Adair County Health Department Team
Kirksville, Missouri

Adair County Health Department Team's nomination read:

As Administrator of the Adair County Health Department, I am nominating my entire team at the Health Department. Please let me explain. During October 2018, I had a stroke and was unable to work for five months. My rehabilitation included the University Hospital, Rusk Rehabilitation Hospital in Columbia, MO, as well as the Adair County Health Department Home Health Agency where I learned to successfully walk again. During my absence, the following team members did their normal jobs in addition to addressing all my administration responsibilities. Below I am documenting my staff, their normal position, their residence, and accomplishments while I was rehabilitating.

Team:	**Residence**
Lori Guffey RN, Clinic Supervisor	Kirksville, MO
Leigha Mayfield RN, Clinic RN	Brashear, MO
Misty Arnold LPN, Clinic	Brashear, MO
Deb Cullum, WIC	Unionville, MO
Jamie Keller RN, Home Health Supervisor	Gibbs, Missouri
Vickie Sollars RN, Home Health	Kirksville, MO
Lora O'Connor RN, Home Health	Edina, MO
Tina Fitzpatrick RN, Home Health	Kirksville, MO
Ron Stewart, Planner	Kirksville, MO
Stewart Blessing, Public Health Environmental Specialist III	Memphis, MO
Kim Boyer, Administrative Secretary	LaPlata, MO
Angie Reinsch, Physical Therapy	Kirksville, MO
Barry McFarland, Physical Therapy Assistant	Kirksville, MO

Team Accomplishments

- Under the direction of Lori Guffey, all administrative duties including reports, quarterly reports, paying invoices, working with our Board of Trustees, grant work, billing and correspondence were completed and in a timely manner. Our 2019 health insurance as well as the FY 2019 budget were also successfully develop ped and implemented by Lori and her team. This required Lori to work many extra hours to complete these duties.
- Team members made sure that #1, Adair Citizens were provided essential services including immunizations, screenings, WIC, and vital records.
- Our Planner successfully managed our Opioid Grant from DHSS including implementing a successful marketing campaign, expanding community partners, and staging Narcan in our community. An Opioid Summit II was also planned and completed for clinicians and the community (200+ attendees at Truman University).
- Lori Guffey and her staff have successfully managed our Missouri Foundation for Health Literacy Grant targeting Congolese community members. This grant successfully moved forward during my absence with many Clinic services interpreted into both French and Lingala. The use of interpreters was also implemented, greatly enhancing our services in the Clinic and WIC (both in Adair and Sullivan Counties).
- Three new staff (an RN, LPN and Clerk were successfully recruited in our Clinic after two staff walked out of the facility with no notice. As you can imagine, this was a "worse case" scenario

for our Health Department but our team rallied behind Lori Guffey and the Health Department continued on serving citizens. I find their effort remarkable.

Summary:

This team all became Rural Health Champions when they had to go to the next level to successfully operate the health department. Through it all, they kept their eye on the ball by taking care of clients first and our rural communities. For these efforts, I am eternally grateful.

Transitions of Care Team
Harrison County Community Hospital – Bethany, Missouri

Harrison County Community Hospital's nomination read:

Who: Harrison County Community Hospital Transitions of Care Team

What: An interdisciplinary Transitions of Care team was established in April 2018 to improve the discharge process; enhance communication between patients, healthcare providers, and other caregivers; and reduce the likelihood of readmission within 30 days. The team included the care coordinator, nursing staff, ancillary departments, home health, primary care clinics and physicians, and a local pharmacy. The team aims to provide education to overcome barriers prior to discharge and provide post-discharge, patient-specific follow-up care at various intervals based on a risk- adjusted assessment performed upon admission.
The improvement strategy involved the following components:

- At admission, a RN completes a LACE Index Scoring Tool (risk assessment tool) to assess a patient's risk of readmission.
- Newly prescribed medications can be delivered to the bedside prior to discharge. This partnership with a local pharmacy is convenient for the patient and provides an opportunity for additional education and instructions about medications.
- The Care Coordinator calls the patient within 72 hours to help identify any areas of concern, clarify any confusion, and confirm any follow-up appointments with primary care providers or specialists.
- All patients can receive a complimentary home visit from a nurse within 72 hours of discharge.

Where: Bethany Missouri
When: April 2018-present

How: The 'Transitions of Care' program aligned with the Triple Aim element of Population Health by addressing all patients who are discharged to home, regardless of admission type or payer source in a holistic, integrated, and coordinated manner. By using Population Health Management we are achieving high quality care outcomes while reducing avoidable healthcare costs. We are educating patients throughout the community through our long-term care facility care coordination; local retail pharmacy program, rural clinics integration, and hospital population follow up care. The goal is to reduce or eliminate the need for a 30-day inpatient re-hospitalization and by keeping the patient in his or her own environment of care for treatment rather than in the hospital setting.

The 'Transitions of Care' program provides an improved experience of care for all hospitalized patients as their preferences are taken into account during their hospital stay and at discharge. We have implemented interventions and processes to move towards a high reliability organization. Hospital Leadership supports improved patient outcomes through hospital-physician alignment, using a network of providers, and clinical integration.

Why: The 'Transition of Care' program helps reduce costs and increase value of care by reducing avoidable re-admissions, using key performance measures to evaluate processes, and sharing information across the care team. They focus on value rather than volume and providing the highest quality of care.

Ozarks Community Hospital's Pain Management and Suboxone Team
Southwest Missouri

The Pain Management and Suboxone Team's nomination read:

Who your nominee is (Name of Team)
Ozarks Community Hospital's Pain Management and Suboxone-certified providers.

- Dr. Chris Billings, pain management
- Dr. Charles Cantrell, pain management
- Dr. Jay Baker, pain management
- Dr. K. Marcus Poemoceah, family medicine
- Dr. Donnie Holden, psychiatry
- Dr. Marty Witucki, psychiatry
- Dr. Adonia Holden-Dunivan, licensed professional counselor
- Amelia "Amy" Jackson, nurse practitioner
- Dr. Arthur Jo Cohn, internal medicine
- Dr. Jackie Beene, family medicine
- Dr. John Kaicher, family medicine
- Gregory Forrester, nurse practitioner
- Amelia "Amy" Jackson, nurse practitioner
- Carol Curless, nurse practitioner
- Paul Taylor, CEO of Ozarks Community Hospital
- More than a dozen nurses and other provider-support members who care for Missourians in need of pain management and opioid addiction treatment.

What your team has done to be Rural Health Champions
More than 1,100 Missourians died because of opioid-related overdoses last year, and preliminary data from the Centers for Disease Control projects that, from 2017 to 2018, Missouri saw around a 16 percent increase in overdose deaths. State and national leaders consider this nothing less than a public health crisis, and Ozarks Community Hospital has accepted this challenge to help rural residents of Missouri through their significant pain management opioid addiction problems. We've made meaningful progress because of the unwavering commitment of the men and women who serve our patients who have chronic pain, treating *more than 2,000 patients* each month who are suffering and need not only relief from pain, but in many cases an alternative to opioid medication.

OCH has adapted facilities and resources to provide basic healthcare for patients in the rural Ozarks who have difficult access to care—specifically including those who suffer from chronic pain and opioid addiction. We have ten (10) Rural Health Clinics in Missouri, addressing pain management, opioid addiction and the mental health conditions exacerbating pain and addiction through direct care and referrals to OCH providers in other facilities. In addition to those Missouri RHCs, we have facilities in northwest Arkansas and north Springfield, Missouri, which treat a significant number of rural Missourians. For example, the OCH facility in Gravette, Arkansas is close to the Missouri border and often sees a higher number of Missouri Medicaid patients than Arkansas Medicaid. The patients we serve in north Springfield are primarily low-income and/or elderly … and rural. Our location in north Springfield near the intersection of I-44 and Glenstone provides rural patients access to healthcare without driving into the city.

Where your Team is Located (Town or Community/County where they work and live)

Our OCH Pain Management clinics are in Gravette, Arkansas (Benton County), Carthage (Jasper County) and north Springfield (Greene County). We have providers treating patients suffering from opioid addiction through Suboxone medication assisted therapy in Gravette, north Springfield, Sparta (Webster County), and Webb City (Jasper County). We have mental healthcare providers in most of our Missouri RHCs as well as Gravette and north Springfield.

When your team became Rural Health Champions (Time frame in Days/months/years)

Ozarks Community Hospital has been operating in more than a dozen rural communities throughout Southwest Missouri for more than two decades.

How your team is uniquely qualified for this award

Due to the increased scrutiny focused on pain management practices, many pain management providers in rural Missouri quit treating patients with chronic pain. OCH providers refused to abandon those patients. While recognizing the need to find alternatives to opioid medication and to reduce the prescribed dosages for those patients who have no alternative to opioid management of pain, OCH has expanded the number of providers, resources and facilities willing and able to address the complex issues surrounding chronic pain. Swimming against the tide has not been easy for OCH and its community of providers. The "knee jerk" reaction to the very real opioid crisis resulted in the stigmatization of both pain patients and the providers who have been treated patients for pain. Increased regulatory scrutiny by state and federal agencies threatening civil and criminal penalties led many providers to view pain patients more as a threat to their practice than human beings in need of care.

Why our nominee is the best team for the Rural Health Champion Team Award

Opioid addiction is a problem, as is the life-altering condition of living with chronic pain. Our providers see many new patients who walk in the door addicted to opioids. They see the destruction this is causing in their patients' lives and in the lives of their families. Our providers listen to those patients and create specific plans for those patients, significantly reducing their need for pain medication while working hard to find other ways to provide pain relief. They understand they are on the front lines in fighting this health crisis and they have proudly accepted this challenge. They have seen lives changed and potentially saved. Our OCH team is committed to help patients in pain to reduce or eliminate their dependence on opioids and get them on the path to a better quality of life. This is our mission!