

**Evaluation Report for the  
Missouri Institute for Public Health  
*Missouri Local Public Health Agency  
Voluntary Accreditation Program***

***2006-2007***

***Prepared by***

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## **Executive Summary**

The Missouri Institute for Community Health (MICH) facilitates dialogue among health care providers, the private sector, community colleges, universities, health and human service associations, and state and local government. The mission is to facilitate and promote excellence in community systems for health and quality of life. Since the mid-1990's, members of Missouri's public health system worked together to define the appropriate role of governmental public health and the core capacity that needs to be in place to improve the health of Missourians. A task force composed of local public health agency administrators, representatives from the Missouri Department of Health and Senior Services, county commissions, and local Boards of Trustees reviewed accreditation at the state and national levels. They developed the Missouri Voluntary Local Public Health Accreditation Model, issued in 2001. The model defines three types of accreditation (primary, advanced, comprehensive) for agencies of different size and capacity. Monitoring the public's health is an overwhelming feat for any size of community and requires reflection at a system level. This report describes the Evaluation for the Voluntary Accreditation Program and provides an overview of the types of evaluation questions, process, intended outcomes, and findings. Recommendations based on the qualitative data are provided.

## Background

In June 2000, the Center for Public Health Services/Missouri Department of Health and Senior Services (MDHSS), in conjunction with the Robert Wood Johnson Foundation, began year two of a two year "Turning Point" project. The goal was to identify the components and best practices of a model public health agency in a community based public health system. By June 2001, the Missouri Model Agency Project (MOMAP) designed a model for a governmental local public health agency based on Missouri's core function-based definition of public health. Seven local public health agencies, selected from a competitive pool of urban, suburban and rural agencies, participated in MOMAP.

In August 1999, the criteria committee, with representatives from MDOH and local public health agencies, identified ten components for a model agency in a community based public health system: consumer protection (e.g., customer service, workforce issues, health communications, etc.).

Ten teams were formed, one for each component. Each team was co-chaired by local agency and state staff persons. A representative from each model site was included on each team along with MDHSS staff with expertise in the area. Team size averaged about fifteen people, with people from the smaller sites sometimes serving on two teams. Over 130 people worked on the teams, and the resulting strategic conversations were incredible.

The charge for each team was to identify the elements that made up their component in a model local public health agency, producing a written document supported by research and best practices from the agencies. A writing team edited and brought all these components together into one written product about best practices for public health. Monthly meetings, along with on-going research assignments, required each participant to spend approximately ten hours per month on the project.

During the first year, some of the most successful aspects of the project included the opportunity for state and local participants to engage in meaningful dialogue and network, practitioners and policy staff having strategic conversations about public health issues, and public health colleagues with differing responsibilities finding common ground to identify and develop best practices or solutions for complex public health issues.

Many of the team members had never had the opportunity to work together. This project was a venue for breaking down barriers between state and local points of view, developing strong working relationships and creating an atmosphere of mutual trust and respect. Together the group chose as their implementation project the establishment of the Missouri Institute for Community Health.

Today, the Missouri Institute for Community Health (MICH) is a broad-based entity that facilitates dialogue among health care providers, the private sector, community colleges, universities, health and human service associations, and state and local government. Our mission is to facilitate and promote excellence in community systems for health and quality of life.

## **The LPHA Accreditation Program**

Accreditation is a credential given to an agency or institution that meets a defined set of standards. Society requires increased accountability and collaboration from public and private sector organizations in today's world of limited resources. For institutions such as hospitals, schools, home health agencies, universities, etc., accreditation standards are well established. Voluntary accreditation for public health agencies can assist in establishing credibility among public and private partners and provide accountability to the public. Standards will establish recognizable quality markers, and validate and support the use of public and private funding for the public health system.

Since the mid-1990's, members of Missouri's public health system worked together to define the appropriate role of governmental public health and the core capacity that needs to be in place to improve the health of Missourians. A task force composed of local public health agency administrators, representatives from the Missouri Department of Health and Senior Services, county commissions, and local Boards of Trustees reviewed accreditation at the state and national levels. They developed the Missouri Voluntary Local Public Health Accreditation Model, issued in 2001. The model defines three types of accreditation (primary, advanced, comprehensive) to choose from, for agencies of different size and capacity.

The Missouri Institute of Community Health (MICH) was selected as the nonprofit agency to administer this program. A Board of Directors leads this organization with representatives from local public health agencies, community organizations, professional associations, state agencies, and colleges and universities comprising the Advisory Council. The Accreditation Council under the auspices of MICH includes local public health agency representatives: 1 MICH Board Member, 1 Academician, 2 MICH Advisory Council Members, and 1 State Health Department Representative. This body further defined accreditation standards and refined the accreditation tools and process.

MICH believes that accreditation:

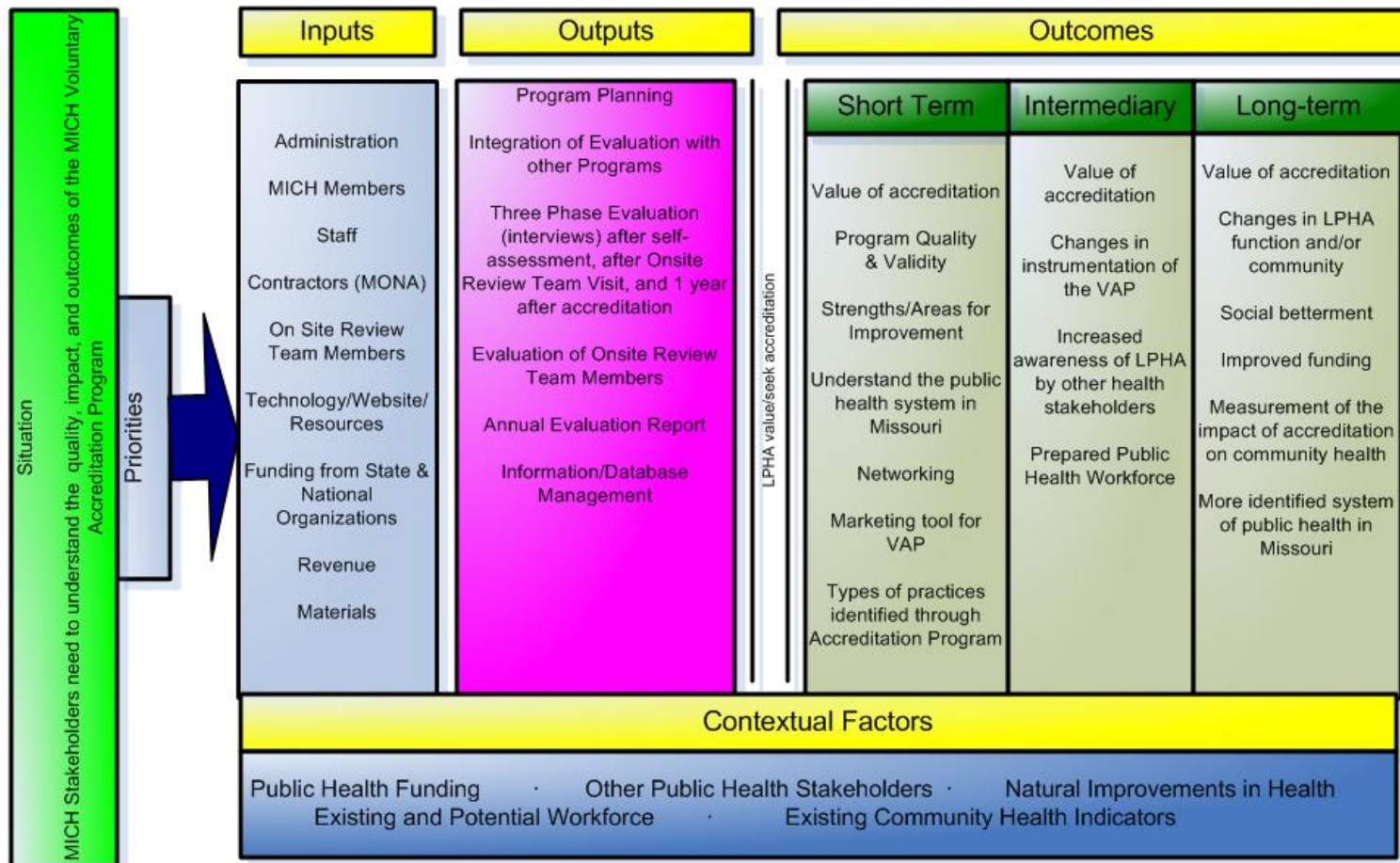
- Provides an opportunity for public recognition and celebration of excellence
- Enhances agency's standing when working with other community agencies that are accredited
- Fosters the best use of available personnel and a climate for ongoing self-study and improvement
- Supports and enhances potential for increased local support and grant funding
- Identifies areas where improvement is needed

## **MICH Evaluation Approach**

The evaluation approach chosen for MICH is one that will lead not only to improved decision making about better designed and implemented programs, but also to the betterment of Missouri communities. The evaluation is based on interviews with the LPHAs. The accreditation program not only acts as an evaluation of the LPHAs performance, but also has a built-in evaluation of MICH as an organization at every phase. The findings from this evaluation include how MICH can improve this program to how LPHAs can better utilize the self-assessment process to improve their departments. This report provides MICH the direction to facilitate organizational and programmatic improvements that will positively benefit the public health infrastructure in Missouri. The evaluation program benefits MICH, the LPHA, and the Missouri public health infrastructure in many ways, but most importantly, provides a mechanism to collect practices for the Missouri Effective Practices Project (MEPP). A logic model was developed for the evaluation of MICH Accreditation Program as noted in Figure 1.



# Missouri Institute for Community Health Evaluation of Accreditation - Logic Model



Monitoring the public's health is an overwhelming feat for any size of community and requires reflection at a system level. In July of 2004, MICH commissioned an evaluation of the Accreditation Program. The evaluation is based on process and impact findings and includes interviews with the LPHAs and the On-Site Review Team members. The accreditation program not only acts as an evaluation of the LPHAs performance, but has a built-in evaluation of MICH as an organization at every phase. The evaluation program benefits MICH, the LPHA, and the Missouri public health infrastructure in many ways, but most importantly, provides a mechanism to collect practices for the Missouri Effective Practices Program (MEPP).

The MICH Evaluation of the LPHA Accreditation Program examines two levels, process and impact. The LPHA who has participated in this program has told MICH that changes occurred almost immediately after reading the accreditation manual and before their onsite visit (for example, staff sought more education and training, policies were changed, staff morale improved, etc.). Because of this, a three-phase evaluation was designed to capture those changes throughout the process (Figure 2). For a more detailed overview of the timeline of the Accreditation Program, see Figure 3.

# Cycle of Evaluation for the MICH Voluntary Accreditation Program

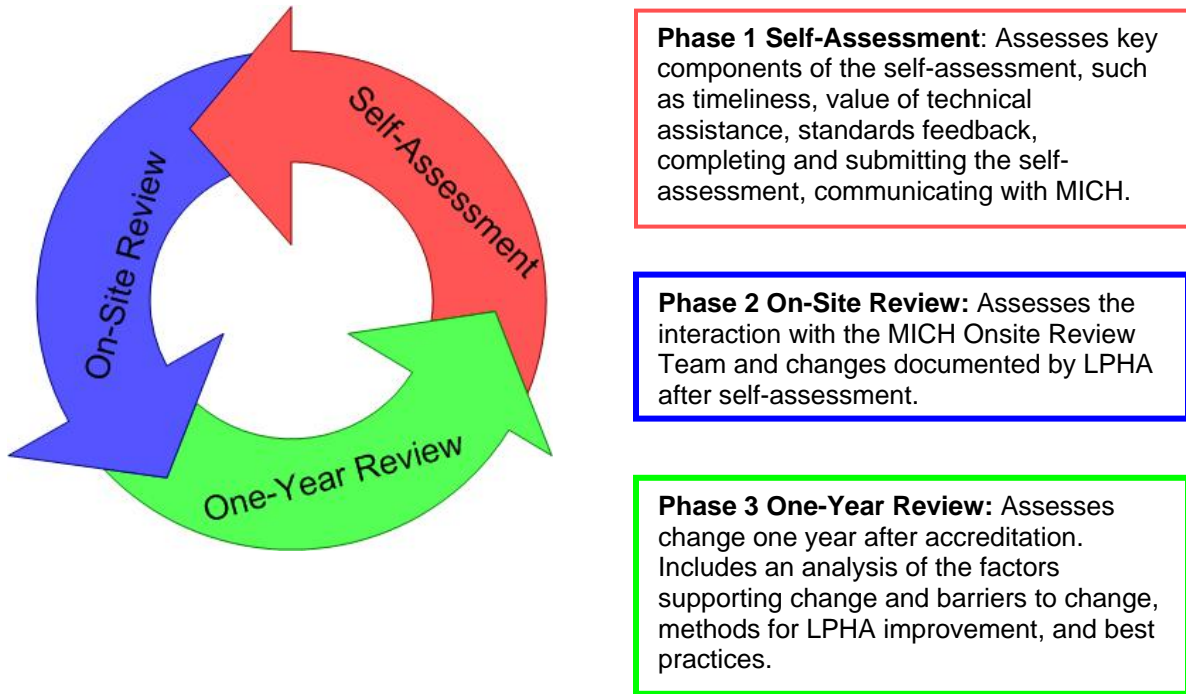


Figure 2.

## Timeline of Local Public Health Agency Accreditation Program with Process and Impact Evaluation

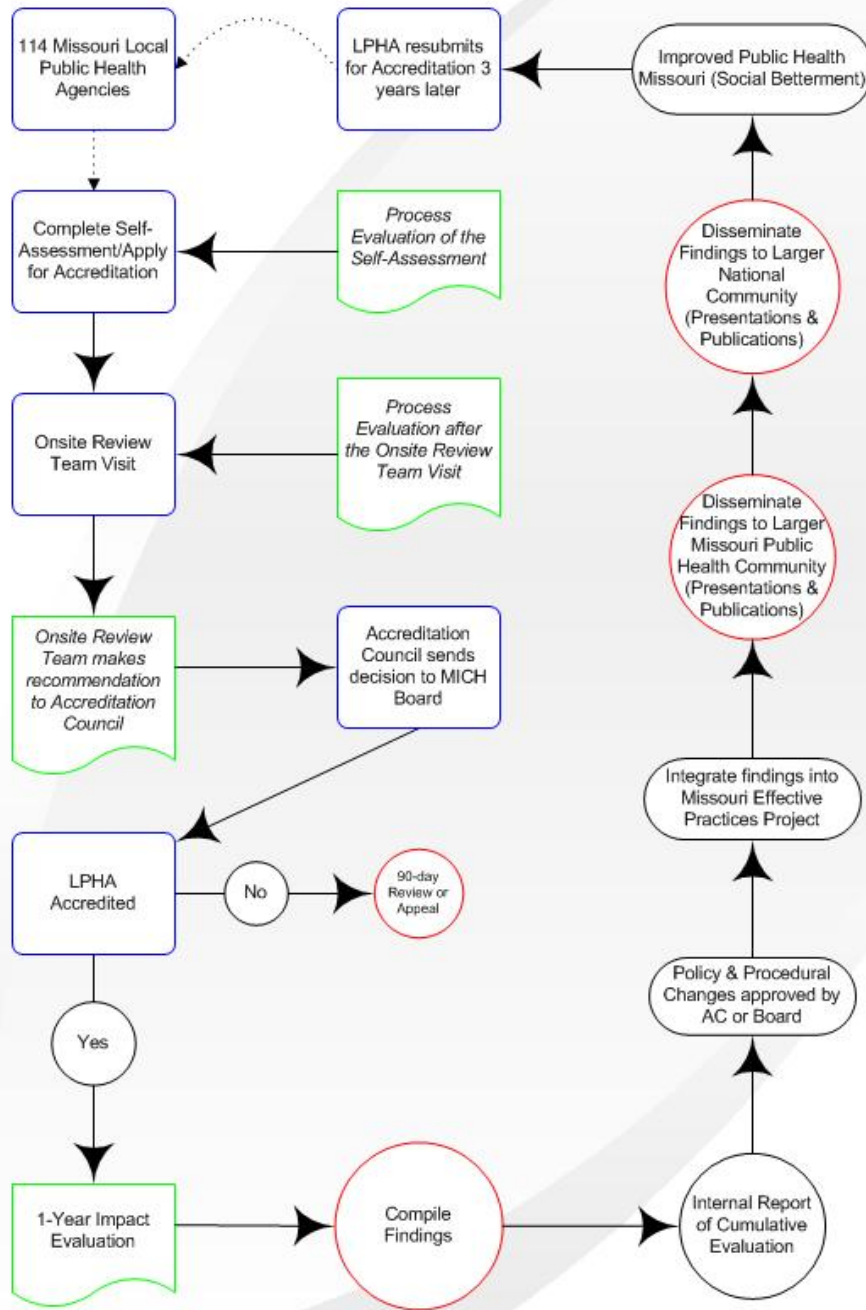


Figure 3.

## Methodology

The methodology consisted of interviewing via phone LPHA and requesting the completion of a website survey from the Onsite Review Team members (OSRT). OSRT member results are discussed in a later section.

During the second year of the VAP, 10 LPHAs were interviewed for varying phases of the evaluation. Any one LPHA could span two evaluation reports depending on their current phase of evaluation (i.e., Phase 1 and 2 in Year 1 Report and Phase 3 in Year 2 Report).

Table 1 identifies the current completed evaluation Phase for each LPHA. To recruit participation in the evaluation, an e-mail was sent to all the eligible counties. With this e-mail, an attachment was provided that explained the request and what the administrator would be asked to do.

<b>Table 1. Requested Counties for Evaluation of Accreditation Program</b>			
<b>County/City</b>	<b>Requested Participation in Phase of Evaluation</b>		
	<b>Phase 1</b>	<b>Phase 2</b>	<b>Phase 3</b>
Butler	◀◀	◀◀	+
Cole	◀◀	◀◀	√
Springfield/Greene	◀◀	◀◀	√
Lafayette	√	√	⌚
Lincoln	◀◀	◀◀	√
Mississippi	◀◀	◀◀	√
Randolph	√	√	⌚
Taney	√	√	√
St. Louis County	◀◀	◀◀	√
+ = missing data; ◀◀ = Year 1 Report; √ = Year 2 Report; ⌚ = in the future			

A phone-call meeting was scheduled and the administrator was called. The evaluation usually took no more than 1 hour depending on the number of phases to complete and how much feedback they were willing to provide. The results consist of Two Phase 1 evaluations, Two Phase 2 evaluations, and Five Phase 3 evaluations.

### *The Instrumentation*

The instrumentation used for the evaluation for both LPHA and OSRT members consisted of several parts:

- A series of questions with a Likert-scale response (comments were also gathered on these questions)
- A series of open-ended questions
- An opportunity for the administrator to provide any comments that may have not been addressed in the previous questions.

### **Results of the Evaluation for LPHA**

This section is organized around several themes related to results of the interviews. Table 2 provides the questions and responses to the Self-Assessment and Onsite Review Team Visit Phases 1 and 2, respectively. At the time of this report, Two LPHA completed Phase 1 and 2 and Five LPHA completed a One-Year Evaluation (Phase 3).

Table 3 outlines the resources and documents, and materials created by the interviewees during the accreditation process. LPHA were asked to identify the benefit to participating in accreditation. Table 4 provides their responses. Additionally, and most importantly, an attempt is made during this evaluation to capture the process, impact, and outcomes changes as they related to the accreditation process. Table 5 delineates those changes. In the interest of making this a continuous quality process, these tables will be updated on a yearly basis so that a cumulative representation of changes made at the LPHA level will be documented.

**Table 2. Interview Questions after Self-Assessment**

After Self-Assessment	Health Department Assigned Code		Scaling Format		
	H	I			
1. How efficient was the application process as a whole?	1	1	1 = efficient	2 = neutral	3 = not efficient
2. Would you consider the website useful or any problems with it?	1	3	1 = useful, no problems	2 = neutral	3 = useful, problems with it
3. How effective was the technical assistance for you?	1	1	1 = very effective	2 = neutral	3 = not very effective
4. Did you contact other health departments during the process?	1	*	1 = yes	2 = not sure	3 = no
<b>After Onsite-Review Team Visit</b>					
1. Was the manager chosen appropriate for this position? If not, why?	1	1	1 = yes	2 = neutral	3 = no
2. Did you feel that the reviewers came to your agency prepared? If not, please explain.	1	1	1 = yes	2 = neutral	3 = no
3. Did you feel assured that the reviewers were going to keep the information they learned confidential? Please explain.	1	1	1 = yes	2 = neutral	3 = no
4. Did the reviewers all arrive on time?	1	1	1 = yes	2 = some	3 = no
5. Please rate the overall level of courtesy of the reviewers during the visit and during the delivery of the exit interview (polite and professional).	1	1	1 = very courteous	2 = neutral	3 = not courteous
6. Did the reviewers provide an explanation of the process that was about to take place?	1	1	1 = yes	2 = neutral	3 = no
7. Did the reviewers stay on task and adhere to the established time schedule?	1	1	1 = very much so	2 = neutral	3 = not at all
8. Do you feel that the onsite review team caused significant interruption in the work schedule of your staff?	1	1	1 = not at all	2 = neutral	3 = very much so
9. Did the reviewers provide an exit interview to you?	1	1	1 = yes	2 = no	
10. Was the information given to you in the exit interview sufficient? Were you given adequate information about the review of your agency?	1	1	1 = yes	2 = somewhat	3 = no
11. Did you understand and was it made clear to you that the final decision for accreditation was made by the Accreditation Council and the MICH Board of Directors and not the OSRT?	1	1	1 = yes	2 = somewhat	3 = not at all
12. Do you feel the scoring thresholds for meeting the standards were appropriately placed?	1	1	1 = yes	2 = neutral	3 = no
13. In 3 years, will you apply again for the same level, no application, or a different level?	3	1	1 = same level	2 = no level/not sure	3 = higher level
14. Self-Assessment Time Burden for Manager	20	*	Hours per week		
15. What was the total cost of going through accreditation?	\$100	*	Amount in dollars (\$)		

\*Note. New question; not asked of this interviewee

Table 3. List of Resources, Documents created from Accreditation Process			
Accreditation Documentation Tracking Sheet	Procedure form for Client Complaints	Public notification of Program Changes	Employee Orientation Checklist

Table 4. Perceived Benefits of Receiving Accreditation		
Better awareness of our methods and procedures.	Accreditation made us look at the whole picture and not at individual pieces or individual employees.	Gave us a broader focus of what we do.
More pride in the organization.	better organized department	involves all of our people
Employees know more now about what we do; a more knowledgeable staff		

### **Identified Process, Impact and Outcome Changes in Phase 1, 2, and 3 for Accredited LPHA**

Tables 5a, b, and c outline the reported changes because of accreditation for these 7 LPHA. Three types of changes were of interest during the evaluation interviews.

Process changes. Changes in documentation, personnel, procedures, policies, and/or the overall logistics of running a public health department.

Impact changes. Changes in knowledge, attitudes, awareness of target population. Also includes changes in resources or funding and increases in personnel.

Outcome changes. Changes directly or indirectly related to changes in morbidity and mortality among the target population.

<b>Table 5a. Process Changes.</b>			
Online documentation activities, training, procedures	Better written policies and procedures.	Improved method for receiving disease reports on “after hours notification”.	Form for external request for help
Logging system for staff development	Job descriptions updated	Developed a strategic plan	Comprehensive Community Resource Document
Introduction to Epidemiology integrated into orientation process	Signed up with Impact Solutions Training	Implemented a CQI committee with a leader. CQI Committee visits one department a month and does in-house monitoring	Connected the Community Health Assessment to our Strategic Plan.
Improved documentation and training and updating files.	Improved perception of the health department in the community because of accreditation.	A scheduled survey for the clients	

<b>Table 5b. Impact Changes.</b>			
Added an environmental health officer and a public health consultant to our personnel.	Because we are accredited, we now have a contract with a University to rotate the nursing students through our department. They need the public health experience for their graduation requirement. Because we were accredited, this relationship was developed.	Because our nursing program is going so well, later in the year they added a rotation program for Registered Dieticians. The outcomes to the community and state are numerous. We will have more qualified nurses in the field who understand rural public health better.	<b>Created a resource Community Health Assessment created through this process and now other organizations use and request this document.</b>
Process helped us establish training standards for our employees. file for each employee now, carry over from accreditation.			

<b>Table 5c. Outcome Changes.</b>
We were seeing bar-b-que stands setting up on people's front porches and the corner. We had no authority to stop this. We started looking at an ordinance and we wrote them ourselves. We presented it to the County Commissioner and they approved the ordinances. Now, they have to have a license before they can open their food establishment, an inspection, or they will be fined \$500. This definitely has an impact on disease incidence in our community. Because we were accredited, we have some credibility with the commissioner's office that we did not have before.

## **Results of the Onsite Review Team Member Yearly Process Evaluation**

An on-line survey was sent to all On-Site Review Team Members as part of the evaluation efforts. Because of the lack of reviews conducted this year, only three members were able to complete the survey (N = 3). One respondent completed one site review and two respondents completed two site reviews each. All respondents indicated the team performed “very well” on these visits. For transcripts of the responses on the survey, please refer to Appendix A. For recommendations related to the reviewers comments, please refer to the Recommendations section.

## **Recommendations and Strategies from Evaluator for the MICH Voluntary Accreditation Program**

These recommendations serve as a starting point and direction for how MICH can use the evaluation results to make improvements through this next year. For the verbatim written transcripts of the interviews on which these recommendations were partially made, please consult Appendix B. The recommendations were formulated based on these sources:

- data collected during the interviews
- attendance at evaluation conferences on evaluation and reporting methods
- meetings with MICH Executive Director, Accreditation Manager, and other Contractors
- findings and recommendations provided by an external audit conducted in July 2006 by Dr. Brenda Joly.

Please note that because there are only to date 10 agencies having completed the VAP, there are limitations in making strong inferences with this qualitative data. However, the data does provide the MICH leadership with ways to improve the quality, logistics, and function of the program.

Recommendation 1: Create a logic model for the operation of Missouri Institute of Community Health and all its programs. A logic model will ensure all stakeholders have the same vision for MICH as its services and programs continue to grow and expand.

Recommendation 2: Streamline and update the Application for Accreditation Form determining the purpose of the form and the intended uses of the data.

Recommendation 3: Consider exploring ways to incorporate an assessment of the Board of Director/Commissions’ role in the function of the LPHA.

Recommendation 4: Convene a workgroup to review the exit review documentation given to the LPHA and timelines for delivery.

Recommendation 5: Review and understand the reasons for low number of applications for the Accreditation Program. Consider developing a social marketing effort with printed

materials sent annually to the LPHA. Make presentations at regional meetings. Advertise program in Friday Facts of the MDHSS and other MOALPHA publications.

*The following recommendations relate to the On-Site Review Team Members (OSRT) evaluation.*

Recommendation 6: Consider creating a checklist in the Instruction Manual of “things to do” to logistically prepare for the On-Site Review Team Members Review (i.e., bathrooms, food, breaks, internet connection, phone, workspace, etc.). Understand what the OSRT members need when they conduct the visits to perform well.

Recommendation 7: Review the quality of preparation for past LPHA for the site visit. Create a written policy about consequences if LPHA are ill prepared and how far in advance they must submit their self-assessment scores before a site visit is scheduled.

Recommendation 8: Continue pairing experienced and less experience onsite review team members together for site reviews.

Recommendation 9: Reconsider the goal of the OSRT visit. Should the purpose be expanded to interview those not involved in the accreditation process, visually inspect the agency, or spend more time during the exit interview?

## Appendix A

### Onsite-Review Team Members On-Line Survey

1. *Is there anything that you need as an OSRT member that would assist you before, during, and/or after a review?*
  - Maps, identifying key areas of interest to provide a background on the communities; fact sheets on the communities could be provided beforehand.
  - Having the self-assessment information ahead of time is a big help. I feel that if an office being reviewed is late in completing their review and submission of the data, we should strongly consider postponing their review.
  - After the last review, I learned to review the site's self-assessment scores.
  
2. *Based on your experiences as a reviewer, what would help the LPHA be better prepared for their visit?*
  - a better understanding of the process and the procedures that will be followed; have documentation in each folder not referenced to another folder or measure;
  
  - They should be encouraged to gather all of their material and place it in folders, and then look through the folders as if they were the review team. This would help them note things that may be so well known, to them, that they fail to realize they haven't documented well. It appeared to me that most seem to "check off" the information as they work on it rather than by going through the completed folders.
  
  - The LPHA need to be prepared for the site visit. If they do their self-assessment and see they are short of points, it would be in their best interest to delay the visit and work on the areas they are falling short.
  
3. *Are there any suggestions for how Teams are created for the on site reviews? Do you find that the team composition makes a difference?*
  - Before a team works together, two of the three members should have at least done one site review; that was the case in the one I did, but it may not have always been the case.
  
  - Current process seems to be working well. The composition does make a difference and it is wise to try to always have some experience on the team as well as bringing along new members.
  
  - Keep experienced reviewers with new reviewers. All teams I have been on have been very cohesive.

4. *Please provide us any comments that would help MICH staff improve the quality of the OSRT visit program.*

- Wording of the report still seems to be an issue. If it is worded too positively, I don't feel the LPHA can understand what areas they need to improve. I feel if they fall short on a specific requirement, it can simply be stated

Example PI 2.2

The agency has a system in place to respond to communicable disease reports or public health emergencies that occur outside of normal business hours.

PI 2.2 was not met because the LPHA did not have a system in place for after hours contact for the public, there was no contact information provided on the answering machine or posted on the door regarding contact after normal business hours.

## Appendix B

### *Open Ended Responses to Questions during Phases 1, 2, 3 of the Interviews*

During the three evaluations LPHA were asked a series of questions more open ended in nature. Those responses are outlined below.

1. How would you improve the LPHA Accreditation standards? Would you add any content or language to the existing standards (Phase 1 question)
  - Some of the application materials didn't seem to have a purpose. If the application were separated into a separate correspondence and with a more thorough statement of goals and objectives. This application needs more substance.
  - There is disappointment from LPHA that the services they provide are not addressed (e.g., dental, mental, etc.). They anticipated this being more a part of the process. Some of the other small LPHA focus more on the clinical services. Will be difficult to get them to buy-in to this. Are we mixing the clinical and the community health?
  - We were surprised that there was nothing about Board of Directors in the instrument.
  - Need to be more flexible on the credentials for health education and more sensitivity about the budgets of these LPHAs because they may not be able to get these types of staff.
  - Don't remember trend analysis being looked for. It said when data is present, there should be period of time. The data inventory wasn't mentioned that day. But, they could have mentioned that. Surveillance activity could be strengthened- did they cover that? Maybe misunderstanding about our funding and other organizations role in surveillance.
  - There was too much duplication of the standards.
2. How to improve the OSRT visit (Phase 2 question)
  - None, they basically planned to leave on Tuesday evening, but couldn't. Very effective. OSRT were familiar because they are part of public health. Independent contracting group could work but would have to have an understanding of public health and MO public health. This process has been the best thing to mature our staff and understand us where we want to go. It propels us to where we want to go.
  - Wish we had know they needed internet connection. Didn't realize steps to the basement were going to be a problem. Maybe if information about what the

OSRT needs could be sent before they come, we could have that.

- Wished we'd know that the board could have come to the opening meeting.
- Not at that time; we had no clue at all if we did well, no feedback. Need a more structured procedure. How do they know that they are really doing this? How do you know that's your rate? Documentation was just the policy. Just surprised that OSRT didn't ask staff questions and observe them. Would be better if they'd go around and talk to staff and see what's going on. Need to visually inspect the agency.

### 3. How can MICH improve the accreditation program?

- Written promotional materials on accreditation would help.
- The online information has almost hurt it because people don't regularly go there. There needs to be a mailed manual every year to every LPHA.
- This program also needs to be more closely tied to MOALPHA. The September 15 conference should have been at the MOALPHA. Maybe also have Taney County's video shown. I mentioned this to the planners at MOALPHA and they seemed like that would have been a good idea. This video shows you can make the process fun and grow closer to your staff.
- Would be good if MICH could develop a press kit. We don't tell people how good we are. We have to if we want to keep getting funding. A communications kit or maybe a conference on media and public health would be helpful. The media can help us do our jobs better if we let them. If we feed them the right information and understand how to use the media and not be afraid of them, they will work for us.
- MICH is concerned about the quality of the product and keeping it up to date; make it simple and not overwhelming; simplify the language. Don't throw too much information out there. Bring change slowly and simplify. This is pretty overwhelming if you aren't familiar with improvement processes.

### Open-Ended Responses to 1-year Evaluation

- We had a CQI process, but the staff weren't bought into it. This accreditation caused the staff to get on board with the CQI philosophy. We have a CQI committee with a leader and a person representing each area in department. CQI Committee visits one department a month and does in-house monitoring and a report about what is needed to improve.
- This accreditation allowed us to connect the Community Health Assessment to our Strategic Plan. We now ask the question, "What are the public health needs of the community?" We tied these needs to what the health department

needs to do. We went through the process and updated the strategic plan, so now there's road map.

- More pride in the organization. I wish the community itself had bought into it more. We didn't get the media coverage we should have. The community should know we are accredited, but they do not.
- The benefit of accreditation was the internal review and understanding the internal workings of my agency. This process sort of makes you do it; otherwise it wouldn't happen. This is the real value.
- Environmental department now keeps a log of problems, who made them, and how they were corrected. Before they were just assigned/delegated and never heard from again.
- We now have a quality assurance piece and it is completed every year. We have a survey for the clients now that is scheduled. We fine tune procedures based on that information. The staff will get complements and that is good for morale.
- I am disappointed to find that only 10 agencies have done this. The health departments out there do not see the advantage. Written promotional materials would help. The online information has almost hurt it because people don't regularly go there. There needs to be a mailed manual every year to every LPHA. This program also needs to be more closely tied to MOALPHA. The 9/15 conference should have been at the MOALPHA. Maybe also have Taney County's video shown. I mentioned this to the planners at MOALPHA and they seemed like that would have been a good idea. This video shows you can make the process fun and grow closer to your staff.
- Food service establishment ordinance passed. We were seeing barbeque stands setting up on people's front porches and the corner. We had no authority to stop this. We started looking at an ordinance and we wrote them ourselves. We presented it to the County Commissioner and they approved the ordinances. Now, they have to have a license before they can open their food establishment they have to have a license, an inspection, or they will be fined \$500. This definitely has an impact on disease incidence in our community.
- University and MCHD create relationship. Because we are accredited, we now have a contract Southeast Missouri State University to rotate the Nursing students through our department to get the public health piece they require for graduation. They couldn't have this relationship if we weren't accredited. Actually it's gone so well, we've added another program for Registered Dieticians. The outcomes to the community and state are numerous, but we will have more qualified nurses out there who understand public health better

and the way we do it in this small rural county. We are also making those connections within the state of Missouri.

- We just market ourselves better. We put our accredited stamp on everything and we think that improves our reputation within the community and other entities.