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*Rural Health*  
**INFORMATION**



**Understanding Health Disparities in Rural America  
- Insights from the CDC MMWR Rural Health Series**

## Housekeeping

- Q & A to follow – Submit questions using Q&A area
- Slides are available at <https://www.ruralhealthinfo.org/webinars/health-disparities>
- Technical difficulties please call 866-229-3239

# Featured Speakers



**Tom Morris**, Director, HRSA Federal Office of Rural Health Policy



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## Racial and Ethnic Health Disparities Among Rural Adults – United States, 2012-2015

**Cara V. James, PhD**

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## Background

- Health differences have been documented between rural and urban dwelling adults
- Some rural health studies have reported on a particular state or geographic region and have been focused on one or two racial and ethnic populations
- Rural communities are becoming more diverse
  - Limited studies have presented national estimates on the varying health status of racial and ethnic groups among rural dwelling adults
  - Unique health and access to care challenges experienced by rural racial and ethnic populations may be overlooked when data are not analyzed for specific population groups



## Background

- Increased attention on rural health issues presents an important opportunity for decreasing disparities in health and health care access between rural and urban communities
- Hispanics, Asians, and NHOPIs represented more than half of the population growth in rural communities (2012)<sup>1</sup>
  - Changing demographics can lead to unmet health needs among new and growing populations
  - Necessary for health care providers to understand and address the unique needs of the populations they encounter

1) [http://www.ruralhome.org/storage/research\\_notes/rrn-race-and-ethnicity-web.pdf](http://www.ruralhome.org/storage/research_notes/rrn-race-and-ethnicity-web.pdf)



## Study Design

- Analyzed 2012-2015 self-reported Behavioral Risk Factor Surveillance System (BRFSS) data from all 50 states and DC on demographic and health characteristics of the US population aged  $\geq 18$  in rural areas
- Identified counties in the BRFSS through a data use agreement obtained from CDC
- Used 2013 NCHS Urban-Rural classification scheme for counties--categorizes counties as large central metropolitan, large fringe metropolitan, medium metropolitan, small metropolitan, micropolitan, and noncore (rural).
  - There were 1,325 noncore counties and 6.1% of the US population lived in these counties.
  - The study sample for most variables contained 263,054 adult respondents in rural counties
- Used SAS-callable SUDAAN software, which takes into account the complex sample design of BRFSS, to analyze data.



## Characteristics Assessed

### Demographic Characteristics

- Race/ethnicity
- Age
- Sex
- Marital status
- Educational attainment
- Annual household income
- Employment status
- Census region
- Census division

### Health-Related Quality of Life

- Fair or Poor Health Status
- Frequent physical distress ( $\geq 14$  days in poor physical health in past 30 days)
- Frequent mental distress ( $\geq 14$  days in poor mental health in past 30 days)
- Activity limitation because of physical, mental, or emotional problems

### Health Care Access and Use

- Could not see doctor in past 12 months because of cost
- Health care coverage
- At least one personal doctor or health care provider

- Length of time since last routine checkup
- Cervical cancer screening
- Breast cancer screening
- Colorectal cancer screening

### Chronic Health Conditions

- Number of (selected) chronic conditions
- Depressive disorder
- Obesity
- Severe Obesity

### Health Behaviors

- Cigarette smoking
- Binge drinking
- No leisure-time physical activity in past month



## Selected Findings: Demographic Characteristics

### Age

- Compared with rural non-Hispanic whites, rural racial/ethnic minorities were more often in the youngest age category (18-44 years).
  - 66.0% of Hispanics
  - 60.5% of Asians and NHOPIs
  - 49.3% of AI/ANs
  - 43.7% of non-Hispanic blacks
  - 36.9% of non-Hispanic whites

### Educational Attainment

- Fewer Hispanics (6.2%), non-Hispanic blacks (8.4%), AI/ANs (8.5%) were college graduates, compared with non-Hispanic whites (16.0%).
- More Asians and NHOPIs (35.4%) were college educated.

### Household income

- More non-Hispanic blacks (61.8%), AI/ANs (56.3%), and Hispanics (53.1%) had annual household incomes  $< \$25,000$  than non-Hispanic whites (31.8%).

### U.S. Census Region

- The largest proportion of 4 out of 5 populations lived in the Southern region
  - 93.9% of non-Hispanic blacks
  - 59.1% of Hispanics
  - 37.0% of Asians and NHOPIs
  - 43.9% of non-Hispanic whites
- The largest proportion of AI/ANs (38.2%) lived in the Western region.



## Selected Findings: Health-related Quality of Life

- **Fair or Poor Health Status**
  - Rates of self-reported fair or poor health were higher among AI/ANs (28.9%), non-Hispanic blacks (28.8%), and Hispanics (28.4%) compared with those for non-Hispanic whites (18.5%)
  - This rate was lower among Asians and NHOPIs (10.4%)
- **Frequent Mental Distress**
  - Compared with non-Hispanic whites (12.5%), the prevalence of frequent mental distress was higher among AI/ANs (17.1%) and non-Hispanic blacks (13.9%)
  - This rate was lower among Asians and NHOPIs (5.4%)



## Selected Findings: Health Care Access and Use

- **Health Care Coverage**
  - Fewer non-Hispanic blacks (73.2%) and Hispanics (61.1%) reported having health care coverage compared with non-Hispanic whites (83.9%)
- **Could Not See Doctor in Past 12 Months Because of Cost**
  - More non-Hispanic blacks (24.5%), Hispanics (23.1%), and AI/ANs (19.1%) said they could not see a physician when needed because of cost than non-Hispanic whites (15.0%)
- **Cancer Screening**
  - Among women aged 50–74 years, more non-Hispanic black women (77.2%) but fewer Hispanic women (60.1%) had a mammogram in the past 2 years compared with non-Hispanic whites (73.4%)
  - Among those aged 50–75 years, fewer non-Hispanic blacks (53.6%), Hispanics (43.4%), and AI/ANs (53.4%) than non-Hispanic whites (61.7%) were up to date with colorectal cancer screening.



## Selected Findings: Health-Related Behaviors

- **Cigarette Smoking**
  - Fewer Hispanics (17.0%) and Asians and NHOPIs (10.9%) were current smokers than non-Hispanic whites (24.7%)
- **Binge Drinking**
  - The prevalence of binge drinking was lower among Hispanics (14.3%), non-Hispanic blacks (11.7%), and Asians and NHOPIs (9.9%) than among non-Hispanic whites (16.3%)



## Selected Findings: Chronic Health Conditions

- **Number of Chronic Conditions**
  - More non-Hispanic blacks and AI/ANs (40.3% of both groups) than non-Hispanic whites (36.0%) reported having multiple chronic health conditions.
  - Fewer Hispanics (27.4%) and Asians and NHOPIs (20.7%) reported multiple chronic health conditions.
- **Depressive Disorder**
  - Depression was more common among AI/ANs (23.2%) than among non-Hispanic whites (20.3%) and less common among non-Hispanic blacks (15.8%), Hispanics (15.9%), and Asians and NHOPIs (5.8%)
- **Obesity**
  - Obesity and severe obesity (45.9% and 12.1% respectively) were more prevalent among non-Hispanic blacks than among non-Hispanic whites (32% and 5% respectively).
  - Obesity (15.5%) was less prevalent among Asians and NHOPIs compared to non-Hispanic whites.



## Implications

- This study found significant racial and ethnic social contextual differences among rural residents
  - Rural racial and ethnic minorities tended to be younger than non-Hispanic whites
  - Rural non-Hispanic blacks, Hispanics, and AI/ANs tended to be poorer and have lower educational attainment
- Developing and implementing future programs and policies to advance health equity in rural communities:
  - Increases understanding of the unique needs of each racial and ethnic population
  - Takes into consideration the variations in the social determinants of health within and among groups



## Next Steps

- More research is needed to:
  - Understand the interaction between race and ethnicity and geography (i.e., regional, state, and local influences)
  - Assessing racial and ethnic disparities within rural communities
  - Monitoring how changing demographics are influencing health disparities among new and growing populations



# Thank you

## Racial/Ethnic Health Disparities Among Rural Adults — United States, 2012–2015

<https://www.cdc.gov/mmwr/volumes/66/ss/ss6623a1.htm>

DISCLAIMER: The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of either the Centers for Medicare & Medicaid Services or the Centers for Disease Control and Prevention.



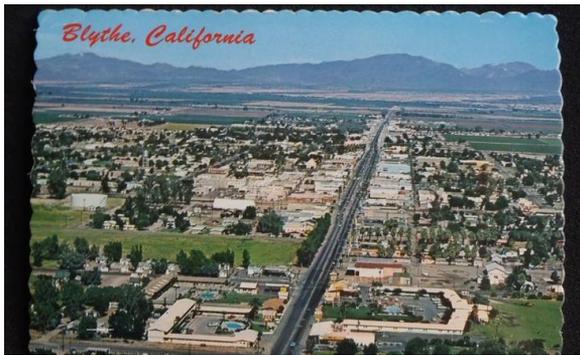
**CONNECTING THE  
DOTS TOWARDS A  
HYBRID INTEGRATED  
HEALTHCARE  
REFORM MODEL IN  
RURAL  
COMMUNITIES**



**PALO VERDE HOSPITAL**  
*Bringing Health & Care Together*



PALO VERDE HOSPITAL DISTRICT 18



**OUR AREA**

BLYTHE CA IS CONSIDERED UNDER THE HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) AND SERVES THE MINORITY WHOM ARE ENROLLED IN MEDICAL SERVICES. ACCORDING TO THE 2015 U.S. CENSUS, BLYTHE IS 23.2% BELOW THE NATIONAL POVERTY LEVEL AND TO INCLUDE, 16.6% ARE WITHOUT INSURANCE

**IN ADDITION**

Of the nearly 19 million patients currently served through these HRSA-funded health centers, 63 percent are racial and ethnic minorities, and 92 percent are below the federal poverty level.

**FURTHERMORE**

There was a Gap identified with the Palo Verde Children's Outreach HRSA Diabetes Grant; out of every 10 students 6 were considered obese and/or over the 95<sup>th</sup> percentile for K-6<sup>th</sup> grade school aged children. (the dominant population was Hispanic)



**Needs:**

**HEALTH DISPARITIES AMONG RACIAL AND ETHNIC MINORITIES WITHIN RURAL AREAS**

- Lack of access to care
- Need For economic development
- Need specialty care
- Medi-Cal & healthcare Services for the minority

## CONNECTING THE DOTS... WHOLE PERSON CARE

- Community Outreach (Parent/Community Support)
- Building Partnerships/Consortium Team Building (Investors, Stakeholders-Riverside County, Local Supports)
- Utilizing All Resources (Educators, Volunteers, etc.)
- Education (Bienestar, BuenaVida, SPARKS) & Training (Promotoras-Community Health Workers, Parents, Teachers and Students)

Chronic Collaborative Care Coordination for high risk population

A1c Monitoring, BMI Calculation, PhQ2/9, SBRT, Training of symptoms of depression/suicide

E.H.R., Data analytics for sustainability  
Integration of Physical and Behavioral

PALO VERDE HOSPITAL DISTRICT 21



## ADDRESSING MULTIPLE HEALTH DISPARITIES FOR MINORITIES WITHIN RURAL COMMUNITIES

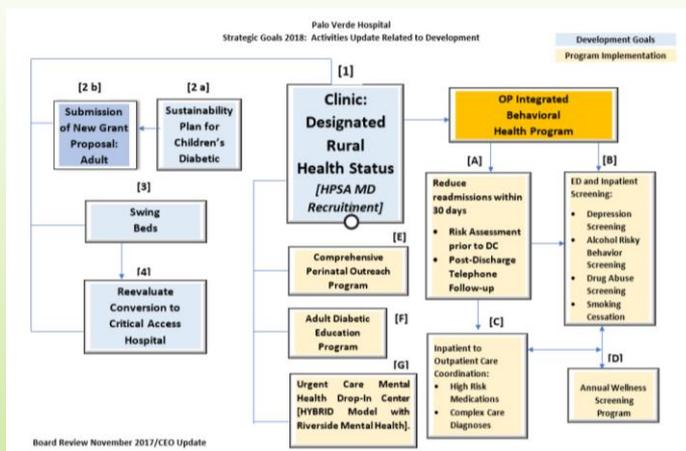
- Diabetes & Depression Education/Awareness
- Substance Abuse
- Annual Wellness
- PhQ-2/9, training of symptoms of suicide/depression

PALO VERDE HOSPITAL DISTRICT 22

Values, beliefs, vision, goals

PVHD Goals:

1. Transform and strengthen health care reform within minority groups
2. Integrate a whole person care with warm hand-offs in multiple settings.
3. Reduce the recidivism of high utilizers for established reduction in healthcare cost by promoting health awareness and education.
4. Establish sustainability with EHR, building Partnerships (Medi-Cal, TCPI-ACA, HRSA) and data collection.
5. Inpatient and outpatient care coordination w/ neighboring private practices.
6. Access to a CM-clinical health coach, reduce readmissions, lower A1c, physical and behavioral health integration.
7. Health education, community outreach & care coordination, staff training and developments.
8. 5150 de-escalation drop-in center in collaboration with RCMH, community health collaboration.
9. EHR value-based payment (templates & billing/coding) tools, capturing of data analytics and interface (EHRs) to support transformation efforts for best practice and patient quality care in whole person and warm hand offs.



PVHD STRATEGIC GOALS 2018

# ACHIEVEMENTS

## PALO VERDE HOSPITAL HAS BRIDGED THE GAP AND INTERTWINED HEALTHCARE DELIVERY WITH RIVERSIDE COUNTY

New Drop In Center For The Mental Health Population at Palo Verde Hospital.



\*\*\*MEDIA ADVISORY\*\*\*

FOR IMMEDIATE RELEASE  
December 14, 2017

CONTACT:  
Darin Schemmer, Office of Fourth District Supervisor V. Manuel Perez, (760) 863-8211

### County Officials to Announce Expanded Behavioral Health, Homeless Outreach Efforts in Blythe

**What:** Supervisor V. Manuel Perez and the Riverside University Health System – Behavioral Health invite media and community members to join them as they announce an expansion of behavioral health and homeless services in the Blythe area

These efforts were developed in response to community needs expressed to Supervisor Perez during his visits and meetings in Blythe and his engagement with Riverside County staff

**When:** 2 p.m. Tuesday, December 19  
Press Conference to Urveil Behavioral Health's Blythe Community Needs Program

**Where:** Blythe City Council Chambers  
235 N. Broadway, Blythe

###

Supervisor V. Manuel Perez represents the eastern two-thirds of Riverside County on the Riverside County Board of Supervisors. Stretching from Palm Springs and Desert Hot Springs south to the Salton Sea and east to Blythe and the Colorado River, the 4<sup>th</sup> District is the largest geographical district in the county.

Supervisor Perez's office hours are 8 a.m. to 5 p.m. Monday through Friday.

## (Medi-2020) Connecting The Dots: Hybrid Integrated Whole Person Healthcare Reform



Liz Manjarrez, Sandra Anaya, Christa Rohde, Megan Allen, and Nemmir Salem, Palo Verde Hospital District



### Introduction

PVHD goals for Medi-2020 is to bridge the whole person care gap by connecting the dots; this will lead the transformation of a "Hybrid Integrated Whole Person Healthcare Reform". In building partnerships (connecting the dots) with the PRIME Initiative, Riverside County Mental Health-RCMH, Transformation Clinical Practice Initiative-TCPI, and Health Resources Service Administration-HRSA it will build a robust healthcare transition program. In addition to providing continuity of care, "warm hand-off" and "whole person" treatment, it will ensure patient best quality health and a reduction in healthcare disparities.

### Identifying The Gap

Since 2015, the PVHD is a part of the Medicare-TCPI and the HRSA Outreach Program. However, there was still a gap in healthcare services; lack of clinical assessment, care coordination, behavioral health and billing/coding structure. Therefore, with the PRIME implementation (1.1, 2.2, & 2.3) the gap is closed. Once the gap is closed, the PVHD will provide healthcare services to all populations: Medi-Cal, Medicare, Non-Insured and Private Pay. With the continuum of community collaboration, data sharing techniques in best practices, and whole person care, these innovative projects will intertwine with the Medi-2020 healthcare redesign.

### Transition & Implementations

The transition and implementation of the PRIME Project Medi-Cal, Allscripts-EHR, TCPI-Lightstream (Interface, Mediators), and adaptive clinical assessments, will exchange an organic collaborative healthcare redesign. Resulting its capabilities in practice a hybrid integrative approach that intertwines Palo Verde Hospital and it's partnerships healthcare implementations. Furthermore, the PVHD has only covering the PRIME Population but also covers the Medicare, private pay, and non-insured with its integrated EHR's (Allscript) billing approach. Most importantly, the PVHD will be able to sustain and increase their return of investments with these projects and methodologies. Therefore, in reaching Medi-2020 this transition and implementation will position each healthcare community to pursue a new level of improved quality healthcare by producing efficiency with warm hand-offs and a seamless transition in patient quality care over the coming years.

**Partnerships**

- Building Bridges
  - Riverside County Mental Health
  - California Health Assoc.
  - PRIME
  - TCPI & HRSA
- Connecting The Dots
  - PVSD
  - City of Blythe
  - Desert Prep Academy

**Collaboration**

- PRIME-Medi-Cal
- TCPI/Medicare
- HRSA & Medicare

**WHOLE PERSON CARE**

- Medical, E.H.R., Data analytics for sustainability
- Complex Collaborative Care Coordination for high risk population
- Integration of Physical and Behavioral Health

**WHOLE PERSON CARE**

- Medicare, E.H.R., Data analytics for sustainability
- Complex Collaborative Care Coordination for high risk population

**WHOLE PERSON CARE**

- Non insured, Medi-Cal, Medicare, E.H.R., Data analytics for sustainability
- In school outreach/diabetic screening, ALC Health Ed. Parent Program

**GAP**

**YR End/DY12**

**Medi 2020 The Outcome:** Behavioral health, outpatient care, physical health, reduce readmissions, lower AIC, physical and behavioral health integration, Health education, community outreach & care coordination, staff training and developments, SISO de-escalation drop-in center in collaboration with RCMH, community health collaboration, EHR value-based payment (templates & billing/coding) tools capturing of data analytics and interface (EHR) to support transformation efforts for best practice and patient quality care in whole person and warm hand-offs, Quality transition discharge planning for warm hand-offs, Whole person care for everyone.

### Blythe, CA

Blythe is regionally located in an under-served rural area on the border of AZ/CA next to the Colorado River. It is also considered under the health professional shortage area (HPSA) and serves the minority whom are enrolled in Medi-Cal services. According to the 2015 U.S. Census, Blythe is 23.2% below the national poverty level and to include, 16.6% are without insurance; therefore, with the integration of the new EHR and PRIME Project it will help identify and assist in Blythe's critical healthcare need. In addition, out of the 24,208 Blythe residents, the PVHD has been serving the community both in an inpatient and outpatient basis, as the following analytics define:

Inpatient: Medicare 48%, Medi-Cal 28%, AHCCCS 2.5%, and 3rd party 16%	HMO 3.4%, self-pay 2.2%
Outpatient: Medicare 25%, Medi-Cal 34%, AHCCCS 1.4%, 3rd party 25%	HMO 2.5%, and self-pay 12%

### Methodologies

For these projects the data collected was obtained following the PRIME Reporting Manual, using total population without any variance and without any local mapping. Clinical staff screened total population patients in ED, Labor and Delivery and outpatient clinic. The metric source utilized and in analyzing the data collection there was Allscripts E.H.R., Excel, SMC, SPM, query reports and manual chart extraction. During this reporting period, the AMS tracking tool template for care coordination was established and utilized as a tracking tool for patient care coordination; tracking of 2 wk increments was used for each encounter and diagnosis.

### Challenges/Results

Some challenges consist of the need for additional staff and training for full encounters to be met. Another challenge was that patients resisted assistance and weren't cooperative with care, there is also a lack of resources, there is no specialty care in the area, due to remote area in addition to HPSA. At this time, PVHD Finance and IT Dept. are continuing to work with Allscripts for new upgrade in updating of templates and coding for billing purposes. A continuum of services and data reports are forthcoming in DY13 in order to meet baseline numbers.

#### 1.1 Integrative Behavioral Health

#### Project 2.2: Care Transitions; Integration of Post-Acute Care

#### 2.3 Complex Care Management For High Risk Medical Populations

PALO VERDE HOSPITAL DISTRICT 26

## Building Tomorrow's Smiles Too

### Linda Matessino, RN, MPH

- Grant Projects Manager

### Innis Community Health Center Inc.

- FQHC with 3 primary sites & 2- School based Health Centers , 1 Fixed based dental & 1 Mobile dental Unit
- Innis, LA – Pointe Coupee Parish in southern Louisiana
- Consortium of 4 other FQHCs operating 5-SBHCs in other rural LA parishes (counties)

### Demographics of Areas Served

- Higher incidence of dental caries in rural populations.
- Additionally, in 2010(nationally) only 40% of children on Medicaid received dental services. In LA it is reported 38%
- All areas in this project are designated:
  - Medically Underserved Areas (MUA)
  - Health Professional Shortage Areas (HPSA)
- Have significant geographic barriers to access to care
- Louisiana has significant oral health statistics
  - 6<sup>th</sup> highest % of 3<sup>rd</sup> grade students in the nation with caries experience (treated or untreated tooth decay) - **65.7%**
  - 2<sup>nd</sup> highest % for untreated tooth decay at **41.9%**. (CDC report)

### Demographics cont'd

- Target areas have a higher % of minorities than does the state or country.
- 3 target parishes and surrounding areas are ranked among the lowest in the state and the nation in per capita income
- All 5 parishes have a higher unemployment rate than the US. The average **-7.6%** (State-6%)(National-4.9%)
- Additionally, the combined % of at-risk students (e.g. eligible for free or reduced lunch) is **77.9%** (2014) compared to **67%** for the state (2014) and **47.5%** US (2013).

### Demographics cont'd

- **Poverty** is a barrier to healthcare in Louisiana.
- Poor, **lower socioeconomic** groups and African Americans are less likely to receive dental care (Rural Healthy People 2010 Report on Oral Health).
- Target area- has high rates of poverty, a large number of African American children, and is located in rural areas where access to care is a challenge and a distinct disparity.
- The **Race** demographics in the area-  
     61% Cauc    < 4% Other  
     35% AA

## Building Tomorrow's Smiles Too History of Grants

**2009-2012:** 3 year grant whereby primary care providers & staff trained to provide oral health screenings + fluoride varnish during well-child visits in primary care settings of 3 FQHCs.

**2012-2015:** 3 yr. grant with shift in access focus to School-Based Health Centers(SBHCs) as Portal of Access operated by rural FQHCs. Goal was ↑Access to kids

**2015-2018:** Expanded into additional SBHCs and added dental case management for referrals.

## Building Tomorrow's Smiles Too



## Building Tomorrow's Smiles Too

### Approach

- Who: School-aged children
- Where: FQHCs with SBHCs
- How: Integrating oral health screening and prevention into primary care, with...
  - Oral health screening within comprehensive physical exam
  - Application of Fluoride varnish (evidence-based to ↓ dental caries)
  - Referral to “dental home” for follow-up care (best practice)
  - Dental Case management (best practice)

## FACTS –ACCESS DISPARITIES

### CHILDREN AT HIGHER RISK OF POOR ORAL HEALTH ARE:

- ✓ CHILDREN IN FAMILIES –LOW SOCIOECONOMIC STATUS
- ✓ CHILDREN WITH LOW UTILIZATION OF DENTAL SERVICES
- ✓ CHILDREN OF RACIAL AND ETHNIC ORIGINS- African Americans, Hispanics, American Indians, and other racial minority groups have disproportionate burden of disease .
- ✓ CHILDREN WHO ARE PUBLICALLY INSURED

## Facts :Disparities cont'd

- A disparity in dental caries exists across socioeconomic and geographic sub-groups in the population
- In children of mothers with a high caries rate, especially untreated caries.
- Significant racial/ethnic disparities in oral health among Children + adults in US.
- AA adults are more likely to report tooth pain, tooth decay, loose teeth, and to have lost more teeth than Cauc adults.
- AA are less likely than Cauc adults to have visited a dentist in the past year.

## Oral Health Care-Disparity

- Rural Healthy People 2010 survey reports oral health ranked 5<sup>th</sup> in need among the 28 focus areas
- Healthy People 2020 initiative contains over 1,200 objectives that serve as a roadmap for tracking the nation's health
- Oral health is 1 of 42 Healthy People topic areas comprising 33 objectives ranging from dental caries , periodontal disease, to access to preventive dental services and program infrastructure

## Barriers to Care-Faced by Families

### Internal

- Parents belief systems & practices anxiety & phobias
- Low parental literacy & understanding
- Lack of parental knowledge re: optimal oral health & prevention
- Home oral care practices viewed asw time consuming when compared to other responsibilities.

### External

- Difficulty locating providers who will take Medicaid pts.
- Lack of health insurance coverage
- Lack of transportation
- Having to miss work to take kids to dentist
- Limited dental hrs to schedule appts.

## Statistics : Yrs. 1 & 2

- Total Oral Health Assessments - 3986  
AA – 64%   Cauc- 33%
- Total Flouride Varnish applications- 3173
- Total Referrals (Preventive & Problematic) – 1511
- Total referrals not seen – 51% - Barriers here

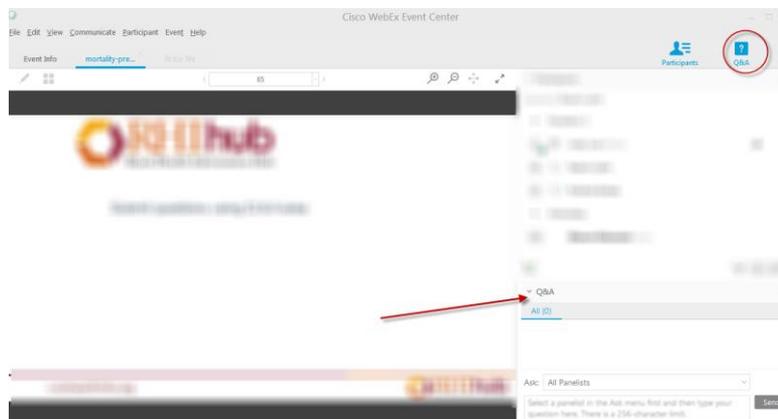
## Building Tomorrow's Smiles Too

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### Thank You!

# Questions?



# Thank you!

- Contact us at [ruralhealthinfo.org](http://ruralhealthinfo.org) with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website

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