



OUTREACH PROJECTS
2004, 2005 and 2006



Note: Map not to scale.

Rural Health
OUTREACH
Grantee Directory
FY 2006

PROJECTS BY STATE

ALABAMA

D04RH04340

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Obesity

East Central Mental Health-Mental Retardation, Inc., has initiated a partnership of community agencies committed to the development and implementation of a comprehensive, countywide health risk prevention and outreach project. The project will focus on preventing school-age obesity and increasing physical activity using the Coordinated Approach to Child Health Model, a school-based nutrition program. Goals of the project are (1) to form a supporting network to the consortia in Alabama's Bullock and Pike counties that reflects the growing cultural diversity; (2) to advance the scope of the existing rural health promotion program to prevent obesity in school-age children; (3) to implement a health prevention and education project in the public schools that will provide school children with the information and skills they need to avoid health-damaging behaviors and to live healthy lifestyles; and (4) to encourage parents and extended family participation in health risk prevention and education programs to dissolve barriers to healthy lifestyles.

The project will target students in grades 3 through 5 in rural Pike and Bullock counties where unmet health needs and at-risk behaviors present serious health risks and contribute to educational and social problems. The target populations will be multicultural, representing all racial, social, and economic backgrounds in the two counties. Contributing to the overall ill health of community youth is the lack of parental awareness concerning health topics and detached parental involvement in child health issues. Implementation of the project will provide students with the skills they need to make healthy choices for life and will strengthen communities by increasing collaboration among parents, teachers, and other school partners.

Access barriers include inadequate or lack of health insurance, lack of Medicaid providers, cultural and spiritual barriers, lack of education and awareness, language barriers, and difficulty getting to a health care facility due to the lack of public transportation. In the past, this project made a significant difference in the lives of youth in Pike County. By expanding this program to Bullock County, more students will be given a head start on a healthier life. Bullock County is designated as a Medically Underserved Area for dental and primary health care professionals.

The network partners consist of eight members of the Pike County Consortium, including East Central Mental Health-Mental Retardation; four members of the Bullock County Consortium; and community supporters in both counties.

D04RH06949

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keywords(s): Heart disease, Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, Disease management, Faith-based health advocacy

The goal of this project is to increase the quality and years of life for individuals of the target population of under and uninsured residents of Talladega County, Alabama with chronic diseases of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes and/or Hypertension. The vehicle by which is through a community partnership using a computer-assisted Parish Nurse Disease Management Program (PNDMP). This PNDMP provides a community based holistic approach and extends the impact of the Parish Nurses with the use of Family Health Advocates (FHAs) using laptop computers to access the management information system. The use of FHAs will expand an existing innovative community disease management program of parish nursing by enabling more clients to be enrolled for a longer period of time. Utilization of a management information system (MIS) by the community consortium providers, a parish nurse and the family health advocates will allow for efficient and effective exchange of information and standardization of data collection in a community setting. Indicators of success of this project will be a 94 percent increase in enrollment, achievement of one or more of individual health goals, an improvement in quality of life as indicated by results of a SF36 survey, a 30 percent increase in pharmaceutical support (or \$250,000), a 50 percent increase in the number of social and health services provided to the target population and a 30 percent increase in the utilization of the community health network MIS. This project builds on existing research on the relationship between spirituality and health, the effectiveness of lay community health workers, and enabling technology. The further development and expansion of a PNDMP in addition to meeting real needs in this rural community provide a replicable model for use in other rural communities.

D04RH06951

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,122 | \$123,292 | \$100,000 |

Keywords: Health promotion/disease prevention (general), School-based primary health care, Faith-based primary health care, Health education

The Rural Assistance Program for Churches and Schools (RAPCS) will provide access to health care for disadvantaged populations in Green, Sumter, and Marengo Counties. These counties are ranked among the poorest in the State and the Nation. They are rural, medically underserved, and have a large African American population. The prevalence rates of numerous chronic health disorders are higher in this area than other comparable areas in Alabama, which overall has higher rates than other States. In addition to higher rates of chronic disease, the area suffers from inaccessibility to health care due to the unavailability of public transportation. There also are major behavioral and social problems, such as teen pregnancy, low birth weight, high tobacco use, and alcohol and drug abuse problems. According to the most recent census data, the average median household income is 36 percent of the State average. These persons also are the ones without health insurance coverage. Those who are covered have government-provided insurance such as Medicare and Medicaid. Census data also show that individuals in the targeted counties have a high school graduation average of 67 percent—below the State average. Low education and employment perpetuate the economic problems and often result in poor health practices and local of knowledge about accessing and using health care resources. These factors and others provide insurmountable barriers to health care in this region of Alabama.

The purpose of this project is two-fold: 1) To improve access to health care by establishing outreach health care sites throughout the counties in schools and churches where people are isolated and lack direct access to health care, and 2) To implement a health education campaign that would increase public awareness of health care resources and services in the community. These goals will be achieved by providing nursing services in local schools and churches; making primary health care services available in schools and churches; and increasing access to preventive health education programs. The target population includes school students, churchgoers, senior citizens, parents, and the working poor. The project consortium includes local hospitals, health centers, school systems, churches, and community-based organizations.

ALASKA

D04RH06909

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Elderly, Telehealth

The service area of this proposed project is the 34 rural communities within the Bristol Bay Area Health Corporation (BBAHC) medical care system in Alaska. Some 8,072 people live in the area, of whom 6,865 are all or part Native. The target population is the 555 persons over the age of 62 that reside in the region. The most significant barriers to care for the elderly are

language and travel to advanced medical care. Some 62 percent of elders in the service area speak a language other than English. Of those, 9 percent do not speak English at all, and 19 percent do not speak English well. There are no connecting roads or bridges between any of the villages either intraregional or to the hospital in Dillingham.

Community Health Aide/Practitioners (CHAP) provide medical services in most of the village clinics, with a few of the subregional clinics staffed with mid-level practitioners that also travel to the smaller villages and provide itinerant care. Telehealth is used increasingly to provide quality health care without the need for the patient to travel. Dillingham has the most accessible hospital; however there is no geriatric specialist available. More advanced care must be sought in Anchorage or beyond. Many elders have to move out of their villages and region as their medical needs increase because of a lack of healthcare services, distance, and travel expenses. This means that an elder is removed from his or her culture, way of life, and family, causing a great deal of stress for both the elder and family members. In the Yup'ik Eskimo and Aleut cultures, the wisdom, knowledge, and life experiences of the elderly are appreciated and acknowledged by the younger generation.

The overall goal of this proposed project is to meet the healthcare needs of elders so they can remain in their communities and stay connected to their homes and families for as long as possible. There are five program goals: 1) To increase access to specialized medical care for persons over the age of 62; 2) To increase patient translation and advocacy services for persons over the age of 62; 3) To increase provider staff knowledge of geriatrics; 4) To increase public awareness and knowledge of geriatric issues; and 5) Increase Medicare enrollment in the target population. Strategies to meet these goals include contracting with an itinerant physician specializing in gerontology or internal medicine; referring elders for assessments and treatment; providing transportation for elders to the specialty clinic; and using telehealth capabilities to provide services to elders in the remote villages; hiring two FTE Patient Advocate/Translators to assist elders in accessing care; providing staff with in-service training and community education regarding geriatric issues; and providing education to identified patients regarding the benefits of applying for Medicare coverage.

The realization of these goals will greatly enhance and improve all aspects of health care for the elderly, which will allow them to remain in their villages and to continue benefiting the entire community. Another benefit of accomplishing these goals is that medical providers, elders, and community members in general will have an increased awareness and knowledge of elder health care issues. Medical staff will be able to provide higher quality health care services with an increased understanding of geriatric assessment and treatment. It is anticipated that this project will be self-sustaining at the end of the 3-year project period.

D04RH06910

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Colorectal cancer

This project will form a Colorectal Cancer Screening Consortium through the Kenaitze Indian Tribe (KIT), the Ninilchik Traditional Council, and the Alaska Native Tribal Health Consortium (ANTHC). Cancer has been identified as the leading cause of death among Alaska Natives, with colorectal cancer as the second leading cause of cancer mortality. For the 5-year period from 1996-2000, Alaska Natives were more than twice as likely to be diagnosed with colorectal cancer as U.S. Whites. A high proportion of Alaska Native colorectal cancers are diagnosed beyond the local stage, suggesting the need for improved screening.

The consortium will serve more than 1,200 Native Alaskan/Native American adults aged 50 to 80 years residing in the rural Alaska communities of Kenai, Soldotna, Nikiski, Kasilof, Sterling, Cooper Landing, Hope, Ninilchik, Anchor Point, and Homer. Lack of flexible sigmoidoscopy services in our tribal health clinics and distance from colorectal screening services in Anchorage are significant barriers to access. Within 3 years, the consortium will increase the percentage of Native Alaskan/Native American adults over age 50 living in the central and southern Kenai peninsula who complete screening for colorectal cancer from the current rate of under 4 percent to a target rate of 50 percent. This goal will be accomplished by developing a flexible sigmoidoscopy clinic at KIT health clinic; sending one advanced nurse practitioner and one registered nurse to ANTHC for approved training in flexible sigmoidoscopy procedures; and conducting weekly flexible sigmoidoscopy clinics to over 500 patients in the next 3 years, with additional colonoscopy referrals to Alaska Native Medical Center.

The consortium will monitor project progress, identify and problem-solve barriers, develop local capacity, and seek ways to expand outreach, networking, and public education. ANTHC will provide intensive training in flexible sigmoidoscopy procedures, as well as onsite follow-up and technical assistance with both Tribes. The two Tribes will set up a referral mechanism, as well as patient pre-screening and flow charts to be placed in patient medical records so that individual patient progress and follow-up can be tracked by medical care providers in each clinic. KIT also will add the Colorectal Cancer package to its RPMS tracking system. Both Tribes will provide patient education and preparation, reminder calls prior to procedures, and assistance with transportation through the low-cost area transit system or mileage reimbursements. Each Tribe will implement public education and outreach.

The project will coordinate its efforts with our local health and social service provider network, the Kenai Health Services Opportunities Collaborative, State Office of Rural Health, State Colorectal Cancer Task Force, and Alaska Tribal/rural providers.

ARIZONA

D04RH06922

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|----------|
| Funding Amount | \$149,996 | \$125,000 | \$99,996 |

Keyword(s): Substance abuse prevention/treatment

The Hardrock Youth Wellness and Prevention Program is a collaborative effort of the Hardrock Council on Substance Abuse, Inc. (a local non-profit corporation), the Hardrock Chapter House (a local governmental subdivision on the Navajo Nation), and the University of Arizona Mel and Enid Zuckerman Arizona College of Public Health's Project EXPORT. The purpose of the collaboration is to strengthen their collective efforts in building a strong infrastructure for substance abuse prevention, intervention and treatment at the community level.

The Hardrock community lies in the heart of the 27,000 square mile boundary of the Navajo Nation and is part of Navajo County in northeastern Arizona. Health disparities are critical health issues for this isolated rural community, especially because of its unique history. It is one of 11 Navajo communities that experienced Federal relocation, land loss and livestock reduction as a result of the 1974 Navajo-Hopi Land Settlement Act. Access to health care is a major problem for the Hardrock community as the distance to hospitals and clinics is over 60 miles away and the community has severely limited and/or nonexistent medical and behavioral health service providers.

The impact and extent of substance abuse has been well documented in the past decade including 19 deaths in the community in 1995. In a recent community-based survey in 2004, 84 percent of respondents reported some association with someone, including themselves, who is abusing alcohol or some other substance. More than two-thirds of respondents knew of someone that was killed due to alcohol or substance abuse since 1995.

The Hardrock Youth and Wellness Program has two main goals: 1) To increase access and participation of youth in substance abuse prevention education by using community-based education programs that encompass the Dine traditional philosophy; and 2) To increase access and participation of youth and their families in culturally appropriate substance abuse intervention and treatment programs. The population to be served will be children and youth (age 4-18) and their families who reside in the Hardrock community. The program will provide direct educational interventions through a 6-week summer program and an additional 2-week long program during winter and spring school breaks. It will also provide intensive outreach, monitoring, and follow up to youth and their families linking them with existing community-based intervention and treatment services.

ARKANSAS

D04RH04335

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$162,765 | \$167,648 | \$172,677 |

Keyword(s): Chronic illness, Diabetes

The consortium for the Chronic Care Education Outreach Program will expand an existing chronic illness self-management education program to focus on the elderly in Woodruff and Prairie counties in the Arkansas Delta region. The program will enhance the capacity of existing community agencies to respond to the needs of the increasing population with diabetes and

other chronic illnesses. Collaboration between community partners will result in organized assessments, planning, and coordination of local resource agencies to cultivate a regional comprehensive continuum of care for people with chronic diseases. The program will use self-management interventions to reduce health disparities and increase access to recommended health care services for people living with diabetes and other chronic illnesses. It also will incorporate a chronic care model used by the Bureau of Primary Health Care and will provide services at long-term care facilities to enhance access by the elderly population. All activities will be coordinated with primary care services currently provided in the area. The program will focus on increased access to prevention, early detection, and treatment of diabetes and cardiovascular diseases through the provision of a comprehensive self-management education class on these chronic illnesses.

Woodruff and Prairie counties, the target counties, have a combined population of 18,280. Seventeen percent of the population is older than 65 years. The Arkansas Department of Health reports that diabetes prevalence increases by age to an estimated 14.6 percent for those older than 65 and estimates that more than 450 residents older than 65 currently have diabetes. In addition, the rates of diabetes, cardiovascular disease, and heart disease are higher in the target counties than in other counties in the state. Residents of Woodruff and Prairie counties live below 200 percent of the Federal poverty level, and the two counties are officially designated as Health Professional Shortage Areas and Medically Underserved Areas. Barriers to access of health services include a 45-minute drive to any kind of specialty care, and much of the population remains undiagnosed for diabetes or cardiovascular disease.

The consortium for the Chronic Care Education Outreach Program consists of White River Rural Health Center, Inc., the lead applicant; Woodruff County Nursing Home; Des Arc Nursing and Rehabilitation Center; Baptist Health; and Arkansas Department of Health Diabetes Control Center.

CALIFORNIA

D04RH05118

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Substance Abuse, Prevention Education

The Mendocino County Health Department and its partners developed the Adolescent Drug Abuse Prevention and Treatment Project (ADAPT) in response to the need for substance abuse prevention and treatment services for rural youth in northern California. ADAPT will team a substance abuse therapist with an intervention specialist to increase youth resiliency—while reducing the incidence and harmful effects of substance abuse—through prevention, intervention, and treatment. The three primary components of the program are substance abuse treatment; prevention education and opportunities for personal growth and development through service learning, project-based modules, and outdoor adventure; and family strengthening services. Program goals are to reduce high-risk behavior for alcohol and other drug use among youth; to increase refusal skills and knowledge of harmful effects of substance

abuse among youth; and to increase prevention knowledge and awareness among parents. Services will be provided at schools, community-based organizations, and county Alcohol and Other Drug Programs (AODP) offices.

Widespread production, use, and abuse of alcohol and other drugs as well as economic impoverishment exist in Mendocino County, which is designated as a Medically Underserved Population. Summary results for the California Healthy Kids Survey show a high level of youth experimentation and involvement with alcohol and other drugs. However, substance abuse treatment services for youth are extremely limited throughout the county, especially in the targeted communities of Willits (population 13,500) and Potter Valley (population 1,900). In Potter Valley, substance abuse treatment is not available in any form; the AODP office in Willits offers limited treatment to youth in alternative school or criminal justice settings, but no treatment to youth in mainstream settings. In addition, residents in both Potter Valley and Willits must travel 25 miles to Ukiah for specialized services, and transportation is very limited. ADAPT will provide services to youth age 13 through 18.

In addition to the lead applicant, the Mendocino County Health Department's Division of Alcohol and Other Drug Programs, ADAPT consortium partners include Howard Memorial Hospital, Nuestra Alianza, Potter Valley Community Center, Potter Valley Community Health Center, Potter Valley Community Unified School District, Sherwood Valley Rancheria, Willits Action Group, and Willits Unified School District.

D04RH06923

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Mobile clinic, Telehealth technology, Primary care services, Specialist consultation

Tulare Local Healthcare District (Tulare District Hospital, TDH) is the lead agency of a consortium composed of. Tulare Community Health Clinic (a Federally Qualified Health Center), public health nurses from Tulare County Office of Education's Migrant Education Program, Tulare County Asthma Coalition, Alta Vista School District, Pixley Union School District, and Love In the Name of Christ (a 501(C)(3) non-profit community based organization).

These partners formed this consortium to address the lack of basic healthcare available in the rural, impoverished areas of Alta Vista and Pixley in Tulare County, which is located in the Central Valley of California. The purpose of the Mobile Clinic/Telehealth Outreach Project is to provide primary health care services and specialist consults, including dental services, to underserved residents in rural Tulare County. TDH will visit each site once a week, on a set schedule, bringing health care directly to the community in a Mobile Health Clinic. Telehealth Monitors placed at each school site will provide live access to the nurse practitioner on the Mobile Clinic, Monday through Friday.

The low income population of these areas is designated a Medically Underserved Population, as well as a Medically Underserved Community. In addition, the target areas are designated as primary care Health Professional Shortage Areas. (Alta Vista is in an unincorporated region east of Porterville, MSSA 231/232.)

The focus of the Mobile Clinic/Telehealth project will be primary care, women's health (with an emphasis on OB care), pediatrics, asthma, diabetes, and hypertension. Specialist consults and dental care will be provided at Tulare Community Health Clinic. Public health nurses from Tulare County Office of Education's Migrant Education Program will work closely with the Mobile Health Clinic to provide these communities with access to health care.

Tulare County has the highest rate of diabetes in the State, and the second highest rate of teenage pregnancy. Central Valley has the highest rate of childhood asthma in California. The target population is Hispanic agricultural workers and their families. The Census Bureau reports that Tulare County has the fifth highest percentage of poverty and the third-highest percentage of people with less than a high school diploma in the nation. Statewide, census statistics reveal that Tulare County has the highest percentage of poverty, unemployment, and lack of education in California. Nearly two-thirds of the population under age 18 in Tulare County live below 200 percent of poverty—the highest rate in the State. Tulare County is the leading agricultural producer in the Nation, yet the Hispanic agricultural workers who harvest these crops live in extreme poverty and suffer from poor housing conditions, malnutrition, and lack of medical care. School officials in the areas targeted by this grant confirm that over 80 percent of students are Hispanic, and 93-100 percent of students at each school qualify for the Federal Free or Reduced Lunch Program.

The Mobile Clinic/Telehealth project will provide primary and preventative medical care for these impoverished communities by taking services directly to the community. By placing permanent telehealth monitors at each site, individuals without transportation can walk to the school sites and receive medical treatment and consultation Monday through Friday. Tulare Community Health Clinic will provide specialist consultations and dental care by referral. Love INC is already well established in all targeted areas, delivering food and basic necessities to the communities through a network of local churches.

D04RH06932

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|----------|
| Funding Amount | \$149,120 | \$124,238 | \$94,942 |

Keyword(s): Satellite clinic, Bilingual specialty services, Telemedicine technology, Substance abuse treatment

Located on Santa Catalina Island, 26 miles off the coast of Long Beach, California, Catalina Island Medical Center (CIMC) provides 24-hour emergency room services, acute care, skilled nursing care, rehabilitation services, and primary care services to residents and visitors of Santa

Catalina Island. There are 3,127 year-round residents of the City of Avalon, the island's only incorporated city. Forty six percent of the island population is Hispanic. Its physical beauty and rustic charm make Catalina an attractive tourist destination, drawing 1,000,000 annual visitors to the island.

While the picturesque Avalon may appear to be an idyllic small town, the City struggles with many of the same problems as much larger cities, and has added barriers to accessing services due to the island's physical isolation from the mainland. Catalina Island is designated a Health Professional Shortage Area. Like most rural facilities, CIMC requires local financial support to keep the doors open. The current needs to be addressed with this project are as follows:

- The rugged West End of Catalina Island has never had local primary medical care services available to its 493 year-round residents, 1,648 summer residents, and hundreds of boaters and divers. To reach CIMC, located in the main city of Avalon for primary care, residents of the West End must travel the 23 mile, 1.25-hour trip over mountainous terrain and partially paved roads. To reach a mainland facility they must travel at least 1 hour by boat, then find ground transportation. The only transportation service between the West End and Avalon costs \$46 per round trip, and only one trip per day is available. Ownership of private vehicles is limited by high barge costs to the island, high cost of required liability insurance, and high gasoline costs (currently \$4.71 per gallon).
- There is a lack of specialty services on all parts of the island. In the main city of Avalon, CIMC's medical providers refer patients in need of specialty care to the mainland, but compliance with these referrals is poor due to financial, logistic, and frequently language barriers, particularly for the low-income population. Especially needy are those patients who require psychiatric services and diabetic patients requiring ophthalmology services.
- Drug and alcohol dependencies are a large problem in our community, but there are no local chemical-dependency treatment programs.

A consortium consisting of Catalina Island Medical Center, Loma Linda University Medical Center, and the USC Catalina Island Hyperbaric Chamber, with the help of the Santa Catalina Island Company and Two Harbors Enterprises, will utilize creative outreach models to bring primary care services through a satellite clinic to the remote island community of Two Harbors. The consortium will also bring bilingual specialty services to the island city of Avalon using telemedicine technology. Services will especially benefit the medically fragile and low-income island residents. In addition, a program feasibility study on development of a chemical dependency treatment program will help the island's sole community health care provider/ Critical Access Hospital to tailor strategic program planning to the unique needs of the island population while striving to develop a positive operating margin to guarantee continuing operations.

D04RH06931

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Health insurance enrollment, Primary care, Dental care, Case management

The Rural Health Services Outreach Grant for Tulare County's Children's Health Initiative specifically focuses on increasing medical and dental access in two, majority-Latino, low-income, rural farm communities of Lindsay and Woodlake within the central California county of Tulare. Lindsay and Woodlake school district Healthy Start and Family Resource Centers and the Children's Health Initiative coalition through First 5 Tulare County are partnering with the Children's Hospital Los Angeles' e-Dental Health program to provide a comprehensive continuum of health care service for uninsured children.

The Tulare County Children's Health Initiative (CHI) is focused on increasing dental and medical health access for children ages 0-18 through outreach and enrollment into publicly funded programs and by offering a new gap insurance product, Healthy Kids, for children ineligible for state Medicaid (known as Medi-Cal) or the State Children's Health Insurance Program (S-CHIP, known as Healthy Families in California). Healthy Kids is a new, local public/private partnership program with comprehensive medical, dental, and mental health benefits mirroring the state Healthy Families program. It is scheduled to launch in January 2006. Healthy Kids will be for children in families with incomes up to 300 percent of the Federal Poverty Level, regardless of immigration status, and is modeled after similar successful programs in other California counties.

The project begins with health insurance enrollment at local sites for children in Lindsay and Woodlake into current public programs Medi-Cal and Healthy Families, if eligible, or Healthy Kids—all in one application and one appointment for all children. An e-Dental Health network at school sites that connects the rural communities of Woodlake and Lindsay with a newly created e-Health Center at Children's Hospital Los Angeles will utilize telecommunications technology to provide dental consultation and treatment or treatment referral. Participation in the e-Dental program requires some sort of insurance coverage. It is estimated that 30 percent of the two towns' children are ineligible for public programs. These children will qualify for the new Healthy Kids program. Referral appointments from the school e-Dental site to local dentists will be tracked by local case managers, along with quarterly follow-up with families of children enrolled into Healthy Kids in order to provide health care utilization assistance.

Project funds will provide a.5 FTE Certified Application Assistor/case manager each in Woodlake and Lindsay and Healthy Kids insurance premium costs for 55 children ages 6-18, which will allow services identified by the e-Dental and other health providers to be accessed. First 5 Tulare County will subsidize Healthy Kids premium costs for children ages 0-5.

DELAWARE

D04RH04341

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Prenatal Services

La Red Health Center (LRHC) will expand an existing program to offer prenatal and labor/delivery services to underserved and vulnerable pregnant women in Sussex County, Delaware. LRHC will develop a formal *promotoras* program, utilizing an indigenous case management model developed to facilitate access to medical care in underserved communities. The goals of this project are (1) to improve perinatal health outcomes and reduce disparities as a result of expanded access to care and education for low-income, at-risk women and (2) to develop a comprehensive countywide *promotoras* program to provide outreach, community health education, case management, and other services to encourage early entry to prenatal care, concordance with medical advice, and subsequent medical care for infants and children.

The program will serve rural Sussex County, which is the largest county in Delaware in terms of land mass and has a population of 156,638. The entire county is federally designated as a Medically Underserved Area, a low-income Health Professional Shortage Area (HPSA), and a dental HPSA. The lack of access to prenatal care for both uninsured and Medicaid-enrolled women has created a crisis in the county. No private obstetricians in western Sussex County accept patients with Medicaid into their practice, other obstetricians in the county limit the number of patients with Medicaid they will treat, and uninsured patients cannot pay the required fees for prenatal care. Most uninsured women served by an existing LRHC program did not seek early prenatal care. This trend, combined with limited provider availability, compounds the problem of early access to care. Thus, there is a tremendous need for LRHC's prenatal services.

To address the demand for prenatal services, LRHC will partner with two private obstetricians, two hospitals, and other state and community agencies and programs to build a countywide network. Existing capacity for the prenatal program will be doubled and complemented by an aggressive campaign of community education urging early entry to care.

FLORIDA

D04RH06933

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| | | | |
|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Primary care, Mental health services, Substance abuse treatment, Dental care

The Rural Health Network of Monroe County, FL, Inc. (RHNMC) was created in 1993 in response to the enactment of Florida Statute 381.0406. This Act mandates the formation of health networks throughout the State in certified rural areas for the purpose of providing "... a continuum of quality health care services for rural residents through (local) cooperative efforts...". In May 2000, through support received from a HRSA Office of Rural Health Policy Outreach grant, RHNMC secured funding to initiate a primary care program, through the use of a single medical mobile van. Since that time, this organization has expanded its services to include yet another mobile medical van, two "fixed site clinics, and a dental clinic, thereby extending services in the Florida Keys over a 120-mile linear island chain.

This project is designed to build upon previous accomplishments established by this network organization through its local partners, and through funding granted by HRSA to create a meaningful, sustainable and lasting provision of comprehensive primary care. In responding to the Florida Statute-mandate to ensure a continuum of care, RHNMC has entered into local communities with an intent of not duplicating services, creating service access where those service may be lacking, and more importantly, to work within and without a network framework to improve health care services where possible. RHNMC seeks to partner with a local for-profit hospital network member and with the largest substance abuse and mental health facility in this county to offer outpatient primary care, outpatient mental health and substance abuse services, and access to dental care for uninsured residents of the Lower Florida Keys—10 hours a day, 7 days a week.

For almost 30 years, the Guidance Clinic of the Middle Keys (GC 1K) has provided mental health and substance abuse services for the people of Monroe County. As a recent (ORHP) outreach grantee (May 2003 - April 2006), GCMK has partnered with RHNMC in the limited provision of its services to the homeless. The Lower FL Keys Health (Hospital) Center (LFKHC; a founding RHNMC member) has voiced its desire to merge the resources of RHNMC, GCMK, and itself to create a seamless and comprehensive health care program targeted to the uninsured and homeless. This project is the first merger of its kind in county history, bringing together a for-profit hospital/primary care service, not-for-profit mental health and substance abuse care and not-for-profit primary and dental care.

GEORGIA

D04RH02552

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| | | | |
|----------------|-----------|-----------|-----------|
| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Diabetes, Hypertension, Pulmonary disease, Asthma

The West Georgia Chronic Disease Initiative (WGCDI) is a community-based treatment, management, and prevention program targeting citizens in Carroll, Haralson, and Heard

counties in rural West Georgia. WGCDI was formed initially in 2001 as a broad partnership with more than 70 local participants and was prompted in part by the results of two community health assessments, which indicated a prevalence of risk factors associated with diabetes and hypertension. Currently, the Initiative has now formed a rural health consortium to guide the program's continued growth and development. The consortium proposes to expand existing protocol for patients with diabetes and hypertension, and add programs targeting asthma and chronic obstructive pulmonary disease (COPD). Increases in county's general population and the "aging" of the area's population have led to an increased need for these services.

The expanded West Georgia Chronic Disease Initiative will serve individuals who currently suffer from diabetes, hypertension, asthma or COPD, or who are at risk for these diseases. The program will place a special emphasis on low-income, uninsured, and underserved individuals, including the community's growing minority populations. Specific target populations include 72 percent Caucasian, 25 percent African American, 2 percent Hispanic, and less than 1 percent Asian.

Members of the West Georgia Chronic Disease Initiative Consortium include the Tanner Medical Foundation (Applicant/lead agency), Carroll, Haralson and Heard County Health Departments, Haralson, Heard, Carrollton City and Bremen City Schools Systems, the Center for Allergy and Asthma of West Georgia, Dr. Sandra Stone of the State University of West Georgia, the American Lung Association of Georgia, and the Tallatoona Economic Opportunity Authority.

D04RH04347

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Oral Health Care

The new Floyd County Dental Clinic will operate as a regional clinic, serving residents of a five-county area in rural northwest Georgia. The goal of the clinic is to increase access to oral health care for residents in the region. The regional dental clinic will offer a full range of pediatric and adult dental services, including outpatient dental care for young children with serious dental needs. The clinic will accept adult and pediatric emergencies and will have an oral surgery program as well. Opening the clinic will provide many residents in the region access to high-quality dental services that are currently unavailable to them. The need for dental services among low-income families in the target area is tremendous. Only four dentists accept Medicaid, and acceptance is sporadic. Low-income families with dental insurance cannot find a provider who will take them as patients. A mobile dental clinic provides limited services to only a fraction of the residents in need of dental care, and clients in need of follow-up care have no local options.

The five counties are located in the foothills of the Appalachian Mountains. The total population of the five-county area is 260,591. According to 2000 Census data, 88 percent of the population

is white, 8 percent is African American, and 4 percent is Hispanic. The Hispanic population in the area has grown significantly in the past 10 years, because of employment opportunities. However, their jobs are often minimum wage with no health insurance benefits.

Access to oral health care is problematic for many residents in the target area, especially for those with low income or who lack insurance. The five county health departments have no public health dental facilities and only one mobile dental van. Four counties in the target area are designated as Medically Underserved Areas or Medically Underserved Populations. One of the counties is designated as a Dental Health Professional Shortage Area.

Consortium members include Floyd County Health Department, Coosa Valley Technical College, Floyd College Health Sciences Division, Floyd Medical Center, Northwest Health District, and Rome/Floyd County Commission on Children and Youth.

D04RH04348

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$198,810 | \$198,092 | \$198,896 |

Keyword(s): Health Education

Experts agree that decisions youth make regarding lifestyle and personal behavior in adolescence have tremendous future consequences. These consequences include, but are not limited to, lifelong substance abuse (e.g., tobacco, alcohol, other drugs); teen parenthood and subsequent low educational attainment and low socioeconomic status; and/or eventual chronic disease (e.g., cardiovascular disease, stroke, diabetes, cancer). The proposed East Central Georgia Regional Teen Wellness Initiative will increase awareness and access to health promotion services by providing ongoing leadership training regarding healthy lifestyles for local youth; encouraging these youth to take a leadership role in planning, implementing, and monitoring local health promotion/education projects; and supporting these youth as they plan and coordinate an ongoing local health lifestyles education outreach campaign for youth in the proposed service area.

The rural underserved service area includes eight counties: Glascock, Jenkins, Lincoln, McDuffie, Screven, Taliaferro, Warren, and Wilkes. The proposed population is 7,452 youth (age 10 to 18). The region displays demographic characteristics similar to many poor rural areas, including high percentage of minority residents, isolation, poverty, negative health indicators, lack of educational attainment, and a struggling rural economy. According to the 2000 census, the region is home to 75,184 individuals: 59 percent white, 40 percent African American, and 1 percent other. More than one out of every four children (age 0 to 17 years) in the region is currently living below the poverty level. Much of this poverty is a result of adolescent childbearing. Nearly one-fifth (18.4 percent) of the total births to region residents were to unwed teen females, and more than one out of every two (56.0 percent) were to unwed mothers (regardless of age). More than one out of every three female-headed households with children under age 18 in the region are currently living below the poverty level.

An estimated 6,920 county residents are in need of alcohol treatment services, and 2,977 are in need of drug treatment. State mental health officials estimate that only 20 percent of those who need treatment services will actually demand or want the assistance. Many of these adults are raising young children and making their children victims of the downward negative spiral of intergenerational addiction and its consequences.

In 2002, 60 percent of all deaths in the region were due to heart disease, stroke, diabetes, and cancer. Death and disability from these diseases are related to a number of modifiable risk factors, including high blood pressure, high blood cholesterol, diabetes, having a sedentary lifestyle, being overweight, and smoking.

The East Central Georgia Regional Teen Wellness Coalition comprises eight county community collaboratives—Glascok Action Partners, Jenkins County Family Enrichment Commission, Lincoln County Family Connection, McDuffie County Partners for Success, Screven County Community Collaborative, Taliaferro County Family Connection, Warren County Family Connection, and Wilkes County Community Partnership (all of which have included and supported school health programs in their strategic plans—as well as Medical College of Georgia, University of Georgia (College of Family and Consumer Science), and the East Central Public Health District.

D04RH04349

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$169,004 | \$160,198 | \$161,620 |

Keyword(s): Dental clinic services, preventative dental care

The goals of the South Georgia Regional Dental Outreach Initiative are to increase the number of individuals who receive preventive dental screening, the number of individuals who have access to dental clinic services, and residents' awareness of the importance of dental hygiene and preventive dental care. To accomplish these goals, the initiative will provide (1) dental services for at least 1,500 individuals; (2) dental health preventive education for more than 15,000 individuals annually through onsite services provided in school systems, pre-kindergarten programs, Head Start, daycare centers, nursing homes, health department clinics, employee screenings at local businesses, and community health fairs and other community sites; and (3) an area dental services referral network for individuals with no other dental care options.

The service area is a five-county underserved area in rural southern Georgia with a population of 67,463 individuals. Demographic characteristics of the region include a high percentage of minority residents, isolation, poverty, negative health indicators, lack of educational attainment, and a struggling rural economy. The racial/ethnic composition is 67 percent white, 32 percent African American, and 1 percent other. Employment prospects for local residents are limited due to lack of funding. Attempts at supporting health and dental health promotion have been inadequate. There is a shortage of dentists in the area, and at-risk residents without private dental insurance must go without preventive dental care and have to ignore dental problems

because of inadequate financial resources. All five counties in the region are Medically Underserved Areas, and three are designated as Dental Health Professional Shortage Areas.

The South Georgia Regional Dental Outreach Initiative comprises the Turner County Board of Education, the lead applicant; Public Health District 8-1; area volunteer dentists; and five community collaboratives—Fitzgerald-Ben Hill Policy Council for Children and Families, Irwin County Family Connection, Turner County Connection, Wilcox County Family Connection, and Worth County Family Connection.

D04RH06912

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,969 | \$124,342 | \$99,968 |

Keyword(s): Physical activity/fitness, Obesity/overweight

From 1991 to 1998, Georgia reported the greatest rate of increase in prevalence of adult obesity (101.8 percent) in the United States. A recent study by the University of Georgia and the Georgia Prevention Institute at the Medical College of Georgia found that Georgia children are more likely to be overweight than previously thought, with approximately 37 percent considered too heavy. With increased numbers of chronic illnesses, health crises, and general poor health, the implications of this large number of overweight and obese children (and adults) impact all health care systems. Washington County, like many rural areas, has a significant number of overweight and obese children and youth who generally do not seek medical services to address the causes, resultant medical problems, or possible remedies. Most commonly, they are uninsured, poor, poorly educated, often isolated, and lack family support in addressing overweight/obesity.

Children are usually at the mercy of parents/caregivers in the matter of food selection, purchase, and preparation. Poor nutrition is compounded by lack of access to a comprehensive fitness program or facility because of limited or non-existent transportation. Rural children are particularly at risk as a result of multiple barriers, many of which are remediable.

The Washington County Community Wellness Consortium, a collaborative of agencies and health providers, has developed a small, multidisciplinary weight loss and fitness model program, the cornerstone of which is martial art taekwondo. This model program began July 18, 2005, with a small grant from Georgia Southern University's Intellectual Capital Partnership Program (ICAPP). This program is already showing positive results in participants. Approximately 50 percent of the children are obese or overweight. Parents and children are enrolled. For the proposed project, additional children will be recruited from schools, health providers, the recreation department, and churches for an after-school and summer program. Transportation, not currently provided, will be provided for students.

Use of a martial arts program is a comprehensive approach to exercise and yields a wide array of benefits, such as increased self-esteem, a positive body image, goal setting, and reduced aggression. Children who participate in this proposed project will be assessed using several standard instruments. A physical exam by a pediatrician will be required. Individual fitness/wellness plans will be developed. Parents/primary caregivers and other adults will be recruited and encouraged to participate as well. The program will include 75 obese/overweight children, 25 parents/primary caregivers, and 50 non-overweight peers and/or adults. To avoid stereotyping obese children, enrollment will be open. All program participants will receive regular nutrition education and food preparation demonstrations provided by the Washington County Extension Service. Children will be required to attend 21 classes in an 8-week cycle (or three classes per week), leading to earning a series of belts. At specific intervals, children's physical and psychosocial progress will be assessed. Interval successes and instructor feedback will motivate children and families to continue their individual plans.

D04RH06911

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$148,994 | \$124,908 | \$100,000 |

Keyword(s): Perinatal health

Evans County Health Department, along with its network partners, seeks to implement Best Babies, a perinatal health program to improve health outcomes for women, infants and children in Candler, Evans, Tattnall, and Wayne Counties in southeast Georgia. Best Babies will offer a comprehensive, integrated approach to perinatal care for women in these counties who are at high risk for adverse birth outcomes including maternal or infant mortality, low birth weight, very low birth weight, or other medical or developmental problems. The coordinated system of care will include identification of women who are at high-risk for poor birth outcomes, intensive case management, and home visits by registered nurses.

Network partners include the lead agency, Wayne Memorial Hospital, Evans Memorial Hospital, Candler County Health Department, Tattnall County Health Department and Wayne County Health Department. Two nurses will be hired to provide services to program participants under the direction of a project director.

The four targeted counties have high rates of poverty, ranging from 27 percent of the population of Evans County to 16.7 percent in Wayne County. The statewide rate of Georgians living in poverty is 12.3 percent. The population of the target area is 66 percent Caucasian, 28 percent Black, and 6 percent Hispanic. Evans, Candler, and Tattnall counties have seen tremendous growth in their Hispanic populations over the past 10 years.

Infant mortality rates (IMR) and neonatal mortality rates (NMR) are higher than those for Georgia and substantially higher than Healthy People 2010 objectives. IMR and NMR rates for Blacks are significantly higher than for Caucasians or Hispanics. Two of the counties, Candler and Tattnall, do not have birthing hospitals, and women must travel long distances to hospitals

in Wayne and Evans counties for delivery. All four targeted counties are Federally designated Medically Underserved Areas. Best Babies is modeled after the highly successful Perinatal Health Partners Program, which provides perinatal services to residents of 10 counties in southeast Georgia.

D04RH06913

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Diabetes

Diabetes is one of the nation’s most common chronic diseases and was the eighth leading cause of death in Georgia in 2001. Unfortunately, the 2000-2001 prevalence of diabetes in two rural southern Georgia counties—Ben Hill (13.2 percent) and Irwin (14.7 percent)—is more than twice that of Georgia (6.9 percent) and the United States (6.2 percent). According to a 2002 publication by the Georgia Hospital Association Research and Education Foundation, Ben Hill and Irwin Counties fall in the top 50 percent of counties in Georgia with the highest hospital admissions for uncontrolled diabetes. Considering this prevalence data, related health indicators—such as high rates of obesity and little physical activity, high poverty levels, and the racial makeup of the populations—it is clear that diabetes is a serious health issue for Ben Hill and Irwin Counties. Since these counties are medically underserved areas additional resources are critical to combat this chronic illness.

The Irwin County Board of Health, as the lead partner, proposes to work with the Ben Hill County Board of Health, Dorminy Medical Center, the Ben Hill County School System, Irwin County Hospital, the Irwin County School System, the South Central Primary Care Center, Irwin County Family Practice Associates (Dr. Howard McMahan), and the South Health District to address diabetes in these two counties. The target population will include individuals who have been diagnosed with type 2 diabetes, with an emphasis on those who do not have insurance and/or who live in poverty; middle school children who need to develop healthy lifestyle behaviors that will lower their risk of becoming diabetic; and the general public. Given the poor health status of many people in these counties, it will be important to provide education and prevention messages to the public at large in order to reduce the incidence of diabetes.

The goals of the project will be to reduce the number of hospitalizations resulting from diabetes or diabetic complications in Irwin and Ben Hill counties by 10 percent, to increase healthy lifestyle behaviors among middle school children, and to reduce the incidence of type 2 diabetes in these two counties through awareness of prevention strategies.

Grant funds will be used to hire a Nurse with a background in diabetes education as the Project Coordinator and a Secretary. The project also will contract with Dorminy Medical Center for 50 percent of a Registered Dietician. Services will include expanded educational classes for diabetics, including individual and group nutritional counseling, and community education programs for the public that will be offered to churches, senior citizen centers, the tech school,

and others. The middle school component will focus on decreasing obesity, increasing physical activity, educating the students/parents about healthy lifestyles, and evaluating the school-based nutrition programs. During the first year, staff will be oriented, educational classes planned, local physicians educated about the project, community education approaches planned, and contact initiated with key school personnel. Program implementation will begin the last quarter of the first year. In the second year, a joint community health fair focused on chronic disease/diabetes will be held for the general public and a 10K Steps-A-Day program initiated in both communities.

IDAHO

D04RH04399

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|----------------|-----------|--------------|--------------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$198,795 | \$178,071.09 | \$181,591.09 |

Keyword(s): Pediatric Obesity

Healthy Families Active Youth is a health promotion and fitness project that will target elementary school children and their parents in two towns in rural southwest Idaho to prevent and treat pediatric obesity. The goal of the project is to promote healthy weight and activity levels in rural children. Objectives include increasing the knowledge of healthy foods, increasing servings of fruit and vegetables, increasing the percentage of children who get at least 30 minutes of physical activity 5 days a week, stabilizing or decreasing the weight of overweight children participating in a weight management program, and promoting appropriate identification and treatment of childhood overweight by health care professionals.

The target population is low-income elementary school children and their families in two towns in rural Canyon and Owyhee counties. Nearly one in five residents in Canyon County is Hispanic, compared to one in four Owyhee County residents. Poverty rates for most of the target area are higher than state averages. The project will serve 1,400 children, at least 100 parents, and 25 health care professionals. Approximately 52 percent of participants will be Hispanics, 46 percent non-Hispanic whites, and 2 percent other ethnicities. The two counties are home to an estimated 25,319 migrant and seasonal farmworkers. An estimated 50 percent or more of migrant workers lack health insurance, compared to an estimated 18 percent of all persons in Idaho. Barriers to access of health services include poverty and lack of insurance. Language, cultural, and education barriers exacerbate health problems for which Hispanics, who make up the majority of migrant and seasonal farmworkers in the state, are at added risk. An estimated 28,000 people in the two counties lack insurance, with many more struggling with inadequate coverage. Both counties are designated as Health Professional Shortage Areas, and Owyhee County and the southern part of Canyon County are also designated as Medically Underserved Areas.

Healthy Families Active Youth partners include Terry Reilly Health Services as the lead agency, Southwest District Health Department, Treasure Valley Family YMCA, Homedale School District, and Caldwell School District. All partners have participated in a broad-based

community coalition of more than 15 organizations that began in October 2003 to address childhood overweight.

D04RH06958

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Primary care, Social services, Elderly, Health promotion/disease prevention (general)

The consortium for this project includes Gritman Medical Center/Adult Day Health, Pullman Regional Hospital, Whitman Hospital and Medical Center, the Council on Aging & Human Services/COAST Transportation, and Region II Area Agency on Aging.

The primary goal of Project ACCESS (Accommodation, Collaboration for Community Education about Services for Seniors) is to increase access to medical care and social services for seniors in the rural areas of Eastern Washington in Whitman County and North Central Idaho in Latah County. The strategies proposed to increase access will enable seniors to live independently and increase the capacity of these rural communities to sustain conditions necessary for early intervention if a senior becomes at risk for problems that may impede her or his ability to living a physically and emotionally healthy life.

First, ACCESS will define and expand the senior community health services network in the rural areas. We will initiate the nationally recognized Gatekeeper program, which is a proactive network of community members trained to identify changes in behavior, routines, and other early warning signs that a senior may be at risk for a health/mental health related crisis. Given the independent nature of rural elders in Whitman and Latah Counties, at-risk seniors would remain invisible to service delivery systems without such a community-based program. Gatekeepers are trained to recognize changes and to contact a local agency on aging to engage the appropriate service delivery system. Grant funds will also initiate care giver support groups in rural communities so that those who care for rural seniors have local access to support, respite care, information, and referrals.

Second, the grant will increase access to primary health care and related social services through an expanded volunteer corps of drivers from rural communities. Volunteer drivers will be recruited and trained by a transportation volunteer coordinator housed at the Council on Aging & Human Services/COAST in Whitman County. In addition, COAST Transportation will also work collaboratively with Latah County to identify and train volunteer drivers to respond to requests in Latah County.

Third, ACCESS will increase access to wellness and disease prevention information and referrals by developing and purchasing materials accessible to all community members and health and human service providers through medical offices, libraries, hospitals, and agencies on aging. Community education programs will also be presented, duplicated, and made

available through similar venues. Local information and referrals will also be made accessible through the Washington and Idaho 2-1-1 telephone systems.

ILLINOIS

D04RH02551

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| Fiscal Year | 2004 | 2005 | 2006 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$165,836 | \$157,055 | \$144,210 |

Keyword(s): Developmental screenings, Healthy lifestyle education

Preschool-age children in a three county rural area of western Illinois are missing vital developmental services because parents and health care providers are not aware of their value and availability. Additional children are denied services because their identified needs do not conform to highly regulated eligibility criteria. Still other children fall in age ranges that force them out of one program before they are eligible for another. Early diagnosis and treatment of children at risk for developmental disorders prevents problems at school and offers huge economic benefits to both the child and the community. Project All Aboard will identify these children through public awareness campaigns, developmental screenings, and provider networking to provide intervention and other needed developmental services to ensure every child has an opportunity to reach their potential.

Project All Aboard targets any preschool child not eligible for other state or locally-funded services in Henderson, Knox, and Warren counties, Illinois. The consortium, which includes the Warren Achievement Center, the Knox County Health Department, the Henderson County Health Department, the Knox-Warren Counties Special Education District, the West Central Illinois Special Education Cooperative, and the Henderson County Rural Health Center, aims to reduce the average age children are first screened for developmental delays from 20 months to 14 months, increase referrals of at-risk children receiving services by 100 percent, and to ensure services to 10 children in the first year of the program, 20 children in the second year, and to 30 children in the third year of the program, who are in need of early intervention services but don't qualify under current guidelines.

D04RH06963

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Perinatal depression

The Project for Perinatal and Postpartum Depression Detection (P2D2) is a collaborative effort of the partner organizations of the Regional Behavioral Health Network (RBHN) and local health departments in a three-county region of rural east central Illinois. All three counties are designated health professional shortage areas for both primary care and mental health. Coles County Mental Health Center, the Human Resources' Center of Edgar and Clark Counties, and Sarah Bush Lincoln Health Center, which comprise the organizations of RBHN, are joining forces with local health departments in Clark, Coles, and Edgar Counties to address the need for screening, assessment, and referral of women with symptoms of perinatal depression.

This project will increase community awareness about perinatal depression, improve access to mental health screenings for childbearing women, and provide assessments and linkages to appropriate treatment for women with symptoms of depression. Through collaboration with the local health departments and the WIC/Family Case Management programs, RBHN will initiate an integrated screening and assessment process directed at reaching women at the greatest risk of depression. Project partners will 1) provide community education about the symptoms of postpartum depression and how women can receive help; 2) improve the efficacy of the cross-disciplinary linkages between the mental health and primary care providers serving postpartum women; and 3) increase the number of postpartum women using behavioral health services.

Screening services will reach an estimated 1,250 women (350 in Year One, 400 in Year Two, and 500 in Year Three). Education and outreach activities will reach an estimated 500 persons each year. A key objective of the project is to strengthen the cross-disciplinary linkages between mental health and primary care services. The Women's Mental Health Program of the University of Illinois at Chicago will provide training for project personnel and workshops for primary and mental health care providers on the issues of perinatal depression and options for treatment. A consultant will facilitate a process mapping of P2D2's screening and assessment procedures to develop a common understanding of the process and work toward developing a uniform protocol that integrates the region's resources for primary care and behavioral health treatment options available to women with perinatal depression. Partnering organizations will jointly host a regional conference to explore and improve the delivery of these treatment options in the targeted service area.

INDIANA

D04RH06943

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,999 | \$124,999 | \$100,000 |

Keyword(s): Mental Health

The Dunn Center, a community mental health center, is collaborating with Family Health Services, Inc. (a local community health center) and Affiliated Service Providers of Indiana, Inc.,

(a network of behavior health providers) to improve the health and wellness of people living in the rural communities of Fayette, Franklin, and Rush counties in Indiana, especially the low income and elderly. These goals will be accomplished by decreasing barriers to care, providing prevention and early intervention education, increasing treatment effectiveness, and expanding the program to include an eight-county region.

These proud, rural communities show the signs of suffering from the fallout of lack of jobs, lack of health insurance or having inadequate insurance, drug and alcohol addiction, and the long term ramifications of chronic illness. Fayette County is partially designated as medically underserved area. Rush County is a health professional shortage area for residents at 200 percent or below the poverty level. All of Franklin County is a health professional shortage area, a medically underserved, and a mental health shortage area.

These challenges are inter-related. The Primary Care Plus + program will be managed and governed by an Advisory Committee composed of specialists with expertise in the integration of mental health services into primary care. Dunn Center, a nonprofit mental health agency, will provide managerial and fiduciary oversight of the program. It also will oversee most aspects of the project's mental health treatment component, including diagnostics, short-term crises management, individual counseling, group psychological education, and group counseling. Patients needing intensive treatment will be referred to the Dunn Center or another appropriate service provider, such as psychiatrists for pharmacological consultations. Dunn Center will also provide transportation and translators.

The program will be housed at Family Health Services' two health centers that serve Fayette, Franklin, and Rush counties. Family Health Services will provide the project director, clinical office space in each county, management of integration to primary care, coordination of services, support staff, child care, and translators as needed. The program will address the racial, cultural, and socioeconomic needs of each patient individually. Affiliated Service Providers of Indiana, Inc., (ASPIN) will provide evaluation and technical assistance related to education and dissemination of outcomes. It also will oversee the replication of this model in Years 2 and 3 of the project in nearby counties.

D04RH06942

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$124,476 | \$99,783 |

Keyword(s): Diabetes

Lifestyles Diabetes Project will provide diabetes education and treatment services to the citizens of Indiana's Gibson and Pike Counties. The project is designed to achieve diabetes awareness and prevention for citizens in the two counties and to provide education and support on self-management for many who have already developed the condition. The project brings together a consortium of local organizations—Gibson General Hospital, the Gibson County Health

Department, the Pike County Health Department, Tulip Tree Family Health Clinic, the Gibson County Council on Aging, the North Gibson School Corporation, and Brink's Family Practice—along with the Indiana State Department of Health Diabetes Prevention and Control Program

Lifestyles Diabetes Project addresses a significant health need. According to the Centers for Disease Control and Prevention and the Indiana State Department of Health, diabetes is the sixth leading cause of death in the United States, the State of Indiana, and Gibson County. In the United States, the number of adults with diagnosed diabetes has increased 61 percent since 1991 and is expected to more than double by 2050. According to the 2003 Indiana Behavioral Risk Factor Surveillance Systems, 7.8 percent of adults age 18 and older in Indiana have been diagnosed with diabetes.

Poor lifestyle choices and lack of awareness are root causes of the increased prevalence of diabetes and its resulting complications. Much of the burden related to diabetes, once developed, can be prevented or delayed with early detection, improved delivery of care, and better education on diabetes self-management. Moreover, better than managing diabetes is preventing its onset in the first place. Convenient access to knowledge, resources, and support—in a familiar setting—makes prevention and self-care more likely. The Lifestyles Diabetes Project aims to provide the people of Gibson and Pike Counties with this access to knowledge, resources, and support.

The Lifestyles Diabetes Project has two primary goals. First, it aims to reduce long- and short-term diabetes-related complications for as many residents as possible who have already developed diabetes. To reach this goal, the project will provide diabetes self-management education following recognized national standards at the project's clinic and at key outreach locations. Second, we aim to promote awareness and prevention of diabetes to as many citizens as possible in the two-county area. To achieve this goal, the project will conduct awareness, assessment, and education sessions at senior citizens' centers, schools, churches, and health fairs. It also will conduct a diabetes awareness and prevention marketing campaign. Success of the project will result in healthier communities in Gibson and Pike Counties, more effective use of existing healthcare resources, and a reduction in community health care costs.

IOWA

D04RH02572

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$195,076 | \$187,061 | \$151,486 |

Keyword(s): Domestic violence, Sexual abuse, Provider education

Health professionals frequently treat survivors of domestic abuse and sexual assault, but physicians often treat injuries only symptomatically. As a result, important opportunities for intervention are missed, and survivors continue to suffer adverse health consequences of physical and emotional abuse. Of the estimated 6.9 million intimate partner rapes and physical assaults committed annually, 2.6 million will result in an injury to the survivor, and more than 695,400 will result in medical treatment. In addition to the climbing medical expenses resulting

from domestic abuse, estimated between \$3 billion and \$5 billion annually, businesses are forfeiting nearly an additional \$100 million annually in lost wages, sick leave, and non-productivity. Survivors of domestic abuse are more likely to experience numerous chronic health problems including depression, post-traumatic stress disorder, chronic pain syndrome, gynecological problems, irritable bowel syndrome, eating disorders, and complications during pregnancy than others.

To address these and other unmet health care needs of survivors of domestic abuse and sexual assault in Mahaska and Keokuk counties, Crisis Intervention Services formed a consortium of local health agencies including the Keokuk County Health Center, Keokuk County Public Health, and the Mahaska Health Partnership (Community Health, Mahaska Hospital, and New Directions). Through a coordinated community response, with leadership and guidance from the Domestic Abuse/Sexual Assault Taskforce, the consortium seeks to provide intensive education for medical and mental health care providers of domestic abuse and sexual assault victimization issues, develop and implement effective screening protocols for medical and mental health providers, develop and implement a Sexual Assault Nurse Examiner (SANE) program, provide extensive education for teenagers and their parents, and develop and implement an extensive public awareness campaign on sexual assault prevention.

The target population is 90 percent Caucasian, 4 percent Hispanic, and a smaller mix of American Indians, African Americans, and Asians and Pacific Islanders.

D04RH02573

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| Fiscal Year | 2004 | 2005 | 2006 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$195,644 | \$199,937 | \$199,992 |

Keyword(s): Mental health, Substance abuse, Education

Experts believe that 1.8 percent of the U.S. general population live with severe mental disorders. According to the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, the rate of severe mental disorders among those entering jail is 6.4 percent for male detainees and 12.2 percent for female detainees. Of these, 72 percent also suffer with alcohol or drug abuse disorders. In 1999, there were 11.4 million admissions to jail, meaning that an estimated 802,000 detainees had severe mental disorders, and 577,440 of those also met the criteria for alcohol or drug abuse. Minorities are disproportionately represented in our criminal justice system, and also experience a higher rate of co-occurring disorders, with Hispanics being the fastest growing group in jail populations, (approximately 8 percent Hispanic versus more 90 percent Caucasian/Non-Hispanic). A great number of people living with co-occurring mental health and substance abuse disorders in the target area of the northwest Iowa counties of Buena Vista, Osceola, Dickinson, Lyon, Emmet, O'Brien, Clay, and Palo Alto face inappropriate incarceration and re-incarceration because they are not diverted from the judicial system into the mental health and substance abuse treatment systems, and cannot be effectively and immediately connected with services following their jail stay to reintroduce them into the community successfully.

The Integrated Service Pathways Network—which includes Northwest Iowa Mental Health Center; Seasons Center for Community Mental Health; Northwest Iowa Alcohol and Drug Treatment; and the sheriff departments and health departments of Emmet, Dickinson, Lyon, and Osceola counties—seeks to address these surprising statistics by diverting people with co-occurring disorders from the traditional criminal justice system/jail by implementing officer training and education of magistrates and other judicial officers, providing in-jail mental health and substance abuse assessment and treatment to detainees, utilizing translation and telehealth technologies as appropriate, and initiating non-traditional case management services to offenders with co-occurring disorders to ease the transition into the community’s support system and break the cycle of arrest, jail, release, and re-arrest.

D04RH06945

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Prenatal care

Marshall County, population 39,311, is located in rural Central Iowa. The county's population has remained stable over the past 50 years; however, the demographics of the population have shifted dramatically in the past 10 years. This demographic shift has resulted in a 480 percent increase in the minority population, which includes a 1,106 percent increase in the Hispanic Community in the past 10 years.

Along with these demographic changes, local officials have witnessed an increase in the number of people living in poverty and an upsurge in the number of uninsured or under-insured residents. For economic reasons, Marshall County is designated as a Health Professional Shortage Area. Further, the county has been designated a Medically Underserved Community, and the immigrant population has been designated as a Medically Underserved Population due to language and cultural barriers in accessing health care services.

The Building Healthy Families project is a culmination of 5 years of research, data collection, review, and program planning. The project draws on the staff, expertise, and available funding of all consortium members, and develops a coordinated service delivery system that avoids duplication of effort.

The Building Healthy Families project is designed to meet the unique cultural, social, and linguistic needs of pregnant Hispanic women living in Marshall County. The project’s goal is to improve prenatal health outcomes via identification and assessment, provision of family support and health education services, and incentives to increase participation in health care and educational opportunities in the community. It will promote rural health care services by expanding our current postnatal home visitation model to include a new and enhanced prenatal service component. This project will address the severe lack of services available to our target group due to cultural and language barriers.

D04RH06946

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Mental health services

The proposed Wayne County Multi-Generational Behavioral Health Project will serve one of the State's most poor, isolated, and distressed areas. This community also is home to the State's largest number of elderly residents over the age of 85. Located in southern Iowa along the Iowa-Missouri border, Wayne County suffers troublesome economic, education, and environmental problems that have for years damaged the mental and behavioral health of its children and youth, families, schools, and communities. These four strata of life will be integrated into this project.

The Project aims to increase access to behavioral health care for children, youth, and isolated elderly members by providing outreach and education resources, and promoting greater community involvement in an integrated network of services. It represents a new transition from mental health to a broader, more pervasive behavioral health condition that has emerged as the county's most telling unmet need. The target population consists of 1,500 Mercer County children and elderly persons.

The project has four goals.

- Goal 1 focuses on school-based identification, problem-solving, and documentation of students with behavioral health problems. It employs a Behavioral/Learning Area Support Team (BLAST) model from the Rathbun Area Mental Health Center in Centerville, Iowa and the UCLA Center for Mental Health in Schools.
- Goal 2 involves linking school-based children and their families to intensive behavioral health services; faculty and staff consultations, counseling, and referrals. AgriWellness, Inc., has joined the Consortium to train and serve project families through Family Support Specialists. A case manager from Rathbun will be employed to counsel and refer children in cooperation with faculty and staff, two in-kind managers, and three Specialists.
- Goal 3 focuses on providing behavioral health services to at-risk children and their families through community-based mentoring development together with professional training.
- Goal 4 involves Sowing the Seeds of Hope (SSoH) training for specialists and staff, and developing a new behavioral health/emergency health care outreach network for rural, isolated elderly persons.

The Consortium has developed from its roots in 1999: It includes Wayne County School District, the Seymour School District, Wayne County Public Health; Wayne County Home Care Aide Agency, Regional Department of Human Services/Wayne County; Area Education Agency 15, Rathbun Area Mental Health Center; Wayne County Hospital, and the local Extension Service. Also represented in the consortium is the Ministerial Alliance of Mercer County, the Wayne

County Response under the auspices of Wayne County Hospital, and six other groups. Consortium and community support organizations assume specific, dynamic roles.

KANSAS

D04RH06947

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Dental

PrairieStar Health Center, a non-profit rural health clinic located in Hutchinson, Kansas, is working with three health care organizations in Kansas' Reno and Harvey Counties to establish the South Central Dental Project. PrairieStar's partners for this effort are Health Ministries Clinic, a non-profit medical clinic in Newton, Kansas (Harvey County); the Reno County Health Department in Hutchinson; and the Harvey County Health Department in Newton.

The South Central Dental Project will establish a dental team that is shared by PrairieStar Health Center and Health Ministries Clinic. The cost of services will be offset by using a sliding fee schedule of discounts based upon the patient's income. This project will especially focus efforts to increase access for pregnant women and children, since these populations are especially vulnerable. Additionally, it will be a model of care that integrates dental services with existing medical services provided by the partner organizations. This integration will include a Performance Improvement Committee that has medical representatives from both non-profit clinics as well as dental staff. This Committee will initially determine performance measures that bridge between dental and medical services, and will meet regularly to measure progress and/or need for improvement in meeting those measures. The Project's primary goal is to provide access to dental care to at least 80 percent of all low-income children and pregnant women without private insurance that receive medical care at a partner organization facility. Currently, these individuals in the two-county area lack access to dental services. Needs assessments conducted in 2004 in both Harvey and Reno Counties show that access to dental care is the greatest unmet health care need in the two-county area. Low-income participants in a Harvey County focus group indicated that this unmet need is so great that it negatively impacts their overall quality of life.

South Central Dental Project staff will include a dentist, two dental assistants, 1.8 FTE dental hygienist, a program manager, and administrative support staff. In addition, funding from the Rural Health Outreach Grant will be used to place case managers at both Health Ministries Clinic and Prairie Star Health Center to assist patients with registration, transportation, and other services that will improve their overall dental experience. The case managers will also contact patients the day before their scheduled appointment to remind them of the date and time to reduce no-show rates.

This project will not only address a tremendous unmet need for dental care for the low-income people in the area, but will also pilot a dental program model integrated with medical care now provided by the participating clinics.

KENTUCKY

D04RH02558

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Health promotion/disease prevention (general)

The seven rural counties that make up the proposed target area for this project (Lee, Owsley, Jackson, Powell, Wolfe, Estill, and Breathitt) are among the poorest counties in Kentucky. Besides being economically disadvantaged, these counties have limited access to health care services. Only two of the seven counties have local hospitals, and the other five counties have, at best, access to limited service clinics that are managed from outside the local area. Within KRHN's service area, five counties are designated as Medically Underserved Areas. The high illiteracy rate in these counties negatively impacts the potential for these populations to gain access to health care services. The socioeconomic stress on the underinsured and uninsured is further exacerbated by the lack of access to local health care services.

KRHN is in phase 1 of a twofold mission to improve access to preventive care services for the underinsured and uninsured in the target area. The proposed services and activities for phase 1 include mammography, prostate and prostate-specific antigen (PSA) screenings, development of a hepatitis screening service, transportation services, educational programs to recruit students interested in the medical field, continuing educational programs for participating health care providers, and public awareness programs in Lee County. Phase 2 consists of KRHN's long-term plan to implement the proposed services and activities in the other 6 counties, while further developing the network system to sustain this and other future collaborative projects. The long-term plan focuses on community development that places an emphasis on the education of children and students throughout the region and continuing education for health care providers.

The Kentucky River Health Network consists of Marcum and Wallace Memorial Hospital (a Critical Access Hospital), the Kentucky River District Public Health Department, Lee County Constant Care (a long-term nursing and assisted-living facility), the Lee County Emergency Medical Services, the Lee County Fiscal Court, and the Lee County Area Technology Center (a vocational technology high school). The target population is more than 98 percent Caucasian and nearly 2 percent African American. While there is a growing number of Hispanics in the region, they are expected to represent less than 1 percent of the total population served by this project.

D04RH02559

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$187,150 | \$187,150 | \$190,781 |

Keyword(s): Dental health, Preventive care

The Surgeon General’s Report on Oral Health (2000) describes oral disease in America as a “silent epidemic.” Healthy People 2000 reports 18 percent of 2- to 4-year-olds have visible decay, and the numbers are rising. More than half of elementary school children have dental decay, and by the time they graduate from high school, it has increased to 84 percent. 99 percent of the population ranging from high school graduation to mid life (age 45) has tooth decay. Children can avoid cavities entirely if provided with early and proper dental care, but not all children receive appropriate oral health care. In children age 5 to 17, 80 percent of cavities are found in a particular subgroup. Specifically, this subgroup is within 25 percent of the lower end of the socioeconomic scale. The problem lies with the success of preventive measures not extending to those at the lower end of the socioeconomic scale. Previous studies conducted indicate that poor children have about five times more unfilled, decayed teeth than children above 300 percent of the poverty line.

The West Kentucky Dental Health Project (WKDHP) is a collaborative community-driven project that aims to build an infrastructure in 12 counties in rural western Kentucky to address early childhood caries and dental caries. The project will target children and families (80 percent Caucasian, 10 percent African American, and 10 percent Hispanic) of the Women, Infants, and Children (WIC) program, Head Start, and first and second graders through educational programming, preventive projects, and activities to increase access to treatment. Similar to goals contained within the Healthy People 2010 Report, WKDHP’s goals are to reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth or untreated dental decay, increase the proportion of children and adolescents under age 19 at or below 200 percent of the Federal poverty level who use the oral health care system each year, and who receive any preventive dental service during the past year, increase access by purchasing restorative services from community dentists for those children without insurance or adequate resources, and to increase the proportion of children who have received dental sealants on their molar teeth.

The WKDHP organizations include the Purchase and Pennyriple District Health Department, the Graves County Migrant Program, the Office of Family Resource and Youth Services Center, Murray Head Start, the West Kentucky Technical College (WKTC) Dental Hygiene/Dental Assisting Program, the Purchase Area Development District (PADD), and the Purchase Area Health Education Center (AHEC).

D04RH06929

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,974 | \$124,987 | \$99,986 |

Keyword(s): Health promotion/disease prevention (tobacco, overweight/obesity, alcohol abuse)

The Kentucky United Methodist Home and its partners—the Kentucky Cabinet for Health and Family Services, and the Madison County Health Department—joined forces to provide health care and human services for low-income children, youth, and families in two rural counties of central Kentucky (Anderson and Madison) through the Connections Rural Health Initiative.

Rural residents in Kentucky and the nation face a number of health disparities—among them, higher rates of the top three leading actual causes of death in the United States (tobacco, overweight, and alcohol)—and barriers to health care, especially access issues that make it difficult for citizens to obtain the care they need. While access/barrier issues abound, Connections is designed to address two in particular: the lack of transportation and the lack of insurance. We chose these two issues because they significantly reduce our families' ability to access the care they need and because the Connections program design helps work around them. Project activities include the following:

- We will provide in-home case management and other services when possible, and we will help families arrange for transportation to other providers and services as necessary;
- We will make the evaluation of each family's eligibility for third-party payment and support programs (Medicaid, KCHIP, K-TAP) a fundamental priority of our case management services, and we will help enroll individuals and families as appropriate.
- The Connections Rural Health Initiative will address identified health care needs, facilitate and encourage healthy behaviors, and help overcome barriers and disparities that interfere with families' ability to foster their own and their children's health.

We have identified four major goals:

- Seventy-five percent of families served will be able to access services independently upon discharge from the Connections program;
- Participation in Connections will result in a reduction in the number of smokers, and especially youth smokers, as compared to baseline measures;
- Eighty percent of the children in the families we serve will have a dental exam and will follow through with treatment in the year after Connections services are provided;
- Partnerships/collaborations begun through the Connections program will be self-sustaining; that is, they will continue beyond the grant period.

We have designed Connections to focus on areas where we believe we can have the greatest impact. By targeting low-income families, we serve those in greatest need. By targeting youth with our psycho-educational programs covering content areas we know significantly impact

health (tobacco, diet/nutrition/exercise, substance abuse/mental health, and oral health/dental care), we maximize our opportunity to break the cycle of unhealthy behaviors and produce long-term results.

Within the three-year period of this grant, we believe we will improve the lives of the families served, strengthen current referral networks and partnerships, create new collaborations, and enhance the health of the rural communities we serve.

D04RH06930

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Dental care, Minority health

This project plans to establish an outreach program developed by the Western Appalachian Kentucky Health Care Access Consortium. The consortium’s mission is to improve access to primary care and dental care among low-income, uninsured, and underinsured residents, with a special emphasis on providing outreach services for the unmet needs of an expanding Latino population. Over the next 3 years, the consortium plans to provide 2,244 primary care visits and 315 dental care visits, as well as outreach, transportation, and other services.

The consortium service area is a contiguous, six-county region of more than 1,400 square miles on the western edge of Appalachian Kentucky. All six of these counties are designated as medically underserved populations/medically underserved areas, and all but one are federally designated Appalachian counties. All counties are rural.

The consortium is an expansion of the successful Montgomery County Migrant Coalition, a 25-plus member organization established in 2001 with funding from the U.S. Department of Agriculture. All consortium members are active participants. The consortium is comprised of four health care agency partners: 1) Montgomery County Health Department, 2) Mary Chiles Hospital, 3) the Family Care Clinic (a rural health clinic), and 4) the Vollmer Dental Office. The consortium also includes two non-health care partners, Montgomery County Cooperative Extension Service and the Montgomery County Industrial Authority, which, with the four other traditional agencies, create an innovative partnership that is well-equipped to fulfill the consortium’s mission.

The six goals of the consortium are to: 1) Expand the existing services of the collaborating organizations; 2) Advocate on behalf of the target population for improved access to existing health care resources; 3) Provide a link between providers and Latino patients; 4) Provide an interpretive link between existing and prospective employers and Latino workers to ensure a healthy Latino workforce; 5) Increase the community’s understanding of Latino culture; and 6) Develop a long-term sustainability plan for the consortium.

Through this project, the consortium will expand its capacity to offer primary care and dental services, and to develop an extensive outreach program. The consortium will use a *promotora* model of community health workers to reduce and eliminate barriers to care that Latinos often face, including the inability to communicate because of language barriers, lack of transportation, inability to navigate the local health care system, occupational barriers, and lack of cultural competency among local service providers.

We believe the creative strategies planned to enhance service delivery can be a model for other rural communities to follow, especially where Latino populations are relative new, such as Appalachia and States beyond the U.S.A-Mexico border. The University Kentucky College of Public Health will assist with process and outcome evaluations, and with the dissemination of findings.

LOUISIANA

D04RH4333

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$197,385 | \$178,963 | \$191,285 |

Keyword(s): Obesity, Chronic Diseases, Health Education

The purpose of the Dubach Health Outreach Project is to provide access to a multidisciplinary community-based intervention to combat obesity and related chronic diseases. The project will focus on primary care and prevention strategies along with wellness strategies that deal with obesity and related risk factors and diseases such as coronary heart disease. A consortium of preventive health service providers and agencies will maximize resources to increase the number of individuals and families receiving preventive care for obesity and related disorders, and foster positive behavior.

The project will target at-risk and obese preteens and teens by implementing a health education, nutrition, and physical education program in targeted schools with a focus on primary prevention and education. The project also will target adults, who will receive secondary and tertiary prevention services such as screening, testing, health education, nutritional assessment, and counseling.

The project will serve the town of Dubach and surrounding rural communities in northern Lincoln Parish, Louisiana, where more than 25 percent of the population lives in poverty. The target populations are rural, low-income Caucasian and African American preteens to adults who are at risk of obesity and its complications and who have high levels of "health illiteracy." The leading causes of death in the targeted population are heart disease, diabetes, and stroke, all of which are aggravated by obesity.

All areas to be served are rural communities in which many residents have low access to primary care and preventive medicine. High consumption of dietary fat and calories and low frequency of exercise contribute to obesity in the target population. Cultural, educational, and socioeconomic barriers to access include lack of exercise facilities, lack of education, and a high

poverty rate. All areas and people to receive services are in a Health Professional Shortage Area and are Medically Underserved Populations. Lincoln Parish is designated as a Medically Underserved Area.

In addition to Louisiana Tech University, the lead applicant, consortium members include Lincoln General Hospital, Town of Dubach, Dubach High School, Dubach Revitalization Coalition, Dubach Restoration and Beautification Organization (DRABO), and Lincoln Council on Aging.

D04RH04336

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| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$195,140 | \$184,890 | \$184,890 |

Keyword(s): Obesity, Diabetes

Healthy Communities of Louisiana—The Obesity Project is a health education and screening project targeting obesity and related diseases such as diabetes, coronary heart disease, and stroke in at-risk African American adolescents and adults. At the core of the problem is the lack of seamless coordination among key agencies providing preventive and medical services along with a high rate of health illiteracy among the target population, rural African Americans. The project will establish a network of preventive health service providers and agencies to increase the number of individuals receiving preventive care and screenings and foster positive behavior. The two-pronged intervention approach will target at-risk school-age individuals as well as at-risk adults who are obese and African American. The goal of the project is to serve the target population at risk for chronic diseases because of obesity through preventive services, aggressive health screening, and education, along with a seamless continuum of care and referral networks. One novel approach the project will use is to target families at family reunions to provide health education and interventions such as screenings.

Rural Bienville and Lincoln parishes in north central Louisiana—the target area—are home to some of the most poverty-stricken areas in the state and in the Nation. More than 20 percent of the total population in the state is below the poverty line, and more than 40 percent of the children in north central Louisiana under age 20 live in poverty. Among female-headed households with children under age 5, the poverty rate is a staggering 80 percent. In 2000, Bienville had a population of 15,563 (44 percent African American), and Lincoln Parish had a population of 42,173 (40 percent African American). Obesity-related diabetes and heart disease in African Americans are at epidemic proportions in the two parishes, and effective strategies are needed to reduce the burden of diabetes and other obesity-related diseases.

Geographically, Bienville and Lincoln parishes are relatively accessible to major highways, and access barriers to needed services are not so much physical distance but rather cultural and socioeconomic. In addition to poverty and lack of education, barriers include disparate medical care for African Americans, cultural mores that place a greater emphasis on preventive care for females than males, and the rural African American emphasis on family. Other barriers include

a high consumption of dietary fat and calories, a sedentary lifestyle, and psycho-spiritual attitudes such as forgoing medical treatment in the belief that God will “fix it.”

Consortium members include the City of Grambling/Grambling Family Medical Clinic; Office of Public Health, Bienville Parish Health Department; Shreveport Black Nurses Association; Partners in Wellness Prevention Project; Bienville Parish School System–Arcadia School Complex; Bienville Health and Wellness Center; and Methodist Ministerial Alliance/St. Duty CME Church.

D04RH06916

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Medication assistance, Telehealth, Chronic Disease

The CEI: Project Outreach will expand upon the Bayou Teche Community Health Network's Information and Help Center, Medication Assistance Program, Telehealth Project, and Chronic Disease Management/Prevention Outreach Programs. Expected results of the project include:

- Increased enrollment in local, State and national programs (i.e., LaChip/Medicaid/Medicare Savings/Care for the Caregiver);
- Continued decrease in non-emergency ER use;
- Increase in outreach partners comprising Community Health Teams;
- Increase in number of comprehensive screenings (i.e. diabetes/blood pressure and service eligibility);
- Establishment of single points of entry for patient mapping;
- Leverage of State funds (\$50,000) and Federal funds (\$150,000);
- Increase in number of residents with an identified medical home;
- Increase in number of churches providing transportation to medical care;
- Consortium access to state-wide meetings and seminars through coordination of teleconferencing equipment; and
- Accumulation of additional data on the target population through Service Point customization and expansion.

ByNet's St. Mary Parish (County) Chamber of Health Coalition, which is comprised of over 70 representatives of health care, social service, consumer, faith-based and governmental entities, identified five key areas of need to improve healthcare in St. Mary and surrounding Parishes. Focus groups and committee research led the coalition to identify education, consumer-finance, transportation, access to medication, and primary and specialty care as key barriers to health care access for residents. In addition, the Health Access Barriers in the State (HABITS) Survey was conducted for the three target counties. The University of Louisiana at Lafayette's Health Informatics Center conducted the surveys used as baseline data for network program evaluation. Emergency room usage, lack of health insurance, transportation, and

inability to afford needed medications were identified as key concerns for all three target areas. In 2001, the network's consortium of members began to implement programs and services to address identified needs. In the aftermath of the September 2005 Hurricane Katrina devastation experienced in the southern coastal region of the United States, the previously identified needs have significantly enhanced to an insurmountable level. St. Mary, Iberia and Terrebonne Parishes have now become home to thousands of survived families requiring these services.

The target population for the project is the underinsured and uninsured residents of St. Mary, Iberia, and Terrebonne Parishes in south central Louisiana along the Gulf Coast. This population has recently experienced an enormous influx due to Hurricane Katrina survivors who have migrated into local communities. Those organizations comprising the consortium are the founding members of the Bayou Teche Community Health Network (ByNet). The State's first vertical rural health network members include two state hospitals, two St. Mary Parish rural hospitals, one St. Mary Parish Federally Qualified Health Center, one Iberia Parish Federally Qualified Health Center, one tribal clinic, one Louisiana Regional Office of Public Health, one social service agency, and a representative of the St. Mary Chamber of Health Coalition.

D04RH06918

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|----------|
| Funding Amount | \$149,722 | \$121,778 | \$93,883 |

Keyword(s): Mental health

There is a lack of behavioral health care services in Louisiana's Franklin and Tensas parishes, both of which are located in the rural, impoverished region of the Mississippi River Delta. There are two key services to be developed under the project—case management and psychological evaluation and treatment services. These services will be provided to individuals at three rural health clinics, long-term care facilities, and home-bound patients. The target population will be primarily African American adults.

The overarching goal of this project is to establish a primary care-based behavioral health program. The eight related goals that support this are:

- To identify and enroll individuals in the behavioral health care management program;
- To ensure individuals receive assessment and treatment services at one of three rural health clinics that are primary care sites in the two-parish service area;
- To expand the behavioral health program to include patients residing in area long-term care facilities;
- To expand the program upon implementation to include patients who are home-bound and actively enrolled as a home health patient;
- To reduce the incidence of serious mental illness, depression, schizophrenia, and generalized anxiety disorders;
- To reduce the proportion of homeless adults who have serious mental illness;
- To ensure program sustainability; and

- To conduct a program evaluation.

D04RH06917

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Infrastructure development, Elderly (education), Medication assistance, Quality improvement

The rural composition of Louisiana’s delta region is a photograph of health care professional shortage areas, extremely low preventive health compliance rates, high poverty rates, vast geographic boundaries, and above-average geriatric populations.

Through a 2004 ORHP Network Development Planning Grant, the Louisiana Rural Health Association, the Louisiana Health Care Review, Assumption Community Hospital, and Assumption Rural Health Clinic developed a network dedicated to increasing adult immunizations and adult vaccinations. Network partners worked together to form the Planning Equals Access for Louisiana (PEAL) Initiative.

With active participation in community forums by community members and natural growth, the initial four network partners expanded to include the Centers for Medicare & Medicaid Services and the Louisiana Department of Insurance Senior Health Insurance and Information Program. It was through this process that PEAL grew from an informal network to an emerging coalition. PEAL members successfully developed a strategic plan with the overarching goal of implementing the comprehensive, mobile strategic plan developed by collaborating partners and existing rural health coalitions. The end results were major quality improvements, transformational changes, and increased access to care in 30 rural Louisiana parishes.

The goals for this project are as follows: 1) To engage partners in making transformational changes that will enhance efficiency, increase access to care, improve service coordination, and improve quality of care; 2) To educate Medicare beneficiaries about their rights and benefits, increase the number of allied health care professionals providing preventive services, expanding the payer network via innovative approaches, and improve the use, distribution, and payment of prescription drugs among Louisiana’s rural elderly; and 3) To identify strategies for sustaining PEAL after ORHP funding ceases.

D04RH06919

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$124,760 | \$99,130 |

Keyword(s): Cardiovascular disease

Richard Parish Hospital (RPH) is a critical access hospital with a 501(c)(3) nonprofit designation. It is located in Delhi, Louisiana, Richland Parish, in the northeast corner of the State, and is the main provider of health care services in the parish. The Richland Parish Hospital-Delhi (RPH-Delhi) Community Wellness and Prevention Program is a model program designed to provide health assessments, health promotion, and health education in settings such as the school, worksite, health care facility, and community.

Richland Parish is a designated health professional shortage area and a medically underserved population. There are significant access barriers to health care as reflected in the income and poverty demographics, health status indicators, and health disparities.

The primary needs to be addressed through this project are as follows:

- To increase the quality, availability, and effectiveness of community-based programs designed to prevent cardiovascular disease, improve health, and improve quality of life;
- To expand the availability of health education resources to underserved, vulnerable, and special-needs populations to reduce cardiovascular disease;
- To decrease the risk factors and the resulting high incidence rate of cardiovascular disease and correlating chronic diseases;
- To strengthen the health care infrastructure and service delivery systems in Richland Parish as they relate to the management and treatment of cardiovascular disease and correlating chronic diseases.

The network has developed the following goals:

- Develop a model comprehensive community cardiovascular disease program in Richland Parish that can be replicated in 10 other parishes;
- Increase community awareness of cardiovascular disease and associated risk factors, with a focus on Syndrome X, tobacco use, and personal stress management;
- Decrease the incidence of cardiovascular disease and the incident of associated risk factors through a behavioral modification focus that targets dietary habits, physical activity, tobacco use, and personal stress levels; and
- Enhance the management and treatment of cardiovascular disease and related risk factors by focusing on early detection, education, behavior modification, and pharmacotherapy.

MAINE

D04RH04331

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|---------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Amount Funded | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Obesity, Clinical Interventions

The Healthy Living Initiative of the Healthy Community Coalition will focus on community and primary care strategies to address obesity, a major risk factor for a number of diseases, as well as behavioral factors that contribute to the obesity epidemic. The initiative will integrate and expand clinical and community-based strategies for promoting proper nutrition and increasing physical activity to reduce the prevalence of overweight and obesity in rural Franklin County, Maine, and several neighboring towns. The initiative will expand the range of clinical interventions available locally for obese and overweight adults and adolescents and will educate health care providers in diagnosing overweight and obesity. A marketing campaign to promote physical activity and good nutrition will educate the community at large.

The target population comprises residents of Franklin County and eight neighboring towns. Greater Franklin suffers from an escalating rate of obesity and overweight among its 40,000 residents. In 2000, 60 percent of adults and 15 percent of children were clinically obese or overweight. The region is at higher risk for obesity and overweight than other areas of the state because risk factors associated with obesity, such as the lack of health insurance and lower education levels, are significantly higher in the county than the rest of Maine. The project will address the unmet needs of the entire population in the area with a focus on the lowest income residents, those at or below 250 percent of the Federal poverty level, who are most likely to need services and least likely to be able to afford access to them. The project also will focus on Franco-American residents who tend to have a lower socioeconomic status as well as poor nutrition and low physical activity.

Barriers to accessing services include the lack of fitness facilities in the area; low-income residents cannot afford the few that are available. After-school activities also are limited. Public transportation is unavailable. Rural residents are geographically far-flung, and geographic distances make travel difficult and time-consuming and require considerable time to accomplish routine tasks. The excessive dependence on vehicles leads to a sedentary lifestyle pivoting around vehicle usage. Seventeen communities in the Healthy Community Coalition service area are designated as either a community or population primary or dental care shortage area, and 18 communities are Health Professional Shortage Areas.

Consortium members include the Healthy Community Coalition, the lead applicant; HealthReach Community Health Centers; the University of Maine at Farmington; and Franklin Community Health Network.

D04RH02555

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$199,913 | \$199,913 | \$199,913 |

Keyword(s): Mental health, Substance abuse

Almost 21 percent of U.S. children age 9 to 17 (15 million persons) have a mental or addictive disorder that causes some impairment. However, studies show that pediatricians do not identify 80 percent of children living with behavioral and emotional problems, and in any given year, it is estimated that less than one in five of these youth receive treatment. The Maine Medical Association recently passed a resolution identifying the lack of mental health care for children as the biggest health issue for the state, an action well supported by Maine's health statistics.

Northeast Health in cooperation with three partner organizations, Mid-Coast Mental Health Center, the Penobscot Bay YMCA, and the Maine Department of Behavioral and Developmental Services joined forces to form the Mid-Coast Mental Health Integration Initiative in an effort to increase access to adolescent mental health and substance abuse services in Knox, Lincoln, and Waldo counties, Maine.

The goals of the Mid-Coast Mental Health Integration Initiative are to improve access to child and adolescent mental health services, reduce the stigma associated with mental health, reduce the number of crisis interventions, improve coordination and cooperation among local health providers, and disseminate an innovative model. Nearly 97 percent of Maine's population is Caucasian. The ethnic mix of this program is similar, targeting 95 percent Caucasian, 2 percent Hispanic, 1 percent Asian, and a mix of African Americans and Native Americans totaling less than 1 percent of the target population. Children between the ages of 0 to 12 make up 40 percent of the target population, while adolescents age 13 to 17, at nearly 50 percent, represent the largest group to be served.

D04RH06920

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$75,000 |

Keyword(s): Aging/Elderly

Health Access Network (HAN) is a 330-funded community health center that provides primary care services to residents of 19 rural communities in Penobscot County—one of Maine's most remote, rural locations in the isolated northern region of the State. The target population for this project is the near elderly (ages 55-64) and the older population (age 65 and above). HAN targeted the elderly population for special attention in its original Section 330 New Access Point grant application submitted in December 2002. Since that time, HAN has worked diligently to meet the needs of its service area's older residents, as well as the near elderly, with nearly one-third of its present patient population falling within the ages of 55-65 and older. One of HAN's main goals is to develop a comprehensive medical and social service resource for the area's aging population.

For this project, HAN's partners include Penobscot Valley Hospital (PVH) and Millinocket Regional Hospital (MRH), both of which are critical access hospitals; the University of New

England; and the University of Maine Center on Aging. An additional 16 local, regional, and statewide organizations and individuals support this project.

According to recent reports, Maine's elderly population continues to increase. Maine's population 65 and older is now at 15 percent, compared to 12 percent for the nation. Maine's aged population ranks third in the country, trailing behind only Florida (17 percent) and West Virginia (16 percent). Its median age (40.6), which has increased by 2 years since 2000, is now the highest in the country. While Maine's population is projected to grow only slightly—less than 9 percent by 2017—the age distribution will change dramatically. Forecasters predict that the number of children will shrink 3 percent; the working-age adult population will grow only 5 percent; and the elderly will jump 38 percent.

The State's near-elderly and elderly population faces significant barriers in access to quality health care and support services, including lack of transportation, limited financial resources, lack of insurance coverage for many services (even for those on Medicare), and an insidious cultural bias against the elderly, promulgated by a youth-obsessed society. Additionally, as a number of needs assessments, discussions, and meetings determined, there is often a "disconnect" between providers of health care and social services, leading to acute fragmentation of care within the health care and social service system. These access issues, coupled with the fragmentation of services, result in poor health outcomes, lack of attention to preventive care, and reduced quality of life for the area's vulnerable elderly population.

The project's primary goals are: 1) To improve access to high quality, locally coordinated, multi-specialty and integrated health care; 2) To expand preventive services, emphasizing specific concerns for older adults, such as substance abuse, tobacco use, injury prevention, obesity, physical activity, mental health, and immunizations; and 3) To expand mental health awareness and services. Project activities include expanded case management with a geriatric focus; vigorous community outreach and education; improved preventive care and screenings; and the promotion of higher education in rural geriatrics.

MARYLAND

D04RH05061

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$199,521 | \$199,521 | \$199,521 |

Keyword(s): Service Accessibility, In-home Care, Behavioral Health

The Worcester Adult Centralized Care, Evaluation, and Support Services (ACCESS) Collaborative will expand services that promote independent, unrestricted living for Worcester County's aging population. Goals include the provision of leadership and direction to the Worcester ACCESS project, increased accessibility to services for older county residents, and increased utilization of available services. New and expanded services will address the need for in-home care services and accessible behavioral health services for older county residents. Worcester ACCESS will increase the accessibility of in-home personal care, chore, and home improvement services using the Asset-Based Community Development approach, which

emphasizes the involvement of community assets in addressing community needs. A behavioral health team, comprising a behavioral clinical specialist and a psychiatrist, will work closely with other health care professionals to ensure that the mental health needs of older adults are met. The project will increase utilization of services and healthy behaviors in the target population through community outreach and education activities. Services will be coordinated through a single point of entry and overseen by the collaborative.

Worcester County, Maryland, is a rural, relatively poor community with complex issues affecting the health and safety of older adults. The current long-term care infrastructure cannot support the population of older residents in need of personal care assistance. The population of residents over age 65 is increasing rapidly, and chronic and disabling conditions make it difficult for older adults in the county to remain independent. The target population—adults age 60 and older—comprises 26 percent of the total county population of 46,543 in 2000. Between 1990 and 2000, the number of adults age 65 and older increased 55.8 percent. The influx of retired persons into the county, Maryland’s only Atlantic seacoast county, has created an additional challenge for service providers. Future growth in the aging population is expected to continue as a result of the retiring population coming into the county as well as the aging of the baby boomer population already living in the county. Access barriers include inadequate long-term care services and the lack of personal care providers, resulting in only 50 percent of total needed care being met. Worcester County is designated as a Health Professional Shortage Area for primary care, dentists, and mental health.

In addition to the Worcester County Health Department, consortium members include the Worcester County Department of Social Services and the Worcester County Commission on Aging.

D04RH06944

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Dental

In 2005, the Eastern Shore Oral Health Action Network (ESOHAN) was developed as a result of an Office of Rural Health Policy Network Development Planning Grant. The primary goal of the ESOHAN is to address disparities in access to, and use of, oral health care services for children and low-income families. Through this network planning process, a service delivery consortium was created to address oral health access issues, particularly in Dorchester County, Maryland. The members of the Eastern Shore Children’s Regional Oral Health Consortium (CROC) include the Eastern Shore Area Health Education Center (AHEC); the University of Maryland Dental School; two federally qualified community health centers, Choptank Community Health System, Inc. and Three Lower Counties, Inc.; and a local hospital, Shore Health System, Inc.

Funds from the outreach grant will be used to improve the availability of and access to preventive, restorative, and rehabilitative oral health care for low-income children on the Eastern Shore.

On the Eastern Shore, dental disease and lack of access to dental care is one of the most pressing health care issues. Considerable oral health disparities remain in this area, especially among the low-income and pediatric populations. Children living on the Eastern Shore exhibit more dental disease than any other area of the State. All six counties in the CROC service area have been designated Dental Health Professional Shortage Areas. Historically, local dentists have not participated in the Medicaid program because of the low reimbursement rates and the complexity of processing claims, creating additional access barriers to dental care for low-income patients. There are no dentists in Dorchester County that accept medical assistance. Children with special health care needs and those with extensive dental disease requiring sedation have to travel at least 75 miles to Baltimore to access dental care.

CROC's work plan focuses on low-income children who are uninsured or enrolled in medical assistance. The target population for Cambridge Dental Center includes the 3,900 children residing in Dorchester County who are eligible for medical assistance. The target population for the hospital-based pediatric dental program includes low-income children in the six counties on the mid and lower Eastern Shore. There are approximately 26,800 children in who are eligible for medical assistance MA in these six counties.

There are three components to the CROC Program: 1) the development of a comprehensive dental center in Dorchester County; 2) the development of a regional hospital-based pediatric dental program for the six mid and lower Shore counties; and 3) the development of community-based clinical and educational training opportunities for dental hygiene students on the Eastern Shore.

MICHIGAN

D04RH04338

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$196,543 | \$183,124 | \$190,139 |

Keyword(s): Behavioral Health, Psychiatric Services

Integrated Behavioral Health Care of Northeast Michigan is an expansion and enhancement project that will build on an existing clinic-based behavioral health service program. Currently, the Alcona Health Centers and Thunder Bay Community Health Services have implemented the Strosahl integrated behavioral health model at six clinics in five northeast, lower peninsula Michigan counties with two behavioral health consultants and one clinical psychologist covering all six clinics, and there is a need for more behavioral health consultants. The project will provide new psychiatric services at four clinics and will add two new behavioral health consultants and neurological health services to address the needs of the substantial elderly population. In the integrated behavioral health care model, psychologists, psychiatrists, and

behavioral health consultants will be integrated members of the primary care system at Alcona Health Centers and Thunder Bay Community Health Services. The expansion of services is holistic, cost-efficient, and very much needed. Eventually, telepsychiatry will be added to improve access to care.

The target area served by the consortium comprises four counties—Iosco, Alcona, Montmorency, and Presque Isle—in the lower peninsula of Michigan. The general population in the service area is 63,000, and the target population is the more than 12,000 rural adults and children in the area estimated to be in need of mental health services, including psychiatric, counseling, and referral services. These individuals face multiple obstacles to services, including low income, lack of education, cultural barriers, rural isolation, stigma, lack of facilities and resources, funding disparities, and age discrimination. The target population is very rural and has less access to adequate health care due to income, education, and transportation issues. There are 0.25 psychiatrists as well as one psychologist and two behavioral health consultants in the four-county service area. The main providers of behavioral health are primary care physicians. The primary reason patients are generally unable to access behavioral health services is the lack of qualified behavioral health specialists in primary health care settings. The target area is designated as a Health Professional Shortage Area and a Medically Underserved Area.

The primary members of the consortium include Alcona Health Centers, Thunder Bay Community Health Services, Alpena General Hospital, and Northern Collaborative Care.

D04RH02574

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| Fiscal Year | 2004 | 2005 | 2006 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$199,910 | \$197,882 | \$199,314 |

Keyword(s): Geriatric care, Mental health

Alzheimer disease is the eighth leading cause of mortality among elderly persons in the United States, accounting for more than 100,000 deaths annually. The cost of irreversible dementia is presently estimated at \$100 billion per year, making the illness our Nation's third most costly medical condition behind heart disease and cancer. At present, most dementia disorders are costly, progressive, and without a cure. The effects are devastating to the caregivers and family as well as the affected individual. It is projected that by 2050, more than 13 million Americans will have Alzheimer disease.

The 6 counties in Michigan's Upper Peninsula targeted for this project are Baraga, Gogebic, Houghton, Keweenaw, Marquette, and Ontonagon counties. This geographical area has an Alzheimer disease rate nearly double that of the state of Michigan. It is conservatively estimated that 5,593 residents (4 percent of the population) suffer from a dementia disorder. Some dementia disorders can be treated; others are irreversible but can benefit from coordinated medical and social management. Unfortunately, many people with memory disorders remain undiagnosed and under-managed. The project recognizes five issues that result in less than optimal care management for people suffering from memory loss: delayed

entry into medical services, variation in care coordination and clinical practice, family member difficulty in recognition and intervention (particularly those geographically distant), caregiver risk for health and psycho/social problems, and the compliance variation in care provided within the home setting.

The applicant, Marquette General Health System, has joined with its network partners, Grand View Health System, Keweenaw Memorial Medical Center, and the Portage Health System to develop Softening the Sunset Journey, a community-based collaborative which seeks to maximize local coordinated care resources toward the improvement of community awareness, early identification, access to care, and caregiver screening for older adult memory loss. Targeted populations include older adults experiencing memory loss and their family members and caregivers. The majority of people experiencing memory loss will be age 65 and older (95 percent), with the remainder of the target population age 18 to 64 (5 percent).

D04RH04339

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): EMS Providers, Capacity Building

The Huron-Sanilac Emergency Medical Services (EMS) Volunteer Recruitment and Retention Project will aggressively seek to reverse the declining number of active EMS providers in this rural area of Minnesota. The project goal is to increase EMS volunteers for Huron and Sanilac counties from 246 to 300 licensed volunteers, with an increase in advanced certifications of 5 percent. This will enable Huron and Sanilac counties to replace outgoing EMS volunteers and build their volunteer rosters. A two-pronged approach includes capacity building and outreach. Project strategies include increasing access to EMS training, reducing barriers to EMS training and service, increasing awareness of the value and importance of EMS, and increasing incentives for EMS volunteers.

The primary target audience is residents living in Huron and Sanilac counties located in the “Thumb” of the mitten-shaped state of Michigan. The Thumb is a sparsely populated area with a disproportionately high number of residents age 65 and older. Health care providers are challenged with meeting the needs of large populations of senior citizens and low-income residents. Both counties are low-income Health Professional Shortage Areas. Because of the overwhelming need for EMS in rural areas, all residents in Huron and Sanilac counties are beneficiaries of the program. In Huron County, 14.6 percent (5,135) of residents live in townships that are designated as Medically Underserved Communities. In Sanilac County, 44.6 percent (19,865) residents live in such designated areas. Four of the six local hospitals are Critical Access Hospitals, and 10 EMS services meet guidelines for a Critical Access Ambulance Model.

In addition to Sanilac Medical Services, Inc., the lead applicant, consortium members include the Huron County Medical Control Authority, Sanilac Intermediate School District, and Huron Intermediate School District.

D04RH06935

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,988 | \$124,999 | \$100,000 |

Keyword(s): Obesity/overweight

The problem is clear: Michigan has the third highest obesity rank in the United States, with 62 percent of adults being overweight or obese. Our children are following in our footsteps. Eleven percent are considered overweight, and 13 percent are at risk for overweight. These youth are likely to become overweight adults with all the serious health conditions, psychological issues, and health care costs that arise with excess weight and energy imbalance.

Two critical access hospitals have joined with their regional referral center to reduce the proportion of children and adolescents who are overweight or obese. The project targets families in three counties in Michigan’s Upper Peninsula—Luce Mackinac, and Marquette. These counties are home to 83,601 people. State statistics suggest there are 5,598 youth ages 5-19 in the service area who are overweight or obese.

This project takes a practical, scientific approach to what is often an emotional issue. We recognize three specific needs:

- Families lack knowledge and basic skills for translating scientific information on nutrition and exercise into everyday practice, which results in less than optimal growth and development for youth.
- Youth who have a high potential for developing metabolic syndrome often experience delayed entry into appropriate services.
- Rural communities lack the critical mass and specialty expertise to provide evidence-based programming for youth weight loss.

Local autonomy will be combined with cooperative regional efforts and evidence-based models for prevention, early identification and treatment. Site coordinators will be placed in each community to implement project activities and coordinate with local stakeholders. Consortium partners will cooperate to develop and deliver coordinated awareness and education curricula, to offer local screenings for metabolic syndrome, and to deliver a video-conferenced treatment program that will demonstrate a reduction in body mass index and improved lab values related to chronic diseases. Local staff will provide patient follow-up and communication streams among health care providers. An evaluation team, headed by a nationally recognized researcher at Northern Michigan University will conduct evaluation for process and outcome measures.

The applicant is Helen Newberry Joy Hospital and Healthcare Center, a critical access hospital with an attached long-term care facility, a rural health clinic, and three outreach health clinics. The consortium partners are Mackinac Straits Hospital, a critical access hospital, and Marquette General Health System, a 364-bed regional referral center. Staff will be dedicated to this project within each partner organization, strengthening each partner’s role while cooperating on all

activities. An advisory group of project staff, community stakeholders, and representatives from the target group will oversee this project.

D04RH06934

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Obesity/overweight

The Thumb Area Nutrition and Physical Activity Campaign is a result of a community health assessment conducted by the Thumb Rural Health Network. Results indicated that the overarching issue related to death rates from heart disease, diabetes, and other chronic disease is obesity. Despite numerous health education programs that address nutrition and physical activity, 66.5 percent of adult residents and 40 percent of youth are overweight or obese. The proposed project is the result of 15 months of research and planning by the task force.

The Tuscola County Health Department will provide project management and partner with three Michigan State University Extension Services, health departments in Huron and Sanilac Counties, and rural hospitals to implement the project. The Task Force has four long term goals: 1) To increase the proportion of adults who are at a healthy body mass index (BMI) from 33.8 percent to 38.8 percent by 2015; 2) To reduce the proportion of adults who are obese from 28.8 percent to 26.8 percent by 2015; 3) To reduce the proportion of children and adolescents that are overweight or obese from 40 percent to 30 percent by 2015; and 4) To increase the proportion of children and adolescents ages 6 to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.

The Thumb Steps Up Task Force has developed a community-wide campaign that goes beyond health education. The campaign is based on State models and Centers for Disease Control and Prevention-recommended programs. Interventions include community outreach and health promotion. Project activities include a social marketing campaign; community presentations; community activity programs; promoting local and State recognition programs for "Promoting Activity Communities" and "Healthy Eating"; and providing technical assistance to grocers, restaurants, human service providers, governmental bodies, schools, and worksites. The Task Force has emphasized the need to address childhood obesity and reach youth who have a greater propensity for change than adults. Research shows that, to impact youth, the adults and environment that they live in must also be changed. Therefore, children, their families, and the communities where they live will be the priority population targeted for interventions. Major outcomes include:

- Outcomes 1 & 2: 60 percent of focus group participants will indicate social marketing messages are credible and have the ability to influence behavior.
- Outcome 3: 90 percent of food outlets/suppliers that participate in an assessment increase their score.

- Outcome 4: Pre- and Post-Health Risk Appraisal Reports indicated a significant improvement in health indicators related to obesity.
- Outcome 5: Nine communities will receive awards from the Michigan Promoting Active Communities Program by 2009.
- Outcome 6: Nine schools complete assessments and have a Health Improvement Plan.
- Outcome 7: The percentage of youth exhibiting healthy eating behaviors will increase significantly.
- Outcome 8: The percentage of youth exhibiting physical activity behaviors will increase significantly.

MINNESOTA

D04RH04364

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$180,019 | \$194,670 | \$200,000 |

Keyword(s): Women's Health

The overall goal of the program is to foster increased capacity and resources to assure rural health delivery of quality programming for women's health, including family planning and risk reduction services in three counties in north central Minnesota. The four program goals include improving access to family services, reducing unintended pregnancy, improving the quality of women's health care services, and improving communication between providers through consortium involvement and improved technology capabilities.

A primary point of access for women during reproductive age is for contraceptive care, and the project seeks to improve acceptance of and access to this service and to make this service more comprehensive for all women. Women will receive contraceptive care and assessment/referral for issues relating to their health. The project will use a community clinic model of service delivery and will work with family planning and general practitioners to build capacity to serve women in a holistic manner.

Unintended pregnancy is a high-priority public health problem in Cass, Todd, and Wadena counties, the low-income, primarily rural area the project will serve. The target population is women of reproductive age, with an emphasis on low-income or uninsured/underinsured women. The majority of the population in all three counties is white. The American Indian population (10.8 percent in Cass County, 0.5 percent in Todd County, and 0.6 percent in Wadena County) receives most services from the Indian Health Service, but the project will serve part of that population in outlying clinics. Todd County has a growing Hispanic community (8 percent), which the project will include as part of the target population.

Many residents in all three counties live in isolation, miles away from medical services, and must travel 75 to 80 miles to receive subsidized family planning services. Many of the most at-risk women have unreliable transportation, making access to care difficult. Other barriers to access include cost and the lack of insurance. A large percentage of the population is uninsured. Thirty percent of the population delay or fail to seek medical care because of cost or lack of insurance. All three counties are designated Health Professional Shortage Areas for primary care and Medically Underserved Areas. The project population is a Medically Underserved Population.

Consortium members include Cass County Health, Human, and Veterans Services; Todd County Public Health; Wadena County Public Health; CentraCare Clinic; Dakota Clinic–Walker; Dakota Clinic–Menahga; Pine River Family Clinic; Wadena Medical Center; and Ottertail Wadena Community Action Council.

D04RH04363

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$180,835 | \$185,993 | \$191,300 |

Keyword(s): Mental Health Services

The Mahnomen County Mental Health Consortium will focus on at-risk children and adolescents and their families, while expanding access of the general population to short-term outpatient services to ensure earlier intervention for individuals and families. The consortium will provide professional home-based mental health therapy services to children and adolescents and their families, with special emphasis on children and adolescents involved in the criminal justice system. It also will provide school-based mental health services to improve both social and academic performance, reduce school dropouts, and decrease out-of-home placements. Functional family therapy and family group decision-making will be adapted to address the special cultural needs of Native American children and families. Outpatient services will be initiated to ensure access to all populations to improved crisis management and to better integrate mental health with primary health services, particularly relevant to the Native American population. The project will establish an interagency process for coordinating early identification, screening, assessment, and intervention. Goals of the project are (1) to develop an interagency network of health, mental health, and human service agencies to implement early identification, screening, referral, and intervention to address the needs of at-risk families, children, and adults in need of mental health care; and (2) to improve access to mental health resources for county residents.

The target population is at-risk children and adolescents and their families in need of multiple services in Mahnomen County, a small rural county in northwestern Minnesota located entirely within the boundaries of the White Earth Indian reservation. The county has a diverse population of 5,215 people, including a significant number of Native Americans (28.6 percent of the population). With 30.9 percent of the population living in poverty, the area is among the poorest in the state and has the lowest per capita income in Minnesota. Unemployment is 8.1 percent. If estimates of the unemployed were expanded to include unemployed people who

are no longer actively seeking work, the percentage of unemployed people in the county would approach 50 percent.

County residents experience mental health problems that are among the most serious of any county in the state. The challenges of poverty, cultural diversity, a failing rural economy, and natural disasters—all barriers to accessing services—also contribute to the need for mental health services. Mahnomen County is designated as a primary medical care Health Professional Shortage Area and a Medically Underserved Area.

Consortium members include Northwestern Mental Health Center, the lead applicant; Mahnomen County Human Services; Mahnomen Health Center; Independent School District No. 432; and White Earth Reservation Health Services.

D04RH06962

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Dental

The Surgeon General's 2002 Report on Oral Health recognizes oral health as a significant health care concern that especially burdens the poor, children, minorities, and the elderly. Minnesota is facing major problems in dental care delivery stemming from current dental workforce shortages and rising health care costs—challenges that are exacerbated in rural communities.

The goal of the Rice Regional Dental Clinic is to increase access to dental care for uninsured and underserved residents in the 12-county service area of west central and southwest Minnesota. Strategies to support this goal include: 1) providing dental care for uninsured and underserved residents in the service area; 2) promoting careers in dentistry among people living in the area through education and public service; 3) engaging area dentists and dental hygienists in public service; 4) increasing the number of dentists and dental hygienists choosing to practice in the service area; 5) providing opportunities for inter-professional education; and 6) strengthening the dental clinic infrastructure.

The dental clinic's target population is underserved residents in the 12-county service area, including public program patients and others who lack dental insurance or the means to access care. Eight of the twelve counties are federally designated Dental Health Professional Shortage Areas. In addition to being home to a large number of American Indians, the 12-county service area includes a significant number of ethnic minorities, including Somali, Latino, and Sudanese populations.

The Rice Regional Dental Clinic will be constructed on the campus of Rice Memorial Hospital in Willmar, Minnesota. The clinic will feature a unique dental education model. Once it is fully

operational, an estimated six dental and dental hygiene students will rotate through the clinic and provide patient care on a year-round basis, supervised by the clinic's staff, which includes a full-time University of Minnesota School of Dentistry faculty member, two dental assistants, and a dental hygienist. An estimated 8,100 patient visits will be conducted annually once the dental clinic is fully operational.

Rice Memorial Hospital is the largest city-owned hospital in Minnesota and has a history of commitment to outreach. The project consortium also includes the University of Minnesota School of Dentistry, which will help staff the Dental Clinic with dental students; Southern Minnesota Area Health Education Center, which will support the dental students and provide links to K-12 and community resources; and Kandiyohi County Public Health and Countryside Public Health, two public health agencies currently serving the target population in the 12-county service area, who will provide the critical link to the target population.

MISSISSIPPI

D04RH04330

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$196,236 | \$185,750 | \$178,123 |

Keyword(s): Primary Health Care, Prevention Services, Health Education

The Claiborne County Rural Health Care Services Outreach project, established by the Claiborne County Family Health Center (CCFHC) and consortium partners, will operate three school-based health clinics to provide primary health care, prevention services, and health education on topics such as diet, nutrition, exercise, high-risk behavior prevention, and tobacco use prevention to students in grades K–12 students in the Claiborne County Public School District. The project also will provide immunization tracking as well as reproductive, dental, and mental health services. Age-specific programs will educate students on becoming responsible for their own health and practicing preventive health. Programs will include personal hygiene, health as part of one's lifestyle, obesity/weight management classes, reproductive health/abstinence education, building positive self-esteem, and assessment for at-risk behavior or at-risk psychosocial environment factors. The school program will operate on a year-round basis approximately 40 hours a week. CCFHC and the county hospital will offer backup services when the school clinics are closed or when additional health care services are needed.

The service area, Claiborne County, is located in the mid-Mississippi Delta region—the poorest region of the United States. The target population is students in the Claiborne County Public School District. Currently, there is limited access to health care in the schools. The majority (approximately 99.8 percent) of the students in the Claiborne County School District are African American, 72 percent of whom are estimated to be at or below the 200-percent Federal poverty level. Of the state's 82 counties, Claiborne ranks 26th in the percentage of births to teens; almost 21 percent of all the babies born in the county are born to teenagers. Barriers to health care in the county mirror the socioeconomic and health care problems of the Delta region, ranging from lack of indoor toilets to illiteracy. The Delta region has one of the highest illiteracy

rates in the Nation, with only 54 percent of the adult population completing high school. In addition to depressed economic conditions and low educational attainment, other barriers include the absence of public transportation and lack of other transportation and phone service.

Claiborne County is a designated Health Professional Shortage Area as well as a Medically Underserved Area/Medically Underserved Population. The county has only three physicians with a physician-to-patient ratio of 1:4,469.

In addition to CCFHC, the lead applicant, consortium members include the Claiborne County Public School District, Claiborne County Hospital, and West Central Public Health District 5 of the Mississippi State Department of Health.

MISSOURI

D04RH04329

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Primary Health Care, Health Education, Social Support Services

The goal of the Lafayette County 4 Health Project, a rural health education and outreach project, is to improve access to primary care health and social support services in the county through an integrated network of local providers. The project will incorporate community education and outreach approaches to connect vulnerable, low-income populations to an integrated network of local health and social support services. In the first year, the project will use community education and health promotion activities to address disease prevention issues and mental health topics with a special emphasis on domestic violence and child abuse. The project, which includes outreach to the seasonal migrant community, will strengthen and expand a referral process among local providers by developing a technology-aided management information system to expedite patient scheduling, intake, and follow-up.

The target population is medically underserved and uninsured residents of Lafayette County, Missouri. There is little ethnic diversity in the population, which is 96.6 white, 2.6 percent African American, 1.2 percent Latino, 0.5 percent Asian/Pacific Islander, and 0.9 Native American. The target population includes nearly 500 seasonal migrant workers and their families. Of the county population of 32,960, 25.5 percent of the residents have incomes at or below 200 percent of the Federal poverty level. In addition to poverty, barriers to accessing services include distance, transportation difficulties, lack of insurance, and lack of providers. There are 19,466 uninsured individuals in the county, and the entire population is classified as underserved because of the dearth of medical providers. The physician-to-population ratio is 3,619:1. Lafayette County is a designated Health Professional Shortage Area.

Consortium members include the District III Area Agency on Aging, Lafayette County Health Department, Lafayette Regional Health Center, and Rodgers-Lafayette Health Center.

D04RH04328

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$192,941 | \$192,292 | \$199,910 |

Keyword(s): Behavioral Health Care

The Mercer County Behavioral Health Outreach Project seeks to increase access of children and isolated rural farm families to behavioral health care by providing outreach and education resources and promoting greater community involvement in an integrated network of services. The four goals are as follows: Goal 1 focuses on school-based identification, problem-solving, and documentation of students with behavioral health problems. Goal 2 involves linkages of school-based children and their families to intensive behavioral health services, faculty and staff consultation, counseling, and referrals. Goal 3 focuses on services to behavioral at-risk children and their families through countywide asset-building activities. Goal 4 involves the training of specialists and staff and development of a new rural behavioral health/emergency disaster health care outreach network of project partners.

The service area is rural Mercer County, which is a farming area located in north central Missouri along the Iowa-Missouri border. It is one of the state's most poor, isolated, and distressed areas. The target population is 921 Mercer County students and 124 farm families in the context of family, school, and community. The county is 98.7 percent Caucasian. In 2002, there were 3,669 residents with a median age of 42.4. Depression is a major health issue, and the county has the state's highest suicide rate. The county does not have a mental health facility, and behavioral health problems afflict both school-age children and adults, especially those living in isolated farm families or alone.

Access barriers include rural isolation, unstable family environments, poverty, and lack of transportation. Mercer County is a designated Health Professional Shortage Area as well as a Medically Underserved Community and Medically Underserved Population.

In addition to Princeton R-V School District, the lead applicant, consortium members include Cainsville R-I School District; Newtown-Harris R-III School District; North Mercer R-III School District; Spickard R-II School District; North Central Missouri Mental Health Center; Harrison County Community Hospital; Mercer County Health Department; Northeast Family Health Clinic; Mercer County Office, Missouri Department of Social Services; and National Alliance of the Mentally Ill of Missouri.

MONTANA

D04RH04398

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$191,318 | \$165,475 | \$155,267 |

Keyword(s): Child Sexual Abuse, Education/Prevention

The Butte Consortium for Sexual Abuse Prevention was formed to address child sexual abuse in Butte and southwest Montana, where the incidence of sexual abuse is unusually high. Primary goals of the project are education/prevention, evaluation, and follow-up. The consortium will employ three strategies: (1) prevention education for preschool and young children (grades K–3) using the Talking About Touching personal safety curriculum; (2) evaluations for suspected victims of child sexual abuse at the Child Evaluation Center; and (3) professional therapeutic support services for the victims and their families as well as for children at risk for sexual abuse. Few children in Butte receive education from their families about how to stop or prevent someone from sexually abusing them, and almost no services are available to assist children or their families once sexual abuse occurs. This project seeks to remedy the lack of services and meet the ever-spiraling needs associated with child sexual abuse and its aftermath.

About 1,300 cases of child abuse or neglect are reported in the area each year. There are 220 registered sexual and violent offenders in Butte, a large number for a community of 33,000. In the past 4 years, more than 370 children were evaluated for child sexual abuse, but research suggests this number is low and represents only about one-fourth of the number of incidents that actually occurred. Butte is a very poor community, where the prevalence of alcohol and drug abuse and violence contributes to the growing problem of child sexual abuse. Ninety percent of the alleged child abuse and neglect cases in Butte involve drugs or alcohol use.

The target population is children at risk for sexual abuse or who have been sexually abused within Butte and the surrounding area. Additional unmet needs in the community—isolated geography, large numbers of low-income residents, depressed economy, and a culture of violence and addictive behaviors—all contribute to the high rate of child sexual abuse. Butte is located in Silver Bow County, a rural area located in the northern Rocky Mountains. Of its population of 33,300, 95.4 percent are Caucasian, 2.7 percent Hispanic/Latino, 2.0 percent Native American, 0.2 percent African American, and 1.1 percent other. Currently, 40 percent of Butte's (Silver Bow County) population lives at or below 200 percent of the Federal poverty level, and 53 percent of the total public school student population qualifies for free or reduced lunches.

Barriers to services for prevention of child sexual abuse include lack of education and awareness, insufficient financial resources, addictions, and lack of therapy and support services for children and families. Butte-Silver Bow County is a designated Health Professional Shortage

Area (HPSA). It is a low-income HPSA and qualifies as a mental health and dental HPSA. It also is a Medically Underserved Area/Population.

Community partners in the consortium include the Butte Silver Bow Primary Health Care Clinic, Inc., the lead applicant; St. James Healthcare; Butte Silver-Bow Law Enforcement Detectives; Butte Silver-Bow County Attorneys Office; Butte Office of Department of Family Services; and Dr. Ken Graham, a private pediatrician.

D04RH03722

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$199,974 | \$199,974 | \$199,974 |

Keyword(s): Provider training, Continuing medical education (CME)

One of the most pressing needs for rural emergency medical services (EMS) systems is ongoing medical oversight. This is true regardless of whether the emergency medical response is provided by a volunteer, government, fire department, hospital-based, or other organization. Rural physicians are required to provide this oversight, often without training or understanding of the task. They are frequently constrained by their ability to travel to medical oversight training offered within or outside their geopolitical jurisdiction. The lack of medical oversight within rural EMS systems impacts patient care, utilization of health resources, and the preparation for large-scale disaster responses.

The Critical Illness and Trauma Foundation, the Burns Telecommunications Center at Montana State University, the Billings Area Indian Health Service, the National Association of Emergency Medical Service Physicians, the National Association of State Emergency Medical Service Directors, and other collaborators seek to modify the delivery format of a training program titled: *Guide for Preparing Medical Directors*, currently distributed by the National Highway Traffic Safety Administration. The goal of the project is to develop the *Guide for Preparing Medical Directors* into an electronically delivered, mentor-supported, self-study program to train medical oversight physicians in rural, frontier, and wilderness locations. By making these materials available online, it is anticipated that medical oversight training will become more widely available resulting in benefits to the emergency medical services and disaster response systems in rural areas. The demographic and ethnographic characteristics of the target population will mirror the rural and frontier populations that the EMS agencies serve. Targeting the states of Alaska, Kansas, and Montana, 40 percent of the secondary and tertiary population served will be Alaskan Natives or American Indians. The remaining ethnic mix will be predominately Caucasian with a substantial mix of Hispanic/Latino individuals.

D04RH06925

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Chronic disease, Diabetes

The Chronic Care Outreach Program (CCOP) was created through the collaborative efforts of Wheatland Memorial Hospital and several urban partners—St. Vincent Healthcare (tertiary hospital and Level II trauma center, internists, and diabetes center); Northwest Research and Education Institute (continuing medical education, community education, the Mansfield Health Education Center and Library, and Partners in Health Telemedicine Network); and the South Central Montana Community Mental Health Center (regional mental health services). All of the urban partners are located in Billings Montana.

The Chronic Care Outreach Program will plan self-management interventions and programs to reduce health disparities and increase access to nationally recommended health care services for residents living with diabetes and other chronic illnesses. All residents of the area living with chronic illnesses will be targeted for this program to reduce poor health outcomes and increase healthy years of life in which they can continue to live on their own. Local health care systems and community resources will be used to streamline activities to prevent duplication of services and bring additional assistance to the population of this area that are living with diabetes and other chronic illnesses.

The service area proposed includes the Wheatland Memorial Hospital (WMH) service area, the lead organization in the consortium. WMH is located in Harlowton Montana, a ranching community in central Montana with approximately 1.6 people per square mile. The population of the service area is estimated to be 4,000 people, with WMH serving residents of Wheatland, Golden Valley, Judith Basin and portions of Sweet Grass and Meagher Counties. The nearest tertiary care facility is 92 miles south of Harlowton in Billings Montana, the largest urban center in Montana. The next closest tertiary care service is located in Great Falls Montana, 130 miles north. Lewistown, Montana, is located 60 miles from Harlowton to the east, which is a secondary care facility.

D04RH06927

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Mental health, Substance abuse

Low-income Lewis & Clark County residents have high rates of mental illness, yet access to affordable mental health care services is almost non-existent. A 2003 survey of 200 Cooperative Health Center (CHC) patients indicated that 23 percent had been diagnosed with depression, 35 percent had had generalized anxiety, 46 percent experienced somatic complaints, and 14 percent had been diagnosed with an alcohol or drug problem. The three-agency consortium formed for this project will provide access to mental health and substance abuse services, regardless of patients' ability to pay.

The CHC will collaborate with two other federally supported mental health/substance abuse service providers in the county, Golden Triangle Community Mental Health Center and Boyd Andrew Community Services. Golden Triangle will provide mental health services to CHC patients with severe mental health problems that are not within the scope of CHC's ability to treat. Boyd Andrew, which provides chemical dependency treatment services, will provide in-service trainings for CHC care providers and hold four appointment slots per month for CHC patients seeking treatment for substance use disorders.

Mental health and substance abuse (MH/SA) services provided will include screening, assessment, diagnosis, case management, cognitive-behavioral therapy, brief problem-solving therapy, solution-focused therapy, mastery of panic and anxiety, brief alcohol intervention, and psychotherapy, when judged appropriate. MH/SA services will be delivered during patients' primary care visits and during one-on-one visits with MH/SA providers, who will include a CHC mental health specialist and a Golden Triangle case manager, both working at the CHC clinic site. Primary care providers will introduce the mental health specialist to the patient in the exam room when the provider determines the patient needs mental health or substance abuse care. This approach will integrate mental health and primary care services, reducing stigma and increasing the number of patients served. All CHC patients will be screened for MH/SA issues 5 afternoons a week at the start of the project, expanding to 5 full days as the project progresses.

The CHC will assess the effectiveness of treatment for depression by using Key Depression Care Measures from the Depression Collaborative. Effectiveness of treatment for anxiety will be assessed with the appropriate sections of Prime MD, a widely used mental health diagnostic/assessment questionnaire. The CHC will track MH/SA patients with an expanded registry modeled on the Depression Collaborative registry. The case manager will use the registry to follow patients' progress and manage their treatments, medications, and connections with necessary community services.

The CHC targets Lewis & Clark County residents living below 200 percent of poverty. Of county residents of all ages, 28.6 percent lived below 200 percent% of poverty in 2000, and 44 percent of those were uninsured. CHC will focus first on delivering MH/SA services to its current patient population, which consisted of 6,082 unduplicated patients in FY 2005. Six percent of the patient population is homeless.

D04RH06926

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$124,936 | \$100,000 |

Keyword(s): Mental health, Substance abuse, Telemedicine

The Rural Access: Mental Health Care Project will increase behavioral and mental health care services to low-income American Indian children and youth living on the Fort Peck Indian Reservation in rural northeastern Montana. The Fort Peck Indian Reservation is one of the poorest areas in the United States, with a poverty index three times higher than the State of Montana. This project was developed by the superintendents of the reservation based school districts, the Tribal Health Department, the Tribal Family Violence Resource Center, Indian Health Service and the Department of Psychiatry, Harvard Medical School in Boston, Massachusetts. The schools district computer communications systems will be upgraded to the compatibility of Massachusetts General Hospital and Harvard Medical School to initiate telemedicine psychiatric counseling services with post-doctoral students at Harvard Medical School. The project also establishes a Harvard Medical School Psychiatric Internship Program that will station a post-doctoral fellow on the Fort Peck Indian Reservation for 6 months per year. The project consortium estimates that psychiatric care services will be increased by 420 new patient visits in both Year 2 and Year 3.

NEBRASKA

D04RH06948

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Mental health

Significant discrepancies exist in the availability of behavioral health resources for persons living in rural areas. For example, in 1999, 87 percent of the Mental Health Professional Shortage Areas in the United States were in non-metropolitan counties (Bird, Dempsey, and Hartley, 2001). In rural Nebraska, there are federally designated Mental Health Professional Shortage Areas in 88 of Nebraska's 93 counties. Of the State's 146 board certified and licensed psychiatrists, 326 licensed practicing psychologists and 1,890 licensed mental health practitioners—a significantly disproportionate number (26 percent)—serve 850,000 rural residents (47 percent of the State's population) residing over a 70,000 square mile area. Meanwhile, 74 percent of behavioral health professionals provide services to the 53 percent of the population residing in metropolitan areas. An estimated 20 percent of children and adolescents ages 9 to 17 also have identifiable mental illnesses each year (Schaffer, Fisher, Dulcan et al., 1996), with even less access to specialty services and preventive care than available for adults.

A consortium consisting of the Good Neighbor Community Health Center (GNCHC), Boys and Girls Homes of Nebraska (BGHN), the East Central District Health Department (ECDHD) –all from rural Columbus, Nebraska—and the Behavioral Health Clinics training program of the University of Nebraska Medical Center (UNMC) have joined forces to address these issues. Using an approach that integrates behavioral health into primary care practice, the consortium will add behavioral health faculty and trainees from the training program at UNMC to its existing array of services at the Good Neighbor CHC and to the diagnostic and treatment services of the Boys and Girls Homes programs. The overall goals of the project are:

- To reduce discrepancies in the availability of outpatient behavioral health care to the rural medically underserved population of east central Nebraska through the provision of expanded services and increased numbers of behavioral health providers
- To reduce the number of inappropriate out-of-home placements for children and adolescents through the provision of integrated behavioral health team evaluations for juvenile justice and child protective service agencies in East Central Nebraska; and
- To evaluate the effectiveness of an integrated behavioral health program in the primary care Good Neighbor Community Health Center and replicate the program in at least one additional site in Nebraska by the end of the 3-year grant cycle.

Funding from the project will go towards: 1) increasing current GNCHC psychiatric availability, 2) providing child-adolescent psychology service provision, and 3) recruitment, training, placement, and retention of behavioral health professionals (social workers, counselors, psychologists, psychiatric nurses, and other behavioral health professionals) in rural primary care settings. Funding will also be used to address the specific needs of the underserved population of Hispanic individuals and families through support for a Spanish-speaking interpreter and a van driver who will assist rural patients with transportation needs to get to their BH appointments.

The Behavioral Health Clinics training program at UNMC has a history of integrating behavioral health into primary care practices and has HRSA training funds (Allied Health and Graduate Psychology Education grants) that will provide further support for this rural behavioral health effort.

D04RH06950

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$90,000 | \$26,625 |

Keyword(s): Dental services

West Central District Health Department (WCDHD) has recognized a need for access to dental care among residents of its service area who either rely on Medicaid or who self-pay for dental care. A survey of residents in the eight counties served by WCDHD confirmed that Medicaid and self-pay residents forego dental care at much higher rates than their privately insured counterparts. Part of the reason for this is that only one dentist in North Platte accepts new Medicaid patients. For the most part, Medicaid patients must travel outside the service area to

get dental care. As a result, WCDHD and other organizations in North Platte have formed a very limited dental clinic for youth up to age 18 whose families meet the income requirements for Medicaid. The experience with that clinic has convinced WCDHD and its partners that a permanent clinic that serves both adults and youth is needed.

Therefore, WCDHD and its partners are establishing a permanent dental clinic in North Platte, Nebraska, to serve Medicaid recipients and low-income self-paying residents. During the first year of operation, the clinic will be open on a half-time basis and will be staffed by a halftime dentist, a full-time dental assistant who will also act as an office manager, and a half-time receptionist that will be staffed by volunteers through the Retired Senior Volunteer Program. During the first year, the clinic expects to serve 1,000 patient visits. Services during the first year will not include more elaborate restorative procedures such as dentures and bridges. During the second year, the clinic will again be open on a half-time basis, but the staff will be expanded to include a half-time dental hygienist. Dental services will also be expanded to include dentures and bridges. During the second year, the clinic expects to serve 1,800 patient visits. In the third year, the clinic will be open on a full-time basis and expects to serve 3,900 patient visits.

Quarterly evaluation meetings with consortium members and dental staff to assess financial and patient flow will be held for the duration of the grant period. WCDHD and its partners intend for the clinic to be self-sustaining by the end of the grant period.

NEVADA

D04RH06921

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,994 | \$124,994 | \$99,998 |

Keyword(s): Telemedicine

The goal of the Rural Dementia Telemedicine Initiative (RDTI) project is to establish a long-term, sustainable method of service delivery to Alzheimer's (dementia) patients, caregivers, and health care professionals involved in the delivery of diagnosis, disease management, and treatment in rural and underserved communities of Nevada and other western states through the Center for Cognitive Aging's (CCA) Alzheimer Disease Diagnostic and Treatment Center (ADDTC) via telemedicine. Through the capabilities that telemedicine offers the RDTI program can bring urban medical specialists face-to-face with patients in geographically remote areas of Nevada and other western states. Individuals identified by community screening sessions or through physicians' offices will also be afforded follow-up care and ongoing medication management. In addition to medical care, the telemedicine project will be used to train health care professionals, health care providers and caregivers; and to provide a venue by which support groups can meet. The project is also aimed at reducing the economic burden associated with long-term care costs for patients, families, and employers through early identification and intervention of Alzheimer's disease and other dementias.

Approximately 381 patients and their families will benefit by using the RDTI program over the next 3 years. This project primarily serves the elderly, 65 year of age and over, including American Indian and Hispanic populations, which are spread over 95,763 square miles in the rural and frontier areas of Nevada alone. The RDTI project, which can tap into existing telemedicine facilities and networks, substantially reduces expenses for equipment and has the potential to become a model for other rural and frontier areas of the country.

D04RH06803

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Human service training

Founded in 1967, Great Basin College (GBC) is the oldest, public community college within the Nevada System of Higher Education (NSHE). Located in the rural high desert of northeastern and central Nevada, GBC's service area covers over 45,000 square miles and includes the counties of Elko, Eureka, Humboldt, Lander, and White Pine. The area has 78,000 residents and has been classified as "frontier" with an average of less than two people per square mile. Overall, GBC's service area encompasses only 3.9 percent of the total population of Nevada.

GBC is developing and implementing a Human Services Certificate Program and a Human Services Associate of Applied Science Degree Program, that will train and educate individuals for jobs that support the delivery of a broad range of health-related services currently lacking in GBC's expansive, rural service area. The human service profession promotes improved service delivery systems by filling positions that address the quality of direct services as well as the accessibility, accountability, and coordination among professionals and agencies of these services. Examples of service delivery settings include mental health agencies; agencies serving the elderly; family, child, and youth service agencies; correctional agencies; and agencies/programs concerned with alcoholism, drug abuse and violence.

The development of the Human Services Program will be accomplished by the project consortium members, which include: Great Basin College, Nevada Department of Health and Human Services, the Nevada State Office of Rural Health, Indian Health Service-Southern Band Health Center, BrightPath Adult Enrichment Center, and Partners Allied for Community Excellence (P.A.C.E. Coalition).

The project will seek to accomplish the following goals:

- To develop and implement a Human Services program that offers a Certificate and an Associate of Applied Science degree;
- Work with service providers to develop 20 practicum/clinical sites for hands-on student learning; and
- Enroll at least 20 students in the Human Services Program.

NEW HAMPSHIRE

D04RH04332

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$182,000 | \$183,031 | \$189,643 |

Keyword(s): Chronic Disease Management, Diabetes, Congestive Heart Failure, Telehealth

The focus of the Rural Outreach for Improvement of Chronic Disease Management Project is implementation of a chronic disease management program for individuals with diabetes and congestive heart failure in rural southwestern New Hampshire. Specific goals for the project are significantly reduced hospitalizations, reduced emergent care, better access to care and services, and improved patient quality of life and satisfaction. Implementation of telehealth technology is an essential element in the program. A primary care physician, cardiologist, or clinic or home care nurse will identify patients at risk for heart failure or diabetes. A feature of the project is incorporation and development of clinical pathways for patients with heart failure or diabetes in relation to acceptable blood pressure, weight, and other markers, so that primary care interventions can occur in a more timely way and “crises” can be avoided. The project will implement wellness and prevention strategies by introducing patients to self-help materials and educational resources upon discharge from an acute hospitalization, clinic visit, or home health care admission.

The service area is rural and isolated with no divided highways. The general population in the area is 97.3 percent white. The chance of experiencing chronic illness increases significantly with age, and the poor and less educated have an increased likelihood of chronic illness. The target population is people older than age 65. A significant proportion of the target population also is at high risk because of poverty, isolation, mental health issues, disabilities, and transportation barriers. Residents older than age 65 represent 13.7 percent of the service area population, and the accelerating older population is a major concern with regard to increasing levels of chronic illness. Income and education levels vary widely across the area, and poverty—often accompanied by lack of education—is a pervasive barrier to accessing health for many in the region, exacerbating problems with insurance, the ability to pay for medications, and transportation. Fifty-six percent of the state’s elderly do not have prescription drug coverage. Problems related to transportation include long distances and travel times to health care resources, lack of coordinated public transportation, and long winters with heavy snow, which make travel difficult for visiting nurses and other home care providers as well as for patients. Two towns (Acworth and Charlestown in Sullivan County) in the service area are designated as Medically Underserved Populations.

The Consortium for Chronic Disease Management includes VNA at HCS, a subsidiary of Home Healthcare, Hospice and Community Services, Inc., the lead applicant; the Cheshire Medical Center; and Dartmouth-Hitchcock Keene (a multispecialty physician practice).

D04RH06788

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Chronic disease, Telehealth

The Caring Community Network of the Twin Rivers (CCNTR) is a recognized nonprofit organization in the State of New Hampshire formed in 1996. CCNTR has been working as a collective to create a coordinated, accessible system of care across the region. This project will enhance existing mechanisms and expand the capacity of the network to provide effective, coordinated, and accessible services throughout the region that improve health outcomes of uninsured clients with chronic illness and provide appropriate services such as emergency room care.

Individuals in the Twin Rivers face higher rates of many health risk indicators than the rest of the state. There are disparities among chronic disease factors, and socio-economic indicators. In addition, residents face significant barriers to access service and prevention programs including: geographic or social isolation, lack of transportation, lack of awareness of services, uncertainty of how to access service, lack of insurance, not enough insurance, and fear of stigmatization or reprisal. These barriers reduce use and inhibit the continuity of care, decreasing the overall effectiveness of the service delivery system.

There are three target groups who will benefit from the activities in this proposal: (1) low-income and uninsured adults, (2) low-income, uninsured and underinsured elderly, and (3) individuals with chronic illness such as diabetes and CVD/hypertension. These populations overlap and are inter-related. The proposed project develops roles that will support several models that have been proven effective in this and other areas, will replicate those models for new populations, and will expand the reach of mechanisms that work well in other parts of the country for use here. These staff positions include:

- 175 days of contracted outreach care coordination each year will be arranged with existing network staff to work with residents that need to be connected to primary care and other supports;
- One FTE disease manager who will work with primary care providers, nutritionists, and other health care professionals to provide health education, counseling, and coordinated care planning to people living with chronic disease;
- .25 FTE project manager to integrate care coordination and disease management with the system of uncompensated care, and overall project management.
- A CCNTR staff evaluator will be contracted. A small amount of consulting time will be used to develop modifications to telehealth tools.

The proposed project will positively impact service delivery in the region. It will: (1) identify best practices in disease management, planned care visits, and coordination currently used by medical providers to implement them region-wide, (2) incorporate the use of electronic tools, developed with an outside source of revenue, to use a shared client data base for health education, coordination, referral, and chronic disease registry (3) enhance client access to the above services and to other services available in the region, and (4) increase the level of disease and care management available, resulting in improved patient health outcomes.

D04RH06908

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Mental health, Telehealth

The Northern Tele-psychiatry Initiative will provide access to child psychiatry through telemedicine in northern New Hampshire. The Northern Tele-psychiatry Initiative will improve the mental health of children and teens, reduce the number of admissions to child psychiatric in-patient units, and help prevent the inappropriate prescribing of psychotropic medications by primary care practitioners to children and adolescents.

The project plans on establishing videoconferencing systems in Wolfeboro and Berlin in Year 1, increasing the number of systems to Conway and Colebrook in Year 2 and installing the final system in Littleton in Year 3. The Northern Tele-psychiatry Initiative will be examining options for changes to the New Hampshire Medicaid State plan and third party payers for telemedicine. The Northern Tele-psychiatry Initiative will also promote the use of child tele-psychiatry through education of community leaders and family members. Finally, the Northern Tele-psychiatry Initiative will evaluate the project on an ongoing basis to ensure the satisfaction of the child tele-psychiatry treatments.

The Northern Tele-psychiatry Initiative covers a medically underserved area. Currently, there are no child psychiatrists in northern New Hampshire, geographically 43 percent of the rural northernmost portion of the State. The target population, which is 98 percent Caucasian, is 24,927 children, age 0 to 17, who are residents of northern Grafton, Carroll, and Coos Counties—a region that covers 4,447 square miles. Due to the loss of traditional industries in northern New Hampshire, the primary jobs are low-paying (an average of less than \$23,000) in the tourism, food service, and retail industries. Access barriers to services include long distances outside of northern New Hampshire to private child psychiatrists or child psychiatric in-patient units; year-long waits for evaluation by private child psychiatrists; lost income to caregivers resulting from the geographic isolation and the lack of local child psychiatrist.

The Northern Tele-psychiatry Initiative consortium members are Northern Human Services, the lead applicant; the New Hampshire Department of Health and Human Services, Bureau of Behavioral Health; NAMI New Hampshire, and the Behavioral Health Network.

NEW MEXICO

D04RH04337

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Early childhood mental health services

The Northern New Mexico Rural Infant Mental Health Consortium project will provide access to mental health services for high-risk families with young children, from birth to age 5. The project will serve the residents of Rio Arriba County, a largely rural and mountainous region between Santa Fe and the Colorado state line. The project will use a three-pronged approach: (1) provide comprehensive, expanded infant mental health services at three sites; (2) provide training, consultation, and capacity-building to health care and early childhood development programs; and (3) increase access to, and utilization of, infant mental health services by developing bilingual outreach materials, home visits, and child assessments and by strengthening collaborative referral networks. The project will utilize a successful, evidence-based model that combines home-based, center-based, and community-based services in counseling, case management, parenting skill development, client advocacy, and early intervention.

The target population is families with young children in Rio Arriba County, which has high rates of poverty, lack of health insurance, alcohol and drug abuse, and other health problems. The county has an extremely high risk of and high prevalence of infant mental health problems—problems that are directly related to the area’s high rates of substance abuse, teen pregnancy, domestic violence, poverty, and child abuse and neglect. Nearly one-quarter of the county’s families live below the poverty level, and 35 to 40 percent of the county’s residents lack health insurance. Approximately 73 percent of the county’s 41,190 residents are Hispanic, and 14 percent are Native American.

Barriers to access to health services include the high rate of poverty, geographic isolation and lack of transportation, lack of health insurance, and inadequate health care resources. The county qualifies as a Medically Underserved Area and includes 13 divisions designated as Health Professional Shortage Areas.

Core members of the Northern New Mexico Rural Infant Mental Health Consortium have come together to address the need for expanded infant mental health services in Rio Arriba County. These partners include Las Cumbres Learning Services, Las Clinicas del Norte, La Clinica del Pueblo, the Rural Psychiatry Program at the University of New Mexico Health Sciences Center, and El Centro de los Niños.

D04RH04334

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Substance Abuse, Mental Health Disorders

The main goals of the project are (1) to increase access to appropriate levels of care for mental health and/or substance abuse services; (2) to increase capacity to provide services to individuals with substance abuse and/or mental health disorders; and (3) to improve access to and management of psychotropic medications. Activities include developing protocols with key referral sources, developing protocols among treatment providers so that individuals can access appropriate levels of care in an efficient and smooth manner, providing technology for distance training and consultation, addressing the shortage of professionals through partnerships with universities and policy changes at the state level, and improving access to psychotropic medications through training and information using best practices. In addition, the project proposes an innovative, comprehensive approach to substance abuse outpatient treatment that incorporates gender-specific and trauma-based approaches, as well as research-based therapeutic practices and supportive services.

The service area includes Grant, Hidalgo, Catron, and Luna counties in southwestern New Mexico. A high percentage of residents in the region live in poverty, ranging from 18.7 percent in Grant County to 32.9 percent in Luna County, compared to 18.4 percent for New Mexico and 12.4 percent for the United States. The percentage of the population below two times the Federal poverty level and not on Medicaid is estimated at 27.9 percent. The project will target children, adolescents, and adults who have mental health or substance abuse disorders as well as their family members. The demographics of the mental health target population are representative of the region where the ethnic breakdown is 51 percent Hispanic/Mexican and 49 percent white. The enhanced outpatient substance abuse treatment will target three subpopulations: (1) adults involved with the court system, (2) substance-abusing adult women with children, and (3) adults with substance abuse or co-occurring disorders. In the target region, there is a severe lack of services for persons with substance abuse and/or mental health disorders. The four counties face tremendous challenges in providing behavioral health services due to barriers such as a shortage of providers and practitioners (especially those who are bilingual), weak linkages with referral sources, a lack of integrated services for co-occurring substance abuse and mental health disorders, the lack of insurance coverage for substance abuse disorders, and culture or language. The target area for the project is a designated Medically Underserved Area and a Health Professional Shortage Area for mental health professionals.

Consortium members include Border Area Mental Health Services, Inc., the lead applicant; Fort Bayard Medical Center–Yucca Lodge; Gila Regional Medical Center; Hidalgo Medical Services; Presbyterian Medical Center; and Ben Archer Health Center.

D04RH02560

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| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$198,651 | \$200,000 | \$200,000 |

Keyword(s): Mental health, Substance abuse

Project R&R offers a solution to the critical need for mental health and substance abuse services in a high-risk, multi-cultural frontier community. The target area consists of the communities in the Penasco Independent School District, and includes all of southern Taos County, the entire Picuris Pueblo reservation, and the southeastern section of Rio Arriba County in north central New Mexico. The target community of 3817 people is spread across an area of 900 square miles. However, there are no incorporated villages or towns within this area and only minimal health services of any type. The actual medical service area, which includes the closest towns of Espanola in Rio Arriba County and Taos in Taos County, each with a hospital, extends the health care service area to 1600 square mile. The racial and ethnic mix of populations to be served reflects the community: 73 percent Hispanic, 14 percent Native American, and 13 percent Caucasian. The two foci of Project R&R are to address mental health and substance abuse and to build resiliency among the youth.

Picuris Pueblo, a federally recognized Indian tribe, and the small traditional Hispanic agricultural villages that make up the target community have long and proud histories. Still existing among the elders is a tremendous amount of knowledge. Their wisdom is not only about the natural world—the wild plants and herbs (*remedios*) that sustained the communities before any health care was available locally—but also about the very concept of neighborliness and community. Through recent discussions with the coordinator of the Rural Psychiatry Outreach Program at the University of New Mexico, Project R&R discovered that any “diagnosis” of its communities would have to include mention of Historical Trauma. Historical Trauma is a clinical diagnosis of an ongoing psychiatric disorder related to loss of land, relocation, economic disarray, and dislocation, which presents with symptomology and negative behaviors including alcoholism, substance abuse, and difficult, often violent, interpersonal relationships. Although the economic and health status data paint a picture of a very troubled community, that is only a part of the picture.

The network partners of the project include the Frontier Education Center, HCH Rural Health of Penasco, the Health Centers of Northern New Mexico – Penasco Clinic, the Taos Public Health Office of the New Mexico Department of Health, the Penasco Independent School District, Picuris Pueblo, and the Health Science Center of the University of New Mexico.

D04RH02557

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| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$192,003 | \$181,365 | \$184,594 |

Keyword(s): Pre/peri/post-natal care, Preventive health

Mora and San Miguel counties are located in rural Northeastern New Mexico. For most of its history, Northern New Mexico has enjoyed a tradition of close-knit, extended families living in convenient proximity for generations. This allowed young people to benefit from the instruction and support of their elders and neighbors. Through poverty and general displacement and isolation, the modern economic structure has extended into local culture in a way that has left people cut off from customary support systems without providing an alternative. One of the results of this shift has been that young, first-time mothers can no longer count on learning how to be parents and care for their children through the traditional extended family process of learning, nor are social service agency's available to rural homebound first-time specific parents. Currently, the children of the largely rural San Miguel and Mora counties are at higher risk for illness, abuse, and even mortality than those in other areas of New Mexico and, in fact, the United States.

The Mora & San Miguel Primeros Pasos/First Steps Program proposes to serve up to 60 first-time parents and their children through the implementation of the research-based Healthy Families America Program. The target population is 88 percent Hispanic, 8 percent Caucasian, and a 4-percent mix of African American and Native American descent. The program will be staffed by family assessment workers and three *promotoras* who will provide intensive home visiting services for the first 3 years of the baby's life.

The goals of the Mora & San Miguel Primeros Pasos/First Steps Program are to promote healthier pregnancies with reduced rates of low birth weight and infant mortality, lower the incidence of child abuse and neglect, and to promote healthy child development through an emphasis on early intervention in developmental delays, immunizations and other preventive health care.

D04RH06939

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$98,702 |

Keyword(s): Diabetes

The word Taos means 'red willow' in the Tewa language. Two features dominate this sparsely populated region—the high desert mesa, split in two by the 650-foot-deep chasm of the Rio Grande; and the Sangre de Cristo range, which tops out at 13,161-foot Wheeler Peak, New Mexico's highest mountain. The County is situated where the western flank of the Sangre de

Cristo range meets the semiarid high desert of the upper Rio Grande Valley. It is comprised of several small villages scattered throughout the mountainous region, the Taos Pueblo, and the Picuris Pueblo, both inhabited for over 1,000 years. The County is spread out over 2,203.17 square miles, with a density of 13.6 persons per square mile.

In this beautiful and rugged landscape, 9.5 percent of the adult population has a diagnoses of diabetes compared to 8.9 percent statewide. Approximately 17 percent of people aged 40 and over in New Mexico have diabetes. Hispanics comprise 58 percent of the population in Taos County. One in four Hispanics are uninsured. In addition to being more prevalent, diabetes in Hispanics tends to be more severe than non-Hispanic whites. Among Hispanics, diabetes occurs at a younger age, more often requires insulin to be controlled, results in more limb amputations, contributes to eye disease, is responsible for six times higher incidence of kidney failure, and results in a death rate two to four times the rate for non-Hispanic whites.

While Native Americans comprise a smaller percent of the population (7 percent) they too are two to three times more likely to be at risk for diabetes and less likely to have private health insurance than either Whites or Hispanics. A combined 65 percent of the Taos County population (58 percent Hispanic and 7 percent Native American) is comprised of at risk populations for diabetes. In a Taos County Needs Assessment process, 144 low income County residents were interviewed in 2001 and over half the families in this interview process did without needed medical care in order to make ends meet, or gave priority to their children's care.

This 3-year outreach proposal is focused on designing a Single Point of Entry and Lay Promotora Program to deliver Prescription Assistance to a target population defined as residents of Taos County 18 years and older with a diagnosis of type 1, type 2, or gestational diabetes who are up to 185 percent of the poverty level.

Holy Cross Hospital is a not-for-profit, 49-bed acute care hospital. Its mission is to provide preventive, curative, and supportive health care services, maintaining high quality standards and using innovative, educational, and cost effective approaches for all members of the culturally diverse Taos community and surrounding areas. Collaborative Action for Taos County Health (CATCH), a consortium, will implement a Prescription Assistance Program to assist residents in accessing no cost/low cost prescription medications. A comprehensive Single Point of Entry and a Lay Promotora Program will help to coordinate appropriate healthcare including prescription assistance, encourage self-management of diabetes through counseling and support, thereby strengthening the ability of residents to reduce the risk and/or severity of diabetes.

NEW YORK

D04RH02591

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| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Primary care, Health promotion/disease prevention (general)

Students in the Norwich School District have been identified with unmet health needs including immunizations, physical exams, acute episodic care for ear infections, upper respiratory illness, pharyngitis, strep infections, dermatitis, injuries including sprains and fractures, and the lack of regular primary health care which would typically result in healthier children. Conditions including lack of dental care, asthma, diabetes, obesity, and mental health issues have been identified as well. When school nurses in the Norwich School District were asked to describe the problems experienced by school-age children, such as cultural, social, geographical, and financial barriers; they cited lack of insurance or being underinsured, high copayments, and the inability of the parent to leave work to access medical care, as relevant conditions. In addition, many students do not have an established “medical home” with regular health care or primary care providers, so their care lacks continuity. Families have low literacy rates, which affects their capacity to use information they receive from school, such as eligibility for certain benefits or good health practices. Navigating the Medicaid system has proven problematic for local families. They often do not understand that they must renew their eligibility periodically and are confused as to how to receive the benefits to which they are entitled.

The target population to be served by the project is 97 percent Caucasian, 2 percent African American, and less than 1 percent of Hispanic, Native American, and Asian school-age students age 4 to 18. Most students live in Norwich, with some coming from the towns of North Norwich, McDonough, East Pharsalia, Plymouth, South Plymouth, or Oxford. The area served is large in geography and short on major highways and public transportation. The lack of public transportation creates incredible barriers to accessing any type of service. Chenango County has suffered severe economic changes due to business closures. Many of the jobs that remain are low paying, with no health or dental insurance.

Along with the other members of the consortium (the Chenango County Catholic Charities, the Chenango Health Network, and the Norwich School District), the Chenango Memorial Hospital plans to improve the health status of its school-age populations by enrolling 90 percent of the target population into school-based health centers by the end of the school year; increasing access to primary care, mental health, and dental care services for students; and increasing enrollment in Medicaid, Child Health Plus, and Family Health Plus.

D04RH04491

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| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$190,762 | \$195,520 | \$199,977 |

Keyword(s): EMS Provider Education, Older Adults, Case Management

In this injury and illness prevention project, the Livingston County Department of Health and its partners seek to maximize the health and quality of life of rural, community-dwelling older adults and will implement a system based on emergency medical services (EMS) to screen, identify, educate, and refer rural-dwelling individuals at risk for preventable conditions. The project also will ensure patient access to long-term health care and social services using case managers

and primary care physicians. Another feature of the project is the education of EMS providers regarding the appropriate care of older adults. During emergency responses, EMS personnel will screen older adults for risk of falling, medication errors, and depression; educate patients and their families during emergency responses about risks; and refer at-risk patients to a case management program. The project will expand an existing case management program to provide at-risk patients with follow-up care and will evaluate the impact of the EMS-based program by assessing critical process and outcome measures.

The target population adults age 60 and older in rural areas of Livingston County, New York. The percentage of older adults in the county is rapidly increasing, resulting in increased demands for community-based and in-home services. The county's population is expected to grow by 4.8 percent between 2000 and 2015, but the population age 60 and older is expected to increase by 31.5 percent and the population age 85 and older by 36 percent. Older adults have a high disease burden, high risk for disability, limited financial resources, and difficulty accessing care. Patients who suffer from falls, depression, and medication errors are at risk for disability, mortality, and institutionalization. These conditions benefit from screening, but access to health care is often limited for the most vulnerable patients. There is a need to prevent diseases, injuries, and disability among older persons to maximize their quality of life and to prevent morbidity, institutionalization, and mortality. No universal access system currently exists for caregivers or recipients of services to identify and access the various services. Older adults and their caregivers typically do not know what services are available or what services they need. This project will affect all service providers and provide older adults with increased ease of access to services. The county is designated as a Medically Underserved Population.

Members of the consortium include the Livingston County Department of Health, the lead applicant, Livingston County Office for Aging, Genesee Valley Health Partnership, Department of Emergency Medicine at the University of Rochester Medical Center, and Tri-County Family Medicine.

D04RH06961

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|----------|
| Funding Amount | \$149,806 | \$124,308 | \$98,673 |

Keyword(s): Diabetes, Telehealth

A consortium has been established between Champlain Valley Physicians Hospital Medical Center, a Regional Referral Health Care Center, Clinton County Health Department, a community health care leader, and the Joint Council of Economic Opportunity of Clinton and Franklin Counties (JCEO), a social service agency that conducts community outreach programs. The project is designed to finance the development, implementation, and evaluation of the North Country Diabetes Project. This endeavor has been designed based on best practice standards including the American Diabetes Association (ADA) Guidelines for quality diabetes self-management training.

The North Country Diabetes Project will target Clinton, Essex and Franklin County residents over the age of 45 who have diabetes or are at risk for developing diabetes. Innovative outreach activities will involve health professionals, as well as community workers, who provide relevant services to this population. This region is medically underserved with shortages of primary care providers. It is also socioeconomically disadvantaged. The median household income is significantly below State and national levels. Education levels are low adversely affecting health behavior and outcomes. This is reflected in the area's level of obesity, smoking, high blood pressure, and lack of regular exercise causing significant rates of diabetes and complications from diabetes. This region reports a higher than State average of hospital admissions resulting in major health care costs and complications due to diabetes, which diminish quality of life.

Diabetes is reaching epidemic proportions in the United States. Diabetes cannot be cured. But it can be managed through life style modifications and appropriate health care. Without this intervention, patients suffer from serious complications—blindness, limb amputations, advanced renal disease and heart disease.

The North Country Diabetes Project will build ongoing community collaboration among core health care providers to increase access to diabetes care through the development of a physician referral network and establish an American Diabetes Association-recognized diabetes self management training program. The project will execute a unique community health approach including screenings, risk awareness, and education sessions, creatively using a registered dietitian at the Health Department, home health care registered nurses, JCEO case managers, and community outreach workers. JCEO volunteers will provide transportation to medical appointments for homebound seniors. Public service announcements will increase community awareness as will telehealth capability of 13 local libraries with Internet access to reliable diabetes education resources and postings for local services. Key community agencies such as the Office of Aging, The Senior Citizens' Council, and the United Way will publicize the project's services.

This project will reduce the impact that diabetes has on the tri-county region by increasing community awareness, improving health outcomes (i.e. decreased blood glucose levels, reduced complications and reduced hospital admissions) and increasing patient quality of life.

D04RH06957

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): School-based services, Dental, Mental health

Bassett Healthcare and six school districts have formed a Consortium that seeks to expand and enhance their School-Based Health Centers (SBHC) to include dental and mental health care programs and community outreach services. Bassett Healthcare and the school districts of Delhi, Edmeston, Laurens, Morris, Sherburne-Earlville, and South Kortright are located in Chenango, Delaware, and Otsego counties—all of which have been designated as Mental

Health Professional Shortage Areas. Delaware County has been designated a Dental Health Professional Shortage Area.

The Consortium has specifically targeted school-age children (5-18 years of age) for services. The seven goals of the project are to: 1) increase the number of children receiving dental health care, 2) reduce the number of untreated caries in children, 3) control the number and severity of new caries developing in children, 4) reduce serious emotional disturbances (SEDs) in children and adolescents, 5) increase the number of children seen in primary care who receive mental health screening and assessments, 6) increase the number of students enrolled in Medicaid and New York State's Child Health Plus Insurance Program, and 7) increase wellness and the access to preventive health care for students and their families without health insurance.

Input from community advisory boards and residents in the three counties determined that a number of barriers preclude the area from receiving adequate dental and mental health care for school-age children. These barriers include: lack of insurance, inability of parents to enroll in public insurance programs, limited numbers of dentists and mental health providers, limited fluoridated water, rural poverty, rugged geography and terrain, inclement weather, and lack of public transportation.

This project will use dental hygienists, a mental health social worker, community outreach staff, portable equipment for dental exams, and PDAs for data storage and case management. Staff will be hired to work in six existing School-Based Health Centers. The Consortium anticipates caring for approximately 2,800 clients.

The applicant organization for the Consortium is Bassett Healthcare, a not-for-profit rural health network of primary and specialty care providers dedicated to patient care, teaching and research. Bassett Healthcare staff will oversee grants administration (including day-to-day operations and fiscal and billing issues), and conduct the evaluation for the project. Members of the Consortium will provide office space, assist in marketing and planning, collect information, and support analysis.

NORTH CAROLINA

D04RH06941

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Chronic disease, Minority health, HIV/AIDS, Mental health, Substance abuse

The Albemarle Hospital Foundation, Inc., and its four consortium members are focusing on providing expanded services to medically indigent, uninsured and underserved adult populations of a six county catchment area of northeastern North Carolina: Camden, Chowan, Currituck, Gates, Pasquotank and Perquimans. The project is designed to deliver inter-related

healthcare activities to curb the multiple illness patterns and the high incidences of secondary conditions among the most disadvantaged by poverty, lack of education, minority status, unemployment, and uninsured or underserved.

Since the Healthy Carolinians 2002 Report, further evidence of the health trends affecting this region have been updated in the 2004 North Carolina Rural Profile by the Rural Economic Development Center and from the State's Center for Health Statistics and the North Carolina State Office of Rural Health. They continue to show that the area is plagued with chronic cardiovascular disease, cancer, respiratory disorders, a growing problem with Type 2 diabetes and obesity. The service area is now seeing HIV/AIDS cases growing exponentially among African Americans and Hispanics ages 20 to 49.

In an effort to expand the adult services of care and support to the medically indigent, uninsured and underserved, the consortium will use grant funds to concentrate on the following activities:

- Reducing, through more cost effective means, rapidly growing infectious disease incidents by providing local access to an infectious disease physician;
- Providing more comprehensive intake coordination, psychosocial and HIV/AIDS counseling, and assist in case management of the expanding patient base;
- Improving drug access to overcome deficiencies of AIDS Drug Assistance Program;
- Overcoming cultural barriers to health care in the growing Hispanic community; and
- Becoming a rural State model for regional community health care partnerships.

By merging divergent service delivery systems and philosophies into a common vision and organization under the community care clinic model, the project hopes to expand services to the medically indigent, who traditionally experience barriers in accessing health care and may not be receiving primary care, much less care for chronic illness and/or chronic illness as a secondary condition of AIDS.

The primary consortium member are the Albemarle Hospital Foundation, Inc., initially organized by Albemarle Hospital to provide community based health care to the medically indigent; the Albemarle Regional Health Services manages the region's core public health functions; Jeff Jones Consortium, a nonprofit organization dedicated to serving persons infected with HIV/AIDS; Northeastern Community Development Corporation (NCDC), a nonprofit organization offering a community Hispanic resource center and assistance in the areas of housing, housing counseling, small business development, child care, and skills training; and the Albemarle Mental Health Center providing a mix of outpatient mental health and substance abuse services.

NORTH DAKOTA

D04RH04326

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$199,781 | \$143,399 | \$122,047 |

Keyword(s): Wellness Programs

The Wellness Interventions Lasting a Lifetime (WILL) project—designed to encourage wellness and healthy lifestyles—will provide education on disease management and prevention to North Dakota residents of Cavalier County, the northwest section of Pembina County, and the northern portion of Ramsey County. The WILL project will be implemented with classes and lectures, screenings, and fitness and nutrition programs to manage chronic disease and their modifiable risk factors. The WILL Network’s goals are to implement the WILL project, to increase awareness of chronic disease conditions, to promote wellness and lifestyle change programs, to increase awareness of activity-related injury prevention and wellness programs, to increase awareness of overall occupational wellness, and to promote self-managed wellness programs. The WILL Network will deliver educational programs on a local, regional, and statewide basis through Internet technology; hold classes, lectures, general fitness and nutrition programs, and screening tests; distribute brochures; take wellness to the next level of activity in the community; and combine all community health-related resources. The project will promote wellness programs to residents of every age, gender, and activity level. Education and promotion will focus on overall wellness, and fitness and nutrition programs, with an end goal of self-managed wellness programs.

Residents of the service area are primarily Caucasians, with 0.99 percent Native Americans living in the area. In rural areas, long distance between health care facilities presents a large barrier to seeking and receiving health care. As the population continues to age, the lack of public transportation compounds this problem. In addition, the mindset and attitudes of rural residents can be a barrier to needed health care services in this area. They generally are stoic, hard-working individuals, often too proud to ask for necessary health care assistance. Depression, due to a declining farm economy, as well as aging and other stress-related issues are examples of health care needs in the service area that would benefit from the promotion of wellness education. Cavalier County is a designated Health Professional Shortage Area.

The network partners are the Cavalier County Job Development Authority, Cavalier County Memorial Hospital, and Cavalier County Health District. Existing and supportive community (ad hoc) members are North Dakota State University Extension Service–Cavalier County Office, Cavalier County Social Services, Walhalla Economic Development, Parish Nurse-Faith Based Organization, Cavalier County Senior Meals and Services, and the City of Langdon.

D04RH06915

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Mental health

The focus of the Standing Rock Reservation's Mental Health First Aid program is to empower non-mental health professionals, including first responders, health providers, and community members to recognize signs, make use of basic skills, and assist with accessing mental health resources in the frontier and reservations areas of North and South Dakota. As mental health

resources are scarce in rural, frontier, and tribal areas, implementing a program at the grassroots level and training health professionals, paraprofessionals, and interested volunteers to better understand mental health issues and provide a supportive environment is an innovative way to address mental health problems.

Suicide in the northern plains region is at epidemic proportions requiring an immediate and innovative mental health response. Through the development of the Mental Health First Aid program, a training and curriculum will be developed consisting of a 12-hour course developed at the Centre for Mental Health Research at The Australian National University, to improve mental health knowledge, skills, and attitudes.

The Mental Health First Aid program uses five basic skill steps to address issues related to suicide: 1) Assessing the risk of suicide; 2) Listening non judgmentally; 3) Giving reassurance and information; 4) Encouraging the person to get appropriate professional help; and 5) Encouraging self-help strategies.

There are three phases to this program. First, the developmental phase includes training for trainers, adapting the Australian curriculum for use on the reservation, and piloting the training on the Standing Rock Reservation and West River Health Service area. These trainings for Standing Rock personnel will be held in the local districts and conducted by the Community Health Representatives in each district. The West River trainers will conduct the training in local communities requiring less travel by the majority of participants and trainers. In year 2, the implementation phase, the training of providers would begin emphasizing training for the medical and emergency personnel in each of the eight districts within the Standing Rock Reservation and throughout the West River Health Service area. All trainings will be conducted by the original trainers from the first year of the project. In Year 3, the expansion phase, the project will expand the previous training to include other sectors of the community such as, business, education, faith/religion, and government/public. Additionally, curricula will be developed for training new trainers and more trainers trained. Dissemination of the program into other Tribal communities would be completed during this phase.

D04RH06914

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Cancer

The health care needs of the area were identified through a community health assessment initiated by the Healthy 8 Communities Network. This group is a multidisciplinary team of 55 members representing over 35 community groups from the eight southwestern counties of North Dakota. Results in 1997 and a repeated survey in 2002 indicated Areas of Opportunity for Health Action, with cancer identified as a significant health priority. The Cancer and Substance Abuse Task Force was formed in 1998 creating the Pathways to Healthy Lives program, which became a reality through funding by a Rural Health Care Services Grant from 2000-2003. The

results of the 2002 assessment revealed the positive impact of the program and identified the need for program expansion to include comprehensive screenings and education for breast, prostate, lung, colorectal and skin cancer.

Pathways to Healthy Lives provides public education focusing on making healthy dietary choices, being physically active, protecting oneself from sunlight and chemical exposure, and preventing initiation or cessation of tobacco products usage. Free breast, prostate, colorectal, and skin cancer screenings to be held in local communities within the eight counties. Collaboration between community leaders, providers, clinics, hospitals, and Pathways to Healthy Lives makes it possible to offer services in local communities where people live, thus increasing accessibility and reducing the amount of distance people must travel.

The consortium for Pathways to Healthy Lives consists of members from Southwestern District Health Unit, Community Action Partnership, and St. Joseph's Hospital and Health Center. These three agencies have partnered together since the inception of the Pathways to Healthy Lives program and to provide advisement and support.

The goals of the Pathways to Healthy Lives program are to: 1) increase awareness of healthy lifestyles, 2) increase the availability of comprehensive screening events, 3) increase the number of cancers identified in the in situ or localized stage by 5 percent over the 1997 numbers documented in the North Dakota Cancer Registry, 4) increase the number of participants in educational programs related to smoking, smoking cessation, and exposure to secondhand tobacco smoke in an effort to reduce the incidence of lung cancer.

The southwest eight counties have significant physical isolation from specialty health care providers. Harsh climatic conditions have a major impact on the ability of residents to seek medical services. Pathways to Healthy Lives serves the 38,365 residents of Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark counties in the 10,000 square mile area of southwestern North Dakota. An American Indian population resides in the northern part of Dunn County. Five and a half of the counties served are designated full Health Professional Shortage Area, and six-and-a-half are Medically Underserved Areas. In 1999, North Dakota had a per capita person income of \$17,769. The national average is \$21,587. Some 11.9 percent of North Dakota residents overall were below poverty level in 1999; however, 17.5 percent of Dunn, 16.9 percent of Slope, and 15.3 percent of Golden Valley county residents were below poverty levels. Also, 12.5 percent of adults in the service area lack health insurance coverage.

OHIO

D04RH06793

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|----------------|----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,00 | \$125,000 | \$100,000 |

Keyword(s): Dental, Women's health, Prenatal care, Diabetes

A consortium of three parties—the Community Health Services (CHS), Mercy Hospital of Willard, and Huron County Health Department—are working together to provide basic primary care and dental services to a target population of adults and children with incomes under 200 percent of the federal poverty level who live in the area of Willard, Huron County, Ohio, as well as the southeast corner of Seneca County and the northeast corner of Crawford County. This rural health outreach grant will enable community health services to expand the operation of the Willard clinic from 5 hours per week to 12 hours per week, to provide expanded prenatal services to the target population, and to provide basic dental services to adults and children.

Within the city of Willard, 16.5 percent of the population has an income less than 100 percent of the federal poverty level. This contrasts with 8.5 percent of Huron County residents and 10.6 percent of Ohio residents whose incomes are less than the poverty level. There is no safety net clinic in the area where uninsured patients may access care on a sliding fee basis other than the CHS Willard clinic, Mercy Hospital's OB/GYN clinic, a twice monthly well-child clinic offered by the Health Department, and the Mercy emergency room. In the Willard area, there are three dentists. Only one is listed on the Huron County Department of Job and Family Services list of dentists who accept new Medicaid patients. Most people in Huron County who need dental care and lack dental insurance and the means to pay simply go without care or must drive 60 minutes to the nearest safety net, the CHS main office in Fremont, Ohio.

Community Health Services plans to close the primary care and dental service gap by expanding services from 5 hours per week at its Willard clinic to 12 hours per week, potentially open on some Saturdays, and engage in a referral arrangements with two Willard dentists who will accept uninsured patients on a modest voucher payment system. This expansion of the Willard clinic will allow the clinic to provide 1700 medical encounters per year, in contrast to the present 700 annual encounters. It will open up sufficient appointment slots to provide pap smears to 90 female adult patients as needed. The additional hours also will ensure that each of the 72 diabetics currently being treated at the clinic can be seen minimally on a quarterly basis and on a monthly basis at the point that their sugar is uncontrolled, and to aggressively treat pre-diabetes. Women in need of prenatal care will be seen at the Mercy Hospital, OB/GYN clinic. Persons in need of dental care will be referred to local dentists. These dentists will provide basic preventive and restorative services to adults and children referred to them through Mercy Hospital, who will assist with the payment of care for at least 85 children and adults each year. The Huron County Health Department will refer children to the dental services through its twice monthly well-child clinic in Willard, and will refer adults who come to its adult clinics.

D04RH06936

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Overweight/obesity

The Goal of the Twin City Hospital (TCH) Healthy Community/Happy Children Outreach Program (HC/H COP) is to provide an innovative, multi-agency means to reduce the number of

overweight and obese men, women, and children of all ages in the Village of Dennison, Tuscarawas County, and the surrounding counties of Carroll, Harrison, and Guernsey. The program will allow a consortium of community agencies to pool precious resources to enhance educational opportunities, outreach, facilities and services through a collaborative countywide effort. Program services will be offered to all populations regardless of their abilities to pay or ethnic backgrounds.

Twin City Hospital Healthy Community/Happy Children Outreach Program (HC/HCOP) information will be disseminated through various promotional efforts such as: mailings, speaker's bureau activity, newspaper articles, radio public service announcements, church bulletins, grocery bag inserts, school handouts, and brochures and fliers placed in area libraries, physician's offices, schools, and Head Start Centers. The project also plans to make information available via the Twin City Hospital's web page at www.twincityhospital.org.

The development of the Twin City Hospital HC/HCOP will address the following health and wellness needs in the community: 1) Lack of affordable diet and exercise training; 2) Need for a central location where people can access health and wellness information that is appropriate for all age levels; 3) Need to provide treatment for obesity among all age groups; 4) Need for enhanced diabetes treatment and education; 5) Need for fitness programs for all ages; 6) Need for child care to allow busy parents the time to participate in HC/HCOP services; and 7) Need to provide local access to these services due to a lack of affordable public transportation in Tuscarawas County.

The Twin City Hospital HC/HCOP will provide the following age-appropriate services to meet the community needs listed above: 1) Provide nutrition and exercise programs for all population groups through a series of two "Fit" programs: Fit for Life for adults and Fit for Fun for children and teens; 2) Provide special health interventions for adults and children who either have diabetes or are at risk for diabetes; and 3) Provide nutrition and exercise information online on the Hospital's website in order to improve access to health and wellness information. While the administrative function of the program will be housed at Twin City Hospital, services will be offered at various locations throughout the community in order to reach all segments of the targeted population. According to the 2000 Census, 90,914 populate Tuscarawas County.

To address transportation needs, Twin City Hospital will use school buildings in towns throughout the service area so that people can access program services without having to drive a long distance.

D04RH06937

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Prescription medication assistance

The RxCUE program is a community-based prescription medication assistance program. This program for southeastern Appalachia Ohio involves a coalition of four core members, and six

additional community agencies and stakeholders. The program will assist any resident with a prescription medication need who is not able to fill the prescription on his/her own. These individuals include uninsured, low-income/fixed income, and those residents experiencing hardships that would legitimately preclude them from fill physician-prescribed medications.

The three core consortium members are the Zanesville Muskingum County Health Department, Eastside Community Ministry, and Genesis Healthcare. Contributing members include Muskingum County Center for Seniors, Muskingum TB and Respiratory Clinic, Alfred Carr, Mental Health and Recovery Services Board, Six County, Inc., and Muskingum County Job and Family Services. These agencies and various affected individuals from the community worked for nearly 3 years to complete a needs analysis, identify target populations, develop budget start-up costs, and develop goals, objectives, and activities. RxCUE will use a three-tier system for assisting clients:

- Tier I will link individuals with free pharmaceutical-sponsored programs.
- Tier II will fill prescriptions from the State pharmacy repository. The State of Ohio passed House Bill 221 provides for the development of a State Pharmacy repository for collection and redistribution of surplus medications from individuals and agencies.
- Tier III will use the stopgap approach to filling medications through outright purchase. The purchase of medications will be done through a cooperative agreement with consortium members that use volunteer pharmacists to fill prescriptions at hospital costs. Grant money will fund the purchase of medications in this tier only. The result is an average savings of 50 percent over purchases from a private pharmacy.

This program will target approximately 1,250 unduplicated clients each year, including senior citizens, low-income individuals and families, and those with financial hardships (who do not have prescription medication insurance coverage or cannot meet deductible/co-payment requirements). Based on local statistics, the greatest needs of this target population include medication for diabetes, hypertension, pulmonary, cancer, and respiratory conditions.

OKLAHOMA

D04RH06794

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Alzheimer's disease; Caregivers

In operation since April 23, 2002, Northeastern Oklahoma Community Health Centers was established in response to the overwhelming need for accessible health care in rural northeastern Oklahoma. The mission of the health center is to provide high-quality preventive and primary health care to eastern Oklahoma. Since its inception, the health center has experienced rapid growth and works within a constructive, collaborative environment to expand

the range of services offered. The health center operates five sites, employs eight full-time providers, and offers the full range of preventive and primary care services.

The target population of the health center is the uninsured and underinsured residents of Cherokee County, Oklahoma; however, health center patients come from across the multi-county region of northeastern Oklahoma—some driving as long as 2 hours to reach the health center. Needs to be addressed include providing information and education to individuals who are caregivers to those suffering from Alzheimer’s disease. Topics of education include available medications and treatments, legal and financial concerns, and caregivers’ high risk for stress-related illness and coping mechanisms that can be used to reduce stress-induced health risks. Services to be provided include a needs assessment, through which community-specific needs will be identified, resources available, and an action plan that will map a path toward meeting those needs. In addition, the importance of “Maintaining Your Brain” will be a focal point for education aimed at delaying the onset, and reducing the severity of, Alzheimer’s disease.

The target population is the service area of Northeastern Oklahoma Community Health Centers, namely Cherokee County, and its four surrounding counties. The goals of this project are:

- To improve the ability of area organizations to better meet the mental and physical needs of caregivers;
- To improve the ability of caregiving families to use health care and support services in their communities;
- To support the mental and physical health caregivers;
- To educate area residents about maintaining brain health and decreasing the impact of Alzheimer’s;
- To use advanced communication tools, including the Internet, to achieve goals more efficiently; and
- To develop a plan for sustainability.

OREGON

D04RH06924

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Diabetes, Overweight/Obesity, Mental health

La Clínica del Cariño, a community and migrant health center in Hood River, Oregon—in partnership with The Next Door, Inc., a community social service agency, and Providence Hood River Memorial Hospital—is supporting a community project entitled Steps to Wellness/Pasos a Salud. This project is intended to improve the emotional and physical well-being of our rural community residents by providing individual and group support and education to people suffering from diabetes and/or obesity. We will particularly emphasize services for low-income and medically underserved English-speaking and Spanish-speaking residents of the rural four county target area.

Recent evidence of the reciprocal and reinforcing relationships between chronic diseases such as obesity and diabetes on depression is startling. Not only can diabetes and obesity (and their sequelae) lead to depression, but depression also can make people more likely to be obese and diabetic. Given the known stigma associated with mental health treatment, which are amplified in a rural community, approaching mental health issues from another common denominator can be an effective way to elucidate the extent of the problem and possible solutions.

Steps to Wellness/Pasos a Salud has the following four goals: 1) To address mental health issues that impact patient self-management of diabetes and/or obesity; 2) To improve patients' ability to manage their diabetes and/or obesity; 3) To improve recognition of the importance of physical activity to the mental and physical health of people with diabetes and/or obesity; and 4) To increase community awareness of diabetes, obesity, and the concurrent emotional issues.

To accomplish these goals, a comprehensive training strategy will be implemented, using the expertise and resources of consortium members, to ensure that project staff members, including co-directors and community health promoters, are well versed in mental health, diabetes, and obesity issues. Services to the community will be provided in a four-pronged approach:

1) Education and support groups for 60 participants; 2) Lay counseling for 10 dialysis patients; 3) Case management services for 35 patients; and 4) Community outreach to 5,000 people through general outreach and 500 people in more intensive, one-on-one contact. In addition, the consortium will meet to choose and provide an intervention for obese children, the first of its kind in our community.

Steps to Wellness will target low-income, uninsured, or underinsured residents in the rural communities of Hood River, Wasco, Klickitat, and Skamania counties, with special attention to Hispanics. The project will direct program activities toward people who struggle with weight management and/or diabetes, or who have a family member with weight management issues or diabetes. The project will also identify and focus upon those, among this population, whose mental distress (depression, anxiety, or stress) is interfering with their disease self-management. Addressing both mental health and obesity/diabetes simultaneously promises to lead to more effective influence on health habits and health outcomes in our community's vulnerable populations.

D04RH06902

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|----------|
| Funding Amount | \$149,982 | \$124,836 | \$99,980 |

Keyword(s): Cardiovascular disease, Stroke, Elderly

Josephine County, much of which is designated as a medically underserved area, is situated in the southwest corner of Oregon. It encompasses a geographical area spanning 1,641 square miles, and supports a population base of 77,123 persons. The over age 65 population in this area is anticipated to increase to 31 percent by 2020—about 20-30 years sooner than is

projected for the nation as a whole. In Josephine County, where currently an astounding 20 percent of all residents are aged 65 or older, residents are besieged by health disparities. Of particular concern is the fact that people in Josephine County are 1.5 times more likely to die from cardiovascular disease than their cohorts throughout Oregon.

The high incidence of cardiovascular disease and stroke, coupled with the growing over age 65 population in Josephine County supports the critical need for this proposed rural outreach project entitled Heart Health: A Rural Prevention and Treatment Program. Three Rivers Community Hospital, Josephine County Public Health Department and AMR of Josephine County, in collaboration with other regional providers and consumers, have developed a rural outreach project with the following four goals: 1) To improve the capacity of Josephine County stakeholders to identify and intervene in men and women's cardiovascular disease specific risk factors; 2) To reduce risk-adjusted rates of cardiovascular disease related morbidity and mortality by increasing the use of evidence-based practices in the prevention and treatment of Josephine County men and women; 3) To improve the capacity of Josephine County men and women at high-risk of cardiovascular disease to manage their health and receive seamless care across the continuum of heart related care; and 4) To improve the capacity for rapid transport and treatment of Josephine County ST segment elevation myocardial infarction (STEMI) patients.

These goals emerged from a community wide planning process and are responsive to the needs of this rural area to reduce risks and improve outcomes for rural elderly men and women who are at high-risk for cardiovascular disease and stroke. The strategies that will be employed and evaluated to achieve these goals include: gender sensitive education programs and materials for providers and consumers; community screenings to identify and intervene with persons at high-risk of cardiovascular disease and stroke; workflow redesign and monitoring geared to increase best practice use and improve rapid transport and treatment; and a health promotion program utilizing case management/self-management to support lifestyle change and behavior modification, resulting in reduced risks and lowered heart related morbidity and mortality rates for Josephine County men and women. This project, and its sustained operation, will significantly expand and enhance treatment and prevention of cardiovascular disease and stroke; a community response to the critical needs of elderly men and women in rural Josephine County.

D04RH06903

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Substance abuse, Mental health, Migrant health

Douglas County is situated in southwest Oregon. It encompasses an area that spans 5,134 square miles and supports a population base of 100,400 persons. A huge expanse of Douglas County, totaling 2,459 square miles, supports a population density of fewer than seven persons per square mile, thus meeting Federal criteria for designation as a frontier area. Douglas County currently holds Federal designations as a health professional shortage area, a mental health professional shortage area, medically underserved area, and as containing a medically

underserved population comprised of low-income residents and migrant and seasonal farm workers.

Douglas County's people suffer from a number of social ills, including elevated TANF rates, elevated food stamp recipient rates, and poor high school completion rates. Documented health disparities include malignant neoplasms, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, hypertension, and infant mortality. The Oregon Primary Care Association (January 2002) estimates that the county's current safety net system of care is meeting the needs for only 6 percent of Douglas County's low-income and medically uninsured residents. Fully 14,345 such individuals lack access to a continuous source of primary care.

Addictive disorders are evident within the population at elevated rates beginning with 12-year-old children. Studies conducted by the Center for Oregon Health Plan Policy and Research confirm that one-quarter of all Medicaid recipients are receiving prescriptions for Vicodin. While elements of addictive disorders are seen in virtually every primary care practice in Douglas County, it is the consensus of the medical community that few resources exist to help either patients or their attending primary care providers. To this end, the Rural Health Care Services Outreach project will establish a program of integrated primary and behavioral health using elements of successful, HRSA-sponsored Health Disparities Collaborative models. In specific, behavioral health nurses placed in primary care settings will provide addiction assessment, intervention, and self-care management planning for 175 patients in Year 1, and 250 patients in each Year 2 and year 3. Intended outcomes include improvements in Global Adaptive Functioning for program participants and reduction in use rates for inappropriate primary care office visits.

The project has established rigorous statistical measures, and will feature the innovative use of the PDSA model for continuing to refine the program along a continuum of quality improvement. The project is sponsored by ADAPT, Inc., Healthcare for Women, Douglas County Independent Practice Association, Douglas County Health and Social Services, and Douglas County Family Development Center.

PENNSYLVANIA

D04RH06797

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Medication assistance

This project is built on the premise that a significant aspect of patient safety that can be improved is in the realm of medication, including prescription, transcription, validation, documentation, ordering, dispensing, administering, and usage of drugs and other pharmaceuticals. Wayne Memorial Hospital, a 98-bed community hospital in rural Pennsylvania, and its consortium of primary care practices throughout Wayne and Pike Counties,

Pennsylvania. The consortium also represents portions of Lackawanna County, Pennsylvania, and Sullivan County, New York. The project will implement an integrated medication safety program called the IMAPS Project, or Improving Medication and Patient Safety.

Through the use of comprehensive information systems and automation the medication processes of ordering, transcribing, dispensing, and administering medication for patients served throughout the Wayne Memorial Health System and the community will be improved substantially. The project will involve sharing this vital medication information between the hospital and the physicians employed in physician practices within the community, both health system entities and private practices. The mechanism for accessing this information will be the Internet through a secured web portal. The project will include enhanced automation and information systems in the following Hospital areas: inpatient units, operating rooms, and emergency services.

The primary goal of the project is improvement in patient safety. A concurrent goal is a reduction in the need for additional services caused by medication errors and the resultant drain on both the patient's resources and the medical resources of this medically underserved community. The objective to accomplish these goals is reduction of medication errors. Success of the project will be measured through quarterly reports identifying the number of medication errors by unit of service within the Hospital. This information will be compared to baseline (historical data) before the new system was implemented. The type of data to be collected and maintained will include: (1) the number of medications administered, both in grand totals and by department and by individual provider (nurse and/or doctor); (2) the number of medication errors and the type of errors (ordering, transcribing, dispensing, or administration errors). Specifically, the project goal will be a 50 percent reduction in medication errors over historical events.

The number of Hospital inpatients that will be affected by this project will be 4,000-4,500 per year. The number of emergency room encounters with potential for interaction with this project is 19,000-20,000 per year. The number of provider orders impacted by this system will be 435-450 per day, or 158,000 to 164,000 per year.

SOUTH CAROLINA

D04RH06789

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,767 | \$124,190 | \$99,615 |

Keyword(s): Chronic disease, Home health services, Self-management

Adults over the age of 65 years residing in Oconee County, South Carolina, have higher rates of many chronic diseases and risk behaviors than their State and national counterparts. This county ranks second in the State for the percentage of the population over 65 years of age at 15.6 percent. Of this population, 12.9 percent live in poverty, compared to the national average of 6.4 percent. Lack of resources makes self-management of chronic disease very challenging, often leading to the need for home health services (HHS). However, even during the episode of

care offered by the two nonprofit HHS agencies in Oconee County, patients exceed the State and national average in HHS patient hospital and emergent care. After discharge from HHS, avoidable incidences of emergent and hospital care arise because of the difficulty the older adult faces in transitioning from home health services to chronic disease self-management.

In the rural, older population of Oconee County, much of this emergent and hospital care is related to congestive heart failure, diabetes, and cardiovascular disease. Frequently, such care could have been avoided if the disease had been more effectively managed through better adherence to the home health care plan and prompt recognition of “red flag” signs and symptoms. Adherence can be improved by building patients’ self-management skills and helping them navigate the complex network of health and social services. This project’s model is designed to improve chronic disease management among rural, HHS patients through trained community volunteers called “Health Coaches.” These coaches will help patients transition from home health services to self-care and family care by offering home-based education, monitoring, support, and referrals, thus reducing the risk for emergent and hospital care.

The role of the Health Coach merges community volunteer with “patient navigator” and includes: 1) Building patient chronic disease self-management skills; 2) Coordinating health care services and provider referrals; 3) Collaborating with community organizations to obtain services and make referrals; 4) Helping with medication management; 5) Arranging and reminding clients about appointment schedules and treatment regimens; 6) Making transportation arrangements for health needs; 7) Facilitating communication between client, family, caregivers, and service providers; 8) Providing and facilitating social support; 9) Implementing nutrition and physical activity educational programs; 10) Facilitating participation in immunization clinics; and 11) Facilitating enrollment in clinical trials.

The project will implement best practices such as those tested in the South Carolina Rural Geriatric Initiative Project (SC GRIP). Health Coaches will be trained using the SC GRIP curriculum for geriatric technicians and will be trained to use the State’s medical management materials, and its information and referral database. The also will be trained to implement Clemson University Extension nutrition and physical activity curricula. The project will build on these successful programs, integrate them with home health services, and organize strategies with the Chronic Care Model framework to coordinate care as the patient transitions along the continuum from acute care to self-care.

SOUTH DAKOTA

D04RH04324

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$199,900 | \$199,446 | \$199,512 |

Keyword(s): Drug Prevention Services, Equine-assisted Learning

The goal of the Southern Hills Leadership and Resiliency Initiative (SHLRI) is to reduce use of alcohol, tobacco, and other drugs by students in five communities in the southern Black Hills of South Dakota. The initiative will provide alcohol, tobacco, and other drug prevention and early

intervention services in grades 5 through 12 in five rural schools. There is an alarmingly high rate of alcohol, tobacco, and other drug use among the youth of in this service area, which is higher than national rates. SHLRI will use a research-based alcohol, tobacco, and other drug prevention program to address the problem through prevention and early intervention of alcohol, tobacco, and other drug addiction. The project will include a prevention curriculum for 5th through 9th grades; parent education; awareness activities for youth; early intervention programming for students in the 9th through 12th grades; incorporation of an alcohol, tobacco, and other drug prevention curriculum into health and physical education classes; and collaboration with mental health providers. Equine-assisted learning (experiential activities involving horses) will be an integral component of the early intervention program.

The target area includes the communities of Custer, Edgemont, Hill City, Hot Springs, and Oelrichs in the southern Black Hills in the southwest corner of South Dakota. South Dakota has a low rate of economic growth and a per capita income among the lowest in the United States. The closest city with 24-hour primary health and mental health services is Rapid City, which is 30 to 80 miles away. In addition, unpredictable weather from October to April and inadequate roads limit accessibility to services. Area schools have experienced continued budget cuts. South Dakota is a rural state with a rugged individualism or frontier mentality, which can be a hindrance to citizens in need of assistance. Parents and community members lack understanding of the significance of early adolescent use of alcohol, tobacco, and other drugs. Cultural barriers exist between Caucasian and Native American Lakota people residing in the area. Barriers to access include poverty, isolation, and cultural differences. The service area is designated as a Medically Underserved Area and Medically Underserved Population.

In addition to the Custer School District, members of the consortium include Lifeways, Inc., a nonprofit alcohol and drug prevention agency; Walking In Grace, a faith-based nonprofit counseling center; Native American prevention specialists; and an evaluator from Black Hills State University.

D04RH04325

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| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$199,386 | \$190,518 | \$192,084 |

Keyword(s): Durable Medical Equipment

The Recycle for Life Program—operated by Easter Seals South Dakota and its partners—has helped thousands of rural South Dakotans with disabilities gain access to durable medical equipment since it began in 1999, but the need for durable medical equipment continues to be an issue. Goals of the program are to strengthen 12 existing volunteer networks and create 8 new volunteer networks to aid in the solicitation, storage, transportation, refurbishing, and redistribution of previously owned equipment; to provide good-quality refurbished medical equipment to an average of 200 individuals per month by enhancing a refurbishing and redistribution system for used durable medical equipment; to educate agencies and organizations that purchase durable medical equipment for clients about medical equipment options; to sustain and expand a statewide equipment loan, donation, and refurbished

equipment redistribution program; to increase a current caseload of 1,500 individuals to 2,400 individuals; and to conduct a statewide campaign for donation of durable medical equipment by individuals and agencies across the state.

Service delivery for medical equipment in South Dakota is a challenge, especially for people with disabilities in rural communities who live far from basic services. Many rural families have either inadequate or no health insurance, leaving them with limited or no access to medical equipment. For individuals with disabilities, access to costly medical equipment is difficult or impossible, and many insurers and health care providers do not cover the cost of assistive devices. More than 97 percent of South Dakota is considered frontier, rural, or reservation; 83 percent of the counties in South Dakota are federally designated Health Professional Shortage Areas, and more than 90 percent are Medically Underserved Areas. Twelve counties in South Dakota are among counties with the highest poverty rates in the United States. According to the 2000 Census, 13.6 percent of state residents have disabilities or chronic illness. In addition, 8.4 percent of South Dakotans are without access to primary care providers, 8.1 percent of the total population was uninsured in 2004, and more than 50 percent of the uninsured live below 200 percent of the federally established poverty level. Easter Seals South Dakota (ESSD) has experienced an influx in the number of requests for medical equipment as state government and other agencies continue to downsize their programs.

Network partners include Easter Seals South Dakota, the lead applicant; the South Dakota Office of Adult Services and Aging; and Northland Rehab Supply.

SOUTH DAKOTA

D04RH06952

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$124,999 | \$99,997 |

Keyword(s): Overweight/obesity; Diabetes

South Dakota Urban Indian Health, Inc., is a non-profit, Federally Qualified Health Center. Through the Keya (Lakota for Turtle) Program - Long Life for Good Health, the Keya Program Consortium seeks to reduce overweight and obesity to prevent diabetes and to improve the health status of those with diagnosed diabetes. The target population is rural Lakota American Indians living off reservations. When relocating to urban (non-reservation) areas, American Indians lose access to free health care provided by Indian Health Service and/or Tribal programs on the reservations. South Dakota Urban Indian Health has been providing health services continuously since early 1978. These clients are served at South Dakota Urban Indian Health clinics in Aberdeen and Pierre.

In addition to South Dakota Urban Indian Health, three other separately owned health care organizations have been working together for planning and implementing Keya Program activities. The other three consortium partners are non-profit health care organizations located

in eastern South Dakota. They include: Avera McKennan Hospital & University Health Center, Avera St. Luke's Health Services, and the Avera Corporate Office. Additionally, 78 rural South Dakota Urban Indian Health clients participated in a needs assessment survey to help plan for the Keya Program.

The Keya Program will expand existing diabetes prevention and education services by fostering the development of new collaborative efforts for delivery of health care among rural American Indians in residing in Pierre, Fort Pierre, and Aberdeen, South Dakota. These towns have large American Indian populations: Pierre (9 percent); Fort Pierre (5 percent); and Aberdeen (3 percent). Keya program goals to be met by April 2009 include the following:

- Rural South Dakota Urban Indian Health clients will witness a 12 percent average improvement in five targeted risk factors (glucose levels, waist circumference, blood pressure, high density lipoprotein, and triglycerides); and
- A framework for Keya Program sustainability for working with rural South Dakota Urban Indian Health clients will be developed. This will be accomplished through a variety of health promotion and education activities targeting exercise and diet, and through continued input from targeted clients.

This project aims to increase the quality and years of a healthy life and to eliminate health disparities among an estimated 873 rural South Dakota Urban Indian Health clients at risk of diabetes development or who have diagnosed diabetes. Several unmet health needs are noted: 1) Sioux American Indians are generally younger, less likely to graduate from high school, have lower incomes, and are poorer in comparison to other South Dakotans, American Indians and all persons in the United States; 2) South Dakota American Indians have the greatest infant mortality rate of any race or ethnic group in the United States; and 3) the South Dakota median age of death due to all causes is 80 years for whites, compared with 57 years for American Indians. The proposed project has planned rural health care outreach services that address social and belief differences of the target population. Linguistic barriers are not present since the target population speaks English.

TENNESSEE

D04RH06938

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Substance abuse, Mental health

Each month, Anderson County, Tennessee, identifies 50 new cases of drug-endangered children (DEC) and/or drug-exposed infants (DEI). Drug-endangered children are those children whose parental drug use is endangering their lives. In Anderson County, 30 percent of the methamphetamine lab arrests include children in the home. And this explosion of methamphetamine production occurs in a community already ravaged by extremely high rates of oxycotin and other drug addiction. Drug-exposed infants are newborn babies whose mothers'

drug use during pregnancy had a harmful impact on that baby. These DEC/DEI are placed in custodial care of the natural parents, a relative, or a foster parent, dependent of the individual circumstances. The custodial parent lacks the knowledge and resources to adequately address the medical, social, emotional, and behavioral development of these at-risk children. By intervening with the family at a critical time, we intend to prevent future problems for the DEC/DEI and their family.

Our goals are to: 1) Ensure the DEC/DEI has a stable, short-term environment (up to 6 months) that addresses the child's physical, emotional, and social well-being; 2) Ensure the parents have the skills and resources to provide positive parenting in a drug free home environment and; 3) Assess and implement a drug treatment plan for the abusing parent. The target number to serve is 72 DEC/DEI families over the 3-year grant period.

Working with our county's Department of Children's Services, Ridgeview Psychiatric Hospital and Center, Inc., will partner with Methodist Medical Center, our region's primary medical health provider, and Anderson County Health Council to deliver integrated medical and mental health services to the 24 DEC/DEI and their families per year immediately upon identification. The DECSS treatment team consists of a registered nurse and a social worker who will conduct assessments and implement treatment plans through a home visitation model. The DECSS treatment intends to work with each DEC/DEI and family for approximately 6 months to stabilize each family unit and facilitate the family's participation with a long-term provider. Our underlying strategy is to intervene when the family is most vulnerable, yet open to learning. We also aim to provide immediate support for critical concerns, and ensure the parents acquire the child advocacy skills so as to prevent future medical, social, and behavioral concerns.

The Drug Endangered Child Outreach Network, which will oversee this project, is committed to expanding the consortium to include additional community stakeholders. The DECSS is being developed as a pilot prevention project designed to address a problem that is reaching epidemic proportions in rural America.

TEXAS

D04RH02913

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2004 | 2005 | 2006 |
| Funding Amount | \$198,725 | \$198,725 | \$198,725 |

Keyword(s): Domestic violence, Mental health

Interpersonal violence within the family is a national concern, with estimates of at least 2 million to 4 million women each year being physically abused across the country. The physical, emotional, and economic impact of this abuse is enormous for women victims and their children. The Texas Council on Family Violence (TCFV) conducted a telephone survey in 2002 regarding domestic violence. They found that 74 percent of all Texans experienced or know someone who has experienced some form of domestic violence. Of the 59 percent that had personal experience, 26 percent had been physically abused, and 31 percent report having been either

physically abused, sexually abused, or threatened by their partner at some point in their lifetime. East Texas exemplifies these problems, as there is a high incidence of family violence and widespread poverty, which increases the risk of mental and physical health problems for women and children in this area. East Texas has a significant medically unserved and underserved population and faces a severe shortage of mental health services. All nine counties in the service area are designated as mental health professional shortage areas, and 7 of the 9 counties are designated with a full medically underserved area status.

CareLink, a collaborative initiative consisting of the Burke Center, a regional community mental health center, the Women’s Shelter of East Texas (WSET), and East Texas Community Health Services, a federally qualified health center, was formed to improve access to comprehensive health screening and treatment for victims of interpersonal violence in a nine county area of east Texas. The initiative will blend systematic screening and assessment for unmet health and mental health needs, health education, professional consultation and training, and the direct delivery of mental health and primary care to the target population of mostly women and children served through the WSET. The ethnic background of the target population is 65 percent Caucasian, 22 percent African American, 12 percent Hispanic, and 1 percent Native American.

D04RH06796

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$125,000 | \$100,000 |

Keyword(s): Health promotion/disease prevention (general); Chronic disease; Mental health, Substance abuse

East Texas Border Health is a 501(c)(3) primary care clinic in rural Harrison County, Texas. For this project, East Texas Border Health has joined forces with Sabine Valley Center, East Texas Council on Alcohol and Drug Abuse, Wiley College, and United Churches Care to deliver integrated primary and mental health care to isolated, chronically ill population groups in Harrison and Marion counties. The target population for this project consists primarily of low-income adults and children with unmet health care needs, especially those with both chronic conditions (diabetes, hypertension, respiratory illnesses) and mental illness.

The goals of this project are threefold: 1) To enhance access to care for 3,000 primarily low income individuals with chronic physical and mental illness over the three year grant period; 2) To provide community-based health education designed to address the deleterious effects of chronic illness and increase capacity for self-care by 1,500 patients over 3 years; and 3) To leverage the increased access to health care and health education to improve treatment compliance and reduce related hospitalizations of participants by 30 percent in 3 years.

Harrison and Marion counties are home to 73,381 residents. The counties' poverty level (17 percent) exceeds the national average by 36 percent. Smaller communities like Marshall and Jefferson have especially high rates, 22.8 percent and 32.9 percent, respectively. Nearly

one in five residents is uninsured, and East Texas Border Health is the counties' only provider of health care without regard to ability to pay. Harrison and Marion counties are designated as Health Professional Shortage and Medically Underserved Areas. Inadequate health care resources and persistent isolation have contributed to an overall mortality rate that surpasses Texas'; including especially high rates of death from cerebrovascular diseases, chronic lower respiratory diseases, and diseases of the heart. Additionally, over 10,000 adults and children in the counties have a serious mental illness, and isolation and resource scarcity cause many to go untreated. The resulting paranoia, confusion, and general distrust impede self-care and primary care compliance, with dangerous effect for those who also have chronic physical health conditions.

The consortium proposes to address existing health care disparities and access issues by introducing three critical resources. (1) A full time Registered Nurse (RN) will travel throughout the counties holding outreach clinics at church facilities located near highly isolated communities. These visits will be coordinated by United Churches Care. Participating churches will identify congregants and others with unmet physical or mental health care needs, assist in making appointments with prospective patients, and provide transportation if needed. East Texas Council on Alcohol and Drug Abuse will support outreach and will connect patients with substance abuse problems to available resources. East Texas Border Health will provide continuity care for patients with chronic illness. (2) The RN will complete a brief mental health assessment with each patient and will arrange for Sabine Valley Center, the state designated Mental Health and Mental Retardation Authority for Harrison and Marion counties, to care and treat eligible individuals identified as having mental health or substance abuse needs. (3) On the days that the RN is seeing patients at the church, Project OutREACH from nearby Wiley College will conduct health education classes in the waiting areas on relevant physical and mental health topics.

D04RH06928

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,998 | \$125,000 | \$100,000 |

Keyword(s): Migrant health, Health promotion/disease prevention (general), Behavioral health

The *Nuevas Avenidas* (New Avenues) Program will establish new routes of primary, preventative, and behavioral health care for medically underserved community members in Hidalgo County, Texas. The *Nuevas Avenidas* Program combines the work of *Promotores* and *Promotoras de Salud* (community health workers) with accessible primary, preventative, and behavioral health care services, case management, grassroots organizing and community coordination. The proposed program is a comprehensive, community-driven response to the health education and health service challenges of uninsured *colonia* families in the targeted area.

Nuevas Avenidas is designed specifically to help low-income, Spanish-speaking families improve and care for their health and take collective action to promote health in their communities. *Nuevas Avenidas* is a formal collaboration between Migrant Health Promotion, Community Hope Projects, AVANCE-Rio Grande Valley, and Tropical Texas Center for Mental Health and Mental Retardation

Hidalgo County, located in the southern tip of Texas, is home to over 600,000 people. Some 88 percent of the population is Hispanic (Mexican and Mexican-American), and 83 percent speak a language other than English at home. About 35 percent of county residents live beneath the poverty level. Almost 1,000 unincorporated rural settlements, or *colonias*, exist outside of city limits. *Colonias* attract low-income families, about one-third of whom migrate for agricultural work in the summer months and who acquire plots of land and build incrementally. Although the unregulated nature of *colonias* makes data collection difficult, *colonia* residents are widely believed to have low rates of insurance coverage and health care service utilization and frequently lack access to basic services such as water, electricity, and waste disposal.

The Consortium members will increase access to and use of primary, preventative and behavioral health services among underserved residents of rural *colonias* in southwestern Hidalgo County by sustaining a community-based health service and referral network, offering peer health education, and supporting community organizing. Migrant farmworkers trained as *promotores(as)* will provide individual and group health education to their peers in the *colonias*, and work with community members to make concrete health improvements in their communities. The entire Consortium will support the *Promotores(as)* and community members by offering culturally competent health services and resources; by providing case management and coordination; and by involving community members in project activities and priorities.

Over the course of the three-year program (May 1, 2006 to April 30, 2009), *Nuevas Avenidas* will provide primary, preventative, and behavioral health services to at least 700 low-income, uninsured individuals previously isolated from appropriate services, and will demonstrate increased knowledge of and access to health services and resources in targeted *colonias*. Annual, community-based assessment surveys will provide evidence of increasing knowledge of, access to and satisfaction with the health care services provided.

D04RH06940

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$147,108 | \$123,470 | \$98,935 |

Keyword(s): Dental care, Diabetes, Chronic Disease, Telehealth

The members of the Matagorda-Wharton Health Access Consortium are the Matagorda Episcopal Health Outreach Program (MEHOP), the Stark Diabetes Center at the University of Texas Medical Branch, and Victa Edwards, D.D.S., an independent contractor who provides dental services out of MEHOP facilities. The service area is Matagorda County, Texas, and the city of Wharton in Wharton County. Both of these counties are rural and designated as

medically underserved areas. The target population is approximately 12,000 low-income, uninsured residents of the service area.

The project has four goals: 1) To improve oral hygiene among low-income residents in Matagorda and Wharton Counties, and to expand a Tooth Fairy program in Wharton County; 2) To improve understanding and treatment of diabetes and other chronic conditions, and the ability of patients to self-manage care through the expansion of interactive telehealth services for consumers and their families and continuing education for providers; 3) To improve continuity of care and reduce financial barriers to care through comprehensive case management services for clients seeking medical, dental, or social services; and 4) To advance public policy regarding dental care, patient education, and case management services for low-income and uninsured rural residents in Texas by sharing outcomes of program activities with selected State and professional agencies and with health professions educators.

MEHOP is a grassroots program established to meet an identified need for health care services for poor residents of all ages. It is the only provider of health and dental services to the uninsured, low-income, heavily Hispanic (32 percent) population of the service area. The clinic's clients have little access to secondary and tertiary medical services, and no access to dental services besides the dentist who contracts to provide care at the MEHOP site. There also is a shortage of health education programs for both patients and providers. Case management services to identify and help remove barriers to care are available on a limited basis but cannot keep up with the demand.

Grant funds will be used to like MEHOP as a practice site for dental students at a nearby junior college, bringing a currently unavailable service to the area. It also would fund an expansion of the Tooth Fairy oral health education program for kindergarten and first grade students in a local school district. Oral health education programs would be available to older students and to the community via videoconferencing technology developed as a result of MEHOP's partnership with Stark Diabetes Center. The technology will bring diabetes self-management classes from the Stark Center to MEHOP patients and extend twice-monthly diabetes lectures to local practitioners. Access to other services for diabetic patients and other medical and dental patients with unmet needs will be enhanced by expanding case management services.

D04RH06790

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|----------|
| Funding Amount | \$149,981 | \$122,314 | \$99,111 |

Keyword(s): Elderly

The Texas Independence Program (TIP) is designed to reduce the need for long-term institutional placement and increase options in the community for the 1,842 frail elderly and disabled residents of Texas' Colorado, Lavaca, and Jackson Counties. TIP will blend primary medical care with preventive and supportive services through enhanced case management provided by project staff. Enhanced case management includes financial and programmatic

integration of primary medical care with case management and home and community-based services, thereby addressing the key risk factors associated with institutionalization. TIP's voluntary enrollees will be served by a panel of six physicians and mid-level practitioners, all of whom are members of the TIP consortium.

TIP aims to increase the cost-efficiency of Medicaid long-term care funds by using enhanced case management to eliminate fragmented service delivery, promote self-care and informal caregiver support, and reduce inappropriate emergency room use, multiple hospitalizations, and nursing home placements caused by preventable medical complications.

The project service area is located between San Antonio, Houston, and Corpus Christi, where the population density (19.5 persons per square mile) is one-quarter that of the rest of Texas and the United States (both 79.6 persons/square mile). In addition to health insurance participation rates and income and education levels significantly lower than Texas and the United States, the region exhibits an increasingly elderly population distribution. Fully 19 percent of the population is 65 years or older (Texas = 9.9 percent, United States = 12.4 percent).

TIP is governed by a 12-member board composed of community hospital leaders, registered nurses with utilization review and home health expertise, rural Health Clinic physicians and mid-levels, and elderly consumers. TIP is based on nationally recognized care models, including PACE (Program of All-inclusive Care for the Elderly) and SOURCE (Service Options Using Resources in Community Environments).

The TIP consortium has an evaluation plan with process, outcome and impact measures designed to determine the extent to which project activities result in cost efficiencies, and improved health outcomes for the elderly and disabled. The consortium will position TIP for sustainability by negotiating a home and community-based services waiver under the authority of Section 1915(c) of the Social Security Act with the state of Texas for enhanced case management, and by replicating TIP in other Texas counties.

VERMONT

D04RH06800

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| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,717 | \$124,947 | \$99,959 |

Keyword(s): Obesity

The Precision Valley Physical Activity and Nutrition Consortium will increase youth and family access to physical activities and increase opportunities for healthy food choices in Springfield and Windsor, Vermont. This will be accomplished through an interdisciplinary consortium that has put together a services network called the "30+5" *Nutrition and Physical Activity Intervention*. "30+5" is short for a recommendation to children and families to get at least 30 minutes of exercise and eat 5 fruits and vegetables daily. The target population is youth 10-13 and their parents.

The intervention combines school nursing and primary care expertise and judgment in clinical assessment with varied community resources for referral. These practitioners will have more levels of service available. The intervention will consist of a brief message and an "action pack" full of information about how, when, and where to find exercise and better nutrition opportunities including family access to low-cost fruits and vegetables, nutrition classes, and structured recreation programs. For youth, active and fun informal sports programs will be increased through volunteer leaders and scholarships for memberships and fees. A second level of intervention consists of the "30+5" clinical dietitian consultant who will counsel youth and families with an emphasis on wellness and prevention using a community outreach model. All staff of the project as well as consortium members will be working together to increase education in the middle schools and the community about the importance of physical activity and nutrition.

Both rural farm communities share a past of machine tool manufacturing which is now only a shadow of what it was a decade ago. Consequently, unemployment is the second highest in the State. The rate of poverty among single-mother families is between 60-70 percent. Median family income is \$6,000-\$7,000 below the state median. Surveys including the 2003 Youth Risk Behavior Survey in Vermont show that, in Springfield, 15 percent of students are at risk of overweight and 13 percent are already overweight in grades 8-12. In Windsor, 17 percent of students in grades 8-12 are at risk of being overweight, and another 17 percent are already overweight. This target group was chosen because the consortium believes that youth represent the most sustainable, long-term potential for obesity-prevention efforts.

VIRGINIA

D04RH05297

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$200,000 | \$200,000 | \$200,000 |

Keyword(s): Physician Education

People Incorporated of Southwest Virginia and its rural health outreach partners will serve low-income families in Buchanan, Dickenson, Russell, and Washington counties, located in rural southwest Virginia. Goals of the program are to improve the overall health of low-income families in the four rural counties, increase physician knowledge of community-based resources to support low-income patients' self-efficacy, and provide community-based experience to medical residents. The project will include home visits by medical residents and human service providers, health education, early intervention for children with special needs, and use of strengths-based practices to assist families in developing self-sufficiency. The consortium also will host an information exchange forum for human service providers and physicians in the four counties. The project will link physicians, medical residents, local health districts, and human service providers.

The target population consists of 180 low-income families served through the agency's Comprehensive Health Investment Program (CHIP) and families with Medicaid-eligible children from birth to age 6. The population in rural southwest Virginia is primarily white (more than 96

percent) from Appalachian or Melungeon heritage. For the estimated 19,679 low-income individuals residing in the area, chronic illness is a way of life. Southwest Virginians age 35 to 54 die from diseases such as chronic liver disease, diabetes, and heart disease at nearly twice the rate of residents from other parts of the state, and they are 67 percent more likely to commit suicide. Significant barriers to service include socioeconomic conditions such as poverty and lack of health insurance, high unemployment, and low education, coupled with geographic isolation and lack of transportation. The service area includes officially designated Health Professional Shortage Areas or Medically Underserved Communities or Populations. All counties to be served through the project are designated Medically Underserved Areas.

Consortium members include People Incorporated of Southwest Virginia, the lead applicant; Mt. Rogers Health District; CHIP of Virginia; and two private physicians.

D04RH06802

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|----------|
| Funding Amount | \$147,318 | \$114,436 | \$99,954 |

Keyword(s): Health promotion/disease prevention (general)

The Rural Health Outreach Consortium, a consortium of health and human service agencies in Bath County, Virginia, has formed to sponsor a community wellness program for county residents. Bath County is a rural, sparsely populated county of 5,073 people nestled in the Allegheny Mountains on the western border of central Virginia. By providing free access to health screenings, the community-based and employer-based HealthConnection Screening reaches out to those whose access to health care has been limited by geographic isolation, costs of health services, and fear or difficulty in seeing a physician. A Bath County Community Hospital (BCCH) health care team of four—a nurse practitioner, a registered nurse, a medication assistance coordinator, and a program coordinator—will visit employer sites and community centers where neighbors, fire and rescue volunteers, and community leaders gather to learn their "health numbers." These numbers are blood pressure, blood sugar, cholesterol, height, weight, and body mass index. Patients will be advised of appropriate follow-up to primary care providers and can come back to the next HealthConnection Screening to check their progress. All tests will be provided by the Bath County Community Hospital at no charge to the participants.

For ongoing wellness care, residents will be encouraged to enroll in HealthConnection Prevention, a preventive health care package offering exams, appropriate ancillary services, such as mammograms, and tracking of health care indicators for follow-up and recall care. Patients will have the opportunity to change risky behaviors and develop healthy habits at each visit with the nurse practitioner or participating physician. Chronic care management, medication assistance, and transportation help are all part of the package.

These services are especially targeted to people for whom the cost of a medical exam is a barrier, primarily those who are uninsured (15-20 percent of the population) or underinsured,

and whose incomes fall below 300 percent of the poverty level. Free or minimum fees will apply to those under 200 percent of poverty (26 percent of population), and discounts up to 300 percent. All exams and tests will be reasonably priced for out-of-pocket payment. Free or reduced price medicines are available to eligible persons upon enrollment with the medication assistance coordinator. Other medication assistance may be available to those over the 200 percent income level.

It is anticipated that 10 percent of the Bath County population of 5,073 will be helped during the first through third years of the project. Recording and tracking the health indicators to remind and encourage residents to receive preventive health care is a goal of the applicant, Bath County Community Hospital (BCCH). By joining efforts with a consortium of community partners (called the Rural Health Outreach Consortium)—such as the Bath County Administration, the Bath County Health Department, the Bath County Department of Social Services, members of the Bath County Fire and Rescue Squads, Bath County Health Care Providers, the Allegheny Highlands Free Clinic, and the Valley Program for Aging, Bath County Community Hospital—the project hopes to see improved health behaviors in county residents.

WASHINGTON

D04RH06795

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| Fiscal Year | 2006 | 2007 | 2008 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$150,000 | \$124,893 | \$100,000 |

Keyword(s): Diabetes, Obesity/overweight, Migrant health

The goals of the *Salud en Sus Manos* (Health in Your Hands) project are to reduce disparities in diabetes, obesity, and other nutrition-related medical conditions; improve access to diabetes, obesity, and other nutrition-related health services; and improve the quality of diabetes, obesity, and other nutrition-related health services for Hispanic and rural residents in the Yakima Valley in Washington. The strategies of the project are to educate outpatient users, participants, and community members on diabetes, obesity, and other nutrition-related medical conditions; build community capacity by recruiting and training diabetes self-management education staff and lay leaders; implement a chronic care model for diabetes, obesity, and other nutrition-related diagnoses and enhance the electronic registry for outpatient users with these conditions.

Yakima Valley Farm Workers Clinic (YVFWC) users with diabetes, obesity, and other nutrition-related medical conditions in a pilot project showed the following poor health status: 70.4 percent had HbA1c >7, 46.5 percent had total cholesterol >200, 51.5 percent had total triglycerides >150, 39.4 percent had HDL <40 (male), 67.7 percent had HDL <50 (female), 60.9 percent had LDL >100, and 84.6 percent had BMI >25.

The activities of the *Salud en Sus Manos* Project are as follows:

- YVFWC will provide medical nutrition education and nutrition self-management education, for outpatient users with diabetes, obesity, and other nutrition-related diagnoses.

- YVFWC and the Yakima Valley Memorial Hospital (YVMH) will recruit, train, and mentor Lay Leaders who will provide Tomando Control de su Salud (Taking Control of Your Health)/Chronic Disease Self Management Program (CDSMP) workshops for community participants.
- YVMH and Radio KDNA will provide weekly diabetes, obesity, and other nutrition and self-management education radio shows for community members, while Prosser Memorial Hospital will provide diabetes self-management education for community members.
- YVFWC will assign Dr. Katherine Smalley to provide medical nutrition education services.
- YVFWC will hire a Coordinator to provide coordination of Tomando/CDSMP self-management education and contract with YVMH to attend the Tomando/CDSMP master trainer training.
- YVMH will provide diabetes and obesity self-management education via weekly radio shows, and Prosser Memorial Hospital will contract a Diabetes Educator to develop and implement diabetes self-management education.
- YVFWC will participate in the Washington State Diabetes Collaborative.
- YVFWC will manage the Chronic Disease Electronic Management System.

The *Salud en Sus Manos* consortium will target Hispanic, low-income, and other underserved users with diabetes, obesity, and other nutrition-related medical conditions in the rural communities of Toppenish, Grandview, and Prosser, Washington. Compared to the population in Yakima County, YVFWC users with nutrition-related diagnoses are more likely to be Hispanic, older, poor, publicly insured, uninsured, and speak Spanish.

WISCONSIN

D04RH04322

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2005 | 2006 | 2007 |
| Funding Amount | \$191,577 | \$189,964 | \$192,758 |

Keyword(s): Dementia Services

This partnership project seeks to improve dementia services and availability in northern Wisconsin. Alzheimer's disease affects approximately 10 percent of the population age 65 and older as well as a small number of persons between the ages of 35 and 65. Because the incidence of Alzheimer's disease appears to double every 5 years after age 65, it is believed to affect nearly half of all persons older than age 85. Population projections through the next 30 years indicate that the number of Wisconsin residents with Alzheimer's disease will increase significantly. This project seeks to formulate a proactive rather than reactive approach to the identified number one health concern in Wisconsin—Alzheimer's disease—and will focus on three major areas of activity: dementia care network development, rural educational outreach, and diagnostic efficacy and clinic support and development. Project efforts will link with local community health centers, rural health clinics, Indian Health Service sites, local public health

departments, and primary medical care professionals. Impact of the project will increase the capacity of primary care physicians and their staff, as well as patient and care partner wellness and the prevention of care partner stress-related diseases processes. The project will not only build service capacity but will also affect service quality and availability.

The estimated total population of persons age 65 and older living in the service area is 62,345: 1,021 African Americans, 2,798 Hispanic, 1,144 Asian, and 11,688 Native American. The estimated population of persons with Alzheimer's disease in the proposed service area is 9,438, and the number is expected to grow to 10,042 during 2010 and to 12,361 by 2020. The target population is older adults, especially those with Alzheimer's disease.

This project will serve 16 counties in the rural and underserved areas of northern Wisconsin. Thirteen of the counties in the service area are Medically Underserved Communities. The project service area includes seven sovereign tribal nations. The area poses serious challenges and threats for persons affected by Alzheimer's disease. Population centers are few and far between, and homes are scattered throughout the area.

While the service area is attractive to vacationers, the environment poses risks to travel, social, and service isolation, and a risk of wandering and death for persons with Alzheimer's disease. In addition, a higher percentage of persons age 65 and older live alone in this area than in the state as a whole. Accessibility to medical and support services is hampered by stigma, geography, and availability. The counties served by this project are characterized by relatively low population densities, smaller average household sizes, and the clustering of resources outside this largely rural service area, all of which create significant challenges and barriers. Barriers to services include long, harsh winters with impassable road conditions; variable road systems, which make travel difficult; the potential for patients with Alzheimer's becoming lost in the national forest or a deserted farm field; and lack of affordable transportation. Other barriers include low literacy and cultural differences experienced especially by Native Americans seeking treatment.

Consortium partners include the Alzheimer's Association of Greater Wisconsin, the lead applicant; Wisconsin Alzheimer's Institute; Northern Area Agency on Aging; and Northern Wisconsin Area Health Education Center.

D04RH04323

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| Fiscal Year | 2005 | 2006 | 2007 |
|----------------|-----------|-----------|-----------|
| Funding Amount | \$189,902 | \$184,220 | \$188,762 |

Keyword(s): Diabetes, Obesity

An estimated 15 percent of children age 6 to 19 in the United States are overweight. The Ho-Chunk Nation data are even more alarming—59.5 percent of children age 5 to 14 and 48.1 percent of children age 15 to 19 are overweight or at risk for overweight.

The ultimate goal of the Ho-Chunk Nation Youth Fitness Project (HYFP) is to prevent, or at least delay, the onset of type 2 diabetes among people of Ho-Chunk Nation, an already high-risk ethnic group. This project will bring together resources and personnel from an already successful Pediatric Fitness Clinic in a collaborative effort to modify the overweight risk factor through improved eating and activity habits. HYFP will expand the prior program to include the following components: (1) offer 90 minutes of fitness, nutrition, and wellness classes, twice a week, to all Ho-Chunk youth age 6 to 18, regardless of weight, for 16 weeks; (2) require parents of the youth participants to attend weekly nutrition and fitness classes; (3) have parents and youth meet weekly with a guidance counselor who will promote positive self-esteem and overall well-being; (4) offer the program to the Tomah/Wyeville area, which has not received these services; and (5) implement the new program in Black River Falls. The HYFP goal is to develop strategies for preventing and reducing childhood overweight through fitness, nutrition, and counseling that can be replicated in other communities and tribal organizations. Parental involvement will be encouraged because parent support is necessary in the success of the child's weight loss.

The target population is 400 Ho-Chunk youth age 6 to 18 and their parents who reside in the Tomah and Black River Falls areas. The jurisdictional lands of the Ho-Chunk Nation, a federally recognized Indian Tribe, cover a 16-county area in central Wisconsin. The majority of the Ho-Chunk lands are located in rural areas that lack access to specialized health care services with the nearest being 50 miles.

The service area faces several other barriers to health care. Ho-Chunk tribal members do not always feel comfortable seeking non-tribal health services, especially with the stigma that often goes with obesity. Until the establishment of HYFP, there was no program addressing childhood overweight being offered within the Black River Falls area and currently there is not a program in Tomah. Treatment for obesity is not covered by most insurance plans, and many families lack financial resources to travel to special program service sites. Monroe and Jackson counties, where project services will be provided, are Medically Underserved Populations and Medically Underserved Areas. In addition, Ho-Chunk Health Care Center serves a Medically Underserved Community.

Consortium partners include the Ho-Chunk Division of Health, Ho-Chunk Education Department, Ho-Chunk Social Services, and Tomah and Black River School Districts.

D04RH06792

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|----------------|-----------|-----------|----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$149,886 | \$124,944 | \$99,994 |

Keyword(s): Health promotion/disease prevention (general)

This project will enhance the efforts of Healthiest Manitowoc County 2010 (HMC2010) through the implementation of four initiatives. HMC2010 is a broad-based, community-driven coalition formed in 2004 to address the most critical health needs of Manitowoc County. HMC2010

addresses six health priorities through seven Community Health Improvement Committees (CHICs) and a Steering Committee. The six health priorities of HMC2010 are as follows: physical activity and nutrition; tobacco use; teen pregnancy and risky sexual behavior; injury prevention; oral health; and alcohol and other substance abuse. The First Initiative, *Know Your Numbers*, will build upon current HMC2010 activities and will provide outreach and a comprehensive health risk assessment to underserved adults, with follow-up counseling and referral to community resources.

This is an overarching project that touches many health care issues. For example, the rate of Manitowoc County adults at healthy weight is currently 34 percent, compared to 42 percent of Wisconsin residents. The Second Initiative, *High School Peer Health Education*, will train high school students at three high schools to creatively deliver key messages both to their peers and to junior high school students that will inform and foster healthy lifestyle choices regarding tobacco use, alcohol and drugs, risky sexual behavior, and physical activity & nutrition.

Manitowoc County's (MC) teen pregnancy rate increased 33 percent between 1995 and 2002, compared to a 27 percent decrease statewide; MC's rate for underage drinking arrests is 128 per 10,000 kids, compared to the state rate of 90 per 10,000; MC high school student smoking rate is 29 percent compared to 24 percent statewide; binge drinking among MC high school students is 30 percent compared to 28 percent statewide; the percentage of MC high school students achieving Healthy People 2010 nutrition (daily vegetable consumption) and exercise (vigorous physical activity) targets is 23 percent and 70 percent, respectively. The Third Initiative, Manitowoc County Network for Child Passenger Safety, will enhance the county-wide network for child passenger safety by ensuring there are an adequate number of certified child passenger safety technicians at both hospitals in the county to provide education to each family of newborns delivered at their hospital, and provide outreach and education to the community regarding child passenger seat safety. Need addressed: In the past 3 years, over 95 percent of child passenger safety seats presented for car seat checks in Manitowoc County were installed incorrectly. The Fourth Initiative, Healthy Teeth Healthy Kids, will provide comprehensive preventive and restorative dental services to 1,305 Medicaid and uninsured children in elementary and middle schools in the schools with the highest rate of poverty in the county.

Only 18 percent of Medicaid recipients in Manitowoc County received dental care in the past year, compared with 23 percent of Medicaid recipients statewide and 73 percent of the total Manitowoc County population. Only one Manitowoc County dentist accepts pediatric Medicaid patients.

D04RH06791

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|----------------|-----------|-----------|-----------|
| Fiscal Year | 2006 | 2007 | 2008 |
| Funding Amount | \$150,000 | \$200,000 | \$200,000 |

Keyword(s): Minority health, Occupational health

Currently, services available to the Hispanic population are limited and fragmented across the four-county region. Reliable data on this population are poor due to fears that the Hispanic

population has about accessing services and providing information due to their immigration status. The overarching goal of this proposal is to reduce health disparities in the Latino/Hispanic population in a four county area by increasing access to health care, providing health information and education, increasing direct health care services, improving occupational health and safety and developing community capacity and infrastructure to deliver culturally competent health care services.

The Alliance for Hispanic Outreach and Regional Awareness (AHORA) is a coalition formed by Wisconsin's Wood County Health Department in September 2003 to assemble providers for discussion about regional strengths and weaknesses in meeting the needs of the rapidly growing Hispanic community in central Wisconsin. AHORA includes representatives from the counties of Clark, Lincoln, Marathon, Portage, and Wood. It has grown to include membership from 42 medical and service providers, non-profit organizations, faith-based groups, Latino service providers, and community volunteers both Hispanic and non-Hispanic.

The model that will be used to provide health and safety outreach for this proposed project is founded on the community health outreach model. The project is designed to address the health disparities and access issues in the Hispanic community in four counties in the north central heartland of Wisconsin. The counties are Wood, Marathon, Clark, and Lincoln counties. The community health outreach services focus on four primary and interrelated services including:

- Providing health information and referral using a community health outreach worker approach that includes a toll-free telephone help line and health navigators to assist Hispanic/Latino individuals to access and benefit from community resources to meet their needs;
- Provide health information to Hispanic families and children through a home visitation model, with bilingual staff that will use a curriculum to provide health information, but will also address individuals' needs for information and support;
- Train bilingual health educators to provide services to women infants and children in the Hispanic community using a train the trainer model developed by the Wisconsin WIC program; and
- Provide occupational health and safety information to Hispanic workers and employers with a variety of educational interventions including health fairs at employer locations, with families, with children in schools, at churches, in the Spanish newspaper, in the AHORA newsletter, and at Hispanic events like the area soccer league.

This activity also impacts the Healthy People 2010 goal addressing socioeconomic factors that influence health.

It is believed that the development of the partnerships created through this grant opportunity will provide regional and cross systems coordination to better assess needs and identify priorities for future systems and service development. In addition, the sense of purpose created by unifying our goals and creating a common vision and shared outcomes will drive the development of quality services for the Hispanic population in north central Wisconsin for years to come.