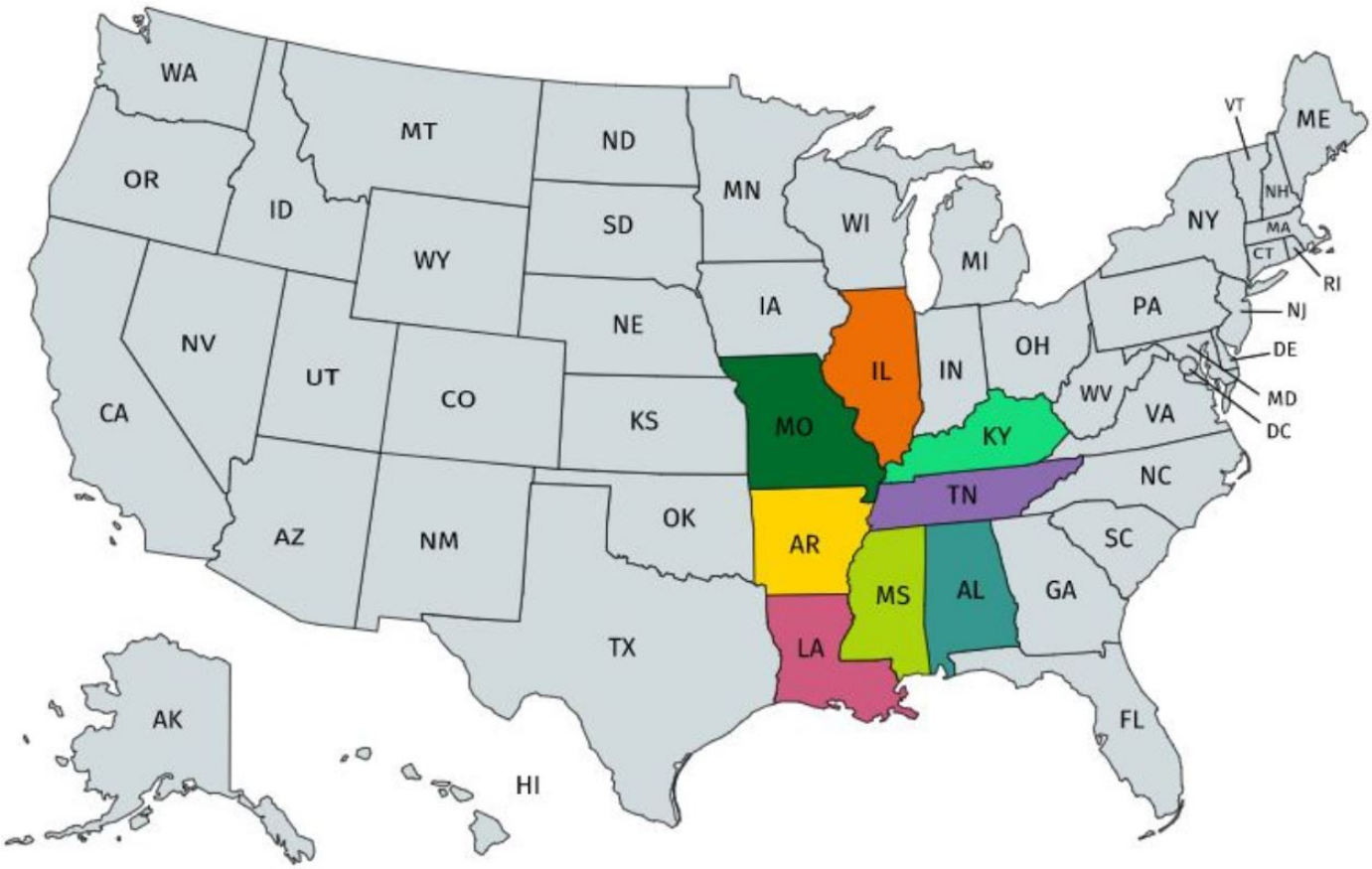
Delta States Rural Development Network Program
SOURCEBOOK



MARCH 2021

HEALTH RESOURCES AND SERVICES ADMINISTRATION
THE FEDERAL OFFICE OF RURAL HEALTH POLICY

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

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Introduction

The Federal Office of Rural Health Policy's (FORHP) Community-Based Division provides resources to help rural communities develop partnerships to jointly address health problems that could not be solved by single entities working alone. FORHP encourages innovative solutions to local health care needs identified by local communities within the eight Delta states (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee).

These multicounty/multiparish projects address delivery of preventive or clinical health services for individuals with, or at risk of developing, chronic health diseases, which disproportionately affect rural Delta communities. Funded entities focus program efforts on one of five focus areas: (1) diabetes, (2) cardiovascular disease, (3) obesity, (4) acute ischemic stroke, or (5) mental health, including related behavioral health.

Through the Delta States Rural Development Network grant program, grantees are expected to propose multicounty projects that:

- Utilize and/or adapt an evidence-based or promising practice model(s) in the delivery of health care services.
- Improve access to and quality of health care in rural areas through sustainable health care programs created as a result of a collaborative approach.
- Demonstrate improved health outcomes and community impact.

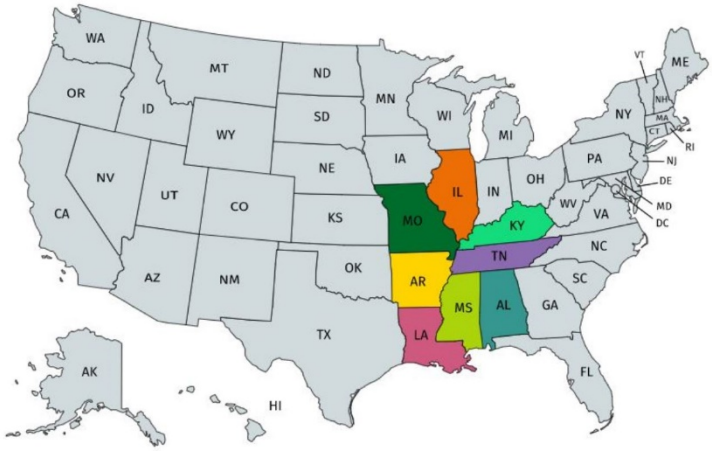
This *Sourcebook* provides a summary of the 12 Delta States Rural Development Network (Delta States) grantees funded during the 2016-2020 grant period. There are profiles of each of the 12 initiatives funded under the Delta States grant program. The reader can search grantee information by state, program focus areas, and evidenced-based model/promising practice.

The purpose of the Delta States program is to fund organizations located in the Delta region that promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the eligible entities participating in the networks in or to: achieve efficiencies; expand access to, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole.

Cohort Snapshot

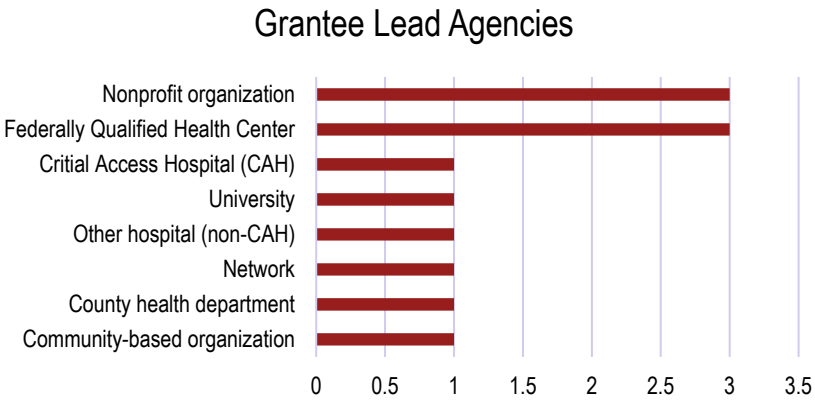
Reach of the Program

During the 2016-2020 funding period, FORHP funded 12 rural health entities across eight Delta region states, and 224 designated counties/parishes with $195,000 to $315,000 per year to implement their Delta States initiatives. *Note:* An extra year of funding was provided due to changes in rural status for some counties/parishes.



Funded Entities

The 2016-2020 cohort consisted of lead agencies representing a cross section of rural health care providers. Several agencies partnered with other provider agencies, health and human service entities, local government agencies like health departments, and universities to implement funded Delta States initiatives.



Targeted Measures

Grantees targeted a range of clinical outcomes during the four-year grant. Their Delta States initiatives aimed to improve access to and the quality of health care and demonstrate improved health outcomes and community impact.

Common outcomes included:

- Expansion of programs into new areas.
- Implementation of new programs.
- Increased patient referrals, access to care, and health insurance enrollment.
- Increased services to youth in school (e.g., increased access to physical activity, nutrition education) and national recognition for programs.
- Increased membership and strengthened networks.
- Increased workforce capacity through training and professional development.
- Decreases in body mass index, A1C, and blood pressure levels.

Grantee Profiles by State

State	Grantee Organization
Alabama	Rural Alabama Prevention Center
Arkansas	ARcare
	Arkansas Rural Health Partnership
Illinois	Southern Illinois University
Kentucky	Baptist Health Madisonville Inc.
Louisiana	Richland Parish Hospital
	The Health Enrichment Network
Mississippi	Delta Health Alliance Inc.
	Jefferson Comprehensive Health Center Inc.
Missouri	Mississippi County Health Department
	Missouri Highlands Health Care
Tennessee	Paris-Henry County Health Care Foundation Inc.

Grantee Profiles by Organization Type

Grantee Organization	Community Based Organization	County Health Department	Critical Access Hospital (CAH)	Federally Qualified Health Center (FQHC)	Network	Nonprofit Organization	Other Hospital (Non-CAH)	University – Medical School
ARCare				●				
Arkansas Rural Health Partnership						●		
Baptist Health Madisonville Inc.							●	
Delta Health Alliance Inc.						●		
Jefferson Comprehensive Health Center Inc.				●				
Mississippi County Health Department		●						
Missouri Highlands Health Care				●				
Paris-Henry County Health Care Foundation Inc.						●		
Richland Parish Hospital			●					
Rural Alabama Prevention Center	●							
Southern Illinois University								●
The Health Enrichment Network					●			

Grantee Profiles by Focus Area

Grantee Organization	Behavioral/Mental Health	Cancer Care Management	Cardiovascular Disease (CVD) Care Management	Case Management	Chronic Disease Management	Chronic Obstructive Pulmonary Disease (COPD) Prevention, Treatment, and Management	Community Based Coordination	Diabetes Care Management	Health Care Education	Health Education/Promotion and Disease Prevention	Health Screenings	Maternal and Child Health	Obesity	Oral Health	Pediatric Care	Pharmacy Assistance	Population Health	Primary Care Services	School-Based Care Coordination	Telehealth/Telemedicine	Transitions of Care	Social Services Related to Health Issues and Referrals to Care	Women's Health
ARCare	●				●		●	●		●	●						●	●		●	●	●	
Arkansas Rural Health Partnership				●	●			●	●	●							●						
Baptist Health Madisonville Inc.										●													
Delta Health Alliance Inc.			●		●		●				●			●									
Jefferson Comprehensive Health Center Inc.								●		●			●	●		●							
Mississippi County Health Department	●		●		●			●		●	●					●	●	●					
Missouri Highlands Health Care					●		●			●							●						●
Paris-Henry County Health Care Foundation Inc.	●	●	●	●	●	●	●	●		●	●				●	●	●	●	●		●		
Richland Parish Hospital										●	●												
Rural Alabama Prevention Center			●	●	●	●	●	●		●	●												
Southern Illinois University	●									●		●							●				
The Health Enrichment Network					●					●	●			●			●						

Grantee Profiles by Target Population

Grantee Organization	Children (0-12)	Adolescents (12-17)	Adults (18-64)	Elderly (65 and older)
ARCare			●	●
Arkansas Rural Health Partnership	●	●	●	●
Baptist Health Madisonville Inc.	●	●		
Delta Health Alliance Inc.				
Jefferson Comprehensive Health Center Inc.	●	●	●	●
Mississippi County Health Department			●	●
Missouri Highlands Health Care			●	
Paris-Henry County Health Care Foundation Inc.	●	●	●	●
Richland Parish Hospital		●	●	
Rural Alabama Prevention Center			●	●
Southern Illinois University	●	●	●	
The Health Enrichment Network	●			

Evidence-Based Models/Promising Practices

Delta States Rural Development Network grantees strengthened their program service delivery by drawing from evidence-based models and promising practice guidelines. Their efforts focused primarily on chronic disease prevention, treatment, and management.

Evidence-Based Model	Grant Organization	Evidence-Based /Promising Practice
Care Coordination Model	Missouri Highlands Health Care	
	Paris-Henry County Health Care Foundation Inc.	
	Rural Alabama Prevention Center	*Reducing Care Fragmentation Model: A Toolkit for Coordinating Care*
Care Transitions Model	Arkansas Rural Health Partnership	
	Delta Health Alliance Inc.	
Chronic Disease Self-Management Program (CDSMP)	Mississippi County Health Department	
	Paris-Henry County Health Care Foundation Inc.	*Living Well with Chronic Conditions, Take Charge of Your Diabetes, and Cancer: Thriving and Surviving (also, Living Well with Chronic Conditions)*
Community Health Worker Model	Delta Health Alliance Inc.	
	Jefferson Comprehensive Health Center Inc.	
	Missouri Highlands Health Care	
Diabetes Prevention Models	Richland Parish Hospital	*Adolescent Pre-Diabetes Prevention Program (adult prediabetes screening model)*
	ARcare	*American Association of Diabetes Educators Chronic Care Model*
	Missouri Highlands Health Care	*Centers for Disease Control and Prevention's (CDC) Prevent T2*
	Arkansas Rural Health Partnership	*Diabetes Empowerment Education Program (DEEP) Model*
	Mississippi County Health Department	*Diabetes Self-Management Program (DSMP)*
	Arkansas Rural Health Partnership	*National Diabetes Prevention Program (DPP) Model*
	Rural Alabama Prevention Center	*Power to Prevent*
Obesity Prevention/ Intervention Models	Rural Alabama Prevention Center	*Body & Soul*
	Jefferson Comprehensive Health Center Inc.	*U.S. Preventive Services Task Force (USPSTF) Screening for and Management of Obesity*
	Mississippi County Health Department	*U.S. Preventive Services Task Force (USPSTF) in the Guide to Clinical Preventive Services*
School-Based/Classroom Interventions and Models	Baptist Health Madisonville Inc.	*Alliance for a Healthier Generation's Healthy Schools Program (HSP)*
	Southern Illinois University	*Coordinated Approach to Child Health (CATCH)*

	The Health Enrichment Network	*Growing Up Fit Together*
	Baptist Health Madisonville Inc.	*GoNoodle®*
	The Health Enrichment Network	*GoNoodle®*
	Baptist Health Madisonville Inc.	*TAKE 10®*
	The Health Enrichment Network	*Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC)*
	Southern Illinois University	*Whole School, Whole Community, Whole Child School Health Model*
	Mississippi County Health Department	*Patient Center Medical Home (Home Health Model)*

Other Evidence-Based Models/Promising Practices	Grant Organization
Mental Health First Aid (MHFA)	Southern Illinois University
Signs of Suicide	Southern Illinois University
CDC School Health Index	The Health Enrichment Network
CDC Oral Health School-Based Sealant Clinic & Fluoride Varnish	The Health Enrichment Network
Painted Play Spaces	The Health Enrichment Network
Value-Driven Healthcare System Model	Delta Health Alliance Inc.
The Interdisciplinary Evidence-Based Practice Model	Arkansas Rural Health Partnership

Grantee Profiles

The following section contains contact information and brief descriptions of the 12 Delta States Rural Development Network Grant Program grantees funded during the 2016-2020 grant period. These descriptions may include program approach, program goals, and key activities for project and program implementation, including the evidenced-based or promising practices utilized, lessons learned, key outcomes and impacts, sustainability approaches, and implications for other communities.

ARKANSAS

ARcare

Arkansas Service Region B

Part Organization Information						
Organization Name	ARcare					
Organization Type	Federally Qualified Health Center (FQHC)					
Address	**Line 1:**	117 S. Second Street				
	City:	Augusta	**State:**	AR	**Zip-code:**	72006
Organization's Project Contact	**Name:**	Steven Collier, CEO; Rebekah Youngman, Program Director				
	Phone:	870-347-2534/870-347-3390				
	Email:	steven.collier@ARcare.net, rebekah.youngman@ARcare.net				

Project Overview	
Project Title	Arkansas Delta States Health Network
Goal(s)	The overarching goal of the 2016-2020 Health in Action (HIA) project is to reduce the incidence of chronic disease health issues for rural Arkansans. This goal was achieved through provider and clinical staff training, community education, coordinated care, and chronic disease self-management programs that included medication management, physical activity, nutritional guidance, and increasing accessibility (expanding programs to 33 clinic sites).
Objectives	• Expand the chronic care management programs to additional nine locations without previous access to these programs • Provide information and materials on chronic disease programs to 150 clients • Implement care coordination and health coaching in network member sites • Implement a referral tracking system between network partners • Increase opportunities for physical activity for five school districts within the network's service area • Increase access to mental/behavioral health training for 75 school district personnel and other professionals working in a related field • Develop a network strategic plan to address sustainability of activities to continue beyond the term of the grant
Focus Area(s)	☒ Behavioral/Mental Health ☒ Diabetes Care Management ☒ Chronic Disease Management ☒ Community-Based Care Coordination ☒ Health Education/Promotion and Disease Prevention ☒ Health Screenings ☒ Population Health ☒ Telehealth/Telemedicine ☒ Transitions of Care ☒ Primary Care Services ☒ Other: Social services related to health issues and referrals to care

Consortium/Network Partners	Organization Name	Role	Organization Type
	ARcare	ARcare's service area includes Cross, Independence, Izard, Jackson, Mississippi, Poinsett, Prairie, White, and Woodruff counties. ARcare was responsible for: • Administering programmatic and financial direction over the project activities and services for the network • Coordinating with the network partners in providing community outreach and educational activities • Directing clinical support to the members for managing chronic disease and identifying socioeconomic health disparities • Providing clinical services to the target population and collecting all programmatic and financial data from network members	FQHC
	Boston Mountain Rural Health Center (BMRHC)	BMRHC participated in the planning of the expansion project as well as providing direct clinical care related to chronic disease to the residents in their rural communities. BMRHC was responsible for: • Meeting the health care needs of residents living in Baxter, Marion, Searcy, Stone, and Van Buren counties • Collecting all grant-related data (programmatic and financial) and submitting to ARcare within the specified time frame	FQHC
	Crowley's Ridge Development Council (CRDC)	CRDC is dedicated to creating opportunities for disadvantaged individuals and families to achieve greater self-sufficiency. CRDC was responsible for: • Providing utility and/or rent assistance, weatherization, drug prevention, and self-sufficiency programs to residents in Clay, Cross, Greene, Jackson, and Woodruff counties • Addressing social determinants of health for affected clients/patients, providing referrals to network-specific programs, and community outreach and education	Community Action Agency
	1st Choice Healthcare	1st Choice Healthcare Inc. participated in the planning of the expansion project as well as providing direct clinical care related to chronic disease to the residents in their rural communities. 1st Choice Healthcare was responsible for: • Collecting all grant-related data (programmatic and financial) and	FQHC

		submitting to ARcare within the specified time frame • 1st Choice Healthcare served residents in Clay, Fulton, Greene, Lawrence, Randolph, and Sharp counties	
Evidence-Based Model(s)/Promising Practice(s)	The evidence-based model adopted by the Arkansas Delta States Health Network is the **American Association of Diabetes Educators Chronic Care Model**. This model has been used by the network members for more than 18 years within their clinic systems. The model has allowed the network to provide a team-based approach in addressing chronic disease issues as well as mental and behavioral health issues with patients. This is a well-established organizational framework for chronic care management and practice improvement. This model of care incorporates the patient, provider, and system-level interventions to create partnerships between health systems and communities. The network members have also developed coordinated care departments to ensure that a team-based care approach is conducted throughout their health care service programs. This funding opportunity has allowed the network to introduce health coaching and care coordination throughout the network's service area. There has been a significant improvement in patient knowledge, health outcomes, treatment plans, and medication compliance.		
Needs Addressed	The network's service area is characterized by high rates of poverty, unemployment, and health issues related to chronic disease. Almost one-quarter of all families with children live in poverty (24.8%), compared to 22.5% in Arkansas and 15.3% nationwide. Individuals earn between $8,357 and $20,996 less than their peers nationwide. Since the pandemic, Arkansas has seen a significant increase in the unemployment rate. The unemployment rate increased from 3.5% to 10.2%. Residents in Arkansas Service Region B suffer from not only economic distress but from physical and mental health distress as well. More than 70% of service area adults are overweight or obese, with less than half of the service area residents meeting recommended physical activity standards. The rates for childhood obesity in the service area are just as startling — more than 40% of service area children are considered overweight or obese according to the county health profiles. Additionally, high cholesterol diagnoses continue to increase, and diabetes and hypertension rates significantly outpace national rates. Further, there is limited primary care availability in the service area. In turn, the tendency not to pursue preventive medical care contributes to higher rates of undiagnosed cardiovascular disease, diabetes, and mental health issues within the target population. The high rates of poverty and unemployment combined with low wages and/or low educational attainment contribute to the following: (1) lack of access to affordable health insurance, (2) limited access to primary health care and specialty care, (3) high rates of adult and childhood obesity and other chronic diseases, (4) limited access, if any, to mental and behavioral health care services, and (5) the need for self-management programs related to chronic disease. The expansion of the Health in Action project was designed to address all of the factors listed above. The network members provide services to a large, widespread coverage area of Arkansas and are the only health care providers in most of the counties that fall within Arkansas Service Region B. Additionally, they are the only clinics that serve low-income and underinsured populations. This project addressed the lack of access to chronic disease–related health services for the target population. Other barriers in the service area include transportation, education, and cultural or linguistic differences. These barriers were targeted in order to provide better access to care and to meet the needs of the communities. The FQHC members offered transportation services to patients seeking care at one of the member clinic sites or a referred special provider. Members also worked with uninsured patients to ensure that they received the resources and information they needed to select the best coverage to meet their needs. Printed health education materials were provided to — or read to — patients to fill in the gap of noncompliance with physician instructions, poor management of chronic conditions, and poor health outcomes. Members of the network also trained staff members and ensured that they were available to meet with the patients, assess their social risks, and determine the next steps for better access to care		

	or assistance. Members were also committed to serving all residents regardless of any cultural, religious, or language barrier.
Target Population(s)	☒ Adults (18-64) ☒ Elderly (65 and over)
Services and Activities	The Arkansas Delta States Health Network members developed program information and brochures for training and program services to distribute at clinic sites, case management offices, and community events. Care teams developed and implemented work-flows for care coordination and health coaching as well as providing chronic disease–specific services to patients. Tracking systems were developed to share data between network partners. Supplies were purchased, and employees provided Painted Play Spaces at elementary schools and parks to promote physical activity for children. Members worked together to form best practice models and implemented models for diabetes education, chronic disease management support groups, and prevention programs for students and faculty within school settings. They developed and implemented drug-prevention curricula and events for network partners and school districts and conducted educational sessions with a focus on mental and behavioral health for school faculty.
Project Results	
Outcomes	Project outcomes resulting from the Health in Action expansion project include: • Network members providing health education, outreach, and chronic disease program services to 74,331 residents in Arkansas Service Region B. • As of May 2020, chronic disease education programs have been expanded from nine to 36 additional clinic sites, and 25 staff members and providers have received program-specific training. Mental and behavioral health training were conducted through education summits and Mental Health First Aid training. In turn,188 medical and education professional staff members attended these summits, and 45 received Mental Health First Aid training certification. • Crowley's Ridge Development Council (CRDC) referred 110 clients to network members for chronic disease–specific education and programs. Network members have provided chronic disease–specific services to 2,748 patients. • All medical network members have implemented care coordination protocols and health coaching within their organizations. • The network has developed a strategic plan that was approved by the Health Resources and Services Administration (HRSA). The network members continue to utilize this plan when determining new locations and services that will be provided throughout the service area. • In Year 4 of the grant (extension year), the network added new activities that aligned with the network goals and objectives. Network members developed partnerships with eight local school districts, offering mental and behavioral health training for teachers and staff members as well as increased physical activity opportunities for the schools through Painted Play Spaces projects and Fun Field Days.
Sustained Impacts	☒ All elements of the program will be sustained Short-term impacts are at the forefront, since communities have been affected by the coronavirus pandemic. Over the past few months, CRDC has been instrumental in partnering with the United Way of Northeast Arkansas and community foundations to provide emergency financial and food assistance to families affected by COVID-19. Telehealth has been a short-term fix to continue providing health care to patients of the network members; however, our hope is that the federal and state governments, Centers for Medicare and Medicaid Services (CMS), and other insurance providers will make long-term policy changes in order for telehealth to be a more feasible and cost-effective option for clinical providers and patients after the pandemic. Long-term impacts include not only the patients services that are available in the community, they also include the

	partnerships and collaboration with other community members to find ways to meet the individual and overall needs of the community. Boston Mountain Rural Health Center developed Walk this Way (a Walk with a Doc program) for their community partners and patients to encourage healthy habits and improve patient engagement by giving access to a clinical provider outside the walls of a clinic. ARcare collaborated with community residents and a local extension office to develop the Woodruff County Warehouse Project to increase access to healthy foods and improve ownership of health issues affecting local communities. The warehouse has been expanded to another county in Arkansas Service Region B and has been discussed for implementation in two other counties in the network's service area. ARcare has also worked with local government, local businesses, students, and teachers in an Education Accelerated by Service and Technology (EAST) Initiative and other community leaders to establish The Market at McCrory. The Market at McCrory is a farmers market held once a month from May to October to provide access to local healthy foods. Network members realize that local government is essential to effective long-term change and regularly cooperate with community leaders to benefit the health care of the communities they serve. Clinical network members have also been able to obtain certifications for adult and youth Mental Health First Aid to ensure staff members know how to recognize mental distress among the patient population as well as community members in general. The long-term effect has been significant over the course of the expansion project. Through this Delta States funding, network members have been able to expand certified chronic disease programs to 33 clinic sites throughout the network's service area. The programs include diabetes self-management, chronic care management, improved coordinated care efforts, mental and behavioral health education, medical nutrition therapy, and transition of care management. Network members have been able to gain provider and community buy-in over the course of the grant. Successful disease-specific programs have allowed network members to strengthen their partnerships with specialty providers, hospital systems, local health departments, and school districts. In addition to increasing the community outreach efforts on available program services, more clinical staff members have been trained on specific program protocols and work-flows.
Challenges and Lessons Learned	One of the most significant challenges that the network's clinical members experienced came in years 1 and 2 of the project. The network's clinical members implemented chronic care management (CCM), and the patients loved it. They enjoyed the encouragement and having someone to talk to about their health issues. However, CCM patients were charged a copay each month after the call. This resulted in the clinic partners losing CCM patients. After much guidance and discussion with the billing department, CFOs, and CEOs, a few clinic partners decided to waive the copay of eligible, qualified CCM patients. The network learned that the billing department should be included when planning and implementing new programs and services. Other challenges faced by the network members over the course of the project were (1) staffing capacity, (2) provider and community buy-in, (3) increased no-show rate, and (4) patient engagement. These challenges were addressed by increasing the number of staff trained and providing program-specific services to the patients, increasing group and individual training among providers and program staff, monthly training on appropriate coding to providers and clinical staff as needed, increasing community education events, implementing text and phone call appointment reminders, follow-up phone calls, and telehealth services. In Year 4 of the grant project, the network was faced with challenges due to the coronavirus pandemic. The pandemic caused panic among patients and clients. In turn, network members had to change the way they provided health care and social service activities. Telehealth was being used on a limited basis throughout the clinical partnership sites. However, the coronavirus pandemic jump-started the network members' telehealth efforts. New work-flows, policies, and training were developed, as well as equipment and devices being purchased in order to provide quality care to the patients. Face-to-face visits had to be limited, and protocols were put in place for staff members, patients, and clients to wear a mask and be screened at the front door. Services were provided in parking lots, curbside, and in tents. One major challenge for the clinical

	network partners regarding virtual visits is that they did not receive the same reimbursement for virtual visits as they would have for face-to-face visits. Additionally, like other providers across the nation during the pandemic, all partners saw a significant loss in revenue, which caused concerns around staff furloughs and the closings of clinic sites or combining clinic sites in order to continue to provide services to the community.
Accomplishments/ Recognitions	Network members have received recognition and acknowledgement for many of the endeavors they have taken on throughout the service area. For two years, ARcare and Boston Mountain Rural Health Center Inc. have been selected to participate in the Arkansas Clinical Transformation Collaborative with the Arkansas Department of Health. ARcare has received the Organizational Trendsetter Award from the Arkansas Diabetes Advisory Council for establishing multiple diabetes self-management education and training sites. ARcare has also received accreditation for a clinical pharmacy residency program through their partnership with the Harding University School of Pharmacy. ARcare and 1st Choice Healthcare Inc. have both received accreditation by the Joint Commission. All medical network members are members of the National Association of Community Health Centers. CRDC is a member of both the Community Action Partnership and the Arkansas Community Action Agency Association.
Considerations for Program Replication/ Implementation	This type of program will definitely benefit other communities that are interested in expanding their primary care program to focus on chronic care management and coordinated care activities. Overall, the patients love the care team approach, especially the monthly check-in phone calls they received from the staff, and support groups/meetings on specific health issues and solutions (physical activity and nutrition education with cooking classes). Clinically, the collaboration of the care team — having each member reviewing the patient's case and care plan — is very effective for patients in understanding their treatment plan and goals. The results are much more effective and efficient for the patients and the care teams. More patients are enrolled in the chronic care management program and diabetes education programs and have been able to improve their health outcomes. Clinical outcomes that may prove as beneficial for other communities include continued improvements in blood pressure, weight, and/or HbA1c levels for patients participating in these programs. Through reimbursement from third-party payers and fee-for-service, the network members have brought in more than $400,000 in program revenue over the past three-and-a-half years. The program income has only been calculated for clinical staff paid from grant funds and/or billing for services. The income is put back into each network member's individual programs before grant funds are utilized.

ARKANSAS

Arkansas Rural Health Partnership

Arkansas Service Region A

Organization Information						
Organization Name	Arkansas Rural Health Partnership					
Organization Type	Other Nonprofit Organization					
Address	**Line 1:**	1969 Lakehall Road				
	City:	Lake Village	**State:**	AR	**Zip-code:**	71653
Organization's Project Contact	**Name:**	Shessa Pieroni				
	Phone:	501-681-0097				
	Email:	shessapieroni@arruralhealth.org				

Project Overview	
Project Title	Arkansas Delta Healthy Communities Project
Goal(s)	• Promote the development of an integrated health care network • Coordinate and connect health care partners and services in the Arkansas Delta Region • Improve quality of health care through a provider education initiative • Improve health outcomes for residents with chronic diseases
Objectives	• Encourage collaboration among service providers and health care system partners • Produce an updated, relevant strategic plan • Expand the referral safety net for patients' health care providers in 10 new counties • Expand communication efforts between health care partners • Increase the number of certified/trained health care providers by 25% • Increase health care workers completing chronic disease certification by 20% • Improve the health outcomes of individuals with diabetes • Decrease barriers to care through patient navigation and assistance services • Improve health outcomes through a clinically integrated network • Provide support/cost savings for hospitals through professional roundtables
Focus Area(s)	☒ Case Management ☒ Diabetes Care Management ☒ Chronic Disease Management ☒ Health Education/Promotion and Disease Prevention ☒ Population Health ☒ Other: Health Care Education

Consortium/Network Partners	Organization Name	Role	Organization Type
	Arkansas Coalition for Obesity Prevention (ArCOP)	• Provided the staff and resources to distribute community grants to assist	Nonprofit

		communities with making them healthier by creating community gardens, walking trails, cooking classes, work site wellness programs, and access to healthy food	
	Arkansas Rural Health Partnership (ARHP)	• Provided project direction, necessary staffing, fiscal management, and grant oversight	Nonprofit
	Community Health Centers of Arkansas Inc.	• Supplied state support and organization for the community health centers participating in the project • Assisted the centers in the Delta States region with implementation	FQHC
	University of Arkansas for Medical Sciences (UAMS) – East	• Assisted with strategic planning and program development during the first years of the Delta States project • Provided staff to implement diabetes education using experienced health educators and dietitians	University
Evidence-Based Model(s)/Promising Practice(s)	**Diabetes Self-Management Education Model (DSME):** Since 2016, the Arkansas Rural Health Partnership (ARHP) has been successful in implementing accredited DSME programs in four previously underserved areas in Arkansas: Drew, Ashley, Phillips, and Jefferson counties. A lesson learned is that hospitals and clinics must invest time and personnel to the DSME accreditation process. Over the past few years, ARHP's infrastructure has allowed for hospitals/members to work together to provide services such as DSME through telehealth capabilities to other facilities, thus creating a network and allowing for the expansion of DSME beyond existing barriers. **National Diabetes Prevention Program (DPP) Model:** One of ARHP's partner hospitals has maintained a successful, ongoing DPP program and is in the third year of offering these lifestyle-change classes. ARHP found that to be successful in implementing and maintaining a DPP program, a dedicated staff person should already be in place providing other, more immediately billable services such as DSME. **Diabetes Empowerment Education Program (DEEP) Model:** The Delta States project trained 32 trainers and 475 students during the past four years. All topics were beneficial to attendees and trainers, but ARHP learned that it was difficult to schedule courses, market classes, and recruit attendees when the authority is not under ARHP's purview. **The Care Transitions Intervention Model:** Jefferson Regional Medical Center conducted a pilot using advanced practice nurses (APNs) to meet patients with chronic diseases prior to discharge and follow up with phone calls. The project improved health outcomes in patients and reduced readmissions. The process and outcomes of this pilot study were published and distributed to all ARHP member hospitals. ARHP recognized the readmissions pilot as a best practice. ARHP found that in order for the pilot to be successful in implementation, a dedicated staff should be in place. **The Interdisciplinary Evidence-Based Practice Model:** Interdisciplinary providers of all backgrounds in the region received certifications to meet continuing education requirements. ARHP expanded the program and renamed it Health Education for Local Providers (HELP). The model works so well that ARHP is using it as a component in most grants.		
Needs Addressed	The target population experiences significant barriers to accessing care, including unemployment, low socioeconomic status, low educational attainment and literacy level, age-related discrimination, and lack of transportation. The region also has other challenging factors, including		

	poor eating habits, lack of physical activity, smoking, and preventable hospital stays. These issues contribute to the target population having a high rate of chronic diseases, specifically diabetes and cardiovascular disease. Additionally, many counties have limited health care providers and resources, requiring residents to travel long distances to reach needed chronic disease services. Further, due to the lack of providers, there is a critical need to educate health care professionals of all educational backgrounds. This struggle also extends to the health care providers in the region who need continuing education, training, and the support of their peers. The shortage of providers and health care workers makes it imperative that training and education be available on-site and through distance-learning opportunities, specifically to address the chronic disease burdens that plague the Delta region. ARHP's 14 rural hospital members and all components of the project addressed challenges, including lack of health care providers, financial woes, the costs of outsourcing, the need for patient resources, and support for their health care providers. ARHP's Arkansas Delta States grant program was designed to reduce health disparities, decrease barriers to care, expand management of chronic disease, improve provider education, and improve health outcomes, primarily through increasing the availability of well-trained providers within the communities while implementing evidence-based practices that target chronic diseases, specifically diabetes. ARHP recognized that it was critical to offer locally available, high-quality services to meet the needs of the community. As a result, ARHP has provided access to quality health care and education for patients, and education and training for health care providers throughout the Delta States service area as well as establishing multiple programs (DSME, DPP, DEEP) that benefit the community.
Target Population(s)	☒ Children (0-12) ☒ Adolescents (13-17) ☒ Adults (18-64) ☒ Elderly (65 and over)
Services and Activities	Throughout the past four years, ARHP's Delta States grant program addressed the needs of the hospitals, health care workers, and patients by providing programs intended to empower all entities to succeed. Programs that were provided to residents and patients throughout the 19-county service region include prescription assistance, insurance enrollment, diabetes education programs, Cooking Matters classes, care coordination, patient navigation, and community grants to combat obesity and promote healthy lifestyles. All of these programs addressed needs that the communities themselves felt were important enough to prioritize in the community health needs assessments that were conducted throughout the service area in 2013-2016. The project continued to support member hospitals, clinics, and providers in the service area with increasing educational opportunities to reach health care facilities and staff members, including online compliance, orientation, continuing education, and training; on-site simulation training; assistance with becoming certified diabetes sites; assistance with hospital readmissions; and monthly professional roundtables.
Project Results	
Outcomes	**The project provided significant outcomes for health care providers, patients, and community members including:** • On-site training and certification opportunities that provided health care workers with the tools and knowledge to feel confident in their response to emergency situations. CareLearning provided online health care orientation, education, and training, which not only provided quality programs to participating hospitals and clinical staff in the region but also created a cost savings to the hospitals by decreasing the costs for human resource personnel and employee time and effort. Through the project, 157,346 CareLearning instructional sessions were conducted. • Professional roundtables formed in the last year of the project have proven to be the most valuable component of the entire project during the COVID-19 crisis. The professional roundtable platform, which was created by ARHP to bring hospital and clinic directors and

	staff together to create cost-savings and support at the regional level, became a centralized form of communication, support, and crisis intervention across the region and continues to grow in popularity and participation by health care workers. • ARHP has addressed its hospital members' community health needs assessments as well as the needs of the residents and patients in the region through: o Diabetes education and support programs (475 patients participated in the DEEP program, 538 patients participated in the DSME program, and 228 patients participating in the DPP program) o Cooking classes o Care coordination efforts (517 care coordination calls were provided) o Patient assistance services (3,570 free prescriptions were provided to patients) o Insurance enrollments for 1,096 individuals o Community grants that have improved the health of 88,854 Delta residents o Cost saving for patients and providers ($3.7 million saved in prescription drug costs for patients, and 9,840 individuals served through the readmissions pilot project)
Sustained Impacts	☒ Some parts of the program will be sustained **Sustained impacts of the project include:** • **Health Care Providers/Hospitals and Clinics**: The training and educational initiatives provided through the Delta States project have equipped hospitals and clinics in the region to improve the quality of care for their patients by providing instruction/training from the same experts that teach/train UAMS medical students, residents, and providers. The assurance that residents are receiving the same quality of care locally as those in urban areas of the state is comforting and reassuring. When patients utilize their local health care resources more frequently, this is reflected in the financial bottom line of the hospitals and clinics. • **Patients/Community Members**: Patient/community education and assistance programs through this project will continue to impact patients' ability to manage their disease, live a healthier life, and stay out of the hospital. **Short-term impacts of the project include:** • Demonstrated improvements in patient health outcomes for the rural communities served • Increased support for rural primary care providers • Improvements in quality of care and delivery of services • Improved patient engagement with providers • Expansion of access, coordination, and quality of essential health care services • Improved patient and provider satisfaction • Increased reimbursements for essential health care services • Increased efficiencies within partner clinics • Increased access to locally available health workforce training **Long-term impacts of the project include:** • Improved quality of care across the region • Increased retention rates of patients and providers

	• Decreased chronic care morbidity rates in the region • Improved health status within the region • Improved health and well-being of adult patients diagnosed with diabetes throughout the region • Increased financial viability and sustainability of clinic partners • Decreased outward migration of residents due to lack of available health care services and providers • Decreased time and cost required for providers and staff to travel to and attend needed training to maintain certifications • Increased rural residencies and new providers to fill critical health workforce gaps • A stronger health care system and economy
Challenges and Lessons Learned	Throughout the project there were several challenges and lessons. • **Shortage of health care workers**: The Arkansas Delta faces physician recruitment issues, hospital financial struggles, and a lack of health education opportunities locally to produce more health care workers, all of which cause a shortage of staff in health care organizations. These shortages limit the ability for current hospital/clinic staff to have the time to participate in extra activities, including continuing education opportunities. ARHP was able to address these issues by providing on-site educational opportunities that were convenient for staff members and online educational opportunities that could be accessed at any time. Project staff members were able to work with hospitals to increase attendance by providing training in shifts throughout the workday/night, providing some of the mandated class work virtually, and working with all hospital partners to provide training that could be accessed at different locations for all health care workers. • **COVID-19 Pandemic:** ARHP's rural hospitals and workers were not prepared for a potential surge of patients that needed critical care. While the state of Arkansas had a very organized trauma system, it was determined quickly that the Arkansas Delta region was not organized for a major crisis situation. Many of the hospitals in the region did not have the staff, resources, finances, supplies, equipment, knowledge, or capability for what could have been a crisis. The structure of the ARHP organization and its strategic alignment with UAMS provided access to needed education, support, staffing, and assistance to all health care organizations in the service area.
Accomplishments/ Recognitions	Professional roundtables formed in the last year of the project have proven to be the most valuable component of the entire project and were extremely valuable during the COVID-19 crisis. When the first case of COVID-19 hit the partnership area, ARHP immediately coordinated professional roundtable conference calls among the clinical directors of member hospitals. The purpose of the calls was to understand what the member hospitals' immediate needs were in order to be able to help them to become better prepared to handle the potential influx of cases in their facilities. These calls also served to bring the partnering facilities even closer together and allow them to lean on one another for support and guidance during the pandemic. ARHP was able to discuss and share nursing, respiratory, and pharmacy policies and procedures surrounding the pandemic, such as the loading and maintenance doses of critical care drips, caring for ventilated patients, appropriate techniques to don and doff personal protective equipment, etc. These calls also consisted of multiple discussions and the sharing of resources for implementing a consistent treatment approach for caring for COVID-19 patients. The member hospitals also discussed staffing modules that were being implemented, along with rationales for the modifications. Through the collaborative efforts of the professional roundtable calls, hospitals were better able to care for the more critically ill patients and to prepare for a potential surge. Additionally, with the collaborative efforts of ARHP and UAMS, the network was able to bring some much-needed education including visual instruction for infection control and isolation precautions,

	best practices for rapid COVID-19 assessment screening processes, quick-reference clinical guidelines for drip conversions, quick-reference guidelines for the most commonly used COVID-19 ventilator settings, and best practice for the management of proning a patient as part of the COVID-19 treatment plan. ARHP and staff members also received the following recognition over the course of the project: the Federal Office Rural Health Policy (FORHP) Rural Health Champions for Creative Partnerships and the National Rural Health Fellows Program in 2018, and the National Cooperative of Health Networks Outstanding Health Network and Healthcare Hero Awards Innovative Hero in 2019.
Considerations for Program Replication/ Implementation	ARHP's experience as an organization that started with five hospitals and working with those five members to find valuable programs to offer led to the expansion of current hospital members. ARHP's journey has taught us to listen to our members and respond to the voice and needs of our community. ARHP's Delta States project put many valuable pieces in place that helped the network realize that organization was critical to the network's survival and success, and now more than ever, ARHP's members are committed to their mission to work together to increase access to care and quality through collaboration. ARHP believes it is important to point out that sometimes starting with the basics to develop partnerships and potential collaboration gives everyone an opportunity to find the middle ground, and that can be the most important step. ARHP began with the Delta States grant in 2013 with providing health care provider education, patient assistance services, and patient education. These initiatives led to expanding upon these ideas and led eventually to the development of a valuable organization to its members. Through this project, efforts to bring health care education to rural providers through telehealth and on-site training opportunities have been the most impactful and beneficial service that ARHP has been able to provide for its members. The direct line to UAMS has provided many opportunities the network would not have had if such a relationship did not exist. Rural health care entities often are threatened by larger health care providers, so aligning in a way that can provide resources to rural providers without talking away from the local control of the rural provider is crucial. Aligning the organization to succeed means being open to partnerships, and in health care, this is imperative.

KENTUCKY

Baptist Health Madisonville Inc.

Service Region A

Organization Information						
Organization Name	Baptist Health Madisonville, Inc.					
Organization Type	Other Hospital (Non-CAH)					
Address	**Line 1:**	900 Hospital Drive				
	City:	Madisonville	**State:**	KY	**Zip-code:**	42431
Organization's Project Contact	**Name:**	Kelcey Rutledge				
	Phone:	270-824-3736				
	Email:	kelcey.rutledge@bhsi.com				

Project Overview			
Project Title	Baptist Health School Wellness Initiative		
Goal(s)	The goal of the project is to enhance the culture of wellness in the Baptist Health School Wellness Initiative (BHSWI) service area schools by involving school staff, students, parents, and community organizations.		
Objectives	• Maintain school wellness initiative participation • Expand sustainable wellness committee framework to include service area elementary, middle, and high schools • Promote community wellness throughout the service area		
Focus Area(s)	☒ Health Education/Promotion and Disease Prevention		
Consortium/Network Partners	**Organization Name**	**Role**	**Organization Type**
	The Alliance for a Healthier Generation	• Provided and trained staff on usage of its Healthy Schools Program online wellness committee development tool, affording Baptist Health Madisonville access to specific training, reports, and data sets on participating schools' activity	School Wellness Promotion
	The University of Kentucky College of Dentistry	• Provided oral health presentation information used at Wellness Tours for students, schools, and community events	University
	West Area Health Education Center (West AHEC)	• Guided staff on continuing medical education accreditation and insight on presentations	Health Promotion
Evidence-Based Model(s)/Promising Practice(s)	The promising practice model identified and adopted was the **Alliance for a Healthier Generation's Healthy Schools Program (HSP)**. It is an online wellness group development tool that uses a coordinated approach to create wellness group action plans, explore resources, and implement strategies and activities focused on creating a healthy school environment. By using the HSP, schools are able to assess wellness activities, save and update assessment progress, and retain action plans to address health and wellness issues. The HSP was adopted to assist diversified, multilevel wellness group initiation and integrated efforts within public schools in the Western Kentucky Rural Mississippi Delta Service Area. The program incorporates action planning		

	to address health issues and supports implementation of activities to address health needs. BHSWI project specialists utilized the HSP to monitor school wellness group activity, provide feedback, advise of necessary actions, and offer technical assistance. Participating schools designate a school champion to steer wellness group efforts and then complete the HSP assessment on wellness activity questions. The results are then organized into action plans to address the needs identified. The only adaptation was that schools were responsible for implementing physical activities in addition to required physical education standards as an ongoing wellness group action plan item.
Needs Addressed	Kentucky has disproportionately high chronic disease rates. Many are impacted by obesity, and Kentucky has some of the highest rates for obesity and inactivity nationwide. Nationally, Kentucky ranks the eighth-highest for adults who are obese (34.3%) and fourth-highest for 10- to 17-year-olds who are considered obese (19.6%). Poverty, low income, low educational attainment, and physical inactivity each contribute to Kentucky's high obesity rate. From 2013 through 2017, Kentucky Delta counties' average median household income was $41,897, compared to $46,535 for Kentucky and $57,652 nationally. During the same period, the counties had an average per capita income of $23,216, compared to $25,888 for Kentucky and $31,155 nationally. Additionally, most Delta counties have a higher unemployment and poverty rate (5.4%) than Kentucky collectively (4.3%) and the national rate (3.9%). Further, according to a 2018 report from Trust for America's Health and the Robert Wood Johnson Foundation, Kentucky placed 31st for percentage of high school students (22%) who were physically active at least 60 minutes per day. BHSWI was designed to address the obesity epidemic in western Kentucky through enhancing a culture of wellness in service area schools through building a sustainable coordinated wellness leadership group, or wellness committee framework. Ultimately, the project worked to implement a sustained wellness model with activity for students throughout matriculation, influencing healthy lifestyle habits into adulthood.
Target Population(s)	☒ Children (0-12) ☒ Adolescents (13-17)
Services and Activities	Activities are centered on childhood obesity prevention and wellness promotion for elementary, middle, and high school students residing in the 20 rural Delta counties in Kentucky. School wellness leadership groups, or wellness groups, were the driving force to help implement school wellness programs, activities, and services with district accountability and community support. Key activities for crafting a sustainable wellness leadership group framework included: (1) School wellness group framework establishment and retention (2) School-based physical activity and/or movement programming beyond required health and physical education (3) Wellness Tours, interactive and fun school assemblies including healthy lifestyle presentations on proper eating, oral health, anti-drugs, internet safety and anti-bullying, and daily physical activity (4) Wellness training opportunities for school staff members (5) Wellness education presentations for service area residents with a focus on reaching the low-income population and geographically challenged areas
Project Results	
Outcomes	Outcomes from project efforts include: • **School wellness group framework establishment and retention.** The number of participating schools expanded to include all but two public service area schools. The number of participating schools expanded from 107 (92 elementary, nine middle, and six high schools) to129 schools (75 elementary, 27 middle, 27 high schools) by the end of the grant cycle. All 129 participating schools established wellness groups, selected school champions to guide wellness efforts, and assessed health needs, developed action plans to address issues, and implemented activities to enhance wellness culture. All but six schools

	submitted all required meeting minutes. • **School-based physical activity and/or movement programming beyond required health and physical education.** Seventy schools utilized TAKE 10!® and/or similar classroom-based physical activity curriculum. • **Wellness Tours.** Seventy-one Wellness Tours were held with 14,385 students and 987 teachers attending. Students were pre- and post-tested on the healthy eating, oral health, anti-bullying and internet safety, and anti-drug abuse content covered in Wellness Tour presentations. For the four-year funding period covering the August 2016 through May 2020 school years, the average pretest score was 66%. The average post-test score was 86%. • **Wellness training opportunities for school staff.** Two hundred thirty-one school representatives were trained on classroom and school physical activity incorporation at nine events. • **Wellness promotion presentations for service area residents.** Wellness Nights, other school events, community-based events, and project-hosted professional development events were attended by 52,628 Delta residents.
Sustained Impacts	☒ Some parts of the program will be sustained To reach the goal of enhancing the culture of wellness in participating service area schools, staff sought to assist participating schools with verification of enacted/strengthened wellness policies, including U.S. Department of Agriculture (USDA) dietary guidelines, physical activity opportunities for staff, and school and/or classroom physical activity opportunities beyond required health and physical education. Though only elementary schools and school districts are required by the Kentucky Department of Education (KDE) to have active wellness policies, 107 of 129 participating schools have updated school wellness policies. All Delta service area public school districts signed memoranda of understanding (MOU) with the host agency, Baptist Health Madisonville Inc., for school participation. The MOUs outline the guidelines for school wellness groups and named points of contact responsible for continuation of school wellness groups should funding cease, increasing the likelihood of sustainability. Wellness groups consist of school administration, school staff, students, parents, and community organizations, facilitating multilevel community involvement with enhanced school wellness culture. The approach affords all community levels the opportunity to participate in instituting physical activity opportunities for school staff, students, and community members, bolstered by strengthened district and school wellness policies. **School wellness group framework**: In having signed the MOUs with the initiative, school superintendents have assigned a school district employee to serve as the primary contact between the district and the initiative. That designee is responsible for retention of long-term school wellness leadership group framework retention. The framework requires school principals to serve on school wellness groups to retain leadership involvement and assume responsibility should the funding cease. Annually, schools submit wellness reports to the KDE to assess overall effectiveness. Wellness performance reporting determines funding for individual schools and is highly important. Each school wellness report has a component inclusive of KDE Whole School Whole Community Whole Child (WSCC) model requirement evaluation. WSCC requirements mandate that each local educational agency (school district) form district wellness leadership groups that have to meet biannually to govern wellness activity. Likewise, each elementary school has to retain a governing body to assess and address wellness issues and meet at least four times per year. KDE allows schools to use the Alliance for a Healthier Generation's HSP Assessment and Action Plan as forms of required, annual wellness reporting. Participating schools are familiar with completing and updating their Healthy Schools Program assessments by the same deadline set forth by KDE to

	meet reporting requirements. Therefore, the benefits of having required district staff include overseeing personnel, familiarity of required wellness reporting and wellness policy assistance originating from initiative participation, and an increased likelihood of school districts continuing the school wellness group framework beyond funding. **School and/or classroom-based physical activity programming beyond required health and physical education**: By incorporating exercise with learning, schools teach children that physical activity is valuable, a good lesson at an early age. Many teachers reported it reduces stress and reminds them of their own need for physical activity benefits. A one-time purchase of TAKE 10!® curriculum is all that is necessary for a school. The project has already purchased curricula for participating schools for their continuing use. For the upcoming funding period, the project plans to offer GoNoodle® Plus to participating elementary schools, an online suite of physical activity videos deigned for classrooms. **Short-term impacts:** One hundred twenty-nine service area schools have functioning wellness groups to promote an enhanced culture of wellness. At least 70 schools have incorporated physical activity curricula into classroom settings beyond health and physical education courses. Students have been impacted as they enjoy the fun videos, are able to increase physical activity levels, and recenter to focus on curriculum though working off excess energy. Through school and community presentations, and project-hosted professional development, students, community members, and school staff have enriched knowledge of the importance of proper diet, physical activity, and healthy lifestyle habits beyond their association with school. **Long-term impacts:** All 23 service area public school districts have committed to sustained school-level wellness activity even if grant funding ceases. Years of project-initiated school wellness framework activity, in combination with wellness promotion efforts of other agencies in Kentucky, have contributed to wellness reporting requirements by KDE. Joint wellness promotion efforts of the project and similar programming nationwide have assisted with legislation that now regards health and physical education as equally important requirements as other school subjects. The federal Every Student Succeeds Act requires schools to include health and physical education and activity in school curricula with annual verification reporting required at the school level.
Challenges and Lessons Learned	**Project Title:** School representatives largely did not make a connection between the Kentucky Delta Rural Project and the host agency Baptist Health Madisonville Inc. The project was rebranded the Baptist Health School Wellness Initiative in August 2017 to increase relatability to the host agency, create familiarity of Baptist Health in the service area, and increase community awareness of Baptist Health Madisonville Inc. to sustain program offerings beyond funding. **School Wellness Leadership Group Framework:** A pilot was conducted when the 2016 funding cycle began, and some wellness groups were formed on a limited basis. Although they were not the primary activity focus and were not retained, lessons emerged. For instance, numerous sets of meeting minutes were incomplete. To capture pertinent information, a meeting agenda and minutes template was drafted and provided to schools, and this helped the schools immensely. Many of the school champions were untrained on wellness group procedures, so a systematic participation requirement checklist was created and provided to school champions with step-by-step instructions, with emphasis on school wellness groups being the impetus for sustained wellness activity. Typically, the school champions were physical education (PE) teachers with time constraints and numerous duties. Given the varying demand on teachers' time, the BHSWI project specialist position is a critical part of the sustainability of the work of the wellness groups. The personal relationships were also an important driver in school participation retention. Also, at the beginning of the funding period, four wellness meetings were required at least quarterly each year. To allow incentive payment before the end of the grant year, schools meeting requirements received incentives after the second meeting in January or February. Some schools did not submit all timely subsequent meeting minutes, although they had received the incentive. Starting in the 2018-2019 school year, meetings were required bimonthly in August, October,

	December, and February to ensure submission and not interfere with end-of-year activities (i.e., skills testing). Incentives were not granted until schools submitted wellness group meeting minutes and staff verified that all program participation requirements were met. Additionally, most of the school's physical education budgets were strained. In some cases, schools were operating on budgets of $100 or less for health and PE programming and equipment. Therefore, for meeting program requirements, schools receive tiered incentives, increasing based on achievement levels. Schools received a base $500 incentive for meeting base wellness group requirements, having four bimonthly meetings per year, and annually completing or updating their Healthy Schools Program wellness assessment and action plan. To encourage planning and initiation of effective policy changes and activities to address health issues, schools were given an additional $1,500 if they were National Healthy Schools Award bronze, silver, or gold recognition eligible. If a school submitted the National Healthy Schools Award recognition application, it was given another $500. Submission of the National Healthy Schools Award recognition application was important, since the application required schools to submit evidence of updated, enacted school wellness policy; verification of meeting nutrition standards; inclusion of food offerings meeting USDA Smart Snacks in school guidelines; adequate health and physical education; physical activity beyond required health and PE; and employee wellness opportunities. **Healthy Schools Program:** Schools completed the Healthy Schools Program (HSP) online assessment and action plan to review wellness activities and strategize for addressing issues. However, the HSP website was revised in October 2019. School updates were required by the end of August 2019, as opposed to the standard September deadline, allowing less time for updates. The action plan was not functional until December. Therefore, action plan verification was not available in verifying requirements before granting school incentives. **TAKE 10!®:** During years 2 and 3, a control study was completed to measure TAKE 10!® effectiveness. TAKE 10!® incorporates 10-minute physical activity breaks into classroom curricula. Four schools were selected, two in very rural settings, and two in higher-populated areas. For the first year of the study, third-grade students participated. In the second year, third- and fourth-grade students were targets for year-over-year comparison. Students were given Polar fitness sensors to monitor activity for two weeks of participating in TAKE 10!® and two weeks with no participation. Classroom teachers were provided iPad computers with PolarGoFit applications and trained on data recording and monitoring. Students enjoyed participating and the schools appreciated the participation incentives, yet data comparing student movement while participating in TAKE 10!® activities versus movement while not doing TAKE 10!® was negative. PolarGoFit data for 157 children at two elementary schools were analyzed. These data were collected by five different teachers. Data consisted of an overall score for all fitness sessions. This overall score was in turn converted to a 100-point scale. The average overall score was 100.91, which was translated by the program to a 46.66 on the 100-point scale. This 46.66 equates to a letter grade of F. Two factors contributed to the negative scoring, including (1) one school received the lowest standardized testing scores in the state during Year 1 of the study and focused on testing in Year 2 instead of participating and (2) devices were accidentally not synced on all days, causing data not to be recorded properly. Project staff members learned the lesson that a trial run is necessary to ensure proper device functionality and recording, with a subsequent live study.
Accomplishments/ Recognitions	Key successes include the expansion in number of participating schools from 92 to 129 over the course of the grant cycle, expansion to 70 schools that utilized TAKE 10!® and/or similar classroom-based physical activity curricula, and the establishment of 129 school wellness leadership groups or committees. Additionally, the program received the Alliance for a Healthier Generation Outstanding Partner 2017 Award for creating healthier environments that support youth in developing lifelong healthy habits.

Considerations for Program Replications/ Implementation	The project's sustainable school wellness leadership group framework-building process could benefit other rural communities with similar needs. Training for implementing the Healthy Schools Program is offered by the Alliance for a Healthier Generation at no cost, and alliance documents may be used with proper permission. The Healthy School Program online tool, used to assist school committee development and physical activity efforts, is available free of charge for schools. The memorandum of understanding template used for the project and school districts is available from the alliance and is replicable in other communities. **School and/or classroom-based physical activity programming beyond required health and physical education:** Though the TAKE 10!® curriculum is no longer available for purchase, GoNoodle® is available at no charge for schools. Videos are easily accessible, come in a wide range of topics, are fun for students engaging in physical activity, and assist teachers with student refocusing in burning excess energy. The basic GoNoodle® program was piloted in this grant cycle and was so well-received that the Wellness Initiative plans to pay for the GoNoodle® Plus program for schools if refunded for the next Delta grant cycle. **Wellness Tours:** Wellness Tours can be adapted to include all elementary school grade levels. The presentations are PowerPoint-based and easily transferrable to others. One community health–oriented position can coordinate travel, location, times, dates, and other event coordination with attending schools, and the only costs associated with the events are for sound, system, and logistics support services and busing costs for student and teacher travel. Costs are reasonable, as the event is no more than four hours total from setup to breakdown. Estimated busing costs are $150 per school. At an average of five schools needing busing per event, an agency could host 100 schools through 20 tours for $15,000. **Training opportunities for school staff and wellness promotion presentations:** Professional development meetings were training opportunities for school staff to equip attendees with anti-obesity information to administer wellness efforts in their schools and train others on covered content. The opportunities are replicable, as workshop presentations are PowerPoint-based and easily available to others for duplication. Events hosted by interested organizations are of relatively minimal costs at approximately $3,500 per event. Many events have no costs other than mileage, as numerous community organizations offer free booth space and/or speaking time. **Incentives:** The incentive model is duplicable as the amount allowed per target recipient can be increased or lowered to accommodate budget limitations. The project negotiated a discount with the nation's largest school fitness equipment supplier to allow maximum value of dollars spent as incentives for participating schools. Organizations interested in replication could likewise negotiate discounted rates as well as taper down incentives yearly to deter reliance on incentives for participation.

MISSISSIPPI

Delta Health Alliance Inc.

Mississippi Service Region A

Organization Information						
Organization Name	Delta Health Alliance					
Organization Type	Other Nonprofit Organization					
Address	**Line 1:**	435 Stoneville Road				
	City:	Stoneville	**State:**	MS	**Zip-code:**	38776
Organization's Project Contact	**Name:**	Lee Whittington				
	Phone:	662-686-3867				
	Email:	lwhittington@deltahealthalliance.org				

Project Overview			
Project Title	Delta Heart Health Network		
Goal(s)	The program goals for patients include reduced 30-day unplanned rehospitalizations, improved health outcomes, enhanced chronic disease management, and care coordination in partnership with hospitals within the Delta Health Alliance service area. The program strategy focuses on stronger engagement of patients in developing and implementing their own customized health and wellness plans.		
Objectives	• Utilize community health workers (CHWs) to deliver care transitions services to facilitate care coordination and improve communication between hospital settings and outpatient clinics for patients with a diagnosis of heart disease that are discharged back into their communities • Deliver community-based health education, awareness programs, heart screenings, and other outreach services • Finalize and operationalize a data-collection plan for all outcome and process measures, in cooperation with network partners, state databases, and hospital systems • Conduct in-depth analysis and evaluation of outcome and process data • Develop an evaluation report and distribute to key stakeholders • Develop a long-term sustainability plan to ensure ongoing operations and continuation of services by demonstrating economic impact of community education, care transitions, and value of alerting/analytics systems		
Focus Area(s)	☒ Cardiovascular Disease (CVD) Care Management ☒ Chronic Disease Management ☒ Community-Based Care Coordination ☒ Health Screenings ☒ Oral Health		
Consortium/Network Partners	**Organization Name**	**Role**	**Organization Type**
	Delta Regional Medical Center; South Sunflower County Hospital; Bolivar	• Worked directly with program management to develop work-flows to benefit all involved — patients, case	Hospital

	Medical Center; Baptist Memorial Hospital–North Mississippi	management/hospital staff, and Delta Heart Health staff. This consisted of planning for when the CHWs would be in the hospital seeing patients, and connections to hospital EMRs for information regarding diagnoses, demographic information, treatment plans, and discharge information	
	North Sunflower Medical Center	• Worked directly with program management to develop work-flows to benefit all involved — patients, case management/hospital staff, and Delta Heart Health staff. This consisted of planning for when the CHWs would be in the hospital seeing patients, and connections to hospital EMRs for information regarding diagnoses, demographic information, treatment plans, and discharge information	Critical Access Hospital
Evidence-Based Model(s)/Promising Practice(s)	The Delta Heart Health Network (DHHN) utilized three evidence-based models to achieve its goals, including: (1) The Value-Driven Healthcare System Model supported by the U.S. Department of Health and Human Services (HHS) for improved interoperability of health information technology (HIT) systems (2) The community health worker (CHW) model promoted by the Office of Rural Health Policy (3) Dr. Eric Coleman's Care Transitions Model for improved care coordination The initial program strategy was to utilize the Mississippi Health Information Network (MS-HIN). In spring 2019, the MS-HIN network lost funding and disbanded. The program shifted gears, and while continuing to use both the CHW and Care Transitions models, moved the CHWs into the partnering hospitals within the Delta service counties for direct patient contact. Working closely with case management departments, the CHWs were able to find those patients suffering from heart-related diagnoses and offer services. If interested, the patients consented to be a part of the 45-day post-discharge program, which like the Coleman Care Transitions program, included both phone calls and home visits. These phone calls and home visits were aimed at educating the participants about their conditions, thereby decreasing the possibility of readmission during the first 30 days. By shifting to direct patient interaction in the hospitals, CHWs were able to talk in person with the patients to establish rapport. Having face-to-face contact in the beginning also allows the CHW to confirm participant's contact information and give information about the program and ways to contact the CHW.		
Needs Addressed	This project serves a population of over a half million people, 28.2% of whom live in poverty, and 50.6% of whom are African American. In a state that is often ranked last in the nation for many economic and education factors, this 21-county area of Mississippi stands out as having significantly worse outcomes than even the abysmal state averages. The Centers for Disease Control and Prevention (CDC) reports that cardiovascular disease (CVD) is the leading cause of death in the Mississippi Delta. In 2012, heart disease and stroke were the first- and sixth-leading causes of death in the Mississippi Delta. Heart disease was responsible for 244.4 deaths per 100,000, whereas strokes were responsible for 49 deaths per 100,000. Additionally, health literacy is drastically low in comparison to the rest of the United States. One in five adults does not have functional basic literacy skills, and nearly one-quarter of adults in the service region didn't graduate high school. As a result, there is a barrier in the understanding of individual health conditions, also making it difficult for patients to understand complicated health care advice or		

	medication instructions. The region is also a food desert, where most individuals do not have access to the fresh fruits and vegetables they require to follow a heart-healthy diet. The intention of the program is to educate participants on their heart-related conditions, to help them understand their condition, and to better care for themselves once at home. This is accomplished through the provision of disease-related education. The program also provided guidance to patients on the appropriate times to contact their primary care provider. The program was also designed to improve care management in partnership with the clinical delivery site case management departments by continued communication post-discharge between the patient and the case management department. Specifically, this project was designed to fill the gap between in-patient care and discharge. Often, the patient goes home to family members ill-equipped to take care of them and without resources to keep them from returning to the hospital. The hope was and still is to meet those patients/participants where they are and assist not only with the learning and understanding aspect but also to act as a liaison between them and the case management staff at the hospital in instances where the assistance of a social worker is needed.
Target Population(s)	☒ Adults (18-64) ☒ Elderly (65 and over)
Services and Activities	CHWs received daily lists of those inpatients who had a heart-related diagnosis from case management in the partner clinical delivery sites. These CHWs approached patients to gauge interest and enroll them if they were interested. Starting the day after discharge from the hospital, the 45-day process of the program began. During the 45-day period, the participants received phone calls and home visits. The CHWs also provided community outreach events — providing blood pressure screening and educational information pertaining to health improvement and heart disease.
Project Results	
Outcomes	Patients enrolled in the program have had statistically significant changes in their diet and exercise after participation in the program (specifically increases in physical activity, reduction in soda and sugar consumption, and increases in low-fat dairy and variety of vegetable consumption). These outcomes were particularly meaningful because habits and norms around food and nutrition are contributors to the cardiac issues experienced by patients. These entrenched habits are difficult to change, but the promise of seeing such progress for these patients demonstrates both the usefulness of the intervention and the possibility for programs conducted through home visits. *Patient activation*, defined as patient knowledge, skill, and confidence for self-management, also improved substantially, as measured by the Patient Activation Measure (PAM) assessment. Home visits and other interactions with CHWs gave patients additional opportunities to ask questions and to have the discharge information reiterated and explained in lay terms, enabling patients to understand what they were told at time of discharge and to access this information when they could absorb it rather than during the stressful time of hospitalization or during the hectic discharge process. During the project period, 30-day readmission was reduced to 29.6% for patients with a congestive heart failure diagnosis who were enrolled in the program. As of April 30, 2020, 1,032 patients were provided with Care Transitions program services following discharge from partnering hospitals. An average savings of $906.75 per patient, for a total of $81,607.53, has been calculated using PAM for all patients enrolled through April 30, 2020.
Sustained Impacts	☒ Some parts of the program will be sustained In working closely with hospital case management, the case managers were able to see firsthand the benefits of CHWs. By scheduling post-discharge calls for educational purposes, CHWs were also able to check on the participants' quality of life and address any needs the participants had. Any needs that could not be met within the project or that required professional attention were reported to the case management director for further attention. This sheds light on the need for case management to follow patients more closely post-discharge. Although no long-term

	processes or procedures have been put into place on the hospital level, there are plans for improvements in case management post-discharge care plans. Having seen the successes of the care transitions with the Delta Heart Health team, the hospitals were able to see the value of this program for patient care and also the financial benefit of preventing readmissions. The data demonstrating lower readmission will be useful in advocacy to continue the program as part of ongoing casework. The relationship formed between hospital partners and DHHN program staff has been a great success for the project. DHHN program staff and the hospitals also worked together in areas of health education and health fairs in the service area, providing information to residents who otherwise would not be reached. These partnerships will open doors to other opportunities in the future, including continued readmission prevention programs, the sustained implementation of the activities of this project in case management, and in other aspects of CHW readmission mitigation programming. In the short term, the Delta Heart Health Network has improved outcomes in hospital readmission rates. Individual patient impacts are long-lasting. Individual patient health and disease education, along with check-ins, assist with the patient's understanding of the disease process, and the emotional support from CHWs calling and visiting in the home provides lasting impacts on each participant. The hope is this will also spread throughout that person's daily contacts. Observing the impact on the individuals will also impact the ways that the case managers interact with patients in both the inpatient and outpatient setting.
Challenges and Lessons Learned	During the work of this project, the disbanding of MS-HIN was a significant challenge that required staff to pivot to hospital-based recruitment. As a result of this shift in recruitment strategy, the staff has learned how best to serve the people of the Mississippi Delta. Direct contact between the patient and CHWs has aided in developing rapport with the participants, allowing for a more open interaction where the participant can share any personal issues that the CHW can help address. The project management and staff learned that they cannot become complacent and must always stay aware and prepared for change if necessary. Additionally, working with hospitals has provided a sustainable pipeline of patients in need of services. However, because hospitals may have other priorities that compete with the program, being dependent on the hospitals has been difficult. Developing strong communication and open pathways with hospital partners has been very important to the success of the project.
Accomplishments/ Recognitions	A success from the program was the process of adjusting course to place CHWs in the hospital for direct contact and to introduce patients to the project. This change helped to establish rapport and assisted with continuity within the project. Participants who formed that relationship at onset were more likely to complete the 45-day program.
Considerations for Republications	The program experienced difficulties in partnering with hospitals and asking them to change their work-flow to accommodate our programming. The Delta Health Alliance has worked as a stand-alone overlay to their work, which allowed them to focus on their required work. They have seen the positive impact on patients with having a readmission prevention follow-up strategy. Thus, they are integrating that into their work. But asking them to make any changes without demonstrated success is difficult in a resource-starved environment. The hospitals in this region have limited resources. The additional support that the heart health program has been able to provide to patients with one-on-one support and education is effective but resource intensive. The hospital's priority is meeting acute needs, and there are limited resources for other staffing models that include additional staff. For this reason, the focus of sustainability is on integrating the functions of CHWs into case management protocols.

MISSISSIPPI

Jefferson Comprehensive Health Center Inc.

Mississippi Service Region B

Organization Information						
Organization Name	Jefferson Comprehensive Health Center					
Organization Type	Federally Qualified Health Center (FQHC)					
Address	**Line 1:**	405 Main Street				
	City:	Fayette	**State:**	MS	**Zip-code:**	39069
Organization's Project Contact	**Name:**	George Dixon				
	Phone:	601-786-3475 ext. 1035				
	Email:	georgedixon@jchchealth.org				

Project Overview	
Project Title	Mississippi SHINE Project
Goal(s)	Provide health education, promotion, and screenings focused on obesity, diabetes, and oral health.
Objectives	• Maintain and strengthen the existing community-based network of health and social service providers committed to providing enhanced services and increased access to medically disadvantaged residents within the 20 Southwestern Mississippi counties • Provide health education, prevention, and obesity management services to 15,000 individuals annually • Conduct 15,000 health screenings to include blood pressure checks and glucose test readings annually to adults and adolescents • Provide nutrition and oral health education and exercise information to 12,000 individuals annually
Focus Area(s)	☒ Diabetes Care Management ☒ Health Education/Promotion and Disease Prevention ☒ Oral Health ☒ Pharmacy Assistance ☒ Other: Obesity

Consortium/Network Partners	Organization Name	Role	Organization Type
	Southeast Mississippi Rural Health Initiative Inc.	• Assisted with implementing the objectives of the grant work plan • Provided screening, oral health supplies, health education, and marketing to a four-county region • Assisted with sustainability plans, work plans for competitive grant years, and the dissemination of information to communities and stakeholders	FQHC

	Jefferson Comprehensive Health Center (JCHC)	• Assisted with implementing the objectives of the grant work plan • Provided screening, oral health supplies, health education, and marketing to a four-county region • Assisted with sustainability plans, work plans for competitive grant years, and the dissemination of information to communities and stakeholders • Managed the subcontract quarterly reporting process with special emphasis on the expense and budget sections • Evaluated components of the project, including the design and implementation of data-collection tools and methods for program monitoring and evaluation	FQHC
	Southwest Mississippi Opportunity	• Assisted with implementing the objectives of the grant work plan • Provided screening, oral health supplies, health education, and marketing to a four-county region • Assisted with sustainability plans, work plans for competitive grant years, and the dissemination of information to communities and stakeholders	Community Nonprofit
	Sharkey Issaquena Community Hospital	• Assisted with implementing the objectives of the grant work plan • Provided screening, oral health supplies, health education, and marketing to a four-county region • Assisted with sustainability plans, work plans for competitive grant years, and the dissemination of information to communities and stakeholders	Hospital
Evidence-Based Model(s)/Promising Practice(s)	**Obesity Evidence-Based Practice**: In June 2012, the U.S. Preventive Services Task Force (USPSTF) released a recommendation on screening for and management of obesity in adults. This evidence-based practice includes screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions. The USPSTF found adequate evidence that intensive, multicomponent behavioral interventions for obese adults can lead to an average weight loss of 4 to 7 kg (8.8 to 15.4 pounds). These interventions also improve glucose tolerance and other physiologic risk factors for cardiovascular disease. The USPSTF found inadequate direct evidence about the effectiveness of these interventions on long-term health outcomes (for example, death, cardiovascular disease, and hospitalizations). **Community Health Worker (CHW) Evidence-Based Practice:** The unique role of CHWs as culturally competent mediators (health brokers) between providers of health services and the members of diverse communities has been extensively documented. Also documented is the		

	CHWs' effectiveness in promoting the use of primary and follow-up care for preventing and managing a variety of health care concerns, including hypertension, diabetes, and nutrition.
Needs Addressed	The Mississippi SHINE program is located in an area known as the Mississippi River Delta Region. This region is among the most socioeconomically disadvantaged areas of the United States. The counties within this region typically have poorer health outcomes than peer counties in the same states and the rest of the country. Various measures of disease burden for Delta counties, such as mortality rates from all causes, cancer, and heart disease, are approximately 10% higher than in non-Delta counties in the same states and 20% higher than the rates in the United States overall. Local citizens had the opportunity to voice their concerns regarding access to health care and services that were needed through focus group sessions and individual interviews. Over the past 10 years, the networks have continued to receive input from the target population. For instance, the Jefferson Comprehensive Health Center (JCHC) surveys its patient population twice a year to receive feedback about needed services. In addition to surveying the target population and the community leaders, the SHINE staff also analyzed health indicators in the service area by utilizing the Health Profiles and the County Health Rankings & Roadmaps for each of the counties in the project service area. The SHINE project director also analyzed the needs assessment of the Sharkey Issaquena Hospital — one of the network members. All of the data analyzed confirmed the high prevalence of obesity and diabetes in the state and especially in the target area. Therefore, the decision was made to focus on obesity and diabetes for the 2016-2020 project period.
Target Population(s)	☒ Children (0-12) ☒ Adolescents (13-17) ☒ Adults (18-64) ☒ Elderly (65 and over)
Services and Activities	Mississippi SHINE is a network of local networks. The success of this project involves collaboration among and between multiple organizations cooperating within a local health network arrangement to provide a variety of health programs and services to individuals within the region, including health education, screenings, prevention information, navigation, and referrals. A CHW works on behalf of each of the five local networks to conduct community outreach and education, organize health fairs and screenings, develop local partnerships to support health and well-being, and support patients in gaining access to health care. Key activities over the grant period include: • Participation in health fairs, and Lunch and Learns • Free blood pressure, glucose, and BMI screenings • Program presentations in support of Breast Cancer Awareness Month, Heart • Health Month, and other observations • Mississippi Tobacco Free Coalition Partnership • Cavity Free Kids training • Distribution of 57,600 toothbrushes, with toothpaste and dental floss • Distribution of 1,200 diabetes meters and test strips • Back-to-school events — summer camps, Wacky Saturday, school fun day
Project Results	
Outcomes	Program monitoring and evaluation rely heavily on quarterly reports. Consortium members/local networks reported to JCHC/SHINE on a quarterly basis. Process evaluation primarily consists of

	documenting the completion of objectives and activities as stated in the work plan. Outcomes evaluation involves the collection of numerical data associated with each planned activity. Some key outcomes resulting from Mississippi SHINE efforts include: • 31,499 individuals were provided health information and services • 6,182 participants were referred to health care providers • 99% of JCHC adult patients had a follow-up plan documented • 54% of patients aged 3-17 had documented counseling on nutrition and physical activity • 5,063 patients were screened in one year • 22,721 health screenings were conducted • 21,897 individuals received oral health education information and exercise information
Sustained Impacts	☒ Some parts of the program will be sustained **Consortium impacts:** • New and stronger bonds have developed between consortium partners. The consortium has remained strong, and its partners are committed to working together to provide programs, information, and support for healthy communities. The consortium will continue to meet quarterly to identify and collaboratively address community health priorities. • The consortium partners have influence in their respective communities and will thus continue to be examples to other organizations interested in improving community health. **Program Activity Impacts:** • Mississippi SHINE has increased the awareness and knowledge of services available to residents of the service area. Specifically, 21,721 pieces of information and screening for blood pressure, diabetes, and BMI have provided the service area with knowledge and access to care. • Another impact of the program is providing diabetes supplies and blood pressure machines. Providing diabetic supplies such as meters, test strips, and lancets gave residents of the service area an opportunity to know their numbers and take charge of controlling their diabetes. Noteworthy is that 27.68% of participants had a hemoglobin A1c less than 8%. These services have allowed patients who could not afford these supplies an opportunity to know their numbers and help the noncompliant patients to strive to get their numbers under control. • Additionally, 31,499 pieces of information have been provided to the target population on obesity, healthy eating, and exercise. This could motivate individuals to make lifestyle changes.
Challenges and Lessons Learned	Successfully fostering and maintaining an active and engaged collaboration among local and region-level participants was a challenge throughout the program period. Competition for limited resources within an economically depressed region is the primary barrier to collaboration. Collaboration can add value and offer potential for savings to existing services and programs; however, it takes a commitment of time and patience to develop and maintain a trust threshold high enough to reach a comfort level among participating agencies. This trust level allows collaborative relationships to blossom into concrete results. JCHC engaged in ongoing efforts to maintain communication and interaction among all program participants. One of the biggest challenges the Mississippi SHINE project faced was the lack of participation at events. This was primarily due to financial hardships. Potential participants had no transportation to go to events or had to work extra jobs to overcome financial problems. The COVID-19 pandemic added new challenges to the implementation of program activities. The pandemic

	created barriers to hosting community events and severely limited access to communities, schools, and health fairs. Mississippi SHINE pivoted to virtual engagement with participants and created new protocols for CHW activities during the pandemic. CHWs were able to connect with community members by "plugging in" to events and locations where people would gather for services, such as food distribution sites and water distribution events.
Accomplishments/ Recognition	A major accomplishment was the training of nine individuals as community health advocates in the Cavity Free Kids program. The community health advocate training program provides a curriculum using a train-the-trainer model. It trains individuals on how to perform blood pressure, glucose, and BMI screenings. The Mississippi Department of Health provides the Cavity Free Kids training. The individuals trained learn to recognize cavities in kids and give them the necessary assistance in getting to a dentist. These two programs were essential to the improvement of the SHINE initiative. Also, during the grant period, a new partnership was developed with the Mississippi Department of Health's Division of Dental Services to integrate oral health education, screenings, and referrals for clients in the service area. This partnership has resulted in more clients getting connected to a source of oral health care. Additionally, the Mississippi SHINE program was recognized by several newspaper clippings that talked about services. The program staff also received thank-you letters from clients.
Consideration for Program Replication/ Implementation	When considering a program for implementation, be sure it can be tailored to the specific basic needs of the target populations. For example, because of the oral health program, siblings no longer have to share toothbrushes if the family could not afford to purchase multiple toothbrushes. The program also provided education that helps kids understand the importance of healthy teeth and what dental health means to the body.

MISSOURI

Mississippi County Health Department

Missouri Service Region B

Organization Information						
Organization Name	Mississippi County Health Department					
Organization Type	County Health Department					
Address	**Line 1:**	1200 East Marshall				
	City:	Charleston	**State:**	MO	**Zip-code:**	63834
Organization's Project Contact	**Name:**	Jody Diebold, Project Director				
	Phone:	573-683-2191				
	Email:	jdiebold@misscohealth.com				

Project Overview	
Project Title	MPower
Goal(s)	The goals of the MPower initiative are to (1) improve health and wellness through delivery of services for individuals with, or at risk of developing, diabetes in the counties with the highest unmet needs; (2) improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke in the counties with the highest unmet needs; (3) empower all residents of Service Region B to adopt healthier lifestyles; and (4) ensure persons with, or at risk of, chronic disease can obtain necessary prescription medication.
Objectives	• **Objective 1-1**: Increase the number of staff members cross-trained as leaders for the evidence-based Diabetes Self-Management Program (DSMP) from zero to three by November 2017 • **Objective 1-2**: Increase the percentage of adult patients with diabetes who had a hemoglobin A1c level less than 8% by 10% from an average baseline of 57.5% to 59.2% by July 2017, to 60.9% by July 2018, and to 63.2% by July 2019 • **Objective 1-3**: Increase the percentage of patients aged 18-75 with diabetes who had blood pressure less than 140/90 mm/Hg from 56.5% to 57.6% by July 2017, to 58.7% by July 2018, and to 59.9% by July 2019 • **Objective 1-4**: Increase the percentage of adult patients with diabetes receiving at least one lipid profile (or all component tests) during the measurement year by 10%, from a baseline of 19% to 20.9% by July 2019 • **Objective 2-1**: Increase the proportion of adult patients whose blood pressure is adequately controlled (< 140/90) from an average baseline of 65.5% to 68.7% by July 2018 • **Objective 2-2**: Increase the proportion of adults whose most recent LDL-C test is < 100mg/dL during the measurement year by 10%, from a baseline of 18.9% to 19.5% by July 2017, to 20% by July 2018, and to 20.8% by July 2019 • **Objective 2-3**: Increase the percentage of patients aged 12 and older screened for clinical depression using a standardized tool and follow-up plan documented to 24.9% by July 2019 • **Objective 2-4**: Increase the percentage of adult patients who were screened for tobacco use at least once during the two-year measurement period *and* who received cessation

<table>
<tr><td></td><td colspan="3">counseling if identified as a tobacco user from 6.1% to 15% by July 2018 and 20% by July 2019
• Objective 2-5: Increase the number of enrollees in the Chronic Disease Self-Management Program (CDSMP) by 10% from baseline 158 per year to 174 per year by July 31, 2019
• Objective 2-6: Increase the number of participants completing the CDSMP program by 15% from baseline 90 per year to 109 per year by July 31, 2019
• Objective 3-1: Increase the number of adult patients with a calculated body mass index (BMI) in the past six months or during the current visit documented in the medical record and, if the most recent BMI is outside parameters, a follow-up plan is documented, from a baseline average of 164 to 6,900 by July 31, 2020
• Objective 3-2: Increase the number of social media followers from a March 2017 baseline of 869 to 1,125 by July 31, 2020
• Objective 3-3: Incentivize county health departments to communicate with health care providers, community members, and partners
• Objective 3-4: Increase the number of participants enrolled in CDSMP and/or DSMP by 10% from a baseline of 303 per year to 333 per year by July 2020
• Objective 3-5: Increase the number of participants who complete the CDSMP and/or DSMP program by 15% from a baseline of 256 per year to 294 per year by July 2020
• Objective 4.1: Increase the number of people receiving prescription drug assistance by 5% from the 446 served during the period August 2018 through July 2019 to 468 by July 2020</td></tr>
<tr><td>Focus Area(s)</td><td colspan="3">☒ Behavioral/Mental Health
☒ Cardiovascular Disease (CVD) Care Management
☒ Diabetes Care Management
☒ Chronic Disease Management
☒ Health Education/Promotion and Disease Prevention
☒ Health Screenings
☒ Population Health
☒ Pharmacy Assistance
☒ Primary Care Services</td></tr>
<tr><td rowspan="3">Consortium/Network Partners</td><td>Organization Name</td><td>Role</td><td>Organization Type</td></tr>
<tr><td>Mississippi County Health Department (lead agency)</td><td>• Coordinated clinical strategies through the Diabetes Center in Charleston
• Utilized the influenza vaccination clinic as a means to screen adults for chronic diseases and referred individuals to available services
• Engaged staff in training to become certified leaders/facilitators for the evidence-based chronic disease programs (CDSMP and DSMP)
• Ensured that trained facilitators were available and able to implement the evidence-based programs</td><td>Health Department</td></tr>
<tr><td>Cape Girardeau County Health Center</td><td>• Secured funding to establish electronic health record systems for the county health departments</td><td>Health Department</td></tr>
</table>

		• Utilized the influenza vaccination clinic as a means to screen adults for chronic diseases and referred individuals to available services • Engaged staff in training to become certified leaders/facilitators for the evidence-based chronic disease programs (CDSMP and DSMP) • Ensured that trained facilitators were available and able to implement the evidence-based programs	
	Bollinger County Health Center; Dunklin County Health Department; Madison County Health Department; New Madrid County Health Department; Pemiscot County Health Center; Perry County Health Department; Scott County Health Department; St. Francois County Health Center; Ste. Genevieve County Health Department; Stoddard County Public Health Center; Washington County Health Department	• Utilized influenza vaccination clinics as a means to screen adults for chronic diseases • Engaged staff in training to become certified leaders/facilitators for the evidence-based chronic disease programs (CDSMP and DSMP) • Ensured that trained facilitators were available and able to implement the evidence-based programs	Health Department
	Southeast Missouri (SEMO) Health Network	• Provided primary care and mental health services through the patient-centered medical home (PCMH) delivery model	Federally Qualified Health Center (FQHC)
	The Dexter Community Regional Healthcare Foundation	• Coordinated the prescription drug assistance program	Private Foundation
	Bootheel Counseling Services (BCS) and Family Medical Clinic	• Provided mental health services for the counties of Scott, Stoddard, Mississippi, and New Madrid • Provided primary care services through its medical clinic	Mental Health Center and Rural Health Clinic
	Southeast Missouri Regional Arthritis Center (RAC)	• Promoted the chronic disease self-management programs (CDSMP, DSMP, and Walk with Ease) • Coordinated the leader trainings and supported the programs by posting course schedules, locations, and descriptions on their website	Regional Arthritis Center
	Southeast Missouri Food Bank	• Commodity supplemental food program served low-income, food-insecure seniors in 10 of the 13 Missouri Region B counties	Hunger Relief Agency

Evidence-Based Model(s)/Promising Practice(s)	The MPower Consortium has adopted the evidence-based **Chronic Disease Self-Management Program (CDSMP)** and **Diabetes Self-Management Program (DSMP**). There is evidence that participation in these programs increases participants' self-efficacy and psychological well-being and improves clinical indicators such as high blood pressure, lipids, glycemic levels, and BMI. Since August 2016, 45 leaders have been trained to implement the CDSMP program, and 350 individuals have completed the program. Forty-nine leaders have been trained to implement the DSMP program, and 237 individuals have completed the program. Southeast Missouri (SEMO) Health Network provides primary care and mental health services through the **patient-centered medical home (PCMH) delivery model**. PCMH has been shown to reduce racial and ethnic disparities and result in significantly lower health care costs and improved life expectancy for those with chronic diseases. A total of 3,864 residents are currently enrolled in the medical home program. Bootheel Counseling Services (BCS) and its Family Medical Clinic provide care through the Health Home Model. The Health Home Model expands the traditional medical home model by building additional linkages to community-based systems of support and strengthening integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. A partnership between BCS and SEMO Health Network improved coordination and access to services for individuals with chronic disease who are at risk for depression. A total of 695 patients are currently enrolled in the health home program. Further, clinical services follow the recommendations outlined by the **U.S. Preventive Services Task Force (USPSTF)** in the *Guide to Clinical Preventive Services*. Clinical services include screening for diabetes, blood pressure, cholesterol, and obesity. Additionally, the Mississippi County Health Department (MCHD) maintains status as an American Diabetes Association Recognized Education Program to ensure that educational programs meet the National Standards for Diabetes Self-Management Education (DSME).
Needs Addressed	Missouri Service Region B is facing a health crisis, largely driven by the prevalence of chronic diseases. Dunklin, Mississippi, New Madrid, Pemiscot, and Scott counties have historically had the highest unmet needs and have been specifically targeted through the project. The target area is located in rural Southeast Missouri, in the area commonly known as the Bootheel. Approximately 16% of residents of the five-county area are Black/African American, compared to 7.5% in Missouri Service Region B. Also,19.42% of the residents live in households with an income below the federal poverty level (FPL). Specifically, 17.11% of Whites and 44.54% of Black/African Americans live below the poverty level. Additionally, a shortage of health professionals contributes to the health crisis. The 13 counties are primary medical, dental, and mental health service Health Professional Shortage Areas. Eleven of the counties are also designated Medically Underserved Areas. In 2014, the primary care physician rate was 56.4 per 100,000 persons, compared to a state rate of 83.6 per 100,000 persons. The rate ranged from a low of 8.07 per 100,000 persons to a high of 97.38 per 100,000 persons. Access to preventive care and self-management resources is limited, which contributes to poor health outcomes in Missouri Service Region B. Residents are disproportionately plagued with chronic conditions such as heart disease, diabetes, and obesity. Among adults, 10.6% have diabetes, compared to 9.2% of adults nationally. Eight percent of adults have heart disease, compared to 4.4% in the United States. Collectively, diabetes, heart disease, and stroke accounted for 1,604 of the 4,536 deaths in Missouri Service Region B in 2017. The exceedingly high rates of chronic diseases verify the need to continue evidence-based programs to improve outcomes. Prior to the grant program, agencies acted alone with little attention to developing true collaborative efforts. Budget shortfalls created an environment of limited resources and increased awareness of the need for a unified approach. These factors motivated the agencies to join together to address the increasing incidence of chronic disease through evidence-based practices.

Target Population(s)	☒ Adults (18-64) ☒ Elderly (65 and over)
Services and Activities	All 13 county health departments utilize influenza vaccination clinics as a means to increase access to prevention services. Chronic disease risk assessments conducted at these clinics identify individuals with chronic conditions. The individuals identified with a chronic condition are referred to CDSMP/DSME programs and other services provided through the project. A team of registered dietitians provide chronic disease education and support services. SEMO Health Network and Bootheel Counseling Services provide primary care and mental health services. Uninsured individuals with chronic diseases are provided prescription medications through patient-assistance programs.
Part 1c: Project Results	
Outcomes	The following outcomes have been achieved: • Increased the number of trained self-management program facilitators (three CDSMP master trainers and two DSMP master trainers) • Increase in the number of residents who were provided direct services (12,442 individuals from 2016-2017, 13,097 individuals from 2017-2018, and 19,562 individuals from 2018-2019) • Increase in the proportion of adult patients whose blood pressure is adequately controlled (63% from 2016-2017, 59% from 2017-2018, and 69% from 2018-2019) • Increase in the percentage of patients with diabetes who had a hemoglobin A1c less than 8% (60% from 2016-2017, 62% from 2017-2018, and 68% from 2018-2019) • Increase in the proportion of adults whose most recent LDL-C test is < 100mg/dL • Increase in the percentage of patients aged 12 and older who were screened for clinical depression and had a follow-up plan documented (80% from 2016-2017, 81% from 2017-2018, and 88% from 2018-2019) • Increase in the percentage of adult patients who were screened *and* who received cessation counseling intervention if identified as a tobacco user (91% from 2016-2017, 90% from 2017-2018, and 97% from 2018-2019) • Increase in the number of adult patients with a calculated BMI in the past six months or during the current visit documented in the medical record *and*, if the most recent BMI is outside parameters, a follow-up plan is documented (90% from 2016-2017, 68% from 2017-2018, and 89% from 2018-2019) • Increase in the number of social media followers by 10%
Sustained Impacts	☒ Some parts of the program will be sustained The project has increased capacity to implement evidence-based chronic disease services. This will contribute to fewer complications related to chronic disease over the long term through its coordination of physical activity, nutrition education, self-management behaviors, and medication access/adherence. The funding allowed the consortium members to develop much-needed capabilities to improve the quality of chronic disease programs, enabling outcomes to change. By continuing to work cooperatively to achieve common goals, the consortium has the potential to achieve lasting effects in the community. A well-developed rural health network offers a more stable and effective continuum of care. Ultimately, these strategies will enhance quality of care and improve health outcomes.
Challenges and Lessons Learned	Recruiting community members to participate in the CDSMPs was a challenge. As a result, the health departments began utilizing influenza vaccination clinics as a means to engage community members in chronic disease risk assessments and facilitate linkage to the self-management programs. There were also challenges with the new Patagonia electronic health record (EHR)

	systems. Many of the health departments reported identical problems with the systems. The lesson learned was that implementation of the EHR requires persistence in resolving issues. Some of the collaborative partners also experienced staff turnover. There were also challenges with keeping staff certified to facilitate the self-management programs. Offering the staff training and updates more frequently ensured that facilitators were appropriately certified. On the other hand, multimedia marketing contracts were established with BOLD Marketing and Raycom. This helped to increase brand awareness of the MPower initiative and supported creation of a website for the initiative and a provider referral portal. In 2017, the project partners began prescheduling the self-management classes. This strategy helped keep the partners engaged to regularly schedule/host the classes and improved marketing capacity.
Accomplishments/ Recognitions	One of the greatest successes of the grant program is the development of partnerships across the 13 counties. Partnerships with University of Missouri Extension (MU) and the Missouri Arthritis and Osteoporosis Program (MAOP) expanded the availability of the CDSMPs. MU Extension recruited and trained county extension staff to implement the CDSMP and DSMP. MAOP coordinated efforts of both the Southeast Missouri Regional Arthritis Center (RAC) and the Eastern Missouri RAC in St. Louis. Additionally, a partnership was developed with Aging Matters, they are also known as the Southeast Missouri Area Agency on Aging. Aging Matters coordinated the CDSMPs at senior centers in an 18-county area. A marketing plan was developed to increase participation in the project activities and to improve utilization of health care resources in 2016. A marketing consultant assisted the consortium to brand the project, select MPower as a name for the initiative, create a logo, and develop a website. The website provides information, locations, and dates for evidence-based diabetes and other CDSMPs, influenza clinics, and prescription-assistance programs. Strategic placement of advertising spots on Pandora and YouTube helped direct traffic to the MPower website. A Facebook page devoted to the project was linked to the website to facilitate enrollment into classes and to utilize social media to provide reliable health information. The development of the logo, the website, and the Facebook page helped with brand awareness across the region. BOLD Marketing submitted the MPower website to the Service Industry Advertising Awards (SIAAwards). The website earned a Gold Award. Additionally, in February 2018, MCHD received an honorable mention in the category of information dissemination (criterion 1) for the Community Based Division (CBD) Rural Health Community Champion awards.
Considerations for Program Replication/ Implementation	The consortium was designed to meet the needs of Southeast Missouri and leverage available resources and relationships. The work plan's outcome measures were developed and defined to allow for evaluation findings (process, outcome, and impact) to inform quality improvement and program design in other communities with similar needs. Systematic approaches to improve the public health system are an area of interest in virtually every rural community. County-based public health departments, FQHCs, and community mental health centers operate all across the United States. The programs implemented by the MPower partners could be implemented by other collaborating organizations to improve chronic disease management in poor, rural settings, where chronic disease prevalence is high and educational status is low. Emphasis was placed on training and equipping leaders to implement the evidence-based chronic disease self-management programs. The county health departments were encouraged to recruit and engage staff and community volunteers to lead the programs. The network also worked with the University of Missouri Extension to recruit and train staff and volunteers from county extension offices. These strategies have strong potential to be replicated.

MISSOURI

Missouri Highlands Health Care

Missouri Service Region A

Organization Information						
Organization Name	Missouri Highlands Health Care/Big Spring Medical Association, Inc.					
Organization Type	Federally Qualified Health Center (FQHC)					
Address	**Line 1:**	PO Box 157				
	City:	Ellington	**State:**	MO	**Zip-code:**	63638
Organization's Project Contact	**Name:**	Amie Brooks				
	Phone:	573-323-4253				
	Email:	abrooks@mohigh.org				

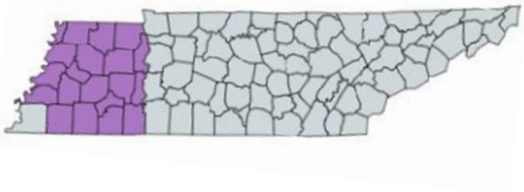
Project Overview	
Project Title	Delta States Rural Development Network Grant Program
Goal(s)	Project goals included improving health outcomes for persons at risk of, or diagnosed with, diabetes; improving cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; reducing the risk of childhood obesity; expanding community health worker (CHW) capacity throughout the Delta Region to improve overall health; utilizing an integrated behavioral health and primary care model to screen for depression and connect patients with brief behavioral health intervention or behavioral health therapy at eight clinic locations; and improving women's health and prenatal care outcomes in Delta Service Region A.
Objectives	• Decrease the percentage of diabetic patients whose HbA1c levels are greater than or equal to 9% from baseline of 32% to 20% • Increase the percentage of adults with hypertension whose blood pressure is under control (< 140/90) from 61% to 67% • Hire four full-time equivalent CHWs to provide health education, patient support, and outreach to the community • Increase the percentage from 15% to 30% of patients aged 12 and over who were (1) screened for depression with a standardized tool and (2) had a follow-up plan • Improve access to gynecological and obstetric care in Missouri Delta Service Region A • Improve access to women's health preventive screening services in Missouri Delta Service Region A • Engage network partners in focused initiatives for improvement
Focus Area(s)	☒ Chronic Disease Management ☒ Community-Based Care Coordination ☒ Health Education/Promotion and Disease Prevention ☒ Population Health ☒ Women's Health

Consortium/Network Partners	Organization Name	Role	Organization Type
	Missouri Highlands Health Care	• Coordinated project activities and provided grant project oversight, including the hiring and management of project staff, management of grant funds via accounting system, and coordination of monthly meetings via phone and quarterly in-person meetings	FQHC
	Douglas County Health Department (lead health department)	• Worked with consortium members to provide a variety of health literacy training and assessments and services related to chronic disease management • Maintained the web-based resource database and communication of shared best practice among health department partners	Health Department
	Howell County Health Department; Oregon County Health Department; Ozark County Health Department; Reynolds County Health Department; Shannon County Health Department; Texas County Health Department; Wright County Health Department	• Provided evaluation data as requested and quarterly direct service reporting • Attended monthly phone call meetings and quarterly in-person meetings in order to communicate grant program progress and identify successes and challenges of grant program activities	Health Department
	Carter County Health Department	• Provided evaluation data as requested and quarterly direct service reporting • Participated in health literacy training and implementation	Health Department
	Parkland Health Mart Pharmacy	• Provided diabetes self-management health education training to consortium partners on a quarterly basis	Pharmacy
	Ripley County Health Department	• Provided evaluation data as requested and quarterly direct service reporting • Participated in health literacy training and implementation	Health Department
	Whole Kids Outreach	• Coordinated community and home-based activities to promote preventive services to individuals with, or at risk of developing, chronic health diseases • Identified individuals who did not have access to primary care or behavioral health care services and communicated with Missouri Highlands Health Care's (MHHC's) Community Health Worker Care Coordination program	Faith-based Organization
	Whole Health Outreach	• Coordinated community and home-based activities for elderly or at-risk families and identified individuals who did not have access to primary care or	Faith-based Organization

		behavioral health care services for referral to MHHC's Community Health Worker Care Coordination program	
Evidence-Based Model(s)/Promising Practice(s)	Network members utilized evidence-based model programs as identified on the Rural Health Information Hub, including (1) clinical partnerships, (2) telehealth, (3) CHWs, and (4) self-management tools. The evidence-based models were adapted to rural challenges (i.e., lack of broadband internet and transportation) by utilizing telehealth services and conducting home visits by telephone. Patients utilized health care services — if they were informed of the service and had access to utilize the service (i.e., cellphone or personal computer). The CHWs helped to coordinate these activities by routinely reminding the patients of their appointments and communicating to the clinical staff if the individual needed to utilize telehealth services.		
Needs Addressed	Residents of the 16-county region (Missouri Delta Service Region A) are challenged by generational poverty and face numerous barriers to health care, including lack of transportation, low levels of employment, lack of access to facilities, lack of access to health care services, and rural environment. The target population for the project includes underserved residents at risk of diabetes, residents aged 40 and over who are considered overweight or obese (55,720), and women over the age of 21 who are considered underserved (58,732) (U.S. Census and Behavioral Risk Factor Surveillance System (BRFSS) Data). The Delta States grant program was designed to address the challenges and barriers faced by the target populations. The challenges include a lack of coordination of community resources and services, a lack of access to health care services, and a lack of health literacy education and resources. The barriers include a lack of financial resources to pay for health care, transportation barriers and geographic location, lack of health care providers, and cultural attitudes where preventive care is not embraced.		
Target Population(s)	☒ Adults (18-64)		
Services and Activities	The Delta States grant program conducted the following types of activities: care coordination provided by CHWs; diabetes prevention education; health literacy policy development, implementation, and education; access to dietitian counseling; access to behavioral health care services; and access to primary health care services.		
Project Results			
Outcomes	• 780 individuals participated in the Delta Care Coordination Program • Of the Delta Care Coordination Program enrollees, 9.8% of the target patient population applied for and received Medicaid coverage. Additionally, 12% of the target patient population applied for and received disability benefits, and 7.8% of the target patient population had established food pantry participation • 62% of CHWs received their CHW certification • 202,127 individuals received direct care services, including behavioral health services, primary care, women's health, health screenings, telehealth, and care management services. Of this population, 24,221 had no insurance or were underinsured • 10 health departments and two faith-based organizations were trained in health literacy best practices and adopted health literacy policies, and 78% of consortium members' staff received health literacy training		
Sustained Impacts	☒ All elements of the program will be sustained The sustained impacts include healthier women and children due to the increased access to women's health and prenatal services. The CHW and care coordination services have helped patients receive needed health care and coverage and have empowered them to be advocates for their own health. The region has built workforce capacity by increasing the number of staff with CHW certifications.		

	The expansion, continued development, and implementation of health literacy policies has increased the quality of culturally and linguistically appropriate care and health education across Service Region A. In addition, there has been an increased identification of needed community resources and services, increased access to medical and behavioral health care services, and development of sustained relationships among consortium members.
Challenges and Lessons Learned	Challenges included a lack of transportation to needed medical and behavioral health care services, lack of broadband internet in the rural environment, lack of qualified staff to hire for staff positions, and the COVID-19 pandemic. These challenges were addressed by connecting residents to organizations that could provide transportation to medical services, identifying the need of broadband services on community needs assessments, increasing advertising for staff positions and increasing trainings and education offered to current staff, and conducting Zoom teleconference calls and meetings during the pandemic in order to maintain communication about the progress of the Delta States grant program.
Accomplishment/ Recognitions	Local government officials and community leaders (i.e., librarians, public school administration, sheriff departments, and Head Start administrative staff) have personally thanked the consortium members for their contributions and coordinated efforts to the local communities.
Considerations for Program Replication/ Implementation	CHWs are a model that can be utilized by other communities to provide care coordination services and provide expanded access to health care and social services. Additionally, the PRAPARE tool allows for the staff to evaluate the needs of patients and identify needed medical and social services.

TENNESSEE



Paris-Henry County Health Care Foundation Inc.

Tennessee Service Area Region A

Organization Information						
Organization Name	Paris-Henry County Healthcare Foundation					
Organization Type	Other Not-for-Profit Foundation					
Address	**Line 1:**	301 Tyson Avenue; P.O. box 1030				
	City:	Paris	**State:**	TN	**Zip-code:**	38242
Organization's Project Contact	**Name:**	Tory Daughrity				
	Phone:	731-633-82266				
	Email:	tdaughrity@hcmc-tn.org				

Project Overview	
Project Title	West Tennessee Delta Initiative
Goal(s)	The primary goal of the project is to expand regionwide obesity prevention services, including pediatric, adult, and family-focused health education on obesity prevention across multiple settings. Additional goals include providing resources to support and expand health screenings, clinical case management, nutritional counseling, pharmacy assistance, and other health services that are related to obesity and chronic disease prevention and treatment, and establishing patient- and family-centered care coordination programs to address interrelated medical, social, developmental, behavioral, emotional, and financial needs.
Objectives	• Establish new partnerships • Provide prevention health education using the 8-5-2-1-0 Every Day! messaging • Provide chronic disease self-management education utilizing evidence-based programs • Implement a patient- and family-centered care coordination program • Implement a chronic disease care coordination program to assist patients with diabetes and other chronic health conditions • Build capacity for using data/evaluation to sustain programs
Focus Area(s)	☒ Behavioral/Mental Health ☒ Cardiovascular Disease (CVD) Care Management ☒ Chronic Obstructive Pulmonary Disease (COPD) Prevention ☒ Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management ☒ Case Management ☒ Cancer Care Management ☒ Diabetes Care Management ☒ Chronic Disease Management ☒ Community-Based Care Coordination ☒ Health Education/Promotion and Disease Prevention ☒ Health Screenings

	☒ Population Health ☒ Pediatric Care ☒ School-Based Care Coordination ☒ Transitions of Care ☒ Pharmacy Assistance ☒ Primary Care Services		
Consortium/Network Partners	**Organization Name**	**Role**	**Organization Type**
	Paris-Henry County Health Care Foundation (PHCHF)	• Chaired and approved the agendas for all consortium meetings and ensured that meetings were documented • Conducted an annual A-133 audit of the grant • Contracted with Methodist LeBonheur Community Outreach (MLCO) to support other consortium members to deliver health education and services • Ensured that MLCO worked with an internal evaluation team to oversee data collection and to implement project evaluation activities, including reporting	Not-for-profit foundation
	Henry County Medical Center (HCMC)	• Chronic disease self-management classes • Care coordination	Not-for-profit hospital
	Methodist Le Bonheur Community Outreach (MLCO)	• Served as a pediatric health care provider and prime contractor for the Delta project • Provided evidence-based pediatric case management and health education programs focused on obesity, diabetes, and cardiovascular disease • Administered the memoranda of agreement (MOA) with the consortium members • Oversaw and managed subcontracts with Hardeman County Community Health Center (HCCHC) and U.T. Extension Service to carry out programs	Not-for-profit hospital
	Hardeman County Community Health Center (HCCHC)	• Provided chronic disease management, health education, and pharmacy assistance for adults • Care coordination	FQHC
	University of Tennessee Extension Service County Offices (20) (UTE)	• Provided chronic disease management education for adults and healthy lifestyles education to school children	University Extension Services
	Bells City School	• Participated in pediatric case management and health education programs	Local Education Agency

		• Behavioral health care coordination	
	Crockett County Schools	• Participated in pediatric case management and health education programs • Behavioral health care coordination	Local Education Agency
	Dyersburg City Schools	• Participated in pediatric case management and health education programs	Local Education Agency
	Dyer County Schools	• Participated in pediatric case management and health education programs	Local Education Agency
	Haywood County Schools	• Participated in pediatric case management and health education programs	Local Education Agency
	Humboldt City Schools	• Participated in pediatric case management and health education programs	Local Education Agency
	Lauderdale County Schools	• Participated in pediatric case management and health education programs	Local Education Agency
	Obion County Schools	• Participated in pediatric case management and health education programs	Local Education Agency
	Tipton County Schools	• Participated in pediatric case management and health education programs	Local Education Agency
	Trenton Special School Districts	• Participated in pediatric case management and health education programs	Local Education Agency
	Northwest TN Head Start/Early Hard Start	• Participated in pediatric case management and health education programs	Head Start Programs
Evidence-Based Model(s)/Promising Practice(s)	**Care coordination** is an evidence-based program that is applicable in rural settings. Three consortium members, Paris-Henry County Health Care Foundation (PHCHF), Methodist Le Bonheur Community Outreach (MLCO), and Hardeman County Community Health Center (HCCHC), have established care coordination programs, using health educators and navigators to help monitor at-risk patients and assist them in managing their chronic conditions. The adult care coordination and navigation programs implemented by PHCHF and HCCHC assist patients in following up with their health care providers appropriately, encourage medication compliance, and facilitate referrals as appropriate. Patients are also referred to the pharmacy assistance program as needed. This model has resulted in reduced hospital readmission rates as well as greater medication compliance. The pediatric care coordination and navigation programs have been coupled with individual health counseling and behavioral health services. Follow-up and regular communication take place with the patient and family. Patients are assisted in making appropriate appointments, receive follow-up communication, and are educated and assisted in taking an active role in their health care experience. An overarching health education strategy that the consortium uses to address obesity is the **8-5-2-1-0 Every Day!** program. It is an adaptation of the 5-2-1-0 Let's Go! model, which has been referenced as a promising practice in publications by a number of organizations, including the Centers for Disease Control and Prevention. This promising practice was adapted to include the *8* signifying the importance of getting eight or more hours of sleep each night. This model is		

	presented to all ages, but particularly children, as a "recipe" for a healthy lifestyle. Individual and group health education is based on this model. Additionally, three evidence-based chronic disease–management programs delivered by the University of Tennessee Extension Service County Offices (UTE) and Henry County Medical Center (HCMC) have all been delivered at points during the grant cycle. These Stanford University programs, **Living Well with Chronic Conditions**, **Take Charge of Your Diabetes**, and **Cancer: Thriving and Surviving**, have not been adapted or implemented differently from their original format. However, during this time, Stanford has piloted a workplace version of Living Well with Chronic Conditions to help meet at-risk patients with limited time in their own environment.
Needs Addressed	The West Tennessee region includes 20 counties that are predominantly rural. According to a recent analysis, West Tennessee has trailed the rest of the state in job creation over the past decade, has experienced higher unemployment, and lags other parts of the state in educational attainment. Poverty is seen throughout the region, and there are significant health disparities due to poverty and lack of access to preventive health care. The West Tennessee region, like many other rural areas, has a shortage of health care services. Thirteen of the 20 counties are designated by HRSA as Primary Care Health Professional Shortage Areas (HPSAs). Haywood, Hardeman, Lake, and Lauderdale counties are geographic Primary Care HPSAs in which the entire county has a shortage of health care professionals, whereas Madison County is a partial geographic Primary Care HPSA. Obion, Weakley, Dyer, Benton, Henderson, Decatur, McNairy, and Hardin have primary care shortages affecting primarily low-income populations. Further, only three of the 20 counties are not HRSA-designated Medically Underserved Areas (MUAs). Every county in the region is also designated as a mental health HPSA. Additionally, West Tennessee residents have rates of overweight/obesity, diabetes, heart disease, hypertension, and stroke that exceed those for the state as a whole, and lower daily intake of healthy foods. The primary target population for the Delta consortium is adults and children in rural communities throughout the region who have or are at risk for obesity, diabetes, and cardiovascular disease, based on lifestyle and other factors.
Target Population(s)	☒ Children (0-12) ☒ Adolescents (13-17) ☒ Adults (18-64) ☒ Elderly (65 and over)
Services and Activities	Activities for the West Tennessee Delta Initiative were centered around partnerships and community involvement, health literacy and education, chronic disease management and prevention, pharmacy assistance, care coordination, health screening and counseling, and capacity-building. Partnerships and community involvement were maintained in each of the 20 counties by regularly attending health council and other committee meetings, participating in community outreach events, servicing schools in at least nine of the 20 counties, and holding regular meetings with consortium members and managed care organizations. Further, health literacy and education were provided through multiple promising practices and evidence-based programs for children and adults, including 8-5-2-1-0 Every Day!, Power U, Living Well with Chronic Conditions, Take Charge of Your Diabetes, Cancer: Thriving and Surviving, Tai Chi, and Dining with Diabetes. Comprehensive well-child screenings, care coordination, and health counseling were provided through Le Bonheur's patient- and family-centered care coordination program. Additionally, both HCCHC and PHCHF provided health screenings, care coordination, counseling, chronic disease management, and pharmacy assistance to adult patients throughout the region. Capacity-building was delivered in the form of effective evaluation and data collection.
Project Results	
Outcomes	**Providing health literacy and education services to children resulted in the following outcomes:** • At least a 27% increase in fruit and vegetable consumption • A 28% increase in physical activity

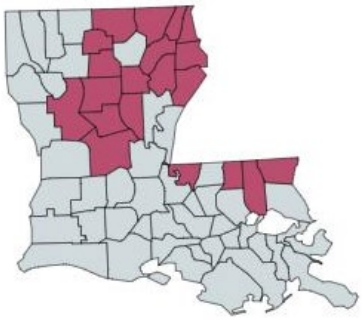
	• A 23% increase in water consumption **Providing health literacy and education services to adults resulted in the following outcomes:** • More than 50% reported making healthier food choices and/or preparing healthier meals • 60% and 50%, respectively, reported self-monitoring of their blood sugar and an improvement in HbA1c levels • More than 30% reported fewer visits to the emergency room **Chronic disease management and care coordination activities conducted by PHCHF and HCCHC resulted in the following outcomes:** • At least 40% of participants decreased their BMI • At least 35% decreased their weight • At least 30% had a reduction in blood pressure • At least 25% had a reduction in their HbA1c levels • There was well over a 73% reduction in emergency room utilization • There was at least a 32% decrease in hospital admissions • More than $78,000 was saved on prescriptions from pharmacy assistance **The pediatric Behavioral Health Navigation program resulted in:** • At least 60% of patients showing improved behaviors in academic performance, behavior at home, and behavior at school • At least 48% of families showed an increase in parental involvement
Sustained Impacts	☒ Some parts of the program will be sustained Residents of rural West Tennessee have benefited through improved access to chronic disease management and pharmacy assistance options, as well as linkage to primary care providers, community-based resources, and health education. Obesity-prevention messaging through the 8-5-2-1-0 model has and will continue to have a long-term positive impact on West Tennessee communities, as children and their families translate their increased knowledge of the components of a healthy lifestyle into better nutritional choices and more physical activity. Additionally, multiple health literacy and education programs have instilled priceless knowledge and changed behaviors across several age groups in the communities served. In addition, these programs have increased public/patient awareness and understanding about the serious impact of obesity in causing chronic diseases. The Behavioral Health Navigation and Chronic Disease Management programs have fostered empowerment of families to address and overcome barriers to care, thereby optimizing health outcomes. Additionally, the Behavioral Health Navigation Program pilot raised awareness of the benefits and importance of behavioral health care. The school district in which this program was piloted has increased its capacity to address behavioral health, as demonstrated by the hiring of a school counselor to serve their three elementary schools and approximately 520 children. Moreover, patient and partner stories demonstrate that many families throughout the rural communities are embracing the lifestyle changes that individual patients learn. This generational impact will improve health outcomes for rural communities.
Challenges and Lessons Learned	The primary challenges of the West Tennessee Delta Initiative programs were centered on participation and staffing. Adequate participation in some of the health literacy courses proved to be a challenge. The candid and readily available audiences are of the older population whose

	chronic diseases are greatly developed. It was very difficult to engage the younger generation, for whom the education and learned behaviors may have had greater impact. This particular challenge was addressed in many meetings and discussions with partners. The developer of the evidence-based Stanford University chronic disease management programs piloted a workplace version of Living Well with Chronic Conditions. Hiring staff for new programs and staffing turnover, resulting in a delay in the start date, also proved to be a challenge. Turnover resulted in lost time spent training and educating new staff and delays in appropriate data collection and reporting. Also, lack of transportation was identified as a barrier to care for the targeted population. Finally, the COVID-19 pandemic presented a unique challenge during Year 4 of the grant cycle, resulting in many programs greatly changing their delivery approach or being unable to continue.
Accomplishments/ Recognition	The West Tennessee Delta Initiative was awarded a Network Planning Grant through HRSA in 2017-2018 to create and formalize a network board and written bylaws. The consortium has also been awarded a Rural Health Network Development Grant for 2020-2021 to provide funding for two full-time staff positions to coordinate, manage, and develop the West Tennessee Telehealth Network. The Le Bonheur Community Outreach mobile unit and Delta grant teams received the quarterly Miracle Award from their parent organization for going above and beyond for a patient and family served by the Delta program. Le Bonheur Community Outreach also received a $5,000 grant from a local school that receives Delta grant services. Meghan Larson, LCSW, from MLCO received recognition as a 2018 Child Advocate of the Year from the Northwest Tennessee Council on Children and Youth. Throughout the grant cycle, programs and outcomes were presented at several conferences: FORHP All-Programs Meeting in 2018, National Rural Health Association Annual Conference in New Orleans in 2018, Southern Obesity Summit in Charleston, Pa., in 2019, and the Children's Health Fund Fall Conference in Phoenix in 2019.
Considerations for Program Replication/ Implementation	Based on experiences and outcomes, it is important to consider meeting patients and families where they are. This is where grant programs have had the most success. School-linked behavioral health care navigation services can be extremely beneficial to patients and school partners by serving those with the most needs in a community environment with scarce resources. Care navigation and chronic disease management services being coupled with a hospital admission or primary care provider (PCP) visit increases opportunity and compliance. Through successes and challenges, it was learned that health literacy programs must be delivered in methods that are convenient to participants.

LOUISIANA

Richland Parish Hospital

Louisiana Delta Service Region A



Organization Information						
Organization Name	Richland Parish Hospital					
Organization Type	Critical Access Hospital (CAH)					
Address	**Line 1:**	407 Cincinnati Street				
	City:	Delhi	**State:**	LA	**Zip-code:**	71232
Organization's Project Contact	**Name:**	Patrick Cowart				
	Phone:	318-878-6346 office, 985-974-1679 cell				
	Email:	pcowart@delhihospital.com				

Project Overview	
Project Title	Louisiana Adolescent Pre-Diabetes Prevention Program
Goal(s)	The overarching goal of the Adolescent Pre-Diabetes Prevention Program is to continue to expand the Promising Practices Model Richland Parish TRAC Pre-Diabetes prevention program within the adolescent population by continued programmatic implementation in high schools in the 20 parishes designated as Louisiana Service Region A.
Objectives	• Expand the project to include additional schools in the 20-parish service area • Increase awareness of prediabetes/ prediction of prediabetes on the part of parents, school staff, community, and local health providers in the 20-parish service area • Decrease the incidence of type 2 diabetes through aggressive/preventive management of prediabetes among high school students in grades nine through 12 • Increase health awareness among faculty and staff at participating schools • Encourage through healthy lifestyle education the adoption of healthy or healthier lifestyles for adolescents and families • Facilitate sustainability of the program by crafting a strategic plan and a sustainability plan that will continue to support, implement, and sustain the initiative
Focus Area(s)	☒ Health Education/Promotion and Disease Prevention ☒ Health Screenings

Consortium/Network Partners	**Organization Name**	**Role**	**Organization Type**
	Richland Parish Hospital	• Ensured staffing and administrative oversight of the project	Critical Access Hospital
	Christus St. Francis Cabrini Hospital SBHCs	• Served as a service delivery point at five schools and as a "laboratory" to test new ideas and strategies related to student screenings and healthy lifestyle education	Tertiary Hospital
	West Feliciana Parish Hospital	• Contributed administrative knowledge	Critical Access Hospital

		• Served as a sounding board before new ideas and strategies were tested through the Christus St. Francis Cabrini SBHCs • Provided staffing for one prediabetes prevention coordinator	
	Atlanta High School; Beekman Charter School; Bogalusa High School; Calvin High School; D'Arbonne Woods Charter School; Delhi High School; Epps High School; Family Community Christian School; Franklin Parish High School; General Trass High School; Glenmora High School; Grant Parish High School; Independence Magnet High School	• Provided access to students, and fostered and promoted the activities of the program at their schools • Provided input into project planning through active participation in the consortium through both structured and informal conversations at consortium meetings and face-to-face visits by project staff, email, and texts	High School
	Jena High School; Jonesboro-Hodge High School; Lakeview High School; LaSalle High School; Lincoln Preparatory School; Madison Parish High School; Natchitoches Central High School; Oak Grove High School; Rayville High School; Jewel M. Sumner High School; Tensas Parish High School; West Feliciana Parish High School	• Provided access to students, and fostered and promoted the activities of the program at their schools • Provided input into project planning through active participation in the consortium through both structured and informal conversations at consortium meetings and face-to-face visits by project staff, email, and texts	High School
	Bogalusa High School Based Health Center; Delhi Community School Based Health Center; Glenmora High School Based Health Center; Grant Jr./Sr. High School Based Health Center; Jena High School Based Health Center	• Provided access to hard-to-reach students • Used their influence on their campuses to help recruit students for participation in the program • Provided input into project planning through their active participation in the consortium through both structured and informal conversations at consortium meetings and face-to-face visits by project staff, email, and texts	School-Based Health Center (SBHC)
	Lakeview Jr./Sr. High School Based Health Center; Madison Parish High School Based Health Center; Family Services Center School Based Health Center; Natchitoches Central High SBHC; Richardson	• Provided access to hard-to-reach students • Used their influence on their campuses to help recruit students for participation in the program • Provided input into project planning through their active participation in the	School-Based Health Center (SBHC)

	Medical Center SBHC; Tensas Community Health SBHC	consortium through both structured and informal conversations at consortium meetings and face-to-face visits by project staff, email, and texts	
Evidence-Based Model(s)/Promising Practice(s)	This project is based on the **Adult Pre-Diabetes Screening Promising Practice Model** developed in Richland Parish, LA. (2009-2012), with origins in a 2006-2009 cardiovascular screening program that identifies participants with prediabetic blood sugar levels. The Adult Pre-Diabetes Project focused on early detection of prediabetic blood sugar levels and diabetes prevention through (1) repeat screenings using American Diabetes Association (ADA) guidelines; (2) health education focusing on diet, lifestyle, and physical activity; and (3) medical oversight. A 2012 expert analysis of the Adult Model Pre-Diabetes Program found a statistically significant association between program participation and reduced rate of progression from prediabetes to diagnosed diabetes compared with medical literature reports of 5% per year for prediabetic persons and 11% per year for persons with impaired glucose tolerance. There was no progression to diagnosed diabetes in any enrollee with a follow-up HbA1c within 14 months of initial screen.[1,2] The Adolescent Pre-Diabetes Prevention Program adapted the promising practice Adult Pre-Diabetes Screening Promising Practice Model to the high school population, ages 14-18. With parental and student consent, project staff conduct phased prediabetes screening in 26 high schools in the 20-parish Region A to identify students at risk for prediabetes. The key project tasks included: • Continuation of strategies for gaining and maintaining access to each of the 26 high schools in the 20 parishes and for obtaining parental/student consent for prediabetes screening and program participation in these school settings. • Continuing the collection of data for prediabetes risk factors, which include (1) weight, (2) body mass index/body mass index percentage (BMI), (3) risk factors questionnaire, and (4) A1c venous testing. The project did not diagnose but identified students “at risk” and at “high risk” for prediabetes. • Continuing to refine the effective and efficient group screening process and flow for high school screenings that were administered by project and school-based health center (SBHC) staff (as available), with repeat screenings for students identified as “at risk” for prediabetes. • Continuing the revision/implementation of the preventive health education component to teach “at-risk” student participants about nutrition, lifestyle, and physical activity to reduce prediabetes risk. • Continuing to reach rural and minority students including African American, Latino/Hispanic, Native Americans, and Asians through prediabetes screenings and preventive health education. **(References**: 1. Dexter Cahoy, Ph.D., LA Tech University. Preliminary analysis of the pre-diabetes data with follow-up (between 12-14 months). 2. Paul W. Grandon, M.D. “Every Ending has a NEW Beginning!” *TRAC Newsletter,* spring 2012).	
Needs Addressed	The 20 parishes included in the project collectively represent one of the most severely and chronically economically distressed regions, not only in Louisiana but also in the United States. The region experiences high rates of poverty and unemployment. Residents of the region also experience higher mortality rates, lower health care utilization, and poorer access to health care compared to other residents of the state. All 20 parishes have been classified as a Population Group Designation Health Professional Shortage Area (HPSA). All parishes are also designated as a Medically Underserved Area (MUA). In the past, diabetes has been viewed as an older person’s disease, and most of the medical attention went toward preventing or treating the serious complications of the disease. With data indicating that type 2 diabetes is occurring at increasingly younger ages, and based on strong community input and strategic planning input		

	from our partners, it was decided to reach out to a younger population designated as prediabetic while time remains for them to make healthy lifestyle changes. Collaborative diabetic education programs for adolescents are nonexistent in the project service area. Programs that exist are primarily tailored for the older adult diabetic population. Some adolescent general health education is provided by SBHCs and local primary care doctors. SBHCs are located in only approximately half of the parishes in the Louisiana Delta service region. Many schools are considered "feeder schools" to the SBHCs, and transportation must be provided for students to access their services. This results in very little increase in access to care for the off-campus students. By bringing the clinical and educational project staff to the high school campuses, the goal is to fill the current gaps in the areas of diabetes prevention and healthy lifestyle education for those students.
Target Population(s)	☒ Adolescents (13-17) ☒ Adults (18-64)
Services and Activities	The Adolescent Pre-Diabetes Prevention Program encompasses the following three activities: • Student prediabetes detection and education, which includes an initial student screening and, for students admitted into the program, two follow-up screenings each academic year. Screenings include blood pressure and weight measurements, calculation of BMI/BMI percentage, and measuring A1c blood hemoglobin levels. The education component includes a group of six lessons throughout the academic year conducted in small settings. • Faculty and staff wellness screenings are offered to all faculty and staff at each of the 26 schools participating in the adolescent program. The screenings are designed to promote health status awareness among the faculty and staff. Measurements include blood pressure, weight, BMI, cholesterol (total, HDL, LDL, non-HDL, cholesterol/HDL ratio, triglycerides, and heart age). This service to faculty and staff helps increase awareness of the importance of screenings and healthy lifestyle education for students. • Consortium activities include convening consortium members (schools, SBHCs, and institutional members) once during the fall and once during the spring semester to address current trends, needs, and concerns and to expand knowledge of health and mental health issues faced by high school students.
Project Results	
Outcomes	The consortium has become a viable organization focusing on the oversight of the project as well as overall student wellness issues. SBHCs have been instrumental in assisting with screenings and have continued to learn how an organized, effective screening process, done collaboratively, can increase the capacity to screen students and generate billable revenue. Principals and staff increased their knowledge of prediabetes and diabetes, which, along with faculty and staff wellness screenings, continues to reinforce positive attitudes and behaviors. Schools that have SBHCs on their campuses have demonstrated higher program performance measures than schools that do not have SBHCs on their campuses. Project staff and the program have been accepted as part of the fabric of the high schools, with the project staff being the "go-to" resource for student health–related issues. Locally, community agencies and organizations have become knowledgeable of the project and the effects it is having on the lives of participants. In turn, the project expanded to include five additional high schools. In addition, as a result of the successes of the project, the Adolescent Pre-Diabetes Prevention Program will be integrated into 12 nonprogram SBHCs. The Adolescent Pre-Diabetes Prevention Program has produced the following results: • **A1c Blood Hemoglobin Levels**. During the grant period, 19% of participants experienced a decrease in A1c levels, and 65% maintained their initial A1c level. Combined, 84% of program participants were successful in managing their A1c level. This is an indicator that participants were able to grasp the concepts of how sugars affect the hemoglobin molecule

	and ways to prevent increases and/or to manage current levels. • **BMI Percentage**. Of the 635 participants, 19% decreased their BMI percentage, and 65% maintained their BMI percentage. Success in decreasing or maintaining BMI percentage is also an indicator that participants were able to grasp and implement concepts related to diet, nutrition, and making healthier food/snack choices. Once participants master the concepts for managing A1c blood hemoglobin levels, healthy diet, and nutrition, along with positive reinforcement from the project staff, family, teachers, and friends, they have the necessary tools and knowledge to delay or prevent the onset of type 2 diabetes. • **Student Screening Consents Returned**. The return rate for student screening consent forms has increased by 6% since Year 1 of the project. In Year 1, 45% of the total freshman population returned consent forms, while in Year 4, 51% of the total freshman population returned consent forms. This was an increase of 162 students. • **Screening Process Refined and Implemented**. The screening process was refined to facilitate quicker screening times (less time out of class for students) and increased data-gathering accuracy. • **Faculty and Staff Screenings**. Seventy-four percent of faculty and staff participated in the faculty and staff screenings. • **Consortium**. Fifty percent of school members, 100% of SBHC members, and 100% of institutional members attended the fall and spring consortium meetings.
Sustained Impacts	☒ Some parts of the program will be sustained The project has created a highly effective process for building collaboratives and has established a method of health screening that can easily be replicated and adapted to other health/wellness applications. Through the school-based prediabetes screening of students with identified risk factors (BMI percentage, family history, ethnicity) more of the population of low-income, uninsured, and minorities at risk will have increased access to screening and the opportunity to learn preventive strategies to overcome their risks for diabetes. The project has also contributed to a cohort of young adults in each parish who participated in community-oriented prediabetes and prediabetes-prevention activities during their formative years. Over time, all of the students who have participated in the program will result in a critical mass of residents in positions of influence to promote physical and nutritional environments conducive to healthier living. The most powerful anticipated sustained impact from this project will be a measured reduction in the degree of disparity in diabetes diagnosis, morbidity, and mortality, especially among African Americans, Hispanics, Native Americans, and Asians in the 20-parish service region.
Challenges and Lessons Learned	A key challenge when working with adolescents is how to reach and engage this population. Through the implementation of faculty and staff wellness screenings that enlightened the faculty and staff to the importance of health screenings, and with their buy-in, an entire support structure for student engagement was created. Screening numbers have risen, and an increased number of students have been admitted to the program. Student interest in the information contained in the Healthy Lifestyles lessons was significantly increased when lesson handouts were reworked, and age-appropriate design was provided by a graphic artist. Another key lesson learned is that it is often easier and much more effective to engage professionals to design materials targeted to the adolescent population. Also, the development of effective partnerships with the schools and SBHCs is an ongoing process. Changes in school leadership and mandates from the Louisiana Department of Education and local school boards sometimes challenge the effectiveness of the partnerships. However, education for new school leadership and work within the consortium are collaborative ways to address mandates that affect the schools' participation level. As a continuation of the 2013-2016 Adolescent Pre-Diabetes Prevention Program, lessons learned are as numerous as in the earlier years of the project. The greatest lesson learned is that there is ultimately a way to get to "Yes" when working with partners, schools, SBHCs, and students and parents. The key to this lesson is to listen carefully, think creatively, ensure

	inclusiveness, and celebrate when solutions are found and agreed upon. There are always challenges to previous policies, procedures, and methods. The most serious challenge to date has been the COVID-19 pandemic and the effects it has had on the education community and environment. The solution to this challenge is the program extending into the fall 2020 semester to complete final screenings and educational lessons for students.
Accomplishments/ Recognition	The project has produced three key accomplishments. The first is the creation of a highly effective process for building collaboratives that included methods for breaking down silos, thinking about student wellness as a component of the education and success of students, and exploring and adapting new and innovative ways to communicate with others outside the realm of comfort for school administrators. The second is the establishment of a method for health screening that can easily be replicated and adapted to other health/wellness applications in group settings while ensuring privacy and confidentiality of protected information, with greater speed and accuracy of screening information. The third is the development of the Lifestyle Education component to promote recognition by students of the potential to prevent prediabetes and diabetes through better choices in their health and nutrition habits. The project was named the 2017 Rural Program of the Year by the Louisiana Rural Health Association. In 2018, project members presented "Adolescent Pre-Diabetes Prevention Program — Intervention and Implementation Strategies" at the National Rural Health Association and "Small Steps … Exceptional Results … Empowering Adolescents to Reduce Risk Factors for Pre-Diabetes" at the Southern Obesity Summit. Additionally, the article "The Adolescent Pre-Diabetes Prevention Program" was published on the Rural Health Information Hub website.
Consideration for Program Replication/ Implementation	Over seven years, this project has created a program/process that is effective and efficient for screening and educating adolescents about type 2 diabetes. Outcomes achieved by the project are indicative of a well-planned program that, through much trial and error, has mastered the craft of effectively communicating with adolescents about the seriousness of prediabetes and diabetes. When creating similar projects or initiatives, potential programs should not reinvent the wheel. Rather, they should identify similar programs and, after careful research and planning, use as many features of a previously implemented program as is feasible. A clean data-gathering system, in addition to determination of necessary measures, is imperative for being able to analyze measures and indicators for determining outcomes.

ALABAMA

Rural Alabama Prevention Center

Alabama Service Region A

Organization Information						
Organization Name	Rural Alabama Prevention Center					
Organization Type	Other Community-Based Organization					
Address	**Line 1:**	301 Prairie Avenue				
	City:	Eutaw	**State:**	AL	**Zip-code:**	35462
Organization's Project Contact	**Name:**	Loretta W. Wilson				
	Phone:	205-372-3514				
	Email:	Lowwebb9@aol.com				

Project Overview	
Project Title	South West Alabama Health Improvement Initiative (SWAHII)
Goal(s)	The overarching goal of SWAHII is to promote and support healthy lifestyles throughout Alabama's Delta counties through the implementation of programs geared toward the prevention and care management of chronic diseases.
Objectives	• Increase individuals' knowledge to assist them in making lifestyle changes that prevent or reduce the impact of chronic disease and its associated factors through prevention and management strategies • Reduce frequent use of the emergency room, prevent unnecessary hospitalization, and reduce repeat hospital admission
Focus Area(s)	☒ Cardiovascular Disease (CVD) Care Management ☒ Chronic Obstructive Pulmonary Disease (COPD) Prevention ☒ Chronic Obstructive Pulmonary Disease (COPD) Treatment and Management ☒ Case Management ☒ Diabetes Care Management ☒ Chronic Disease Management ☒ Community-Based Care Coordination ☒ Health Education/Promotion and Disease Prevention ☒ Health Screenings

Consortium/Network Partners	**Organization Name**	**Role**	**Organization Type**
	Community Health Education Resource Center	Ensured objectives of SWAHII were carried out by: • Encouraging creative and lasting collaborative relationships among a group of diverse health providers • Ensuring that the applicant organization received regular input from relevant and concerned entities within the health sector	Community-Based Organization

		• Ensuring that the grant-funded project addressed the health needs of the identified service region • Assisting with the development of program modules, programs, and a strategic plan	
	Tuskegee Area Health Education Center; Auburn University	Ensured objectives of SWAHII were carried out by: • Encouraging creative and lasting collaborative relationships among a group of diverse health providers • Ensuring that the applicant organization received regular input from relevant and concerned entities within the health sector • Ensuring that the grant-funded project addressed the health needs of the identified service region • Assisting with the development of program modules, programs, and a strategic plan	University
	Monroe County Hospital; Hill Hospital of Sumter County	Ensured objectives of SWAHII were carried out by: • Encouraging creative and lasting collaborative relationships among a group of diverse health providers • Ensuring that the applicant organization received regular input from relevant and concerned entities within the health sector • Ensuring that the grant-funded project addressed the health needs of the identified service region • Assisting with the development of program modules, programs, and a strategic plan	Hospital
	Project Horseshoe	Ensured objectives of SWAHII were carried out by: • Encouraging creative and lasting collaborative relationships among a group of diverse health providers • Ensuring that the applicant organization received regular input from relevant and concerned entities within the health sector	Mental Health Agency

		• Ensuring that the grant-funded project addressed the health needs of the identified service region • Assisting with the development of program modules, programs, and a strategic plan	
Evidence-Based Model(s)/Promising Practice(s)	**The Body & Soul Wellness Model:** This model was utilized for chronic disease prevention in churches. Body & Soul is an evidence-based wellness program developed for African American churches. The program encourages church members to eat a healthy diet rich in fruits and vegetables every day for better health. Four unique components make up the program: pastoral leadership, educational activities, a church environment that supports healthy eating, and peer counseling. Church members who are at risk of developing chronic diseases, based on their family history, BMI, A1c levels, and other risk factors, were enrolled in the Body & Soul wellness chronic disease prevention program. The program focused on the prevention of obesity, heart disease, diabetes, and stroke, with an emphasis on smoking cessation. To ensure that churches had the necessary resources and staff, SWAHII consortium members agreed to allot a stipend to support a coordinator and other items needed to implement the evidence-based program. This approach worked well, and more churches were added to the Body & Soul wellness program. **Care Management of Chronic Diseases Model:** The SWAHII partners utilized the Reducing Care Fragmentation Model: A Toolkit for Coordinating Care. This toolkit was designed for clinics, practices, and health systems focused on improving care coordination by transforming the way they manage patient referrals and transitions. Patients who present to the participating hospitals' emergency rooms with a diagnosis of diabetes, congestive heart failure (CHF), or chronic obstructive pulmonary disease (COPD) were referred to the care management program for care coordination services. Referrals for mental health evaluation and treatments and home health services were also made for patients meeting the criteria for these services. One key program adaptation included the integration of home visits as a part of the care management visits. Partnering agencies were asked to make home visits and/or network with the home health agencies their participants utilized. This approach ensured that gaps of services were eliminated. During home visits, the SWAHII care coordinator was able to identify patient needs, such as wheelchairs and other assistance. In Year 2, the Care Coordinator Tool Kit was amended to include a minimum of two home visits a month. Additionally, to ensure that the hospitals did not feel overwhelmed, SWAHII changed its model to dedicate a staff person (registered nurse) who would review patients' information via the hospitals' electronic health record. This approach worked well, and more patients were referred for chronic care management. **Power to Prevent Model:** The National Diabetes Education Program's Power to Prevent program is composed of 12 sessions designed to help people bring healthier habits into their lives to prevent diabetes. The program is effective in encouraging, African Americans who are at increased risk for type 2 diabetes, to become more physically active and to eat more healthful foods to prevent or delay onset of the disease.	
Needs Addressed	Nearly all communities within the Alabama Delta counties are rural and sparsely populated, with counties and communities as far as 30 miles apart. The areas are largely minority (83% Black), (13% Caucasian), and (4% Hispanic). People within these counties are also medically and dentally underserved, with higher chronic disease prevalence rates than elsewhere in Alabama. SWAHII's target populations included individuals aged 15-64 residing in Alabama Service Region A. These individuals were reportedly at risk of developing, living with, and/or dying of a chronic illness. Further, more alarming is the number of people without health insurance coverage and those who are covered on Medicare and/or Medicaid. Additionally, low levels of formal education (only 31% graduate from high school) reinforce the economic problems and often result in poor health practices and lack of knowledge about accessing and using health care resources early. Lack of access to health care is also brought about largely by the lack of transportation, another significant challenge. Such barriers have resulted in delayed access to health care as a condition		

	worsens, ultimately requiring a trip to the emergency room. Not only does this impact a person's health, it also threatens the closure of hospitals, especially when patients lack health insurance. SWAHII was designed to address the insufficiencies and limited access in the following areas: • Hospital and primary care clinics unable to offer care coordination services due to limited support staff to navigate patients through the system • Limited opportunities for church leaders to educate their members about leading a healthy lifestyle • Limited health care providers in rural areas, resulting in target populations being less likely to have regular access to a primary care doctor, especially during the evening and weekends • Insufficient screening and educational opportunities within a health care facility for those with chronic diseases • Insufficient support groups to offer classes for those who have chronic disease • Limited educational opportunities for people to learn about available resources that would impact their ability to self-manage their care • Low literacy, lack of health insurance, limited transportation or travel time to health care providers, waiting time for care, and limited healthy food choices
Target Population(s)	☒ Adults (18-64) ☒ Elderly (65 and over)
Services and Activities	During the past four years, the SWAHII program, funded by the Delta States grant program, implemented the Body & Soul wellness program in churches throughout 18 counties for a total of 144 churches. During the implementation of SWAHII, partners were contracted to implement five series of classes (six weeks per class), per year, in two participating churches (2 churches x 18 counties = 36 churches) per year. These classes focused on education, healthy cooking, and physical activities. Classes were held one day a week, more if agreed upon by the participants, with a minimum of 15 participants per county served. Through the Care Management Program, SWAHII-partnering hospitals provided a minimum 13 visits, (face-to-face or non–face-to-face) for nine months for at least 30 patients with a diagnosis of diabetes, CHF, or COPD. Other activities included a series of health fairs, screenings, and distribution of resources via a resource database maintained by partners with information about community service providers who could assist with health-related and social needs, such as transportation.
Project Results	
Outcomes	During the four years of implementing SWAHII in communities throughout Alabama Delta Service Region A, the evaluation confirmed that patients who received routine managed care and preventive services experienced fewer emergency room visits and hospitalizations; improved blood sugar control, blood pressure, and lipid levels; and fewer negative health effects of comorbid conditions. Participants in chronic disease prevention classes demonstrated a change in knowledge, behavior, and biometric measures. Care coordination services resulted in improved quality of life for patients with diabetes, CHF, and COPD and also had a positive financial impact on participating hospitals. Specific program component outcomes include: • **Body & Soul Wellness Program**. One hundred forty-four churches were served with more than 4,050 churchgoers participating in activities geared toward increasing knowledge of the impact of chronic diseases. Churches developed policies that eliminated the serving of unhealthy foods and sugary drinks during events, as well as prohibiting smoking while on church property. Churches also started exercise programs, created community gardens, and built new relationships throughout the community with other organizations and leaders. Participants showed an increase in their consumption of fresh fruits, vegetables, and low-fat dairy products; increased physical activity; and a reduction in weight, A1c levels, and

	cholesterol. • **Power to Prevent Program**. Of the 1,620 participants, 65% of the participants experienced a reduction in their BMI, blood pressure, blood sugar, and cholesterol. • **Care Management of Chronic Diseases Program**. Participating hospitals provided care coordination services to more than 360 patients with chronic conditions. Participants had increased education opportunities about their chronic illness, learned how to effectively take their medication, were provided with a home health intervention, and received frequent calls from care coordinators and timely assistance with resources. Hospitals reported seeing a moderate reduction in emergency room and sick clinic visits. Additionally, hospitals that previously did not have the funding to staff care coordinators now offer a revenue-generating service they never had before.
Sustained Impacts	☒ Some parts of the program will be sustained The short-term and long-term impacts will involve changes in health care design and systematic changes to primary care practices and health systems to improve their quality, efficiency, and effectiveness for the purpose of improving patient outcomes. Using models such as the Body & Soul and chronic care models has shifted the health system's focus from reacting to the acute care needs of individuals to proactive engagement of a population of patients and focusing on their health goals, needs, and abilities to achieve desired health outcomes. The SWAHII program has helped reshape health care delivery in the following ways: • **Health Literacy and Cultural Competency.** SWAHII has helped patients access, process, and understand basic health information and services needed to make appropriate decisions. • **Health Risk Assessment.** SWAHII performed several health risk assessments in an effort to collect information from patients to form a snapshot of the patients' overall health, identify health risk factors, and develop personalized prevention and care plans. • **Patient-Centered Medical Home.** SWAHII helped primary care practices place patients in a medical home where they can have consistency in care. • **Practice Facilitation.** SWAHII offered providers a range of quality-improvement approaches that helped to improve primary health care processes and outcomes, including the delivery of preventive services, by encouraging an ongoing relationship with their patients. Ultimately, the long-term impacts of the programs are: • Established sustainable care coordination programs that support individuals with chronic diseases. • Established sustainable church wellness programs that support parishioners eating healthy and exercising regularly to prevent and delay chronic diseases. • Improved health outcomes for patients receiving care coordination related to diabetes, COPD, and CHF. • Improved patient knowledge of the importance of self-monitoring of blood glucose, improved dietary habits, and glycemic control, especially in the short term. • Reduced health care utilization and cost. • Sustainable services for continual care coordination for chronically ill patients. • More involvement and participation from the faith community in wellness initiatives
Challenges and Lessons Learned	**Memorandum of Understanding Challenges.** There were issues related to the memorandum of understanding (MOU) and how to reimburse for services rendered. These issues (e.g., cost-based reimbursement verses a standard one-twelfth of the total amount funded per month) were

	discussed and clarified with network partners. It was determined that the MOU, as signed for each year, would define reimbursement procedures going forward. Any changes for the upcoming year would be communicated by the lead agency a minimum of one month prior to the end of the current grant year. To ensure compliance, the project director reinforced grant funding guidelines and funding disbursement requirements during quarterly meetings. **Program Curriculum Implementation Challenges.** Challenges identified by partners during implementation included maintaining participation during the Power to Prevent sessions. Participants are required to attend all six sessions for the purpose of showing program impact. At the first session, a clinical assessment is conducted, a follow-up is done at Session 3, and a final assessment at Session 6. If a participant drops out after the first session, it can impact the overall outcome of the project. During our quarterly meeting, strategies were put in place to ensure participants attended and completed all sessions. Strategies included offering incentives for completion of Sessions 1, 3, and 6, as well as highlighting churches and their participants in the newspaper and in other social media outlets. **Partnership Compliance Challenges.** There were delays with some partners providing services to communities as agreed. More than 85% of the counties served are implementing the program guidelines as required. In Year 2, two partnering agencies reported starting late due to delays in getting the necessary paperwork from churches. In most rural areas, churches meet only once or twice a month, making it difficult to get paperwork done in a timely manner. The procedure was amended to include conference calls with pastors to get their authorization to allow another leader in the church to sign in their absence to avoid delays in signing agreements and beginning program activities with the church.
Accomplishments/ Recognition	Success is demonstrated by the approximately 65% of participants who improved their overall health status. Other accomplishments included 100% partnership collaboration, 95% participation in Body & Soul, 100% completion of pre- and post-test questionnaires, 90% completion discharge from the care coordination program, 85% completion of Power to Prevent program, and 100% coordination of community health fairs and screening. Additionally, SWAHII was featured in the Rural Health Information Hub in February 2019. The published article was titled “Rural Patients with Chronic Disease: A Nonprofit Organization and a Health Department Leverage Federal Funding to Provide Health Education and Care Coordination,” and it was written by Kay Miller Temple, M.D.
Considerations for Program Replication/ Implementation	The evidence-based models identified and implemented as part of SWAHII can be implemented in other rural areas. This prototype has been extended to other organizations and agencies in Alabama, especially in counties with the same or similar disadvantages, as defined by their educational, financial, and other needs. Results and outcomes have been shared at local and state conferences, like the Rural Alabama Prevention Center’s annual wellness conference, which provided an opportunity for potential replication in other communities with similar needs. The relationships developed with members of the consortium partners and the community as a whole have also provided a strong foundation for replication.

ILLINOIS

Southern Illinois University

Service Region A

Organization Information						
Organization Name	Southern Illinois University					
Organization Type	Other University — Medical School					
Address	**Line 1:**	975 S. Normal Avenue, Mail Code 6892				
	City:	Carbondale	**State:**	IL	**Zip-code:**	62901
Organization's Project Contact	**Name:**	Jeff Franklin				
	Phone:	618-453-1251				
	Email:	jfranklin@siumed.edu				

Project Overview	
Project Title	Illinois CATCH onto Health! Promoting Children's Health in the Illinois Delta Region
Goal(s)	The Illinois CATCH onto Health Consortium (ICHC) will enhance and expand the current successful school-based efforts by adding a strong emotional and mental health component. This expanded focus will incorporate the Signs of Suicide (SOS) curriculum, provide bullying and character education, train community and school personnel in Mental Health First Aid (MHFA), and strengthen the region's mental health workforce serving school-age children.
Objectives	• Maintain ICHC as an active and functional consortium • Implement Coordinated Approach to Child Health (CATCH) curriculum in Illinois Delta Region schools • Implement CATCH early childhood Sunbeatables pilot project curriculum in Illinois Delta Region Head Starts and early childhood programs • Pilot the implementation of the Signs of Suicide curriculum in Illinois middle and high schools through the Whole School, Whole Community, Whole Child (WSCC) school health model • Continually evaluate the completion of goals and objectives and assess impact of the physical education program • Expand, establish, and sustain the implementation of school-based health programs following the WSCC model, and the Centers for Disease Control and Prevention's (CDC's) Coordinated School Health Program model • Improve communication, raise awareness, and increase capacity of parents to talk with their children regarding health behaviors • Implement a marketing plan to disseminate Illinois Delta data and work • Work with schools currently implementing CATCH to incorporate a school garden into health education efforts • Develop best practices for promoting a healthy social and emotional climate in the Illinois Delta Region schools
Focus Area(s)	☒ Behavioral/Mental Health ☒ Health Education/Promotion and Disease Prevention

	☒ Maternal and Child Health ☒ School-Based Care Coordination		
Consortium/Network Partners	**Organization Name**	**Role**	**Organization Type**
	Southern Illinois Healthcare	• In Year 1, developed a strong strategic plan, including a defined vision statement, focus, mission statement, and refined goals that continued to guide the work • Worked with other consortium partners to create and possess a shared understanding of the goals, objectives, and work plan of the organization and those measurable outcomes identified to ensure benefits to the members and success for the organization • Worked together with the project director to create opportunities for joint promotion, marketing, and undertaking of special initiatives of importance to the group • Participated in monthly meetings to foster group cohesiveness, overall grant responsibility, and program ownership • Kept everyone involved and focused on the project at hand	Not-for-Profit Hospital System
	Egyptian Public and Behavioral Health Department; Southern Seven Health Department; Jackson County Health Department; Franklin/Williamson Bi-County Health Department	• In Year 1, developed a strong strategic plan, including a defined vision statement, focus, mission statement, and refined goals that continued to guide the work • Worked with other consortium partners to create and possess a shared understanding of the goals, objectives, and work plan of the organization and those measurable outcomes identified to ensure benefits to the members and success for the organization • Worked together with the project director to create opportunities for joint promotion, marketing, and undertaking of special initiatives of importance to the group • Participated in monthly meetings to foster group cohesiveness, overall grant responsibility, and program ownership • Kept everyone involved and focused on the project at hand.	Public Health Department Multicounty

Evidence-Based Model(s)/Promising Practice(s)	**Whole School, Whole Community, Whole Child School Health Model:** The efforts of ICHC are directed at the whole school, with the school in turn drawing its resources and influences from the whole community and serving to address the needs of the whole child. It is the belief of ICHC that this framework will provide a sustainable policy, systems, and environmental approach for improving students' learning and overall health. This model is used with schools from providing education in the classroom to continuing education opportunities to the staff. **Coordinated Approach to Child Health (CATCH):** CATCH is designed to include classroom teachers, physical education (PE) teachers, school nutritional service staff, and children's families and guardians in the planning and implementation of the program. The coordination among these components designates CATCH as a coordinated school health program. Support to local PE teachers and classes through various CATCH equipment, materials, and lesson plans is provided. In addition, nutritional education components are taught in the classroom. **Mental Health First Aid (MHFA):** MHFA is delivered in two separate courses, one focusing on mental health for adults and one focusing on mental health for youth. These courses frame the material unique to the environmental, social, and biological factors that may impact an individual's mental health. The work has included faith-based communities, universities, community colleges, after-school groups, and other community organizations that interact with youth. **Signs of Suicide (SOS):** The SOS prevention program is a school-based depression awareness and suicide-prevention program designed for middle school and high school students. The goals of the program are to decrease suicides and suicide attempts through education, encourage help-seeking personally or on behalf of a friend, reduce stigma around mental health, engage parents and school staff as partners, and encourage schools to develop community-based partnerships to support student mental health.
Needs Addressed	The Illinois Delta Region includes the 16 southernmost counties of Illinois. The Illinois Delta region is primarily White (counties ranging 64.4% to 97.5%). However, two counties have a higher percentage of Black residents than any other county in the state (Alexander, 32.3%, and Pulaski, 31%). The average poverty rate in the Delta counties ranged from 12.9% to 30.3%, with all counties exceeding both state (12.6%) and national (11.8%) rates. The 2014 County Health Rankings also identified 15 of the 16 counties as ranking in the lower 50th percentile of Illinois counties for health outcomes, a summary measure of morbidity and mortality. Seven Delta counties were among the 10 Illinois counties with the poorest health outcomes in the state. County Health Rankings also includes another summary measure, health factors, which is based on weighted scores for four types of factors: behavioral, clinical, social and economic, and environmental. Fourteen Delta counties are ranked in the lower 50th percentile for health factors, and four Delta counties are among the 10 counties with the worst health factors ranking in the state. Delta counties also have rates of age-adjusted suicide that exceed state and national rates. In the United States, the age-adjusted death rate (2009-2013) for suicide is 12.3 per 100,000 (Illinois, 9.4 per 100,000). In the Delta counties, the age-adjusted death rate (2009-2013) for suicide is 16.3 per 100,000, ranging from 12.7 per 100,000 to 30.2 per 100,000. This regional rate is 30% higher than the national rate. Illinois Delta Region residents, particularly school-age children, were the target population during this grant cycle. Improving data from the Illinois Youth Survey (IYS) confirms that this region's children are at risk of modelling the unhealthy living and poor health habits of their parents. Delta children have high levels of physical inactivity and obesity and poor eating habits. Their emotional health is also fragile, with high rates of sadness, hopelessness, and bullying. Most importantly, family and social support is lacking. There are high rates of child abuse and neglect, and fewer than half of the children live with both parents. Also, there are alarmingly high rates of childhood poverty that limit opportunities for these children to succeed. This grant focused on improving the lives of the Delta's children, lowering chronic disease rates, lowering obesity rates, increasing physical activity, and offering a path to break the cycle of multigenerational poor physical and mental health.

Target Population(s)	☒ Children (0-12) ☒ Adolescents (13-17) ☒ Adults (18-64)
Services and Activities	The grant program supports the work completed by ICHC, which primarily provides school-based health interventions and education. Consortium members also provide various community education presentations, events, and workshops designed for educating the regional community to better serve Illinois Delta youth and their well-being.
Project Results	
Outcomes	**CATCH Programming (with respect to physical activity and nutrition):** • 2014 data indicated that 14% of Illinois Delta youth ate fruit four or more times per day in the past seven days, with 11% reporting the same for vegetables. 2018 data from the IYS showed that 22% of Illinois Delta youth ate fruit and 25% ate vegetables four or more times per day in the past seven days. • Using eighth-grade data, in 2014, 25% of Illinois Delta youth were overweight or obese. In 2018, 15% of Illinois Delta youth were overweight or obese, indicating a decline in the target population utilizing the ICHC programming. • ICHC used the System for Observing Fitness Instruction Time (SOFIT) to determine the amount of time students were spending in moderate-to-vigorous physical activity (MVPA) during their PE classes. Delta students spend approximately 66% of PE class engaging in MVPA. These results are well above SHAPE America's recommendation that students engage in MVPA during PE classes at least 50% of the time. • The program also led to schools adopting healthy food policies influencing items sold in vending machines and in the cafeteria. **Mental Health Programming (MHFA, SOS):** Mental Health First Aid courses were offered on an average of one every two months by the consortium's members. These courses were offered completely free to community members or to select groups who requested the course — • The program forced each organization to reevaluate their mental health distress policies and procedures. In schools, this led to the adoption of new mental health policies and a greater emphasis on how to help students in distress. • The program also assisted schools in adopting a Social-Emotional Learning (SEL) curriculum and in beginning to incorporate the components into classroom settings and the overall school atmosphere. • The IYS results did not indicate a clear improvement between 2014 and 2018. However, Illinois Delta youth reporting of experiencing bullying was 7% in 2018, whereas in 2014, 10% of youth reported experiencing bullying. • Through the consortium's efforts to provide MHFA trainings, more than 1,000 community members have received training — school staff, employees of youth-focused programming, and faith-based individuals — on how to identify mental health distress and how to help the individual find appropriate professional help. **County Health Rankings:** • The 2014 rankings identified 10 of the 16 Illinois Delta counties as ranking in the lower 50th percentile of Illinois, with seven counties among the bottom 10 with the poorest health outcomes. The 2019 rankings identified 10 Illinois Delta counties being in the lower 50th percentile, with only five counties among the bottom 10 with the poorest health outcomes. • Much of the consortium's community work is difficult to quantify and measure objectively.

	However, using macro-level data such as the County Health Rankings, the region has improved over the course of the grant cycle. Many of the specific activities of the grant are connected to the improvements.
Sustained Impacts	☒ All elements of the program will be sustained Through regular assessment of the CATCH program in PE classes, it is apparent that the continued involvement and support with the CATCH schools has resulted in increased and sustained levels of MVPA for students in the classes. Each year, the regional partners continue to add more schools that participate in the CATCH program and get existing schools to implement more educational modules. Additionally, the work in the community and schools around mental health, suicide, and social-emotional learning has positively impacted the stigma surrounding mental health, especially in rural areas. In turn, more youth and adults are reaching out for help with their own mental health distress. Further, the regional effort to educate and equip the community with the skills and knowledge necessary to assist youth during mental health distress or crisis has created a sustained impact of understanding and empathy for individuals having mental health struggles. This work has directly contributed to a reduction in classroom disruptions for Delta schools from 2017 to 2019, as recorded by the Illinois Five Essentials Survey. The ICHC work continues to support schools and districts in focusing on the importance of school climate and student well-being as crucial health outcomes. And the partners work regularly with schools to adopt school wellness policies around healthy eating options and physical activity. Also, engaging schools in program planning using assessments such as the CDC's School Health Index (SHI) is the final component that aids in solidifying longer-term impacts.
Challenges and Lessons Learned	As a program focused on school-based programming, there is a double challenge of traditional issues with implementing programs in schools (time, funding, desire to add more work) as well as the unique challenges facing rural areas. As such, much of the work becomes collaborative and intimate with many of the schools. Many of the evidence-based programs utilized in the schools were adapted to fit the needs of each individual school or district. This often meant less time in the classroom than what is typically recommended for most of the programs. Therefore, constant work and testing is done from year to year on how to adapt best practices in rural areas where resources are scarce and other school activities take precedence.
Accomplishments/ Recognition	The ability of the consortium to offer Mental Health First Aid courses to community members, organizations, and industries throughout the grant cycle has been a huge success in increasing the capacity of our region related to mental health. In a region with very few mental health professionals, being able to provide community members with a basic level of knowledge and skills is crucial. One of the agency partners, Southern Seven Health Department, has implemented CATCH physical activity and nutrition standards for pre-K into their Head Start standards across all their locations. This is incredibly important, as now these children are being exposed to education and skill acquisition to be physically fit and healthy. The consortium feels very strongly about the use of the CDC SHI as a valuable tool to help schools understand how to restructure their setting to best impact their students. It is required that all partnering schools complete the SHI every five years and submit an action plan surrounding the results of the tool. Additionally, the consortium received the CATCH Award for Excellence in Regional Health in 2017 for the work that continues to be done through this grant. In addition, the project director and other members of the consortium have presented at national and regional conferences about the work being done through the grant.
Considerations for Program Replication/ Implementation	Success and experience in implementing mental health, suicide, and social-emotional learning initiatives in rural Southern Illinois have been accomplished through constant commitment to working directly with the communities and schools to identify their own needs and then aligning those with the services provided. Additionally, coupling this with a level of autonomy to individuals and schools helps to promote buy-in to the program and helps with tailoring the program.

LOUISIANA

The Health Enrichment Network

Louisiana Service Region B

Organization Information						
Organization Name	The Health Enrichment Network					
Organization Type	Network					
Address	**Line 1:**	P.O. Box 566; 713 E. 7th Avenue				
	City:	Oakdale	**State:**	LA	**Zip-code:**	71463
Organization's Project Contact	**Name:**	Donna H. Newton, MS				
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Project Overview	
Project Title	EatMoveGrow (EMG)
Goal(s)	EatMoveGrow (EMG) utilizes the Whole School, Whole Community, Whole Child (WSCC) model to reduce the incidence and prevalence of childhood obesity and its related chronic diseases. To accomplish this, EMG has developed four goals: (1) teach students in their formative years how to lead a healthy lifestyle, (2) improve children's health environment during the school day, (3) provide families with education necessary to support healthy environments at home, and (4) provide improved access to oral health as a second program area.
Objectives	• Implement EMG educational curricula in grades pre-K to 3 at 40 schools • Implement Growing Up Fit Together (GUFT) Jump Start curriculum at 30 daycares/Head Starts • Increase student activity opportunities during the school day at all 70 GUFT and GUFT Early Years partner sites • Engage family members in child's health status through biometric screening • Establish the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) program to fuel policy and practice improvements for children birth to age 4 in 30 early care or Head Start programs • Establish school wellness committees (SWCs) to drive school health environment policy change • Conduct classroom-level activity studies using Polar accelerometers to promote increased activity levels in 15 schools • Develop a new oral health outreach model that will work within the current constraints of the challenging Louisiana oral health environment • Provide oral health preventive services at 12 highest-need sites
Focus Area(s)	☒ Chronic Disease Management ☒ Health Education/Promotion and Disease Prevention ☒ Oral Health ☒ Population Health

Consortium/Network Partners	Organization Name	Role	Organization Type
	Health Enrichment Network (lead agency)	• Offered a unique area of expertise and valuable resources • Hosted one or more staff positions • Participated in program development and implementation	Network
	Louisiana Department of Health's Bureau of Family Health (BFH)	• Offered a unique area of expertise and valuable resources • Hosted one or more staff positions • Participated in program development and implementation	Health Department
	Louisiana Rural Health Association	• Offered a unique area of expertise and valuable resources • Hosted one or more staff positions • Participated in program development and implementation	Association
	Bunkie General Hospital	• Offered a unique area of expertise and valuable resources • Hosted one or more staff positions • Participated in program development and implementation	CAH
	Louisiana State University (LSU) School of Dentistry	• Offered a unique area of expertise and valuable resources • Hosted one or more staff positions • Participated in program development and implementation	Medical School
	Southwest Louisiana Area Health Education Center (SWLAHEC)	• Offered a unique area of expertise and valuable resources • Hosted one or more staff positions • Participated in program development and implementation	AHEC
	Southeast Louisiana Area Health Education Center (SELAHEC)	• Offered a unique area of expertise and valuable resources • Hosted one or more staff positions • Participated in program development and implementation	AHEC
Evidence-Based Model(s)/Promising Practice(s)	**The Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC),** a national evidence-based assessment, was utilized to assist 27 daycare or Head Start sites to make improvements in nutrition and physical activity programs, impacting 1,744 children from birth to age 4. The Centers for Disease Control and Prevention (CDC) School Health Index was used in elementary schools to assess 36 sites and support the development of 30 school wellness committees (SWCs). EatMoveGrow (EMG) supported SWCs and documented the implementation of 40 new wellness policies, generated $587,945 to support wellness programming and infrastructure changes, and created 85 new activity programs in rural elementary schools. GUFT, the promising practice-healthy-lifestyles classroom curriculum, was taught in 27 early childcare programs and 41 elementary school sites. This		

	curriculum, including nutrition, physical activity, healthy lifestyle, screen time, and 5-2-1-0 lessons, was developed specifically for a rural audience and designed to meet Louisiana Department of Education standards and benchmarks. Pre- and post-evaluations in EMG classrooms demonstrated a 10% increase in health knowledge. An additional component of the program provided extensive technical assistance and resources to increase student physical activity throughout the school day with evidence-based classroom movement breaks (Brain Breaks) and activity intensifiers for physical education (PE) and recess time. Through the **GoNoodle** classroom activity program, EMG tracked an additional 2,158,530 minutes of new classroom activity breaks. **The Walking Classroom** is an additional strategy that was used by some schools to increase physical activity without sacrificing instructional time. Further, **Painted Play Spaces** was another strategy developed and implemented by EMG to focus on more movement in schools with less recess and PE equipment. This low-cost playground-marking project was implemented at 18 sites and replicated by three urban organizations and one national organization (after seeing results in the rural parishes). An evaluation of the Painted Play Spaces activity demonstrated an average increase in moderate to vigorous physical activity of 38% and a 17% increase in metabolic equivalent (MET) rate during recess. Additionally, EMG hosted six professional development conferences providing 36 hours of health and wellness training to 275 teachers, and provided funding and continuing PE certification opportunities to 48 teachers. EatMoveGrow also supported a second program focused in the high-priority area of oral health identified by a Louisiana Service Region B (SRB) needs assessment and screenings, and Medicaid utilization data. This program utilized the CDC evidence-based prevention methods offering school-based screening at schools, where 3,500 dental sealants were placed, and 1,500 doses of fluoride varnish were applied. EMG also piloted the first school-based clinic partnership with the state's Medicaid managed care organization (MCO) to provide case management services for children identified with urgent care needs during clinic visits. The main modifications made to these models were (1) combining the successful elements of multiple evidence-based programs into one cohesive project approach, (2) adding biometric screenings and accompanying send-home materials and parental education offerings, and (3) including Polar Accelerometer Classroom Studies and multiple physical activity technical assistance resources to increase physical activity opportunities for all children. The baseline measures that were tracked throughout the grant period to demonstrate health status improvement included documented policy, systems, and environmental (PSE) changes in schools; documented increase in minutes and intensity of school day activity using Polar accelerometer physical activity data; increased healthy lifestyle knowledge evaluated through pre- and post-program student testing; and the number of children receiving in-school oral health services and case management.
Needs Addressed	Louisiana ranks 50th in overall health; however, Service Region B has elevated health needs much greater than that of the state. The population of Louisiana Service Region B is 49% White, 43% Black, and 5% Hispanic (2018-2019 Performance Improvement and Measurement System data). Louisiana also has the highest number of children living in poverty (28%) in the nation (18.4% national average). Statewide, 67% of school-age children are economically disadvantaged. Slightly more, 69%, of children in Service Region B are economically disadvantaged, which also makes them statistically more likely to be obese. Childhood obesity is one of the most pressing public health threats facing Louisiana. According to the 2018 Behavioral Risk Factor Surveillance System (BRFSS), Louisiana ranks fourth in the nation for adult obesity (36.8%). Among children and adolescents, Louisiana also ranks fourth in the nation for obesity (20.8%) (2018 National Survey of Children's Health). Studies indicate that without intervention, 40% of these children will become obese adults. Additionally, research indicates that access to early quality childhood education is an important change that can support people on a path to a healthier life.

	EatMoveGrow's position in the community has disrupted the cycle of poor health that disproportionally impacts children living in Service Region B during their formative years (grades K–3). In 2018, 35% of children (grades 1, 2, and 3) participating in EatMoveGrow had a BMI that categorized them as overweight or obese, a statistically significant improvement from three years prior (38%) of 3 points. Through the four program goals informed by evidenced-based strategies and high-touch, one-to-one support, EMG has provided more equitable health opportunities and closed health gaps for more than 15,000 at-risk children. To continue building on this success, EMG will provide schools technical support and resources for healthy school environments.
Target Population(s)	☒ Children (0-12)
Services and Activities	EMG provides support to schools to create an infrastructure for health by starting with developing school wellness committees. The EMG program includes direct interventions, such as curriculum implementation, support for policy changes, support for grant acquisition, technical assistance, and school-based oral health services.
Project Results	
Outcomes	**Improved health knowledge and practice:** • 10% increase in pre- and post-knowledge tests • 22 health and wellness school policies enacted by EMG schools including healthier lunchrooms, increased recess, healthy snack policies, field day activities, and promotion of water over sugary beverages • 30 new wellness committees created **Increased access to healthy living opportunities:** • 15 new resources connected to schools (e.g., water bottle filling stations, school garden, cafeteria enhancements, online classroom activity program) **Decreased BMI levels in the target population:** • 2019 BMI numbers showed 43% of EMG participants' BMI data moved in a healthy direction • 82% of schools made nutrition improvements • 93% of schools increased minutes and intensity of physical activity • Students were significantly more active after Painted Play Spaces were implemented (14%, 15%, and 20%) at three schools that were examined • In-class interventions like the Walking Classroom and GoNoodle had smaller but still statistically significant increases in activity level for academic time • Increased classroom activity minutes by 2,158,530 minutes with the GoNoodle resource **Increased access to oral health services:** • 22 school-based sealant/fluoride varnish clinics conducted over the grant period in dentally underserved parishes • Creation of the Rural Oral Health Network, which includes LSU School of Dentistry, LSU School of Public Health, and Louisiana Department of Health
Sustained Impacts	☒ Some parts of the program will be sustained EMG intentionally utilized the WSCC model to create an infrastructure for sustainable PSE changes in the rural environment of health. EMG health educators supported WSCC-based

	PSE changes to include assembling proficient SWCs, offering highly specialized technical assistance to improve all aspects of school capacity around physical activity and nutrition, and implementing sustainable GUFT curricula in kindergarten to third-grade classrooms throughout the region. EMG's success stands out from other projects' successes because of their capacity- and community-building. These aspects are crucial because they help to create the sustainability that is critical in creating the long-term public health improvement associated with the project. While embedded health educators will no longer serve as champions within schools, the sustained impacts of the project include: • **Policy changes within schools.** Providing schools with healthy lifestyle curricula for both classrooms and activity periods will prepare students to make healthy decisions for a lifetime. Policy changes surrounding minutes and intensity of student activity during the school day will create lifelong awareness for personal health. The PSE focus and assessment training provided by EMG prepares SWCs to continue work on their unique health priorities, independently serving students in perpetuity. • **Continued use of EMG resources.** Forty schools will permanently retain the rights to full GUFT curriculum in 200-plus individual classrooms. The physical activity and nutrition resources and physical environmental changes at EMG schools (i.e., Painted Play Spaces, Walking Classroom, PE equipment, school gardens, water bottle fill stations, PE continuing education) will serve Service Region B schools well into the future. • **Access to services.** Throughout the state, dentally underserved areas will have new access to Medicaid case management for eligible children who face barriers to access. Increased access to evidence-based oral health prevention in the highest-need dental Health Professional Shortage Area parishes of Service Region B will also be available. • **Continuation of activities and services.** With the improvement in student performance and improved school morale, school administrators valued EMG activities as a creditable program. Involving parents and students in meaningful roles on SWCs has empowered them as advocates for EMG continuation. These local leaders within each school will provide ongoing advocacy and continue to build the culture of health throughout rural Louisiana. • **Leveraged support through other grant-funding opportunities.** Through EMG technical assistance, schools have received an additional $82,885 from other grant opportunities to support school health environments.
Challenges and Lessons Learned	**Lack of Department of Health and Department of Education health positions staffed at the local level:** Louisiana faces challenges in serving rural Louisianans because the Department of Health and the Department of Education are responsible for statewide support to 64 parishes. However, these agencies have no local offices or staff. Without community-level presence, rural communities are left without access to many basic services. EMG plays an important role in connecting to, advocating for, and ensuring the delivery of the services and resources from state agencies to which these communities are entitled. **Rural schools lack guidance and resources for recess and classroom physical activity**: Louisiana does not require elementary schools to have daily recess or classroom physical activity but requires public schools to provide at least 150 minutes per week of quality moderate to vigorous physical activity for students. With little guidance around recess or classroom physical activity, schools do not have the resources, skills, knowledge, or facilities to support safe and engaging physical activity. EMG's interventions directly support more movement in schools through providing recess enhancements, curriculum for classroom physical activity, and training for teachers on implementation. **Rural schools lack support and resources for PE curriculum:** Louisiana requires

	students to take PE for 150 minutes per week in elementary school and middle school. However, the state does not have a method for enforcing the PE requirements and does not provide schools or school districts with a recommended curriculum or adequate budgets for equipment. EMG has the potential to broadly share program successes in utilizing evidence-based free PE curriculum (Online Physical Education Network, or OPEN) and providing staff continuing education for uncertified teachers tasked with PE responsibilities. **Vast geography:** While EMG consortium members are located in the southern portion of Service Region B (SRB), the neediest communities are located in the northernmost portion of the region. To address the challenge of expanding services to the most northern areas of SRB, EMG leadership will continue to seek new partnerships in the northern portion of the region. This will allow the program to serve the highest-need schools more richly in Catahoula and Concordia parishes.
Accomplishments/ Recognition	The EMG team's fidelity to best practices was successful by engaging with schools as members of the community and tailoring the support. This empowers the schools and builds capacity. Once the people at a school believe they can be healthier, EMG's mission becomes part of their school's culture, and success follows. Schools' successes occur naturally as teachers and administrators share their stories with peers, and this creates credibility and buy-in for the program. The culmination of years of work, strong partnership development, a multitude of interventions, and the success of integrating EMG health educators into schools have created an unprecedented impact on obesity in EMG schools — last year BMI numbers showed 43% of EMG participants' BMI changed in a healthy direction. The EatMoveGrow formula is working. Further, Aetna Foundation's National Health Equity Workgroup utilized the EMG model as a guide to rural communities to bridge access gaps. A representative from EMG also now serves as a Louisiana representative to the Oral Health 2020 Network and the Louisiana Medicaid Quality Improvement Oral Health Subcommittee. EMG staff have presented at the Rural Oral Health Summit at Campbell University and the HRSA National Conference. EMG staff have also presented at the Louisiana Association of Health, Physical Education, Recreation, and Dance (LAHPERD) convention; the Southern Childhood Obesity Conference; and the Bi-Annual Childhood Obesity Conferences on successful implementation of EMG programs and outcomes. Further, EMG was presented the OPEN PhysED Impact Award at the 2017-2018 SHAPE Conference in Nashville, Tenn., the HRSA Champion of Leadership Award in 2018, and the 2017-2018 Service Award by LAHPERD.
Consideration for Program Replication/ Implementation	Two factors are of key importance for anyone wanting to implement a program similar to EMG. First, it is critical to identify a champion at each school who will be an advocate for the program. From experience, it is the PE teachers or administrators who are most often the champions, but anyone who is committed to health is viable. Second, the health coordinators must be open to listening to the needs of the school. Schools are more likely to implement interventions they believe serve their needs. Building a strong relationship with the school is more important than any single intervention that EMG offers, and once a strong relationship is established, other interventions are more likely to be successfully implemented.

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Glossary of Terms[1]

Term	Description
Behavioral/mental health	Behavioral health is the promotion of emotional health, the prevention of mental illnesses and substance use disorders, and treatments and services for mental and substance use disorders. Mental health is a person's condition with regard to their psychological and emotional well-being.
Cancer care management	Cancer care management is a set of activities intended to improve the care of patients with cancer and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage cancer.
Cardiovascular disease (CVD) care management	Cardiovascular disease (CVD) care management is a set of activities intended to improve the care of patients with CVD and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage CVD.
Case management	Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.
Chronic disease management	Chronic disease management is an integrated care approach to managing illnesses that includes screenings, check-ups, monitoring and coordinating treatment, and patient education.
Community-based care coordination	Community-based care coordination is a partnership among health care professionals, clinics and hospitals, specialists, pharmacists, mental health professionals, community services, and others working together to provide patient-centered, coordinated care.
Community-based organization (CBO)	Community-based organizations are nonprofit organizations that service local community needs through volunteers, sponsorships, and donations.
County health department	A county health department is a basic function of a county government that develops, implements, and administers programs and services that are aimed at maintaining a healthy community.
Critical Access Hospital (CAH)	Critical Access Hospital is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services. Eligible hospitals must meet the following conditions to obtain CAH designation: have 25 or fewer acute care inpatient beds, be located more than 35 miles from another hospital, maintain an annual average length of stay of 96 hours or less for acute care patients, and provide 24/7 emergency care services.
Diabetes care management	Diabetes care management is a set of activities intended to improve the care for patients with diabetes and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage diabetes.
Evidenced-Based Practice	The development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioral science theory and program planning models.[2]

[1] U.S Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy Delta States Rural Development Network Program Funding Opportunity Announcement, Fiscal Year 2020. https://www.hrsa.gov/grants/find-funding/hrsa-20-087

[2] Brownson, Ross C., Elizabeth A. Baker, Terry L. Leet, and Kathleen N. Gillespie, Editors. Evidence-Based Public Health. New York: Oxford University Press, 2003. https://phpartners.org/tutorial/04-ebph/2-keyConcepts/4.2.2.html.

Federally Qualified Health Center (FQHC)	Federally Qualified Health Centers are community-based health care providers that receive funds from the Health Resources and Services Administration (HRSA) to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.
Health education/promotion and disease prevention	Health education is any combination of learning opportunities designed to facilitate voluntary adoption of behaviors conducive to good health. Health promotion is any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health. Disease prevention is specific, population-based and individual-based interventions for primary and secondary (early detection) prevention, aimed to minimize the burden of diseases and associated risk factors.
Health screenings	Health screenings are the use of technology and procedures to differentiate those individuals with signs and symptoms of a disease from those less likely to have the disease.
Network	A network is a formal organizational arrangement among at least three separately owned health care providers or other entities that provide or support the delivery of health care services. The purpose of a network is to foster collaboration and integration of functions among network entities to strengthen the rural health care system.
Obesity	Obesity is a condition characterized by the abnormal or excessive accumulation and storage of fat in the body. In children, obesity is defined as a BMI at or above the 95th percentile. In adults, obesity is defined as having a BMI of 30 or more.
Oral health	Oral health is the regular preventive care of the teeth and gums.
Other hospital (non-CAH)	Critical Access Hospital is a designation given to eligible rural hospitals by the Centers for Medicare and Medicaid Services. Eligible hospitals must meet the following conditions to obtain CAH designation: have 25 or fewer acute care inpatient beds, be located more than 35 miles from another hospital, maintain an annual average length of stay of 96 hours or less for acute care patients, and provide 24/7 emergency care services.
Pediatric care	Pediatric care is a branch of medicine that focuses on the health needs of newborns, children, and adolescents, including preventive care, sick visits, mental health services, wellness exams and physicals, and medication management.
Promising Practice	A model with at least preliminary evidence of effectiveness in small-scale interventions or for which there is potential for generating data that will be useful for making decisions about taking the intervention to scale and generalizing the results to diverse populations and settings.21 An example of a promising practice is a small-scale pilot program that generates positive outcome results and justifies program expansion to new access points and/or service.
Population health	Population health are the health outcomes of a group of individuals, including the distribution of such outcomes within the group. Population health outcomes are the products of multiple determinants of health, including medical care, public health, genetics, behaviors, social factors, environmental factors, and the distribution of disparities in the populations. Improving population health could impact disease prevalence.
Primary care services	Primary care services are services provided to a patient around health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of health care settings.
School-based care coordination	School-based care coordination is care coordination in schools that involves school nurses organizing the care of students by sharing information and maintaining communication among those concerned with the needs and care of students with chronic conditions. Those involved in this integrated health care include families, health care providers, teachers, and other school staff members.

Telehealth/telemedicine	Telehealth is the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.
Transitions of care	Transitions of care is the movement of a patient from one setting of care to another. Settings of care may include hospitals, primary care practices, specialty care practices, long-term care facilities, home health, and rehabilitation facilities.
Women's health	Women's health refers to the branch of medicine that focuses on the treatment and diagnosis of diseases and conditions that affect a woman's physical and emotional well-being.

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Regional Service Areas

During this grant cycle, all the Delta States will have regional service areas. These service areas are based upon natural geographic as well as State Public Health System Regional formations. Alabama, Illinois, Kentucky and Tennessee have single-service regions that encompass all their Delta counties. Due to the higher number of counties/parishes located in the States of Arkansas, Louisiana, Mississippi and Missouri in relation to their Delta States counterparts, these States will have two regional service areas. The regional service areas will allow the Delta Grant Program to sustain a greater and more efficient impact across a larger geographical distance, wherein multiple recipients will be awarded to address prevalent health care issues and disparities.

The service areas for single-service region states are defined as follows:

State	Service Region
Alabama	**Service Region A:** Barbour, Bullock, Butler, Choctaw, Clarke, Conecuh, Dallas, Escambia, Greene, Hale, Macon, Marengo, Monroe, Perry, Pickens, Sumter, Washington, Wilcox
Illinois	**Service Region A:** Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Perry, Pope, Pulaski, Randolph, Saline, Union, White, Williamson
Kentucky	**Service Region A:** Ballard, Caldwell, Calloway, Carlisle, Christian, Crittenden, Fulton, Graves, Hickman, Hopkins, Livingston, Lyon, Marshall, McCracken, McLean, Muhlenberg, Todd, Trigg, Union, Webster
Tennessee	**Service Region A:** Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, McNairy, Madison, Obion, Tipton, Weakley

The service areas for multi-service region states are defined as follows:

State	Service Region
Arkansas	**Service Region A:** Arkansas, Ashley, Bradley, Calhoun, Cleveland, Chicot, Dallas, Desha, Drew, Grant, Jefferson, Lee, Lincoln, Lonoke, Monroe, Phillips, Ouachita, St. Francis, Union **Service Region B:** Baxter, Clay, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Marion, Mississippi, Poinsett, Prairie, Randolph, Searcy, Sharp, Stone, Van Buren, White, Woodruff
Louisiana	**Service Region A:** Caldwell, E Carroll, Franklin, Grant, Jackson, La Salle, Lincoln, Madison, Morehouse, Natchitoches, Rapides, Richland, St. Helena, Tangipahoa, Tensas, Union, Washington, West Carroll, West Feliciana, Winn **Service Region B:** Acadia, Allen, Ascension, Assumption, Avoyelles, Catahoula, Concordia, Evangeline, Iberia, Iberville, Jefferson, Lafourche, Point Coupee, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Landry, St. Martin, West Baton Rouge
Mississippi	**Service Region A:** Attala, Benton, Bolivar, Carroll, Coahoma, Holmes, Grenada, Lafayette, Leflore, Marshall, Montgomery, Panola, Quitman, Sunflower, Tallahatchie, Tate, Tippah, Tunica, Union, Washington, Yalobusha **Service Region B:** Adams, Amite, Claiborne, Copiah, Covington, Franklin, Humphreys, Issaquena, Jefferson, Jefferson Davis, Lawrence, Lincoln, Marion, Pike, Sharkey, Simpson, Walthall, Warren, Wilkinson, Yazoo
Missouri	**Service Region A:** Carter, Crawford (except in Sullivan City), Dent, Douglas, Howell, Iron, Oregon, Ozark, Phelps, Reynolds, Ripley, Shannon, Texas, Wright, Butler, Wayne **Service Region B:** Bollinger, Cape Girardeau, Dunklin, Madison, Mississippi, New Madrid, Pemiscot, Perry, St. Francois, St. Genevieve, Scott, Stoddard, Washington

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