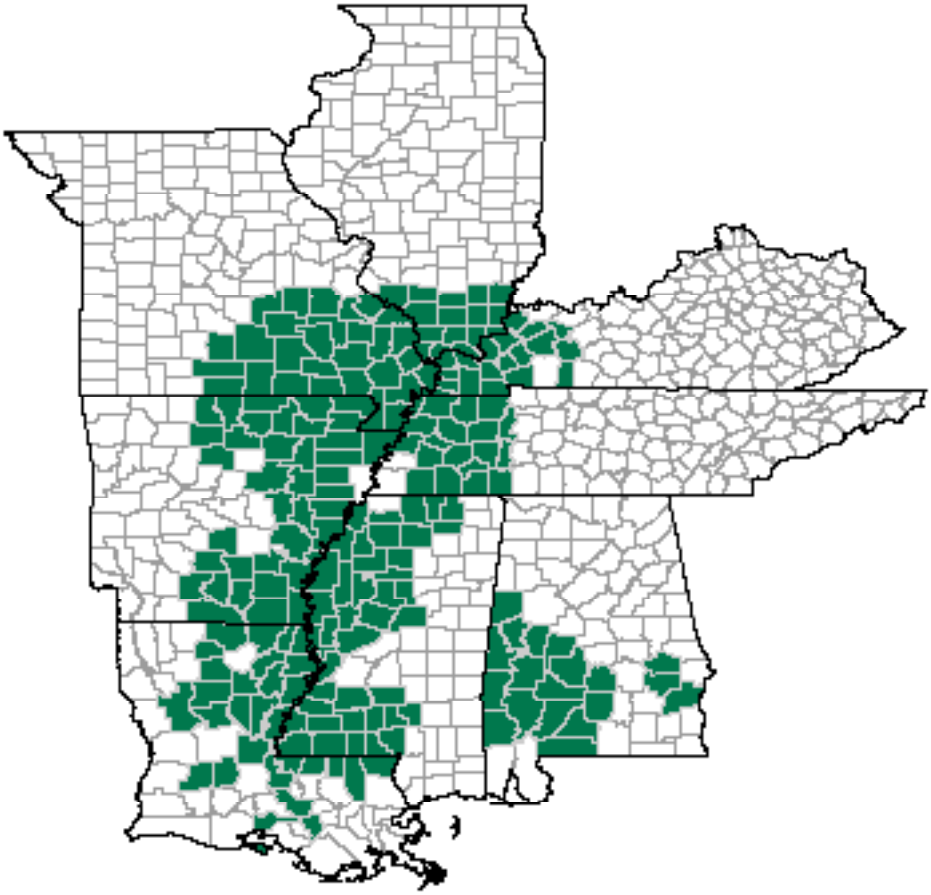
Delta States Initiative Report



May 2004

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Overview of the Delta States Initiative

The Mississippi River Delta region encompasses 240 counties, 209 of which are rural, in eight States: Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri and Tennessee. Compared with the rest of the U.S., the Delta region has persistently high rates of poverty (22.8 percent versus 14.7 percent) and unemployment (7.8 percent versus 6.0 percent). Population growth in the Delta is now less than half the national average.

Residents of the Delta have much poorer health outcomes than those living elsewhere in the U.S. For example, rates for infant mortality (10/1,000 versus 8/1,000) and low birth weight (9.1/1,000 versus 6.9/1,000) are very high and provide a clear indication of the overall poor health status of this population.

These lower levels of health status are most often the result of an inadequate supply of local health care services, especially primary care providers. While the Delta has, on average, a greater number of hospital beds and community health centers than the rest of the country, all Delta counties are currently designated as Medically Underserved Areas (MUAs) and most are Health Professional Shortage Areas (HPSAs)—primary care, mental health and dental HPSAs. The physician-to-population ratio is 22.7 percent lower in the Delta than the rest of the nation.

To address the severe health disparities that are pervasive throughout the Delta, since Fiscal Year 2001 Congress has appropriated $6.8 million each year to the Office of Rural Health Policy (ORHP) in the Health Resources and Services Administration (HRSA). Of these funds, $5.3 million has been competitively awarded in each of the eight states within the Delta. With these funds, ORHP administers:

- The **Delta States Rural Development Network** (DSRDN) Grant Program awards grants for the provision of technical assistance to help underserved rural communities identify and better address health care needs; and
- The **Delta Rural Hospital Performance Improvement** (RHPI) Project, a demonstration program that helps small rural hospitals improve their financial and operational performance. The RHPI Project invests more than $1 million each year, through a contract, to provide comprehensive and targeted consultations to small rural hospitals in the Delta region.

The purpose of this report is to provide an overview of these two programs and the accomplishments achieved thus far.

Delta States Programs Partnerships with Philanthropy

In addition to the Delta States Rural Development Network Grant (DSRDN) Grant Program and the Delta RHPI Project, numerous philanthropic organizations are investing substantial resources to improve health care in the region. ORHP has developed constructive partnerships with regional and national philanthropies to ensure resources targeted for health are coordinated. The private philanthropic partners include the Bowers Foundation, Foundation for the Mid South, Robert Wood Johnson Foundation's Southern Rural Access Program (SRAP), the Kellogg Foundation's Emerging Market Partnership Program (administered by the Enterprise Corporation of the Delta), Rapides Foundation, Pfizer Foundation and the Walton Foundation. Examples of these partnerships include:

Mississippi. The Southern Rural Access Program (SRAP) provides matching funds for two of the Mississippi Delta State Rural Development Network program's local networks. DSRDN Grant Program and SRAP funds are also blended to support the State-level technical assistance function for the local networks involving the SRAP lead agency, the Mississippi Primary Health Care Association. The Bowers

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Foundation and SRAP support the Mississippi Hospital Association for a practice management technical assistance service that works closely with the Delta RHPI Project to strengthen the financial performance of small rural hospitals and other safety net providers. The Bowers Foundation, Emerging Markets Partnership and SRAP co-fund a pilot effort at two Delta Region Mississippi Community Colleges to train entry-level hospital billing and coding clerks, an effort designed to help improve these hospitals' financial performance.

Arkansas: The DSRDN Grant Program and SRAP have joined forces to co-fund technical assistance staff and SRAP funds are also being used to provide matching funds for local networking/Community Encourager activities. The Emerging Markets Partnership and Foundation for the Mid South have provided support for the planning and piloting of a community health worker initiative that is working closely with key DSRDN Grant Program partners in Arkansas. The Walton Foundation's Delta Bridge project recently pledged start-up support for a much larger community health worker demonstration project that will potentially involve a Medicaid waiver and additional financial support from both the Emerging Markets Partnership and the Robert Wood Johnson Foundation. The SRAP-funded network technical assistance staff have also been working closely with the Delta RHPI Project.

Louisiana: The DSRDN Grant Program and SRAP have joined forces to co-fund the Louisiana State University Health Sciences Center to provide leadership and technical support for the local networks and community encouragers. The Rapides Foundation supported a needs assessment in Delta Parishes that complements the DSRDN Grant Program efforts. The Pfizer Foundation has supported a community development networking project in other parishes in Louisiana that is closely modeled after the DSRDN Grant Program and SRAP model. The lead agency for the DSRDN Grant Program, the Southeast Louisiana AHEC, also administers a SRAP-supported loan fund that improves access to capital for small hospitals, community health centers and other providers. Similar SRAP-supported loan funds also operate in Mississippi and Louisiana.

Alabama: The DSRDN Grant Program and SRAP have joined forces to co-fund two Community Encouragers in two Delta States program counties.

I. The Delta States Rural Development Network Grant Program

The goal of the **Delta States Rural Development Network (**DSRDN) Grant Program is to strengthen community organizations so that they can develop and implement projects that address local health needs.

The DSRDN Grant Program was established in Fiscal Year 2001 with a three-year grant period. With the first year of funds, each of the eight network grantees created a statewide steering committee of key health organizations. The grantees subcontracted the funds to networks of community-based organizations, giving approximately $17,000 per county. Each local network receives funds from the grantee to address the major health concerns it determines are greatest.

Most communities used their first-year funds to create partnerships and conduct community health needs assessments. Many of the grantees employed the "Community Initiated Decision Making" (CIDM) model for carrying out grant activities, which involves hiring "Community Encouragers" to solicit active citizen participation throughout the planning process (See Appendix IIIA on page 65). With continuation funds, the community networks are implementing projects that address the highest priority needs identified and are leveraging additional funds to support these projects. Examples of needs identified by these local networks include:

- Primary health care
- Dental care
- Mental health services
- School-based health services
- Transportation for the elderly
- Emergency transportation
- Outreach programs for the uninsured
- Behavioral intervention programs for substance abuse and teen pregnancy prevention
- A feasibility study for constructing an Assisted Living Facility
- Support for Community Health Centers to improve access to care for the uninsured through community outreach partnerships, and
- Development of regional resource referral systems.

Eligibility

The Office of Rural Health Policy is using the Congressional definition of the service area of the Delta Regional Authority (DRA) to define the service area for the DSRDN Grant Program minus those counties that are not rural. Further details, a map of the region and a list of counties in the service area of the authority can be found at DRA's web site: http://www.dra.gov . A list of Delta Eligible Areas can also be found at: http://ruralhealth.hrsa.gov/funding/Delta.htm

Current Status (See textbox, next page)

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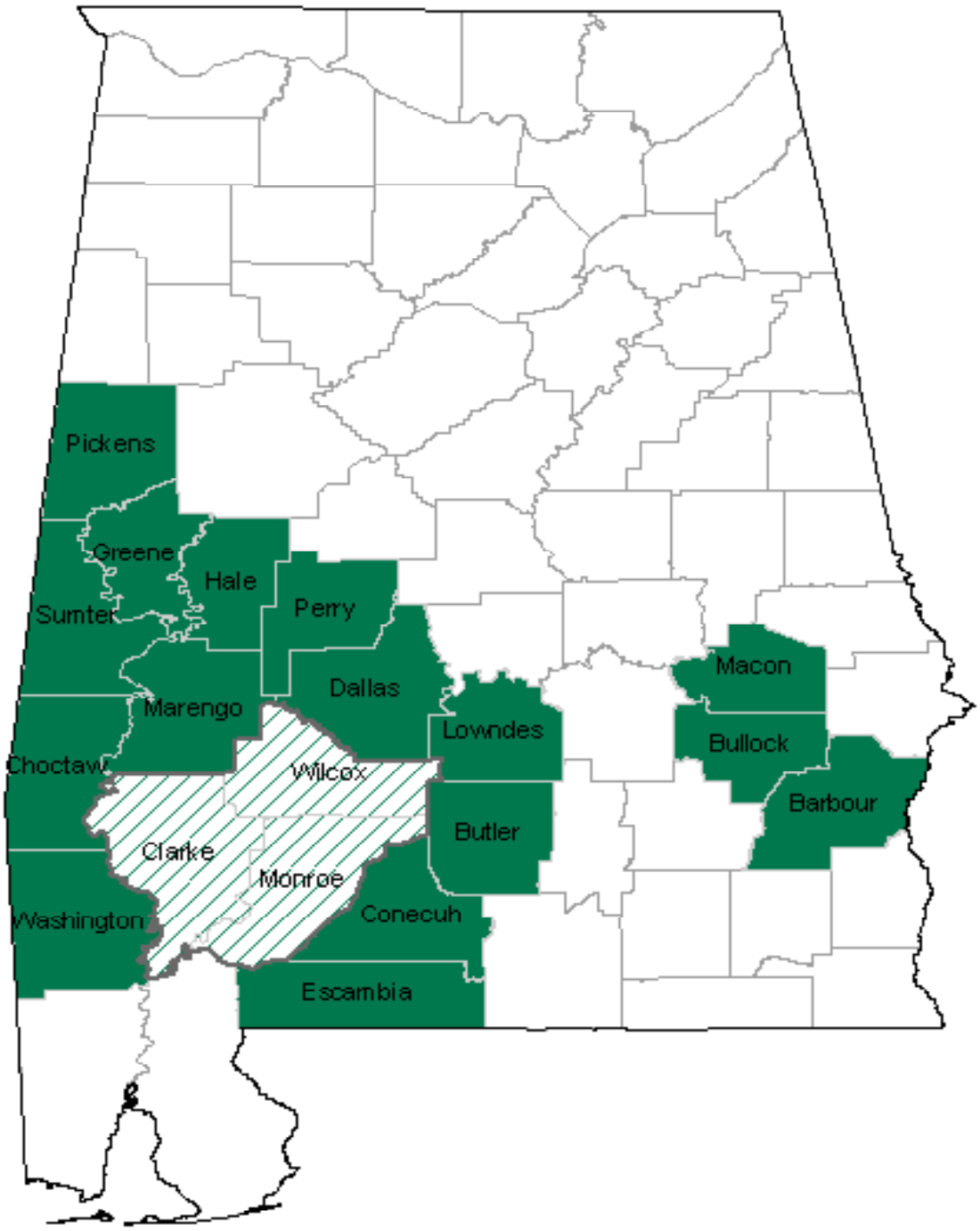
Current Networks and Grantees in the Delta States Rural Development Network Grant Program

State	Grantee	# Eligible Counties	Annual Award Amount
Alabama	Alabama Delta Rural Health Network Program	19	$385,501
Arkansas	Arkansas Delta Rural Development Network	38	$942,831
Illinois	Illinois Delta Network	16	$409,941
Kentucky	Trover Foundation, Inc.	19	$484,201
Louisiana	Better Health for the Delta	29	$733,301
Mississippi	Mississippi Delta State Rural Development Network	41	$1,132,801
Missouri	Missouri Primary Care Assoc.	28	$708,861
Tennessee	Tenn. Department of Health	19	$484,201

Alabama

Delta State Networks



ALABAMA DELTA RURAL HEALTH NETWORK

Alabama has one of the highest heart disease death rates in the nation.[1] Health disparities are even more prominent in the specific counties eligible for Delta grant funds in comparison to other regions of Alabama. The 15-county Alabama Delta Region (ADR) is the poorest, most rural, most economically depressed, and most medically underserved region of the state. Approximately seven percent of Alabama's population lives in the Delta region, an area that accounts for 25 percent of Alabama's land area. In contrast, 68 percent of Alabama's population lives in Metropolitan Statistical Areas (MSAs) covering 31 percent of the land area. Twelve counties have more than 2,500 residents per primary care physician and, at most, there are no or very few ambulatory care specialists. Approximately 20-30 percent of residents of the Delta region are either uninsured or underinsured.[2]

The 19 eligible counties in Alabama are:

Barbour, Bullock, Butler, Choctaw, Clarke, Conechuh, Dallas, Escambia, Greene, Hale, Lowndes, Macon, Marengo, Monroe, Perry, Pickens, Sumter, Washington, Wilcox

Grantee and Statewide Partners

The Alabama-Tombigbee Regional Commission (ATRC) serves as the lead grantee for the **Alabama Delta Rural Health Network Program (ADRHN)**. The Statewide Network Partners are:

Alabama-Tombigbee Regional Commission (ATRC)

The ATRC is a regional, planning, and development organization. Established in 1969, the commission serves Choctaw, Clarke, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, Washington, and Wilcox Counties.

South Central Alabama Development Commission (SCADC)

Based in Montgomery, SCADC is a non-profit organization that provides planning and economic development services to its member governments. SCADC assists local governments in preparing planning strategies that enable local officials to make informed decisions regarding the future of their communities.

West Alabama Planning and Development Council (WAPDC)

WAPDC is one of twelve regional councils in Alabama concerned with rural health issues and improving the quality of life for the people of its region. Greene, Hale, and Pickens counties (Delta counties) are members of the West Alabama Planning and Development Council.

All of these organizations have staff working in each of the identified Delta counties. By combining the ongoing activities of these agencies with existing programs of the network partners, there is network presence in each of the counties.

Network Conception

In August 2001, the ATRC joined with the WAPDC, the SCADC and several other organizations to form the Alabama Delta Rural Health Network Program, a 15-county regional health development network. In August 2002, ADRHN expanded the health development networks to include four more counties. Currently the network includes all 19 eligible counties. (See textbox, next page).

Goals

The goals of the ADRHN are to cultivate a healthier community by identifying primary, secondary and tertiary health services and resources to address local epidemiological and demographic needs. Local networks aim to address the needs of the underserved, underinsured and uninsured population.

Program Activities

In conjunction with ADRHN, local networks assess health care needs, plan projects, develop rural health networks and seek project funding. ADRHN developed and supported efforts by local-level rural health networks to 1) address unmet health needs (including health promotion and disease prevention); 2) improve access to health care; and 3) improve the health care system in the Alabama Delta.

Specific themes of the activities proposed by the networks include:

- Transportation issues
- Physician recruitment and retention

[1] http://www.statehealthfacts.kff.org/

[2] Alabama Dept. of Health

- Emergency Medical Service (EMS) improvement
- Medication assistance programs

Outlook

ADRHN plans to build a regional health information network using Internet-based technology, develop partnerships to increase statewide and local organization participation and perform a year-end review. ADRHN will also assist local networks in prioritizing needs, developing intervention strategies, identifying external funding sources and evaluating local network performance.

ALABAMA DELTA RURAL NETWORK PROGRAM CONTACT:

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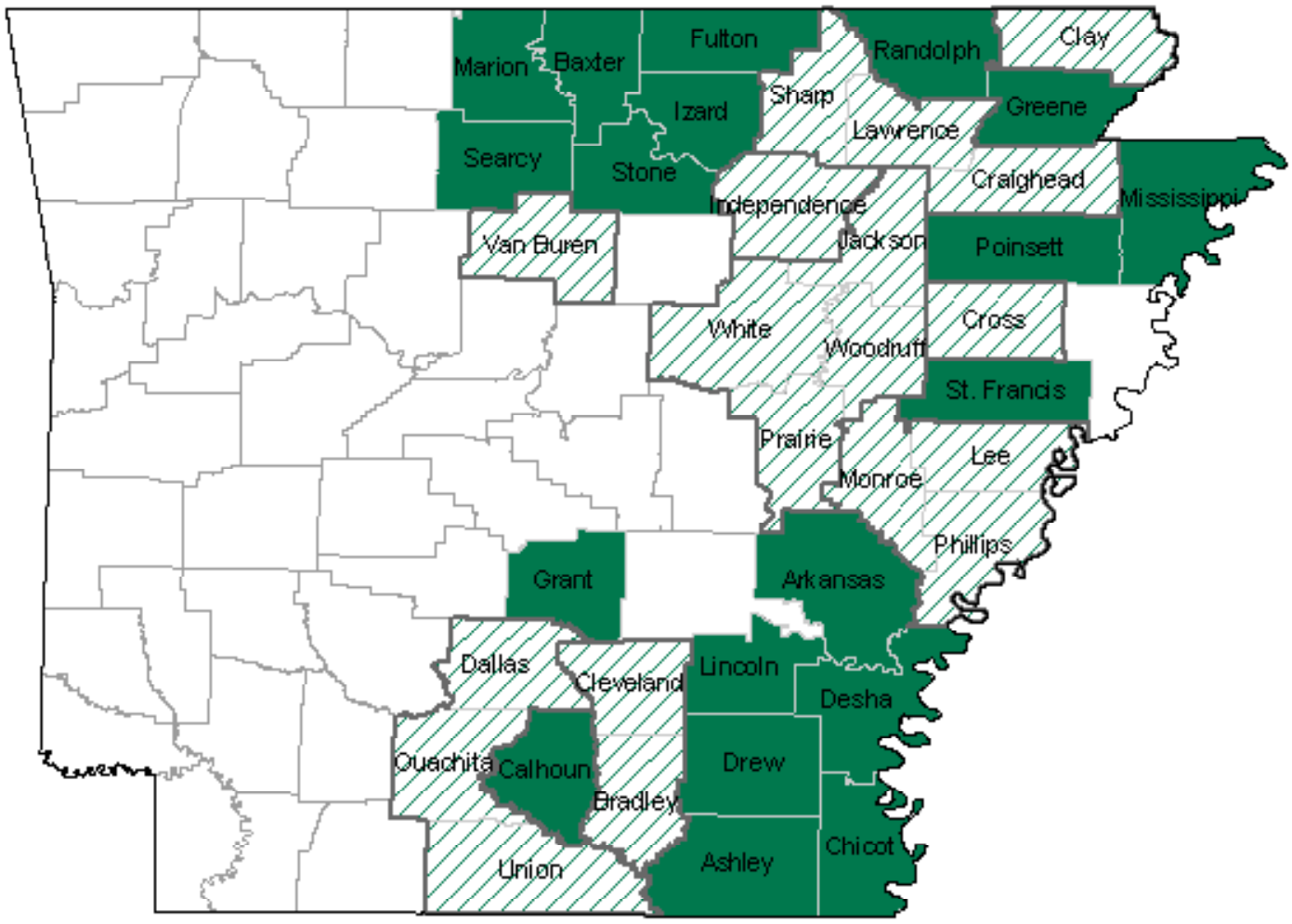
Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding
Barbour Co. Network	Barbour	***	***	***
Bullock Co. Network	Bullock	$5,000	$17,700	$17,700
Butler Co. Commission	Butler	***	$5,000	$14,000
Choctaw Co. Rural Health Network	Choctaw	$17,700	*	*
Tri-County Community Resource	Clarke, Wilcox, and Monroe	$17,700	$17,700	$17,700
Conecuh County Network	Conecuh	**	$5,000	$14,000
Dallas Co. Rural Health Network	Dallas	$17,700	$17,700	$17,700
Escambia Co. Rural Health Net.	Escambia	**	$5,000	$14,000
Greene Co. Health Network	Greene	$17,700	$17,700	$17,700
Hale County Healthcare Authority	Hale	$17,700	$17,700	$17,700
Lowndes Co. Health Network	Lowndes	$17,700	$17,700	$17,700
Macon Co. Health Care Task Force	Macon	$17,700	$17,700	$17,700
Marengo Co. Hlth Care Task Force	Marengo	$17,700	$17,700	$17,700
Monroe County Network	Monroe	**	$5,000	$14,000
Perry Co. Health Care Task Force	Perry	$17,700	$17,700	$17,700
Pickens Co. Rural Health Network	Pickens	$17,700	$17,700	$17,700
Sumter Co. Healthcare Consortium	Sumter	$17,700	$17,700	$17,700
Washington Co. Rural Hlth Net.	Washington	$17,700	$17,700	$17,700
Wilcox Co. Healthcare Consortium	Wilcox	$17,700	$17,700	$17,700

* County not engaged in year 2 and year 3. Funds not distributed due to failure to follow program guidelines.
** Counties were added in year 2 after the initiation of the Alabama Delta Rural Health Program in the Farm bill.
*** County currently establishing to build Network.

Arkansas

Delta State Networks



ARKANSAS DELTA RURAL DEVELOPMENT NETWORK

Arkansas has consistently ranked in the lowest 20 percent of states in published national health status rankings. The region's generally poor health status indicators include unusually high infant mortality rates and age-adjusted death rates (including high age-adjusted cancer and cardiovascular disease death rates). There are 38 counties in the targeted Arkansas Delta region, which encompass 26,235 square miles on half (50 percent) of Arkansas' land mass. These 38 counties contain a population of 853,959 representing 32 percent of the total Arkansas population. More than half of the Delta region's population is rural, with 55 percent of the population residing in communities of less than 2,500.[1]

The 38 eligible counties in Arkansas are:

Arkansas, Ashley, Baxter, Bradley, Calhoun, Chicot, Clay, Cleveland, Craighead, Cross, Dallas, Desha, Drew, Fulton, Grant, Greene, Independence, Izard, Jackson, Lawrence, Lee, Lincoln, Marion, Mississippi, Monroe, Ouachita, Phillips, Poinsett, Prairie, Randolph, St. Francis, Searcy, Sharp, Stone, Union, Van Buren, White, Woodruff

Grantee and Statewide Partners

The grantee for the **Arkansas Delta Rural Development Network (ADRDN)** is the Mid-Delta Community Consortium (MDCC). ADRDN has four statewide partners:

Mid-Delta Community Consortium (MDCC)

MDCC, the lead agency, was created by five Delta-based organizations to develop the strategies values of community-based public health improvement.

Arkansas Department of Health (ADH)

ADH is the state's public health agency. This unit develops programmatic technical expertise through benchmarking, participating in the development of performance measures and promulgating rules and regulation. The Department of Health's participation in the Delta Network will be through the Hometown Health Improvement Initiative, the Office of Rural Health and Primary Care, the Office of Minority Health and the Phillips County Health Unit.

University of Arkansas for Medical Sciences (UAMS)

UAMS will participate in ADRDN though three branches of the institution—the College of Public Health, Regional Programs and the Arkansas Center for Health Improvement.

Community Health Centers of Arkansas, Inc. (CHCA)

CHCA is the state's Primary Care Association. Its staff and Board of Directors work extensively with Arkansas' rural communities with residents, business leaders and other health care providers identifying their health care needs and assisting in the development of networks and systems of service delivery.

Network Conception

In 2001, a 22-member State steering committee reviewed, revised, and finalized grant applications and guidance. The MDCC Board approved and disseminated these grant applications to eligible counties interested in forming health networks. MDCC used a variety of methods to distribute guidance and information about grant workshops to potential applicants: through regional newspapers and newsletters, the Internet and flyers distributed at association meetings. In addition, they sent targeted mailings to local health entities such as community health centers, local health units, hospitals, rural health clinics, health providers, cooperative extension offices and community-based organizations. The Project Director planned and organized five regional workshops for key stakeholders and potential local network members to publicize the funding opportunity, review its requirements and explain the guidance. Three local health units, an area AHEC and a community health center hosted the workshops.

In 2002, MDCC funded networks linking 34 counties. In the later part of 2002 and early 2003, they incorporated the remaining four counties into existing networks and/or established single or multi-county networks for a total of 38 delta counties. To date, the Arkansas Delta Rural Development Network includes 23 local networks. (See textbox, next page.)

Goals

The ADRDN's mission is to improve the health and health

[1] Mid Delta Community Consortium Newsletter, February 2003, Volume 1

Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding
Arkansas Co. Partners In Health	Arkansas	$16,375	$11,586	*
Ashley Health Education Network	Ashley	$16,375	N/A	*
Baxter Co. Hometown Health Improvement Network	Baxter	$16,375	N/A	*
Bradley Co. Hometown Health Coalition	Bradley, Cleveland	$16,375	$24,000	*
Calhoun Co. Rural Health Net.	Calhoun	$16,050	N/A	
Craighead Co. Healthy Start	Craighead	N/A	$12,000	*
Chicot Memorial Hospital Net.	Mississippi	$16,375	$12,000	*
Crowley's Ridge Rural Health Coalition	Greene	$8,187	$100,000	*
Delta Health Care Consortium	Desha	$16,346	$12,000	*
Delta-Hills Rural Health Net.	Independence, Van Buren	$32,750	$24,000	*
Drew Co. Hometown Health Improvement Coalition	Drew	$16,353	$12,000	*
Fulton Co. Hometown Hlth Coalition	Did Not Enter Into Agreement	N/A		
Grant Co. Hometown Health Coalition	Grant	$16,375	N/A	*
Izard-Stone Rural Health Network	Izard, Stone	$32,631	$24,000	*
Lincoln Co. Hometown Health Net.	Lincoln	$16,375	$12,000	*
Marion Co. Hometown Health	Marion	$16,375	N/A	*
Mississippi Co. Hometown Health Steering Committee	Mississippi	$8,187	$12,000	*
Mississippi River Delta Health Assoc.		N/A	$100,000	*
North East Arkansas (NEAR)	Sharp, Lawrence, Craighead, Clay, Cross	$106,438	-	
Delta Health Net		$78,688	N/A	*
Ouachita Co. Rural Health Network	Dallas, Ouachita, Union	$16,375	$48,000	*
Poinsett Co. Rural Dev. Network	Poinsett	N/A	$12,000	*
Randolph Co. Hometown Hlth Alliance	Randolph	$12,000	N/A	
SAFE KIDS of N. East Arkansas (NEA)		$40,937	N/A	*
Searcy Co. Delta Dev. Network	Searcy	$12,000	N/A	*
St. Francis Co. Rural Health Network	St. Francis	$16,375	$12,000	*
Tri-County Rural Health Network	Lee, Monroe, Phillips	$49,125	$100,000	*
White River Delta Dev. Network	Jackson, Prairie, White, Woodruff	$65,000	$99,666	*

* Now accepting applications for Year Three funds.

care of Arkansas Delta residents by:

1) Facilitating the development of local rural health networks serving a 38-county area in the Arkansas Mississippi River Delta; and

2) Fostering "grassroots initiatives" in these counties.

Specific objectives of the program are to:

- Assist Delta communities to form local health networks
- Develop and implement a process by which local networks can obtain funding from various sources
- Provide ongoing technical assistance to support the development and sustainability of local health networks.

Program Activities

Network Activities: Individual networks identified ways to use their planning grant funding. The majority of local networks conducted community health needs assessments. Thus far, local networks have conducted 17 assessments involving 11,888 respondents. Networks started to examine health resources, establish health priorities, develop strategies for interventions to address health priorities, develop written intervention plans, and design and implement health-related programs for their communities. Based on needs assessment results, some networks have selected an area of focus for future health initiatives and are in the preliminary stages of implementing these projects. Examples of specific projects are:

- Access to health care for the homeless
- Outreach to the migrant Hispanic population providing language appropriate and culturally competent services
- Seat belt awareness
- Comprehensive health care management for people with sickle cell anemia
- Physical fitness awareness
- Establishing a centralized health care coalition
- Prevention and awareness of obesity
- Health care vocational curriculum for high school students
- Pharmacy drug assistance program
- Local health fairs
- Media awareness campaigns
- Tobacco prevention

In an effort to keep the local networks abreast of technical assistance options, ADRDN activities and funding opportunities, MDCC conducted two regional conferences for participating networks in May 2003.

Technical Assistance: In addition to financial resources, ADRDN provides technical assistance to the networks. All networks are assigned a technical assistance provider and can access all technical services on an as-needed basis. Qualified staff members/consultants offer technical workshops using participatory methods in areas such as organizational development, resource development, board development, participatory rural appraisal, research and development.

Outlook

Further analysis will support the "Grassroots Initiative" of the Networks and their future plans to develop and implement health strategies through disease prevention/progression, disease management, and health education/health promotion to improve access to health care and improve the health care system in the Mississippi Delta.

The Statewide Steering Group, the Technical Assistance Provider (TAP) Team and the ADRDN Project Director are collaborating to establish an evaluation plan for the project. In addition, ADRDN plans to implement a state plan to provide technical assistance. The program will continue to publish a quarterly newsletter for state partners, networks, network partners and other stakeholders.

ADRDN awarded two types of subcontracts this year: 1) subcontracts for planning activities and 2) subcontracts for project implementation. Applicants who previously received planning grant funds were eligible to apply for a second year of planning funds.

MDCC will continue to develop and support efforts of local-level rural health networks to address unmet health needs, improve access to health care and strengthen the health care system in the Mississippi Delta.

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Illinois

Delta State Networks

ILLINOIS DELTA NETWORK

While the majority of Illinois' population lives in northern urban areas, the majority of the state's land area is considered rural. The Illinois Delta Network consists of the southernmost 16 counties located in the most rural and impoverished area of the state. Additionally, 15 of the counties are designated as medically underserved areas (MUAs). Regional county data sets maintained by the Center for Rural Health and Social Service Development show that 10.7 percent of residents in the designated area are uninsured, compared to the overall state rate, which is 9.7 percent. Additionally, 16.2 percent of Delta residents have not seen a medical provider within the past two years, while the state rate is 15.8 percent. Of Illinois Delta residents, 20.4 percent are obese, and 32.9 percent have a sedentary lifestyle, while the state rate is 19.5 percent and 27.2 percent, respectively. The rate of smoking in the targeted area is 26.1 percent; for the state of Illinois it is 22.7 percent.[1]

The 16 eligible counties in Illinois are:

Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Perry, Pope, Pulaski, Randolph, Saline, Union, White, Williamson

Grantee and Statewide Partners

The Southern Illinois University's Center for Rural Health and Social Service Development (CRHSSD) is the **Illinois Delta Network (IDN)** grantee and lead agency. The Statewide IDN partners include the following 12 organizations and agencies listed below:

Illinois Health Education Consortium, Midwestern University (IHEC)

IHEC, a non-profit organization based in Downers Grove, works to improve primary health care for the underserved through health professions education and health careers development.

Egyptian Area Agency on Aging

Based in Carterville**,** the Egyptian Area Agency on Aging helps older adults in Southern Illinois remain independent. They provide information on a variety of services for seniors.

Illinois Department of Human Services, Office of Mental Health

The Office of Mental Health funds and coordinates mental health treatment and support services for people with serious mental illness and limited resources.

Illinois Department of Public Health, Center for Rural Health

The goal of the center is to improve access to primary health care in rural and underserved areas of Illinois and to encourage community involvement in health issues. The center also serves as an information clearinghouse on rural health issues.

Illinois Hospital Association

The Illinois Hospital Association, with offices in Naperville, Springfield and Carbondale, represents more than 200 hospitals and health systems and the patients and communities they serve. They work to strengthen and unite hospitals and make high-quality affordable health care available to all residents.

Illinois Institute for Rural Affairs (IIRA)

Located at Western Illinois University, IIRA works to improve the quality of life in rural areas by developing public-private partnerships with local agencies on community development projects in rural areas.

USDA – Rural Development – Urbana and Vienna, IL

USDA-RD is committed to helping improve the economy and quality of life in all of rural America. Their financial programs support essential public facilities and services such as water and sewer systems, health clinics and emergency service facilities**.**

University of Illinois Extension - Urbana and Vienna, IL

The University of Illinois Extension operates outreach centers distributed around the state. These centers are involved in health education activities, community service projects and projects that are designed to meet local needs.

Illinois Primary Health Care Association (IPHCA)

IPHCA is a non-profit organization representing Illi-

[1] Illinois Department of Public Health, 1998

nois' Community Health Centers (CHC) and Migrant Health Centers (MHC). These members operate approximately 160 sites statewide and serve more than half a million patients annually.

Rural Partners

Rural Partners is a member-driven forum that links individuals, businesses, organizations, and communities with public and private resources to maximize the potential of rural Illinois.

Southernmost Illinois Delta Empowerment Zone

This zone covers a portion of the southern five counties of the Delta region, which are designated as a Federal Empowerment Zone. The zone concentrates its efforts in the development of infrastructure, economic development, tourism, sense of community, learning and education, housing and health.

Southern Illinois University's Center for Rural Health and Social Service Development (CRHSSD)

The mission of the CRHSSD is to develop healthier communities in Southern Illinois, the state, and the region in partnership with those committed to improving health and social services. The CRHSSD conducts research, needs assessments, demonstration projects, program evaluations and training. They test new models of health care delivery and develop policy recommendations to improve health in the rural community.

Network Conception

Early in 2002, CRHSSD staff marketed the availability of funds to health and social service agencies in each of the 16 eligible Delta counties. Southern Illinois University's Public Affairs Office also sent press releases to over 40 newspapers, and local radio and television stations. CRHSSD staff held informational meetings to explain how organizations could apply for funds.

IDN reviewed the applications and awarded funds to 10 networks covering 14 of the 16 eligible Delta counties. As of November 2003, there are 33 organizations/ agencies serving on the 10 local networks. Five organizations in both Massac and Randolph counties will join the project in Year Two and will conduct medical transportation needs assessments. The local networks are only required to have three partners. After conducting a multicounty needs assessment in Year One, Franklin, Saline and Williamson will have separate Year Two implementation projects. (See textbox, next page).

Goals

The goal of the IDN is to support and strengthen community organizations' abilities to develop and implement successful projects to address local needs to improve access to primary care services for residents of the Illinois Delta Region.

Specific program objectives are:

- Create and fill coordinating and fiscal positions to implement the IDN project
- Develop and maintain the IDN as an active and functional network
- Improve access to primary care services for Illinois Delta residents through the development of local network groups
- Provide training and technical assistance for the local networks and the local network's program coordinators
- Assist the local networks in conducting comprehensive needs assessments and summarizing data for use in planning project development and implementation
- Hold an Illinois showcase conference

Program Activities

CRHSSD offers support to the local networks with their respective projects, provides training sessions for local staff and reviews and evaluates the progress. Before initiating projects, the local networks were required to show proof that a participatory planning process was used to establish health care priorities. The majority of the local networks used their Year One funds to conduct health care needs assessments and will use Year Two funding to initiate projects identified by county residents as health care priorities for their communities.

Examples of network projects are listed below:

- Nine of the networks have or are in the process of conducting community needs assessments to determine and prioritize their communities' health needs. These needs assessments included 13 of the 14 counties. The networks have conducted 88 key informant interviews, 43 focus groups discussions and 11 community-wide goal-setting meetings. Although not required, four networks conducted surveys.

- Two needs assessments examined the accessibility to primary health services by uninsured or underserved individuals.
- One network is assessing the health care needs of the school-age youth of the county.
- One network is collecting baseline data to ascertain the medical transport needs of a two-county region. The network hopes the data will support the development of an area public transportation system.
- A network developed and distributed a brochure listing all of the health care service providers in the county.
- After conducting a needs assessment, a local network established that an assisted living facility was a top health priority for the community. The network then used Year One IDN funds to conduct a feasibility study for the construction of an assisted living facility in the county.
- The 2nd Annual IDN Showcase Conference was held on Oct. 8, 2003. The morning session consisted of local network presentations about their progress during the past year. During the afternoon sessions, presentations entitled "Meeting Challenges and Overcoming Barriers" and "Moving from Assessment to Implementation" were made by guest speakers.

Outlook

IDN has a variety of activities planned for Year Two. For example, the program will continue to 1) develop local networks, 2) summarize data from the Year One community needs assessments, and 3) provide technical assistance to local networks and Community Encouragers (local

Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding
Johnson Co. Health Care Initiative	Johnson	$17,063	$17,085	$17,085
Union Co. Local Health Needs Assessment Project	Union	$17,063	$17,085	$17,085
Alexander/Pulaski Medical Transport Needs Assessment Project	Alexander and Pulaski	$34,126	$34,170	$34,170
Pope/Hardin Counties CIDM Project	Pope and Hardin	$34,126	$34,170	$34,170
Perry Co. Health Council	Perry	$17,063	$17,085	$17,085
Franklin, Williamson and Saline Co. Local Health Needs Assess. Proj.	Franklin, Saline and Williamson	$51,189	—	—
Franklin Co. Health Care Project	Franklin	*	$17,085	$17,085
Saline Co. Health Care Project	Saline	*	$17,085	$17,085
Williamson Co. Health Care Project	Williamson	*	$17,085	$17,085
Hamilton Co. Assist. Liv. Facility Proj.	Hamilton	$17,063	$17,085	$17,085
White Co. CIDM Project	White	$17,063	$17,085	$17,085
Jackson Co. Health Care Project	Jackson	$17,063	$17,085	$17,085
Gallatin Co. CIDM Project	Gallatin	$17,063	$17,085	$17,085
Randolph Co. Med. Public Transport. Needs Assess.	Randolph	*	$17,063	$34,170
Massac Co. Transportation Needs Assessment for Medical Care	Massac	*	$17,063	$34,170

* These counties were actively engaged in year 2.

project coordinators).

The new local networks will conduct medical public transportation needs assessments using their county's designated Year One funds. Three new lead agencies will assume responsibility for existing local networks. At least two of the local networks are incorporating as not-for-profit organizations.

The preliminary results of the local needs assessments show a need for better public awareness of existing health care and social services, improved medical public transportation and increased urgent and dental care services. The local networks that have completed their needs assessments are preparing their printed Community Health Plans and will then prepare to implement the priorities determined by the findings of the needs assessments.

Community Encouragers will continue to meet every two months to receive additional training and to network with one another. Report writing, media relations and grant writing are topics for future training

In addition, the 3rd Annual IDN Showcase Conference highlighting the local projects in the IDN program will be held in the fall of 2004.

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Kentucky

Delta State Networks

KENTUCKY DELTA RURAL DEVELOPMENT NETWORK

Fifty-six percent of the population in Kentucky lives in rural areas.[1] It has one of the highest heart disease and cancer death rates in the nation. [2] The number of hospital emergency visits is considerably higher than the national average. Six of the 19 rural Kentucky Delta counties do not have hospitals, 15 have medically underserved area (MUA) status and nine have Health Professional Shortage Area (HPSA) status. Data also indicates that 16 of the 19 counties have fewer primary care providers per 1,000 individuals than the state ratio of 1:734. Death and disease rates related to colon cancer, heart disease, lung cancer and motor vehicle accidents are unfavorably high, in contrast to peer counties, for nearly all of the 19 rural Kentucky Delta counties.[3]

The 19 eligible counties in Kentucky are:

Ballard, Caldwell, Calloway, Carlisle, Crittenden, Fulton, Graves, Hickman, Hopkins, Livingston, Lyon, Marshall, McCracken, McLean, Muhlenberg, Todd, Trigg, Union, Webster

Grantee and Statewide Partners

The grantee for the **Kentucky Delta Rural Development Network (KDRDN)** is the Trover Foundation, Inc. The three Statewide partners are:

Trover Foundation

Serving western Kentucky and the surrounding area, the Trover Foundation provides high-quality, high-tech health care services including physician and hospital services, educational programs and health fairs. Their health care delivery system includes a 410-bed acute care regional referral center and a multi-specialty clinic with 10 satellites.

University of Kentucky Center for Rural Health

The center collaborates with communities to develop effective approaches to health service delivery; collects, analyzes and disseminates information regarding rural health resources; and conducts research relating to health professions, rural health policy, community development and distance learning.

West Kentucky Corporation

West Kentucky Corporation is a municipal corporation of the Commonwealth of Kentucky that builds and maintains consensus, cohesion and cooperation necessary for regional economic development.

Network Conception

Trover Foundation, the UK Center for Rural Health, and the West Kentucky Development Corporation are uniquely suited to develop local networks and to provide technical assistance to Delta counties. All three organizations have:

- Service area responsibilities in the 19 rural Delta Counties and experience in developing networks to meet community needs
- Contracts and affiliations with a broad range of public and private entities and stakeholders in the rural Delta counties
- Experience administering large grants and a demonstrated ability to meet fiduciary and reporting responsibilities

Development of local networks has been guided by the following rationale:

- Local networks (i.e., counties) should be phased in to assure that all networks receive equal opportunities for technical assistance and funding.
- Existing community-level relationships/partnerships should be used as the foundation for development of local networks.
- Community Initiated Decision Making (CIDM) is an effective process by which to evaluate, determine and prioritize local health service needs.
- Community Encouragers can effectively spark community interest in health issues, develop and maintain networks, facilitate the CIDM process and engage in development activities.
- Local networks can be “grown” to facilitate multi-county networks at a future date.

[1] Population Distribution by Metropolitan Status, state data 2000-2001, U.S. 2001

[2] http://www.statehealthfacts.kff.org

[3] HPSA and MUA-BHCDANET Information System and Kentucky Hospital Association, 2001

Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding	Special Pro. Allocat.***
Ballard Co. Health Council	Ballard	$17,600	$17,000	$17,000	$15,000
Caldwell Co. Health Council	Caldwell	$17,000	$17,000	$17,000	$15,000
Carlisle Co. Health Council	Carlisle	$17,000	$17,000	$17,000	$15,000
Hickman Co. Health Council	Hickman	$17,000	$17,000	$17,000	$15,000
Livingston Co. Health Council	Livingston	$17,000	$17,000	$17,000	$15,000
Marshall Co. Health Council	Marshall	$17,000	$17,000	$17,000	$15,000
McLean Co. Health Council	McLean	$17,000	$17,000	$17,000	$15,000
Muhlenberg Co. Health Council	Muhlenberg	$17,000	$17,000	$17,000	$15,000
Trigg Co. Comm. Health Coun.	Trigg	$17,000	$17,000	$17,000	$15,000
Webster Co. Health Council	Webster	$17,000	$17,000	$17,000	$15,000
Calloway Co. Health Council	Calloway	*	$17,000	$17,000	$15,000
Crittenden Co. Health Council	Crittenden	*	*	$17,000	$15,000
Fulton Co. Health Council	Fulton	*	*	$17,000	$15,000
Graves Co. Health Council	Graves	*	*	$17,000	$15,000
Hopkins Co. Health Council	Hopkins	*	*	$17,000	$15,000
Lyon Co. Health Council	Lyon	*	*	$17,000	$15,000
McCracken Co. Health Coun.	McCracken	**	**	$17,000	$15,000
Todd Co. Health Council	Todd	*	*	$17,000	$15,000
Union Co. Health Council	Union	*	*	$17,000	$15,000

* Due to lack of staff, these counties were engaged in the next funding cycle.

** Efforts to develop networks in McCracken County have not been fruitful due to the fact that the county has considerable resources, its population exceeds 40,000 and existing networks chose not to accommodate program requirements.

*** **Special Project Allocation** funds are available to each county that meet core program requirements.

Goals

The goal of the Kentucky Delta Rural Development Network program is to assure that each participating Delta county will have:

- A network that will enhance access to primary care
- An action plan for development of primary care services
- A methodology for continued citizen involvement in the local health care system
- The knowledge and organizational capacity to improve the community's health status and reduce health disparities in the health system

Program Activities

All networks engage in a modified Community Initiated Decision-Making (CIDM) process for a period of nine to 12 months. CIDM requires rational, informed decision-making by all segments of the community. Members of the County Health Council and the Community Encouragers (CEs) facilitated this process. The CIDM process is designed to: 1) engage citizens (consumers and providers) to identify local health needs and problems; 2) collect, analyze, and interpret data to better define needs and problems; 3) promote within the community a collective sense of identity, future and direction; and 4) prioritize

needs and course of action in a written plan.

The statewide network maintains ongoing communications with all the local networks. Community Health Specialists (CHSes) maintain ongoing communication/consultation with CEs and health councils in all 19 counties. CHSes provide direction and encouragement to the CEs, serve as a resource for information, respond to data requests, review and comment on proposed activities and plans and facilitate networking amongst people and organizations. In addition, they provide training in an effort to broaden understanding of health issues and build capacity in planning and development.

Other state-level network activities include:

- Marketing the project to new Delta Counties and obtaining buy-in
- Recruiting and training CEs
- Convening Advisory Committee and CE Regional Meetings

Outlook

The KDRDN will provide additional structure and direction to the CEs and local networks in terms of development activities. The Network will continue to help CEs and local networks develop the projects they have elected to work on using supplemental funds, and it will continue in its capacity-building efforts (i.e., providing training workshops). The KDRDN program will engage local networks in the following ways during Year Three of the grant:

- Assist local networks in implementing Special Initiatives Projects
- Provide no less than three skills development training/workshops to build local capacity
- Assist 10 to 14 Delta counties in developing pharmaceutical-assistance programs
- Assist four to eight counties in developing transportation-assistance programs
- Assist in coordinated efforts to recruit providers
- Assist in coordinated efforts to develop EMT systems
- Assist local networks in developing after-hours and free clinics

All networks have completed community needs assessments and identified future projects. These projects will address a variety of issues including the need for:

- Mental health services
- Health literacy education
- Emergency Medical Technician (EMT) training and certification courses
- Upgrading of EMS equipment for local ambulance services
- Automatic External Defibrillator (AED) purchase, training and distribution
- Diabetes Information Seminars ("Living with Diabetes")
- Tobacco cessation programs for women
- A donation center for recycling of medical equipment (wheelchairs, walkers, electric beds, etc.)
- Walking trails in the park
- 10,000 Steps Walking Program (cardiovascular fitness program)
- Marketing of regional substance abuse services
- Child and adult day care programs
- Dental assistance
- School health promotion
- Substance abuse prevention programs in schools
- First aid training for school faculty
- Driving safely
- Public transportation
- Independent community health clinics

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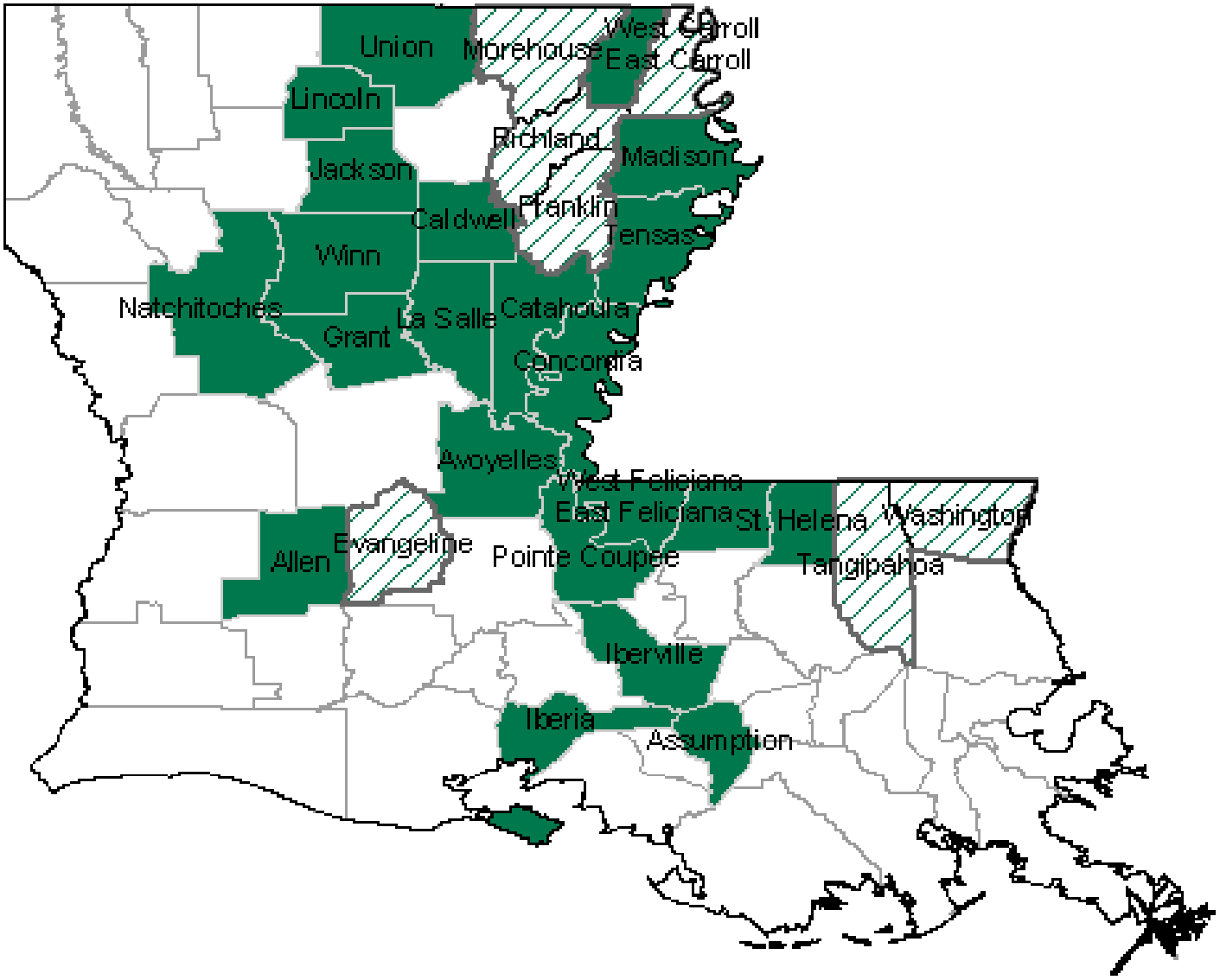
Louisiana

Delta State Networks



BETTER HEALTH FOR THE DELTA

In many rural parishes in Louisiana, residents have no health insurance, transportation, funding for medication or adequate health provider support. Louisiana has one of the highest cancer and heart disease death rates in the nation; hospital emergency room visits are considerably higher than the national average; and Louisiana has only a 66 percent childhood immunization rate, ranking it 49th in the nation.[1] Some of the most severe health disparities are centered in the parishes eligible for Delta grant funds.

The 29 eligible parishes in Louisiana are:

Allen, Assumption, Avoyelles, Caldwell, Catahoula, Concordia, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Pointe Coupee, Richland, St. Helena, Tangipahoa, Tensas, Union, Washington, West Carroll, West Feliciana, Winn

Grantee and Statewide Partners

The lead applicant for the **Better Health for the Delta** program is the Southeast Louisiana Area Health Education Center. A representative from each of the following organizations comprises the Statewide network partners:

Louisiana Rural Health Access Program (LRHAP)

Sponsored by the Robert Wood Johnson Foundation and the LSU Foundation/Pfizer Foundation, LRHAP improves access to primary health care in rural communities in south central Louisiana.

Louisiana State University Health Care Services Division (LSUHCSD)

LSUHCSD provides access to high quality medical care for residents through the development of a medical and clinical work force. It operates the State hospital system, which is the largest provider of inpatient and outpatient services to the underserved.

Louisiana Rural Health Association (LRHA)

LRHA is a non-profit organization dedicated to improving the health of rural residents through educational programs that enhance its members' professional skills and keep them abreast of the latest health care issues.

Louisiana Office of Primary Care and Rural Health (OPCRH)

This organization collects and disseminates health information within the State. They coordinate rural health interests and activities and provide technical assistance.

Rapides Foundation

The Rapides Foundation is a philanthropic organization that provides grants to organizations in a nine-parish service area to improve health and well-being in Central Louisiana.

Southwest Louisiana Health Education Center (SWLAHEC)

SWLAHEC programs focus primarily on health professions**,** health education, clinical services and community coalitions. SWLAHEC serves as a fiscal agent for Federal, State, local and private foundation project grants or service contracts.

Central Louisiana Area Health Education Center (AHEC)

Central Louisiana AHEC is a non-profit community-based agency that offers a variety of education-based services to meet the needs of health care providers in a 17-parish region. It is dedicated to increasing the number of primary health care professionals and improving access to quality health care.

Southeast Louisiana Area Health Education Center (SELAHEC)

SELAHEC works to improve the supply and distribution of health care professionals within the State through community and academic educational partnerships, so that Louisiana residents will have greater access to quality health care.

North Louisiana Area Health Education Center (NLAHEC)

NLAHEC is a non-profit organization that brings health care education and resources to rural and underserved communities throughout North Louisiana.

Louisiana Primary Care Association (LPCA)

LPCA is a State association of Community Health Cen-

[1] http://www.statehealthfacts.kff.org

ters that provide a comprehensive array of primary health services for individuals who lack access to health care.

Louisiana Office of Rural Health (LSORH)

LSORH serves Louisiana communities by collecting and disseminating information within the State, coordinating rural health interests and activities, providing technical assistance and working to increase the recruitment and retention of primary care physicians and mid-level health care professionals in rural areas of Louisiana.

Louisiana Public Health Institute (LPHI)

Louisiana Public Health Institute is a non-profit organization based in New Orleans. Its purpose is to advance public health efforts to prevent disease and to promote positive health practices through collaboration among health care professionals, researchers, educators and those involved in policy development.

Network Conception

Modeled after the Robert Wood Johnson Foundation's Southern Rural Access Initiative, the goal of the Louisiana Delta State Rural Development Network's Better Health for the Delta project is to strengthen the ability of rural community organizations to develop and implement successful network projects. This project strives to empower community groups to identify common problems or goals, mobilize resources and reach the goals they have collectively set. The partner organizations of the Network provide planning, implementation and evaluation oversight for all grant initiatives. The structure is designed to meet the primary goals of assisting local communities to enhance rural health network development, assessing health care needs, planning projects and seeking funding for their projects. Each organization has a designated representative with the authority to commit agency resources when necessary. The partner members have planned a staffing pattern and organizational structure that reduces duplication of effort, ensures full use of limited Statewide resources and replicates best practices and strengths of previous efforts to improve rural health. (See textbox, next page, for a complete list.)

Goals

The primary goal of the Better Health for the Delta program is to improve the health status of State residents within the network area. The program intends to build new primary care capacity through developing rural provider networks. Specific goals include:

- Forming and maintaining an effective network
- Increasing local capacity to assess health needs and develop fundable interventions
- Promoting its programs
- Conducting ongoing program evaluation

Program Activities

The Better Health for the Delta program has worked to empower community groups to identify common health concerns, develop goals and establish local networks. The Statewide partners provide technical assistance, outreach workshops and presentations to the local networks. The program encourages the networks to develop and implement strategies for achieving goals. Specific activities of the Statewide partners include funding Community Encouragers to support coalitions, facilitating health services assessment and planning activities and guiding coalitions to develop and manage local, State and national health resources.

After conducting community needs assessments, each network developed projects to improve the health status of residents. Examples of local network activities are:

- Establishing a mental health network that focuses on children in the Assumption Parish
- Expanding existing transportation services for patients in St. Landry and Evangeline Parishes
- Providing specialty care via telemedicine in East Feliciana Parish
- Improving oral health in Catahoula and Allen Parishes
- Enhancing the health care delivery system in Grant Parish
- Encouraging youth to enter the health care professions in Iberia Parish

Outlook

The Better Health for the Delta program is now working to form and maintain effective local networks. Year Two planning grantees will have completed their Memorandums of Agreement as part of developing their local partnerships. During their second year, it will develop its network plans and will help network members assess health needs and develop fundable interventions using a collaborative approach. The grantees also will begin to modify

and restructure their local health delivery systems to be more responsive to the needs of community members. Statewide rural leaders have conducted a second Delta State Regional Development Network (DSRDN) Grant Program retreat, which was facilitated by Karen Minyard of the Georgia Policy Institute.

As part of its initiative to provide Internet access to health professionals, SELAHEC has leveraged part of its DSRDN Grant Program money by applying for and receiving more than $500,000 in grants. SELAHEC received an IADL grant for $87,000 to support Internet access to six rural venues—a direct link to its goal to provide Internet access for health professionals, five of which are in its Delta catchment area. In addition, SELAHEC received a $500,000 Robert Wood Johnson rural loan fund support grant. In order to apply for this grant, it had to find $300,000 in local, additional "seed capital". This was accomplished by obtaining a $300,000 ten-year interest-free loan from the Louisiana Public Facilities Authority (LPFA). This new $800,000 will be added to a previous $500,000 from LPFA and a $100,000 USDA Rural Business Enterprise Grant. Finally, SELAHEC applied for and was granted a $37,248 grant from the Louisiana Office of Rural and Primary Care to engage a .25FTE loan originator and to acquire software to streamline its application process. Almost all of the anticipated loan

Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding
Assumption Mental Health Network	Assumption	*	$17,000	**
United Comm. Health Ctr. (UCHC)	Evangeline and St. Landry	*	$17,000	**
St. Gabriel Health Clinic	Iberville	*	$17,000	**
RKM Primary Providers for a Healthy Feliciana	East Feliciana	*	$17,000	**
Outpatient Medical Center	Madison	*	$17,000	**
Catahoula Parish Hospital Dist. #2	Catahoula	*	$17,000	**
Bunkie General Hospital	Avoyelles	*	$17,000	**
HOPE Ministry	Pointe Coupee	*	$17,000	**
Ward Seven Hospital	Grant	*	$17,000	**
West Feliciana Parish Network	West Feliciana	*	$17,000	**
The Health Enrich. Network (THEN)	Allen	$17,000	*	**
Iberia Parish Network	Iberia	*	$17,000	**
Central LA Rural Health Network	LaSalle	*	*	$17,000
The Northern Lousiana Alliance	Morehouse, E Carroll, Richland, Franklin	*	$68,000	**
Tri-Ward General Hospital	Union	*	$17,000	**
St. Joseph Arts	Tensas	*	$17,000	**
Concordia Council on Aging	Concordia	*	$17,000	**
Southeastern University	Tangipahoa, Washington	*	$34,000	**
Louisiana Tech University	Lincoln	*	*	**
Caldwell Parish Network	Caldwell	*	*	**

* These networks had yet to be engaged and were allocated funds during the next funding cycle.

** Currently in the awarding process for these networks.

fund activities are related to the Delta project.

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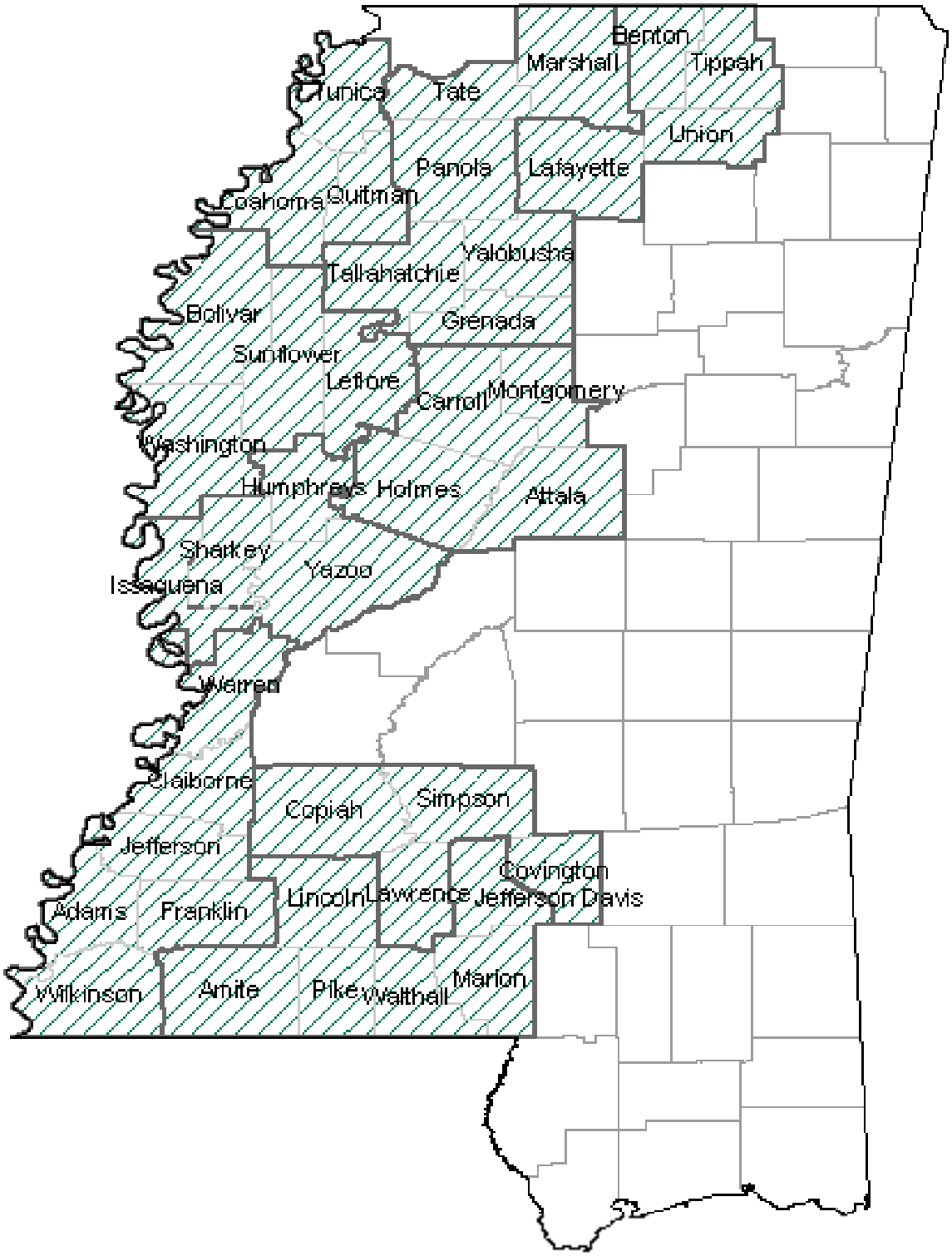
Mississippi

Delta State Networks



MISSISSIPPI DELTA STATE RURAL DEVELOPMENT NETWORK

Sixty-six percent of the population in Mississippi lives in rural areas.[1] The state has the highest rate of heart disease deaths and the third highest cancer rate in the nation. Mississippi ranks third in the nation for teen birth rate at 66.7 per 1,000.[2] These health concerns are even more severe in the 41counties eligible for funds through this grant.

The 41 eligible counties in Mississippi are:

Adams, Amite, Attala, Benton, Bolivar, Carroll, Claiborne, Coahoma, Copiah, Covington, Franklin, Grenada, Holmes, Humphreys, Issaquena, Jefferson, Jefferson Davis, Lafayette, Lawrence, Leflore, Lincoln, Marion, Marshall, Montgomery, Panola, Pike, Quitman, Sharkey, Simpson, Sunflower, Tallahatchie, Tate, Tippah, Tunica, Union, Walthall, Warren, Washington, Wilkinson, Yalobusha, Yazoo

Grantee and Statewide Partners

The lead agency of the **Mississippi Delta State Rural Development Network (MDSRDN)** is the Aaron Henry Community Health Center. The State network partners are:

Aaron Henry Community Health Center

Established in 1979 in Coahoma County in Clarksdale, the Aaron Henry Community Health Center provides health services to the community. As a Federally Qualified Health Center, Aaron Henry also has satellite clinics covering six Delta counties.

Delta Health Cooperative, Inc.

Established in 1998 in Washington County, Delta Health Cooperative, Inc. provides disease management and health education services.

The Mississippi Primary Health Care Association

Based in Hinds County in Jackson, this membership organization represents the State's 21 Community Health Centers (CHCs) and other community-based health care providers. They represent the interest of its members in national, regional, and Statewide efforts to improve access to health care for the medically underserved.

Network Conception

In order to create the networks, an Objective Review Committee (ORC), consisting of five health, social service and educational professionals from across Mississippi, evaluated each proposal. The ORC then submitted recommendations to the State network partners who, in turn, awarded funds to seven of the eight applicants in September 2002. These seven networks covered 33 of the 41 eligible counties. Approximately four months later, a second Request for Proposal was issued and two additional networks received funds in June 2003. MDSRDN now consists of nine networks covering all 41 counties. A list of current networks is in the textbox on the next page.

Goals

The aim of the MDSRDN is to support the development of community-based, multi-county health networks in order to expand access to primary health services throughout the entire 41-county service area. These networks will involve local citizens, health care providers and other civic and social service agencies. MDSRDN will provide technical assistance across the state's Delta counties to help local level rural health networks address their unmet health care needs.

Specific goals are:

- Establish a strong State network to improve Mississippians' access to primary care
- Establish strong local rural health outreach networks (RHONs) in all five Delta regions of the state
- Conduct outcome and process evaluations for State and local network activities

Program Activities

Each local network dedicated its first-year activities to planning and infrastructure building. Trained Community Encouragers in each local network assumed responsibility for administering the project on a daily basis and solicited participation from local residents and health professionals. An indigenous steering group helped guide each project at the local level and ensured community repre-

[1] Population Distribution by Metropolitan Status, state data 2000-2001, U.S. 2001

[2] http://www.statehealthfacts.kff.org/

sentation. Through community-based health needs assessments, each project identified local health concerns and selected a focus issue or issues.

The State network partners, in collaboration with a project advisory board and the MDSRDN staff, manage the Mississippi Delta project. The project advisory board has 25 members from across the service area. Members represent the State Department of Health, local universities and colleges, community health centers and a variety of health and social service organizations. The MDSRDN staff includes a project director, training and communications manager and an administrative assistant. The participation of these entities allows for both diversity and community cohesiveness. MDSRDN conducts media campaigns at the State and local level promoting the networks. The networks participate in Federal and State meetings, workshops, conferences and health initiatives. Each network submits programmatic and financial reports, as prescribed by the project management plan, and participates in an evaluation plan.

Examples of the local networks' progress and current activities follow.

TCQ Network has recently expanded to include 12 partnering organizations. The Community Encourager has promoted the network through involvement in community outreach and health education functions sponsored by other local organizations. A needs assessment was conducted through key informant interviews and focus group sessions leading TCQ to concentrate future activities on cardiovascular disease and diabetes. The network has developed a work plan to address these two health concerns and scheduled it for immediate implementation. As part of the work plan, TCQ has developed a sustainability strategy that includes grant writing and other fund-raising activities. Some of the Network's key planned activities are:

1) Develop a health resource directory for distribution throughout the area

2) Conduct various community education/outreach activities designed to increase awareness and change adverse health behaviors

3) Develop a speaker's bureau to augment other educational initiatives

Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding
4-County Youth Health Risk Network*	Benton, Tippah, Union, and Lafayette	*	$73,680	$73,680
Western Hills Health Partnership	Marshall, Tate, Panola, Yalobusha, Tallahatchie, and Grenada	$110,520	$110,520	$110,520
TCQ Health Network	Tunica, Coahoma, and Quitman	$55,260	$55,260	$55,260
Delta Diamond Health Network	Bolivar, Sunflower, Leflore, and Washington	$73,680	$73,680	$73,680
Central MS Rural Dev. Network	Carroll, Montgomery, Holmes, and Attala	$73,680	$73,680	$73,680
HISY -MDSRDN Project	Humphreys, Issaquena, Sharkey, and Yazoo	$73,680	$73,680	$73,680
Southwest Quadrant MDSRDN	Warren, Claiborne, Jefferson, Adams, Franklin, and Wilkinson	$110,520	$110,520	$110,520
Southwest MDSRDN	Amite, Lincoln, Pike, Walthall, Marion, and Jefferson Davis	$110,520	$110,520	$110,520
Teen Health Network*	Copiah, Lawrence, Simpson, and Covington	*	$73,680	$73,680

* These two networks did not receive funding until 7/1/2003. A second application phase was conducted to identify lead agencies for these two geographic areas.

4) Contract with a health educator/exercise specialist to provide health instruction and to design exercise programs

Delta Diamond Health Network includes four counties in the Mississippi Delta region. Membership in Delta Diamond has increased from seven original participants to 34 partner organizations. To build community awareness of the network and encourage participation, the network held speaking engagements and distributed brochures and health fact sheets to the community. The network conducted health surveys, focus groups and key informant interviews to identify local health priorities. Some of the primary problems identified were:

1) Difficulty accessing health care, particularly for those without insurance/Medicaid/Medicare;

2) Lack of knowledge regarding what health services exist within the community and how to access these services; and

3) Lack of education regarding the impact of behavior on health status/outcomes.

To address these primary health concerns, Delta Diamond's primary goal is to develop an infrastructure that will support a system of comprehensive, accessible and affordable health care. The primary method for achieving this goal is to construct a database/directory of local health services to identify gaps in health resources, and to implement an electronically based health care delivery system to provide streamlined referrals and patient care management. Implementation of plans designed to achieve this goal began January 1, 2004.

Humphreys, Issaquena, Sharkey, Yazoo MDSRDN Project consists of three health networks covering four counties. The project is working to expand the capacity of these three individual networks to further impact the health of the counties they serve. Primary first-year activities included media campaigns to raise awareness of the network and its activities and a telephone survey of 1,526 households to determine the use of health services, evaluate the perceived quality of services and assess the prevalence of health conditions. This health information will be made available to the public and used by various groups including local hospitals and other health decision makers, and by the local network project and other community groups to assist in grant writing, securing additional funds and designing health education campaigns. These activities are currently underway and are scheduled to continue with plans to reassess the major community health indicators some time in the future.

Central Mississippi Rural Development Network covers four rural, Delta counties. A local health council has been established in each county to ensure community representation and participation throughout the project. Representatives from each county health council serve on the overall local network advisory board. This network structure provides an effective means of communication and collaboration between the local, grassroots level and the regional, four-county network.

As a result of the community health needs assessment, obesity and diabetes were identified as the two primary health concerns in the area. The project will address these health issues through education seminars and workshops, summer camps that target children, healthy cooking classes and other community outreach activities. Implementation began November 2003.

Southwest MDSRDN Project covers a large geographic area consisting of six counties. A local health network is being developed in each of these counties with a separate, community-based steering group in each. In addition to various media activities designed to increase awareness and participation in the project, Southwest MDSRDN conducted a health needs assessment through 30 key informant interviews and 16 focus group sessions. As a result of this assessment, the project has identified three primary health concerns to guide the second year of its program and beyond: 1) Teenage Pregnancy, 2) Obesity, and 3) Colon Cancer.

Long-term goals are to reduce the incidence of each of these primary health concerns by 40 percent before September 2010. Short-term goals are to increase awareness, educate residents on prevention and increase the capability of residents to access appropriate treatments associated with each. Community education campaigns have begun and will include workshops, health fairs and the distribution of print media, as well as public service announcements.

Other local networks are involved in similar activities. In total, MDSRDN will conduct 164 focus group discussions and 205 key informant interviews covering the 41-county service area. The primary health issues identified by the other remaining networks are:

- **Western Hills Health Partnership** will address issues including, but not limited to, chronic illnesses, transportation, substance abuse, alcoholism and pregnancy within six Delta counties.

- The **4-County Youth Health Network** plans to address health risks in youth ages 13-20.
- The **Southwest Quadrant-MDSRDN**, a six-county network, plans to promote accessibility and cost-effective delivery of health services.
- The **Teen Health Network** is focusing on abstinence education for school children. Other components of the program include a wellness approach to provide early entry into prenatal care and education on parenting skills for pregnant teens as well as the fathers. The project service area consists of four counties.

Outlook

The networks have identified local health concerns through detailed community needs assessments, and each has established projects designed to address these issues. As demonstrated, the networks plan to address a variety of health care issues. However, it is anticipated that the focus of each network will, and should, change from time to time. Each network is organized in a manner that will allow for constant feedback from multiple sectors of the community. Input from residents/patients is as important as input from local health professionals. This dialogue is necessary to meet the challenges of the ever-changing health industry, changes in health policy and new and emerging disease states. An intended side result is forming a connection between the community, the providers and the local health system. The best, and most effective, solutions to local health challenges are found by developing the capacity of each local health system to take ownership of its health needs and work together to identify the best approaches to solving those problems.

The MDSRDN has successfully leveraged $27,000 as a grantee of the Delta States Rural Development Network Grant Program, which it has contracted with the Mississippi Primary Health Care Association to support its activities. With this money, the MDSRDN will provide training, materials and other kinds of support to each of its local networks, which will enable them to apply for and receive additional grant funds.

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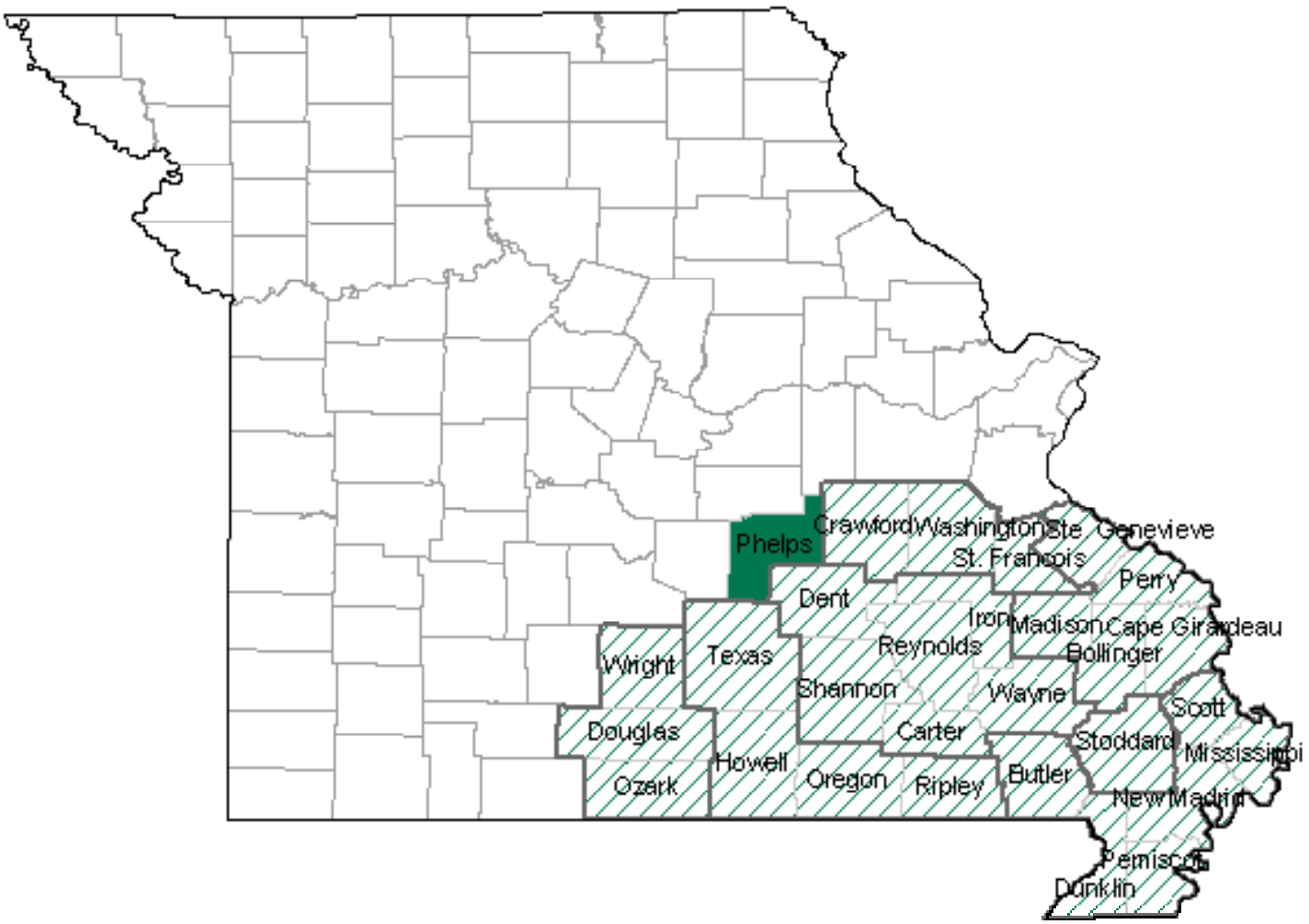

MISSOURI DELTA RURAL HEALTH NETWORK

The 29 designated Delta counties in Missouri are located in the southeastern region of the state. All of Missouri's Delta counties are designated as Primary Care Health Professional Shortage Areas. The availability of primary health providers, oral health providers and behavioral health care providers has been a chronic barrier to accessing health care in all rural areas of the State. The Division of Medical Services, Department of Social Services has not been able to implement Medicaid Managed care in rural areas due to the shortage of physicians and the willingness of available physicians to staff the various plans. The Missouri Delta region also experiences a lack of non-emergency transportation, large poverty populations and significant uninsured and Medicaid populations.

The 29 eligible counties in Missouri are:

Bollinger, Butler, Cape Girardeau, Carter, Crawford, Dent, Douglas, Dunklin, Howell, Iron, Madison, Mississippi, New Madrid, Oregon, Ozark, Pemiscot, Perry, Phelps, Reynolds, Ripley, Ste. Genevieve, St. Francois, Scott, Shannon, Stoddard, Texas, Washington, Wayne, Wright

Grantee and Statewide Partners

The Missouri Primary Care Association administers the **Missouri Delta Rural Health Network (MDRHN)**. The following organizations have been formally designated as Statewide network partners:

Missouri Primary Care Association (MCPA)

MCPA, which has been in existence since 1994, works with Community Health Centers, the Missouri Department of Health and the Missouri Department of Social Services to improve primary care access. The MPCA currently is working to improve the primary care delivery system through community development in two Delta areas, West Plains and Potosi.

Missouri Department of Health (MDOH)

The MDOH will make available other departmental entities such as the Missouri Office of Rural Health, Primary Care Office and the Community Health Assistance Resource Team to help MDRHN with planning and assessment needs.

Missouri Area Health Education Centers (MAHEC)

The MAHEC network consists of seven regional program offices that cover the entire state. It recruits medical personnel to the region from schools located in other areas of the state.

Southeast Missouri State University (SEMO)

SEMO, the largest State University in the Missouri Delta region, has broad experience in network development.

Missouri Rural Health Association (MRHA)

This association has the mission of safeguarding and improving the health of rural Missourians. MRHA has a Board that consists of two representatives from each of the seven regions of the state. The MDRHN will have one representative from MRHA on its Board to bring a Statewide rural perspective.

Network Conception

In Year One of the MDRHN, the "Social Reconnaissance", an information gathering and organizing method for learning a community's characteristics, was used throughout the 29 county Missouri Delta region, beginning in June 2001. During interviews and community meetings, secondary health data was collected and analyzed. The information was processed in a strategic planning format in the Fall of 2001, leading to the first two years of network development and individual community operation. Community Health Centers (CHCs) were chosen to act as lead agents for their networks.

Late in the second year, the regional network identified priority network development areas as: Pharmaceutical Access, 211 First Call for Help and Regional Disease Collaboration Participation and Enhancement. Site visits then narrowed the focus to pharmacy access as a way to build a service delivery network. Field staff coordinated a site visit from a pharmaceutical access consultant.

As the project enters its third year, four of the seven CHCs have employees whose prime responsibility is to act as MDRHN coordinators. Network participants include but are not limited to Head Start agencies, Senior Centers, AHEC offices, Food Banks, Migrant Education Programs, County Health Departments and others.

Goals

The mission of the MDRHN is to improve access to health care and to eliminate disparities in the Mississippi Delta

Region. In addition, the program hopes to develop communities of healthy people by identifying vulnerable populations and determining critical health needs through community assessments.

The goals of the MDRHN include:

- Create an infrastructure to coordinate and support health system improvement efforts
- Establish network linkages to exchange information and resources among Federal, State/regional and local networks
- Identify and support local health improvement efforts
- Sustain the health improvement efforts of the local networks through administrative and technical support
- Establish an evaluation strategy for process, access and health outcomes

Program Activities

Big Springs Medical Association (BSMA)

BSMA chose to work on the issue of Emergency Medical Services (EMS) and set out to develop effective lines of communication between the eight EMS providers that serve a five-county area. In addition, BSMA has been working on expanding services through two key activities: collaborating with a community-based program in Black, Missouri that primarily serves troubled boys; and developing a tele-health program at their Ellington location, through a video link–up with mental health professionals at the University of Missouri.

Central Ozarks Medical Center (COMC)

COMC continues to focus on an expansion into the Rolla area of Phelps County. As the only health center in the MDRHN that resides outside of the officially designated "Delta Area," COMC faces some unique challenges. With those challenges in mind, COMC has been working with MPCA and the MDRHN office in Sikeston to develop more awareness of FQHCs and the value they add to any rural community's health care continuum. It also has been working on a plan to ensure sliding fee medical services are available to the citizens of Phelps County.

Cross Trails Medical Center (CTMC)

With second year funding CTMC has worked to develop an expanded dental program. It has developed contractual relationships with a number of dentists and dental specialists. In addition, it has expanded the number of community activities and screenings that its Dental Hy-

Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding
Big Springs Medical Assoc.	Reynolds, Shannon, Carter, Iron, Dent, Wayne	$101,100	$101,100	$101,100
Central Ozarks Medical Ctr.	Phelps	$33,700	$16,850	$16,850
Cross Trails Medical Ctr.	Cape Girardeau, Bollinger, St. Genevieve, Madison, Stoddard (50%), and Perry	$92,675	$92,675	$92,675
Douglas County Public Health Service Group	Douglas, Ozark, and Wright	$50,550	$50,550	$50,550
Southern Mo. Community Ctr.	Howell, Oregon, Ripley, and Texas	$50,550	$67,400	$67,400
Great Mines Health Ctr.	Washington, Crawford, and St Francois	$50,550	$50,550	$50,550
Southeast Mo. Health Network	Dunklin, Mississippi, New Madrid, Pemiscot, Scott, Butler, and Stoddard (50%)	$109,736	$109,736	$109,736

gienist has engaged in. CTMC also is implementing a computerized Patient Assistance Program and is expanding its diabetes education program, including full implementation of the Disease Collaborative model at their Marble Hill Clinic. Finally, CTMC has continued to provide support to First Call For Help, with service expansions of those services into both Perry and Stoddard Counties. These expansions were initiated with the idea of being able to tie these services into emergency plans to ensure proper dissemination of information during times of emergency.

Douglas County Community Health Care Clinic (DCCHCC)

DCCHCC continues to engage in MDRHN activities through an innovative collaborative agreement between the FQHC and Douglas County Public Health Department. DCCHCC's Delta activities have focused around public education and developing a plan to address medical workforce issues. DCCHCC's community facilitator has created community-based health education programs dealing with smoking cessation, and cardiovascular, diabetes and other health education issues. In addition, DCCHCC has worked closely with their AHEC in developing middle and high school health professions awareness programs and campaigns. These programs have been coupled with an increased usage of dental and medical student rotation programs. DCCHCC's other activities include teen pregnancy and abstinence programs, and the development of a food pantry.

Great Mines Health Center (GMHC)

Using MDRHN funding, GMHC has hired new clinical staff, purchased laboratory equipment to increase the number of primary and secondary prevention services it can offer on-site and has identified and recruited medical, dental and mental health professionals. GMHC also has worked to increase its infrastructure and clinical capabilities and is applying for FQHC and FQHC Look A Like status.

Southern Missouri Community Health Center (SMCHC)

SMCHC has used Delta funding during years one and two to assist with writing its FQHC new start application and to recruit providers. SMCHC has hired staff to design a comprehensive pharmaceutical assistance program. Plans for this program include the acquisition and utilization of a computerized system designed to track both indigent drug assistance and distribution of samples provided by pharmaceutical representatives. These activities will also support, and be supported by, any regional pharmaceutical program developed as part of the MDRHN initiative. In addition, SMCHC plans to hire a full-time community development staff member so that it can implement its community-based health promotion program. This program will be greatly enhanced when SMCHC begins providing dental services out of its West Plains clinic location.

Southeast Missouri Health Network (SEMO)

As part of its MDRHN activities, SEMO has developed a strong collaborative relationship with Crossings, an Eleven County mental health/substance abuse program (MH/SA), in which SEMO has agreed to provide MH/SA counseling to the program participants. SEMO also has hired an Outreach Coordinator and a Community Development Specialist with the specific goal of increasing its level of visibility within the communities that it serves. In addition, the network plans to participate in the BPHC-sponsored Cardiovascular Collaborative, and is in the process of recruiting a Diabetic Nurse Educator. Finally, SEMO has developed a Medication Assistance Program. This program has been a large part of SEMO's Delta activities over the past two years and it is hoped that SEMO will be utilized, in some way, as the hub of a regional Medication Assistance Program.

Outlook

Some collaborative goals of the Community Health Center Networks are to develop an organizational emergency preparedness plan; write a grant to a private foundation to request supplemental funding in order to develop a network-wide communication system, shared database and evaluation plan, and to support network facilitators; continue to develop health promotion and health education programs focused on special populations such as adolescents, women with children and senior adults; and continue to work for access to mental health and oral health care within the primary care delivery systems.

The MDSRDN Grant Program has successfully leveraged more than $700,000 as a grantee of the Delta States Rural Development Network Grant Program. As part of its work with EMS issues, the Big Springs Medical Association applied for and was awarded a Missouri Foundation for Health grant in excess of $700,000 that will provide training, equipment and expanded recruitment opportunities to each of its eight EMS providers.

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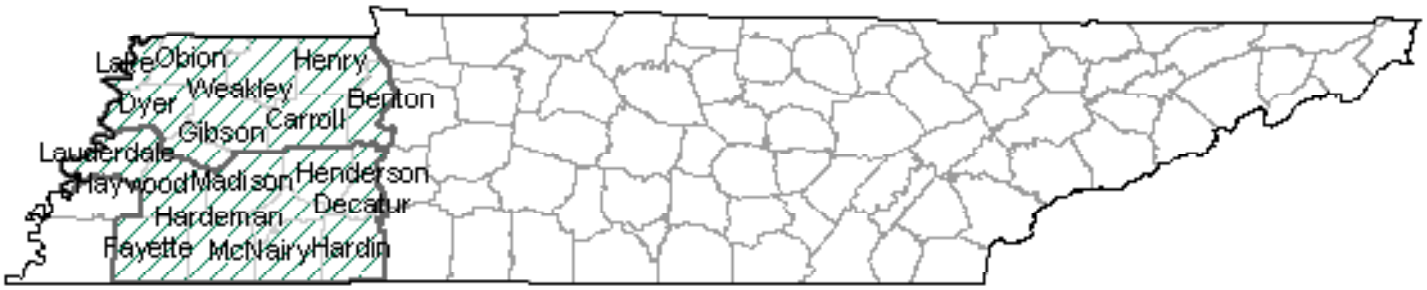

TENNESSEE DELTA STATE RURAL DEVELOPMENT NETWORK

In Tennessee, the number of prescriptions per capita is the highest in the nation. Hospital emergency visits are considerably higher in Tennessee than the national average. Poverty continues to be an overwhelming problem for this rural Delta population. Other barriers that inhibit access to care include geography, low levels of educational attainment and a lack of culturally appropriate programs and services. Delta mortality rates from cardiovascular disease and cancer are much higher than State and national rates.

The 19 eligible counties in Tennessee are:

Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, McNairy, Madison, Obion, Weakley

Grantee and Statewide Partners

The Tennessee Department of Health is the grantee for the **Tennessee Delta State Rural Development Network (TDSRDN)**. The state network partners are:

Tennessee Department of Health

The efforts of the Tennessee Department of Health to improve assessment, one of the core functions of public health, resulted in the Community Diagnosis process, which the department has implemented to assist Tennessee communities and local and regional health departments in fulfilling the mission of public health.

State Office of Rural Health

The SORH played a significant role in the development of the network structure and the design of its evaluation matrix. The SORH serves as a central forum for the project partners to exchange information and ideas and to formulate policy.

University of Tennessee Department of Nursing

The UTM Department of Nursing manages the annual educational conference component of the Tennessee Delta project. Two such conferences have been held with average attendance of more than 300. The conferences have provided local health care providers and health professions students with data and intervention strategies related to heard disease, cancer, stroke and diabetes in the Mississippi River Delta counties of West Tennessee.

Network Conception

While the overall goal of the grant program is for each state to establish networks within the first year of funding, the state of Tennessee, in a progressive move to improve conditions, already had Community Health Councils in place. The grantee has built upon this existing community health-planning infrastructure to meet the requirements of the DSRDN Grant Program. Tennessee has invested heavily in community-based health planning since 1996. The "Community Diagnosis" process and the county health councils that facilitate that process were developed specifically to support county-level assessments and collaborations to address shared problems. The extra money the State has received through this grant has helped it capitalize on the foundation it has established and move towards implementing the grant program. Needs assessments, project plans, subcontracts and plans for evaluation are part of the progress that the program has implemented, to date.

The networks have been rationally grouped into geographical service areas based on patterns of health care usage. Local networks will request funding through a Request for Proposals process. Funding through this initiative will be available to all Delta counties in the West Tennessee service area. Networks also known as County Health Councils were established in 1996 through a natural selection process. There is a network in each county within the grant service area. The composition of each network in each county was designed to be broadly representative of the community it serves.

Goals

The Tennessee Delta State Rural Development Network (TDSRDN) has the following goals:

- Establishing operating structures for the Statewide and local networks
- Implementing the project management plan
- Developing assessments
- Developing project plans
- Developing subcontracts
- Evaluating results

Program Activities

The Northwest and Southwest Regional Delta Networks have:

- Conducted a community needs assessment to identify priority health issues facing the region and individual counties. Priority areas were diabetes, heart disease, cancer and stroke.
- Held a Delta State Conference focusing on health disparities in the West Tennessee Delta Region
- Established interventions and services

Outcomes from the Network's activities range from developing an effective working partnership among three competitive hospital systems representing 19 West Tennessee counties, to the development of interventions to address the priorities identified through the community health assessments.

The local and regional networks are working to design and implement data-driven, county-specific interventions to reduce health disparities related to heart disease, stroke, diabetes and cancer. Local county networks are partnering to achieve economies of scale to ensure that the interventions selected are appropriate and based on tested models.

Outlook

The TDSRDN's current initiative addresses the underlying causative factors contributing to new rates of cancer, diabetes, stroke and cardiovascular disease. The networks have been established to address reducing morbidity and mortality rates of the diseases aforementioned. Through the remainder of the current budget year, the grantee will be focusing on completion of the assessment, conducting the conference, developing model intervention plans and finalizing the scope of services for subcontracts. Since the project relies on existing staff donated to the project (rather than the Community Encourager model), the grantee expects a significant surplus. The applicant intends to request that unobligated funds be rolled into the second year of the project. In Year Two of the project, the plan is to implement the work scope described in a planned scope of services.

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Network	Participating Counties	Year 1 Funding	Year 2 Funding	Year 3 Funding
Northwest Regional Health Council	Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion, and Weakley	$208,813	$208,813	$208,813
Southwest Regional Health Council	Chester, Decatur, Fayette, Hardeman, Hardin, Haywood, Henderson, Lauderdale, McNairy, and Madison	$229,788	$229,788	$229,788

II. The Delta Rural Hospital Performance Improvement (RHPI) Project

A financially stable hospital is crucial to a community's health, as well as its economy, especially in rural areas. Hospitals not only provide residents with essential health care services, they also are a major employer and help fuel the local economy.

Unfortunately, many small rural hospitals are struggling to stay afloat in the face of:

- Severe workforce shortages
- Geographic isolation
- Inadequate reimbursement
- Increasing costs
- Poor access to capital
- New regulatory requirements
- Growing numbers of underinsured patients

These challenges are particularly acute in the Mississippi River Delta region where poverty and unemployment contribute to most small hospitals' financial losses. Currently, more than 100 small rural hospitals in the Delta provide inpatient and outpatient care, emergency medical services and nursing home care. In the Delta Region, the average operating margin for hospitals, a key indicator of their long-range financial success, is a loss of almost $550,000 per year. Given this situation, hospitals face daunting obstacles in obtaining access to much-needed capital.

The Delta Rural Hospital Performance Improvement (RHPI) Project is a program designed to preserve health care access in rural communities by addressing problems that challenge small rural hospitals. The RHPI Project:

- Provides on-site technical assistance to hospitals in the Delta region to help them improve their financial, clinical and operational performance;
- Collects and disseminates business tools, information and databases that hospitals can use to help themselves;
- Helps build State and regional capacity that can provide ongoing assistance to rural hospitals in the Delta.

The emphasis of the program is on improving the hospital's performance and long-term financial success. The exact nature of the assistance is worked out with the hospital to make sure that the help needed is the help delivered.

Guiding Principles

1. Coordinate with all other rural hospital-related programs and activities in the region.

2. Customize the project approach to the needs and circumstances of each State and to the region. (Do not assume to know what's best for any State or hospital.)

3. Build local ownership and local capacity so that hospital performance improvement activities can be sustained after the project period.

4. Be inclusive, work with everyone committed to accomplishing the project goals.

5. Utilize the principles of continuous quality improvement throughout the project, including:

- Factual approach to decision making;
- Fixing systems and not people;
- Broad involvement of staff and consumers; and
- Emphasis on building and sustaining leadership.

Eligibility

To benefit from this program, a hospital must be located in one of the designated counties of the Mississippi Delta Region and must have 50 or fewer staffed beds.

Eligible hospitals complete a brief two-page application, which is available on-line at http://deltarhpi/ruralhealth.hrsa.gov, and submit it to RHPI Project staff. The opportunity to apply is continuous throughout the three-year project period. Following receipt of a hospital's application, RHPI Project staff conducts conference calls with the applicant hospital administrator. Calls also are held with the State Offices of Rural Health, State hospital

associations and the RHPI Project team to discuss the applicant hospital's readiness and ability to benefit from the program.

Who Administers the Delta RHPI Program?

In September 2001, the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, entered into a three-year contract with Mountain States Group, which administers the program in partnership with the Rural Health Resource Center.

Current Status

At the end of its second year, the Delta RHPI Project had received 63 applications, which constitutes 52 percent of eligible hospitals within the Delta Region. Twenty hospitals had received comprehensive assessments and assistance and 20 hospitals received targeted assistance. This project also works closely with the Delta States Rural Development Network Program. This report provides some examples of the work accomplished by the Delta RHPI Project so far in each of the eight Delta States.

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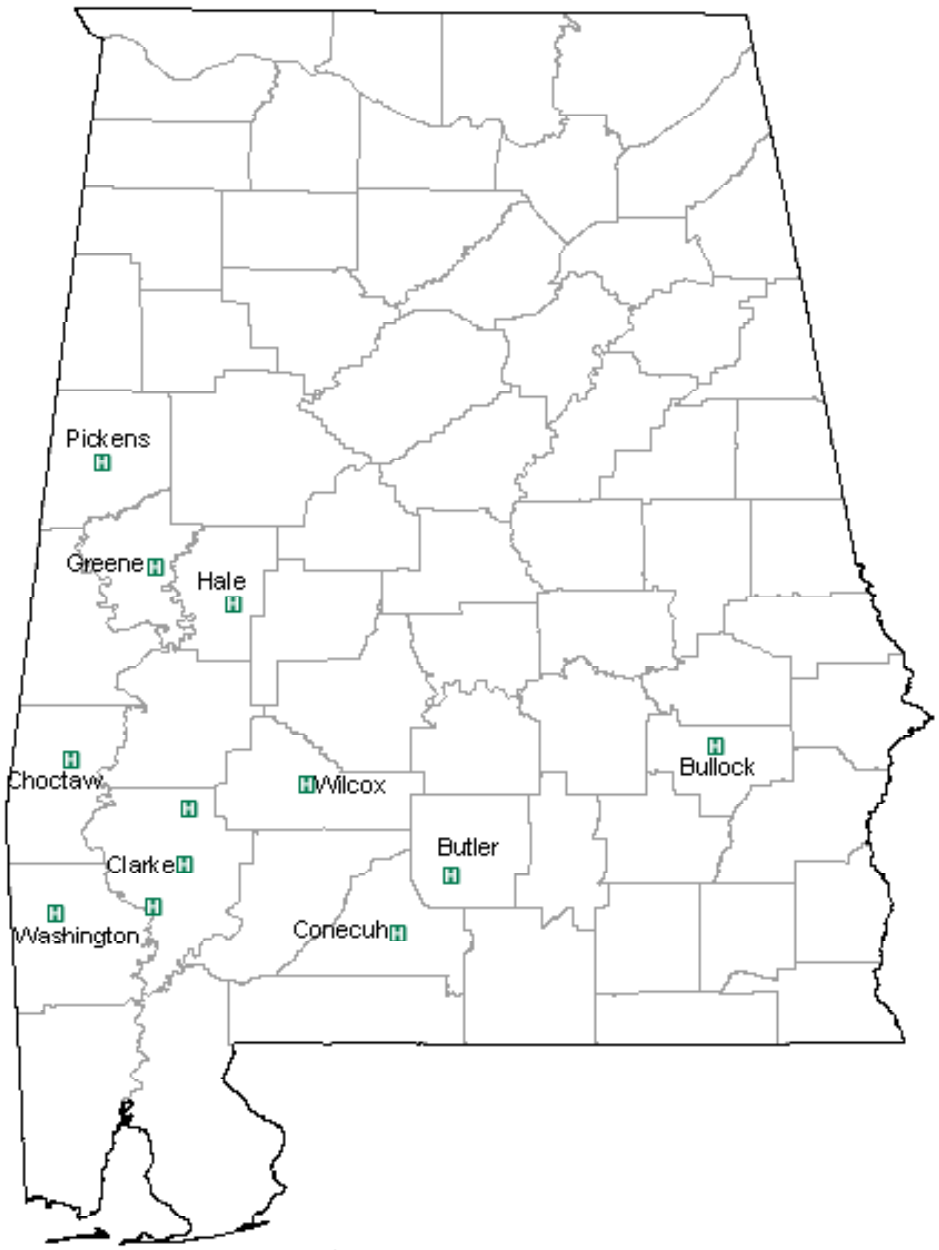

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Eligible and Participating Hospitals

Alabama has 12 eligible hospitals located in the Delta Region. As of March 2004, five hospitals had applied for technical assistance.

Consultations Provided

The three hospitals in Alabama that have received consultations participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/Expense Management, Physician Practice Management and Organizational Architecture.

Consultations in Focus

Jackson Medical Center
Jackson, AL

Jackson Medical Center is one of the few for-profit hospitals in the region. At the time of the consultation, the medical center was working with two other communities in the county to evaluate whether one regional medical center should replace the three small rural hospitals currently in the county. The recommendations were designed to be relevant to JMC's future market position, regardless of external events. It was found that the two most controllable actions the medical center can take is to maximize current relevance, market share and profitability in the local market; and to continue to play a vital role in the political, business development and consensus building process associated with the regional medical center initiative.

The consultants found that JMC is a well-run facility, but it is short of primary care physicians. It was recommended that the center develop a strategy for recruiting physicians, particularly pediatricians, given that 28 percent of the population is under 18. It was recommended also that the center should consider adding another Internal Medicine physician with perhaps a specialty in pulmonology.

Washington County Infirmary
Chatom, AL

A comprehensive performance improvement assessment was conducted in January 2004. The consultation provided education in the area of swing bed utilization, which was a priority for the hospital. As of a report generated March 16, 2004, swing bed utilization was up 135 percent from the previous year. Since implementation, the hospital has had patients in the swing bed every day. All

Hospital	County	Participation Date	Status
Bullock County Hospital	Bullock	–	*
Evergreen Medical Center	Conecuth	–	*
Georgiana Hospital	Butler	–	*
Greene Co. Hospital	Greene	Jan. 2002	Comprehensive
Grove Hill Memorial Hospital	Clarke	–	*
Hale County Hospital	Hale	–	*
Hill Hospital of Sumter Co.	Sumter	–	Application received
Jackson Medical Center	Clarke	April 2003	Comprehensive
John Paul Jones Hospital	Wilcox	–	*
Pickens Co. Medical Center	Pickens	–	Application withdrawn
Thomasville Infirmary	Clarke	–	*
Washington Co. Infirmary	Washington	Jan. 2004	Comprehensive

* Has Not Applied, as of March 2004

staff are now educated on swing bed use. The next step is to market the swing bed service to the public.

What Participants Are Saying About the Project

"I attended two hospital reviews provided to Alabama hospitals by the Delta RHPI Project. I have been impressed with the depth of the reviews.... Bringing an outside team in to assess operations provides the catalyst for collaboration between management and staff to implement performance standards in all departments. The reviews in Alabama identified additional revenue potential for both hospitals through changes in completing cost reports. The reviews also provided opportunity for one hospital to obtain technical assistance and encouragement to pursue a strong swing bed program. The staff concluded that implementing a swing bed program will not only increase revenue with minimal additional costs but also significantly improve continuity and transition of care for patients." Dr. Clyde Barganier, Director, **Alabama Office of Primary Care and Rural Health**

"The performance improvement report from the RHPI Project is an excellent document, with information and direction. It pointed out information on out-migration that we were not aware of at the time. The [Stroudwater Associates] consultants came with information from other small rural hospitals so this was relevant. And the consultants have been very responsive to questions and concerns; and have presented responses with documentation, citing where they got the information. This gives credibility to the information. The consultation balanced the things we were doing well and pointed out areas needing improvement. It was non-threatening. We have made progress on our action plan. We recently had our one-year anniversary of being a CAH. We learned a lot from the consultants about the benefits of CAH that we were not taking advantage of—this was extremely helpful." Doug Tanner, CEO, **Washington County Infirmary,** Chatom, Alabama

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Or visit the project's web site at:
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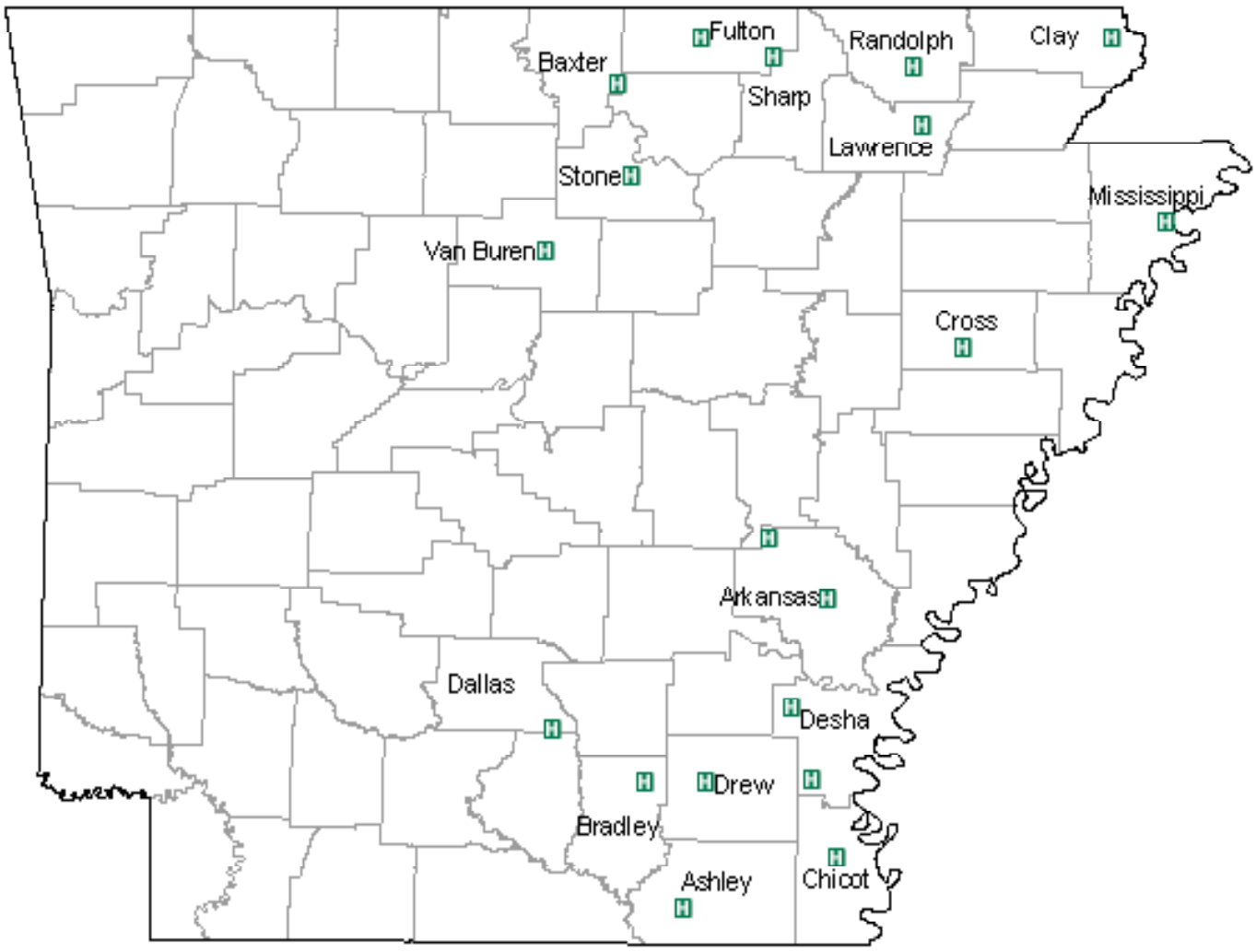
Rural Hospital Performance Improvement (RHPI) Project

Arkansas



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Eligible and Participating Hospitals

Arkansas has 19 eligible hospitals located in the Delta Region. As of March 2004, 11 hospitals had applied for technical assistance.

Consultations Provided

The technical assistance provided to participating hospitals included community engagement, strategic planning, revenue enhancement and customer service. Hospitals in Arkansas also participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/ Expense Management, Physician Practice Management and Organizational Architecture. Two hospitals in Arkansas participated in both the comprehensive performance improvement assessment and the targeted consultation. One hospital participated in the project's Balanced ScoreCard pilot project.

Consultations in Focus

Ashley County Medical Center
Crossett, AR

Ashley County Medical Center and RHPI Project consultants worked with community physicians to gain support for increased inpatient volumes. Together, they identified pulmonology and oncology as secondary care specialties needed in the community. In addition, a hospitalist was hired to manage inpatients and share time in the emergency room. As a result, two community physicians, who

Hospital	County	Participation Date	Status
Ashley County Medical Ctr.	Ashley	Aug. 2002	Comprehensive
Bradley County Medical Ctr.	Bradley	June 2003	Targeted
Chicot Memorial Hospital	Chicot	–	*
Cross Ridge Community Hospital	Cross	February 2003	Targeted
Baptist Memorial Hospital-Osceola	Mississippi	–	*
Dallas County Hospital	Dallas	–	*
Delta Memorial Hospital Assoc.	Desha	–	*
DeWitt City Hospital	Arkansas	September 2003	Comp. & Targeted
Drew Memorial Hospital	Drew	April 2003	Targeted
E. Ozarks Regional Health System	Sharp	–	*
Fulton County Hospital	Fulton	October 2002	Targeted
Lawrence Memorial Hospital	Lawrence	December 2002	Comp. & Targeted
McGehee-Desha Co. Hospital	Desha	–	Application received
Med. Ctr. of Calico Rock, Inc.	Izard	–	Application received
Ozark Health Medical Ctr.	Van Buren	–	Application received
Piggott Community Hospital	Clay	Nov. 2002 /Nov. 2003	Comp. & Targeted
Randolph County Medical Ctr.	Randolph	–	*
Stone County Medical Ctr., Inc.	Stone	–	*
Stuttgart Regional Medical Ctr.	Arkansas	–	*

* Has Not Applied (as of March 2004)

used to refer all cases outside the community, are doing their work through the hospitalist. Referrals have increased inpatient volumes an average of four to five patients per day. At an average reimbursement rate of $900 per patient per day, Ashley County Medical Center has increased revenues by over $1 million annually.

DeWitt Hospital & Nursing Home
DeWitt, AR

This hospital and nursing home participated in targeted and comprehensive consultations. An on-site customer service training program was implemented through the RHPI Project, which targeted front-line staff. Front-line staff received customer service training and established a Customer Service Investigation team (referred to as CSI-DeWitt) that works on identifying and recognizing employees that excel. As a result, the hospital improved employee wage scales, made some equipment improvements and refocused its recruitment process to find the right people for the job. Also, a survey of employees after the program was initiated showed a 26 percent improvement in overall job satisfaction.

Fulton County Hospital
Salem, AR

The RHPI Project team worked with the Fulton County Hospital management team and a member of the board of directors to develop a strategic plan. The hospital predominantly serves the elderly and poor; at the time of the consultation, approximately 82 percent of inpatient charges were Medicare and Medicaid. Recommendations included: define a sustainable scope of services; aggressively pursue medical staff retention and recruitment strategies; concentrate development on outpatient services; maintain local EMS and emergency room services; and develop more inpatient and outpatient strategies focused on the needs of the elderly. The recommended starting point was to limit acute inpatient care and to increase the use of swing beds.

Lawrence Memorial Hospital
Walnut Ridge, AR

Administrator Lee Gentry engaged local physicians to identify how the hospital could create a more efficient and supportive environment. As a result of the action plan developed under the RHPI Project, the hospital has increased support from local physicians and the community at-large and has already experienced a modest increase in physician usage. Physician engagement is now measured on a regular basis and will provide additional opportunities for improvement. In addition, project consultants conducted a community assessment and health care services economic impact study. Community leaders have a greater understanding of the importance of the hospital's economic impact—439 employees with an annual payroll of $6.8 million. Through community leader engagement and a renewed focus on customer satisfaction, the hospital is enjoying a more positive image in the community.

What Participants Are Saying About the Project

"The State Office of Rural Health & Primary Care saw this program as an opportunity for our hospitals to get highly specialized recommendations to problems that were specific to their location. The State was eager to participate in every hospital project to gain expertise in hospital operations and to, hopefully, increase the State's ability to perform some of the same reviews, but at a much less comprehensive level, and to additionally know when it would be better suited for the hospital to have access to consulting groups for the advice they sought. This was the perfect vehicle to bring the community together and hear first-hand how important it is to support the hospital in their community. This placed a very tangible product before the community and allowed them to meet regularly to address the important health care issues." Sandy Hayes, **Arkansas Department of Health**, **Office of Rural Health and Primary Care**

"This is going to be the bedrock upon which we build our plans," said Franklin Wise, hospital administrator of **Fulton County Hospital**, a 50-year-old Hill-Burton facility in Salem. "It's where we start our future."

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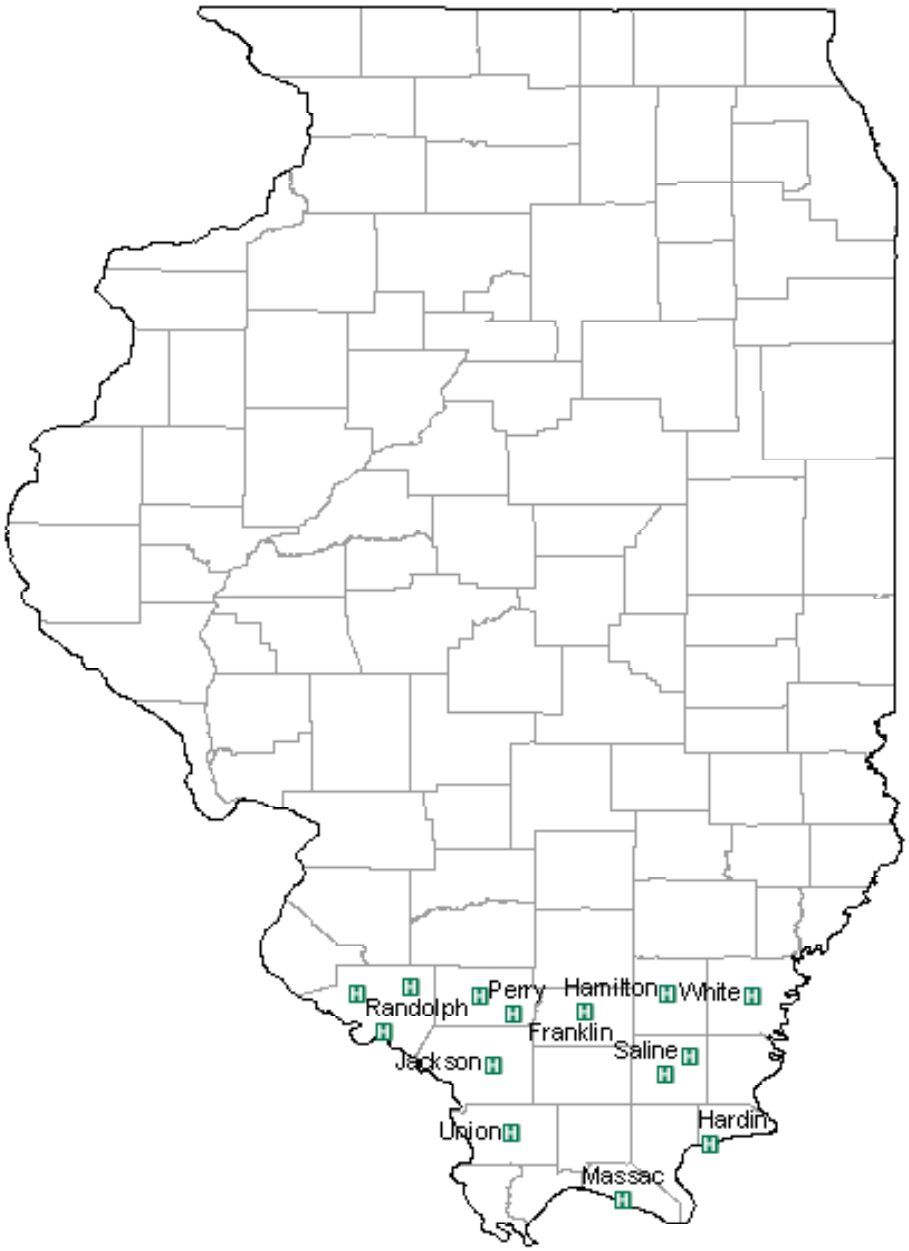
Illinois



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Eligible and Participating Hospitals

Illinois has 14 eligible hospitals located in the Delta Region. As of March 2004, eight hospitals had applied for technical assistance.

Consultations Provided

Hospitals in Illinois received targeted consultations and also participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/Expense Management, Physician Practice Management and Organizational Architecture.

Consultations in Focus

Hamilton Memorial Hospital District
McLeansboro, IL

RHPI Project consultants found that the primary challenge for this hospital is preparing for a number of transitions in medical staff leadership. Recommendations focused on Medical Staff Development Planning and a strategy to work with a regional Federally Qualified Health Center (FQHC). Other clinical and business office recommendations focused on process improvements. The hospital is interested in on-going participation in a strategic measurement system.

Marshall Browning Hospital in DuQuoin, IL and **Pinckkneyville Community Hospital** in Pinckkneyville, IL

The goal of this targeted consultation was to bring the two hospitals together to discuss merging. The two hospitals are in Perry County, approximately 12 miles apart. They collectively serve an estimated one-third of the inpatient admissions generated by county residents, with the remainder going to Carbondale (30 minutes away) or St. Louis (1.5 hours away). Both hospitals are in need of significant renovation and/or replacement facilities. The consultant presented scenario planning for Perry County,

Hospital	County	Participation Date	Status
Ferrell Hospital	Saline	October 2002	Targeted
Franklin Hospital & Skilled Nursing Facility	Franklin	–	*
Hamilton Memorial Hospital District	Hamilton	July 2002	Comprehensive
Hardin Co. General Hospital	Hardin	February 2003	Targeted
Harrisburg Medical Ctr.	Saline	–	Application received
Marshall Browning Hospital	Perry	–	Current
Massac Memorial Hospital	Massac	March 2004	Comprehensive
Memorial Hospital	Randolph	–	*
Pinckneyville Community Hospital District	Perry	–	Current
Red Bud Regional Hospital	Randolph	–	*
Sparta Community Hospital	Randolph	July 2003	Comprehensive
St. Joseph Memorial Hospital	Jackson	–	*
Union County Hospital	Union	–	*
Welborn White Co. Medical Ctr.	White	–	*

* Has Not Applied (as of March 2004)

which led to discussions of the hospitals working together. The work started in May 2002 and continues in 2004 with regular conference calls assessing resource availability for feasibility studies. The small group working together is searching for supporting funds to make further progress.

Sparta Community Hospital
Sparta, IL

Sparta Community Hospital is one of the leading rural hospitals participating in the RHPI Project. RHPI Project consultants observed a strong and effective CEO, CFO and leadership team; a stable, high-quality medical staff; a growing level of community support and involvement; a high level of profitability on key patient-related services; and very high-quality ancillary service equipment. It was recommended that the hospital develop a marketing plan that encompasses regular patient satisfaction surveys, community focus groups to discuss different needs and community education programs. It was recommended also that the hospital set a goal to add two additional swing bed patients per day, increase IP acute care admissions, search for a pediatrician willing to have a clinic and develop a formal pre-registration process for patients to preverify insurance coverage and reduce the number of patient no-shows.

What Participants Are Saying About the RHPI Project

Randy Dauby, administrator from the **Hamilton Memorial Hospital District**, McLeansboro, Illinois, stated that the RHPI Project has helped their hospital shift its focus from mere cost containment to total revenue enhancement. As a result, the hospital is considering adding physical therapy services, marketing its laboratory services to other providers, hiring another general surgeon and becoming a Critical Access Hospital.

"RHPI has given those [participating] hospitals financial and operational assessment tools that they otherwise would not have had. In most all cases, these hospitals would not have the financial resources to go out and hire such help. This is our tax dollars hard at work." Barbara Dallas, **Illinois Hospital Association**

"I am very pleased and impressed. Brian and Mary [Stroudwater Associates consultants] were very good. I am so pleased that we participated in this consultation and look forward to receiving the report. Mary was especially helpful with swing bed information." Jeffrey Durham, CEO, **Massac Memorial Hospital**, Metropolis, Illinois

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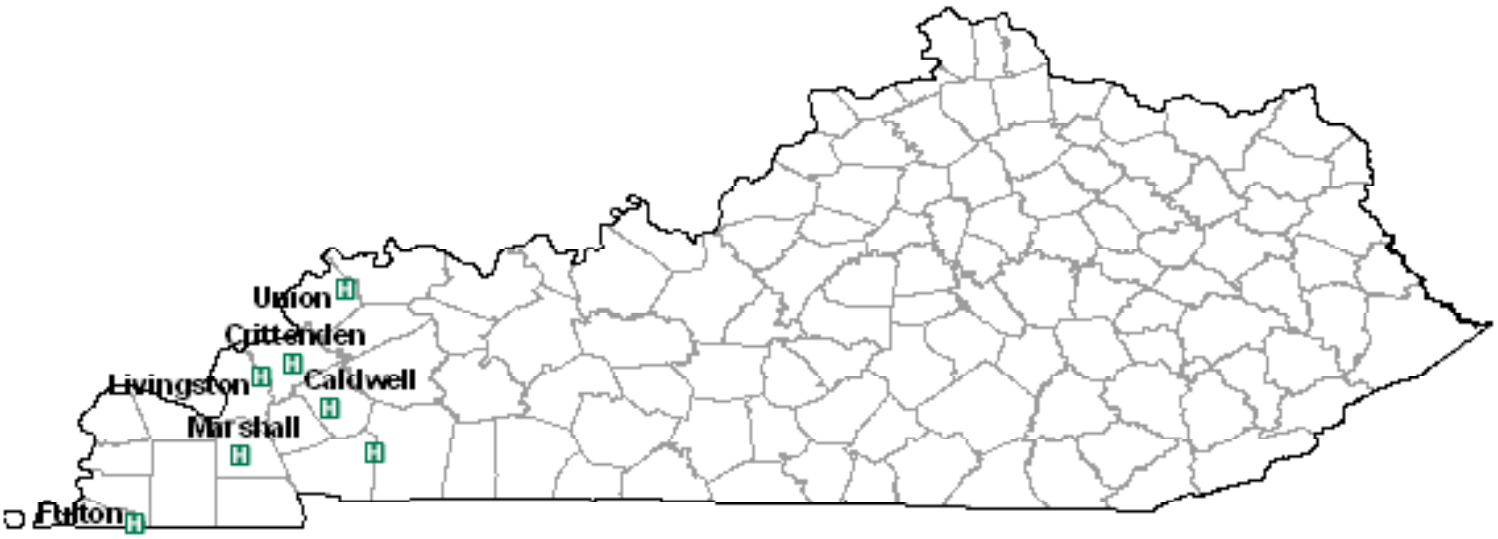
Kentucky



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Eligible and participating hospitals

Kentucky has seven eligible hospitals located in the Delta Region. As of March 2004, seven hospitals had applied for technical assistance.

Consultation areas provided

The technical assistance provided to participating hospitals included information technology assessment, emergency department facility design, organizational culture assessment and physician standards practices. Hospitals in Kentucky also participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/Expense Management, Physician Practice Management and Organizational Architecture. One hospital participated in both a comprehensive performance improvement assessment and a targeted consultation.

Consultations in Focus

Caldwell County Hospital
Princeton, KY

The purpose of this consultation was to assess the hospital's information management system and technology. The report that resulted from the consultation found a lack of automation in order entry and radiology, and redundancy in manual data input. Recommendations included: develop an information system strategic plan where systems for order entry and radiology have an immediate priority, and which also addresses long-range objectives such as physician access to patient information; offer education, early inclusion and active participation of staff members in IT planning and system selection; and implement a new time and attendance system.

Livingston Hospital and Healthcare Services, Inc.
Salem, KY

With the help of RHPI Project consultants, interim administrator Yvonne Maddux created a system for consistent communication with staff. During open quarterly meetings Ms. Maddux shared hospital and financial information with staff members. Over time, attendance grew and staff became actively engaged in hospital operational success, developing ideas for cost-savings. When faced with a workforce reduction, staff participated and department managers led by example agreeing to a 23 percent reduction in wages. Despite the expense cuts, staff satisfaction has remained high—attributed to the improved communications *prior to* the crisis.

Marshall County Hospital
Benton, KY

The purpose of the targeted consultation at this hospital was to review emergency room design and flow, as the hospital was making a case for renovations. The following were identified as important areas for consideration: quick access to a helicopter landing pad; use of the triage process to distinguish between urgent care and true emergency cases; separate and distinct entrances for ambulance traffic; location of the emergency department for quick access to diagnostic imaging, surgery and the ICU; adequate waiting room space and access to a small consulta-

Hospital	County	Participation Date	Status
Marshall County Hospital	Marshall	April 2003	Targeted
Trigg County Hospital, Inc.	Trigg	September 2003	Comprehensive
Crittenden Co. Hospital	Crittenden	–	Application received
Parkway Regional Hospital	Fulton	–	Withdrawn
Methodist Hospital Union Co.	Morganfield	–	Participating
Caldwell County Hospital	Caldwell	July 2002	Targeted
Livingston Hospital & Healthcare Services	Livingston	August 2002	Comp. & Targeted

tion/grieving room; close-in handicapped parking that meets ADA requirements; and planning for future expansion with the least amount of disruption and inconvenience possible.

Trigg County Hospital
Cadiz, Kentucky

This hospital has successfully involved department managers, nurses and physicians in performance improvement efforts. By sharing data, these stakeholders are now actively engaged and supportive of long-term sustainability. The hospital has successfully increased usage by 17 percent with only a three percent increase in costs. The hospital has also improved its business office performance by 32 percent—reducing days in accounts receivables from 114 to 77 within six months.

The RHPI Project comprehensive performance assessment indicated gaps in the types of information shared, and as a result, the hospital sought grant funding to purchase software for collection and use of data. This state-of-the-art system allows physicians and nurses to collaborate in clinical decision-making and engaged department managers on budget issues. The result was increased accountability for improved operations.

The hospital is using the RHPI Project action plan to improve its business office performance and is investigating the feasibility of bringing business office functions back in-house after being outsourced for several years.

What Participants Are Saying About the RHPI Project

"The application is easy—this is important to hospitals. It has been beneficial to the hospitals in Kentucky and the consultants have been great—professional and knowledgeable." Carol Blevins Ormay and Robin Hite, **Kentucky Hospital Association**

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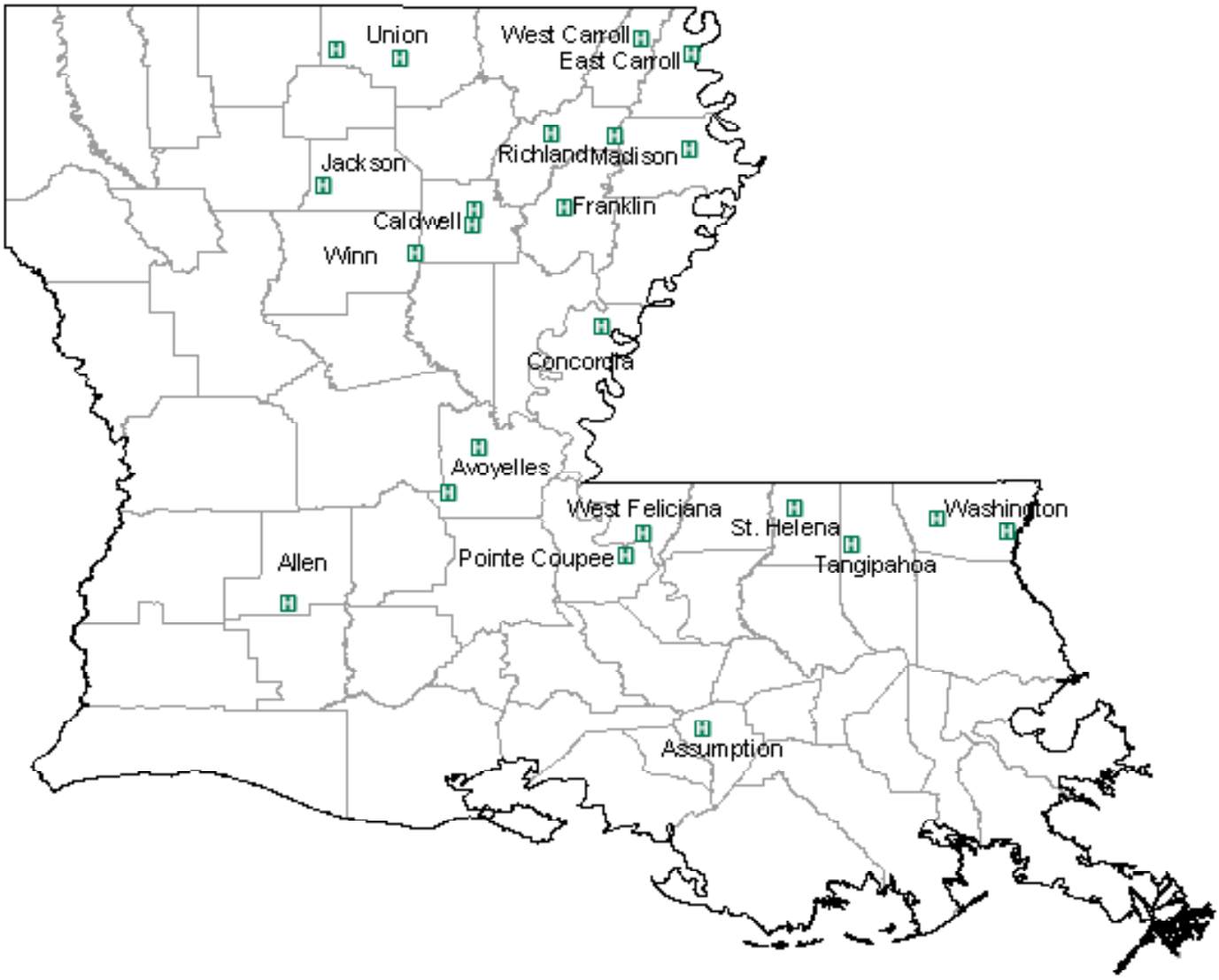
Rural Hospital Performance Improvement (RHPI) Project

Louisiana



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Eligible and participating hospitals

Louisiana has 23 eligible hospitals located in the Delta Region. As of March 2004, 13 hospitals had applied for technical assistance.

Consultation areas provided

The technical assistance provided to participating hospitals included physician recruitment, medical staff development and strategies for market share. Hospitals in Louisiana also participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/Expense Management, Physician Practice Management and Organizational Architecture.

Hospital	County	Participation Date	Status
Allen Parish Hospital	Allen	October 2003	Comprehensive
Avoyelles Hospital	Avoyelles	–	*
Bunkie General Hospital	Avoyelles	–	*
Caldwell Memorial Hospital	Caldwell	–	Application received
Citizens Medical Center	Caldwell	–	*
East Carroll Parish Hospital	East Carroll	Participating	Comprehensive
Franklin Medical Center	Franklin	September 2002	Targeted
Hardtner Medical Center	La Salle	–	*
Hood Memorial Hospital	Tangipahoa	–	Application received
Jackson Parish Hospital	Jackson	October 2002	Comprehensive
Madison Parish Hospital	Madison	–	*
Our Lady of the Lake Regional Medical Ctr.	Assumption	–	*
Pointe Coupee Gen. Hosp.	Pointe Coupee	January 2003	Targeted
Richardson Medical Ctr.	Richland	Current	Comprehensive
Richland Parish Hospital Delhi	Richland	–	*
Riverland Medical Center	Concordia	July 2002	Comprehensive
Riverside Medical Center	Washington	–	*
St. Helena Parish Hospital	St. Helena	–	Application withdrawn
Tri-Ward General Hospital	Union	–	Application received
Union General Hospital	Union	March 2004	Comprehensive
Washington-St. Tammany Regional Medical Ctr.	Washington	–	*
West Carroll Memorial Hospital	West Carroll	–	*
West Feliciana Parish Hospital	West Feliciana	April 2003	Comprehensive

* Has Not Applied (as of March 2004)

Consultations in Focus

West Feliciana Parish Hospital
St. Francisville, LA

Service expansion opportunities were identified by RHPI Project consultants for this hospital, especially in the area of skilled nursing services (swing beds). As a newly designated Critical Access Hospital in a service area that was growing with retirees, expanded services were needed to meet demand. Project consultants first worked with the hospital to align the staff and board with a shared vision, mission and customer service focus—away from the traditional mindset of acute services and toward skilled and outpatient care. Administrator Mark Chustz championed a customer service initiative. He established a measurement system then modified job descriptions and performance reviews to reflect this focus.

West Feliciana Parish Hospital has experienced increased usage, but is limited by its current facility. A plan for renovation and expansion is being developed to address the need for improvements to the emergency room and outpatient services.

Allen Parish Hospital
Kinder, LA

This hospital worked extensively in the community to garner support for re-opening the emergency room to increase inpatient utilization. RHPI Project consultants demonstrated that the long-term viability also required improvements in acute care and swing bed utilization. Administrator Scott Barrilleaux worked with other area hospital CEOs to increase referrals. With a performance aid developed by the RHPI Project, Barrilleaux demonstrated financial benefit to the larger hospitals for those referrals. Project consultants conducted staff training on swing bed service development that included marketing, service delivery, billing and coding. As a result, Allen Parish Hospital's emergency room is open 24 hours each day, and acute care and swing bed utilization have both increased.

Riverland Medical Center
Ferriday, LA

Riverland Medical Center focused on increasing inpatient volumes by expanding physician services. A hospitalist was engaged through an agency, and two internists and a pediatrician were recruited. In addition, administrator Vernon Stevens is exploring the possibility of bringing in specialists from a larger medical center. As a result, inpatient volumes have increased. With the assistance of RHPI Project consultants, the administration is focused on business office operations resulting in improved cash flow and collection rate.

What Participants Are Saying About the RHPI Project

"The swing bed education received through the RHPI Project has proven to be the most beneficial to us. This is something we have implemented and it has been successful." Mark Chustz, CEO, **West Feliciana Parish Hospital**, St. Francisville, Louisiana

"The RHPI Project is a model that we want to replicate in our state with all the rural hospitals. The consultants are technical experts in rural hospitals. They know what they are doing and you get what you need from them." Jack Stolier**, Rural Hospital Coalition**, Orleans, Louisiana.

"They didn't just tell us what was wrong, but how we could fix some things based on their experience. I'd recommend this to every hospital, even if they think they are doing everything right." L. J. Pecot, administrator, **Jackson Parish Hospital**, Jonesboro, Louisiana

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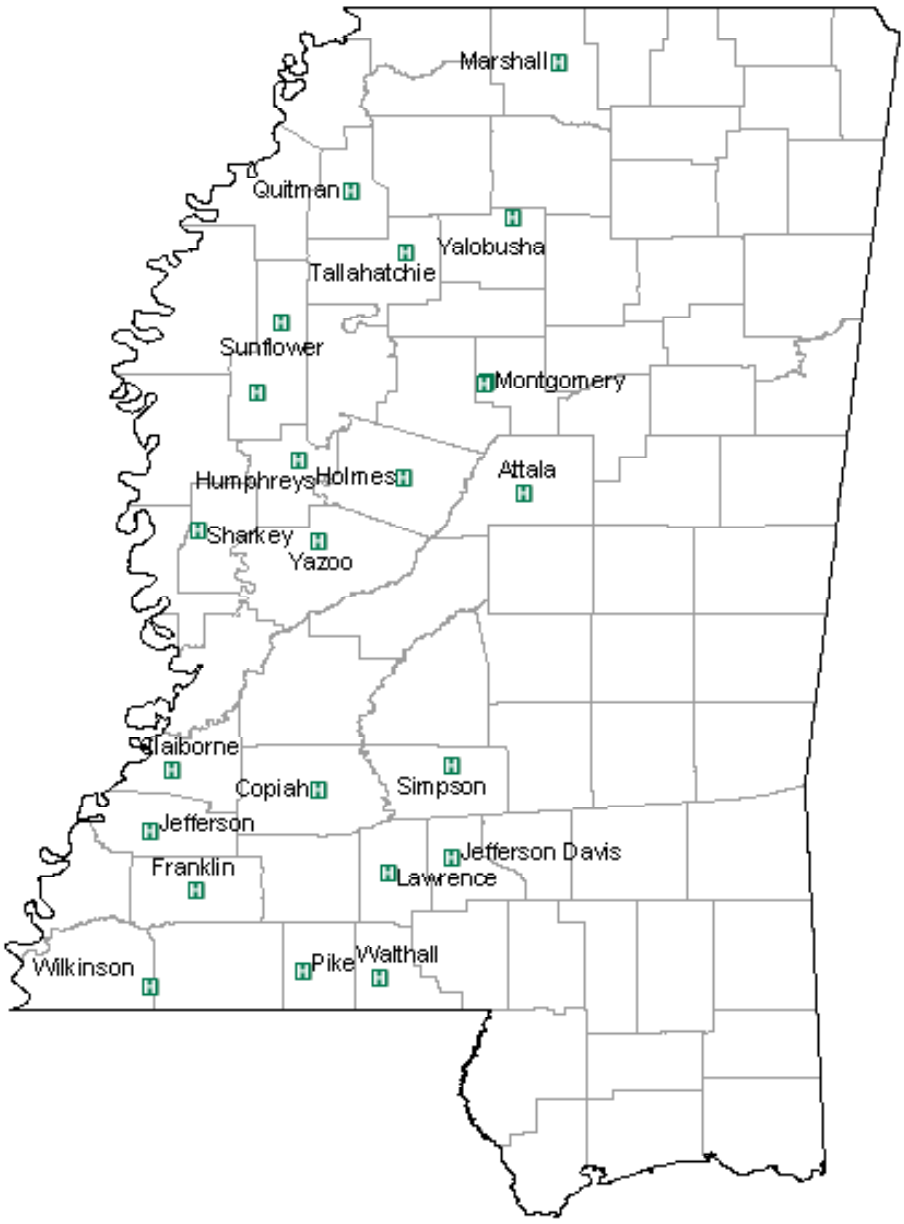
Mississippi



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Eligible and Participating Hospitals

Mississippi has 23 eligible hospitals located in the Delta Region. As of March 2004, 14 hospitals had applied for technical assistance.

Consultation Areas Provided

The technical assistance provided to participating hospitals included community engagement, service line development, co-located hospitals working together toward a coordinated delivery system and strategic planning. Hospitals in Mississippi also participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/Expense Management, Physician Practice Management and Organizational Architecture.

Hospital	County	Participation Date	Status
Alliance Healthcare	Marshall	–	*
Beacham Memorial Hospital	Pike	–	*
Claiborne Co. Hospital	Claiborne	September 2003	Targeted
Field Memorial Comm. Hosp.	Wilkinson	June 2003	Comprehensive
Franklin Co. Memorial Hosp.	Franklin	February 2002	Comprehensive
Hardy Wilson Memorial Hosp.	Copiah	October 2003	Targeted
Humphreys Co. Memorial Hosp.	Humphreys	April 2002	Comprehensive
Jefferson Co. Hospital	Jefferson	–	*
Kilmichael Hospital	Montgomery	August 2002	Targeted
King's Daughters Hospital	Yazoo	–	Application received
Lawrence County Hospital	Lawrence	–	*
Montfort Jones Memorial Hosp.	Attala	Jan. 2004	Comprehensive
North Sunflower Co. Hospital	Sunflower	July 2002	Comprehensive
Prentiss Regional Hospital and Extended Care Facilities	Jefferson Davis	–	*
Quitman Co. Hospital and NH	Quitman	–	*
Sharkey Issaquena Comm. Hosp.	Sharkey	August 2002	Targeted
Simpson General Hospital	Simpson	–	Application received
South Sunflower Co. Hospital	Sunflower	–	*
Tallahatchie General Hospital	Tallahatchie	–	*
Tyler Holmes Memorial Hospital	Montgomery	August 2002	Targeted
University Hospital-Durant	Holmes	Participating	Comprehensive
Walthall County General Hospital	Walthall	November 2003	Comprehensive
Yalobusha General Hospital	Yalobusha	–	*

* Has Not Applied (as of March 2004)

Consultations in Focus

Field Memorial Community Hospital
Centreville, MS

In 2002, lack of malpractice insurance for community physicians reached a crisis point in Mississippi. As a county-owned hospital, FMCH is indemnified from claims in excess of $500,000. As a result, in May 2003, community physicians became staff at this hospital. RHPI Project consultants worked closely with the Mississippi Hospital Association to develop an implementation plan that would help ease the transition from private practice to hospital practice. Recommendations included hiring an outside vendor to help with billing; developing a clear management plan; developing a clear process for billing and collections; and publishing monthly or quarterly reports to physicians to give them information on practice success including information on practice profit and loss, and ancillary service volume.

Montfort Jones Memorial Hospital
Kosciusko, MS

Three of four hospitals surrounding this hospital are small rural hospitals with limited services. The perception in the community is that if residents have to drive 30 or more miles for medical care, they would choose to go to Jackson, which is a 90-minute drive from MJMH. It was recommended the MJMH set a short-term goal for 1.2 additional acute inpatients per day, develop ob/gyn services to focus beyond the Medicaid population, track and monitor nurse productivity and involve physicians in the process of implementing a Case Management model.

Walthall County General Hospital
Tylertown, Mississippi

Walthall County General Hospital followed the RHPI Project performance improvement plan to achieve breakeven financial performance despite a projected $250,000 annual operating loss. Currently, the hospital is realizing a $50,000 monthly operating margin. The financial improvement is attributed to appropriate utilization of swing beds achieved with physician support. Through physician education on swing bed use along with requirements for billing and documentation, average daily census increased from one to six within one month. Swing beds are now a key component of the physicians' care plan for many patients.

What Participants Are Saying About the RHPI Project

"This has been a good project—hospitals have gotten involved in looking at outcomes and what they need to do. They might not otherwise have done this for a variety of reasons including costs. The hospitals would not necessarily get to this level of detail if doing their own assessments. Hospital CEOs are spread too thin to conduct this type of assessment. I think the comprehensive performance improvement assessments and the strategic planning consultations were good for this state. The level of knowledge from the consultants has been great." David Lightwine, Director, **Office of Rural Health**, Mississippi

"Overall the RHPI Project has resulted in very positive outcomes. The benefits to us [the Mississippi Hospital Association] has been significant by increasing awareness of what we can do to provide resources to the hospitals. The hospitals trust the project staff and consultants and both are highly respected. There is rarely a staff meeting at MHA that the RHPI Project is not mentioned. It is very much a part of the work we do. There is still a lot of work to do, but we have seen progress. How do you put a monetary value on something like this?" Mary Patterson, **Mississippi Hospital Association**

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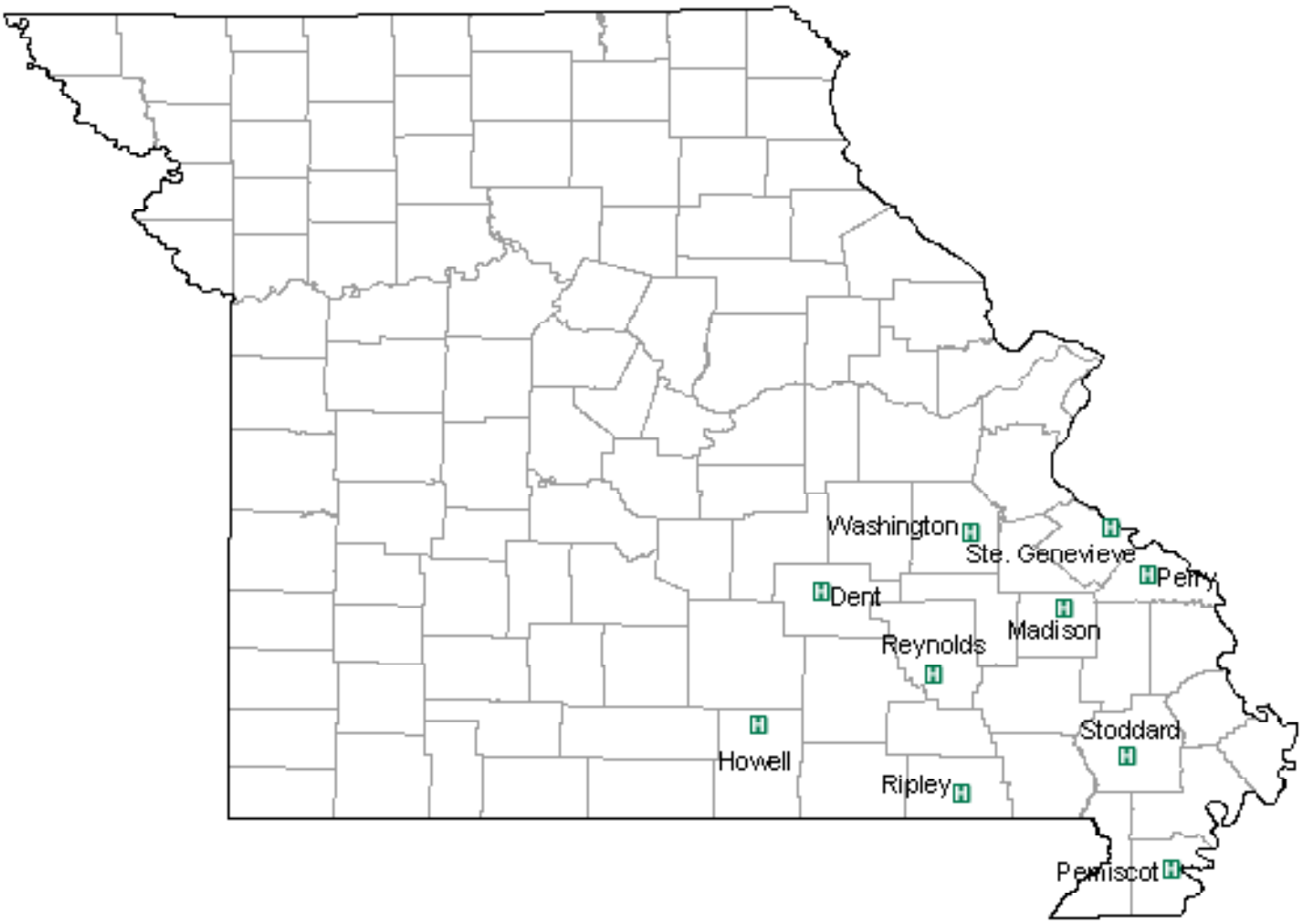
Rural Hospital Performance Improvement (RHPI) Project

Missouri



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Eligible and Participating Hospitals

Missouri has ten eligible hospitals located in the Delta Region. As of March 2004, three hospitals had applied for technical assistance.

Consultation areas provided

The technical assistance provided to participating hospitals included community engagement, service line development, co-located hospitals working together toward a coordinated delivery system and strategic planning. Hospitals in Missouri also participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/Expense Management, Physician Practice Management and Organizational Architecture.

Consultations in Focus

Perry County Memorial Hospital
Perryville, MO

An important area of focus for the consultation was this hospital's Board of Directors structure. The hospital had converted from a public entity to a 501c3 not-for-profit corporation. The board structure was supposed to evolve but had not, resulting in two boards, one from the public entity and the other from the not-for-profit corporation. The consultation recommended a review that will determine specific functions for each board, which will meet separately. Consultants also have been working with the hospital CEO to develop a strategic plan.

Ste. Genevieve County Hospital
Ste. Genevieve, Missouri

A comprehensive performance improvement assessment was conducted in June 2003. It was found that swing beds were under-utilized because staff and physicians were not familiar with its benefits. Assistance from the consultants resulted in educating the physicians. The hospital has seen improvements in this area. Between February 2003 and February 2004, the hospital had a 20 percent increase in swing bed usage.

What Participants Are Saying About the RHPI Project

"A very worthwhile project! Mary and Brian [Stroudwater Associates consultants] were very professional and spoke to our needs—they really know rural hospitals. The consultation and the report was an eye-opening experience for us as we learned a lot." Rita Brumfield, Director of Nursing, **Ste. Genevieve County Hospital**, Ste. Genevieve, Missouri

Hospital	County	Participation Date	Status
Madison Medical Center	Madison	–	*
Missouri Southern Healthcare	Stoddard	–	*
Pemiscot Memorial Health Systems	Pemiscot	–	Application received
Perry Co. Memorial Hospital	Perry	Oct. 2003	Comprehensive
Reynolds Co. Gen. Memorial Hospital	Reynolds	–	*
Ripley Co. Memorial Hospital	Ripley	–	*
Salem Memorial District Hospital	Dent	–	*
St. Francis Hospital	Howell	–	*
Ste. Genevieve Co. Memorial Hosp.	Ste. Genevieve	June 2003	Comprehensive
Washington Co. Memorial Hosp.	Washington	–	*

* Has Not Applied (as of March 2004)

"The RHPI Project has been an excellent resource for the eligible rural hospitals in Missouri. Many of the recommendations made by the consultants have resulted in our hospitals being able to better assess their future direction while at the same time improve their performance. In most cases those resources would have been cost prohibitive without the financial assistance from the RHPI Project." Nick Nichols, **Missouri Hospital Association**

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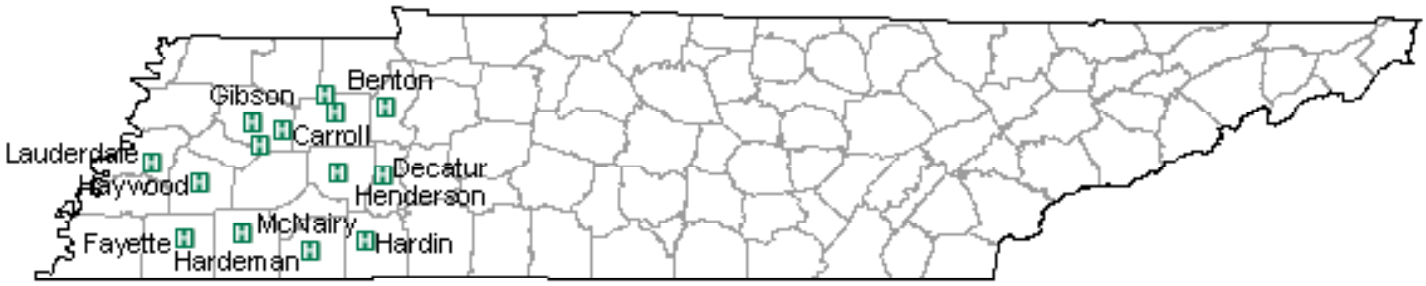
Rural Hospital Performance Improvement (RHPI) Project

Tennessee



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Eligible and Participating Hospitals

Tennessee has 14 eligible hospitals located in the Delta Region. As of March 2004, nine hospitals had applied for technical assistance.

Consultation Areas Provided

The technical assistance provided to participating hospitals included community engagement and strategic planning. Hospitals in Tennessee also participated in the RHPI Project's comprehensive performance improvement assessment, which included the following components: Market/Service Area, Clinical Services, Financial/Reimbursement, Financial/Expense Management, Physician Practice Management and Organizational Architecture.

Consultations in Focus

Gibson General Hospital
Trenton, TN

This hospital participated in a performance improvement assessment (PIA) in November 2003. Recommendations in the pharmacy area included consideration of incorporating medication reporting methodology from the National Coordinating Council and Medication Error Reporting and Prevention; provide the pharmacy director with financial efficiency measures as is done for other departments; and explore alternative staffing during technician vacations. In the business office, it was recommended that up-front collection be refined; a systematic plan be developed to facilitate the imminent transition of coding staff; and that the collection rate of the collections agency be closely tracked as a means of evaluating performance.

Hardin County General Hospital
Savannah, TN

Hardin is one of the best small rural hospitals that participated in the Delta RHPI Project. Its strengths include: operating profits sustained over multiple years; strong and effective CEO and CFO; and entrepreneurial involvement in home health. Recommendations are seen primarily as opportunities for incremental improvement and include: inpatient program development to take advantage of idle space; improvement of the hospital's collection rate; requiring departments to complete Medicare Advance Ben-

Hospital	County	Participation Date	Status
Baptist Memorial Hospital-Huntingdon	Carroll	–	*
Baptist Memorial Hospital-Lauderdale	Lauderdale	–	*
Bolivar General Hospital	Hardeman	–	*
Camden General Hospital	Benton	May 2003	Targeted
Decatur Co. General Hospital	Decatur	–	Application withdrawn
Gibson General Hospital	Gibson	November 2003	Comprehensive
Hardin Co. General Hospital	Hardin	August 2003	Comprehensive
Haywood Park Comm. Hospital	Haywood	Participating	Comprehensive
Henderson Co. Comm. Hospital	Henderson	–	*
Humboldt General Hospital	Gibson	July 2003	Targeted
McKenzie Regional Hospital	Carroll	–	Application received
McNairy Regional Hospital	McNairy	–	*
Methodist Healthcare-Fayette Hospital	Fayette	August 2002	Comprehensive
Milan General Hospital	Gibson	April 2003	Targeted

* Has Not Applied (as of March 2004)

eficiary Notices for non-covered services; and support of departmental accountability by improving access to historical and current information on volume trends.

Methodist Fayette Hospital
Somerville, TN

This hospital is in a unique position to see potential growth as a bedroom community outside a metropolitan area. However, competition is significant. Recommendations in the outpatient area of radiology included upgrading the CT, discontinuing nuclear medicine service and upgrading mammography equipment to meet new Federal standards.

Milan General Hospital
Milan, TN

This hospital participated in a targeted consultation focusing on community engagement. This helped increase awareness at the community level of local health services available and resulted in a community health directory, a community health impact analysis and a detailed economic and health data report. It was found that the economic impact of all health services in the community is significant—with a total employment of more than 24,000 people and direct economic activities of more than $18 million.

What Participants Are Saying About the RHPI Project

"In Tennessee, we appreciate all the help and support the staff and consultants have provided on the Rural Hospital Performance Improvement Project. Project staff have always kept me informed and engaged with all aspects of the program. This support has always been provided in a very effective and efficient manner and always communicated in a very timely manner." Bill Jolley, **Tennessee Hospital Association**

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http://deltarhpi.ruralhealth.hrsa.gov/

III. Appendices

Appendix A

Community Initiated Decision Making (CIDM)

Community-Initiated Decision Making (CIDM) is a process of community involvement that leads to informed decision-making and the development and implementation of plans for the future of the community's health care system. Overall, the purpose is to use the knowledge within the community to help the community become aware of the health care system's role and informed about the problems, allowing local decision-making processes to determine how health care needs are to be met in the future. CIDM provides communities with the ability to accomplish this goal through active citizen participation throughout the planning process.

It is important to realize that it is not the intention of this process to presuppose a solution or to implement preplanned activities, rather, CIDM's goal is to build within each community a sense of health care "ownership" and to encourage a decision-making process that will result in a planned response endorsed by the community.

Other CIDM Goals

- Bring health care providers and consumers together
- Provide a consumer-friendly health care system
- Keep local health care dollars in the community

CIDM creates a partnership between health care consumers and local health care providers to examine health care issues, and to make choices for health care system improvements. A "Community Encourager" (CE) is usually employed to coordinate a Community Health Council (CHC), train community members, facilitate the CIDM process, gather data and provide feedback from the community to health care providers. The CE must be a local person who can remain neutral regarding all issues and stakeholders, be respected in the community and have good communication skills. Training and on-going support for Community Encouragers will be provided by the Center for Rural Health and Social Service Development.

Members of the CHC gather data and provide input back into the health care service system. The CHC is made up of citizens representing key segments of the community and health care providers. The community's role includes assessing current health care services, establishing community health care priorities, developing ongoing communication with local health care providers and modifying the health care system to meet community identified needs.

The community planning process will include needs assessment, data collection, focus groups, key informant interviews, a Community-Wide Goal Setting meeting and preparation of summaries and recommendations for change. The CIDM process encourages communities to work toward identification of improvements in health care delivery and the development of additional financial resources.

Some expected benefits from the use of CIDM include: increase in number of patients accessing local health care providers; increase in patient satisfaction and community support for local health care providers, leading to less outsourcing to other communities; increase in wages and salaries kept in the county's economy; and cost saving ideas from the community and improved communication between citizens and the health care community.

The Community Encourager (CE)

Community Encouragers are facilitators, people who encourage and support others in making good decisions for their communities, particularly about health matters. It takes someone with special characteristics to be a good encourager.

Qualities of a good CE

- Friendliness
- Ability to learn
- An interest in health topics
- Being a person other people can talk to easily
- Strong, direct communication style, saying clearly what is meant
- Ability to be impartial in analyzing problems and concerns of the community
- An ability to put yourself in another's place and understand what the others are feeling

Roles of the Community Encourager

- Supporter/Encourager/Teacher
- Advocate/Bridge Builder
- Information Collector/Documenter/Information Provider

The Community Health Council (CHC)

Council members are selected because they represent a specific sector of their community. Council members may represent more than one sector as in the case of an educator who also represents one geographic area of the community.

In the CIDM, Council members are selected because of their hands-on involvement in a community sector, not because they are the leader in that sector. (This is a differentiating characteristic of the CIDM model). The CIDM model taps community members who are often not considered for other community processes. Each CHC member develops and manages a focus group, their "Select Ten," made up of members from their community sector. If a Council member represents more than one sector, they may have more than one "Select Ten." The strength of the CIDM model is the grass-roots level of information this model is able to identify.

There is a tremendous amount of training information available to assist the Community Encourager in training the Community Health Council in group processes and research methods. This level of empowerment also ensures implementation of the recommendations and responses of the CHC.

Implementation of Community Health Council Recommendations

The real strength of the CIDM is the facilitation of actual implementation of recommendations. The Community Encourager acts as the communication liaison between the health care providers in the community and the Community Health Council to move community health care needs from the assessment stage to the implementation phase. As these successes are marketed to the community, with the help of the Community Encourager and the Community Health Council, one success breeds another, and in turn they breed a climate of change that improves both the provision and the utilization of the health care system within the community.

Suggested Time Frame for CIDM Model

Activity
Timeframe

Select/hire Community Encourager (CE)
4-6 weeks

Data Gathering – demographics, census data, economic studies, public health data, etc.
immediately & ongoing

Train CE with CIDM model
1 week

CE's orientation to the community
1 week

Community Awareness to CIDM
ongoing

Form Community Health Council (CHC)
8 weeks

First CHC meeting
Before the end of the eighth week

Coordinating schedules of CHC
4 weeks

Train CHC with CIDM and to conduct Focus Groups
Schedule a one-day Training Workshop (can be scheduled as the third meeting)

Needs Assessment – Focus Groups, Key Informant Interviews
ongoing

Community Wide Goal Setting meeting
6 to 9 months from start of project

Assessing community value and needs
3 to 4 weeks

Planning/Decision Making – Within context of the priority goals identified by the community at the Community Wide Goal Setting meeting, develop a set of recommendations by the CHC to the health care system(s)
2 to 6 weeks

Implementation
ongoing

Appendix B

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