely the responsibility of the CHRC itself – no shared costs. If CHRC staff were employed by the local hospital or some other entity, the base operating costs outlined below could be cut by 50% or more. This large decrease in costs emphasizes the importance of securing in-kind donations and becoming institutionalized within the county government, which is discussed further in the Planning for Sustainability section of this Toolkit.

Estimated Annual Start-up Costs for a CHRC	
Budget Category/Item	**Estimated Cost**
Personnel	
Executive Director (1)	$60,000
Case Manager (1)	$35,000
Office Manager (1)	$30,000
Part-time Driver (1)	$12,000
Facilities	
Office Space	$24,000
Utilities and Internet	$5,400
Office Maintenance	$300
Equipment and Supplies	
Vehicle (1)	$12,000
Vehicle Repairs	$2,000
Fuel	$3,000
Vehicle Insurance	$1,000
Computers, Printers, Office Supplies	$3,000
Travel	$4,000
Client Assistance	$5,000
TOTAL	**$196,700**

In addition to operational costs, the CHRC may have costs associated with any programs and services they offer to clients. When the advisory board determines which services they want to provide (discussed further in the next section), budgetary costs should also be considered. Many of the programs and services that the CHRCs provide are supplemented through government programs and can be provided to clients with no impact on the CHRC budget referenced above. Instead the government programs would contract with the CHRC to assist in paying for the costs related to the program being provided.

Determine Services to be provided by the CHRC

Usually, during the logic modeling process goals are first established followed by then selecting the activities to assist the program in achieving the goals. When selecting activities or services to be offered in the CHRC, the advisory board should take into account the needs of the community (determined from the assessment), existing resources within the community, availability and interest of potential service providers, and the CHRC budget. It is highly recommended that as initiatives are considered, the planning committee should research similar evidence-based, effective programs. A common service offered in the Brazos Valley CHRCs is case management for efficient use of local resources. Case management, as operated in the Burleson Health Resource Center, begins with a comprehensive review of the client and/or family status and needs. At the core of case management is the concept that a client may be at the CHRC for

> **PICK A FEW COMMUNITY-IDENTIFIED ISSUES TO ADDRESS FIRST, THEN BUILD FROM THERE.**
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> Following a community health status assessment, it is tempting to try to address all of the needs identified in the assessment, however, it is much easier to start small and then expand services. Additionally, sometimes determining which needs to address and which services to provide was not always solely about community need, but more about opportunities already present in the community. For example, in Madison County, there was already an audiologist that traveled to Madisonville to provide services, so adding him as a provider within the CHRC was a simple way to provide him with space and infrastructure to provide services to residents with and without insurance. Similarly, in Burleson County, a podiatrist was already traveling to Caldwell to provide his services, so he was also added as a service provider under the Burleson Health Resource Center. When identifying the community needs to be addressed and services to be provided, it is important to consider both needs and resources within the community.

one specific need, but through the comprehensive client inventory, the case manager can connect the client with all resources that can benefit them and/or their family. It is often these resources that are service providers co-locating within the CHRC.

Other services should be determined based on community needs identified during the assessment process. For instance, if a lack of mental health service providers is a significant finding in a community assessment, as it was in numerous Brazos Valley assessments, programs and services to address this problem should be considered. In the case of the Brazos Valley, a newly designed program providing mental health counseling via a secured video internet connection (telehealth), was initially tested in the BV CHRCs. Now telehealth counseling is widely used throughout the Brazos Valley to connect counselors in Brazos County with clients in the rural communities at their respective health resource center thus expanding services while making seeing a counselor more easily accessible. A listing of current services by Brazos Valley resource center can be found on the next page.

PRESENT DAY BRAZOS VALLEY COMMUNITY HEALTH RESOURCE CENTERS

Each of the Brazos Valley Community Health Resource Centers serve as a "one-stop-shop" for local residents to gain access to multiple resources simultaneously instead of having to visit multiple provider locations. Each CHRC provides different services, depending on the local needs and resources available in the community.

Burleson County Health Resource Centers
- Locations: Caldwell, TX and Somerville, TX
- Governance: Burleson County Health Resource Commission
- Support Provided by: Burleson County Hospital District, Burleson County, CHI St. Joseph Health System and Burleson St. Joseph Hospital, City of Somerville, Somerville Independent School District
- Services Provided: Comprehensive Case Management, Low-cost Medical and Dental Care, Sexual Assault Resources, Aging and Disability Services, Mental Health Services, Rent Assistance, Alcohol and Substance Abuse Counseling, Legal Assistance, Parent Education and Anger Management, Linkages to Other Services and Programs

Grimes County Health Resource Center
- Location: Navasota, TX
- Governance: Grimes Health Resource Commission
- Support Provided by: Grimes County and CHI St. Joseph Health Grimes Hospital
- Services Provided: Senior Meals, Transportation, Free Counseling, Educational Programs, Medication Assistance, Telehealth Counseling

Leon County Health Resource Center
- Location: Centerville, TX
- Governance: Leon County Health Resource Commission
- Support Provided by: Leon County
- Services Provided: Senior Services, Transportation, Women, Infants & Children (WIC) Services, Adopt a Meal, Case Management and other services through Project Unity, Telehealth Counseling

Madison County Health Resource Center
- Location: Madisonville, TX
- Governance: Madison County Health Resource Commission
- Support Provided by: Madison County, CHI St. Joseph Health – Madison Hospital, City of Madisonville
- Services Provided: Senior Meals, Transportation, Alcohol & Substance Abuse, Food Bank, Indigent Health Care, Legal Aid, Medication Assistance, Audiology, Sexual Assault Resources, Youth and Family Services, Telehealth Counseling

Washington County Health and Service Center
- Location: Brenham, TX
- Governance: Faith Mission and Help Center, Inc.
- Support Provided by: Faith Mission and Help Center, Inc.
- Services Provided: Non-emergency health services, Women, Infants & Children (WIC) Services, Medication Assistance, STD Screenings, Immunizations, County Indigent Program, Telehealth Counseling

Depending on the breadth of services to be provided by the CHRC, the budget, and the service area population, staffing needs can vary from one to four individuals. At a minimum, a CHRC should employ an Executive Director and an Office Manager. Example responsibilities of CHRC staff can be found in the appendix.

Secure a Facility

In most communities, a CHRC is going to be a facility-based activity; that is, it will require space in some kind of building that has particular characteristics to fit their circumstances. Those characteristics include the types of services to be offered and the parameters of those services (total square footage of the physical space), and type of space needed (waiting room, offices/exam rooms, classroom/meeting space, locker room/exercise space, etc.). Other considerations include if the space provides adequate heating and air conditioning, internet connectivity, adequate parking, and a safe overall environment. If an adequate stand-alone facility is not available or if the CHRC budget cannot cover facility costs, consider co-locating with another local entity or securing donated space from the local county government, hospital district or school district, for example. Both a hospital annex and a school building are among examples of CHRC locations in the Brazos Valley. Community leaders interviewed in the Brazos Valley Case Study had differing opinions about co-location with a clinical entity.

Recruit Service Providers and Establish Agreements

As discussed in the previous section, services to be provided are determined both by community needs and local community resources. Some service providers may already exist in the rural community and can simply be incorporated into the CHRC referral process. If other needs were identified during the assessment process, the CHRC may need to recruit services providers from the local urban hub to co-locate at the CHRC. Often times service providers that are located in the urban hub are actually required to provide services to outlying rural communities as part of their service region, however, many do not have the financial capacity to travel to the rural communities. The CHRC provides these service providers with a location to provide their services at no cost to the provider. Additionally, CHRC staff can offer assistance with scheduling appointments and tracking

clients. Once interested service providers are identified, CHRC staff should meet with the agency's executive director to provide an overview of the CHRC operations and develop a facility use agreement (FUA) to delineate responsibilities of both the service provider and the CHRC. An example FUA is provided in the appendix.
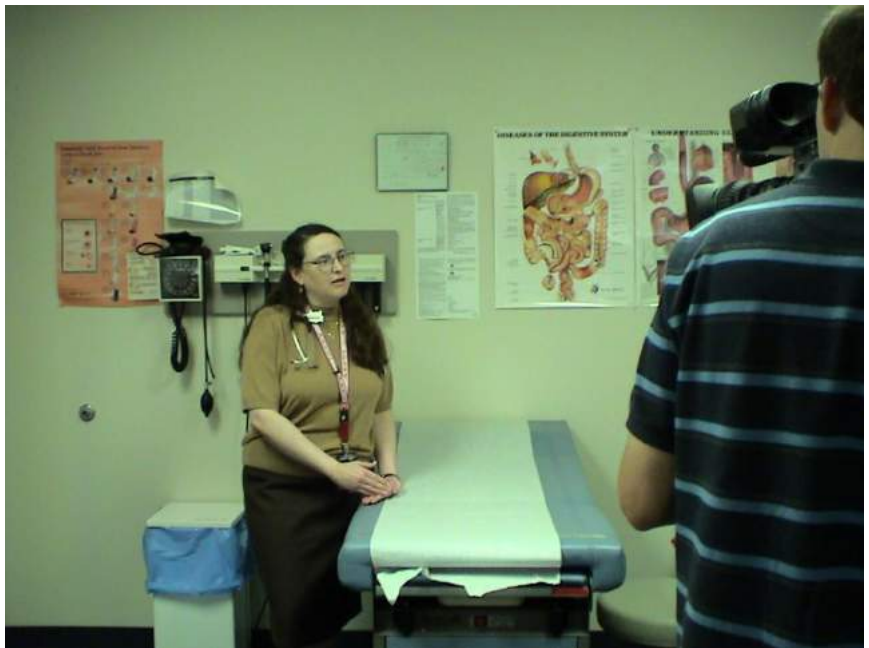
Planning for Sustainability

Developing a plan is a critical part of the sustainability process. A sustainability plan can help the advisory board obtain support from local stakeholders, define short and long-term goals, and document an organizational plan. There are several helpful existing sustainability planning guides that can be utilized by CHRC advisory boards including the Centers for Disease Control and Prevention's Sustainability Planning Guide for Healthy Communities and the Center for Community Health and Development at the University of Kansas' Community Toolbox. As a part of sustainability planning, the

CHRC advisory board must determine a fiscal entity to manage CHRC funding. The advisory board may choose to incorporate into a non-profit organization or they could become institutionalized within the local community government. Once institutionalized into the local government, advisory boards are formally recognized county entities in the form of health resource commissions and may become a line item in the county budget. The county health resource commissions are created through a county ordinance adopted by the county commissioners' court. The county commissioners also appoint the members of the county health resource commission. In addition to providing oversight for the operations of the CHRC, the infrastructure provided by the county offers the CHRC a public entity that can act as their fiscal agent and provide oversight for any monies such as grants or donations acquired by the CHRC.

> **YOU SHOULD HAVE A SUSTAINABILITY PLAN ESTABLISHED FROM THE BEGINNING. THIS WILL FOSTER HRC SUCCESS.**
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> One of the most important elements of the planning process is planning for local sustainability of the CHRC. To ensure sustainability, the community must be committed to ownership of the CHRC and in-kind resources and donations should be fundraised and preserved. The majority of the Brazos Valley Health Resource Centers are locally sustainable today because of the support they receive from the county and/or local hospital district. This support includes funding CHRC personnel salaries, donating facility space, Wi-Fi, utilities, etc. Sustainability planning does not only include securing monetary support, for instance, one of the most important sustainability elements for the Brazos Valley Health Resource Centers has been their institutionalization into the county government through the county commissioners court.

STEP 3: IMPLEMENTATION

Opening and Promoting the CHRC

When the CHRC is ready to open its doors, hosting a grand opening is a great way to spread awareness among the community. A press release should be distributed to local newspapers and radio stations inviting the general public to visit the facility and learn about the services provided. Additionally, in rural communities, the best marketing often occurs by word-of-mouth, so simply having CHRC supporters spreading the word is a great way to encourage attendance. Key leaders,

including governmental officials, should attend to show community commitment of the CHRC. The grand opening should include a ribbon cutting ceremony, tours of the CHRC led by the Executive Director, and the availability of promotional items and brochures describing CHRC services. It is also very important that local press attend the grand opening to take photos and interview CHRC staff for additional promotion after the doors open.

Of course, it is also helpful to develop materials to share throughout the community such as brochures, fliers listing services, etc. In many rural communities, newspapers contain an "around the community" section that allows for free listings for services or special events. This is a great option to take advantage of and promote special events or weekly/monthly support groups or education classes open to the community. Communities that do not have local media can be much more challenging to "get the word out" but alternatives such as asking churches or schools to distribute promotion material can be effective.

Sharing information with local providers and other who may refer their clients or patients to the CHRC is also important and easily done while establishing or maintaining relationships. Finally, having an online presence is essential. Maintaining (and keeping updated) a dedicated webpage and social media presence should be a priority for sharing services offered, special events, and contact information. Public health events such as Breast Cancer Awareness Month, American Heart Month or Public Health Week are examples of national health observances that provide opportunities for the CHRC to reach out to the community. The Office of Disease Prevention and Health Promotion

provides the National List of Health Observances yearly. As of this writing, the list can be found on the website www.healthfinder.gov.

Daily Operations and Management of the CHRC

Daily operations and management of the CHRC are handled by the Executive Director and Office Manager. The responsibilities of these individuals are outlined in the Planning section of this document. In general, the daily operations include opening and closing the facility, managing client data and appointments, and record keeping. Operational policies and procedures should be developed by the advisory board/commission with the assistance of the CHRC Executive Director to ensure proper administration of the CHRC. As with bylaws, it is important to review these periodically to ensure they remain up to date and/or amend as necessary. A template for a CHRC operational handbook is included in the appendix.

Service Coordination and Case Management

One of the primary elements of the CHRC daily operations is the coordination of services. By that we mean making sure that participating agencies are adhering to their schedules, meeting clients, and following up appropriately. On the client side, case management activities involve not only helping the client to identify problems, needs and potential solutions, but also facilitating their participation in services that have been identified to help address those problems and needs. A trained and experienced case manager who is knowledgeable about local resources is critical in this role.

Tracking Clients and Scheduling Appointments

A simple mechanism for oversight of service coordination and case management is tracking client participation and progress and scheduling appointments for the clients and providers. Functioning as this intermediary is time consuming and may not seem like a good investment of staff time from a traditional service provider perspective, but in the CHRCs we have learned this investment is absolutely cost-effective. The office manager has traditionally served this role of scheduling appointments for service providers and communicating with the service provider if/when they have

clients scheduled. From the provider's perspective no appointments could mean they do not need to drive out to the center on that day, thereby saving their organization mileage and out of office costs.

Additionally, tracking the number of clients coming through the resource center is cumbersome. A sign in sheet is an effective method, especially if a CHRC is not comfortable with electronic record keeping. Service providers should be requested to provide a monthly report of their services provided at the CHRC. Inclusion of this as part of the facility use agreement is encouraged to help the CHRC in evaluating the success of the center. Without information from co-locating service providers, the annual report to funders will have less impact. Encounter log examples are provided in the appendix.

Recruiting Additional Services Providers

The process to recruit service providers and establish service provider agreements is discussed in the Planning section of this Toolkit, however, it is important to continuously identify new service providers to match identified community needs. Establishing and maintaining service provider relationships with the CHRC will always be a priority for continuous quality improvement and to ensure that the CHRC is properly assisting the population with their health and health-related needs.

STEP 4: EVALUATION

To evaluate a Community Health Resource Center after it opens requires planning for evaluation in advance. Evaluation provides information that includes tracking client and service provider numbers/visits and satisfaction surveys, yet it can also yield valuable information, if designed appropriately, that can demonstrate the *impact* of the CHRC.

Evaluate & Assess

Planning for the evaluation of a CHRC should be included at the outset of the entire planning process. The logic model developed during the planning phase provides guidance for the evaluation of the CHRC. The logic model's impacts and outcomes will have been translated into the strategic plan's goals and objectives. These goals and objectives are the information needed to plan for an

evaluation. Working with a seasoned evaluator is also important to ensure evaluation measures accurately capture the required data to be able to answer evaluation questions.

The CDC Evaluation Framework (1999) outlines six steps to developing an evaluation. Assuming steps one through three have occurred using a process such as the Partnership Approach (guided by Community Health Development theory and a social reconnaissance), stakeholder engagement and a community description (via the logic modeling process) has occurred. Determining the design of the evaluation is the next portion of the framework and requires the evaluation team to decide on the purpose of the evaluation – questions such as are there any specific standards which need to be upheld and is the desired evaluation feasible (are the resources and knowledge needed available) begin to shape the evaluation plan. At a minimum, facility activity and service usage data should be logged. Ideally, an CHRC's evaluation would also include outcome measures such as return on community investment, improved quality of care, improved effectiveness and cost savings, community relationships, and key leader perceptions.

CDC Evaluation Framework

Usage Data

The evaluation should capture process measures such as how many clients utilize the center, client's use by service, and client's perceptions of services received. Client logs and satisfaction surveys can assist in documenting the reach of the CHRC, and are useful in marketing materials demonstrating the success of the CHRC. Many methods exist for tracking clients and are at the discretion of the individual site based on preference. Client logs may be paper logs where a client signs in each time they visit the center, or it may be electronic which could more easily allow for reporting unduplicated service provision numbers.

In the case of the BV CHRCs, providers using the CHRCs are required to submit monthly reports to the CHRC. This information is then aggregated for a full CHRC center "monthly report."

Client satisfaction surveys are fairly easy to design and examples can be found easily through a quick Google search. The key is to first establish the evaluation question to be answered by the survey and then develop a question and response options that capture the desired information. Satisfaction surveys may simply ask about a client's feelings and aesthetics of the CHRC, or can dive deeper to ask for suggestions for improvement and/or additional services that are needed. When tabulated, the CHRC has an opportunity to make improvements based on client feedback.

Return on Community Investment

In the case of the BV CHRCs, there was a need to document the value of the CHRC to their communities. By examining the cost per client and providing funders with a Return on Community Investment (ROCI) Report, the resource centers were able to exhibit a low cost per person utilizing the resource center. Given the CHRC services provided, counties, cities, and other contributing entities were able to see the small amount invested per person was worth much in the way of health care cost savings.

Return on community investment took into account both resources such as funding and grants, volunteer hours (value based on current year's estimated hourly worth of a volunteer from the Texas One Star Foundation), and any other contributions from service providers. This total was used to create an estimated cost per client. An example ROCI report is in the appendix.

Other Recommended Outcome Measures

Additional measures which can assist in illustrating impact can be documented using a variety of sources - future community health assessments, key leader surveys, health resource center client surveys, network analysis, etc. Targeted measures for each of these include:

- Improved quality of care – Improved quality of care changes could be documented by seeing an increase of self-reported health status and a decrease in prevalence of chronic disease and mortality rates.
- Effectiveness, coordination, and cost savings – Improved coordination and effectiveness would be evident if there were a decrease in numbers of residents who delayed health care due to costs or extended travel time and a decrease in the reported distance traveled for care.
- Perceptions of local leaders regarding access to health care for low-income families can be gleaned from key leader surveys or interviews. Such an inquiry could also determine perceptions about the health resource center and advice or suggestions for improvement.
- Relationships - Growth of relationships between the HRC and service providers and other community organizations can be documented through interorganizational network analysis (ION). A longitudinal ION survey can provide insight into the nature of connections between organizations, the frequency of interaction, and what, if any, resources are exchanged between organizations.

Whatever the evaluation plan derived during the planning process consists of, dedicated resources must be delegated to evaluation to ensure information is collected, monitored, and reported for the sake of continually improving service provision and communicating the HRC's community impact.

Conclusion

The purposes of this "toolkit" was to provide the reader with insights into "how" the Community Health Resource Centers in the Brazos Valley were developed and how they operate. Written to stand alone but also as a companion document to the Case Study, there is some duplication of information. We strongly recommend that anyone interested in CHRCs and/or the process used in the Brazos Valley read both documents.

The Toolkit includes both this narrative as well as an extensive Appendix with further explanation, sample documents, templates, and other resources drawn from the 15 years of experience with this process in the Brazos Valley.

Those intending to replicate the CHRC model or this process in other communities are encouraged to give careful consideration of local factors and conditions that might/will influence how the model/process is implemented in any particular environment.

Faculty and staff of the Center for Community Health Development welcome inquiries from those interested in this approach to discuss how this "customization" might occur in those communities.

> **IF YOU'VE SEEN ONE HEALTH RESOURCE CENTER, YOU'VE SEEN ONE HEALTH RESOURCE CENTER.**
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> Our case study clearly establishes that part of the success of the health resource centers in the Brazos Valley is that they were allowed to develop independently, without pressure to conform to a "cookie cutter" design. Certain similarities resulted from the guiding theory and principles, but from the beginning the Center for Community Health Development and Brazos Valley Health Partnership's leadership encouraged each community to follow its own path in determining which problems to address and what approaches they might take in reaching their solution.
>
> As a result, we see health resource centers that operate under different governance structures and staffing models, in different organizational contexts, and offer differing arrays of services. Our view is that this represents a healthy diversity. Just as one might approach treatment of diabetes very differently for a 20 year old versus a 60 year old, even if their "clinical" indicators were similar, "treating" a community requires the same awareness of how factors impacting health status are at work in different settings.
>
> Some are ready right away, some take time to develop – depends on the culture of the community.

References

Burdine, J. N., Felix, M., & Wendel, M. (2007). The basics of Community Health Development. *Texas Public Health Association Journal, 59(1), 10-11*.

Centers for Disease Control & Prevention. (1999). Framework for program evaluation in public health. *MMWR, 48*(RR11).

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). I*nternet, phone, mail, and mixed-mode surveys: The tailored design method.* Hoboken, NJ: John Wiley & Sons Publishing.

Felix, M. R., & Burdine, J. N. (1995). Taking the pulse of the community. *Healthcare executive*, *10*(4), 8-11.

Felix, M. R., Burdine, J., Wendel, M., & Alaniz, A. (2010). Community Health Development: A strategy for reinventing America's health care system one community at a time. *Journal of Primary Prevention, 31*(1-2), 1-7. DOI 10.1007/s10935-010-0206-8.

Green, L.W., & Kreuter, M.W. (2005). *Health Program Planning: An educational and ecological approach*, 4th edition. New York: McGraw-Hill.

Hanlon, J. J. (1974). *Public health. Administration and practice*. CV Mosby Company, Saint Louis, Missouri, USA.

National Association of County and City Health Officials. (2018). MAPP Framework. Retrieved from: http://archived.naccho.org/topics/infrastructure/mapp/framework/index.cfm

U. S. Department of Health & Human Services. (n.d.). *Planned Approach to Community Health: Guide for the local coordinator*. Atlanta, GA: U.S. Department of Health and Human Services, Department of Health and Human Services, Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion.

Wendel, M., Burdine, J., & McLeroy, K. (2007). The evolving role of partnerships in addressing community public health issues: Policy and ethical implications. *Organizational Ethics: Business, Healthcare and Policy Journal*, *4*(1): 53-64. PMID: 18193773.

W. K. Kellogg Foundation. (2006). *Logic model development guide*. East Battle Creek, MI: W.K. Kellogg
  Foundation.

APPENDIX TABLE OF CONTENTS

The Center for Community Health Development

The Texas A&M University System Health Science Center
School of Rural Public Health

Dear Colleague:

We frequently receive requests for more detailed information on elements of the Partnership Approach for community health status improvements and our population-based community health status assessment methodology. One of those components is our modification and application of the Hanlon Method for Prioritization of Interventions.[1,2] This method allows for decision makers to identify explicit major factors to be included in the priority setting process, to organize the factors into groups that are weighted relative to each other, and to allow the factors to be modified as needed and scored individually. The Hanlon Method groups the criteria into three components each of which is assigned a value on a predetermined scale. The component scores are inserted into a formula that reflects the relative weight of each component in the decision making process. Values derived from these formulas can be compared and used to rank order each of the issues included in the process.

The Hanlon Method has been modified by practitioners to fit varying contexts and the evolution of health issues from acute to chronic disease to social concerns (what we call the broader determinants of health - education, employment, housing, etc.). We have added a dimension to the process which introduces community values into the process. Our experience has been that when this dimension is included the probability for community "buy-in" is substantially increased and the likelihood of intervention success is greatly increased.[3]

On the following pages are a description of the basic Hanlon Method and examples of worksheets used to develop a set of priorities for a particular community. We hope these are helpful. If you have further questions, please do not hesitate to give us a call.

With Regards,

James N. Burdine, Dr.P.H. and Michael R. J. Felix

References
1. J.J. Hanlon, **Administration of Public Health** (C.V. Mosby Co., 1974).
2. Spiegel, A.D., and Hyman, H.H., **Basic Health Planning Methods** (Aspen Systems Corp., 1978)
3. Felix, M., Burdine, J., Abel, A., Wiltraut, C., and Musselman, Y. 2000. *The Social Reconnaissance for Understanding Women's Health* in **Winning in the Women's Health Marketplace**. Genie, J. (Ed.).

The first attachment explains the basic mechanism of the Hanlon Method of Prioritization. Problems identified through a community health status assessment are scored on the basis of the three elements of the Hanlon Method – "size of the problem" – how many individuals are effected, "seriousness of the problem" – the severity of the illness/degree of risk of the behavior, and "effectiveness of solutions" – what is the degree of effectiveness of interventions we have to address the problem?

Using Hanlon's formula of "**(A+2B)C"** allows you to prioritize among various issues. For example, if you look at the example worksheet attached titled "Calculation of Hanlon Scores for Top 10 Intervention Opportunities" we can see that Pap Smears are not obtained by 23.5% of the population of concern (75,325 women based on age/gender criteria for screening in this case). That translates into 17,701 persons at-risk or 8.43% of the total population. Using the Hanlon Method scoring, that yields a "Size of Problem" score of 6 (within the range of 1-9%). The next column, "Seriousness of Problem" is scored a 9 based on the probable mortality of undetected cervical cancer. Similarly, the next column, "Effectiveness of Interventions" is scored a 9 because of the high effectiveness of both the Pap Smear and subsequent treatment if the disease is caught early. By applying the Hanlon equation we get a score of 216 for Pap Smears. When compared to the other items examined in this community, Pap Smears come out with the highest rank.

The second worksheet, titled "Application of Community Values to Hanlon Priorities," takes the items ranked from the first worksheet and modifies the Hanlon scores by examining two local community values the decision making group - in this case the board of directors of a local health district, felt were important to consider. A significant concern of the health district was that they not duplicate services of other organizations, so the extent to which no other organization was likely to fill an identified gap in services was rated. The other value reflected the board's concern over providing services to those with little or no other options for receiving services than the health district.

Scored from 1 to 3 (*Very much/very likely, Somewhat, Not at All*) these elements were added to the Hanlon rank and a final rank order was determined. As can be seen from comparing the "Basic Hanlon Rank Order" column with the "Final Rank Order" column, the "values" step did little to change the ranking. However, for policy and community "buy-in" purposes, in this community, the inclusion of these values was a critical step in the overall determination of priorities.

Although many methods exist for establishing priorities for allocating resources and/or targeting problems and populations for interventions, this approach incorporates key elements in establishing the extent of various problems as well as local values in that process.

HANLON METHOD

Setting priorities for health status improvement: Opportunity=(A+2B)C
A=Size of problem
B=Seriousness of problem
C=Effectiveness of interventions available to address problem

_____

A=Size
Usually defined by prevalence of a condition, characteristic or disease in entire population (but can be among sub-groups of the population as well)

Percent of population with health problem	Score
25%+	9-10
10-24%	7-8
1-9%	5-6
.1-.9%	3-4
.01-.09%	1-2

B=Seriousness
Usually defined by urgency to intervene, severity (leads to death?), disproportionate impact among vulnerable populations, and/or economic impact on community of unresolved problem. Seriousness includes the urgency, severity, impact on costs to community and indicated trend of the problem as a serious factor.

How serious?	Score
Very serious	9-10
Serious	6-8
Moderately serious	3-5
Not serious	0-2

C=Effectiveness of solutions (solubility of problem)
Usually defined by "best real world" expectations, based on outcome evaluations of successful interventions in similar communities. When considering solutions, the effectiveness is for "how well des this intervention solve the problem?" and the percentages indicated below would then indicate the effectiveness of specific programs or ideas. When considering problems, the score is for "how soluble is this problem at all?"

Effectiveness?	Score
Very effective, (80%+)	10
Relatively effective (60-79%)	8-9
Effective (40-59%)	6-7
Moderately effective (20-39%)	4-5
Relatively ineffective (<20%)	0-3

Caculation of the Hanlon Scores for "TOP 10" Intervention Opportunities

Issue	Total Population*	Percent at Risk	Population at Risk	Percent of Total Pop.	Size of Problem	Seriousness of Problem	Effectiveness of Intervention	Total Score	Rank Order
Preventive Screenings:									
Pap Smear	75,325	23.5	17,707	8.43%	6	9	9	216	1
Mammogram	49,049	52.4	25,702	12.24%	7	8	9	207	2
Annual Dental Exam	210,000	24.2	50,820	24.20%	8	6	8	160	6
Blood Pressure Exam	96,600	38.9	37,577	17.89%	8	6	8	160	6
Risk Factors:									
Obesity	210,000	22.6	47,460	22.60%	8	6	8	160	6
Smoke (current)	210,000	20.4	42,840	20.40%	8	9	6	156	7
Seatbelts (always)	210,000	32.8	68,880	32.80%	9	9	8	216	1
Exercise (<3x/wk)	210,000	38.4	80,640	38.40%	9	7	7	161	5
Drink Alcohol (10+/wk)	210,000	9.1	19,110	9.10%	6	8	5	110	9
Poor Nutrition	210,000	30	63,000	30.00%	9	7	7	161	5
Access and Quality of Care:									
Access to Medical Care	46,200	13.3	6,145	2.93%	3	9	5	105	10
Access Limited by Insurance	46,200	33.9	15,662	7.46%	6	9	6	144	8
Have Regular Source of Care	46,200	21	9,702	4.62%	3	9	9	189	3
Regular Source of Care is ER	46,200	31	14,322	6.82%	6	9	6	144	8
Prescription Not Filled - Costs	46,200	25.5	11,781	5.61%	6	9	7	168	4

*(age, gender appropriate)

Application of Local Community Values to Hanlon Priorities

Issue or Problem	Basic Hanlon Rank Order	Community Values:		Summary Score	Final Rank Order
		Gap in Community No One Else Likely to Fill?	Service to Those With No or Limited Options?		
Pap Smear	1	2	1	4	1
Seatbelts (always)	1	3	1	7	3
Mammogram	2	1	1	6	2
Have Regular Source of Care	3	3	1	12	5
Prescription Not Filled - Costs	4	2	1	9	4
Exercise (<3x/wk)	5	3	1	12	5
Poor Nutrition	5	3	1	14	6
Blood Pressure Exam	6	2	3	14	6
Annual Dental Exam	6	2	1	12	5
Obesity	6	3	1	15	6
Smoke (current)	7	2	3	16	8
Assess Liminted by Insurance	8	3	1	18	9
Regular Source of Care is ER	8	1	3	18	9
Drink Alcohol (10+/wk)	9	1	3	19	10
Access to Medical Care	10	2	3	21	11

Scoring:
1 = Very much/very likely
2 = Somewhat
3 = Not at all

Advisory Board/Commission Policies & Procedures Manual

The purpose of this manual is to provide information and direction for the activities of the Community Health Resource Commission (or similar body) responsible for the planning and oversight of the Health Resource Center in your community/county. While many of the items in this manual will remain standard, any item(s) can be re-evaluated and altered or additional items may be included at the discretion of the governing body of your Health Resource Center (hereafter referred to as the "Commission.") All additions or changes to items in this manual should be brought before the Commission for approval and documented in meeting minutes.

1. County Health Resource Commission Ordinance

SECTION I.

      That Your County Health Resource Commission (YCHRC) is hereby created for the purpose of assisting Your County in establishing and managing a Health Resource Center, for the purpose of increasing **access to health resources for residents of your county.**

SECTION II.

      That the Commission provided for herein shall be comprised of ** members to be nominated by and approved by the Commissioner's[1] of Your County, and shall be residents of the County. The board shall consist of representatives from county, businesses, industry, community organizations, education, and members at large.

      ** Ten members of the commission originally appointed shall be for a term of one (1) year. Thirteen member of the Commission originally appointed shall be appointed for a term of two (2) years. Thereafter, the term of each Commission member shall be two (2) years. No Commission member shall serve three (3) successive terms, provided, however, that a Commission member appointed to complete the term of another Commission member shall, at the completion of such term, be eligible for appointment for another full term. One additional position shall always be filled by a county employee who shall serve as a non-voting ex-officio member of the Commission.

***The numbers provided are based on the commission's needs. Some counties have more or fewer commission members depending on commitment and availability. It is usually an odd number for voting purposes and the number of persons who a serve 1-year term is less than those who serve 2-year terms. All numbers for the commission throughout this manual are based on County 3, please see example below:*

Each county has a set number of Commission members:

	Total	**1-yr term**	**2-year term**
County 1	13	6	7
County 2	9	4	5
County 3	23	10	13
County 4	11	5	6

SECTION III.

      That the Executive Director of the Your County Health Resource Commission shall be an additional non-voting ex-officio member of the Commission. The Executive Director shall be custodian of all minutes and records of the Commission and perform such other duties as the Commission and his/her responsibilities to the County of (<u>County's Name</u>). The Executive Director shall work under the supervision and control of the Your County Judge for the purpose of implementing the provisions of this ordinance.

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[1] Commissioners is the term used in Texas for the senior elected officials of county government. The Commissioners Court is chaired by the County Judge, the chief executive officer of the County. Localities with other terminology should substitute those terms as needed.

SECTION IV.

A majority of the members of the Commission shall constitute a quorum for the conduct of business. The members of the Commission shall regularly attend meetings and shall serve without compensation except for reimbursement of authorized expenses attendant to the performance of their duties.

The Commission shall hold an organizational meeting in October of each year and shall elect a Chair, Vice-Chair and Secretary/Treasurer from among its members before proceeding to any other matters of business. The Commission shall meet regularly and shall designate the time and place of its meetings.

The Commission shall adopt Robert's Rules of Order for parliamentary procedure and will keep a record of its proceedings in accordance with the provisions of the Your County. Newly appointed members shall be installed at the first regular meeting after their appointment.

Each year a report shall be submitted to the County Commissioners' Court showing the cumulative attendance of each member with notation of members who have been absent from three (3) consecutive meetings.

SECTION V.

That the Commission shall recommend policies related to **access to health resources** so all county activities may follow a common purpose. The Commission shall have the following responsibilities:

1. Oversight of the Your County Health Resource Center (YCHRC)
2. Develop and plan, in partnership with interested providers, programs enhancing access to care;
3. Evaluate County actions in light of that policy;
4. Determine and recommend to the County Commissioners' Court management and program priorities on a countywide basis;
5. Monitor YCHRC from data collected and evaluated to make an annual report to the County Commissioners' Court; and
6. Carry out such other tasks as the County Commissioners' Court may designate.

To accomplish these responsibilities the Commission **may** establish sub-committees such as, but not limited to, the areas of **planning, services development, fund development and evaluation.**

A Commission member will Chair each sub-committee with an unspecified number of community volunteers chosen by the Commission as working sub-committee members.

SECTION VI.

All Commission expenses, may be paid from donations when, as and if same are received by the County from the general public, business, industry, foundations and other sources for the purposes embraced by the scope of the Commission's purpose and responsibilities administered in accordance with standard County policy and practice governed by state, charter and ordinance.

SECTION VII.

That it is hereby declared to be the intention of the County Commissioners' Court that the sections, paragraphs, sentences, clauses and phrases of the Ordinance are severable, and if any phrase, clause, sentence, paragraph, or section of this Ordinance shall be declared unconstitutional or illegal by the valid judgment or decree of any court of competent jurisdiction, such unconstitutionality or illegality shall not affect any of the remaining phrases clauses, sentences, or paragraphs and sections of this Ordinance, since the same would have been enacted by the County Commissioners' Court without incorporation in this Ordinance of any such unconstitutional or illegal phrase, clause, sentence, paragraph or section.

SECTION VIII.

That this ordinance shall be in full force and effect from and after the date of its passage, and it is so ordained.

PASSED and ADOPTED this_____day of _____, 20xx.

APPROVED AS TO FORM AND LEGALITY:

_____   _____

County Attorney   County Judge

ATTEST:

_____

County Clerk

2. Bylaws of Your County Health Resource Commission

2.1 —Name of Organization and Type of Organization

The name of this organization will be the Your Health Resource Commission.

2.2 —Mission, Purpose and Functions

The YHRC was created for the purpose of assisting the citizens of the County of Burleson in establishing access to health resources.

2.3 —Membership

The Commission will be comprised of nine members to be nominated by and approved by the County Commissioners. The members shall be residents of Burleson County. The Commission shall consist of representatives from business and industry, community organizations, education and members at large.

Four members of the Commission originally appointed shall be for a term of one (1) year. Five members of the Commission originally appointed shall be appointed for a term of two (2) years. Thereafter, the term of each Commission member shall be two (2) years

No Commission member shall more that serve three (3) successive terms, provided, however, that a Commission member appointed to complete the term of another Commission member shall, at the completion of such term, be eligible for appointment for another full term. One additional position shall always be filled by a county employee who shall serve as a non-voting ex-officio member of the Commission.

The County Commissioners' Court shall appoint an Executive Director who shall be an additional non-voting ex-officio member of the Commission. The Executive Director shall be custodian of all minutes and records of the Commission; additionally, he/she will perform other duties as the Commission may deem necessary and consistent with both the responsibilities of the Commission and his/her responsibilities to the County of Burleson.

2.4 —Governance Structure

1. Five members of the Commission shall constitute a quorum for the conduct of business. The members of the Commission shall regularly attend meetings and shall serve without compensation except for reimbursement of authorized expenses attendant to the performance of their duties.

The Commission shall adopt its own rules of procedure and keep a record of its proceedings in accordance with the provisions of the County of Burleson. Newly appointed members shall be installed at the first regular meeting after their appointment.

2. The Commission will establish an Executive Committee to conduct the business of the Commission between meetings of the entire Commission. The Executive Committee will consist of 1) the Chair of the Commission, 2) the Vice-Chair of the Commission and 3) a Member-at-Large, such position to be elected annually from the remaining Commissioners. The Executive Committee will meet at least one time during the quarter and may meet more often as needed.

2.5 —Functions of the Commission

The Commission shall recommend policies related to access to health resources so all county activities may follow a common purpose. The Commission shall have the following responsibilities:

1. Oversight of the Burleson Health Resource Center (BHRC);
2. Develop and plan, in partnership with interested providers, programs enhancing access to care;
3. Evaluate County actions in light of that policy;
4. Determine and recommend to the County Commissioners' Court management and program priorities on a countywide basis;
5. Monitor BHRC from data collected and evaluated to make an annual report to the County Commissioners' Court; and
6. Carry out such other tasks as the County Commissioners' Court may designate.

2.6 —Officers and Duties of Officers

The Commission shall hold an organizational meeting in January of each year and shall elect a Chairman and Vice-Chairman from among its members before proceeding to any other matters of business.

Chair—The BCHRC Chair will preside at all meetings of the Commission and will perform such duties as may be assigned to him/her by action of the Commission and/or the county commissioners.

Vice-Chair—In the event of the absence or inability of the Chair to serve, the Vice-Chair will act as chair. He/she will perform other such duties as may be assigned to him/her by action of the Commission and/or the County Commissioners.

2.7 —Committees

To accomplish the responsibilities of the Commission, the following Standing Committees shall be established:

- Planning
- Services Development
- Fund Development
- Evaluation.

A Commission member will chair each committee with an unspecified number of community volunteers chosen by the Commission as working committee members.

Other committees and/or sub-committees may be formed at any time. In each case a Commission member shall chair the committee or sub-committee.

2.8 —Meetings

The Commission shall meet regularly and shall designate the time and place of its meetings. The agenda will be available for preview and the County Commissioners Court meeting just prior to the Commission meeting.

2.9 —Meeting Attendance Policy

Each year a report shall be submitted to the Commissioners' Court showing the cumulative attendance of each member with notation of members who have been absent from three (3) consecutive meetings. Such absence of three (3) consecutive meetings may constitute an abandonment of the seat and result in the appointment of a replacement to the Commission.

2.10 —Amendments

Any member of the Commission may recommend amendments to these By-laws to the Commission. The proposed amendment must be delivered to each member of the Commission by mail or electronic means at least fourteen (14) days prior to the next meeting of the Commission. At the next meeting of the Commission the proposed amendment will be placed on the agenda. If the Commission votes in favor of the amendment it will be forwarded to the County Commissioners Court for ratification.

3. Commission Membership

3.1   **Commission Members:**

A total of twenty-three Commission members nominated and appointed by the County Commissioners' Court, will serve on the Your County Health Resource Commission.

3.2   **Terms and Requirements:**

a.   Ten members of the Commission originally appointed shall be for a term of one (1) year. Thirteen member of the Commission originally appointed shall be appointed for a term of two (2) years. Thereafter, the term of each Commission member shall be two (2) years.

b.   No Commission member shall serve three (3) successive terms, provided, however, that a Commission member appointed to complete the term of another Commission member shall, at the completion of such term, be eligible for appointment for another full term. One additional position shall always be filled by a county employee who shall serve as a non-voting ex-officio member of the Commission.

c.   The Commission should be composed of either Your County residents or service providers that work in the county. Additional members may serve as non-voting ex-officio members, one of which must be a county employee or an elected county employee.

d.   Commission members are expected to regularly attend meetings. Any member that is absent from three consecutive meetings may be dismissed at the discretion of the Commission.

3.3   **Appointment:**

All new members will initially be recommended to and approved by the YCHRC at a Commission meeting. Once approved by the YCHRC the nominee(s) will then be recommended to Your County Commissioners' Court for final approval.

3.4   **Membership Termination and Vacancies:**

a.   At any time a member can make a formal request to the Commission stating that they would like to step down.

b.   At any time a member that has been absent for three consecutive meetings may be dismissed by a majority vote of the Commission.

c.   Vacancies will be filled using the same procedure discussed in section 2.3.

3.5   **Ex-officio Members:**

a.   The ex-officio member will serve in an advisory capacity to the YCHRC; they do not have voting rights and can serve terms with no expiration.

b.   YCHRC will determine which sectors in Your County to recruit ex-officio members.

c.   A designated member of the Commission will approach the organization/business to request a representative to serve as an ex-officio member to the Commission.

3.6   **Non-voting and Voting Members:**

a. Only the **twenty-three appointed Commission members should be allowed to vote, motion, or second a motion relating to items on the agenda.

b. Members can only vote for themselves. If an absentee vote is necessary the member should inform the Commission Chair, in writing, prior to the scheduled meeting

c. Special guests, ex-officio members, and any other non-Commission members in attendance at any Commission meeting are neither allowed to vote nor are they allowed to provide a motion or second a motion.

4.   YCHRC STRUCTURE

4.1   Commission Governance:

   a. An Executive Director may be appointed by the County Commissioners' Court as a non-voting, ex-officio member.
   b. The Executive Director will develop the agenda for each Commission meeting with the Chair at least one month prior to the meeting.
   c. The Executive Director should ensure copies of all minutes and records of the Commission are readily available.
   d. The Executive Director should oversee the daily operations of the resource center.
   e. The Executive Director is responsible for maintaining relations within the community.
   f. Additional duties may be required if deemed necessary by the Commission or County.

4.2   Commission Governance:

   a. The Executive Committee will include four Commission officers; Executive Director, Chair, Vice-Chair, Secretary, and four at-large members.
   b. The at-large member must be a commission member and will be elected on a biannual basis by the commission every other October, unless there is a vacancy which shall be filled at the next commission meeting.
   c. The Executive Committee will meet to conduct any business in between regularly scheduled Commission meetings.
   d. The Executive Committee will meet at least one time during the quarter and may meet more often as needed.
   e. The Executive Director is not allowed to vote.

4.3   Executive Member Duties:

   a. The YCHRC **Chair** will preside over all meetings of the Commission and will perform duties assigned by action of the Commission and/or the County Commissioners.
   b. In the event of the absence or inability of the Chair to serve, the **Vice-Chair** will act as Chair. He/she will perform other duties assigned by the Commission and/or the County Commissioners.
   c. The YCHRC **Secretary** duties may include: notifying members of meetings, developing an agenda with the Chair and Vice Chair, taking the minutes at all YCHRC meetings and distributing minutes within five business days after the Commission meeting. Other duties as may be assigned by the Commission and/or the County Commissioners.
   d. All Executive Members (Chair, Vice-Chair, & Secretary) will be elected biannually, in October, by a majority vote of the Commission.

4.4   Special Committees:

   a. The Commission can establish special committees to accomplish the responsibilities of the Commission.
   b. Special committees may be developed for, but are not limited to Planning, Services Development, Fund Development and Evaluation.
   c. A Commission member will Chair each committee with an unspecified number of members.

d. Members can include both Commission members and community volunteers chosen by the Commission.

5.   YCHRC Meetings

5.1   Meeting Schedule:

a. The YCHRC will hold at least quarterly meetings, starting in October of each fiscal year, that will take place on the third Monday of the month (except where a regular meeting day is a legal holiday, the meeting shall be held on the following Monday) at the Your County Annex in the Grandroom, beginning at Time(am/pm).

b. The meeting schedule can be revised at any time by a majority vote of the Commission.

c. Additional meetings can always be scheduled at the discretion of the YCHRC.

5.2   Meeting Process:

a. No later than two weeks prior to an YCHRC meeting, letters or emails must be sent out notifying all Commission members of the upcoming meeting including a brief written summary of the agenda to be covered.

b. A meeting letter (**Appendix A**) will be developed by Executive Director and Chair with assistance from the other Commission members if needed. The letter should be on YCHRC letter head and should include date, time and location of the meeting, a brief description of topics that will be covered and any information regarding meal provisions. Attached to the letter should be a copy of the agenda.

c. The agenda (**Appendix B**) will also be developed by the Executive Director and Chair with assistance from the other Commission members if needed.

d. To create a meeting agenda, first review the previous agenda to determine any items that need to be carried over to the new meeting agenda in addition to the standard agenda items. Second, the strategic plan progress should be reviewed and any items that are incomplete should be considered for inclusion in the new meeting agenda. Third, include any other relevant items that need to be discussed. Finally, based on the revised agenda, all meeting materials should be listed in the order they are addressed in the agenda to create a finalized agenda.

e. The agenda must be posted to the County Court office **no later than 72 hours** prior to the Commission meeting date to comply with the Open Meetings Act. To post the agenda, it must first be approved by the Executive Director. Then, two copies of the agenda are taken to the county clerk's office to be file marked. After being file marked, one copy is posted in the District Court building by the County Clerk and the other is kept in the resource center.

f. The agenda should include, but is not limited to, the following:
     i.   Call to Order
     ii.   Welcome and Introductions
     iii.   Review of previous meeting minutes
     iv.   Goals of meeting
     v.   Your Health Resource Center Business
     vi.   Your Health Resource Center New Business
     vii.   Announcements and Updates
     viii.   Next Steps
     ix.   Adjourn

g. Any additional items that need placement on the agenda must be sent to the Commission Chair no later than one week prior to the next commission meeting.

h. Meeting minutes **(Appendix C)** should follow the agenda outline and must include information regarding votes taken for any action items. All meeting minutes should be approved by the Chair and/or Vice-Chair and then distributed to the commission within five business days after the commission meeting.

5.3   Special Meeting Process:

The Commission Chair, Executive Director, or a majority of Commission members can at any time call a special meeting. Whoever calls for the special meeting is responsible for sending agenda items to the Chair in order to post the agenda to the County Commissioner's Court no later than 72 hours prior to the special meeting. The Commission Chair must also notify the Commission members of the special meeting no later than 72 hours prior.

5.4   Meeting Rules:

a. A quorum of Commission members must be present for a meeting to be called to order and action to be taken.

b. The Secretary will be responsible for taking all meeting minutes. In the case where the Secretary is absent the Chair will appoint another Commission member to take minutes. The Secretary or appointed Commission member shall record all motions and votes of "yeas" or "nays".

c. There shall be voting on all action items on the agenda, each Commissioner present shall vote and all votes shall be taken orally.

5.5   Amendments:

a. Any Commission member has the right to offer amendments to proposed bylaws, policies, and procedures.

b. The Commission member shall submit amendments with the page and line number of the proposed bylaw, policy or procedure to be amended at least fourteen (14) days prior to the next meeting of the Commission. The Chair can accept oral amendment as long as the amendment is well understood by all Commission members and a record of the amendment has been made in the meeting minutes.

c. Amendments must not conflict with county code or county ordinances.

5.6   Strategic Plan:

a. A strategic plan should be developed on a biannual basis to give the Commission an opportunity to establish goals, objectives along with action steps to aid in achieving those goals for the next Commission year. Changes can be made throughout the year with approval from the Commission.

b. The Commission at the scheduled July meeting will look over the current strategic plan to delete completed goals, carry over goals that still need to be completed into the following year, or to add any new goals of the Commission.

c. The strategic plan should be created in a table format with goals, objectives and action steps clearly stated. Also, responsible parties and completion dates for all action steps should be stated in the table.

d. The strategic plan will contain appendices that should include but may not be limited to; a YCHRC member list, Your County Ordinance, YCHRC timeline, meeting dates for the next year(s), YCHRC and YCHRC organizational charts.
e. A draft of the strategic plan should be presented and approved no later than the scheduled July meeting and the final strategic plan should be presented at the October meeting.
f. Once the strategic plan has been approved the Commission should present the plan to all current and possible future funders.

6.   FINANCIAL REQUISITES

6.1   Budget Process:

a. A budget should be developed annually to meet the operational and service needs of the health resource center and Commission.

c. Before July 1st the old budget shall be reviewed for any items that will need continued funding. New budget items may be added and a draft shall be prepared for presentation no later than at the July meeting.

d. The budget should include but may not be limited to; budget items, a brief description of budget items, budget amount for budget items or in kind donations, and whenever possible funding sources.

e. The proposed budget for the upcoming fiscal year should be presented and approved no later than at the scheduled July meeting of the current year, so that adequate time will be allotted to request for funding if needed.

6.2   Funding Request:

a. If funding is going to be requested from any entity outside the YCHRC, the Commission should plan to present the finalized budget at the meetings of all entities in which funding will be requested.

b. The YCHRC should contact the entity and ask to be placed on the agenda to present the YCHRC budget and request funding.

c. At least one Commission member should be identified and placed on the agenda as the person who will be presenting the budget.

d. If necessary, a budget packet may be included. The packet should consist of at least but not limited to a cover letter and a copy of the budget. Additional supporting documents for the Commission or health resource center may also be included, such as letters of support from providers, organizations or clients.

6.3   Expenditures:

a. Any purchases for the Commission or the resource center require a Your County Requisition/Purchase Order Form from the County Auditor's office.

b. The form must be filled out and signed by the Executive Director and then faxed to the Auditor's office.

c. The Auditor's office places the order and it is delivered to the resource center.

d. If purchases are made that need to be reimbursed to an individual, a Reimbursement Form **(Appendix G)** should be submitted following the same procedure as the Requisition/Purchase Order Form.

_____

Date

Commission Member/Guest

Address

City, State Zip

Dear:

This letter is a reminder that there will be a meeting of the Your County Health Resource Commission meeting on **Date** at **Time.** We will be meeting in **Room** at **Place.**. Dinner will be served.

At the meeting we will be (major planned activities lis – e.g., reappointing members, discussing the Strategic Plan, receiving updates on the ORPH Grant, discussing HIPAA training and the Open Meetings Act training, planning for Volunteer Appreciation, and considering collaboration with the Your County Community Coalition.)

Please RSVP by Date with _____ at (###) ###-####. If you have any questions or concerns please feel free to contact _____. Thank you again for your time and commitment to the YCHRC.

Sincerely,

First Name and Last Name

Your County Health Resource Commission Chair

Your County Health Resource Commission

Your County Annex

Date - Time (a.m./p.m.)

<u>SAMPLE Meeting Agenda</u>

   I.   Call to Order (Title and First Name and Last Name)
           A. Introductions

  II.   Review Commission Members (Title and First Name and Last Name) (**Action Item**)
           A. Offices
           B. One Year Terms

 III.   Review of Previous Date YCHRC Meeting (Title and First Name and Last Name)
           A. Approval July 23rd Meeting Minutes – note changes (**Action Item**)

 IV.   Announcements (Title and First Name and Last Name)
           A. Update on Facility
           B. Service Update Title and First Name and Last Name)
           C. Article Update

  V.   YCHRC Strategic Plan Update (Title and First Name and Last Name) (**Possible Action Item**)
           A. Present
           B. Review Progress
           C. Updates

 VI.   Funding (Title and First Name and Last Name)
           A. Budget Update
           B. Funding Options/Sources
           C. Non-Profit

VII.   ORHP Grant (Title and First Name and Last Name)
           A. Update
           B. PowerPoint Presentation

VIII.   Case Management (Title and First Name and Last Name)

IX. HIPAA (Title and First Name and Last Name) (**Action Item**)

X. Open Meetings Act (Title and First Name and Last Name) (**Action Item**)
    A. Certification by next meeting

XI. Open House (Title and First Name and Last Name) (**Action Item**)
XII. Volunteer Appreciation (**Action Item**)

XIII. Consideration to Collaborate with LCCC (**Action Item**)

XIV. Next Steps (Title and First Name and Last Name)
    A. Next Meeting January 21st 2008

XV. Adjourn (Title and First Name and Last Name) (**Action Item**)

Meeting Materials

Agenda

LAST Meeting Minutes

List of One Year Term Members

Service Update

YCHRC Strategic Plan

Ordinance/Bylaws

Policies & Procedures Manual

Your County Health Resource Commission Meeting Template

(M/T/W/Th/F/S/Su), Month, Day, Year

Time (am/pm)

SAMPLE Meeting Minutes

Meeting Attendees (list):	Guests (list):
First name Last name	First name Last name
Ex-Officio (list):	Staff (list):
First name Last name	First name Last name

The Your County Health Resource Commission met (date, time, and place). The following are the minutes of the meeting.

Call to Order

At *TIME*, Executive Director, Title and First Name and Last Name, called the meeting to order, then turned it over to Chair, Title and First Name and Last Name, who after thanking Executive Director, introduced current members, new members, and guests.

Review Commission Members

Executive Director explained that officer terms had expired and they needed to re-elect officers. Since no interest was expressed by current members to appoint new officers, Commission member 3 made motion that the officers be reappointed by acclamations. Secretary seconded the motion. The motion was approved unanimously. Executive Director explained to members that the one year term members need to be reappointed and the new members to be approved. The current and new members were read to the group. Executive Director made a motion to approve the new members and reappoint members with expired terms. Commissioner Member 1 seconded the motion. The motion was approved unanimously.

Review of July 23rd YCHRC Meeting

Commissioner Member 1 asked the commission to review the minutes from the July 23, 2007 meeting. It was noted that there were a few misspellings. Commissioner Member 2 made a motion to accept the

minutes with changes. Commissioner Member 3 seconded the motion. The motion was approved unanimously.

Announcements

Executive Director gave an update of the YCHRC facility. He reported that the parking lot still needed to paved and the county is currently waiting on bids because the first set of bids came back to high. The city is also working to improve the road to the center. They have already completed one culvert and plan to complete a second culvert once the weather clears. The Mayor also mentioned he put in for a contract out for someone to pave the street at night. Executive Director also brought up the sound issue at the center. Currently there is not enough insulation at the center and conversations can be overheard. The group discussed possible solutions and it was decided a sub-committee would be appointed to look at available options. Office Manager gave an update on the service numbers from the YCHRC. For the 2006-2007 fiscal year the center had 1,524 encounters of which 539 were unduplicated clients. The center also delivered 273 rides and 539 information and referrals. Commissioner Member 2 also mentioned that she was still working with Commissioner Member 3 on the article for the newspaper.

YCHRC Strategic Plan Update

Executive Director presented the Strategic Plan to the commission. Commissioner Member 2 then explained YCHRC Policy and Procedure Manual and its components and asked commission to please review them before the next meeting. Executive Director asked Commissioner Member 3 to appoint a sub-committee to review the manual. No action was taken.

The group broke for dinner. As members finished their meal Executive Director gave a PowerPoint presentation during dinner explaining what services the commission and the YCHRC provide as well as plans for the future.

Funding

Executive Director asked Commissioner Member 4 to report on the spending from grant funds so far. Commissioner Member 4 explained that the grant was for 3 years and each fiscal year fan from May 1st to April 30th. Commissioner Member 3 asked if the funding could rollover from year to year. Commissioner Member 4 explained the 25% of the grant can be carried over from year to year but county funds had to spend in that fiscal year. Executive Director explained the options for future funding. One of which was the possibility of developing a county-wide or regional non-profit organization. This would allow the group to access donations and grants. Commissioner Member 4 also discussed the possibility of the county accepting tax deductible donations. Executive Director explained that he would bring more information at a future meeting.

ORHP Grant

Commissioner Member 2 gave an update on the progress of the mental health project associated with the ORPH grant. Currently the Center for Community Health Development and the Counseling and Assessment Clinic were working to finalize a protocol that would be used in the service delivery. They were also looking into the options for telehealth and T-1 line installation. She also reported the potential use of a service coordinator to provide assistance with the mental health services as well as

case management. Currently Your County, County 2, and Hospital were discussing the possibility of partnering to hire a service coordinator to work in both counties. Part of the coordinators duties would include assisting with the telehealth services.

HIPAA

Commissioner Member 3 asked Commissioner Member 2 to explain what she had found out regarding HIPPA training. Commissioner Member 2 stated that she is still working to find out more information and resources to be able to HIPAA train volunteer drivers for no charge by the end of the year. Physician volunteered to train drivers at her clinic because she has already done so with her staff and still has resources available. Office Manager agreed to work with Physician to arrange the training. No action was taken.

Open Meetings Act

Executive Director stated that all commission members need to be trained and certified through the Open Government training on the Texas Attorney General's website. Any members who do not have access to a computer need to contact Commissioner Member 5. No action was taken.

Open House

Commissioner Member 6 explained that the sub-committee decided Open House should be postponed until the parking lot has been finished to ensure parking and weather are not an issue. No action was taken

Volunteer Appreciation

Commissioner Member 5 explained that she was working with Commissioner Member 3 to plan an appreciation for the volunteer drivers. A luncheon was set for Monday, October 29th at Commissioner Member's 3 house to recognize the volunteer drivers. Commissioner Member 3 will be donating a meal and anyone who would like to attend should speak with Commissioner Member 5. No action was taken.

Next Steps

Commissioner Member 3 asked the service providers at the meeting to explain their services to the new members. Program Organizer 1 from Rape Crisis and Program Organizer 2 from STAR both shared information on their organizations. Commissioner Member 3 also discussed with the nurses from the clinic that a full-time PA would be starting at the clinic on December 1st. The eligibility requirements for the clinic were also discussed.

Commissioner member 7 asked about the spending of the grant funds. Commissioner Member 4 explained that the amounts spent are specifically laid out. Executive Director suggested a handout be made and distributed at the next meeting which explains the money spent so far. Executive Director also stated that there will be photos taken of the commission at the next meeting on ***Date.***

Adjourn

Commissioner Member 3 stated that the meeting could now be adjourned. Commissioner Member 6 made a motion to adjourn. Commissioner Member 7 seconded the motion. The motion was approved unanimously.

Your County Health Resource Center

Strategic Plan

From Date to Date

Title, First Name, and Last Name

Chairperson

The Purpose

The purpose of the Your County Health Resource Commission (YCHRC) is to assist the Your County in establishing access to health resources and to provide oversight for the operations of the Your County Health Resource Center (YCHRC). Since its establishment in ***Date***, the YCHRC has met multiple times to organize; elect a chair, vice chair, and secretary/treasurer; and set rules for conducting business. The Commission has also established a Space Committee that has worked with the county to secure additional space for expansion of the YCHRC. The newly acquired space has been renovated to improve existing services and the center now consists of both a clinic and a resource center. The YCHRC has diligently worked to meet their mission – "*to improve access to care and the health status of Your County residents through collaboration and coordination of services".*

Thus, the YCHRC Strategic Plan is presented in this document, including the YCHRC goals and objectives that we aim to meet within the next year. Additionally, supporting documentation is provided through several appendices. We will review the plan at least on a quarterly basis and make amendments as necessary as we proceed into the future development of the YCHRC with our Strategic Plan as our guide.

On behalf of the YCHRC, I am pleased to present the Your County Health Resource Center Strategic Plan for Month and Year through Month and Year.

Title and First Name and Last Name

YCHRC Chair

The Priorities

Through discussions at monthly meetings, Your County Health Resource Commission (YCHRC) members have identified strategic priorities to work towards accomplishing in the coming year.

Section I – Commission Leadership & Organization

Goal: Based upon established bylaws and historical, common practices, the commission will formally develop commission policy and procedures.

	Objective	Anticipated Completion Date
1.	**Determine support staff that will assist the commission with meeting procedures (i.e. agenda development, minute writing, and assure compliance with the Open Meetings Act).**	**Month and Year**
2.	**Develop and working budget for the commission and center that includes supplies, staff time, services, and facility costs.**	**Month and Year**
3.	**Develop a commission operational policy and procedure manual to guide the commission's activities.**	**Month and Year**
4.	**Establish process to provide quarterly and yearly reporting on service data, general resource center information, and commission progress to the commission, center service providers, funders, and the Your County community.**	**Ongoing** **Month and Year**

Section II – Center Management and Services

Goal: Further develop and promote the services available at the Your County Health Resource Center (YCHRC) to better serve the residents of Your County.

	Objective	**Anticipated Completion Date**
1.	**Begin offering telehealth for services to Your County residents.**	**Month and Year**
2.	**Develop a plan to secure necessary resources and to implement case management/service coordination into the YCHRC.**	**Month and Year**
3.	**Further investigate various abuse concerns (i.e. substance abuse and alcohol, domestic violence, and child and elder abuse) of Your County residents and increase the availability of prevention and counseling services available to address abuse issues in the county.**	**Month and Year**
4.	**Increase promotion of the YCHRC and its services throughout Your County through outreach and promotional materials, events, and speaking engagements.**	**Ongoing** **Month and Year**
5.	**Implement Office of Rural Health Policy's Rural Health Network Development Grant. Increase access to**	**Ongoing**

		Month and Year
	specialty care and mental health services through telehealth.	

Section III – Evaluation and Data Collection

Goal: Evaluate the center's activities and adjust strategy as necessary to meet the commission's mission to increase access to services and improving the health of Your County residents.

	Objective	Anticipated Completion Date
1.	Determine data to be collected for review by the commission; monitor data/ develop process to make adjustments as necessary and provide feedback to center staff and service providers.	Ongoing Month and Year
2.	Monitor and document the progress of the commission strategic plan.	Ongoing Month and Year
3.	Work with the Regional Health Partnership to establish a comprehensive evaluation strategy regarding the improvement of health status.	Month and Year

The Promise

The Your County Health Resource Center Strategic Plan document discusses the history, communicates the efforts, and expresses the goals and objectives of the Commission for the coming years. In addition, the plan is intended to extend a promise to the Your County community that the Your County Health Resource Commission will commit its resources—leadership, time, talent, financial assets, in-kind donations and more—to provide Your County residents the opportunities to improve their overall health status.

Contact Information for YCHRC

Name & Title	Contact Information
Title, First Name, Last Name YCHRC Office Manager	YCHRC Street Address City, State Zip Code (###) ###-####
Title, First Name, Last Name YCHRC Executive Director	c/o YCHRC Street Address City, State Zip Code (###) ###-####

Appendix D: Example CHRC Logic Model

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACTS
• Leon Healthy Families Network • Leon County Health Resource Commission • Leon Health Resource Center • Success of previous network in developing sustainable services to meet local needs • 2010 Health Assessment • Relationships with BVHP, TAMU, and CCHD • Existing telehealth infrastructure • Community engagement and support • Strong county leadership	Identify and invite additional partners Implement regular communication with network partners and community Receive technical assistance in planning and implementation Identify existing DV and SA resources and services for Leon County residents Establish referral networks with service providers, law enforcement, and judicial Get service coordinator trained to provide classes in anger/stress/financial management and parenting Promote and offer classes Connect victims to resources and coordinate services Identify and develop additional services to prevent domestic violence (i.e., respite care) Establish substance abuse screening services within Leon County Provide referrals and resources for substance abuse treatment Offer substance abuse counseling via telehealth	# partners participating Frequency/channels of communication Amount & types of TA Resources identified Referral networks established orgs participating # topics service coordinator certified to offer # classes offered # participants Sources of referral # clients served # and type of new services developed Screening program established # referrals by agency # clients treated	Increased communication, coordination, and relationships among organizations serving Leon County residents Increase access to timely, accurate information Increase Leon County's capacity to address local health issues Decreased incidence/recurrence of domestic violence Increased awareness of issues and services available Increased access to services Decrease in family triggers that result in violence/alcohol abuse Increased use of coping skills Increased proportion of substance abusers who receive treatment	Development of a sustainable network to address domestic violence and substance abuse in Leon County Decreased impact of domestic violence on Leon County families Decreased abuse of alcohol and other drugs in Leon County

EVALUATION

Operational Handbook Template

The CHRC advisory board/commission is responsible for the oversight of the CHRC. As such, the commission and the CHRC Executive Director should develop an operational handbook to document operational procedures to be followed by all CHRC staff and provider organizations that offer services at the CHRC.

This manual is intended as a reference for daily operations of the CHRC, but it should be noted that the Executive Director will review this handbook on a quarterly basis and update as necessary and appropriate. All changes to the handbook will be approved by the CHRC commission. Any changes to this handbook will be forwarded to all staff and all service providers immediately upon the completion of the revision. Every attempt will be made to ensure that accurate and up-to-date information is provided for persons using this handbook.

Throughout this template, the term "Your Community Health Resource Center" is used and should be replaced with the name of your CHRC.

COMMUNITY HEALTH RESOURCE CENTER OPERATIONAL MANUAL

Your Community Health Resource Center

Your Community Health Resource Center

Street address

City, State, Zip

(xxx) xxx-xxxx Phone

(xxx) xxx-xxxx Fax

CHRC Executive Director

First and Last Name

Phone: (###) ###-####

E-mail:

On-site Service Providers

(Alphabetized by Agency)

Name of Organization/Service Provider

First and Last Name

(###) ###-####

Email address

Other Regional Service Providers

General Information

Name of Organization/Service Provider   First and Last Name

                                              (###) ###-####

                                              Email address

Medical, Dental, and Prescription Assistance

Name of Organization/Service Provider   First and Last Name

                                                (###) ###-####

                                              Email address

Abuse

Name of Organization/Service Provider   First and Last Name

                                                (###) ###-####

                                              Email address

Clothing and Food

Name of Organization/Service Provider   First and Last Name

                                                (###) ###-####

                                              Email address

Rent and Utility Assistance

Name of Organization/Service Provider   First and Last Name

                                                (###) ###-####

                                              Email address

Shelter & Housing

Name of Organization/Service Provider   First and Last Name

                                                (###) ###-####

                                              Email address

Senior Services

Name of Organization/Service Provider   First and Last Name

                                                (###) ###-####

                                              Email address

Children and Youth Programs

Name of Organization/Service Provider   First and Last Name

                                                                                (###) ###-####

                                                                                Email address

Miscellaneous

Name of Organization/Service Provider   First and Last Name

                                                                                (###) ###-####

                                                                                Email address

Your County Health Resource Commission Members

Title and First Name

Last Name

Address

City, State Zip Code

(###) ###-####

Title and First Name

Last Name

Address

City, State Zip Code

(###) ###-####

OPERATIONAL PROCEDURES

OVERVIEW OF THE CHRC

Introduction

The Community Health Resource Center (CHRC) was established as a place where Your County residents could receive assistance in accessing a wide variety of healthcare services. The concept behind the CHRC is to provide a single point of access to a variety of healthcare service providers. The CHRC, began serving Your County in xxx of 20xx.

CHRC Mission

"To improve access to care and the health status of Your County residents through collaboration and coordination of services." (Replace with Your County mission statement)

CHRC Office Personnel

The CHRC is a facility that is owned and operated by _____. The daily operations of the CHRC will be overseen primarily by the Office Manager (OM), who will work closely with the CHRC Executive Director, the Your County Health Resource Commission (CHRC) Chair, and the CHRC Vice Chair to ensure that the center is operated in a manner that enables the fulfillment of the CHRC mission. Additionally, the OM will work with the service providers to coordinate practical aspects of the CHRC such as hours of operation, client scheduling, etc.

CHRC Office Manager

The Office Manager (OM) will be in charge in the absence of the office clerk of the initial client encounter and oversight of daily operations of the CHRC. This will include answering the phone, greeting clients as they enter the CHRC, ensuring sign-in and other paperwork is completed, and directing client flow through the CHRC. The OM will help assist clients with questions and scheduling for future appointments. The OM plays an integral part in establishing a good relationship between CHRC staff and clients. The OM will also aid the CHRC in collecting the necessary data for evaluation purposes. For a complete list of the OM duties, see the Appendix B of this Handbook.

CHRC Vice-Chair

The CHRC Vice-Chair will be responsible for assisting OM with day-to-day problems and situations that may come up.

CHRC Executive Director and CHRC Chair

The Executive Director and the CHRC Chair are responsible for the support, technical assistance and coordination of the various services that are provided at the CHRC. The Executive Director and the CHRC Chair need to have a thorough understanding of the types of services offered by each of the participating providers as well as other available resources in the community.

CHRC Project Coordinator

The Project Coordinator will be responsible for the day to day operations of the Your Health Access Network. The Project Coordinator will provide technical assistance to Project Director for management of project activities; coordinate outreach efforts to local physicians; work with Project Director and Network to develop and implement the referral network, voucher program, and other relevant activities; coordinate specialty care voucher program; maintain office documentation as required; work with Project Evaluator to collect needed data for project evaluation.

CHRC Service Providers

Office space is allotted to service providers by Your County Health Resource Commission (CHRC) in order to facilitate access to healthcare services by CHRC clients. Service providers are individually responsible for ensuring that CHRC clients are offered professional, high-quality services.

PUBLIC RELATIONS

Community Outreach

- The CHRC is responsible for outreach activities that promote the CHRC. This includes attending community meetings, recruiting additional agencies to participate in the CHRC, building community support, and promoting CHRC services to residents in Your County.
- Service providers are encouraged to arrange and attend meetings within the county as necessary to promote the CHRC and all organizations providing services.
- Service providers are asked to keep track of local meetings and/or outreach events in which they speak or present information regarding their program or organization and the CHRC. Providers are asked to provide to the OM the date, type of event, and number of people in attendance at the event. The OM recorded on an Outreach Event Log Sheet, which is discussed in Section Three: Service Provider Procedures.

Public Statements

Media

The CHRC strives to maintain a positive and visible presence Your County. Broadcast and print media outlets, such as radio, television, and newspapers, can aid in accomplishing this goal. All requests to respond to media outlets should be referred to the CHRC Executive Director or the County Judge.

Public Speaking Engagements

Service providers are encouraged to participate in speaking engagements. Speaking engagements include presentations at civic organizations, churches, city council meetings, commissioners' court meetings, hospital board meetings, school functions, etc.

Complaints

General complaints about the CHRC, such as scheduling, services offered, facilities, etc. should be handled by the OM with every attempt made to resolve any immediate issues such as scheduling complaints or messages that have not been delivered. If more intervention is necessary, the OM will inform the CHRC Executive Director or the CHRC Vice and/or Chair who will then decide on the appropriate action.

- Complaints made against the OM should be referred to the CHRC Executive Director or the CHRC Vice and/or Chair.
- Complaints against a service provider should be referred to the CHRC Executive Director or the CHRC Vice and/or Chair who may, if appropriate, contact the executive director of the service provider's organization.

Client complaints about the CHRC in general or any individual associated with the CHRC should be handled in a professional and timely manner. All complaints made by clients will be tracked by the OM on the CHRC Notice of Complaint log (Appendix C).

SERVICE PROVIDER PROCEDURES

The following is a general guide for operational duties for the service providers that work at the CHRC facility as well as other service providers that utilize the facilities. This is intended to be a supplemental guide for specific CHRC functions. Service providers will be expected to utilize this guide in conjunction with the established protocols of their individual organizations.

Potential CHRC Service Providers

If the CHRC Office Manager (OM) or a CHRC service provider is approached by another service provider about utilizing the CHRC either on a regular, itinerant or one-time basis, the service provider should be referred to the CHRC Executive Director or the CHRC Chair. Upon referral, the CHRC Executive Director or the CHRC Chair will follow the Process for New Service Providers, (Appendix D), to make arrangements for the potential service provider to operate out of the resource center.

New CHRC Service Providers

Once a service provider has established their commitment to the CHRC by signing the CHRC Facility Use Agreement, (Appendix E), and participating in the CHRC Protocol Training, the CHRC Office Manager will work with the service provider to determine the availability of space in which the service provider may operate at the CHRC.

Service Provider/CHRC Support and Communication

- Primary operational support for CHRC service providers will be provided by the CHRC OM. This includes scheduling appointments, including transportation, reception and data collection as appropriate. The OM is not responsible for mail-outs, faxes and copying on behalf of service providers, but may assist service providers in any capacity to facilitate operation of the CHRC mission.
- Each service provider will provide the CHRC OM with a valid e-mail address for use as the primary method of communication.
  - This e-mail account must be checked by the service provider on a regular basis.
  - Service providers will provide a cell phone number to the OM so that urgent messages, such as schedule changes, may be reported in a timely manner. Additionally, service providers should provide contact information for their organization's "headquarters" as well.
- Service providers will receive phone messages daily from the OM.
  - If the service provider is present at the CHRC at the time of message retrieval, messages will be given in writing as soon as possible.
  - Otherwise, messages will be written and placed in the provider's folder located next to the copy machine. If a message is sensitive or urgent, the provider will be called and given the message immediately.

Provider Schedule

- Service provider hours are posted as public information. Monthly schedules should be submitted to the CHRC Office Manager on the 15th every month for the subsequent month so that the CHRC Calendar for the subsequent month can be disseminated by the 20th of each month. For example, service providers should forward their June schedules on May 15th so that the CHRC Calendar for June can be printed by May 20th to be posted and distributed.
- Service providers should establish and keep regularly scheduled hours at the CHRC to the extent possible. *The CHRC OM should be notified as soon as possible of any changes in the provider schedule.*
- **If a service provider is unable keep a scheduled appointment, they should contact the OM as soon as possible so that client appointments can be rescheduled. If it is after business hours, they should leave a message at the CHRC. If they need immediate assistance they should contact the CHRC Executive Director.**

Liability

It is the responsibility of the individual service providers to carry liability insurance that covers services provided while using the CHRC facility.

Data Provision

The service providers will maintain records on their individual clients in a manner that will facilitate the accurate tracking of services provided to clients associated with the CHRC.

- **Encounter Log**
  Service providers will utilize the Encounter Log (Services Log, Group Services Log, and Information & Referral Log; Appendix F) to record client encounters and the nature of the service provided. Copies of the Encounter Logs are located in the Appendices Section of this Handbook.

  Service providers may also see CHRC clients away from the CHRC facility.

- **Outreach Event Log**
  Service providers should keep track of meetings and/or outreach events to enable adequate tracking for evaluation. The date, type of event, and number of people in attendance should be recorded on an Outreach Event Log. (Appendix G) Once completed, this log sheet should be provided to the CHRC OM. Blank copies of the log sheet may be obtained from the OM or the OM can e-mail the electronic file upon request.

CLIENTS

Client Relations

- The client will typically speak first to the PARTNER AGENCY Office Clerk upon arriving and last to the office clerk before leaving the CHRC. This first and last impression is a pivotal part of the care delivery model. The most important role of the OM is to facilitate the needs of the resource center clients. This general role will reduce the overall workload of the service providers.
- Each CHRC service provider will offer services to CHRC clients as documented in the CHRC Facility Use Agreement (FUA). To view the FUA, refer to Appendix E.

Client Referrals

- The referral process is important to the overall effectiveness of the CHRC. When appropriate, every attempt should be made by CHRC service providers to refer clients to other CHRC service providers to ensure a continuum of care.
- All referrals should be tracked by the service providers and this information will be tracked by the service provider who refers the client. A referral form for the CHRC is available. Referrals will be useful in the evaluation process of the CHRC and its impact on the community. The CHRC Referral Form is Appendix H.

Eligibility for Services

- Determining client eligibility for services is primarily the responsibility of the individual service provider. The service providers should submit basic eligibility requirements to the OM as information that can be distributed to potential clients in the event that the service provider is not available or is not present at the time of inquiry.

Scheduling Client Appointments

- Client appointments should be scheduled by the service providers. Each service provider should only schedule appointments for themselves.
- Service providers should notify the OM as to whether they will accept "walk-ins" or will see clients by appointment only.

Client Encounters/Record Keeping

- A record is kept of all CHRC client activity. It is important that records are complete and accurate.
- The CHRC Executive Director or the CHRC Vice and/or Chair is ultimately responsible for ensuring that the daily log is current and accurate and will generate monthly reports that reflect client volume and encounters at the CHRC; however, the OM and/or service providers will actually collect the information that is recorded in the daily log.

- When a client visits a service provider at the CHRC, the OM will be in charge of client registration. It is important that complete and accurate information is obtained for every CHRC client on a sign-in sheet. See Appendix I for a sample of the CHRC Sign-in Sheet.
    - Clients are required to enter personal information on the sign-in sheet. For confidentiality purposes the sign-in sheets are individual and once completed should be treated as confidential and filed in a locked cabinet.
    - The sign-in sheet can be printed from the OM's computer. It is located in C:\My Documents\Client information sheet.doc
- The OM is responsible for transferring client information from the sign-in sheet to the Daily Activity Report (Appendix F).
    - The Daily Activity Report is an Excel spreadsheet and is saved on the OM's computer in C:\My documents\CHRC\monthly reports\CHRC daily log.xls

Client Confidentiality

- The OM will oversee the safe storage of sensitive records and documentation and ensure that the items are secure. The OM, CHRC Executive Director, and the CHRC Vice and/or Chair will have access to the locking file cabinet located in the OM office.
- Individual service providers will be responsible for keeping client files in a secure location. The OM will not be responsible for client files, only sign in sheets and encounter logs.
- Any sensitive records that are not filed or do not need to be kept will be shredded by the OM.
- Confidentiality protocol and HIPAA Laws will be adhered to as individual organizations assist clients.
- Consent should be obtained by the client prior to sharing information with other service providers.

CHRC FACILITY

Overview

- CHRC service providers will have office space to enable private consultation with their clients. The CHRC Office Manager will assign office space according to past schedules and will change provider's space when scheduling conflicts arise.

Office Equipment

- The CHRC is equipped with basic office equipment that is available for use by service providers. This equipment includes a multi-function copier/printer/fax/scanner, and a document shredder.
- For assistance with any of the CHRC office equipment see the OM, or the corresponding equipment manual (all manuals are located in the filing cabinet in the reception area). The OM should be notified as soon as possible if any problems with any of the CHRC office equipment. Repairs or maintenance will be ordered as necessary. **Only the OM will be responsible for changing toners or cleaning machines owned by Your County.**
  - The fax machine is part of the multifunction unit located in the OM's office. The fax machine uses its own phone line. Send faxes using the same procedure as making a phone call. (Refer to procedure under the "Telephone" in this section of the protocol.)
  - No action is required to receive a fax. The fax line and phone line have two distinctive rings therefore; you are able to distinguish between an incoming phone call and an incoming fax.
- The document shredder is located in the OM's office. **Please do not feed more than five sheets of paper at one time.**

Keys

- The OM will supply PARTNER AGENCY Office Clerk, PARTNER AGENCY Nurse, PARTNER AGENCY Doctor, County Judge, and the Executive Director with keys to the front and back doors of the CHRC. Lost keys should be reported to the OM. Any fees to replace the lost keys will be the responsibility of the organization and not the CHRC. The OM will maintain a log of all distributed keys.
- The offices within the CHRC remain unlocked; therefore, keys for the individual offices are not required however, the OM's office will be locked when OM is not in the office.
- If an organization decides to stop providing services from the CHRC then their keys should be turned into the OM upon vacating the office space. Additionally, if a service provider representative has been terminated, it is the responsibility of the executive staff of the organization to obtain the CHRC key from the terminated employee and return to the CHRC OM. If the key of the terminated employee is not returned to the OM, the responsible organization will pay to have the CHRC locks changed.
- If a service provider will need to use the CHRC after hours arrangements must be made with the OM prior to that day.
- All doors will remain locked after hours even if someone is in the facility.

Storage

- Service providers will be given enough storage space for adequate record keeping and to facilitate daily CHRC operations.
- Service providers needing to securely store client records will need to provide their own locking filing cabinet.

Mail

The mailing address for the CHRC is:

> Community Health Resource Center
>
> Address
>
> City, State Zip Code

The Physical address for the CHRC is:

> Community Health Resource Center
>
> Address
>
> City, State Zip Code

Telephones

- Telephones in the CHRC are located in the reception area and in each office.
- Service providers will have access to a phone system. Each of the offices within the CHRC is equipped with a phone.
  - The main CHRC number is: (###) ###-####.
  - These telephones can be utilized for local calling, toll free (800) calls, and calling card calls (*no* long distance calling). If a long distance call is necessary, please use your personal or your work cell phone.
  - To answer the phone, simply lift the handset.
  - To make outgoing calls, simply lift the handset, dial "9" and then dial the desired number.
  - All calls placed to locations outside of Your County require a three digit area code before dialing the number. These are not long distance calls if "1" is not dialed before the area code.
  - The telephone system is equipped with an intercom which can be used to call any other phone within the CHRC. To use the intercom, lift the handset and press the button (at the top right portion on the phone) that corresponds with the desired location within the CHRC.

Internet

- Internet access is proved via a wireless router by Valor. See the OM if you experience difficulties accessing the Internet within the CHRC.

Personal Equipment

- The CHRC service providers are responsible for providing office equipment necessary to perform their job duties. The equipment includes a computer or laptop, printer, and furniture.
- Service providers should also provide supplies, such as folders, hanging files, post-it notes, copier/printer paper, etc. These supplies can be stored in the storage closet if needed.

Opening and Closing the CHRC

- The CHRC hours of operation are from 8:00 AM – 12:00 noon and 1:00 PM – 5:00 PM Monday through Friday. These hours are published for the public and someone must be at the CHRC constantly during these hours of operation.
    o From 12:00 noon until 1:00 PM each day, the OM will lock the doors, and post the "Be back at 1:00 PM" sign on front door. The OM will use this time for lunch. The CHRC phone is not answered during this hour.

- Opening procedure:
    o Unlock the front door
    o Turn on all lights
    o Adjust thermostat
    o Turn on computer and open daily log
    o Check answering machine and relay messages or take other necessary actions

- Closing Procedure:
    o Lock the front door
    o Save daily log and turn off computer
    o Ensure answering machine is turned on
    o Adjust thermostat
    o Turn off all lights

Holiday Scheduling

- Once holidays are established, a sign designating an upcoming holiday and office closure should be posted outside the CHRC Entrance and in the CHRC lobby as well as in each office **10 working days prior to the holiday.**
- **PARTNER AGENCY Holiday Schedule**
    o Tuesday, January 1, 2008- New Years Day
    o Monday, February 18, 2008- President's Day
    o Monday, May 26, 2008- Memorial Day
    o Friday, July 4, 2008- Independence Day

- o Monday, September 1, 2008- Labor Day
- o Thursday, November 27, 2008- Thanksgiving Day
- o Friday, November 28, 2008- Day After Thanksgiving
- o Wednesday, December 24, 2008- Christmas Eve
- o Thursday, December 25, 2008- Christmas Day

- **Your County Holiday Schedule**
  - o Tuesday, January 1, 2008- New Years Day
  - o Monday, January 21, 2008- Martin Luther King Day
  - o Monday, February 18, 2008- President's Day
  - o Friday, March 21, 2008- Good Friday
  - o Monday, May 26, 2008- Memorial Day
  - o Friday, July 4, 2008- Independence Day
  - o Monday, September 1, 2008- Labor Day
  - o Monday, October 13, 2008- Columbus Day
  - o Tuesday, November 11, 2008 – Veterans Day
  - o Thursday, November 27, 2008- Thanksgiving Day
  - o Friday, November 28, 2008- Day After Thanksgiving
  - o Wednesday, December 24, 2008- Christmas Eve
  - o Thursday, December 25, 2008- Christmas Day
  - o Friday, December 26, 2008- Day After Christmas
  - o Wednesday, December 31, 2008- New Years Eve Day

Emergency Situations

- In case of an emergency at the CHRC, 9-1-1 should be called. Emergencies should then be reported to the OM who will contact the CHRC Chair and the CHRC Executive Director as necessary.
- Please try to document emergency situations including the situation, those involved, the outcome, etc. once 9-1-1 has been contacted.

GENERAL RESPONSIBILITIES

Facility and Equipment:

1. Open the center at 8 am and prepare office for the day's activities as well as close the office at 5 pm
2. Responsible for ensuring all doors are locked at all times when staff is not in the building
3. Ensure the lobby is presentable for clients
4. Check mail at main hospital daily
5. Keep schedule on answering machine and door with updated hours
6. Turn off all equipment at close of business daily (except answering machine and fax)
7. Maintain all equipment for the center and inform the Executive Director when maintenance or replacement is necessary
8. Inform the Executive Director or Commission Chair if any necessary office supplies are low

Phone and Communication:

1. Answer the phone during regular business hours
2. Provide clients with necessary information about the center. (i.e. business hours, location, and available services)
3. When appropriate provide clients with referral information
   (i.e. phone numbers and locations of organizations, eligibility for organizations, and availability of organizations)
4. Follow up with organizations assisting clients
5. Ensure the answering machine is on when away from the phone
6. Check answering machine messages at opening and regularly throughout the day
7. Check email at opening and regularly throughout the day

Clients:

1. Greet clients and provide information
2. Attend to general client need and refer to other organizations/ services when appropriate
3. Answer questions and provide literature for those needing information
4. Provide translation services when needed for Hispanic clients
5. Assist clients with Medication Assistance computer

Service Providers:

1. Schedule client appointments
2. Notify providers of upcoming appointments
3. Occasionally provide assistance with office work and copy and fax documents
4. Deliver all phone, machine, and e-mail messages promptly via e-mail
5. Inform service providers on changes and updates
6. Serve as a liaison between providers and commission
7. Ensure all service providers adhere to the operational procedures for the center

Data Collection:

Example Office Manager Responsibilities

1. Ensure all clients fill out a sign-in sheet
2. *Transfer daily sign-in sheets to daily log and Q system*
3. *Keep accurate and organized files on clients and paperwork*
4. Continuously update the client and daily logs with accurate information
5. Provide monthly service reports to commission

Promotion:

1. Contact organizations and agencies to ensure all promotional items are fully stocked (i.e. brochures, flyers, etc.)
2. Fax promotion information to various businesses in the community
3. Update and redistribute promotional items when necessary

Commission:

1. Serve as staff to the County Health Resource Commission
2. Prepare meeting materials for Commission meetings (i.e. Meet with Chair and Vice chair prior to meeting, develop agenda, copy and distribute all meeting materials)
3. Email meeting reminder to members 3 weeks prior to the meeting
4. Send out meeting notices and materials 7 working days prior to meeting
5. Deliver Commission meeting agenda to county 72 hours prior to meeting
6. Attend all Commission meetings
7. Write and report Commission meeting minutes to appropriate people

Interagency Meetings:

1. Maintain a relationship with all local service providers and organizations
2. Develop the agenda and meeting materials for the meeting
3. Email meeting reminder to members 3 weeks prior to the meeting
4. Send out meeting notices and materials 7 working days prior to meeting
5. Write and distribute minutes to appropriate people

SERVICE RESPONSIBILITIES

Transportation:

1. Take the initial request for a ride from the client and determine eligibility of client
2. Contact volunteers to find a driver willing to take the client
3. Schedule the date and time with both the client and driver
4. Complete necessary paperwork with client and driver
5. Schedule repair and regular maintenance of vehicle (i.e. oil change, tires rotation, and washing)
6. Serve as a liaison between the Commission and the Area Agency on Aging (administrator of the transportation program)
7. Maintain relationship with volunteer drivers and service providers

Example Office Manager Responsibilities

Information and Referral:

1. Work with clients to determine client's needs (i.e. utility assistance, childcare, health needs, or job training)
2. Research organizations relevant to client's needs
3. Either directly contact organizations or provide clients with necessary contact information
4. Follow up with organizations when necessary on client's behalf

Medication Assistance:

1. Ensure the computer is turned on daily and properly running for client's use
2. Provide necessary amount of paper to client for printing applications
3. Assist client with process if necessary
4. Monitor computer for improper use

Telehealth:

1. Schedule appointments with provider and Telehealth coordinator
2. Turn unit on and ensure the proper functioning
3. Ensure any necessary paperwork in completed

Process for New Service Providers

1. Obtain contact information for the interested service provider and forward information to the CHRC Chair and Executive Director.
   - Obtain office number, cell phone number, e-mail address, and the physical address of the provider's office.
   - Obtain above information from both the individual coming out to the CHRC and the executive director of the entity.

2. Upon obtaining contact information, CHRC Chair and Executive Director will meet with the agency's/organization's executive director and service provider to:
   - Provide an overview of the CHRC operations, the CHRC FUA and the CHRC.
   - Determine the agency's/organization's interest in providing services at the CHRC.

3. The Office Manager will develop Facility Use Agreement (FUA).
   - The FUA will *specifically* delineate the responsibilities of both the service provider and CHRC.
   - The CHRC Office Manager will obtain the organization's executive director's signature on the updated FUA solidifying the commitment of all parties involved

4. The CHRC Office Manager will provide information on availability of resource center space and the monthly schedule to the service provider.
   - Give service provider information regarding the layout of the available space they may utilize based on the CHRC schedule as well as the service provider's availability.
   - Provide service provider with the monthly schedule of the CHRC with its operating hours.
   - Address any needs that the service provider requests.
   - Give the service provider a set of keys to the CHRC and update the key log with the Office Manager.
   - Obtain service provider's schedule and add to monthly calendar.
   - The CHRC Office Manager should follow up with a letter or e-mail to the service provider detailing the verbal agreement regarding the service provider's schedule and the usage of CHRC space. This written correspondence should be carbon copied to the service provider's executive director and the CHRC Chair and Executive Director. A copy of this correspondence should be kept on file at the CHRC.

5. The CHRC Office Manager should then update contact information, service provider information, etc. in the CHRC Handbook and in the CHRC brochure.

Facility Use Agreement

Between

Your County Health Resource Commission

And

Your Health Resource Center Service Providers

This Agreement is entered into by and between the parties subsequently listed for the purpose of determining their respective participation in the Your Health Resource Center (YCHRC) and related activities.

I. Contracting Parties
Parties to this Facility Use Agreement (Agreement) are the Your County Health Resource Commission (YCHRC) and all Service Providers identified in each appendix of this document, hereinafter collectively referred to as YCHRC Service Providers.

All notices to parties under this Agreement shall be in writing and sent to the names and addresses as stated in each appendix of this agreement. Parties the Agreement (Agreement) may change such names and addresses by notification to the other, and any such change shall take effect immediately upon receipt of such notice.

II. Facility Use Agreement Term
The term of this agreement shall be one (1) year, beginning Month Day, Year and ending Month Day, Year, and may be renewed by mutual written agreement of the parties. Thereafter, the Agreement will be renewed on an annual basis, with the term beginning January 1 and ending December 31 of the same year.

III. Purpose
This Agreement describes an understanding between the YCHRC and the YCHRC Service Providers concerning their respective participation in the YCHRC. The YCHRC will consist of local and visiting providers that have agreed to contribute and share various resources within this network. The general purpose of this network is to provide coordinated service delivery of health and social services in a single location to residents of Your County for the purpose of improving access to care and overall health status. The location of the YCHRC is Address, City, State Zip Code. The office space, utilities, janitorial service, local phone service and Internet have been donated by Your County.

IV. Participation at the Your Health Resource Center
A broad range of participation by various service providers is strongly encouraged at the YCHRC. To encourage such participation, categories of participation and the associated responsibilities are outlined below.

A. YCHRC Affiliate

The YCHRC Affiliate is considered to be any service provider which does not offer services at the YCHRC but wishes to participate in various YCHRC activities. A service provider who chooses to sign this Agreement as an YCHRC Affiliate agrees to the following:

1. Affiliate will attend quarterly interagency meetings held at the YCHRC.
2. Affiliate will provide referrals to the YCHRC as appropriate.
3. Affiliate will distribute information about the YCHRC at their facilities.
4. Affiliate will provide contact information so that the YCHRC staff can add the affiliate to the YCHRC Service Provider mail and e-mail group for the purposes of disseminating information between the YCHRC, YCHRC Affiliates and YCHRC Service Providers.
5. Affiliate provides service information, e.g. brochures, to the YCHRC for distribution at the YCHRC.

In turn, the YCHRC staff will be required to provide the following:

1. Facilitate interagency meetings on a quarterly basis.
2. Disseminate YCHRC information to Affiliates, including a report regarding YCHRC services and Your County Health Resource Commission activities on a monthly basis.
3. Make referrals to Affiliate.
4. Distribute Affiliate information at the YCHRC.

B. YCHRC Service Provider

The YCHRC Service Provider offers services at the YCHRC as agreed upon in this Agreement. A service provider who chooses to sign this Agreement as an YCHRC Service Provider agrees to comply with the following items in addition to the specific agreement outlined in the appropriate organization appendix of this agreement.

1. Attend quarterly interagency meetings held at the YCHRC.
2. Make referrals to all YCHRC Service Providers and Affiliates as appropriate.
3. Provide contact information so that the YCHRC staff can add the service provider to the YCHRC Service Provider mail and e-mail group for the purposes of disseminating information between the YCHRC, YCHRC Affiliates and YCHRC Service Providers.
4. Provide data to YCHRC staff as specified in the YCHRC Protocol for the purposes of reporting and evaluation.
5. YCHRC Service Providers will arrange to provide all equipment and supplies needed to provide their services at the YCHRC.
6. YCHRC Service Providers agree to adhere to all YCHRC guidelines as set forth in the YCHRC Operational Manual, provided to YCHRC Services Providers upon signature of this Agreement.
7. Provide input into the YCHRC Communications & Outreach Plan and participate as available in promoting the YCHRC.

8. Agree to not utilize office equipment or related supplies of the YCHRC Office Manager in exchange for no facility usage charge.

In turn, the YCHRC Service Provider can expect the following:

1. YCHRC staff will facilitate quarterly interagency meetings.
2. Dissemination of YCHRC information to Service Provider, including a report regarding YCHRC services and Your County Health Resource Commission activities on a monthly basis.
3. The YCHRC Office Manager may schedule appointments and provide communication support on behalf of the YCHRC Service Provider if requested by the YCHRC Service Provider.

V.   Facility Oversight
The YCHRC will be managed on a daily basis by the Your County Health Resource Commission Chair, Vice Chair and Executive Director. Each of these designees may be contacted through the Your County Judge's office. The YCHRC Office Manager is a Your County employee who is directly supervised by the Your County Judge and/or his designee.

VI. Compensation
Any fee for services provided is collected at the sole discretion of each individual YCHRC Service Provider. All billing and collection activities for service provided are the sole responsibility of each individual service provider. Monetary compensation for services will not be shared among YCHRC Service Providers or the Your County Health Resource Commission.

VII. Expense Allowance
Each YCHRC Service Provider shall pay for its own fees, costs and expenses with respect to preparation to participate and actual participation in the operations of the YCHRC including attendance at service provider meetings, preparation of documents and travel.

VIII. Insurance/Liability
Each YCHRC Service Provider participating at the YCHRC is responsible for liability insurance of its own services and employees. Service providers shall provide a copy of the liability insurance to the YCHRC Chair.

IX.   Approvals
By signing the attached appendices as appropriate, all parties indicate that they agree with the statements contained in this Agreement. They will abide by the duties and roles outlined in this agreement, and will work together as contemplated herein. Furthermore, by the signatures attached, each partner agrees that any client data shared amongst the partners will be shared in accordance with HIPAA requirements.

COMMUNITY HEALTH RESOURCE CENTER

Activity Report for MONTH/YEAR

Information and Referral

WIS: Walk-ins for info, referral or service	0	# persons	0	NS: No-shows	0	# persons	0
WIN: Walk-ins, not related to info, referral or service	0	# persons	0	CM: Meetings	0	# persons	0
TCIS: Incoming Telephone Calls - Service related	0	# persons	0	PR: Presentations	0	# persons	0
TCIN: Incoming Telephone Calls - Not Service related	0	# persons	0				
TCOS: Outgoing Telephone Calls - Service-related	0	# persons	0				
TCON: Outgoing Telephone Calls - Not Service-related	0	# persons	0				

Total Requests for Information, Referral, or Service   0   **# persons**   **0**

(sum of service-related incoming calls and walk-ins)

Services

STAR Program

STRN: New Client	0	# of persons	0
STRE: Existing Client	0	# of persons	0

Rape Crisis

RCN: New Client	0	# of persons	0
RCE: Existing Client	0	# of persons	0

Audiology

AN: New Client	0	# of persons	0
AE: Existing Client	0	# of persons	0

BVCASA

BCN: New Clients	0	# of persons	0
BCE: Existing Clients	0	# of persons	0

County Indigent

Encounter Log Templates

		# of persons	
CIN: New Clients	0	# of persons	0
CIE: Existing Clients	0	# of persons	0
Office Manager			
OMN: New Clients	0	# of persons	0
OME: Existing Clients	0	# of persons	0

Transportation

TNC: New clients 1st trips	0	# of persons	0
TEC: Existing clients 1st trip of month	0	# of persons	0
TFU: Follow-up trips for existing clients	0	# of persons	0
Total number of clients transported this month	**0**	**# of persons**	**0**
Total number of trips provided this month	**0**	**# of persons**	**0**

Encounter Log Templates

Total New Client Service Encounters   **0**

Total Existing Client Service Encounters   **0**

Total Number Client Service Encounters (sum of service coordinated client visits, client trips, interagency visits)   **0**

Total Number Client Encounters (sum of Requests for info, referral, service, client visits by SC, client trips, interagency visits)   **1**

Date	Time	City	Code	Name of agency or person	# of persons	Action Taken
12/1/20xx		Your	TCIS	Doe, John	1	Called re: Medical Assistance. Needed info about local clinics.

Return on Community Investment Report
Madison Health Resource Center 2010-2011

Over the past eleven years, the Center for Community Health Development (CCHD) has worked with Brazos Valley communities to improve health status and increase access to care. Since late 2003, five health resource centers have been established in four rural Brazos Valley counties. During this time, CCHD has assisted each county in tracking how the health resource centers have been used. As this process has developed over time, more sophisticated information has been requested and collected from the counties and CCHD. This report will attempt to answer some of those requests and provide suggestions for future data collection that describe the benefits of the health resource centers to the community.

What is "return on community investment?"

In the corporate world, stakeholders are kept up to date on what their investments have produced in terms of number of people served or assisted by a specific project. However, a deeper evaluation is necessary to create a complete picture of what the investment has yielded. More than just number of people served, we aim to capture additional resources brought into each community through technical assistance, increased efficiency, and leveraged services. Other community benefits include health care cost savings, changes in use of health services, and improved quality of life.   The purpose of this report is to provide an analysis for your community on their investment in the local Madison Health Resource Center (MHRC) and the benefits received for those investments.

Total community investment was calculated using the health resource center's budget for the 2010-2011 fiscal year, which is defined as the period between October 1, 2010 and September 30, 2011. Total leveraged resources account for how the community's financial input was able to be used to acquire additional resources such as grants, in-kind services, donations, volunteer time, Center for Community Health Development staff time and program evaluation. Staff and student time was calculated as percent effort dedicated to county-level work multiplied by FY2010-2011 salaries or wages. Volunteer hours have been estimated by the Independent Sector to be valued at $21.79 per hour for 2011 (http://www.independentsector.org/programs/research/volunteer_time.html).

Madison County 2010-2011

Health Resource Center Services

Between October 2010 and September 2011, 3,425 units of service (not including provision of information and referrals or transportation rides) were provided at the Madison County Health Resource Center to 951 unduplicated clients. This is an increase from 211 units of service provided in the previous year. Services accessed include audiology, energy housing assistance (Project Unity), hospice, qualifying individuals for county indigent health care, educational events, legal aid, medication assistance, rape crisis counseling (SARC), Scotty's House, senior meals, service coordination, substance abuse treatment services (BVCASA), transportation, counseling and skills training for at risk youth (STAR), and information and referral. A breakdown in specific services is provided in the Table 1.

Table 1: FY2010-2011 Madison Health Resource Center Services (Total Encounters)		
	2009-2010	*2010-2011*
Audiology	324	386
Brazos Valley Community Action Agency Energy Housing Program	357	279
County Indigent Health Care	30	53
Lone Star Legal Aid	7	0
Madison County Senior Meals Program	46	34
MHRC Educational Events	320	629
Medication Assistance Program (MAP)	78	73
Office Manager	38	220
Project Unity	454	403
Sexual Assault Resource Center	5	7
STAR Program (Twin City Mission)	221	326
Service Coordination	287	609
Transportation (riders)	286	336
Transportation (# of rides)	1656	3483
Information & Referral	3376	16,563

Leveraged Resources

The community investment in the health resource center, based on the FY2010-2011 budget, was $34,000. This includes money allocated to the resource center by Madison County and the City of Madisonville. This financial input was increased by in-kind donations from St. Joseph Regional Health Center which totaled $25,100. An estimated $21,987 in additional resources was provided by the Center for Community Health Development staff and graduate assistants through the time dedicated to and/or working directly in Madison County. Monetary value of services provided by other agencies at the MHRC totaled nearly $102,333 (Ronnie Baker, County Indigent Health Care, Energy Housing, BVCASA, Hospice, Lone State Legal Aid, Sexual Assault Resource Center, STAR, and Project Unity).

Summary

In the fiscal year 2010-2011, $34,000 was invested by Madison County and the City of Madisonville to fund the Madison Health Resource Center. For each dollar ($1.00) invested by Madison County and the City of Madisonville, almost $7.23 in contributed services or in-kind donations was received from other sources ($245,691 total donated or in-kind services); this is an increase of $0.73 from the previous year. This increase was made possible by the addition of available services and an increase in the number of volunteers.

The health resource center provided 3,425 individual units of direct service (averaging approximately $9.93 per unit of service). For all units of service (including information and referral as an indirect service) 19,988 units of service were provided, averaging $1.70 per unit of service. There was a substantial increase in the number of in-kind services provided at the MHRC from additional providers.