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**OUTREACH PROJECTS**  
**2009, 2010, 2011, and 2012**



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Rural Health  
**OUTREACH**  
Grantee Directory  
FY 2009

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**ALASKA**  
***Cross Road Medical Center***

**Grant Number: D04RH12768**

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**PROGRAM DIRECTOR**

Andre Hines, CEO  
CRMC  
P.O. Box 5  
Glennallen, AK 99588  
Phone: (907) 822-3203  
Fax: (907) 822-5805  
E-mail: ahines@crossroadmc.org

**TOPIC AREAS**

Chronic Disease, Oral Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 148,946
- Year 2 – 122,300
- Year 3 – 98,000

**PARTNERS TO THE PROJECT**

Cross Road Medical Center, Wenger's Country Store, Copper River Record, and Community Church, McCarthy local newspaper

**AREAS SERVED**

Kenny Lake, McCarthy and Nelchina in the Copper River Basin, Valdez-Cordova Census Area, Alaska.

**TARGET POPULATION SERVED**

Geographic isolation, transportation difficulties, severe weather and having to travel long distances for primary care makes access to care very challenging. Unemployment, poverty, the harsh Alaskan life and the impact of profound fluctuations in daylight hours contribute to a population that engages in high risk behavior. As a result, residents in these three villages experience markedly high rates of illness, unintentional injuries and deaths, chronic disease, obesity and sedentary lifestyles, mental health conditions, high usage of drugs and alcohol abuse, Fetal Alcohol Syndrome among their babies, severe domestic violence and suicide. The health needs are extreme.

**PROJECT SUMMARY**

Cross Road Medical Center (CRMC) is a private nonprofit Federally Qualified Community Health Center, which has been operating for five years. Our previous organization, Faith Hospital, served our service area, rural Glennallen and the Copper River Basin for over 50 years. All area residents (10,000+) are welcome to receive care through CRMC, but our target population is low-income, uninsured and underinsured populations and others who have difficulty accessing care. We estimate that this represents approximately a third of the Basin's population. Our challenge is that these residents are scattered throughout our service area that is the size of Ohio. Almost 500 of these residents live in three remote villages that don't have primary care services. We will change that. This Project focuses on bringing care to the residents of three villages out in the bush (Kenny Lake, Eureka and McCarthy). Working collaboratively with village organizations, we will send the Project's Outreach/Care Team (a provider,

## ALASKA

### *Cross Road Medical Center*

**Grant Number: D04RH12768**

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nurse and licensed clinical social worker) to each village on a regular, rotating basis. Our services will improve each village's community health.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# ALASKA

## *Eastern Aleutian Tribes*

Grant Number: D04RH07940

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### **PROGRAM DIRECTOR**

Liam Chris Devlin  
3380 C Street, Suite 100  
Anchorage, AK  
Phone: (907) 564-2501  
Fax: (907) 277-1446  
E-mail: chrisd@eatribes.net

### **TOPIC AREAS**

Hospice/Medicare

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000.00
- Year 2 - 125,000.00
- Year 3 - 100,000.00

### **PARTNERS TO THE PROJECT**

Eastern Aleutian Tribes, Providence Hospice, Aleutian Pribilof Islands Association, and Alaska Native Tribal Health Consortium this demonstration will allow Eastern Aleutian Tribes (EAT) to expand access to hospice services for rural Alaskan residents by using its mid-level practitioners and health aides to provide in-home hospice services.

### **AREAS SERVED**

Both tribal and non-tribal members, who reside within the Eastern Aleutian Tribes and Aleutian Pribilof Islands Association service area.

### **TARGET POPULATION SERVED**

According to the Alaska Native Epidemiology Center, malignant neoplasms accounted for 50% of the total Alaska Native death count in the Aleutians East Borough between 1998 and 2002. (Alaska Native Epidemiology Center, Regional Health Profile for Eastern Aleutian Tribes for Eastern Aleutian Tribes, April 2006). There were a total of 1,120 reported cancers in Alaska Natives in the Anchorage Service Unit. The top five cancers among Alaska Natives were (highest to lowest) lung, colon/rectum, prostate, orallpharynx, and stomach. Cancer incidence rates are greater for Alaska Natives in the Anchorage Service Unit than for the United States white population. (Alaska Native Epidemiology Center, Regional Health Profile for Eastern Aleutian Tribes, April 2006).

### **PROJECT SUMMARY**

The proposed Rural Alaska Hospice Outreach (RAHO) project is designed to test whether hospice services provided by a rural demonstration hospice program to Medicare beneficiaries in rural Alaska who lack an appropriate caregiver and who reside in rural areas of Alaska would result in wider access to hospice services, benefits to the rural community, and a sustainable pattern of care.

Medicare Hospice care is an entitled benefit covered under the Medicare Hospital Insurance program and is available to all beneficiaries enrolled in Medicare Part A. However, rural Alaskans are being denied

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## *Eastern Aleutian Tribes*

**Grant Number: D04RH07940**

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access to hospice care because CMS Conditions of Participation (COP) require specifically defined services that are not possible in very rural, isolated areas of the United States -like bush Alaska. Tribal and non-tribal healthcare organizations in Alaska must collaborate to work with current COP's or change paradigms such that hospice services are: 1) facilitated or enhanced through the collaboration of tribal and non-tribal entities and, 2) authorized to be provided beyond the current service area definition that is classically defined by close geographic locality to the providers of care.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# ALASKA

## *Kodiak Island Health Care Foundation*

Grant Number: D04RH16320

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### **PROGRAM DIRECTOR**

Brenda Friend, Executive Director  
1911 E Rezanof Drive  
Kodiak, AK 99615-6602  
Phone: (907) 512-2813  
Fax: (907) 418-2476  
E-mail: bfriend@kodiakchc.org

### **TOPIC AREAS**

Diabetes, Chronic Disease, Elderly

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 128,028.00
- Year 2 - 125,000.00
- Year 3 - 100,000.00

### **PARTNERS TO THE PROJECT**

Kodiak Community Health Center, Brother Francis Shelter, and the Senior Center of Kodiak

### **AREAS SERVED**

Kodiak, Kodiak Borough, Alaska

### **TARGET POPULATION SERVED**

We provide critically needed primary care services for the large low-income population throughout this rural Borough.

### **PROJECT SUMMARY**

Kodiak Community Health Center (KCHC) is Federally Qualified Community Health Center. Our mission is to provide high quality, accessible and sustainable primary and preventive health services to residents of Kodiak Island regardless of their ability to pay. The service area encompasses 7,500 square miles. Kodiak is a rural community in the Gulf of Alaska, approximately 250 southwest of Anchorage. The need for health care – acute, preventative care and chronic disease management – in Kodiak is enormous. A substantial number of people make their living through seasonal spring and summer fishing, but do not make enough to carry themselves and their family through the long winter. Furthermore the cost of health insurance for business owners is so high that many no longer provide this benefit to their employees. Similarly, independent fishermen have a difficult time affording health care coverage and a number of individuals and families have resident-alien status and are not eligible Medicaid for Medicare.

KCHC will provide its target population with 2.00 FTE Outreach RNs that will conduct outreach to seniors, the homeless (through our Project collaborators) and workers and residents of Cannery Row and the surrounding area of Boat Harbor. These new positions will provide outreach, facilitate access to care by reducing key barriers, will assist patients with insurance enrollment and will help patients navigate the fragmented and complex health care delivery system among providers on Kodiak Island and Anchorage.

## ALASKA

### *Kodiak Island Health Care Foundation*

**Grant Number: D04RH16320**

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We will be conduct outreach to the general populations, with a special focus on persons at risk for or diagnosed with chronic disease.

96% of our patients will live below the federal poverty level. 25% of our patients will be children. 60% of our patients will be female. 31% of our patients are expected to be people of color, primarily Pilipino and Asian. Many of our patients will be immigrants/refugees and roughly 30% of our Program population will speak a non-English language at home. We look forward to the opportunity to working with over 2,000 residents/patients during this Program Period.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# ALABAMA

## *Coosa County Board of Education*

Grant Number: D04RH07932

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### **PROGRAM DIRECTOR**

Lucy Browning  
Coosa Board of Education  
P.O. Box 37  
Rockford, AL  
Phone: (256) 377-2385  
Fax: (256) 377-2385  
E-mail: lbrowning@coosaschools.k12.al.us

### **TOPIC AREAS**

Mental Health

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 139,785.00
- Year 2 - 124,971.00
- Year 3 - 99,993.00

### **PARTNERS TO THE PROJECT**

This project is a joint effort of a consortium with 3 member agencies, Coosa County Public Schools, Cheaha Mental Health, and the Alabama Parent Education Center. These partners are completing work on an Integrating Mental Health in Public Schools planning grant from the U.S. Department of Education. The planning grant provided the consortia with the opportunity to meet frequently with each other and other key stakeholders to identify mental health needs in our community. Our community has been designated as a medically underserved community because of the limited mental health services available.

### **AREAS SERVED**

The entire community of Coosa County has been a part of the development of this project. When we began to identify the limited mental health services in our community as a problem community as a problem, we formed the Coosa County Partnership for Youth.

### **TARGET POPULATION SERVED**

Coosa County is a small, rural, isolated county in central Alabama. According to the U.S. Census, the population is 11,500 in a county that covers 652 square miles. The population density is 19 people per square mile and approximately 9 housing units per square mile. Our county has approximately 4,682 households, 30% of which have children under the age of 18 in the home.

### **PROJECT SUMMARY**

The Coosa County Partnership for Youth is an exciting opportunity for our community. We are committed to improving the lives of youth by examining and improving the systems and processes for accessing mental health services in Coosa County. Funding from this application will allow us to work collaboratively to identify strategies for getting kids to more effective, evidence-based treatment as we build a system that eliminates the barriers to learning that all youth face. We will maximize that opportunity by working to inform the entire community about mental health issues, the importance of early identification, and how to access services. Coosa County will become a pioneer in Alabama for



**ALABAMA**

***Coosa County Board of Education***

**Grant Number: D04RH07932**

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effective and collaborative strategies to improve the link between families, schools and mental health services.

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

## ALABAMA

### *Sylacauga Alliance for Family Enhancement, Inc.*

Grant Number: D04RH12673

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#### **PROGRAM DIRECTOR**

Margaret Livingston Morton  
Executive Director  
Sylacauga Alliance for Family Enhancement, Inc.  
78 Betsy Ross Lane  
P.O. Box 1122  
Sylacauga, AL 35150  
Phone: (256)-245-4343  
Fax: (256) 245-3675  
E-mail: mortonm@safesylacauga.com

#### **TOPIC AREAS**

Disease Management—Adults, School Age Children and Families with Diabetes, CVD

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

This unique consortium, Designers of Talladega County Objectives and Measurements (DOTCOM), incorporating grassroots health leadership by faith communities consumers and providers has implemented a program of coordination of health services.

#### **AREAS SERVED**

Talladega County, AL

#### **TARGET POPULATION SERVED**

To increase the quality and years of life for adults and at-risk children with obesity, hypertension, diabetes and cardiovascular disease through an expansion of the Parish Nurse Program.

#### **PROJECT SUMMARY**

The overarching goal of the Talladega County Rural Health Outreach Program is to increase the quality and years of life for residents of Talladega County by expanding the existing Parish Nurse Disease Management Program (PNDMP) to include adults, school-age children and their families with diabetes, cardiovascular disease, hypertension, and obesity. The multiple and varied sources of information obtained and analyzed by the Designers of Talladega County Objectives and Measurements (DOTCOM) consortium, confirm the serious issues of the obesity and chronic disease burden in Talladega County. The added burden of poverty in this underserved rural environment has left prevention and intervention responsibilities to community supporters who have come together to expand, link, integrate and synergistically build on limited resources to impact the effect of the diseases of diabetes, cardiovascular disease, hypertension and obesity. Targeted interventions strategies for individuals at risk have been recommended by *Healthy People 2010* to occur at the prevention stages and at the access and quality of care stages. Based upon this data, the DOTCOM Governing Council has committed to expand the scope

## ALABAMA

### *Sylacauga Alliance for Family Enhancement, Inc.*

**Grant Number: D04RH12673**

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of the existing Parish Nurse Disease Management Program (PNDMP) in the following five areas:

1) expand the membership of the DOTCOM Governing Council to include the Alabama Department of Education and the three school districts in the county; 2) revise the targeted diseases to include diabetes, cardiovascular disease, hypertension and obesity; 3) expand the targeted population to include school-aged children who are at risk for diabetes, cardiovascular disease, hypertension and obesity; 4) develop a referral process at the school/community level to case management for the school-aged population to provide access and improved care; and 5) develop, in partnership with the Alabama Department of Education and the three county school districts, a standardized approach to implementing research-based strategies that ensure the support for healthy life choices for both children and adults in the target population. Emphasis will be placed on a program delivery model that provides educational opportunities promoting the link between proper nutrition and exercise/physical activity and quality and length of life. As a result, children will develop better decision making skills to make healthy life choices, thus reducing their risk of developing chronic diseases. Those with chronic diseases will be better equipped to manage their disease and experience improved quality and increased years of life.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# ALABAMA

## *Troy University*

Grant Number: D04RH12670

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### **PROGRAM DIRECTOR**

Dr. Bernita Hamilton  
400 Pell Avenue  
Troy, AL 36082  
Phone: (334) 670-3745  
E-mail: bernitah@troy.edu

### **TOPIC AREAS**

Health Promotion, School-Based

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Troy University, Bullock County School System, Bullock County Hospital, Main Drug Store, and Southern Springs

### **AREAS SERVED**

Union Springs, Bullock County, Alabama

### **TARGET POPULATION SERVED**

Health promotion and illness prevention programs in school children

### **PROJECT SUMMARY**

Eight years ago, a consortium of over 20 community agencies in Pike County, Alabama was formed to promote children's health initiatives. This community partnership resulted in two phases of health promotion and illness prevention programs in school children: Healthy Schools, Healthy Kids. Phase II added an intervention based on a national health program which emphasized proper nutrition and physical activity through educational curricula and through changing environmental conditions in the school. Assessment of children in both phases, revealed risks for future chronic conditions related to obesity. To continue the momentum started by the partnership, a more focused local model which emphasizes continuous wellness promotion in school children is being proposed and if found effective can be replicated in other rural areas both on the state and national level.

A registered nurse will serve as the manager of the wellness program and will coordinate educational activities and assessments, teach and support school staff endeavors, refer at-risk children to proper health care, and work with parents and community members. The nurse will also work to bridge the gaps between mandated wellness policy and the realities of implementation. The consortium members will support the program through man-power and resources. The model: Healthy Schools, Healthy Kids, Healthy Families can demonstrate to school administrators, state agencies, and legislators how a designated health promotion's nurse with community support can ultimately influence health behaviors in children and their families. A local elementary school in Bullock County, Alabama which is in an

# ALABAMA

## *Troy University*

**Grant Number: D04RH12670**

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underserved rural, poverty area with a large number of minorities will be the site for the model. The health nurse along with help from the consortium members would supply health services to numerous at-risk, culturally diverse, elementary children. Emphasis of this program would be on promoting positive health behaviors in children and their families, to improve future health outcomes.

Troy University is requesting **funding preference** for a project focusing on wellness and disease prevention. The project strategies will promote healthy living, prevention of disease, screenings for preventable disease and health education.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

## ALABAMA

### *Tuskegee Area Health Education Center, Inc.*

Grant Number: D04RH12671

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#### **PROGRAM DIRECTOR**

Benjamin P. Rackley  
2400 Hospital Road  
Building 68  
Tuskegee, Alabama 36083  
Phone: (334) 727-0550  
Fax: (334) 725-2742  
E-mail: Benjamin.Rackley@va.gov

#### **TOPIC AREAS**

Wellness and Disease Prevention—Diabetes, Obesity

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,978
- Year 2 – 124,878
- Year 3 – 99,903

#### **PARTNERS TO THE PROJECT**

Tuskegee University College of Veterinary Medicine, Nursing and Allied Health, Macon County Health Department, and Bullock County Health Department.

#### **AREAS SERVED**

In Macon County, Alabama: Tuskegee, Shorter, Notasulga, and Franklin In Bullock County, Alabama: Union Springs

#### **TARGET POPULATION SERVED**

To address wellness, health education, and disease prevention as they relate to diabetes, hypertension, and obesity among residents in Bullock, Dallas and Macon Counties.

#### **PROJECT SUMMARY**

During 2005-2007, Alabama had the 4<sup>th</sup> highest rate of diabetes among adults in the U.S. Alabama also had the 2<sup>nd</sup> highest hypertension rate during 2003-2007. In 2005, the highest prevalence of diabetes in the state occurred in the three counties – Bullock, Dallas, and Macon. In 2007, Alabama had the second highest obesity rate in the nation (30.3%). The three counties ranked among the top 12 most obese counties in Alabama (Macon had the highest rate).

The Rural Health Education Network (RHEN) was established to address wellness, health education, and disease prevention as they relate to diabetes, hypertension, and obesity among residents in Bullock, Dallas and Macon Counties. RHEN is a collaborative partnership between the Tuskegee Area Health Education Center, the Bullock County Health Department, and the Macon County Health Department. RHEN is also strongly supported by other entities, including the Dallas County Health Department, two school districts, Montgomery AIDS Outreach, and several churches in the target areas. The overarching, long-term aim of RHEN is to reduce illness, disability, and premature death among our target population. The primary intermediate goals that will lead to this aim are to (1) improve health outcomes of participants with

## ALABAMA

### *Tuskegee Area Health Education Center, Inc.*

**Grant Number: D04RH12671**

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diabetes, hypertension and obesity and (2) increase healthy lifestyle behaviors among participating residents in our service area. An additional aim of our consortium is to ensure the long-term sustainability of RHEN and its programming.

Of the many obstacles encountered by our target population, RHEN will strive to overcome: health illiteracy and a lack of health education available to the public; language barriers faced by the growing monolingual Spanish-speaking population; distrust of medical providers; and problems accessing and utilizing healthcare services available. These barriers will be addressed through RHEN's planned activities – i.e., provision of free health screenings conducted in varied settings throughout the community, referrals to healthcare providers and related follow-up, and telehealth education in the target communities. Anticipated results are early identification of disease, better coordination of care, improved health outcomes, enhanced health promotion and public awareness, and improved health literacy in our target service area.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# ARKANSAS

## *Conway Regional Medical Center, Inc.*

Grant Number: D04RH16368

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### **PROGRAM DIRECTOR**

Willie Sullivan  
2302 College Avenue  
Conway, AR 72034  
Phone: (501) 513-5585  
Fax: (501) 450-2392  
E-mail: wsullivan@conwayregional.org

### **TOPIC AREAS**

Mental Health Services for Elders and Caregivers

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 149,998.00
- Year 2 - 124,926.00
- Year 3 - 99,995.00

### **PARTNERS TO THE PROJECT**

Conway Regional Medical Center, Faulkner County Council on Aging, Inc., United Adult Care Center, Inc., and Home Instead Senior Care – Conway

### **AREAS SERVED**

Faulkner, Conway, Perry, Van Buren and Cleburne Counties in the state of Arkansas

### **TARGET POPULATION SERVED**

Seniors to avert serious conditions.

### **PROJECT SUMMARY**

Conway Regional Medical Center (CRMC), the applicant, is the largest healthcare provider in a five-county rural area of north central Arkansas. It provides acute care and is located in a HPSA rural-eligible tract. It has more than 1,100 employees and a medical staff of more than 180. In 2007, the emergency department treated more than 40,000 patients, making it one of the busiest in the state, and CRMC charity care exceeded \$4,000,000.

The target service area is Faulkner, Conway, Perry, Van Buren and Cleburne Counties. **All five counties are Health Professional Shortage Areas (HPSAs) for mental health services.** Two of the counties are also HPSA-designated for primary medical care services. This need is exacerbated by statistics showing Arkansans live in one of the poorest states in the nation and they are one of the least healthy populations including self-reported poor mental health days. At the same time, a higher percentage of Arkansans are seniors as compared to the entire country.

With this grant, CRMC will create the new Conway Regional Senior Outpatient Mental Health Center to be open seven days a week. It will be limited to Medicare patients – almost all are 65 year of age or older. The clinic will enable seniors to avert serious conditions by receiving appropriate medications and therapy and by learning about adult day care, in-home “sitter” services, home meal deliveries, etc. to



## ARKANSAS

### *Conway Regional Medical Center, Inc.*

**Grant Number: D04RH16368**

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improve their quality of life. A major public awareness campaign will increase the community's awareness of mental health issues.

CRMC will work closely with its consortium members Faulkner County Council on Aging, Unity Adult Care Center, and Home Instead Senior Care. Together they will coordinate "free" patient transport, mental health literacy for groups of seniors, multiple presentations of a seminar for caregivers of mentally ill seniors, promotion of the clinic to referral sources, and other outreach. Two PhD faculty members of Arkansas State University, with grant evaluation expertise, are committed to this project. With careful planning and dedicated personnel, the new clinic will become self-sufficient by the end of the third grant year and, in so doing, will continue to provide seniors with the mental health services they so desperately need.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

## ARKANSAS

### *Ozark Mountain Health Network: Faith and School Rural Outreach: Reach Out and Connect*

Grant Number: D04RH07898

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#### **PROGRAM DIRECTOR**

Darrell Moore  
Ozark Health Foundation  
Phone: (501) 745-7004, ext. 107  
E-mail: darrell.moore@myozarkhealth.com

#### **TOPIC AREAS**

Chronic Disease

#### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000.00
- Year 2 - 181,944.00
- Year 3 - 115,297.00

#### **PARTNERS TO THE PROJECT**

The ministerial alliance, the school districts and Ozark health Foundation.

#### **AREAS SERVED**

Ozark Mountain Health Network (OMHN) serves the residents of Van Buren and Searcy counties.

#### **TARGET POPULATION SERVED**

Community health center, rural health clinics, federally qualified health center, nursing shortage area, state, and local health departments.

#### **PROJECT SUMMARY**

The project focuses on primary care and wellness and disease prevention strategies. OMHN (or any of their partners or any organization in the service area) has not received a rural health network outreach grant. We have received the rural health network planning grant in 2003 and the network development grant in 2005.

The current service providers in this area include Ozark Health, Inc.; Boston Mountain Rural Health Center, Inc.; DHHS/DOH/Van Buren County local health unit; DHHS/DOW/Searcy County local health unit; Health Resources of Arkansas, Inc.; Ozark Health Foundation; Baptist Health, Inc.; and seven primary care physicians. All (there are no health care providers in the area who are not involved) of the current service providers in this two county area are involved in OMHN. These providers' missions are consistent with the mission of OMHN, and each of the providers will be positively affected by goals and activities of the outreach program.

**ARKANSAS**

***Ozark Mountain Health Network: Faith and School Rural Outreach:  
Reach Out and Connect***

**Grant Number: D04RH07898**

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**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# ARKANSAS

## *White River Health System, Inc.*

Grant Number: D04RH12736

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### **PROGRAM DIRECTOR**

Angela Dugger  
Project Development Coordinator  
1710 Harrison Street  
Batesville, AR 72501  
Phone: (870) 262-1927  
Fax: (870) 262-3248  
E-mail: adugger1@wrhc.com

### **TOPIC AREAS**

Health and Wellness

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 143,643.17
- Year 2 – 116,238.04
- Year 3 – 99,280.18

### **PARTNERS TO THE PROJECT**

The Wellness Works Program is a collaboration between White River Health System (WRHS), University of Arkansas for Medical Sciences' (UAMS) Area Health Education Center (AHEC) -North Central, and the White River Planning and Development District (WRPDD). Together these three separately owned entities make up the White River Health Consortium (The Consortium) and are working to provide the Wellness Works Program to North Central Arkansas worksites and communities.

### **AREAS SERVED**

Cleburne, Fulton, Independence, Izard, Jackson, Lawrence, Sharp, Stone, and Van Buren Counties.

### **TARGET POPULATION SERVED**

Adults who live and work in parts of nine counties of North Central Arkansas that characteristically uninsured and underserved.

### **PROJECT SUMMARY**

The Wellness Works Program is a collaboration between White River Health System (WRHS), Area Health Education Center (AHEC) North Central, and the White River Planning and Development District (WRPDD). Together these three separately owned entities make up the White River Health Consortium (WRHC) and will work to implement the Wellness Works Program in the North Central Delta Region of Arkansas.

The Wellness Works Program is a data driven approach to worksite wellness allowing both individual and organizational behavior change. For the past three years, WRHS has provided pilot site worksite wellness services to 24 worksites in Independence County. At these worksites, managers and owners have noted behavior changes and reduced healthcare costs using data generated by the Wellness Works Program and insurance claims. The WRHC is now ready to expand the program to nine counties of North Central Delta region of Arkansas. These counties are characteristically uninsured and underserved. Situated between the

## ARKANSAS

### *White River Health System, Inc.*

**Grant Number: D04RH12736**

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rugged terrains of the Ozark Mountain foothills and the Delta Region's farmland, the area has remained sparsely populated with small communities.

The Wellness Works Program has three components: 1. Preventive Health Screenings 2. Health Education 3. Organizational and Behavioral Support. The preventive screenings will include: a health risk assessment survey of preventative healthcare services. These services will include flu shots and screenings for blood pressure, cholesterol, glucose and body fat and body mass index measurements in order to determine their risk for stroke, heart disease, diabetes and cancer. Participants will then be counseled regarding their diagnostic results and set individual short term wellness goals for themselves with help from a registered nurse, pharmacist, dietician or health educator. Employers are provided valuable aggregate data in the form of an Executive Data Report regarding which health related risk factors their workforce is facing as a group. This valuable information can be used to determine future benefit needs, health education spotlights and worksite wellness program focus. Individual participant health information is protected by HIPPA. The health education component will include individual counseling provided after the health assessment and continuing health education literature focusing on chronic disease prevention. CDC and Department of Health literature will be utilized to help provide additional education and support to participants. The Organizational and Behavioral Support will include: health education support for human resources staff and will provide health resources roundtables.

At the health resource roundtables employers and community health stakeholders will discuss resources, strategies and implementation plans for worksite and community outreach efforts.

**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

# ARKANSAS

## *Corning Area Healthcare, Inc.*

Grant Number: D04RH12734

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### **PROGRAM DIRECTOR**

Brigitte McDonald  
Executive Director  
1300 Creason Road  
Corning, AR 72422  
Phone: (870) 857-3399  
E-mail: brigmcdonald@yahoo.com

### **TOPIC AREAS**

Children's Health—Early Periodic Screening Diagnosis and Treatment Services

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 134,983.00
- Year 2 – 124,723.57
- Year 3 – 99,946.20

### **PARTNERS TO THE PROJECT**

Corning Area Healthcare, Inc., (CAHI), Mid-South Health Systems (MSHS), and Black River Area Development Corporation (BRAD)

### **AREAS SERVED**

Northeast Arkansas: Clay County, Randolph County, and Lawrence County

### **TARGET POPULATION SERVED**

Low-income youth age 0 – 18 living in the Arkansas Counties of Clay, Lawrence, and Randolph.

### **PROJECT SUMMARY**

**The Need Statement** – Project REACH is driven by a recognition that the health care system often fails to address the needs of children in poverty. Consequently, children lack access to appropriate healthcare services.

**Applicant Purpose:** The purpose of Project REACH – Rural Education and Advancement of Children's Health - is to increase access to and coordination of quality health care services for children. This will be achieved through education and outreach to increase the number of children receiving Early Periodic Screening Diagnosis and Treatment (EPSDT) services.

These services will increase primary and mental health services within a primary care setting.

**Project Target Population:** Low-income youth age 0 – 18 living in the Arkansas Counties of Clay, Lawrence, and Randolph.

**Request for Funding Preference:** Project REACH qualifies for Funding Preference as a Health Professional Shortage Area (HPSA) and a Medically Underserved Community (MUC).

**ARKANSAS**

***Corning Area Healthcare, Inc.***

**Grant Number: D04RH12734**

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**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# ARIZONA

## *Chiricahua Community Health Centers, Inc.*

Grant Number: D04RH06922

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### **PROGRAM DIRECTOR**

Jennifer “Ginger” Ryan  
Chiricahua Community Health Centers, Inc.  
10566 Highway 191  
P.O. Box 263  
Elfrida, AZ  
Phone: (520) 642-2222  
Fax: (520) 642-3591  
E-mail: gryan@cchci.org

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000.00
- Year 2 - 125,000.00
- Year 3 - 100,000.00

### **PARTNERS TO THE PROJECT**

Rural school districts (Elfrida, Double Adobe, Ash Creek, Cochise, McNeal and Pearce) and a federally qualified community health center (Chiricahua Community Health Centers)

### **AREAS SERVED**

Sulphur Springs Valley of southeastern Cochise County

### **TARGET POPULATION SERVED**

Children in the remote and sparsely populated Sulphur Springs Valley of southeastern Cochise County.

### **PROJECT SUMMARY**

The Sulphur Springs Valley Health Care Consortium is a group of rural school districts (Elfrida, Double Adobe, Ash Creek, Cochise, McNeal and Pearce) and a federally qualified community health center (Chiricahua Community Health Centers) dedicated to providing primary dental and medical care to the students and their families. The plan is to place CCHCI's Mobile Dental Unit at each school to provide full dental treatment plans for eligible students. The initial screenings (including x-rays and an examination by a Dentist) and services of the Dental Hygienist will be done without charge. In addition, a board certified pediatrician will perform medical assessments on the children, focusing on respiratory issues, two times per month.

The program is in response to requests from community groups for dental and medical services for children in the remote and sparsely populated Sulphur Springs Valley of southeastern Cochise County. CCHCI, whose headquarters are in Elfrida, acquired a state-of-the-art mobile dental facility in July of 2006 with funds from a grant from the Office of Oral Health, Arizona Department of Health Services. The unit is equipped to provide both dental and medical services.



## ARIZONA

### *Chiricahua Community Health Centers, Inc.*

**Grant Number: D04RH06922**

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The plan is for the unit to travel to one school at a time. A Dentist will examine the children and provide a treatment plan. Once the necessary restorative work has been completed, sealants and varnishes will be provided to prevent tooth decay. The program includes education on good oral hygiene for both the students and their families. A pediatrician will provide medical assessment focusing on asthma screening and other respiratory related issues. Once all of the eligible children in a school have been seen, the unit will move to the next school. During the summer months, the unit is scheduled to provide services in remote, underserved areas.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

## ARIZONA

### *Hardrock Council on Substance Abuse, Inc.*

Grant Number: D04RH12675

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#### **PROGRAM DIRECTOR**

Germaine Simonson  
Project Director  
P.O. Box 26  
Kykotsmovi, AZ 86039  
Phone: (928) 725-3501  
Fax: (928) 725-3501  
E-mail: gsimonson@hotmail.com

#### **TOPIC AREAS**

Substance Abuse

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Hardrock Council on Substance Abuse, Inc., Rocky Ridge Boarding School, and the Mel and Enid Zuckerman Arizona College of Public Health

#### **AREAS SERVED**

Hardrock, Navajo Nation, Navajo County, Arizona

#### **TARGET POPULATION SERVED**

Arizona residents suffer from many health disparities. None, however, are more glaring than those seen in American Indian (AI) communities.

#### **PROJECT SUMMARY**

The Hardrock Council On Substance Abuse, Incorporated (HCOSA, Inc.) is a non-profit organization 501(c)3 (attachment 9) based in the rural community of Hardrock chapter, which is in the center of the Navajo Nation. As a result of a series of alcohol and substance-abuse-related deaths in 1999, HCOSA, Inc. formed an alliance that currently enables this rural non-profit to receive funds that otherwise would get lost and filtered down to an already disenfranchised community. With money received three years ago (2006) from HRSA/Rural Health Outreach, HCOSA, Inc. has been able to establish the Hardrock Youth Wellness and Prevention Program (HYWPP), which seeks to address youth who have been affected by Hardrock's dark past of relocation, land loss and overall impoverished conditions that continue to affect families to this day; additionally, funds were used to establish a behavioral health services office with a Behavioral Health Specialist, Danny Kescoli.

In its current re-application HCOSA, Inc. is seeking further funds to develop current programs such that family awareness become key factors in delivering programs across all of HCOSA, Inc.'s programs. In previous years, for example, the Hardrock Youth Wellness and Prevention Program served those youth that chose and were able to attend and as it was not a compulsory program. Under the Strengthening

## ARIZONA

### *Hardrock Council on Substance Abuse, Inc.*

**Grant Number: D04RH12675**

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Youth and Families of Hardrock Chapter proposal, emphasis will be given to develop a specific group of youth (HYLP), whose regular attendance will be required, that will eventually serve as resources for other youth in the community. In terms of behavioral and mental health, HCOSA, Inc. has plans to expand individual counseling to include family counseling as well. Due to an anticipated and expanded number of clientele, HCOSA, Inc. will hire an intern to help with the workload. Overall, in the next three years, the shift is being made from assisting healthy and well individuals to healthy and well families, thereby better servicing the community at large.

HCOSA, Inc.'s application as "Strengthening Youth and Families of Hardrock Chapter" is requesting funding preference for this application because the Hardrock community is located in an officially designated health professional shortage area (HPSA). According to the Office of Health Systems Development at the Arizona Department of Health Services, the following are designated HPSAs: Hopi and Tuba City. The Hardrock community is located 25 miles north of the Hopi Health Care Center (Critical Access Hospital) and 25 miles west of Pinon Health Care Center, and is located within the boundaries of the Navajo Nation Area Indian Health Service, Chinle Service Unit and the Tuba City Health Care Corporation. Lastly, the Hardrock community is located within Navajo county, which is designated as a federal medically underserved area (MUA).

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

# ARIZONA

## *El Centro for the Study of Primary & Secondary Education*

Grant Number: D04RH12676

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### **PROGRAM DIRECTOR**

Betty Chavez  
101 Avenue B  
San Manuel, AZ 85631  
Phone: (520) 385-3028  
E-mail: bchavez@luzsocial.org

### **TOPIC AREAS**

Alcohol and drug abuse prevention

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

A consortium between Adelante Juntos, the Mammoth-San Manuel Unified School District, the Hayden-Winkelman Unified School District, the Pinal County Sheriff's Office, and the Kearny Police Department will implement the STOP! Underage Drinking Project.

### **AREAS SERVED**

Gila and Pinal Counties in Arizona

### **TARGET POPULATION SERVED**

The program will target alcohol use and abuse through a culturally sensitive curriculum aimed at Latino youths in grades 6-12. Presentations, alcohol free-cultural awareness celebrations, town hall meetings to educate the community, and a school-based alcohol awareness/social norms campaign are program activities.

### **PROJECT SUMMARY**

The STOP! Underage Drinking Program is an alcohol use and abuse prevention program primarily targeting Latino youth in grades 6 through 12 in four rural mining communities located in Pinal County and Gila County in Arizona. The four rural mining communities: San Manuel, Mammoth, Hayden, and Winkelman have higher rates of current alcohol use and binge drinking than the state or nation. Alcohol use and abuse is associated with the three leading causes of death among youth: unintentional injuries, suicide, and homicide. The two counties where these four rural communities are located report higher rates of all three causes of death compared to all of Arizona. Reducing alcohol use by adolescents in these communities will improve health by eliminating the primary factor contributing to these three causes of death.

Goal 1 of this project is to reduce the prevalence of underage use of alcohol and binge drinking among Latino middle and high school students in the four rural mining communities.

To achieve this goal, the STOP! Underage Drinking Project will implement the Sembrando Salud curriculum, a culturally-sensitive, effective alcohol reduction program, with at least 200 6<sup>th</sup> through 12<sup>th</sup>

## ARIZONA

### *El Centro for the Study of Primary & Secondary Education*

Grant Number: D04RH12676

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grade students each year. The expected outcome objectives of Goal 1 include: 1) to increase the perception that alcohol is harmful to one's health among the target students by 5%; 2) to decrease the frequency of binge drinking among the target student by 5%; 3) to increase the disapproval of alcohol abuse among the target students by 5%; 4) to decrease the past 30-day use of alcohol among the target youth by 5%; and 5) to increase the communication skills of the target students by 5%. The prevention messages of this school-based curriculum will be supported and reinforced by Goal 2: to reinforce cultural pride and create positive social norms and practices related to alcohol use and abuse through the presentation of the Aztec Alcohol Prevention Model to Latino youth, their families, and community participants. To achieve this goal, the following objectives have been identified: 1) to provide at least 8 presentations per year of the Aztec Alcohol Prevention Model; 2) to organize and implement 4 alcohol-free cultural celebrations; 3) to host 4 annual town hall meetings to educate community members about the dangers of underage drinking and alcohol abuse; and 4) to implement a culturally competent school-based alcohol awareness/social norms campaign aimed at binge drinking by Latino middle and high school student in the consortium schools.

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

# CALIFORNIA

## *Lake County Tribal Health, Inc.*

Grant Number: D04RH12677

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### **PROGRAM DIRECTOR**

Pat Hubbard  
925 Bevins Court  
Lakeport, CA 95453  
Phone: (707) 263-8382  
E-mail: phubbard@lcthc.org

### **TOPIC AREAS**

Tribal Health, prenatal, drug abuse, fetal alcohol

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Lake County Tribal Health Consortium, Inc., Health Leadership Network, Lake County Public Health Services, Lake County Mental Health Services, Lake County Alcohol and Other Drug Services, Easter Seals of Northern California, and Healthy Start.

### **AREAS SERVED**

Lake County, California, including the two incorporated cities of Lakeport and Clearlake

### **TARGET POPULATION SERVED**

The Project will serve Native American pregnant and parenting women, their young children, and their partners, plus grandparents, aunts, uncles, and extended family.

### **PROJECT SUMMARY**

The Project will meet these needs by offering comprehensive services in a socially and physically reassuring setting, already accepted by the Native American population. The Project will expand LCTHC's trusted and successful Big Valley Preschool/Parenting Center ("BVC") to create the Native Communities Cultural Wellness Center (the "Center") designed by the Target Population. The centerpiece of the Project is the innovative 33-session weekly Cultural Wellness Class ("CWC"). A Pomo artist will teach pregnant and parenting women (and their partners) traditional crafts. Participants start with simple beads and end with a traditional baby basket to: "Welcome the Spirit". The process bonds mothers with their children, partners, and each other, giving them the strength and support to choose prenatal sobriety. The Project will provide counseling, relapse prevention, Nurturing Parenting classes, and other supports, including referrals, primary care, and a nurse home visitor. Partners can join the CWC or the Men's Group. The next generation will be born FASD-free, growing up into adults who can live happy lives and raise healthy children in nurturing homes. The Project is a cost-effective investment, as medical costs for even one child with FASD can exceed \$242,000 (almost 2 years of Project funding). This Project will benefit future generations and the entire community.

**CALIFORNIA**

***Lake County Tribal Health, Inc.***

**Grant Number: D04RH12677**

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**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# CALIFORNIA

## *The Sierra Institute for Community and Environment*

Grant Number: D04RH12752

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### **PROGRAM DIRECTOR**

Jonathan Kusel  
4438 Arlington Road  
Taylorsville, CA 95983  
Phone: (530) 284-1022  
Fax: (530) 284-1023  
E-mail: jkusel@sierrainstitute.us

### **TOPIC AREAS**

School Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

School Nurses Organization, Northern Sierra Rural Health Network, California School Health Centers Association, and the University of California at Davis/Pediatrics

### **AREAS SERVED**

Quincy and Greenville, CA

### **TARGET POPULATION SERVED**

Improving healthcare accessed and student academics

### **PROJECT SUMMARY**

The purpose of this project is to develop comprehensive and accessible healthcare services and education through a telehealth program offered through schools, and to improve assessments and interventions for students needing diverse healthcare and behavioral health services in order to improve student learning. Networked health services will be achieved through Telehealth technology linking geographically isolated schools (pre-kindergarten through high school) in Plumas County, California to primary care providers and subspecialty consultation. Under the auspices of the Sierra Institute for Community and Environment, a broad-based Consortium has been established including community members, the countywide school district, two healthcare districts, local medical and mental healthcare providers, the Plumas County Public Health Agency, Plumas County Mental Health, and regional players including The Children's Partnership, School Nurses Organization, Northern Sierra Rural Health Network, California School Health Centers Association, and the University of California at Davis/Pediatrics. A total of 11 organizations have committed to participate on a broad-based Consortium. The Consortium has been meeting since June of 2008 to identify needs and develop the project. The group held six focus group meetings with parents of special needs children, other parents, teachers and administrators, and high school students to identify needs and issues of concern, and discuss the potential of the project. Healthcare access was identified as a major concern and need. In this Northern California county of Plumas, the rural service area is approximately 1300 square miles, has an average population density of



## CALIFORNIA

### *The Sierra Institute for Community and Environment*

**Grant Number: D04RH12752**

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82 pop/sq miles and a total of 18% of the population in poverty and 34% at or below 200% of federal poverty level. Other challenges include a severe school nursing shortage with nurse to student ratio of 1:1,067 in a dispersed district. With cooperation between Plumas Unified School District; the local healthcare districts, and University of California at Davis, using telemedicine technology we will identify and address health issues affecting student performance. Expected outcomes will be tracked using markers as grades, standardized test scores, and subjective reports from teachers and parents, completion rates of grade level, disciplinary actions, truancy rates, and school violence.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# CALIFORNIA

## *Woodlake Public Schools/Woodlake Family Resource Center*

Grant Number: D04RH12648

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### **PROGRAM DIRECTOR**

Irma S. Rangel  
Director  
168 N. Valencia  
Woodlake, CA 93286  
Phone: (559) 564-5212  
Fax: (559) 564-5301  
E-mail: irangel@woodlake.k12.ca.us.

### **TOPIC AREAS**

Mental Health, Minority Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,995
- Year 2 – 124,937
- Year 3 – 99,943

### **PARTNERS TO THE PROJECT**

Our three primary Active Partners are the Family Healthcare Network, the Woodlake Police Department, and the Woodlake School District.

### **AREAS SERVED**

The town of Woodlake

### **TARGET POPULATION SERVED**

The REACH Project aims to help every person in our community receive the mental health services that will make our whole community healthier and safer. The children of undocumented immigrants are often United States citizens who attend school, live in our communities, and are typically underserved by the medical system due to fear, misunderstanding, lack of services, and lack of resources.

### **PROJECT SUMMARY**

The REACH Project is an exciting collaborative effort spearheaded by the Woodlake Family Resource Center. REACH stands for Restoring Every Adult and Child to Health. This program is committed to creating a national model for implementing Healthy People 2010 Initiatives to improve the lives of children and families by *restoring their mental health*. We hope to examine and improve the systems for accessing mental health services in a large, isolated, predominately Hispanic, agricultural region. We hope to give children and families the opportunity to receive culturally appropriate and evidence-based treatment as we eliminate the barriers to accessing services in rural and impoverished communities. Multiple funding streams will be effectively blended to establish strategies to better inform the entire community about mental health issues, the importance of early identification, and how to access services. This project aims to be a model for effective and collaborative strategies to improve linkage between families, schools, police, and mental health services.

## CALIFORNIA

### *Woodlake Public Schools/Woodlake Family Resource Center*

**Grant Number: D04RH12648**

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The Woodlake Family Resource Center, through the REACH Project, will meet and address these needs areas by: (1) Providing direct mental health counseling to every child and adult who reaches out for help regardless of insurance status, (2) Conducting an area wide campaign to create an awareness of mental health issues among those who suffer these conditions and their family members, (3) Facilitating the REACH Consortium as the nexus of communication, referral and support for the Project and (4) Studying, evaluating, and publishing a model for effective service delivery of mental health services in similarly situated impoverished, rural communities throughout the state and beyond.

The REACH Project is requesting a funding preference for its geographic target area as an officially designated health professional shortage area (HPSA), and for serving medically underserved populations (MUPs). In addition, one of the REACH Project Active Partners, Family HealthCare Network, is a facility federally designated to qualify the target population as a medically underserved community (MUC).

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# CONNECTICUT

## *Generations Family Health Center*

Grant Number: D04RH07903

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### **PROGRAM DIRECTOR**

Dr. Margaret Ann Smith, DMD  
1315 Main Street, Suite 2  
Willimantic, CT 06226-1953  
Phone: (860) 450-7471 ext. 132  
Fax: (860) 450-7475  
E-mail: margaret.ann.smith@penemco.com

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

GFHC, EASTCONN and the Windham Public Schools (WPS)

### **AREAS SERVED**

Rural Windham

### **TARGET POPULATION SERVED**

Income preschool and school-aged children and young pregnant women

### **PROJECT SUMMARY**

The *Save Smiles Oral Health Project* reduces oral health disparities for low income preschool and school-aged children and young pregnant women in rural Windham, which is located in the poorest county in Connecticut. Windham's population is 55% Hispanic; 45% of the Hispanic population is uninsured. Thirty-one percent of Windham children live in poverty; 50% are on Medicaid, and 31% speak a language other than English at home. Windham has the highest rate of homelessness in Connecticut and a population that includes many recent immigrants, who are migrant workers. High rates of drug use and teen pregnancy compound the problems of endemic poverty in Windham.

Children and low income young pregnant women have high rates of gross dental decay and few options for oral health care. Apart from GFHC's dental clinic, which has a long waiting list, there is only one dentist in Windham who accepts Medicaid reimbursement. There are no pediatric or dental specialists in the area who accept Medicaid. Since 1994, Windham has been a designated dental shortage area.

The project's goals are based on a comprehensive community planning process and needs assessment that began in early 2006. Participants in the planning process represented the majority of our target population. Project goals focus on providing access to oral health services in community settings, providing preventive services, including age-appropriate oral health instruction, and implementing a

## CONNECTICUT

### *Generations Family Health Center*

**Grant Number: D04RH07903**

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community education and advocacy campaign to increase the community's dental IQ and lessen oral health disparities locally and statewide. *Save Smiles'* goals are designed to:

- increase awareness about and access to oral health care for the target population;
- provide preventive services that will lessen the target population's need for emergency and restorative oral health services;
- create a replicable, cost-effective project;
- build Windham's cultural competence;
- increase community and legislative support for oral health care for all; and increase the oral health status of the community.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# COLORADO

## *High Plains Community Health Center*

Grant Number: D04RH12669

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### **PROGRAM DIRECTOR**

Jay Brooke  
201 Kendall Drive  
Lamar, CO 81052  
Phone: (719) 336.6999  
Fax: (719) 336.0265  
E-mail: jbrooke@highplainschc.net

### **TOPIC AREAS**

Health Promotion

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 123,230
- Year 2 – 109,920
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

High Plains Community Health Center, Prowers County Public Health, Lamar Community College, Lamar Parks and Recreation, and Lamar School District RE-2

### **AREAS SERVED**

Holly, Gradada, Lamar, and Wiley Cities

### **TARGET POPULATION SERVED**

Primary Healthcare services for Hispanic residents

### **PROJECT SUMMARY**

Located on the Great Plains in southeastern Colorado, Prowers County is home to a total population of 13,776. 38% of Prowers County residents are Hispanic, and the county's poverty rate of 22.5% is more than double the rate for the state of Colorado. Median household income and levels of adult educational attainment in Prowers County also fall far below state and national averages.

The rates of obesity, cardiovascular disease, and diabetes in Prowers County exceed comparable figures for Colorado and the U.S. Local health data also indicates that the prevalence of obesity and related chronic diseases is currently increasing rapidly.

As a result, leaders from High Plains Community Health Center, Prowers County Public Health, Lamar Community College, Lamar Parks and Recreation, and Lamar School District RE-2 have joined together to address these serious health concerns by forming the Prowers County Nutrition, Exercise, and Wellness Motivation and Empowerment (NewMe) Coalition. These diverse organizations have committed to a shared goal of preventing and reducing obesity and chronic diseases by promoting good nutrition and increased physical activity for all Prowers County residents.

## COLORADO

### *High Plains Community Health Center*

Grant Number: D04RH12669

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The NewMe Coalition bases its strategy for comprehensive community intervention on the Socio-Ecological Model of Health Behaviors and the Chronic Care Model with the following goals:

- increase service providers' capacity to provide systematic patient-centered education, case management, and support for healthy eating and active living
- integrate education, counseling, and support for healthy eating and active living into routine primary and preventive care
- Facilitate weight loss and maintenance of healthy weight
- Support effective patient self-management to improve clinical outcomes for obesity-related chronic diseases
- Promote a community environment that supports healthy eating and active living

The NewMe Coalition has designed its intervention strategy to increase providers' capacity and skills to effectively promote nutrition and exercise while also motivating, educating, and empowering individuals to make healthy behavior changes. The resulting partnership between activated patients and improved health systems can dramatically improve health in Prowers County by reducing rates of obesity and chronic disease.

As a project focusing on primary care or wellness and disease prevention, the Prowers County NewMe Coalition requests HRSA's funding preference two for this application.

**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

# DELAWARE

## *La Red Health Center, Inc.*

Grant Number: D04RH12674

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### **PROGRAM DIRECTOR**

Brian Olson, CEO  
505 A W. Market Street  
Georgetown, DE 19947  
Phone: (302) 855-2020 x 116  
Fax: (302) 855-2025  
E-mail: bolson@laredhealthcenter.org

### **TOPIC AREAS**

Mental Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

La Red Health Center will serve as the lead agency of a consortium composed of Delaware Division of Substance Abuse and Mental Health, CHEER (Sussex County Senior Services agency with 9 centers), Brandywine Counseling, Inc., the Central & Southern Delaware Community Health Partnerships, the Delaware Ecumenical Council on Children and Families, and the Delaware Rural Health Initiative.

### **AREAS SERVED**

Sussex County, Delaware

### **TARGET POPULATION SERVED**

The entire county is federally designated as a Medically Underserved Area (MUA), a low-income HPSA, a Dental HPSA, and –in western and southern Sussex - a Mental Health HPSA. The target population is older residents age 60+.

### **PROJECT SUMMARY**

**Goals:** a) the completion of community outreach and mental health education to seniors through implementation of a Gatekeeper program, b) the use of volunteer caregivers and other community resources to supplement the Gatekeeper model; e.g., transportation assistance, and c) the implementation of specialized services to directly support the needs of low-income, and at-risk rural seniors that otherwise would not access services.

**Needs and Target Population:** The program's service area is Sussex County, Delaware, characterized as rural in nature and having the largest land mass of Delaware's three counties and a population of 187,236. Since 2000 the County has grown by an estimated 14 percent, gaining almost 23,000 persons. The entire county is federally designated as a Medically Underserved Area (MUA), a low-income HPSA, a Dental HPSA, and –in western and southern Sussex - a Mental Health HPSA. The target population is older residents age 60+. More than a quarter (28.2%) of all County residents in 2008 is aged 60 and over. Nearly 3% (2.8%) are aged 85 and older. The elderly population is projected to increase to 34% of the



## DELAWARE

### *La Red Health Center, Inc.*

Grant Number: D04RH12674

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Sussex County population by 2020. There is a significant lack of mental health services for the growing senior population in the service area and a striking lack of data to support the identification of mental health needs for this population. There is a shortage of mental health professionals in the County; specialty geriatric mental health services are virtually non-existent. Isolation and stigma contribute to the problem.

**Proposed Program:** La Red Health Center will serve as the lead agency of a consortium composed of Delaware Division of Substance Abuse and Mental Health, CHEER (Sussex County Senior Services agency with 9 centers), Brandywine Counseling, Inc., the Central & Southern Delaware Community Health Partnerships, the Delaware Ecumenical Council on Children and Families, and the Delaware Rural Health Initiative. Utilizing the best practices' Gatekeeper model, the Consortium will use community members who deal with older adults as frontline assessors for case finding and referrals. Community-based capacity to detect and refer seniors who exhibit symptoms of mental health illnesses and co-occurring conditions will be enhanced. The project expects to reach 10,000 seniors with education through the use of organizations and partners that have existing relationship and trust with seniors. By creating this internal capacity within the most appropriate organizations, the "institutionalization" of outreach and education, and ultimately sustainability of the project will be initiated. The project will create and implement a Gatekeeper "train the trainer" mechanism for using front-line assessors to help detect and report persons who may be in need of care/consultation, utilize volunteer caregivers, where appropriate, to build trust, counteract stigma, and facilitate continuum care through provision of basic enablers such as companionship, transportation and promote and disseminate outcomes to stakeholders, policymakers, et al.

#### **ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# FLORIDA

## *Washington County Health Department*

Grant Number: D04RH12703

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### **PROGRAM DIRECTOR**

Karen Mathis  
P.O. Box 648  
Cipley, FL 32428  
Phone: (850) 638-6240, ext. 151  
Fax: (850) 638-6244  
E-mail: karen\_mathis@doh.state.fl.us

### **TOPIC AREAS**

Chronic Disease, Minority Health/Cultural Competency, Uninsured

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Washington, County Health Department, North Florida Community Hospital, and Bay Medical Society–Bay Cares Program

### **AREAS SERVED**

Washington County, Florida

### **TARGET POPULATION SERVED**

Low-income children and families

### **PROJECT SUMMARY**

The purpose of "Team Care Project's - Patient Assistant Program" (Team Care - PAP) is to improve the health status and well being of low-income children and families in Washington County through an integrated health care services and case management system to be conducted at outreach clinics and after normal business hours. *Our three areas of focus include (1) chronic disease, (2) minority health/cultural competency and (3) the uninsured.*

Washington County is a poor rural county. When compared to the state average, the county has higher overall morbidity and mortality rates from cardiovascular diseases and diabetes. It also has a high teenage pregnancy rate, and high infant mortality rate. Injuries rank as the third major cause of death in the County. Data has shown that access to a coordinated primary care along with disease management play a major role in preventing complications from these conditions and consequently costly treatment. Indeed, the primary care setting is ideal for early detection and treatment of high cholesterol, hypertension, diabetes, pneumonia as well as early referral to health education classes on healthy diet, exercise, diabetes, smoking cessation, and injury prevention. It is also the ideal setting to initiate appropriate prophylactic treatments such as aspirin therapy, flu vaccination, mammograms, family planning, counseling, etc.

# FLORIDA

## *Washington County Health Department*

**Grant Number: D04RH12703**

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Team Care - PAP will use a multi-component approach to help those who cannot afford health insurance and are not eligible for federal or state assistance to navigate their way through an increasingly complex health system, assuring that they have access to primary care and preventive services, needed specialty care, and health education, while at the same time, diminishing the risk of missed or conflicting care. Professional consultants and staff will work together to implement the planned activities under the umbrella of the Community Health Council. Our activities will be guided by the Healthy People 2010 objectives, the CDC preventive guidelines, and the standards of the Agency for Health Research and Quality.

To assure that services have the intended impact, a practical program evaluation as well as a quality improvement approach will be utilized during the program implementation. Team Care - PAP will also collaborate with other community programs to conduct bi-annual community need assessment and health risk assessment of the target population.

Finally, it is important to mention that Washington County Health Department has the experience and the infrastructure to administer such a program as we have administered multiple federal and state grants in the past. Indeed, we have the advantage of laying down the foundation and paving the way to continue a better, improved, and matured program implementing the successful strategies, and avoiding the failed ones. It is noteworthy to mention here the overwhelming praise that we received from our clients and medical providers and their support to continue our services.

### **ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# FLORIDA

## *Rural Health Network of Monroe County Florida, Inc.*

Grant Number: D04RH12704

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### PROGRAM DIRECTOR

Daniel E. Smith  
1010 Kennedy Drive  
Key West, FL 33040-0001  
Phone: (305) 289-8917  
Fax: (904) 259-4761  
E-mail: dsmith@rhnmc.org

### TOPIC AREAS

Oral Health

### PROJECT PERIOD

May 1, 2009 – April 30, 2012

### FUNDING LEVEL EXPECTED PER YEAR

- Year 1 – 150,000.00
- Year 2 – 125,000.00
- Year 3 – 99,265.29

### PARTNERS TO THE PROJECT

The Baker County Family YMCA and Faith Bible Church

### AREAS SERVED

Baker County Florida

### TARGET POPULATION SERVED

Florida Keys Area Health Education Center and Monroe County School District

### PROJECT SUMMARY

**Project Abstract:** The *Baker County Health Department (BCHD)*, a public health department in central rural northeastern Florida, works to attain its goals by preventing and controlling the spread of acute, chronic and infectious disease through early intervention and education to those persons who are unable to access care from the private sector. The purpose of this *Beat Diabetes* program will be to reach out to the target population of low-income, underserved and uninsured adults in Baker County who are pre-diabetes or diabetes patients. Through this program, the *Beat Diabetes* Consortium will provide screening and testing services, education focused on evidenced best practices such as prevention, maintain control measures and support exercise classes at various locations in the county. In addition, an ongoing community-wide social marketing program will be established in order to foster a better understanding of how to change lifestyles (*prevention*) and manage diabetes (*control*).

The goals of this program are directly linked with Healthy People 2010 Subsections 5-1: Increase the proportion of persons with diabetes who receive formal diabetes education, 5-2: Prevent diabetes, 5-4: Increase the proportion of adults with diabetes whose condition has been diagnosed, 5-12: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year, 5-13: Increase the proportion of adults with diabetes who have an annual dilated eye examination, 5-14: Increase the proportion of adults with diabetes who have at least an annual foot examination, 5-15: Increase the proportion of persons with diabetes who have at least an annual dental examination, and 5-

## FLORIDA

### *Rural Health Network of Monroe County Florida, Inc.*

Grant Number: D04RH12704

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17: Increase the proportion of adults with diabetes who perform self-blood glucose monitoring at least once daily. It is the intent of this project to use prevention and control programs to reduce the impact of the disease and its associated economic burden with an underlying goal of improving the quality of life for the target population. Through the establishment of a community-based consortium, **BCHD**, working in cooperation with the **Baker County Family YMCA (YMCA) and Faith Bible Church**, will implement educational workshops, sponsor outreach and screening events at outlying locations, conduct physical activity classes, provide test strips to low-income, uninsured people with diabetes through partnerships with the BCHD clinic, train community partners to continue to sustain program activities and initiate a social marketing campaign to create a greater awareness about diabetes in Baker County. The total number of clients projected to benefit from the **Beat Diabetes** project testing, screening and classes are: 200 in year 1, 150 in year 2 and 125 in year 3. The number of encounters projected for the various advertising efforts of the social marketing program will be 103,467 for each year of the program.

#### **ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# FLORIDA

## *Baker County Health Department*

Grant Number: D04RH12702

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### **PROGRAM DIRECTOR**

Robert Woods  
480 W. Lowder  
St. Macclenny, FL 32063  
Phone: (904) 259-3152, ext. 2250  
Fax: (904) 259-4761  
E-mail: robert\_woods@doh.state.fl.us

### **TOPIC AREAS**

Diabetes, Obesity

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,762.51
- Year 2 – 124,190.89
- Year 3 – 99,265.29

### **PARTNERS TO THE PROJECT**

The Baker County Health Department, the Baker County Family YMCA and the Faith Bible Church

### **AREAS SERVED**

Baker County Florida

### **TARGET POPULATION SERVED**

Low-income, underserved, and uninsured adults

### **PROJECT SUMMARY**

The *Baker County Health Department (BCHD)*, a public health department in central rural northeastern Florida, works to attain its goals by preventing and controlling the spread of acute, chronic and infectious disease through early intervention and education to those persons who are unable to access care from the private sector. The purpose of this *Beat Diabetes* program will be to reach out to the target population of low-income, underserved and uninsured adults in Baker County who are pre-diabetes or diabetes patients. Through this program, the *Beat Diabetes* Consortium will provide screening and testing services, education focused on evidenced best practices such as prevention, maintain control measures and support exercise classes at various locations in the county. In addition, an ongoing community-wide social marketing program will be established in order to foster a better understanding of how to change lifestyles (*prevention*) and manage diabetes (*control*).

The goals of this program are directly linked with Healthy People 2010 Subsections 5-1: Increase the proportion of persons with diabetes who receive formal diabetes education, 5-2: Prevent diabetes, 5-4: Increase the proportion of adults with diabetes whose condition has been diagnosed, 5-12: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year, 5-13: Increase the proportion of adults with diabetes who have an annual dilated eye examination, 5-14: Increase the proportion of adults with diabetes who have at least an annual foot examination, 5-15: Increase the proportion of persons with diabetes who have at least an annual dental examination, and 5-

# FLORIDA

## *Baker County Health Department*

Grant Number: D04RH12702

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17: Increase the proportion of adults with diabetes who perform self-blood glucose monitoring at least once daily. It is the intent of this project to use prevention and control programs to reduce the impact of the disease and its associated economic burden with an underlying goal of improving the quality of life for the target population. Through the establishment of a community-based consortium, **BCHD**, working in cooperation with the **Baker County Family YMCA (YMCA) and Faith Bible Church**, will implement educational workshops, sponsor outreach and screening events at outlying locations, conduct physical activity classes, provide test strips to low-income, uninsured people with diabetes through partnerships with the BCHD clinic, train community partners to continue to sustain program activities and initiate a social marketing campaign to create a greater awareness about diabetes in Baker County. The total number of clients projected to benefit from the **Beat Diabetes** project testing, screening and classes are: 200 in year 1, 150 in year 2 and 125 in year 3.

### **ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# FLORIDA

## *Putnam Behavioral Healthcare*

Grant Number: D04RH12738

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### **PROGRAM DIRECTOR**

James Lynam  
Project Director  
330 Kay Larkin Drive  
Palatka, FL 32177  
Phone: (386) 329-3780, ext. 8669  
Fax: (386) 329-3784  
E-mail: jameshlynam@yahoo.com

### **TOPIC AREAS**

Mental Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

The Department of Juvenile Justice, Putnam County Sheriff's Office, Putnam County School District plus representatives from the agencies that now comprise our Consortium that will execute the United Vision program

### **AREAS SERVED**

Communities encompassed within the borders of Putnam County, Florida.

### **TARGET POPULATION SERVED**

Mental Health services including medication management, Substance abuse treatment (Adults only), Detoxification (Adults only)

### **PROJECT SUMMARY**

Putnam County has been effective in providing prevention and diversion programs to our youth. In 2007-2008 a total of 605 juveniles were referred to prevention, diversion or intervention programs (through the Juvenile Crime Prevention Office) for services. One hundred and eighteen (19.5%) of these juveniles were identified and found to be in need of additional assessment, counseling or other services due to mental health, substance abuse or co-occurring disorders. Due to the lack of funding and resources, Putnam County has not been able to provide these children with the necessary measures they so desperately need after being identified.

**The United Vision program closes this gap** by providing a shared Outreach Liaison to work in partnership with all three consortium members and other community agencies to make certain clients are receiving appropriate care with integrated treatment plans.

The United Vision program provides clients with a thorough assessment starting with a basic medical physical screening, counseling, psychiatric evaluations and/or clinical diagnosis. The Outreach Liaison



## FLORIDA

### *Putnam Behavioral Healthcare*

**Grant Number: D04RH12738**

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will generate and administer individually tailored integrated treatment plans with regularly scheduled counseling sessions, comprehensive family strengthening and resiliency classes and if necessary recommended medication therapy. With the consortium working in sync, we can provide the resources and tools necessary to Putnam County families that encourage their children to flourish and become healthy and socially competent individuals with a new sense of self-confidence and a true belief in their own ability to do well, become successful and be productive.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# GEORGIA

## *Georgia Southern University Research and Service Foundation*

Grant Number: D04RH16319

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### **PROGRAM DIRECTOR**

Jacob C. Warren, Ph.D. and K. Bryant Smalley, Psy.D.  
Georgia Southern University  
P.O. Box 8015  
Statesboro, GA 30460  
Phone: (912) 478-2289  
Fax: (912) 478-5811  
E-mail: jwarren@georgiasouthern.edu

### **TOPIC AREAS**

Access, Health Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 142,340
- Year 2 – 96,767
- Year 3 – 67,137

### **PARTNERS TO THE PROJECT**

Georgia Southern University, the Magnolia Coastlands Area Health Education Center, and the Bulloch County Health Department

### **AREAS SERVED**

Bulloch County, Georgia

### **TARGET POPULATION SERVED**

High rates of uninsurance and poverty and low availability of health care

### **PROJECT SUMMARY**

The goal of the Community Health Access Network for Grassroots Education and Screening (CHANGES) project is to increase access to health education, preventive screening, and early detection by establishing a sustainable community network of educators, students, community organizations, and churches to take physical and mental screening and education health fairs to rural and underserved populations throughout Bulloch County, Georgia. Bulloch is a rural area with high rates of uninsurance and poverty, and low availability of health care. Around 75 fairs will be taken throughout Bulloch County, serving an estimated 7500 people.

The fairs will be put on by a consortium of departments at Georgia Southern University, the Magnolia Coastlands Area Health Education Center, and the Bulloch County Health Department. Within Georgia Southern University, the College of Public Health will provide students and faculty to perform behavioral screenings including food choices, exercise habits, and behavioral risk factors, as well as preventive education in those areas. The Psychology Department will provide students and faculty to perform screenings for anxiety and depression, link participants to care at the community psychology clinic operated by the Psychology Department, and offer education on mental health issues important to rural populations. The School of Nursing will provide nursing students to the fairs to assist with obesity and

## GEORGIA

### *Georgia Southern University Research and Service Foundation*

**Grant Number: D04RH16319**

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diabetes screening activities. The Magnolia Coastlands AHEC will assist with providing health professions students to help with fair operations, in training volunteers in cultural competency, and in providing educational resources to participants in the health fairs. The Bulloch County Health Department will assist by providing blood pressure and vision screenings, educational outreach, and assisting in connecting individuals with primary care as needed. In addition, each church participating in the fairs will receive an automatic blood pressure cuff and blood glucose testing supplies to allow for continued cardiovascular and diabetes screenings beyond the course of the funding of the study, as well as educational materials on physical and mental health conditions important to rural populations to serve as a health information resource. Each church will identify a health representative from within the congregation who will be trained in the use of the equipment to ensure its correct and ongoing use. The project will also link participants with needed care through the University-run community psychology clinic, and the network of referrals of both the County Health Department and the GSU Rural Nursing Outreach Program.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

# GEORGIA

## *Polk County Health Department*

Grant Number: D04RH12766

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### **PROGRAM DIRECTOR**

Andrea Hinojosa  
Southeast Georgia Communities Project  
300 S. State  
St. Lyons, GA 30436  
Phone: (912) 526-5451  
Fax: (912) 526-0089  
E-mail: ahinojosa38@aol.com

### **TOPIC AREAS**

Diabetes

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 138,947
- Year 2 - 124,999
- Year 3 - 100,000

### **PARTNERS TO THE PROJECT**

Southeast Georgia Communities Project, East Georgia Healthcare Center, Inc., and Meadows Wellness Center

### **AREAS SERVED**

Appling, Candler, Emanuel, Evans, Long, Tattnall and Toombs counties in rural Southeast Georgia.

### **TARGET POPULATION SERVED**

The target population includes Latino families with one or more members diagnosed with diabetes.

### **PROJECT SUMMARY**

The goal of Latinos Reduciendo el Diabetes (LaRED) is to reduce morbidity and mortality related to diabetes among Latinos by providing culturally and linguistically appropriate non-medical case management, individualized health education, and access to clinical services for diabetic program participants.

The mission of Southeast Georgia Communities Project is to promote all aspects of human dignity through self-empowerment of farmworkers and other low-income residents to become partners and contributors in problem-solving and decision-making in the communities in which they live and work. During 2005, over 2,000 clients received one or more of our services.

The target population includes Latino families with one or more members diagnosed with diabetes. Census 2000 reports significant expansion of the Latino population in southeast Georgia. Toombs County residents are now 8.9% Latino and Candler County's percentage of Latino residents is approaching 10%. During peak harvesting months, the number of Latinos in the region increases as migratory workers and their families arrive to pick the area's crops, including Vidalia Onions and tobacco. The average income of farmworkers is \$8,000 per year, placing them well below poverty and among the lowest paid workers

# GEORGIA

## *Polk County Health Department*

**Grant Number: D04RH12766**

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in the nation. Latinos in southeast Georgia are predominantly Mexican and Mexican American from Mexico, Texas and Florida. However, the population is far from homogenous with immigrants from Guatemala, Honduras, Puerto Rico and Cuba.

LaRED will have two components. The first component targets Latino diabetics with non-medical case management and individualized education, using a home visiting model. The educational curricula and materials will be adapted from Diabetes Today, National Institutes of Health and the Cooperative Extension service. The second component will educate 335 adults and youth each year on diabetes risk factors and prevention strategies, including healthy diet and lifestyle.

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# GEORGIA

## *SE Georgia Communities Project*

Grant Number: D04RH07905

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### **PROGRAM DIRECTOR**

Malindy R. Ely  
125 E. Ware Street  
Cedartown, GA 30125  
Phone: (770) 749-2270  
E-mail: mrely@dhr.state.ga.us

### **TOPIC AREAS**

Primary Care

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

The partnership for this grant includes Polk County Health Department, which will serve as the lead applicant, Polk Medical Center, Polk County Council for Children and Families, Harbin Clinic, the Polk County Department of Family and Children Services and the Northwest Health District.

### **AREAS SERVED**

Polk County, Georgia

### **TARGET POPULATION SERVED**

Polk County's low income, uninsured and underinsured residents are the target population for this application.

### **PROJECT SUMMARY**

Polk County Health Department is requesting Rural Health Outreach funds to initiate non-emergent primary care services for low income, uninsured and underinsured families that face extreme difficulties accessing affordable medical care. Services will include chronic disease assessment, treatment and follow-up, ongoing health education and linkages to other community resources and services including nutritional counseling and oral health. The project will also facilitate prenatal care.

Polk County is located in northwest Georgia, at the foothills of the Appalachian Mountains. The population of 41,091 is 69.6% white, 16.3% black and 11.7% Hispanic. Eleven percent of families live below poverty, compared with 9.9% statewide. Per capita income is \$21,754, lower than Georgia's overall per capita income of \$30,914. The partnership for this grant includes Polk County Health Department, which will serve as the lead applicant, Polk Medical Center, Polk County Council for Children and Families, Harbin Clinic, the Polk County Department of Family and Children Services and the Northwest Health District. Partners have met to agree on the services and activities of the grant and have worked together to create the program plan and long and short term outcomes. A logic model, developed by partner representatives, outlines project inputs, outputs, outcomes and measurements and is included in the project narrative.

# GEORGIA

## *SE Georgia Communities Project*

Grant Number: D04RH07905

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Short term outcomes will include a demonstrated increase in the number of patients with knowledge of chronic disease management and the need for consistent preventative care, an increase in the number of women receiving prenatal care in the first trimester and an increase in the number of appropriate referrals to the emergency room. We also expect to develop a sustainability plan during the first year that will be implemented during the second and third years of the grant. Long term outcomes include a decrease in emergency room visits for primary care services, decrease in complications from chronic medical conditions and a reduction in barriers to access to affordable medical care.

We are requesting a **funding preference** under Categories 1 and 2. Regarding eligibility for Category 1, Polk County has been designated a Primary Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration (HRSA). The lead applicant and recipient of grant funds for the partnership is Polk County Health Department. This application meets criteria for Category 2 as its focus is on primary care and wellness/disease prevention. The project will offer non-emergent primary care services to the county's low income, uninsured and underinsured residents as well as promote primary and secondary prevention strategies.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

# GEORGIA

## *Evans County Health Department*

Grant Number: D04RH12767

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### **PROGRAM DIRECTOR**

Cindy Hart  
Bulloch County Health Department  
1W Altman Street  
P.O. Box 2009  
Statesboro, GA 30459  
Phone: (912) 764-3800  
E-mail: crhart@dhr.state.ga.us

### **TOPIC AREAS**

Maternal/Child Health—Perinatal Care

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Network partners include the lead agency, Evans County Health Department, and Wayne Memorial Hospital, Candler County Health Department, Tattnall County Health Department and Wayne County Health Department

### **AREAS SERVED**

Candler, Evans, Tattnall and Wayne Counties

### **TARGET POPULATION SERVED**

To improve health outcomes for rural women, infants and children in Candler, Evans, Tattnall and Wayne Counties in southeast Georgia.

### **PROJECT SUMMARY**

Evans County Health Department, along with its network partners, is applying for Rural Health Outreach funding to implement Best Babies, a perinatal health program to improve health outcomes for rural women, infants and children in Candler, Evans, Tattnall and Wayne Counties in southeast Georgia. Best Babies offers 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 includes identification of women who are at high-risk for poor birth outcomes, intensive case management and home visits by registered nurses.

Best Babies, originally funded as a Rural Health Outreach grant in 2006, is making three significant programmatic changes in this application:

1. Provision of interconceptual care. Currently, Best Babies staff can not offer interconceptual care to its participants. Creation of the Public Health Outreach Worker (PHOW) position will fill this



# GEORGIA

## *Evans County Health Department*

Grant Number: D04RH12767

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gap. The PHOW will continue to work with participants after delivery to assure that they and their family are linked with vital community services and resources. They will also provide family planning information and other health education to interconceptual clients.

2. Expansion of the Consortium to include community partners. Strategies and activities have been included that will expand community marketing and promote and facilitate consortium membership.
3. Developing relationships with new birthing hospitals. With the imminent closure of Evans Memorial Hospital, one of the primary birthing centers in the area, a major change will be to foster relationships with OB/GYNs and birthing hospitals in Bulloch and Toombs Counties. These entities are at present largely unfamiliar with the program.

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

We are requesting a funding preference under **Funding Preference 1**. The applicant is a local health department. Two of the counties served by the program are HPSAs.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# GEORGIA

## *Irwin County Board of Health*

Grant Number: D04RH12769

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### **PROGRAM DIRECTOR**

Bridget Walters  
Project Director  
407 West 4th Street  
Ocilla, GA 31774  
Phone: (229) 468-5003  
E-mail: bmwalters@dhr.state.ga.us

### **TOPIC AREAS**

Diabetes, Health Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

The Irwin County Board of Health, as the lead partner, will work with the Ben Hill, Berrien, and Cook County Boards of Health, Dorminy Medical Center, Irwin County Hospital, Memorial Hospital of Adel, Berrien County Hospital, Irwin Family Medicine, Nashville Eye Center, Berrien County Collaborative, Cook Family Connections, Adel Family Medicine, Adel Recreation Department, and the South Health District to address diabetes in these communities.

### **AREAS SERVED**

Irwin, Ben Hill, Berrien, and Cook Counties, Georgia

### **TARGET POPULATION SERVED**

The target population will include low income, uninsured adults who have been diagnosed with type 2 diabetes and the general public with an emphasis on high risk groups including African Americans and Hispanics.

### **PROJECT SUMMARY**

The Centers for Disease Control and Prevention now states that there are almost 24 million Americans with diabetes. The prevalence data from 2005 indicates that 5.5% of our nation's people are diabetics. In the state of Georgia, the prevalence of diabetes increases to 7.4%. A closer look at home reveals that Ben Hill (10.9%), Irwin (9.8%), Berrien (9.6%), and Cook (10.0%) Counties all exceed the national and state percentages. In addition to this prevalence data, other risks such as high rates of obesity, little physical activity, high poverty levels, and the racial composition make it clear that diabetes is a serious health issue for Ben Hill, Irwin, Berrien, and Cook Counties. According to the 2008 publication of the Georgia Health Disparities Report, these counties indicate overall racial inequalities with health disparities. Additional medical resources are a necessity to combat this chronic disease. Therefore, Sweet Dreams, a diabetes education program currently serving Ben Hill and Irwin Counties, proposes to expand into the neighboring counties of Berrien and Cook. The Irwin County Board of Health, as the lead partner, will work with the Ben Hill, Berrien, and Cook County Boards of Health, Dorminy Medical Center, Irwin

# GEORGIA

## *Irwin County Board of Health*

**Grant Number: D04RH12769**

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County Hospital, Memorial Hospital of Adel, Berrien County Hospital, Irwin Family Medicine, Nashville Eye Center, Berrien County Collaborative, Cook Family Connections, Adel Family Medicine, Adel Recreation Department, and the South Health District to address diabetes in these communities.

The target population will include low income, uninsured adults who have been diagnosed with type 2 diabetes and the general public with an emphasis on high risk groups including African Americans and Hispanics. The goals of the project will be to reduce the number of hospitalizations resulting from diabetes or diabetic complications by 10% and to increase community awareness of the importance of preventing and early detection of type 2 diabetes in Ben Hill, Berrien, Cook, and Irwin Counties.

Grant funds will be used to provide educational classes for diabetics, including individual and group nutritional counseling, and community education programs for the public that will be offered to groups such as churches and senior citizen centers. An experienced diabetes nurse and registered Dietitian will provide the education with the assistance of culturally competent peer educators. Peer educators will be trained in the prevention and treatment of type 2 diabetes and will be awarded a stipend for providing education services to target minority groups. In addition to these services, a system will be developed and funded through this program to help patients in accessing financial assistance for their diabetic medications and supplies.

### **ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# HAWAII

## *The Bay Clinic, Inc.*

Grant Number: D04RH12679

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### **PROGRAM DIRECTOR**

Paul Strauss  
Chief Executive Officer  
224 Haili Street  
Hilo, HI 96720  
Phone: (808) 961-4083  
Fax: (808) 961-5678  
E-mail: pstrauss@bayclinic.org

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Lutheran Medical Center Dental Residency Program, and the Office of Social Ministries

### **AREAS SERVED**

Hilo, Keaau, Pahoa, Naalehu County: Hawaii Districts: Hilo, Puna, Kau, Hawaii

### **TARGET POPULATION SERVED**

To provide oral health services to the rural and underserved areas of East and South Hawaii Island.

### **PROJECT SUMMARY**

Bay Clinic, Inc. is a nonprofit community health center with four locations in remote and rural sites throughout the East and South Hawaii Island. We provide primary medical care, dental care, and behavioral health care services to 15,000 patients with 47,000 visits annually. We are a federally qualified health center and we provide health care services to all people regardless of ability to pay. We strive to eliminate barriers to health care access and to improve access to the underserved, which are the majority of the residents of our service area<sup>1</sup>. Our mission is to provide high quality, patient-centered, comprehensive health care that is accessible, affordable, coordinated, culturally competent, and community directed for all.

Hawaii County residents experience multiple barriers to oral health care access. This is due to a high rate of residents who are uninsured or on Medicaid (55%) and a lack of dentists who serve this population<sup>2</sup>. There are only three providers who serve this population of 37,000 low-income residents of East Hawaii. David Satcher, M.D. stated that 20% of the population suffers from 80% of the oral health disease in America<sup>3</sup>. Those most at risk, in our target population are children, people with chronic diseases, developmentally disabled, the recent immigrant and the elderly.

## HAWAII

### *The Bay Clinic, Inc.*

**Grant Number: D04RH12679**

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This rural outreach project will bring critically needed dental health care services to individuals and families who experience the most challenges in oral health access. Barriers faced by East and South Hawaii Island residents include large geographic areas with limited transportation options, high poverty rates, cultural and language differences, little knowledge on how to access health care services, and a critical lack of providers and facilities providing oral health care to rural Hawaii. Through an innovated consortium of partners, this collaboration builds upon the strengths of each organization to bring dental care to 2,375 individuals over three years where there currently exists no to very limited access to care. Our goal, consistent with Healthy People 2010, is to increase the proportion of children and adults who use the oral health care system each year. We will increase access by 675 patients with 1,350 encounters in year one, 800 patients with 1,600 encounters in year two and 900 patients with 1,800 encounters in year three. The partnership will consist of Bay Clinic as the lead organization, Lutheran Medical Center to provide staff in the form of a dental resident, and the Office of Social Ministries, who is contributing a Mobile Dental Van and its technological equipment.

We are requesting \$150,000 in year one, \$125,000 in year two, and \$100,000 in year three to help support start-up funds for staff and operations for this start-up project. We have confirmed in-kind support of \$375,000. A funding preference is requested for Preference #1: HPSA and MUP.

Our entire service area is identified by HRSA's Bureau of Primary Health Care as experiencing a shortage of oral health providers and has medically underserved populations.

<sup>1</sup> 43% of East Hawaii residents are at or below FPL. 78% are Native Hawaiian / Asian American / Other Pacific Islander, 21% of these individuals are uninsured with 55% of the total population on Medicaid.

<sup>2</sup> Oral Health for the Underserved – Hawai'i Island. Oral Health Task Force 2008

<sup>3</sup> Surgeon General's Report – Oral Health in America - 2002

#### **ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

**HAWAII**  
**NA PU'UWAI, Inc.**  
**Grant Number: D04RH12678**

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**PROGRAM DIRECTOR**

William Akutagawa  
P.O. Box 130  
Kaunakakai, HI 96748  
Phone: (808) 560-3653  
E-mail: wakutagawa@napuuwai.com

**TOPIC AREAS**

Behavioral Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

The proposed Lana'i Consortium for Integrative Behavioral Health Care (LCIBHC) is comprised of (3) members: Na Pu'uwai (NP), I Ola Lahui (IOL), and Lana'I Community Health Center (LCHC).

**AREAS SERVED**

Islands of Lanai and Molokai (County of Maui, State of Hawaii)

**TARGET POPULATION SERVED**

Residents of the island of Lana'i with preference given to Native Hawaiian and Filipino groups

**PROJECT SUMMARY**

The proposed Lana'i Consortium for Integrative Behavioral Health Care (LCIBHC) is comprised of (3) members: Na Pu'uwai (NP), I Ola Lahui (IOL), and Lana'I Community Health Center (LCHC) and seeks to expand integrative behavioral health care services through the establishment of sustainable relationships among health care community agencies, the provision of evidenced-based, culturally competent mental health and substance abuse services, chronic disease management, and the development of an appropriately trained and culturally competent psychology workforce. The partnership between NP, IOL, and LCHC strategically combines the unique qualities and strengths of each organization to support these above goals. Since 1984, NP has provided needed community-based health care for rural, medically underserved populations such as Native Hawaiians and Filipinos, on the islands of Molokai and Lanai. IOL is a psychology training program and member of the Association of Psychology Post doctoral and Internship Centers whose primary mission is to provide quality, culturally-minded behavioral health training to address health provider shortages in medically underserved communities, while simultaneously providing services to the communities most in need. LCHC is Hawaii's most recently formed community health center. Nearly a decade of needs assessment activities and collaborative projects served to inform the establishment, mission, and objectives of LCHC, and now responds directly to Lanai's community health care needs and is the optimal clinical setting to support the training and service goals of the LCIBHC.

**HAWAII**  
***NA PU'UWAI, Inc.***

**Grant Number: D04RH12678**

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A significant proportion of Lanai's total population is comprised of ethnic minorities with significant health care concerns. Filipinos and Native Hawaiians make up over 75% of the island's population and are at high risk for increased morbidity and mortality due to severe health care barriers they face as one of Hawaii's rural and remote areas. A "snapshot" of Lanai's health challenges includes inadequate prenatal care, poor dental health, substance abuse, high teen pregnancy rates, diabetes, limited and inadequate mental health services, and an elderly population in need of community-based support. Further, due to its geographic isolation, Lanai suffers limited economic resources and access to quality health and specialty care, educational challenges, and geographic separation from urban areas with major medical centers encumbered by restricted and costly travel options.

Behavioral health services will consist of identification, assessment, and treatment of a range of psychological concerns to include depression, anxiety, substance abuse, domestic violence, and chronic disease management. A post-doctoral psychology fellow will be placed on Lanai, as well as, oversight from licensed clinical psychologists to provide program, clinical, and technical support.

Residents of the island of Lana'i with preference given to Native Hawaiian and Filipino groups; however, services are offered to all, regardless of ethnic background and/or socio-economic status.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# ILLINOIS

## *Sarah Bush Lincoln Health Center*

Grant Number: D04RH12733

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### **PROGRAM DIRECTOR**

Matt White  
Manager of Health Communities  
104 Professional Plaza  
Mattoon, IL 61938  
Phone: (217) 258-4195  
Fax: (217) 258-2354  
E-mail: mwhite@sblhs.org

### **TOPIC AREAS**

Oral Health, School Based

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

The project includes a consortium of 59 partners – 52 local schools, 6 local health departments, and a two-year college.

### **AREAS SERVED**

East central Illinois counties Clark, Coles, Cumberland, Douglas, Edgar, Effingham, Jasper, Moultrie and Shelby

### **TARGET POPULATION SERVED**

Targeting low income children in a nine-county area of rural East Central Illinois.

### **PROJECT SUMMARY**

Sarah Bush Lincoln Health Center (SBLHC) requests support for the expansion of its Women & Children First Dental Program, an oral health outreach program, targeting low income children in a nine-county area of rural East Central Illinois. The Women & Children First Dental Program provides oral health education, screenings, diagnostic services, preventive and restorative care to low-income children at no cost to the program participants. Eligibility for program participation is based on financial need, as determined by the child's eligibility for the Free or Reduced Meals (FRM) program. The Dental Program serves as a home of dental care for eligible clients, providing opportunity for regular preventive care in accordance with recommendations of the American Dental Association.

The project includes a consortium of 59 partners – 52 local schools, 6 local health departments, and a two-year college. The expansion of the Dental Program will address an unmet need for restorative dental services to the target population of low-income children, aged birth to 19 years, (estimated population of more than 15,600 children, nearly half of whom exhibit an immediate need for restorative care). The Dental Program currently provides restorative services in office based clinic settings on days when volunteer dentists and their offices can be scheduled. The availability of the volunteer dentists and the



## ILLINOIS

### *Sarah Bush Lincoln Health Center*

**Grant Number: D04RH12733**

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ability of the program's clients to travel to a clinic outside of their own community presently limit the program's capacity to deliver restorative care. Thus, many clients are on a waiting list for these appointments.

By transforming its delivery model to a truly mobile oral health program, SBLHC can provide restorative services via a self-contained mobile dental unit equipped with three operatories and staffed to support an additional 3,150 encounters in the first year. The program will continue its current portable services (which focus on delivering education, screening exams and preventive services), and the addition of the mobile unit will provide increased capacity for delivery of restorative care to children in need. Activities described in the attached Project Work Plan will reach an estimated 3,500 children (6,474 encounters) in Year One, with an estimated 5% annual growth of services. Local or other non-federal funds will be used to purchase and equip a mobile unit, and Rural Health Care Services Outreach funds are sought for support of a portion of personnel and other operating costs.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# INDIANA

## *Affiliated Service Providers of Indiana, Inc.*

Grant Number: D04RH12660

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### **PROGRAM DIRECTOR**

Kathy L. Cook  
CEO  
1015 Michigan Avenue  
Logansport, IN 46947  
Phone: (317) 471-1890  
Fax: (317) 471-1891  
E-mail: kcook@aspin.org

### **TOPIC AREAS**

Mental Health/Diabetes

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,999
- Year 2 – 124,999
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Affiliated Service Providers of Indiana, Inc. (Behavioral Health Network); Anthony Wayne Services (Intellectual Disabilities Services Provider); MDwise (Medicaid Managed Care Provider); Schaller Anderson (Medicaid Managed Care Provider)

### **AREAS SERVED**

Rural Counties of Indiana

### **TARGET POPULATION SERVED**

Patients and caregivers from mental health, intellectual disabilities, and managed care organizations to address diabetes management

### **PROJECT SUMMARY**

Improve health outcomes through enhanced diabetes management in persons with intellectual disabilities and mental illness in rural counties of Indiana. Inform and train care givers on best practices of diabetes management and strategies for working with the targeted population to improve health outcomes. Address the need for collaboration among providers to achieve health targets. Conduct interdisciplinary trainings for care givers from mental health, intellectual disabilities, and managed care on diabetes management, mental illness, and intellectual disabilities. Conduct webinars regarding nutrition, exercise, and medication management. Develop a list-serv for ongoing professional development. Create e-learning modules to meet the professional development needs of rural primary care providers and office staff related to effective strategies for working with the targeted population. 5. Sustain collaboration through joint planning activities and regular clinical communication.

**INDIANA**

*Affiliated Service Providers of Indiana, Inc.*

**Grant Number: D04RH12660**

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**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# INDIANA

## *Indiana Rural Health Association*

Grant Number: D04RH12662

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### **PROGRAM DIRECTOR**

Matt Serricchio  
2900 W. 16th Street  
Bedford, IN 47421  
Phone: (812) 478-3919  
Fax: (812) 232-8602  
E-mail: mserricchio@indianarha.org

### **TOPIC AREAS**

Mental Health, Telemedicine

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 124,600
- Year 3 – 99,600

### **PARTNERS TO THE PROJECT**

This project also has recruited the participation of the Vermillion-Parke County Health Clinic (VPCHC).

### **AREAS SERVED**

Vermillion County, Indiana

### **TARGET POPULATION SERVED**

Mental health services in children

### **PROJECT SUMMARY**

Many rural areas of Indiana face severe shortages of mental health specialists of all disciplines. Rural community mental health centers and primary care clinics have unmet needs for mental health practitioners. Telemedicine can overcome many geographical barriers to providing specialty care to underserved areas if important financial and practical difficulties, in addition to technical hurdles, are effectively addressed.

This project seeks to improve access to high quality mental health specialty services in rural areas of Indiana by establishing a telemedicine practice model that will sustainably support a rural peer-to-peer telemedicine network. In the first phase, a community mental health center will designate one or more staff mental health professionals to practice at two or more rural community mental health centers via telemedicine. In addition we will connect a FQHC to two mental health practitioners and an associated RHC. We will provide installed equipment and ongoing training to support a telemedicine service allowing the mental health professionals to practice “virtually” as employees of the organization providing services. Once the service is established, the grant will focus primarily on developing the administrative, technical, and billing expertise needed by the host institutions to sustain the model. The second grant phase will follow a similar pattern to facilitate the placement of mental health specialists (clinical psychologists, advanced practice nurses with mental health specialization, or clinical social workers) under contract into high need rural health organizations that are underserved by local mental

## INDIANA

### *Indiana Rural Health Association*

**Grant Number: D04RH12662**

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health resources. In all phases, investments in equipment and support will be made to facilitate initial adoption, but grant-related activities will focus primarily on building host organizations' skill sets and a replicable/sustainable program that can continue into the future without grant support.

This project will demonstrate success by showing (1) a significant increase in the number of rural mental health center patients with access to a psychiatrist, (2) a significant increase in the number of rural primary care patients with access to integrated specialty mental health services, (3) a significant increase in the children with mental health conditions who have access to a mental health provider who specializes in children, and (4) a significant and sustained increase in the number of mental health specialist clinical hours available in rural areas of Indiana.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

## INDIANA

### *Vermillion-Parke Community Health Center*

Grant Number: D04RH16278

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#### **PROGRAM DIRECTOR**

Elizabeth J. Morgan  
777 South Main Street  
Clinton, Indiana 47842  
Phone: (765) 828-1003  
Fax: (765) 832-1030  
E-mail: emorgan@vpchc.org

#### **TOPIC AREAS**

Primary Care, Mental Health

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,784
- Year 2 – 124,629
- Year 3 – 99,178

#### **PARTNERS TO THE PROJECT**

Vermillion-Parke Community Health Center (VPCHC), Hamilton Center and Richard G. Lugar Center for Rural Health

#### **AREAS SERVED**

Clinton and Cayuga in Vermillion County, Indiana

#### **TARGET POPULATION SERVED**

Primary-mental health care system to better serve our at-risk patients.

#### **PROJECT SUMMARY**

National data indicate that child abuse and neglect is an enormous problem in the United States. According to the 2006 Child Maltreatment and Fatality Statistics, an estimated 3.6 million referrals, involving approximately 6.0 million children were made to Child Protective Services.

According to data from the Federal Administration of Children and Families, much of this maltreatment and abuse happens within the family unit. Data are similarly sobering for Indiana. Each year, more than 20,000 Indiana children are abused and neglected.

Patients frequently present in a primary health care setting with social and mental health issues. The World Health Organization estimates the prevalence rate of psychiatric disorders in children alone that visit primary care facilities is 12 to 29 percent, with only 10 to 22 percent recognized by health care workers. This presents a missed opportunity to identify and work with patients to reduce risk factors that lead to instances of child abuse and neglect.

While it is recognized that integration of primary health care and psychosocial services is important, our health care systems often work in silos, such that it can be difficult to move patients through both systems simultaneously for maximum effectiveness and impact. In addition, our educational systems also often

## INDIANA

### *Vermillion-Parke Community Health Center*

**Grant Number: D04RH16278**

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work in silos, with students training in separate locations. According to a recent article published in *Psychosomatics*, “integration will improve patient access to health care, increase the rate of evidence-based practice, improve patient health and satisfaction, and reduce long-term costs.”

Through this grant initiative, we propose to create an integrated primary-mental health care system to better serve our at-risk patients. This initiative will also serve as a model for health professions students to experience best practices at work in our rural communities. Goals as a part of this initiative include (1) Create an innovative model that integrates behavioral health care and primary health care processes among a community mental health center, a Rural Health Clinic and a Federally Qualified Health Center, resulting in increased access to mental health care services, particularly to services that reduce the risk of child abuse and neglect within the targeted service area; and (2) Increase health professions students’ awareness of mental health issues and provide opportunities for these students to experience first-hand an integrated model of primary and mental health care services in a rural community, particularly to services designed to strengthen parent/child relationships and reduce risk factors associated with child abuse and neglect. The target area for this proposed project includes all of the Vermillion-Parke Community Health Center’s (VPCHC) service area. VPCHC is a Federally Qualified Health Center (FQHC) located in Vermillion County in west-central Indiana. VPCHC’s service area includes all of Vermillion County as well as all of neighboring Parke County.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

**IOWA**  
***Upper Des Moines Opportunity***  
**Grant Number: D04RH07918**

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**PROGRAM DIRECTOR**

Veronica McFadden  
Upper Des Moines Opportunity  
620 Michigan, Suite 4  
Storm Lake, IA 50588  
Phone: (712) 213-9287  
Fax: (712) 732-1471  
E-mail: vmcfadden@udmo.com

**TOPIC AREAS**

Oral Health

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 143,085
- Year 2 - 125,000
- Year 3 - 100,000

**PARTNERS TO THE PROJECT**

There are two other consortium partners, United Community Health Center (UCHC), a federally qualified community health center, and Lakes Area Community Empowerment (Lakes CE).

**AREAS SERVED**

The geographic service area is twelve counties in rural northwest Iowa: Buena Vista, Clay, Dickinson, Emmet, Hamilton, Humboldt, O'Brien, Osceola, Palo Alto, Pocahontas, Webster, and Wright.

**TARGET POPULATION SERVED**

The target population is families with young children ages 0-5, residing in rural northwest Iowa.

**PROJECT SUMMARY**

The *applicant and lead agency* for the proposed project is Upper Des Moines Opportunity, Inc (UDMO). There are two other *consortium* partners, United Community Health Center (UCHC), a federally qualified community health center, and Lakes Area Community Empowerment (Lakes CE). The project title is *Early Smiles*. The target population is *families with young children ages 0-5*, residing in rural northwest Iowa. The purpose of the project is to “create an oral health care system”. The geographic service area is twelve counties in rural northwest Iowa: Buena Vista, Clay, Dickinson, Emmet, Hamilton, Humboldt, O'Brien, Osceola, Palo Alto, Pocahontas, Webster, and Wright.

After completion of a comprehensive oral health needs assessment, four needs were identified:

1. Limited *leadership and capacity* to effectively implement a prevention-focused early childhood oral health initiative.
2. Missed opportunities by early childhood health professionals to *assess, screen, treat, and educate families* of the importance of oral health care for young children.



# IOWA

## *Upper Des Moines Opportunity*

**Grant Number: D04RH07918**

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3. Unrecognized and different *attitudes, belief, and knowledge* that prevent families from seeking oral health care and understanding the need for such care.

Lack of knowledge among the general community and policy makers of the importance *for preventive oral health care* for young children and the unmet oral health needs and health disparities for families with young children.

**ORHP Contact:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# IOWA

## *Hancock County Memorial Hospital*

Grant Number: D04RH12698

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### **PROGRAM DIRECTOR**

Laura Zwiefel  
Phone: (641) 843-5153  
Fax: (641) 843-5100  
E-mail: zwiefell@mercyhealth.com

### **TOPIC AREAS**

Diabetes

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,993
- Year 2 – 124,978
- Year 3 – 99,990

### **PARTNERS TO THE PROJECT**

Hancock County Memorial Hospital, Ellsworth Municipal Hospital, Franklin General Hospital, Kossuth Regional Health Center, Mercy Medical Center – New Hampton, Mitchell County Regional Health Center, Palo Alto County Health System, and Regional Health Services of Howard County

### **AREAS SERVED**

Chcikasaw, Franklin, Hancock, Hardin, Howard, Kossuth, Mitchell, and Palo Alto.

### **TARGET POPULATION SERVED**

Identify families with one or more adults or children age 10 years and older who have pre-diabetes or high risk factors for developing diabetes

### **PROJECT SUMMARY**

Hancock County Memorial Hospital, a critical access hospital located in north central Iowa, is partnering with seven other critical access hospitals in the region to 1) Identify families with one or more adults or children age 10 years and older who have pre-diabetes or high risk factors for developing diabetes and 2) Offer these families a holistic, evidence-based program combining education, support, and lifestyle interventions to help them improve their health status and reverse habits that may lead to Type 2 diabetes and its destructive complications.

This project will directly serve 3,000 persons located across an eight county region of north central Iowa that has an exceptionally high and rapidly growing rate of diabetes as well as obesity and sedentary lifestyles that contribute to this debilitating and costly chronic medical condition. Iowa BRFSS data indicates approximately 8.3% of north central Iowa adults have been diagnosed with diabetes compared to the U.S. median of 7.3%. BRFSS estimates also indicate over 62% of all adults in these eight counties are overweight or obese as are 65% of Hispanic adults. The Iowa Department of Public Health estimates up to 40% of Iowa children are at high risk of developing Type 2 diabetes due to obesity and unhealthy lifestyles and Hispanic children are more likely to progress toward this disease.

## IOWA

### *Hancock County Memorial Hospital*

**Grant Number: D04RH12698**

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Over three years, our project will conduct 120 pre-diabetes/diabetes community screenings for high-risk adults and children ages ten and older and assist those who appear likely to have undiagnosed diabetes to access primary care and diabetes education. We will also design and offer 42 pre-diabetes classes for families with one or more adults or children who have prediabetes and/or other high-risk factors for developing diabetes. Two classes will be specially designed to meet the socio-economic, cultural, and language needs of Hispanic families clustered in one county of our service area. The total population of the region is 96.9% non-Hispanic white. Approximately 93% of the persons directly served through the project will be white-/non-Hispanic and 5% will be Hispanic.

This coordinated program will increase the number of high risk north central Iowa families who: 1) Are knowledgeable about pre-diabetes/diabetes and able to access medical and community health resources that can halt or reverse this dangerous condition; 2) Become aware that a family member has diabetes, pre-diabetes or are at high-risk for developing the disease; 3) Receive structured pre-diabetes education which combines evidenced based information with enjoyable opportunities to exercise and eat healthy foods; 4) Eat five or more fruits or vegetables daily; 5) Get recommended levels of physical activity; 6) Stabilize or reduce their glucose levels, and 6) Stabilize or reduce their body mass index and/or weight.

We are requesting a Funding Preference based on Health Professional Shortage Areas and Medically Underserved Areas in our eight county project service area. In addition, our project focuses on wellness and includes disease prevention strategies.

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# KANSAS

## *Four County Mental Health Center*

Grant Number: D04RH07908

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### **PROGRAM DIRECTOR**

Steven Denny  
Four County Mental Health Center  
P.O. Box 688  
3751 West Main Street  
Independence, KS  
Phone: (620) 331-1748  
Fax: (620) 332-1940  
E-mail: sdenny@fourcounty.com

### **TOPIC AREAS**

Mental Health

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000.00
- Year 2 - 125,000.00
- Year 3 - 100,000.00

### **PARTNERS TO THE PROJECT**

Southeast Kansas Area Agency on Aging (AAA), Montgomery County Public Health Department, Wilson County Public Health Department, The Sanctuary at Fredonia Regional Hospital (area provider of geriatric psychiatric care), Behavioral Health Unit at Coffeyville Regional Medical Center, Windsor Place Assisted Living, Gran Villa Assisted Living Neodesha Facility, Gran Villa Assisted Living Fredonia Facility, Windsor Place Assisted Living, and Four County Mental Health Center.

### **AREAS SERVED**

Through the Senior Outreach Services Consortium outreach and community-based services will be expanded in Montgomery County and initiated in Wilson County, Kansas.

### **TARGET POPULATION SERVED**

The target population is older adults, age 60 or older with unmet mental health and substance abuse treatment needs. These seniors are currently not being served by traditional methods due to financial, structural, and personal barriers including access and stigma. Program recipients will be older adults who are continuing to live in their own homes or are in assisted living facilities. The untreated mental health and substance abuse issues of these individuals put them at risk for exacerbation of physical health problems, suicide attempts, premature moves to long term care settings, and psychiatric hospitalization or residential alcohol/drug treatment.

### **PROJECT SUMMARY**

The Senior Outreach Services (SOS) Consortium will provide mental health and substance abuse outreach services to elderly in the rural Southeast Kansas counties of Wilson and Montgomery.

In addition to outreach, non-traditional services that include community based case management and in-home therapy will be provided by this project. Structural and personal barriers including access and

## KANSAS

### *Four County Mental Health Center*

**Grant Number: D04RH07908**

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stigma. Unmet mental health and substance abuse treatment needs results in premature placement in long-term facilities; inpatient hospitalizations for psychiatric and substance abuse problems; increased suicide risk; and exacerbation of medical problems.

The Senior Outreach Services Consortium will:

- Develop and maintain a Consortium of community agencies involved in elder care to address mental health and substance abuse treatment needs and related issues for older adults.
- Improve elder care by providing increased access to mental health and substance abuse treatment services.
- Improve mental health status for program recipients as evidenced by decreased symptoms of mental illness and substance abuse resulting in improved quality of life and functioning.
- Reduce stigma and increase community awareness of mental health and substance abuse issues for older adults in Montgomery and Wilson County communities through the SOS Consortium.

The Consortium will form a focus group to address the needs of seniors.

The program will outreach to older adults, age 60 or older, with unmet mental health and substance abuse treatment needs. These seniors are currently not being served by traditional methods due to financial,

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

# KANSAS

## *Valley Heights USD #498*

**Grant Number: D04RH07909**

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### **PROGRAM DIRECTOR**

Philisha Stallbaumer  
Health Education Action Partnership  
119 N. Kansas Avenue  
Frankfort, KS  
Phone: (785) 292-4453  
Fax: (785) 292-4455  
E-mail: philisha@sbeconline.org

### **TOPIC AREAS**

School (nutrition)

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

### **PARTNERS TO THE PROJECT**

Valley Heights, USD #498 has formed a partnership with the Marysville, Vermillion, Nemaha Valley, and AxtellBern school districts and Nemaha Valley Community Hospital, Community Memorial Hospital (Marysville), Community Hospital Onaga, and Nemaha and Marshall County Health Departments in an initiative called *Promoting Healthy Lifestyles*.

### **AREAS SERVED**

Marshall and Nemahan Counties

### **TARGET POPULATION SERVED**

The communities and individuals specifically and directly targeted in the *Promoting Healthy Lifestyles* initiative in year one are children in pre-kindergarten through grade 12<sup>th</sup> grade from Axtell, Blue Rapids, Frankfort, Marysville, Summerfield and Waterville, Kansas in Marshall County and Bern, Centralia, and Seneca, Kansas in Nemaha County.

### **PROJECT SUMMARY**

Rural Kansas faces challenges of an increase in sedentary lifestyles, increase in overweight and obese citizens, and an increase in chronic disease. This is because of the struggle to adequately promote healthy lifestyles in their communities through nutrition and physical activities.

Geographical location makes it difficult for rural communities to have access to needed resources to help battle what could be called an obesity crisis in Kansas, with 60.6% of the adult population being overweight and obese. It is the early unhealthy habits children are learning that lead to adult obesity and chronic diseases.

Valley Heights, USD #498 has formed a partnership with the Marysville, Vermillion, Nemaha Valley, and AxtellBern school districts and Nemaha Valley Community Hospital, Community Memorial Hospital

## KANSAS

### *Valley Heights USD #498*

**Grant Number: D04RH07909**

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(Marysville), Community Hospital Onaga, and Nemaha and Marshall County Health Departments in an initiative called *Promoting Healthy Lifestyles*. These school districts and health care facilities make up a consortium called the Health Education Action Partnership (HEAP) and serve 17 small rural communities in Northeast Kansas. In these communities it is time to change the scene and begin promoting healthy habits that will reduce health risks and increase children's chances for longer, healthier, more productive lives.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# KENTUCKY

## *Kentucky River Foothills Development Council*

Grant Number: D04RH07900

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### **PROGRAM DIRECTOR**

April Stone  
Kentucky River Foothills Development  
176 12<sup>th</sup> Street  
Clay City, KY  
Phone: (606) 663-9011  
Fax: (606) 663-1254  
E-mail: cfn1@foothillscap.org

### **TOPIC AREAS**

Diabetes

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 149,357
- Year 2 - 124,561
- Year 3 - 99,519

### **PARTNERS TO THE PROJECT**

Powell County Health Department, the Estill County Health Department, the Powell County Cooperative Extension Service, and the Estill County Cooperative Extension Service.

### **AREAS SERVED**

Comprised of the rural counties of Estill and Powell.

### **TARGET POPULATION SERVED**

Provide medical and supportive services to low-income adults with diabetes and related conditions residing in Powell and Estill counties, Kentucky.

### **PROJECT SUMMARY**

Kentucky River Foothills Development Council, Inc. proposes a Rural Health Care Services Outreach Grant program to provide medical and supportive services to low-income adults with diabetes and related conditions residing in Powell and Estill counties, Kentucky. The Promoting Health among Diabetics (PHD) program will be offered in collaboration with four additional Consortium members: the Powell County Health Department, the Estill County Health Department, the Powell County Cooperative Extension Service, and the Estill County Cooperative Extension Service. The proposed program will provide supplemental diabetic supplies and equipment; prescription assistance services; transportation for non-local specialty care for diabetes and related conditions; and nutritional counseling including nutrition, diabetes self management and fitness education. The PHD project will serve 200 participants annually, for a total of 600 over the three-year project term.



**KENTUCKY**

***Kentucky River Foothills Development Council***

**Grant Number: D04RH07900**

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**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

## KENTUCKY

### *Ephraim McDowell Health Care Foundation, Inc.*

Grant Number: D04RH12773

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#### **PROGRAM DIRECTOR**

Ann T. Smith  
217 South Third Street  
Danville, KY 40422  
Phone: (859) 239-2361  
E-mail: asmith@emmc.com

#### **TOPIC AREAS**

Women's Health--Breast/Cervical Cancer

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Brenda Cowan Coalition of Kentucky, and six rural county health departments

#### **AREAS SERVED**

Boyle, Casey, Garrard, Lincoln, Mercer and Washington Counties, Kentucky

#### **TARGET POPULATION SERVED**

Women with low health literacy

#### **PROJECT SUMMARY**

The Ephraim McDowell Health Foundation proposes a Rural Health Care Services Outreach Grant to provide breast and cervical cancer awareness, outreach and screening to low-income women residing in Boyle, Casey, Garrard, Mercer, Lincoln, and Washington counties, Kentucky. The Foundation will partner with the Brenda Cowan Coalition of Kentucky (BCC) and the 6 county Health Departments in the service area. Breast and cervical cancer are prevalent in Kentucky and in the targeted counties.

The Sister-to-Sister project will target low-income residents of the targeted counties who often have difficulty obtaining screenings due to lack of health insurance or other financial assistance for screenings, and lack of awareness of resources available to help offset costs. This project will provide assistance with accessing available health resources such as the Kentucky Women's Cancer Screening Program. The project will also target women with low health literacy, many of whom may be unaware of risks and the need for routine screening. Sister-to-Sister will offer community-wide awareness activities, including trained volunteer Community Health Advisors. The project will also target women with specific barriers to screening which are common in the target population, including obesity and chronic illness; as well as sub-populations with higher rates of breast and cervical cancers, including minorities. This project will offer tailored messages as part of overall project outreach. The tailored messages will be designed to help recruit women with obesity, chronic diseases, and other barriers into the program. Perhaps most importantly, the project will provide breast and cervical cancer screenings to the target population through 12 annual screening fairs (two per county), enabling the target population to access health care.

## KENTUCKY

### *Ephraim McDowell Health Care Foundation, Inc.*

**Grant Number: D04RH12773**

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Ephraim McDowell Health Foundation specifically requests a funding preference. The funding preference requested is: 1) Service area located in officially designated health professional shortage area (HPSA) and/or serves a medically underserved population (MUP). Boyle, Casey, Garrard, Lincoln, Mercer and Washington counties are Health Professional Shortage Areas, according to the HRSA web site; and Casey, Garrard, Lincoln and Washington counties are MUA's, according to HRSA's website.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# KENTUCKY

## *Ohio County Hospital Corp*

Grant Number: D04RH12681

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### **PROGRAM DIRECTOR**

Blaine Pieper  
CEO  
1211 Old Main Street  
Hartford, KY 42347  
Phone: (270) 298-7411  
E-mail: bpieper@ohiocountyhospital.com

### **TOPIC AREAS**

Access, Health Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,216
- Year 2 – 124,879
- Year 3 – 95,884

### **PARTNERS TO THE PROJECT**

Green River District Health Department, Ohio County Family Wellness Center, and Together We Care

### **AREAS SERVED**

Ohio County, Kentucky

### **TARGET POPULATION SERVED**

To provide no- or low-cost medical care for eligible residents.

### **PROJECT SUMMARY**

Ohio County is located in the central portion of western Kentucky. According to the Kentucky Center for Rural Health, Ohio County is a designated Health Professional Shortage Area (HPSA) and a Medically Underserved Community (MUC). From routine preventive screenings to critical surgical procedures, accessing the services needed to maintain one's health can be a difficult task for those living in rural America. Rural living has many positive attributes, including low crime rates, quiet neighborhoods and wide open spaces. However, residents of rural areas also face many challenges. One of these key challenges is access to quality and affordable health care. Ohio County residents face numerous barriers to accessing health care services, including a lack of healthcare coverage, transportation to health care facilities and the lack of primary care physicians. In Kentucky, 18.2% of the adult population does not have health care coverage. The Green River District, which includes Ohio County, has a higher percentage of those lacking health care coverage (21.5%) than both the state and national numbers (18.2% and 14.1%, respectively). One of the key components of this problem is affordability. According to the Kentucky Department of Health, in 2004, 16% of Ohio County's population is living below the poverty level. In 2004, a family of four was considered to be living in poverty with a combined income of \$18,850 or less. Currently the amount has increased to \$21,200 or less. This poses a significant barrier to access. Without health insurance, individuals and families cannot get the medical care they need. Ohio County Hospital and the designated Consortium Members will implement the Wellness Mission Program for Ohio County Residents. The Wellness Mission Program will provide no- or low-cost medical care for

## KENTUCKY

### *Ohio County Hospital Corp*

**Grant Number: D04RH12681**

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eligible residents. Eligibility will be determined through a variety of factors including health status, health care insurance coverage and a commitment and desire to improve one's health. The primary issue the program will address is access to health care, specifically due to lack of health insurance. The Wellness Mission Program will address three main goals; 1) to increase access to health care services for Ohio County residents, 2) to improve the health of Ohio County residents, and 3) to increase awareness and knowledge of health problems and solutions and the Wellness Mission Program's health care services through health education.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

# KENTUCKY

## *Lotts Creek Community School, Inc.*

Grant Number: D04RH12680

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### **PROGRAM DIRECTOR**

Alice S. Whitaker  
5837 Lotts Creek Road  
Hazard, KY 41701-9024  
Phone: (606) 785-4461  
Fax: (606) 785-0983  
E-mail: owenslone@yahoo.com

### **TOPIC AREAS**

Wellness

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

The University of Kentucky Cooperative Extension Service – Knott County and the University of Kentucky North Fork Valley Community Health Center

### **AREAS SERVED**

Knott and Perry Counties in Kentucky Part of the Appalachian Region of Kentucky

### **TARGET POPULATION SERVED**

High levels of poverty, low educational attainment and many health disparities.

### **PROJECT SUMMARY**

Lotts Creek Community School, Inc. along with its consortium partners, the University of Kentucky Cooperative Extension Service – Knott County and the University of Kentucky North Fork Valley Community Health Center propose the *Wellness Education Program*, an integrated school, parent, and community approach for enhancing the health and well-being of families in Knott and Perry Counties in Kentucky. This Rural Health Outreach Program will expand the delivery of new health care services through: 1) a school-based health program; 2) school-based oral health care; 3) in-home health and nutrition education; 4) monthly and in-depth, hands-on nutrition classes; 5) referrals to primary, oral and mental health services as necessary; 6) an annual health fair; and 7) establishment of a fitness center for use by the school and community.

The project will serve Knott and Perry Counties in eastern Kentucky which are part of the United States' Central Appalachian region. The target area is characterized by high levels of poverty, low educational attainment and many health disparities. The project will annually target 325 students in grades K-12 through the Lotts Creek Community School-based health program, 730 students through oral health services, and 176 community participants through in-home health education and nutrition education services. The anticipated unduplicated numbers served for the three-year period are: a total of 375 students through the Lotts Creek Community School-based health services program, 1,430 students

## KENTUCKY

### *Lotts Creek Community School, Inc.*

**Grant Number: D04RH12680**

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through oral health services and 448 participants through community-based services for a total of 2,253 participants.

The project goals (and corresponding objectives) have been established and will be achieved through realistic and relevant activities that are culturally, linguistically, socially and religiously competent as follows: **Goal 1:** To implement the RHO project with Continuous Quality Improvement (CQI) and adherence to the goals, objectives and work plan; **Goal 2:** To provide participants with health education literacy leading to an understanding of health promotion and disease prevention concepts; **Goal 3:** To promote wellness and lifestyle changes leading to self-managed wellness care; and **Goal 4:** To disseminate project results and to undertake efforts to sustain the project after the RHO grant period. In addition to the stated goals above, the project is also in-line with the goals of Healthy People 2010 as well as their focus areas which include educational and community-based programs, nutrition and overweight areas, oral health, and physical activity and fitness.

Lotts Creek is contracting with the University of Kentucky School of Medicine to provide outside evaluation to ensure an effective program for participants.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

# KENTUCKY

## *People's Clinic Foundation, Inc.*

Grant Number: D04RH12682

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### **PROGRAM DIRECTOR**

Mattie Burton  
P.O. Box 962  
Morehead, KY 40351  
Phone: (770) 351-3378  
E-mail: mburton@shawnee.edu

### **TOPIC AREAS**

Access, Health Promotion

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 134,580
- Year 2 – 124,400
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

People's Clinic, St. Claire Regional Medical Center, Journey Well, Morehead State University and five local churches

### **AREAS SERVED**

Bath, Carter, Elliott, Fleming, Menifee, Morgan and Rowan Counties, Kentucky

### **TARGET POPULATION SERVED**

Project is focused on uninsured individuals who are not eligible for Medicaid. Focus is on obesity, physical fitness, and tobacco use in Appalachian community.

### **PROJECT SUMMARY**

*Lasting Changes* is a community-based health initiative that improves access to medical care for uninsured people ages 19-64. It will be initiated in seven northeastern counties of rural Appalachian Kentucky: Bath, Carter, Elliott, Fleming, Menifee, Morgan and Rowan. Each of these counties has high rates of poverty, unemployment and uninsured people. Five of the seven counties are Medically Underserved Areas (MUA) and Health Professional Shortage Areas (HPSA) with Physician to Population ratios well below national standards.

To improve access to medical care, community volunteers approached People's Clinic, St. Claire Regional Medical Center, Journey Well, Morehead State University and five local churches with an idea to develop and implement a community-based health initiative, *Lasting Changes*, to teach people the skills they need to change habits and behaviors that are detrimental to their physical and mental health. Building and using these skills results in lifestyle changes that lead to long-term positive health outcomes. The program will identify participants using the People's Clinic, community-based healthcare and social service providers, church-based referrals and self referrals.

**The Lasting Changes program has two goals: establish an infrastructure that promotes community wellness and second, facilitate the lasting behavior changes among uninsured residents that**



## KENTUCKY

### *People's Clinic Foundation, Inc.*

**Grant Number: D04RH12682**

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**promote health and wellness.** The program establishes an infrastructure using local churches as outreach locations where monthly meetings and education sessions are guided by Wellness Coaches. These Coaches are church-based registered nurses who work with participants to meet their individually established health and wellness goals.

The program facilitates lasting behavior change by incorporating support and education provided by the Wellness Coaches. These Coaches advocate and use Prochaska's and DiClemente's Stages of Change model as a framework to help people effect personal changes and establish positive lifestyle habits that lead to improved levels of health and wellness. Participants receive a health exam, blood work and a health risk analysis. The results are used to help them identify goals and make long-term lifestyle changes that lead to positive health outcomes.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

## KENTUCKY

### *Montgomery County Kentucky Health Department*

Grant Number: D04RH12774

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#### **PROGRAM DIRECTOR**

Jan Chamness  
Public Health Director  
Montgomery County Kentucky Health Department  
117 Civic Center  
Mt. Sterling, KY 40353  
Phone: (859) 498-3808  
E-mail: Janm.Chamness@ky.gov

#### **TOPIC AREAS**

Mental Health

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Six member agencies including the health department, a hospital, a primary care provider, a dentist, cooperative extension and the industrial development director.

#### **AREAS SERVED**

Western edge of Appalachian Kentucky

#### **TARGET POPULATION SERVED**

Mental health services for low-income, uninsured and underinsured residents

#### **PROJECT SUMMARY**

We propose to expand El Puente, an outreach program developed by the Western Appalachian Kentucky Health Care Access Consortium that provides primary care and dental care, to include mental health services for 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 three years the Consortium plans to provide 540 primary care visits, 600 dental visits, and 200 mental health visits as well as outreach, transportation and other services.

The Consortium service area is a contiguous five-county region of more than 1,200 square miles on the western edge of Appalachian Kentucky. The Consortium is an expansion of the successful Montgomery County Migrant Coalition, established in 2001 with USDA funding. In 2006, the Consortium received a HRSA Rural Health Care Services Outreach Grant to establish the El Puente program. We believe the creative strategies used to enhance service delivery can be a model for other rural communities, especially where Latino populations are relatively new. Now that we have a vetted model, we are anxious to expand the program to include needed mental health services.

## KENTUCKY

### *Montgomery County Kentucky Health Department*

**Grant Number: D04RH12774**

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The recently-expanded Consortium is comprised of five health care agency partners, including the health department, a hospital and health care providers representing primary care, dental and mental health (a new partner in 2008); and six non-health care partners including cooperative extension, the industrial authority, and new partners the arts council, public library, parks and recreation, and an independent evaluator. Consortium members will donate \$303,750 in in-kind contributions for the three-year project.

The six goals of the Consortium are to: 1) Continue to provide current services while expanding to include mental health services; 2) advocate on behalf of the target population for improved access to existing health care; 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 continue to offer primary care, dental services and an extensive outreach program and will expand its capacity to provide mental health services. The Consortium uses a promotora model of community health workers to reduce and eliminate barriers to care that Latinos face, including language barriers, lack of transportation, inability to navigate the health care system, occupational barriers, and lack of cultural competency among service providers.

The Consortium is requesting HRSA Funding Preference 1 based on the fact that the service region contains counties that are designated by HRSA as HPSA, MUC or MUP.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

## LOUISIANA

### *Hospital Service District No. 1-A of the Parish of Richland*

Grant Number: D04RH12686

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#### **PROGRAM DIRECTOR**

Jinger Greer  
Richland Parish Hospital  
407 Cincinnati Street  
Delhi, LA 71232  
Phone: (318) 878-5171  
Fax: (318) 878-6125  
E-mail: jgreer@delhihospital.com

#### **TOPIC AREAS**

Health Education/Promotion, Diabetes

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,828
- Year 2 – 124,828
- Year 3 – 99,282

#### **PARTNERS TO THE PROJECT**

The Richland Parish Hospital; the Richland Health Coalition; the Delhi Rural Health Clinic; SAPA, Inc., and the Richland Parish Sheriff Department.

#### **AREAS SERVED**

Parish of Richland, State of Louisiana

#### **TARGET POPULATION SERVED**

To expand the availability of diabetic screening and health education resources to underserved, vulnerable and special-needs population to reduce diabetes in these populations.

#### **PROJECT SUMMARY**

The applicant, Richland Parish Hospital (RPH), is a Critical Access Hospital with a 501(c)(3) Nonprofit designation. RPH is located in Delhi, Louisiana, Richland Parish, in the northeast corner of the state. The hospital is a main provider of health care services in the parish. The Richland Parish Hospital-Delhi's (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.

There are significant barriers to access to health care in Richland Parish as reflected in the income and poverty demographics, health status indicators, and health disparities. Federal funding will be used to expand the existing RPH Community Wellness & Prevention Program to provide services to the underserved, vulnerable and special needs population in Richland Parish. The Parish has a population of 20,981.

## LOUISIANA

### *Hospital Service District No. 1-A of the Parish of Richland*

Grant Number: D04RH12686

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The primary needs to be addressed through the Rural Health Care Services Outreach Grant are:

- a. The need to increase the quality, availability, and effectiveness of community based programs designed to detect those with pre-diabetes
- b. The need to expand the availability of diabetic screening and health education resources to underserved, vulnerable and special-needs population to reduce diabetes in these populations.
- c. The need to develop a comprehensive plan following national guidelines, in the management of pre-diabetes and thereby decrease the future rise and incidence of DMII in Richland Parish
- d. The need to strengthen the health care infrastructure and health care delivery systems in Richland Parish as they relate to the current diagnosis and management of pre-diabetes

To address the above identified needs the network has developed the following goals:

*Goal 1:* Develop a model comprehensive community program in Richland Parish to screen for, diagnose and implement a plan of treatment for pre-diabetes.

*Goal 2:* Increase the community and local health care providers' awareness of prediabetes and its importance in predicting future diabetic events.

*Goal 3:* Decrease the incidence of future diabetes mellitus type II in Richland Parish by aggressive management of those patients found to have a pre-diabetic state.

*Goal 4:* Enhance the management of patients in the pre-diabetic state by identifying the most cost/time effective strategy of management.

#### **ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

**LOUISIANA**  
***Louisiana Tech University***  
**Grant Number: D04RH12685**

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**PROGRAM DIRECTOR**

Dr. Mary Murimi  
261 CTH  
Phone: (318) 257-3026  
Fax: (318) 257-4014  
E-mail: murimi@latech.edu

**TOPIC AREAS**

Diabetes, School-Based

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

St. Mathew Baptist Church, Church of the Living God, Dubach Church of God in Christ, Dubach High School, Greater Pleasant Grove Baptist Church, Hopewell Baptist Church, and Union Baptist Church

**AREAS SERVED**

Lincoln and Claiborne Parishes in Louisiana

**TARGET POPULATION SERVED**

Local high school and African American churches

**PROJECT SUMMARY**

Diabetes is epidemic in the United States, and a disproportionate burden in African American populations. The Diabetes Prevention Program (DPP) demonstrates that lifestyle modification can prevent diabetes in the majority of high-risk individuals. Proposed, is a community-based participatory intervention entitled “Diabetes Intervention Aimed at Total Enhancement of Community Health.” The intervention includes two components: (1) a church-based, peer-mediated education program to improve dietary patterns, increase physical activity, and reduce weight in adults at risk for diabetes; and (2) a school-based, program that will target all at-risk students and their parents and teachers. The training and teaching of all sessions will be delivered by a diabetes educator. This project will be implemented in two rural and underserved parishes: Lincoln and Claiborne Parishes in Louisiana. The successful completion of DIATECH will constitute an important advance toward national goals related to diabetes prevention and control, and specifically foster progress toward Healthy People 2010 objectives 5,19, 21 and 22.1

**Targeted Population:** The project will target a local high school and African American churches in the target area. Approximately 25% of the residents live in poverty, with high levels of “health illiteracy”. Cancer, heart diseases, diabetes, and stroke are among the leading causes of death. The project boundaries are Census Tract 9601 Block Groups 2 and 3 in Lincoln Parish Louisiana.

# LOUISIANA

## *Louisiana Tech University*

**Grant Number: D04RH12685**

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**Overview of Project Plan:** The proposed project has established a formal consortium of preventive health service providers that will maximize resources, increase the number of individuals and families receiving preventive care for Diabetes and its related disorders, and foster a sense of positive behavior that reflects health and self-help. Interventions will include health education sessions, group and individual behavior modification counseling, increased physical activities and nutritional assessment and counseling.

**Approach:** Critical to this project are the use of the CHM and the use of point-of-testing counseling. Both strategies facilitate the multiplier effect and lifestyle behavior changes.

**Sustainability:** Through the concerted efforts of the consortium, and the CHM, it is envisioned that the target population will increase its use of preventive services to fight diabetes, decrease the detrimental effects of diabetes in a sustainable manner.

**Evaluation:** Both process and outcome evaluations will be conducted to both improve the service delivery and measure the achievement of the stated goals. In addition, an external evaluator will be contracted to evaluate the process and outcome of the complete project.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# LOUISIANA

## *Innis Community Health Center, Inc.*

Grant Number: D04RH16498

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### **PROGRAM DIRECTOR**

Linda Matessino  
6450 LA Highway, Suite B  
Innis, LA 70747  
Phone: (225) 492-3775  
Fax: (225) 492-3782  
E-mail: linda@inchc.org

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,882
- Year 2 – 124,790
- Year 3 – 99,922

### **PARTNERS TO THE PROJECT**

Innis Community Health Center, Louisiana State University School of Dentistry, Central Louisiana Area Health Education Center, and Louisiana State University School of Public Health

### **AREAS SERVED**

Pointe Coupee Parish, Louisiana

### **TARGET POPULATION SERVED**

Improving oral health of infant and toddlers from low income and vulnerable families.

### **PROJECT SUMMARY**

Dental caries is common among all childhood age groups; however the Centers for Disease Control and Prevention recently reported a 15.2% increase in caries among children ages 2 through 5 years receiving Medicaid. The contrast between those living below as compare to above the poverty level is also stark. Nearly 30% of poor preschool children have untreated dental caries compared to only 6% of preschool children from families above 300 percent of the federal poverty level. Louisiana is consistently ranked at or near the bottom in all health determinants including oral health.

Building Tomorrow's Smiles will provide early intervention in the form of oral screening exams and fluoride varnish applications for infants and toddlers, develop professional education for healthcare providers in order to increase access to care, and serve as a platform for dental care advocacy. Services will be to Medicaid infants and toddlers in Pointe Coupee Parish to alleviate and enhance the oral health of the most vulnerable of Louisiana's rural population.



**LOUISIANA**

***Innis Community Health Center, Inc.***

**Grant Number: D04RH16498**

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**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

**MARYLAND**  
***Allegany Health Right***  
**Grant Number: D04RH16341**

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**PROGRAM DIRECTOR**

Cathy Petit  
12 N. Liberty Street, Suite 104  
Cumberland, MD 21502  
Phone: (301) 777-7749  
Fax: (301) 777-5162  
E-mail: cpetit@allconet.org

**TOPIC AREAS**

Oral care and prevention through education

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Allegany Health Right (AHR), the University of Maryland School of Nursing Governor's Wellmobile (Wellmobile), Tri-State Community Health Center (TSCHC) and the Western Maryland Area Health Education Center (WMAHEC)

**AREAS SERVED**

Allegany County

**TARGET POPULATION SERVED**

Oral health needs of the low-income uninsured/underinsured population.

**PROJECT SUMMARY**

The Oral Health and Prevention Consortium, consisting of the lead agency, Allegany Health Right (AHR), the University of Maryland School of Nursing Governor's Wellmobile (Wellmobile), Tri-State Community Health Center (TSCHC) and the Western Maryland Area Health Education Center (WMAHEC) has developed a comprehensive plan to address the oral health needs of the low-income uninsured/underinsured population of the County in a project that spans prevention to intervention.

Allegany County, population 74,930, is a medically underserved and economically depressed region located in the Appalachian Mountains of western Maryland. Nearly thirty-seven percent (36.75%) of Allegany County residents live below 200% of federal poverty and almost twenty-two percent (21.7%) of its population are uninsured. This project targets the low-income uninsured/underinsured adult county residents since access to oral health care and prevention services are particularly difficult for this population. This project seeks funding preference as a designated Health Professional Shortage Area as designated by the Health Resources and Services Administration for both primary care and dental care.

Over the past five years, AHR has been providing emergency dental services to the target population of Allegany County through a unique dental access program. A network of area dentists and oral surgeons

## MARYLAND

### *Allegany Health Right*

**Grant Number: D04RH16341**

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has agreed to provide emergency dental services at a reduced rate upon referral from AHR. The proposed project will expand these much needed services and provide emergency dental treatment for 200 additional clients per year.

The sustainability of this project is of utmost importance to the Consortium. Therefore, a part-time coordinator will be hired to carry-out and evaluate a feasibility test of purchasing dental coverage for clients as an effort towards sustainability.

In addition to expanding direct services, this project proposes educational efforts and oral health screenings. Both TSCHC and the Wellmobile plan to provide oral health screenings and teaching for all their low-income uninsured/underinsured clients; reaching a total of 500 clients per year. In addition the Wellmobile will provide further education through two community outreach events. The WMAHEC plans to provide additional community education to reach 130 people through two Mini-Med programs that relate oral health to systemic health. In addition, the WMAHEC will provide a Continuing Medical Education program for approximately 160 professionals regarding the relationship between oral health and systemic health.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MARYLAND

## *Eastern Shore Area Health Education Center*

**Grant Number: D04RH12650**

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### **PROGRAM DIRECTOR**

Jacob F. Frego, Executive Director  
814 Chesapeake Drive  
P.O. Box 795  
Cambridge, MD 21613  
Phone: (410) 221-2600  
Fax: (410) 221-2605  
E-mail: jfrego@esahec.org

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Eastern Shore Area Health Education Center (lead agency); the University of Maryland Dental School; two federally qualified community health centers, Choptank Community Health System, Inc. and Three Lower Counties, Inc.; the local hospital, Shore Health System; the Kent County Health Department and the Chester River Health System.

### **AREAS SERVED**

Eastern Shore

### **TARGET POPULATION SERVED**

Low-income children on the Eastern Shore of Maryland

### **PROJECT SUMMARY**

Health Services Outreach Grant (RHOG) funding to improve the availability of and access to preventive, restorative, and rehabilitative oral health care for low-income children on the Eastern Shore of Maryland through 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 a community-based outreach and education program. The founding members of the CROC include the Eastern Shore Area Health Education Center (lead agency); the University of Maryland Dental School; two federally qualified community health centers, Choptank Community Health System, Inc. and Three Lower Counties, Inc.; and the local hospital, Shore Health System. The CROC Program, currently in the third year of RHOG funding, has been a tremendous asset in improving access to oral health care. With the success of the CROC Program in the mid and lower shore area, the Consortium has been working with community leaders on the Upper Eastern Shore, particularly Kent County, to improve access to oral health care in that area. As a result, two new Consortium members have joined CROC, the Kent County Health Department and the Chester River Health System. CROC is

# MARYLAND

## *Eastern Shore Area Health Education Center*

**Grant Number: D04RH12650**

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applying for additional RHOG funding to expand office-based, hospital-based, and community-based dental services into the Kent County area, with a focus on Hispanic children and their families.

**Oral Health Disparities.** On the Eastern Shore of Maryland, dental disease and lack of access to dental care is one of the most critical health care issues. Considerable oral health disparities remain in this area especially among the low-income and pediatric populations. School-aged children in Maryland have three times the national average of untreated tooth decay. Children on the Eastern Shore have the highest percentage of untreated dental decay in Maryland. Most of the Eastern Shore is considered dentally underserved. 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.

**Target Population.** CROC's work plan focuses on low-income children who are uninsured or enrolled in Medical Assistance. The expanded program will also target Hispanic children and their families. Statistics from the first two years of the CROC Program have shown that, among low-income children in the area, a disproportionately high number of Hispanic children have severe dental disease.

**Proposed Services.** There are four components to the expanded CROC Program: 1) the development of innovative partnerships for referrals and transportation to oral health services; 2) the expansion of hospital based pediatric dental services to the Chester River Health System; 3) the development of innovative partnerships for workforce development and training; 4) and the expansion of outreach/educational services for the Hispanic population.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MARYLAND

## *Somerset County Health Department*

Grant Number: D04RH12655

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### **PROGRAM DIRECTOR**

Colleen K. Parrot  
7920 Crisfield Highway  
Westover, MD 21871  
Phone: (443) 523-1760  
Fax: 410-651-3425  
E-mail: [charity@dnhm.state.md.us](mailto:charity@dnhm.state.md.us)

### **TOPIC AREAS**

Diabetes Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Somerset County Health Department, Atlantic General Hospital, McCready Health Services Foundation, and University of Maryland Eastern Shore.

### **AREAS SERVED**

Worcester and Somerset Counties

### **TARGET POPULATION SERVED**

Undiagnosed, diagnosed, and untreated needs

### **PROJECT SUMMARY**

The Somerset County Health Department through the Tri-County Diabetes Alliance consortium will expand an existing Diabetes program to focus on adults over the age of 45 in Worcester and Somerset Counties in Maryland. The program will enhance the capacity of existing community agencies to respond to the needs of the increasing population diagnosed with diabetes or those who are at risk of developing diabetes. 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 diabetes. The program will use self-management interventions to reduce health disparities and increase access to health care services for people living with diabetes. It also will incorporate a chronic care model used by the Bureau of Primary Health Care and will provide services at local health departments and diabetes care centers. The program will focus on increased access to prevention, early detection, and treatment of diabetes through the provision of a comprehensive self-management education model. The project is designed to finance the development, implementation, and evaluation of the Tri-County Diabetes Alliance's Closing the Gap on Diabetes project. This endeavor has been designed based on best practice standards including the American Diabetes Association's guidelines for quality diabetes self-management and care.

# MARYLAND

## *Somerset County Health Department*

**Grant Number: D04RH12655**

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The Closing the Gap on Diabetes project will provide diabetes education and treatment services to the citizens of Worcester and Somerset counties. The two primary goals of the project are to reduce short-term and long-term diabetes-related complications along with reduction of hospitalizations by 10% for those who have already developed diabetes. To reach this goal, the project will provide diabetes self-management education following recognized national standards at several project clinics and at key outreach locations. Second, the consortium aims to promote awareness and prevention of diabetes to the tri-county area. To achieve this goal, the project will conduct awareness, assessment utilizing the ADA risk assessment test, and education sessions in the community at churches, health fairs, and schools as needed and/or requested.

The region of Worcester and Somerset Counties in Maryland is medically underserved with shortages in primary care providers. It is socioeconomically disadvantaged and the unemployment rate is significantly above the national and state standard. Education levels are low and poverty level is 2½ times higher than the state average. 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, which ultimately diminish quality of life.

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# MARYLAND

## *St. Mary Hospital*

Grant Number: D04RH16343

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### **PROGRAM DIRECTOR**

Lori Werrell  
25500 Point Lookout Road  
P.O. Box 527  
Leonardtown, MD 20650  
Phone: (301) 475-6019  
Fax: (301) 475-6143  
E-mail: lori\_werrell@smhwecare.com

### **TOPIC AREAS**

Chronic Disease, Diabetes, CVD, Health Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 108,316
- Year 2 – 106,569
- Year 3 – 97,729

### **PARTNERS TO THE PROJECT**

St. Mary's County Department On Aging, the St. Mary's County Department of Social Services, and the Minority Outreach Coalition of St. Mary's County, Inc.

### **AREAS SERVED**

St. Mary's County, Maryland

### **TARGET POPULATION SERVED**

Special emphasis on reaching the minority, low income, uninsured, and elderly communities.

### **PROJECT SUMMARY**

St. Mary's Hospital of St. Mary's County, Health Connections Department is the lead agency for the Living Well: Connecting the Steps to Healthy Living (Living Well) program. The program's community consortium includes the St. Mary's County Department On Aging, the St. Mary's County Department of Social Services, and the Minority Outreach Coalition of St. Mary's County, Inc. The goal of Living Well is to increase the quality and years of life for individuals with chronic diseases. Living Well is comprised of three programs, the Stanford University Chronic Disease Self Management Program, the St. Mary's Hospital, American Diabetes Association Recognized, Diabetes Self Management Education Program, and St. Mary's Hospital Outpatient Congestive Heart Failure Education Program. The program is designed to target the population of St. Mary's County Maryland with a special emphasis on reaching the minority, low income, uninsured, and elderly communities. Living Well addresses the needs of those with chronic illnesses who have barriers to better self-management of their conditions. By improving individuals' disease self-management skills, Living Well impacts several of the Healthy People 2010 objectives. The program complements the St. Mary's Hospital "Get Connected to Health" Project, a low cost primary care service for the low income and uninsured residents of the county, targeting the medically underserved Lexington Park, Maryland area. Living Well is a referral destination for "Get Connected to Health" Participants. Consortium members and non-consortium partners will also serve as



# MARYLAND

## *St. Mary Hospital*

**Grant Number: D04RH16343**

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reciprocal referral sources for this program. Physician education will be provided to improve referral from local physicians and better incorporate the Chronic Care Model into the healthcare system of the county.

Funding preference is requested for this proposal. For funding preference 1, the county has a Medically Underserved Area (MUA), Chaptico/Milestown Service Area (Minor Civil Divisions (MCD) District 4 and 7) which is part of the service area of the grant. Preference 2 is requested because the program will be providing health education and disease management services to the general public as well as to supplement the services of our new primary care service using our mobile out reach unit called "Get Connected to Health."

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

**MAINE**  
***Medical Care Development, Inc.***  
**Grant Number: D04RH12692**

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**PROGRAM DIRECTOR**

Dr. Margaret Gradie  
11 Parkwood Drive  
Augusta, ME 04330  
Phone: (207) 622-7566, ext. 260  
Fax: (207) 622-3616  
E-mail: mgradie@mcd.org

**TOPIC AREAS**

Diabetes

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,336
- Year 2 – 124,994
- Year 3 – 99,978

**PARTNERS TO THE PROJECT**

26 DSME provider sites located in all 16 counties in the state

**AREAS SERVED**

16 counties in Maine

**TARGET POPULATION SERVED**

Adult population in Maine had diabetes

**PROJECT SUMMARY**

Diabetes is a serious and growing health problem across the country. In the ten-year period between 1994 and 2004, the annual incidence of diabetes (new diagnoses) increased by 23 percent, while the prevalence (those living with the disease) increased by 62 percent. In 2005 the Maine CDC, Diabetes Prevention and Control Program estimated that about 7.4 percent of the adult population in Maine had diabetes. That meant more than 77,000 people, a figure that has been increasing each year since 2000, a trend that the CDC says will continue through at least 2020. Diabetes Self Management Education (DSME) is considered best practice, but as documented in Healthy People 2010, only about 40 percent of people with diabetes ever attend the standard group intervention. In 2006 the Maine CDC published a study that documented the barriers to DSME participation in Maine. Barriers included: (i) an aversion to group classes, (ii) lack of perceived need for the information, (iii) group sessions offered at times/dates that are not convenient, (iv) transportation challenges, and (v) lack of information about the program.

In response to the barrier study, MCD developed the Telephonic Diabetes Education and Support (TDES) Program. The program concept was that the convenience and flexibility afforded by a telephone-based intervention would significantly increase participation in DSME and improve health outcomes. The TDES Pilot Program was conducted in 2006, followed by a larger implementation of the program during 2007-2008 in partnership with the State of Maine Office of Employee Health and Benefits (SOM). The results demonstrated that TDES is an effective methodology for presenting Diabetes Self-Management

# MAINE

## *Medical Care Development, Inc.*

**Grant Number: D04RH12692**

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Education (DSME) that does improve clinical health outcomes. MCD, with SOM formed a Consortium to expand access to IDES in partnership with other employers, in partnership with 26 DSME provider sites located in all 16 counties in the state. TDES makes DSME accessible for Maine rural residents.

This proposal requests funds that would enable the Consortium to expand and enhance TDES to serve more people with diabetes and further improve outcomes by:

1. Build MCD capacity to expand and enhance the TDES program
2. Expand the TDES program to more people with diabetes living and working in rural Maine
3. Improve participant outcomes by broadening the scope of the TDES intervention
4. Strengthen Evaluation
5. Develop infrastructure to assure TDES Sustainability

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# MAINE

## *St. Andrews Hospital*

Grant Number: D04RH12754

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### **PROGRAM DIRECTOR**

Thomas Beard  
6 St. Andrews Lane  
Boothbay Harbor, ME 04538  
Phone: (207) 633-7820  
E-mail: thomasb@standrewshealthcare.org

### **TOPIC AREAS**

Women's Preventive Care--Obesity and Chronic Care

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 139,756
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

The Consortium includes: St. Andrews Hospital, the Boothbay Region School District, John F. Andrews Family Care Center, Miles Medical Group – Pediatrics, Spring Harbor Hospital, and MaineHealth.

### **AREAS SERVED**

Boothbay Region of Maine

### **TARGET POPULATION SERVED**

Rural area with high rates of poverty, lack of insurance, childhood asthma and teen substance abuse

### **PROJECT SUMMARY**

The Boothbay Student Health Consortium proposes to improve the physical and mental health of 823 students in grades K-12 through collaborative and integrated approaches to the delivery of school based care. The Consortium includes: St. Andrews Hospital, the Boothbay Region School District, John F. Andrews Family Care Center, Miles Medical Group – Pediatrics, Spring Harbor Hospital, and MaineHealth. Through shared staffing, contractual agreements and collaboration, the Consortium will: 1) significantly expand the capacity of the existing School Health Center and 2) increase student access to integrated mental health services at the school and local primary care sites. The project targets the Boothbay Region of Maine, a rural area with high rates of poverty, lack of insurance, childhood asthma and teen substance abuse. The project responds to recommendations made by local students and parents.

Key strategies include:

- Expanding the current eight hour per week position of nurse practitioner to 40 hours per week, so that students have daily access to comprehensive healthcare services.
- Expanding the current 20 hour per week position of school based social worker to 40 hours per week, so that students have daily access to mental health services.
- Add one hour weekly of a psychiatric nurse practitioner to School Health Center staff, to provide medication management services for students with complex mental health disorders.

# MAINE

## *St. Andrews Hospital*

**Grant Number: D04RH12754**

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- Add two hours weekly of a medical director position to oversee the School Health Center.
- Utilize evidence-based mental health assessments and referral protocols established with Consortium members that practice integrated care.
- Use telemedicine equipment newly available at St. Andrews Hospital through a federal grant obtained by Spring Harbor Hospital, to link students with child psychiatrists.

The nurse practitioner will engage students, parents and community members in a School Health Center Advisory Board that will provide leadership to outreach and health promotion activities. The project director will monitor contractual agreements and engage the Consortium in collaborative planning, decision making, and evaluation processes. He will coordinate efforts with an evaluation consultant to develop and implement an evaluation plan, and with HRSA technical assistance staff to develop a sustainability plan. The School Health Center will take steps needed to meet the credentialing requirements and contracting standards of health plans, so that services can be sustainable through third party reimbursement. Lessons learned about collaborative, integrated service delivery; the implementation of referral protocols with local and regional healthcare providers; and sustainability of services; will be shared with other small rural communities so that the model can be replicated. This application requests funding preference because Lincoln County is a Primary Medical Care Health Professional Shortage Area (HPSA), as documented in Section VI.

### **ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MICHIGAN

## *Eastern Upper Peninsula Intermediate School District*

Grant Number: D04RH07915

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### **PROGRAM DIRECTOR**

Lisa Jo Garliardi  
Eastern Upper Peninsula Intermediate School District  
315 Armory Place  
Sault Sainte Marie, MI 49783  
Phone: (906) 632-3373, ext. 132  
E-mail: lgagliardi@eup.k12.mi.us

### **TOPIC AREAS**

School-based

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000.00
- Year 2 - 125,000.00
- Year 3 - 100,000.00

### **PARTNERS TO THE PROJECT**

Collaborative efforts among six consortium members: Eastern Upper Peninsula Intermediate School District, Brimley Area Schools, Rudyard Area Schools, Engadine Consolidated Schools, War Memorial Hospital, and Mackinac Straits Hospital.

### **AREAS SERVED**

Eastern Upper Peninsula Intermediate School District.

### **TARGET POPULATION SERVED**

The consortium will target the 4 - 18 age population, with approximately 40% Native American and 60% Caucasian ethnicities. The school based health clinics will result in 4,500 health service encounters during the first year for 400 children.

### **PROJECT SUMMARY**

The Road to Good Health project begins with a unique approach to providing health care to extremely rural communities by developing a consortium of schools and health care providers to establish school based health clinics at three school sites. Collaborative efforts among six consortium members: Eastern Upper Peninsula Intermediate School District, Brimley Area Schools, Rudyard Area Schools, Engadine Consolidated Schools, War Memorial Hospital, and Mackinac Straits Hospital. The consortium will target their efforts to the areas with the “worst of the worst” health care access according to the U.S. Department of Health and Human Services Health Resources and Services Administration designations: Trout Lake, Dafter, Chippewa, Superior, Garfield, and Bay Mills Townships. Goals of the Road to Good Health are: 1) To work together to strengthen the collaborative relationships within the consortium and expand to include additional health care providers and, 2) To capitalize on existing building and transportation infrastructure to overcome geography and inclement weather (typical barriers to access to health care in northern climates) to provide high quality health care at early stages of life for rural residents with limited health access.

## MICHIGAN

### *Eastern Upper Peninsula Intermediate School District*

**Grant Number: D04RH07915**

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Children in these townships face every possible barrier to receiving high quality health care. In addition to being federally-designated Medically Underserved Populations, the following barriers exist: elevated rates of chronic illness, unemployment rates that exceed the state average, excessive rates of single-parent families, extreme poverty, heightened rates of abuse and neglect, high rates of working parents in minimum wage jobs, extremely rural location, few health care providers, high uninsured rates, extreme weather conditions, treacherous roads, isolation, and few recreational or cultural draws for new medical providers. These are the needs we will address through school based health clinics.

A community needs assessment shows that the biggest barriers to health care access in the region are transportation, lack of insurance (10% - 13% of our children are uninsured, compared to 8% uninsured in the State of Michigan), and schedule conflicts for working parents. The school based health clinics will address these barriers by bringing the services to the children, along with an aggressive insurance outreach component. A nurse practitioner and social worker/therapist will provide 70 hours/week of prevention and education activities, as well as primary care and mental health services for the designated school districts. The consortium will target the 4 - 18 age population, with approximately 40% Native American and 60% Caucasian ethnicities. The school based health clinics will result in 4,500 health service encounters during the first year for 400 children.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# MICHIGAN

## *Grand Traverse Regional Health Care Coalition*

Grant Number: D04RH07916

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### **PROGRAM DIRECTOR**

Arlene Brennan  
The Grand Traverse Regional Health Care Coalition  
3155 Logan Valley Road  
Traverse City MI 49686  
Phone: (231) 935-0799  
Fax: (231) 935-0795  
E-mail: brennangtrhcc@charterinternet.com

### **TOPIC AREAS**

Medical, dental, vision and mental health services

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

### **PARTNERS TO THE PROJECT**

Dental Clinics North, The Traverse Bay Area Intermediate School District, Community Health Clinic, Inc., and The Grand Traverse Regional Health Care Coalition.

### **AREAS SERVED**

Northwest Michigan

### **TARGET POPULATION SERVED**

The target population is 62,250 people from 5 years old to seniors all of whom are low-income or highly vulnerable to oral disease.

### **PROJECT SUMMARY**

The Grand Traverse Regional Health Care Coalition (GTRHCC) is a community-based network with a mission to improve access to medical, dental, vision, and mental health for those underserved citizens in our area in Northwest Michigan.

**Summary of the Need**—The target population is 62,250 people from 5 years old to seniors all of whom are low income or highly vulnerable to oral disease. This represents 37% of the total population in the 5 county area. The evidence is clear, from our interviews and focus group of members of the target group, that they have no access to dental care. This group does not visit the dentist, 27% has active decay, and 18% look forward to having no natural teeth by age 65. The incidence of sealant protection and fluoride protection is 18%. Even with Medicaid for children only 25% of all children are receiving preventive care. This is a dental profession underserved area.

**Our Partners**—Our partner organization, Community Health Clinic, Inc has been in existence for 28 years and has been providing some dental care to low income patients they serve. The Clinic has formed successfully a small volunteer dentist program to provide emergency procedures. Last year, the Clinic



# MICHIGAN

## *Grand Traverse Regional Health Care Coalition*

**Grant Number: D04RH07916**

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provided approximately \$62,000 of free dental care. Another partner is Dental Clinics North who provides dental services. Traverse Bay Intermediate School District is working with us to launch the school based programming.

**Our Goals**—Our clients indicate that they need access to dental care and a “Dental Home”. These goals are important for Health People 2010. This Collaborative will attack dental access by integrating existing resources of our community as well as adding resources to meet the needs. To really make a difference one dental record will be used in all Coalition service areas as our partner, Dental Clinics North will allow us to use its innovative Health Information Technology (paperless dental record).

Our program is multi-fold:

- School Age Programs
  - Give Kids a Smile: oral health education, nutrition, cleaning, fluoride treatment, application of sealants, oral exams, and referral to local dentists for treatment to every student in all schools in the 5 county area (approximately 28,800 students)
  - School Referrals - in cooperation with the health department and TBAISD, provide exams and preventive treatments at its Career Technology campus for students from 10 - 19 and refer them for appropriate treatment
- Expand the existing volunteer Dentist program to encourage all dentists and hygienists to contribute 4% of annual revenue, so as spread the treatment load over all dental professionals.
- Establish a Mobile Dental Clinic which will become the “Dental Home” for these patients with staffing drawn from an organized Volunteer Dental Program to include preventive and treatment by volunteer hygienists, assistants, and dentists
- Enhance the existing Northern Dental Plan (which provides reduced fee dental service) to allow payroll deductions of the patient pay amount.

**Benefits**—The 3 year outreach grant funding will allow the Collaborative to improve the oral health in this community by providing access to those who are most vulnerable: those with low income and children. This effort is sustainable because of the broad collaborative of support and by the program design. The difficult part is getting the processes in place. The Coalition will supplement HRSA grant funds with the help of our community-based collaborative.

### **ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MICHIGAN

## *Baraga-Houghton-Keweenaw*

Grant Number: D04RH07917

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### **PROGRAM DIRECTOR**

Teresa Frankovich, M.D., M.P.H., FAAP  
BHK Child Development Board  
700 Park Avenue  
I-Ioughton, MI 49931  
Phone: (906) 482-3663  
Fax: (906) 482-7329  
E-mail: tlfranko@bhkfirst.org, bhk@bhkfirst.org

### **TOPIC AREAS**

School (nutrition)

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 149,918
- Year 2 - 124,998
- Year 3 - 100,000

### **PARTNERS TO THE PROJECT**

The Healthy Families Project is a collaboration between BHK Child Development Board, an \$8-million non-profit agency that operates Head Start programs; Portage Health, the community's leading healthcare provider; and the Western U.P. District Health Dept., the region's state-funded public health and education organization.

### **AREAS SERVED**

Baraga, Houghton and Keweenaw counties in Michigan's Upper Peninsula are rural, rugged and remote.

### **TARGET POPULATION SERVED**

The project will serve 400 preschool aged children and 400 parents per year. Families to be served will typically be considered at risk for several reasons: including low family income, single-parent household, history of substance abuse and other factors identified through the state of Michigan's risk factor index.

### **PROJECT SUMMARY**

Baraga, Houghton and Keweenaw counties in Michigan's Upper Peninsula are rural, rugged and remote. The region, known as the Copper Country for its copper-mining past, is home to approximately 1,500 children aged 3 to 5. The area has higher overweight/obesity rates, poverty rates, and alcohol and tobacco use rates than the state of Michigan. This in turn raises the community's risk for chronic illnesses such as cardiovascular disease, diabetes and cancer. Long, snowy winters and extreme travel distances (residents live in towns, townships and rural locations spread across a 2,504-square-mile area with a population density of 19 people per square mile) contribute to isolation and sedentary lifestyles. Health services beyond basic medical care are mostly non-existent.

The Healthy Families Project is a collaboration between BHK Child Development Board, an \$8-million non-profit agency that operates Head Start programs; Portage Health, the community's leading healthcare provider; and the Western U.P. District Health Dept., the region's state-funded public health and

# MICHIGAN

## *Baraga-Houghton-Keweenaw*

Grant Number: D04RH07917

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education organization. The project seeks to improve the health and wellness of rural families with young children. The project has three cornerstone goals, each of which has specific, measurable objectives. The goals, which align with Healthy People 2010 goals, are to: 1) To improve the health and wellness of 400 preschool children; 2) To increase the health and wellness of 400 families with preschoolers; 3) To further expand collaboration between agencies/institutions promoting wellness and disease prevention and to increase utilization of their services by community members. Key activities include inclusion of research-based and validity tested physical activity and nutrition curricula in preschool classrooms; parent-involvement activities including out-of-classroom and out-of-home wellness educational classes and sessions, use of three regional Family Wellness Centers with adult and child exercise areas, educational information and health homework and special events such as sledding trips; and development of a communitywide Healthy Families Advisory Group to expand collaboration among service providers and increase service utilization rates. BHK Health Director and pediatrician Teresa Frankovich, M.D., M.P.H., will serve as project director. Erin Carter, M.S. (exercise physiology) will serve as Project Coordinator. Contractual staff will include dietitians, health educators and experienced fitness staff. An independent Ph.D.-level evaluator will conduct an independent evaluation. The project requests funding preference for these two reasons: 1) HPSA; 2) Project Focus-Wellness and Disease Prevention.

The project will serve 400 preschool aged children and 400 parents per year. Families to be served will typically be considered at risk for several reasons: including low family income, single-parent household, history of substance abuse and other factors identified through the state of Michigan's risk factor index.

### **ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# MICHIGAN

## *Borgess-Lee Memorial Hospital*

Grant Number: D04RH12760

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### **PROGRAM DIRECTOR**

Sharon Curran  
420 W. High Street  
Dowagiac, MI 49047  
Phone: (269) 226-3080  
E-mailsharoncurran@borgess.com

### **TOPIC AREAS**

HIT

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Borgess-Lee Memorial Hospital (Dowagiac, MI); Community Health Center (Coldwater, MI); Three Rivers Health (Three Rivers, MI)

### **AREAS SERVED**

Cass County, Michigan

### **TARGET POPULATION SERVED**

Residents of this rural region

### **PROJECT SUMMARY**

In 2002, the Borgess Health Alliance (BHA) joined with 6 rural community hospitals in the region to establish the Southwest Michigan Telehealth Network. The purpose of the Network has been: “To improve access to health care, continuing education for health professionals, health education for the community, and to increase organizational efficiencies through the development and provision of distance learning and telemedicine technologies.” The project encompasses the three rural counties/communities of Cass, St. Joseph and Branch Counties, located along the southern border of the Southwest Michigan Telehealth Network region. For this application, 3 of the 6 end-sites of the South West Michigan TeleHealth Network chose to participate including: Borgess-Lee Memorial Hospital (Dowagiac, Mi); Community Health Center (Coldwater, Mi); Three Rivers Health (Three Rivers, Mi). The region’s 159,313 residents average a density of just 106 persons per square mile as compared to the statewide average of 175 persons per square mile. Data from the National Center for Health Statistics and the Michigan Department of Community health show that residents of the region have a significantly higher rate due to stroke, coronary heart disease, cancers, motor vehicle injuries, and unintentional injuries, than both the state and the Healthy People 2010 target rates.

From 2006 through 2008, the Southwest Michigan TeleHealth Network Board identified and prioritized the following telehealth strategies for this project.

## MICHIGAN

### *Borgess-Lee Memorial Hospital*

**Grant Number: D04RH12760**

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1. Use TeleStroke services to increase appropriate use of t-PA and increase rural access to neurological specialists, in order to: (a) reduce stroke death rate to a rate of less than 55 deaths per year in the three target communities; (b) increase number of patients receiving t-PA treatment for stroke by 75 per year; and reduce hospitalizations for stroke by 75 admissions per year.
2. Use existing Telehealth video conferencing systems to provide interpreter services to clinicians/patients during healthcare encounters, in order to: (a) improve patient satisfaction with their health care encounters where cultural / language barriers exist; and (b) improve clinician satisfaction with patient encounters where cultural / language barriers exist.
3. Use existing telehealth videoconferencing systems to provide Prenatal Care Education, Infant Care Education, Smoking Cessation Programs, Coronary Heart Disease prevention, Breast Cancer prevention/education, and suicide prevention programs at the 3 rural end-site communities. The programs are designed to help reduce county death rates for: (a) stroke to less than 55 deaths/1,000; (b) lung and colon cancer to less than 59 deaths/1,000; and (c) suicides to a rate of less than 10 deaths/1,000 in the three target communities.

**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

# MICHIGAN

## *Eastern Huron Ambulance Service*

Grant Number: D04RH12668

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### **PROGRAM DIRECTOR**

Leslie Hall  
Network Director  
P.O. Box 265  
Caro, MI 48723  
Phone: (989) 284-5345  
Fax: (989) 672-4973  
E-mail: lesliann.hall@yahoo.com

### **TOPIC AREAS**

EMS

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Bingham Ambulance Service, Central Huron Ambulance Service, Croswell EMS, East Huron Ambulance Service, Elkton EMS, Marlette EMS, Sanilac EMS, Scheurer EMS, and Sebawaing Ambulance Service

### **AREAS SERVED**

Huron and Sanilac Counties

### **TARGET POPULATION SERVED**

Senior citizen and low income populations

### **PROJECT SUMMARY**

“Seventy-two percent of trauma deaths in a rural county occurred at the scene proving the critical nature of the first hour following the actual incident.” (Rural Healthy People 2010). Winter road conditions, large geographic regions, remote wooded and agricultural areas, all cause delays for EMS professionals to reach the emergency scene for residents in Huron and Sanilac Counties, Michigan. In response to this critical need, the nine EMS services in the region, as members of the Huron-Sanilac EMS Network, developed the First on Scene community education and outreach program. First on Scene was developed to ensure that having a prepared and trained person “First on Scene” becomes the norm, NOT the exception. The project builds on successful recruitment and retention programs funded by two grants from the Office of Rural Health Policy from 2005-2009. First on Scene expands existing services through four new components. The new and enhanced programs target the general population, vulnerable populations, and EMS professionals:

1. Community Education and Training: In rural areas it is common for a neighbor, employee, or family member to be the only person at an emergency scene for an average of 15 minutes. This time can extend to an hour or longer depending on road conditions and the remoteness of the area. Model programs that specifically address agriculture and wilderness related incidents will be

# MICHIGAN

## *Eastern Huron Ambulance Service*

**Grant Number: D04RH12668**

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utilized to teach residents basic first aid. Presentations, distribution of materials, and educational events will also educate children, special needs families, and the elderly about steps they can take to prepare for emergencies. The project will also utilize the File of Life and Special Needs Identification programs.

2. **Cardiovascular Health Screenings and Education:** In a survey of residents in the region, as few as 54% recognized the five major symptoms of a heart attack or stroke. Only 84% indicated that calling 911 would be their first step if they believed someone was having a heart attack or stroke. Early recognition of a heart attack or stroke is critical to saving lives and decreasing the damage from a heart attack or stroke. First on Scene will provide education on the warning signs, cardiovascular health screenings, and CPR training.
3. **Advanced EMS Professional Education:** Due to low call volumes and the infrequent occurrence of many conditions, advanced training is extremely important to rural providers. First on Scene will provide advanced training for EMS professionals and hospital staff that address the unique needs of special populations and conditions.
4. **Increasing Coordination of the Trauma Care System:** Operating under a largely volunteer, part-time, and on-call system increases the likelihood of fragmented emergency care in rural areas. This project will decrease fragmentation by developing a core training program, providing EMS operations training, developing mutual aid agreements, building relationships between EMS professionals and hospital staff, and updating EMS supplies.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MICHIGAN

## *Thumb Rural Health Network*

Grant Number: D04RH12759

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### **PROGRAM DIRECTOR**

Lonnie J. Stevens  
210 South First Street  
Harbor Beach, MI 48441  
Phone: (810) 987-3622  
E-mail: trhnstevens@sbcglobal.net

### **TOPIC AREAS**

Health screening and dental services

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Michigan Communities Dental Clinics, Michigan Department of Corrections, Michigan Representative Terry Brown, 84th District, and Michigan Senator Jim Barcia, District 31

### **AREAS SERVED**

Huron, Sanilac, and Tuscola Counties, Michigan

### **TARGET POPULATION SERVED**

Includes low income, uninsured residents

### **PROJECT SUMMARY**

In August 2007 the Thumb Rural Health Network (TRHN), a 13 member network of hospitals and health departments, met to discuss how to increase access to care for the uninsured. TRHN is located in the rural counties of Huron, Sanilac, and Tuscola - an area commonly referred to as the “Thumb” of the mitten shaped state of Michigan. Seeing no clear end to the steady decline of the economy, providers recognized a growing and urgent need.

While nearly 1 in 8 Americans live at or below poverty, almost 1 in 3 people in Michigan are living at or below the national level. The Thumb suffers from higher than state average unemployment rates and has few services to meet the needs of the target population. There are NO free clinics in the service area, NO dentists accepting adult Medicaid, and NO Federally Qualified Health Clinics. The area also has numerous provider shortage designations. In addition, healthcare providers located in the Thumb are struggling to keep their doors open. Seven of the eight local hospitals are Critical Access Hospitals and there are no tertiary providers in the region. Public health departments have suffered from local and state funding cuts due to Michigan’s 8-year depression. Additionally, the State of Michigan’s County Health Plan for the low income, uninsured could not be expanded to include the region due to lack of state funds.

Despite the economic barriers, TRHN members pressed forward to research and explore options for improving access to care for the uninsured. The result was a pilot project to address primary care issues



## MICHIGAN

### *Thumb Rural Health Network*

Grant Number: D04RH12759

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utilizing a medical home concept- Partnering for Health. The Partnering for Health program is an innovative approach to providing a healthcare safety net for low income and uninsured adults and children who do not meet other public assistance guidelines-often the working poor. The project is unique in that it provides access to care and improves patient outcomes through a coordinated process. This process maximizes the use of existing services, is integrated with the existing healthcare system, is comprehensive in nature, incorporates expectations and support for personal accountability, reduces stigma associated with “charity care”, and increases efficiency of providing charity care. The project was piloted in April 2008 on a small scale to test the concept. The success of the program for both participants and providers prompted TRHN to develop an expanded and enhanced service plan for which they are seeking federal Rural Healthcare Outreach grant funds. The new service plan has four program components: 1) primary care centered around the medical home concept and expanded to include testing services, 2) two free/low cost dental clinics, 3) a free/low cost eye glass and exam program, and 4) health promotion and screening services. The *long-range goal* of the project is to help individuals of all ages increase life expectancy and improve their quality of life regardless of ability to pay. The shorter term *project goal* is to increase access to primary care, dental care, and vision care for low income, uninsured residents of the Thumb.

#### **ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MICHIGAN

## *Marquette General Hospital*

Grant Number: D04RH12758

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### **PROGRAM DIRECTOR**

Rose Young  
420 West Magnetic Street  
Marquette, MI 49855  
Phone: (906) 225-4733  
Fax: (906) 225-7696  
E-mail: ryoung@mgh.org

### **TOPIC AREAS**

Telehealth, Continuing Health Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Marquette General Hospital, Borgess Health Southwest Michigan TeleHealth Network, University of Kansas Medical Center, Indiana University School of Medicine

### **AREAS SERVED**

The States of Michigan, Kansas, and Indiana

### **TARGET POPULATION SERVED**

Health professionals in Kansas, Indiana and Michigan who seek continuing education units

### **PROJECT SUMMARY**

A federally designated telehealth resource center, four professional education provider organizations, and a technology organization are melding their expertise to enhance access to continuing education programming for rural health providers. Partners acknowledge the impact that professional education has on the quality of health care and the challenges rural providers experience in obtaining qualified education.

The *Midwest Alliance for Health Education* was initiated with a one year ORHP Network Development Planning Grant (2008). This proposal represents the next steps in providing services to rural health providers and moving the Alliance toward service functionality. It addresses the problem of limited access to qualified education that is experienced by rural health professionals and by personnel who are responsible for staff development within their organizations. Alliance membership is all-inclusive and is open to individuals, organizations, health care networks, and Alliance sponsors.

The populations to be served are health professionals in Kansas, Indiana and Michigan who seek continuing education credits (CEU) for relicensure or recertification (estimated number = 470,000). Baseline surveys on access to programming and utilization of technology were conducted in 2008. Resurveys during years two and three of the grant project will provide strong outcome measurements.

# MICHIGAN

## *Marquette General Hospital*

**Grant Number: D04RH12758**

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While rural professionals within the three states are the focus of this project, most resources and services will be available on a national basis via the Internet.

Services are based within a robust web site that provides a searchable database of educational opportunities; program matching where professionals are informed of opportunities based on license requirements and interest; a data repository for credit tracking; an inventory of license and credential requirements; a dashboard to track return on investment for organizational members; and a home base for web-enabled education. The Alliance will broker programming from current content providers and develop programming where needs are identified.

Benefits for the target audience will be the increased access to qualified continuing education. Benefits for organizations will be enhanced efficiencies. Benefits for the communities will be retention of health professionals and quality health care.

This project requests funding preference 1 as Marquette General Hospital (applicant) is located in, and serves, officially designated health professional shortage areas and medically underserved communities. The web site (<http://bhpr.hrsa.gov/shortage/index.htm>) shows Marquette County to hold partial designation for all types of HPSAs and partial designation for MUA/MUP. As a tristate project, this application includes HPSAs, MUCs, and MUPs in all three states.

### **ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

**MICHIGAN**  
***Sterling Area Health Center***  
**Grant Number: D04RH12666**

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**PROGRAM DIRECTOR**

Roger Rushlow  
CEO  
725 E. State Street  
Sterling, MI 48659  
Phone: (989) 654-2491  
Fax: (989) 654-2348  
E-mail: rrushlow@sterlinghealth.net

**TOPIC AREAS**

Recruitment and retention of health providers

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,600
- Year 2 – 122,680
- Year 3 – 92,760

**PARTNERS TO THE PROJECT**

Alcona Citizen's for Health, Sterling Area Health Center, and St. Joseph Health System

**AREAS SERVED**

Northeast Michigan including the counties of Alcona, Arenac, Iosco, Ogemaw, and Oscoda.

**TARGET POPULATION SERVED**

Residents over age 55 who suffers from chronic disease.

**PROJECT SUMMARY**

The Northern Michigan Recruitment Network (NMRN) will increase access to primary care services to the underserved and uninsured and underinsured residents of Alcona, Arenac, Iosco, Ogemaw, and Oscoda counties in the Northeast Area of Michigan's Lower Peninsula through an innovative, collaborative approach to provider recruitment and retention services. This goal directly supports the first goal articulated by both Healthy People 2010 and Rural Healthy People 2010, recruiting and retaining qualified personnel as a prerequisite to quality health care services.

The three organizations that form the integrated rural health network are:

- Alcona Citizen's for Health, a Federally Qualified Health Center that provides comprehensive primary care services in Alcona, Alpena and Iosco counties;
- Sterling Area Health Center, a Federally Qualified Health Center, that provides comprehensive primary care services in Arenac and Ogemaw Counties; and
- St. Joseph Health System, a regional hospital that serves the five-county proposed service area with a hospital in Tawas City and Rural Health Clinics in Arenac, Iosco and Oscoda Counties.

# MICHIGAN

## *Sterling Area Health Center*

**Grant Number: D04RH12666**

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The network service area has an estimated population of 87,117 and extremely high rates of poverty. The area covers a region of 2,700 square miles with an average population density of 32.2 persons per square mile. Isolation in combination with a lack of transportation resources, compounded by poverty and harsh climatic conditions creates a challenging situation for residents to access healthcare.

The service area is economically disadvantaged. Seventy-two percent (72%) of the service area's population is medically disenfranchised. Over Thirty Seven percent (37.5 %) of the population lives below 200% of Federal Poverty Level (FPL). The area median income for the service area is \$29,764, well below the median household income of \$44,221 in Michigan and \$41,994 in the United States. The service area has a high proportion of residents over age 55 who suffers from chronic disease. The population of residents over age 55 in the service area is 41.4%, much higher than that of Michigan and the U.S at 22% each.

The goals of the Northeast Michigan Recruitment and Retention network are 1) to expand access to primary care services for the communities in the identified underserved areas 2) to develop support services that assist in the retention of existing health care service providers 3) to form partnerships with educational institutions and 4) to recruit additional partners and expand the network service area.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

**MINNESOTA**  
***County of Koochiching***  
**Grant Number: D04RH12756**

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**PROGRAM DIRECTOR**

Ric Schaefer  
Project Director/Arrowhead Health Alliance Director  
Koochiching County Community Services  
1000 5th Street  
International Falls, MN 56649  
Phone: (218) 724-3312  
Fax: (866) 822-2598  
E-mail: ricschaefer.sc@gmail.com

**TOPIC AREAS**

Home Visits, Child Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Carlton, Cook, Koochiching and Lake Counties

**AREAS SERVED**

Carlton, Cook, Koochiching and Lake Counties

**TARGET POPULATION SERVED**

Pregnant women and children from birth to age five.

**PROJECT SUMMARY**

The proposed project will improve health outcomes for women, infants and children in a very rural, remote and underserved region of northeastern Minnesota by: 1) expanding access to home visiting services by public health nurses; 2) improving outreach to at-risk populations; and 3) strengthening local multi-disciplinary consortiums of service providers in each county.

Project activities will focus on serving families at high risk for poor parenting outcomes, including teen parents, low income pregnant women, families involved with child protection services, children with developmental delays, parents at risk for child maltreatment, pregnant women with a history of chemical dependency and parents with mental health issues. Unmet health care needs of the target population have been identified using multiple methods (surveys, analysis of state and local data, local interviews). Data suggests that pregnant women and those with infants/young children in the four county service area are likely to be poorer, more isolated/rural than others in the state, less likely to be employed, more likely to smoke, more likely to be Native American, less likely to have prenatal care in the first trimester, more likely to be on medical assistance, more likely to have postpartum depression and more likely to encounter barriers to accessing health care and community based services than others in the state.

# MINNESOTA

## *County of Koochiching*

**Grant Number: D04RH12756**

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Project consortium partners include human service and/or public health agencies from Carlton, Cook, Koochiching and Lake Counties. These agencies have created the Arrowhead Health Alliance, a formal partnership governed by a joint powers board, to improve the availability and sustainability of local services, enhance prevention strategies and promote coordination and integration among providers. Project activities will include developing and implementing home visiting programs in Cook, Koochiching and Lake counties, based upon an effective service delivery model developed by Carlton County. Program elements will include prenatal and universal postpartum home visits, screenings and assessment for various risk factors including postpartum depression, and enrollment of infants and young children in the Follow Along program to identify children in need of further evaluation. Local multi-disciplinary consortiums of providers will be convened monthly to develop an effective referral system between health care providers and public health, better coordinate services to local families and improve service delivery. An additional element of this project will focus on developing innovative methods to publicize and promote home visiting services in the four county area through the development of web-based/electronic marketing methods and offering incentives for participation. Free pregnancy tests will also be offered to encourage prenatal home visits and enrollment in the Health Promise Incentive Program.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# MINNESOTA

## *The Evergreen House*

Grant Number: D04RH07924

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### **PROGRAM DIRECTOR**

Gary Russell  
Evergreen House, Inc.  
622 Mississippi Avenue  
P.O. Box 662  
Bemidji, MN  
Phone: (218) 751-4332  
Fax: (218) 751-8070  
E-mail: gary@evergreenhouse.org

### **TOPIC AREAS**

Maternal/Child Health

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

### **PARTNERS TO THE PROJECT**

Partnership with Red Lake Children and Family Services, the Cass Lake Family Center, and Community Resource Connections, Inc.

### **AREAS SERVED**

Medically underserved populations in Northern Minnesota.

### **TARGET POPULATION SERVED**

To initiate a collaboration to provide the only early crisis intervention family support services available to American Indian youth and families within a 2-county area in rural, northern Minnesota.

### **PROJECT SUMMARY**

Evergreen House requests a federal Rural Health Outreach Grant from HRSA in the amount of \$375,000 over three years (May 2007 through April 2010) to initiate a collaboration to provide the only early crisis intervention family support services available to American Indian youth and families within a 2-county area in (serving the Leech Lake Tribe) for two days each week, and allow one day per week in Bemidji at the Evergreen Shelter for service coordination, team meetings, and supervision. Early Intervention Family Support Services would provide approximately 60 families annually with counseling services to: encourage early identification and assessment of mental health issues for youth and/or parents, promote dental health care and annual physicals for youth referred for a residential stay at the Evergreen Shelter.

The project will serve a poverty-level and low-income Native American population – both adolescents and their families - who have behavioral and mental health issues that affect their health and safety. The majority of clients have no outside health insurance and rely primarily upon Indian Health Service hospitals and clinics. Native youth and families served will be those living on the Leech Lake and Red Lake Reservations in northern Minnesota (both are federally-recognized tribes) as well as Native



# MINNESOTA

## *The Evergreen House*

**Grant Number: D04RH07924**

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Americans living in Bemidji. Both reservations are designated Medically Underserved Areas and their populations are designated Medically Underserved Populations. The two reservations are also designated Health Professional Shortage Areas.

The program's objectives are: 1) to stabilize crisis situations for youth and families served; 2) to improve access to formal mental health treatment services and diagnostic assessments; 3) to improve access to chemical health assessments that can result in treatment services; 4) to improve family relationships and family communication for youth and families receiving counseling; and 5) to increase youth and family use of other health care services and community resources.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# MINNESOTA

## *Mississippi Headwaters Area Dental Health Center*

Grant Number: D04RH12735

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### **PROGRAM DIRECTOR**

Jeanne Edevold Larson  
Executive Director  
P.O. Box 279  
Bemidji, MN 56619  
Phone: (218) 444-3984  
Fax: (218) 444-6318  
E-mail: jedevoid@paulbunyan.net

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,000
- Year 2 – 124,300
- Year 3 – 97,000

### **PARTNERS TO THE PROJECT**

Mississippi Headwaters Area Dental Health Center (MHADHC); Community Resource Connections (CRC); Beltrami County Health and Human Services (BCHHS)

### **AREAS SERVED**

Northwest MN Counties: Beltrami, Clearwater, Hubbard, Cass, Koochiching, Itasca, Mahnommen, Lake of the Woods

### **TARGET POPULATION SERVED**

Income people who are eligible for subsidized care programs

### **PROJECT SUMMARY**

This grant award would leverage more than \$500,000 of local investment into the creation of a community access dental clinic for low income residents of north central MN. Grant funds will augment this new access with patient support and outreach to assure patient success. Through a consortium of three providers, along with long term collaboration among the dozens of agencies and individuals who are committed to this project—we will serve more than 5,000 people per year with dental care, who now are forced to travel long distances to receive care—and we will support them by addressing barriers to access and barriers to patient success.

**Need:** This entire rural region of northern Minnesota is a Dental Health Professional Shortage Area. Grant funds will be used to provide patient outreach and support services that will increase patient success at a new community dental clinic, thereby improving public health indicators. Currently, thousands of people in the target population are turned away because dentists have exceeded their ability to provide care for lower reimbursement rates. Families are forced to drive hundreds of miles to find care and many simply go without.

# MINNESOTA

## *Mississippi Headwaters Area Dental Health Center*

**Grant Number: D04RH12735**

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**Proposed Services:** A Patient Support Center within the new dental access clinic will provide:

- A Treatment Coordinator will advise patients of their recommended treatment plan and work with them to address barriers to success
- insurance counseling to assist patients in Medical Assistance and other subsidized care program enrollment issues;
- information and referrals to help families access social and private services that are available in the community to help them achieve their health and self sufficiency goals;
- on-site child and teen checkups;
- child care for patients with young children; and
- assistance in finding transportation and addressing communication barriers

**Target Population:** This project will serve low income people who are eligible for subsidized care programs and who live within several northern Minnesota counties, roughly within a one hundred mile radius of Bemidji and centrally located near three American Indian Reservations.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MINNESOTA

## *North Country Hospital*

Grant Number: D04RH16369

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### **PROGRAM DIRECTOR**

Robert Rutka, M.D.  
1300 Anne Street NW  
Bemidji, MN 56601-5103  
Phone: (218) 333-6422  
Fax: (218) 333-5880  
E-mail: rrutka@nchs.com

### **TOPIC AREAS**

Provider Coordination

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Cass Lake Hospital and Red Lake Hospital

### **AREAS SERVED**

Beltrami or Cass counties in Minnesota

### **TARGET POPULATION SERVED**

Small community hospitals and public health programs

### **PROJECT SUMMARY**

People being treated in small community hospitals and public health programs in north central Minnesota have difficulty accessing secondary healthcare, most typically for cardiovascular issues, chronic diseases, and diabetes, at the larger regional hospital serving the area. When they do succeed in receiving treatment at the regional hospital and then return to their communities, it is not unusual that within a week they are readmitted for the same condition.

The most common access point to the regional hospital for patients being treated in these smaller community facilities and programs and who have been referred to the regional hospital for higher levels of care is currently through the Emergency Department. Excessively long wait times in the Emergency Department can discourage patients from making the trip and accessing the care they need. When they do make the trip and get through the Emergency Department and are admitted for care in the regional hospital, treatment is often delayed and/or duplicated due to poor communication and ineffectual transfer of information and records between organizations. Then, after patients receive care at the regional hospital and return to their communities, the same breakdown occurs. Communication and transfer of information and records does not occur back to the local hospitals and public health programs that are prepared to help these patients follow their discharge plans. Premature re-hospitalization is often the result.

# MINNESOTA

## *North Country Hospital*

**Grant Number: D04RH16369**

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Therefore, North Country Regional Hospital in Bemidji, Minnesota, Cass Lake Hospital 20 miles to the east, and Red Lake Hospital 30 miles to the north, have formed a consortium to create a *Multi-Facility Care Coordination Program*. The two goals of this program are to:

- (1) Improve access to comprehensive, high-quality secondary healthcare services at North Country Regional Hospital, and
- (2) Reduce by 30% readmissions for the same condition within seven days to any hospital.

Our overall strategy for achieving both of these goals is to focus on improving coordination, communication, and understanding between North Country Regional Hospital, Cass Lake Hospital, and Red Lake Hospital. To achieve goal #1 and improve access to healthcare, we will implement a pre-care coordination process that reaches out and smoothes the way from the Cass Lake and Red Lake hospitals into North Country Regional Hospital. In addition, we will emphasize developing cultural competency of our staff members at all our consortium hospitals. To achieve goal #2 and reduce readmissions, we will implement a post-care coordination process to help patients return to their communities and be successful with their discharge plans.

Funding preference is requested as a Medically Underserved Community (MUC). All members of the consortium are located in and all services will be provided in either Beltrami or Cass counties in Minnesota, both of which are designated as medically underserved areas. Both Cass Lake PHSIHS Hospital and Red Lake PHSIHS Hospital.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# MINNESOTA

## *Rice Memorial Hospital*

Grant Number: D04RH12737

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### **PROGRAM DIRECTOR**

Dale Hustedt  
301 Becker Avenue, SW  
Willmar, MN 56201  
Phone: (320) 231-4226  
Fax: (320) 231-4869  
E-mail: dhus@rice.willmar.mn.us

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Rice Memorial Hospital, University of Minnesota School of Dentistry, and Southern Minnesota Area Health Education Center

### **AREAS SERVED**

Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Pipestone, Pope, Redwood, Renville, Stevens, Swift, Traverse, and Yellow Medicine

### **TARGET POPULATION SERVED**

Children face significant oral health care

### **PROJECT SUMMARY**

At a national level, oral health has been recognized by the Surgeon General's Report on Oral Health as a significant health care concern. Oral health for children is of particular concern, as dental caries are the most common chronic disease suffered by children. And while advances in dentistry have significantly benefitted some children, significant disparities remain. Rural children face significant oral health care disparities. Four factors contribute to this disparity: 1) low income and lack of dental insurance; 2) special needs status; 3) race and ethnicity, and 4) a shortage of qualified dental providers.

The goal of the Pediatric Dentistry Residency Project at the Rice Regional Dental Clinic is to increase access to dental care for underserved children in the 17-county service area of West Central and Southwest Minnesota. Activities to support this goal include: 1) providing dental care for underserved children in the service area; 2) promoting better oral health among people in the area through education and public service; 3) increasing the number of Pediatric Dentists choosing to practice in the service area; 4) providing opportunities for interprofessional education; and 5) continuing to develop and strengthen Dental Clinic infrastructure.

# MINNESOTA

## *Rice Memorial Hospital*

**Grant Number: D04RH12737**

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The proposed Pediatric Dentistry Residency Project will significantly expand services at the Dental Clinic, which currently lacks both the capacity and the specialty expertise to adequately serve children who have complex oral health needs. In this project, two Pediatric Residents will each complete rotations of 4 days per month (for a total of 8 days per month) at the Dental Clinic, providing an estimated 768 *new* pediatric patient visits annually. New patients will include children who are low income or lack dental insurance, children with special health care needs, and children from minority ethnic and racial groups.

The proposed project's primary service area includes 17 counties in West Central and Southwest Minnesota--Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Pipestone, Pope, Redwood, Renville, Stevens, Swift, Traverse, and Yellow Medicine. Twelve of the 17 counties are federally designated Dental Health Professional Shortage Areas

Lead applicant Rice Memorial Hospital is the largest city-owned hospital in Minnesota and has a history of commitment to outreach services. Other consortium members include the University of Minnesota School of Dentistry, which will provide the Pediatric Dental Residents, Southern Minnesota Area Health Education Center, which will provide support to Residents and coordinate their community education activities, and Kandiyohi County Public Health and Countryside Public Health, agencies that will provide the critical link to the target population.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# MISSOURI

## *Southeast Missouri State University*

Grant Number: D04RH07917

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### **PROGRAM DIRECTOR**

Sandy Ortiz  
Southeast Missouri State University  
One University Plaza, MS 1900  
Cape Girardeau, MO  
Phone: (573) 651-5980  
Fax: (673) 651-5981  
E-mail: sjortiz@semo.edu

### **TOPIC AREAS**

Mobile (Oral, HL)

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

### **PARTNERS TO THE PROJECT**

Southeast Missouri State University, Campbell Housing Authority, Delta Area Economic Opportunity Corporation (DAEOC), Oasis Center, and Trinity Community Church

### **AREAS SERVED**

The four southernmost counties located in the Missouri Bootheel, a rural, economically depressed area with critical health care needs represented by a range of health disparities.

### **TARGET POPULATION SERVED**

Dunklin, Mississippi, New Madrid and Pemiscot counties) have been well documented.

### **PROJECT SUMMARY**

The Southeast Health On Wheels (S.H.O.W.) Mobile Project is a mobile health literacy, health promotion, disease prevention, direct primary care program. The program is designed to serve the four southernmost counties located in the Missouri Bootheel, a rural, economically depressed area with critical health care needs represented by a range of health disparities. The program is administered by the College of Health and Human Services of Southeast Missouri State University. The success of this program is significantly enhanced by the active collaboration and partnership with area organizations and agencies, including a specific consortium of local grassroots organizations, faith-based groups and care providers.

The needs of the target population (Dunklin, Mississippi, New Madrid and Pemiscot counties) have been well documented. The residents of the target counties experience significantly higher rates of teen pregnancy, inadequate prenatal care, infant death rates, asthma hospitalization rates, diabetes hospitalization rates, cardiovascular disease deaths, and deaths attributed to smoking when compared to state-wide data. Additionally, residents of the target counties experience more frequent emergency room visits for chronic illness when compared to the state rates. The four target counties have also been identified as having “significantly higher” age-adjusted death rates for all causes.



# MISSOURI

## *Southeast Missouri State University*

**Grant Number: D04RH07917**

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Services provided by the S.H.O.W. Mobile include, but are not limited to, health literacy programs and activities (monthly national themes will be addressed as well as interventions relevant to individuals/groups as requested indicated), health promotion interventions (physical examinations and dental sealants/fluoride), disease prevention activities (vision, hearing, depression, cholesterol, blood pressure, nutrition, diabetes, and dental screenings), and the provision of primary care (diagnosis of acute episodic illness as well as diagnosis and management of chronic conditions). Telehealth services will provide residents of the target population the opportunity for sub-specialist care. The programs and services of the S.H.O.W.

Mobile will be available to all residents of the target counties, realizing that many residents are uninsured, underinsured, or face significant access to care barriers. A well documented and recurring theme identified as a barrier to care has been transportation. The mobile nature of this project serves to address this barrier.

The target population of the S.H.O.W. Mobile resides in the four southern most counties of the Missouri Bootheel: Dunklin, Mississippi, New Madrid, and Pemiscot. The residents of these counties experience higher than average poverty and unemployment rates, are geographically isolated, and have limited opportunities for educational attainment and economic stability. All of the target counties have been identified as either geographic or low income Primary Care Health Professional Shortage Areas (HPSA) as well as Medically Underserved Areas (MUA) and/or Medically Underserved Populations (MUP).

The amount of funding being requested for this project is \$150,000 in Year One (\$375,000 over three years).

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# MISSOURI

## *Saint Francis Medical Center*

Grant Number: D04RH12699

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### **PROGRAM DIRECTOR**

Kelly HeiRonimus  
211 Saint Francis Drive  
Cape Girardeau, MO 63703  
Phone: (573) 331-5794  
E-mail: kheironimus@sfmc.net

### **TOPIC AREAS**

Health Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 145,816
- Year 2 – 123,124
- Year 3 – 95,875

### **PARTNERS TO THE PROJECT**

Saint Francis Medical Center, Scott County Health Department, New Madrid County Health Department, Dunklin County Health Department, Pemiscot County Health Department, and Southeast Missouri State University

### **AREAS SERVED**

Cape Girardeau County, Dunklin County, New Madrid County, Pemiscot County, and Scott County, Missouri

### **TARGET POPULATION SERVED**

Adults ages 25 and older who have a history of tobacco use, exposure to secondhand smoke or other carcinogenic agents.

### **PROJECT SUMMARY**

Saint Francis Medical Center will join in partnership with four county health departments and Southeast Missouri State University (SEMO) to implement the Southeast Missouri Lung Cancer Outreach Project. The proposed project will provide lung health awareness education in five counties in Southeast Missouri (Cape Girardeau, Dunklin, New Madrid, Pemiscot, and Scott Counties), and lung cancer screenings to this population using spirometry (Forced Vital Capacity) testing and PET CT scans in order to promote early detection of lung cancer. SEMO faculty will provide external evaluation of the project.

Missouri is among the top five states, including Alabama, Kentucky, Mississippi, and Tennessee, with the highest mortality rates from lung and bronchus cancer (63.5 per 100,000). The greatest concentrations of lung cancer incidence and deaths in the state are found in Southeast Missouri. Smoking rates in Southeast Missouri closely correlate with lung cancer mortality in the same region. The average adult smoking rate in the five participating counties is 32.5%, more than nine percent higher than the rest of the state and 11.6% higher than the U.S. rate. Clearly, any strategy to reduce lung cancer deaths in Missouri must target early detection efforts in the southeast region of the state.

# MISSOURI

## *Saint Francis Medical Center*

**Grant Number: D04RH12699**

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The project will develop a lung health awareness program in conjunction with four local health departments. The program will provide lung health education materials and information to the public during health fairs, community events, and other venues. The program will also provide spirometry FVC (forced vital capacity) testing as an early detection screening for lung cancer to adults in the service area through community-based screening clinics. Clinic participants found to have abnormal FVC results will be referred for a PET CT scan to rule out or confirm a diagnosis of lung cancer. Participants who receive a diagnosis of lung cancer via CT will be referred to a local oncologist and to a cancer patient navigator to ensure access to timely and coordinated lung cancer treatment.

The target population for this program will be adults ages 25 and older who live in the rural counties of Cape Girardeau, New Madrid, Scott, Dunklin and Pemiscot in Southeast Missouri and who have a history of tobacco use, exposure to secondhand smoke or other carcinogenic agents.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# MISSOURI

## *Regional Health Care Clinic, Inc.*

Grant Number: D04RH12701

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### **PROGRAM DIRECTOR**

Christine Stewart  
821 Westwood  
Sedalia, MO 65301  
Phone: (660) 826-1751  
E-mail: cstewart@rhcc-pettis.com

### **TOPIC AREAS**

Telehealth Healthcare Delivery

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Katy Trail Community Health, Pathways Community Behavioral Health, and Care Connections

### **AREAS SERVED**

Warsaw, Benton County, Missouri

### **TARGET POPULATION SERVED**

Adults, with an emphasis on older adults (65+).

### **PROJECT SUMMARY**

The Harbor Village Consortium was organized in response to results of detailed community assessments and planning that demonstrated an evident need for integration of primary and behavioral health services. Because Benton County has the second highest aging population age 65 and older in Missouri (30 percent) and the median age for residents is 45.6 compared to 37.4 for Missouri, the primary target population is adults, with an emphasis on older adults (65+).

Elderly persons with mental health problems are more likely to seek help in primary care facilities than in mental health settings. They are also more likely to have physical co-morbidities, compared with younger patients. The primary care physician plays a pivotal role as the first health care contact for an aged population and needs to work closely with a mental health provider to achieve positive health outcomes. As a result, the proposed goal and objectives of the Harbor Village Consortium are focused primarily on integrating primary care and mental health services through a coordinated and integrated network of care. Each of the five objectives and corresponding strategies will help the Harbor Village Consortium achieve its goal of a coordinated and integrated network of care that is person/family-centered and addresses the bi-psychosocial needs of individuals across the lifespan, with a particular focus on the aging.

The priorities identified in the needs assessment related to chronic disease, mental health and suicide prevention. Therefore, the programs are focused on health and wellness and collaboration between

# MISSOURI

## *Regional Health Care Clinic, Inc.*

**Grant Number: D04RH12701**

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primary care and behavioral health providers to impact chronic disease and depression. Services to be provided include primary care, preventive health and wellness services, and mental health services through a single entry point and co-location of providers.

**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

**MISSISSIPPI**  
***Magee General Hospital***  
**Grant Number: D04RH12746**

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**PROGRAM DIRECTOR**

Eddie Mahaffey  
300 Third Avenue, SE  
Magee, MS 39111  
Phone: (601) 849-7310  
E-mail: emahaffey@mghosp.org

**TOPIC AREAS**

Cancer

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Magee General Hospital, HealthTrust and Magee Medical & Surgical Clinic

**AREAS SERVED**

Simpson County

**TARGET POPULATION SERVED**

Uninsured women aged 35-49 years at highest risk; uninsured, medically underserved, poor and minority

**PROJECT SUMMARY**

The Magee General Hospital (MGH) a non-profit hospital is applying to The Department of Health & Human Services' Rural Healthcare Services Outreach Grant to implement a breast cancer education and screening program for minority, uninsured women aged 35-49 years in and around Simpson County. The grant calls for a collaborative between three independent entities. The three entities are Magee General Hospital, HealthTrust and Magee Medical & Surgical Clinic. Collectively, the three entities have partnered to form The Magee General Hospital Breast Cancer Awareness Initiative. The grant is a three-year funding opportunity beginning May 1, 2009 and ending April 30, 2012 for a total of \$375,000.

Each of the three consortium members will commit to specific roles and responsibilities as follows. Magee General Hospital, applicant and lead consortium member will provide facilities to conduct mammography services; provide staff to conduct mammography; coordinate and order materials and equipment needed for grant activities. HealthTrust, second consortium member will commit to generate new income for this project via grant solicitation; work to develop new partnerships; organize and facilitate quarterly consortium meetings and attend conferences, events, and functions related to Breast Cancer Awareness to maintain "Best Practices" standards. Magee Medical & Surgical Clinic will commit facility-appropriate surgical procedures based on grant funds provided to support the related costs; provide surgical procedures to program participants as needed based on grant funds provided to support the related costs; participate in patient referral program; participate in quarterly consortium meetings, and pre-screening of potential clients.

# MISSISSIPPI

## *Magee General Hospital*

**Grant Number: D04RH12746**

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Our target market was established based on the needs of the women at highest risk; uninsured, medically underserved, poor and minority. The Breast Cancer Initiative will collectively work together to create a network to assist this population.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

**MISSISSIPPI**  
***Delta Health Alliance, Inc.***  
**Grant Number: D04RH12672**

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**PROGRAM DIRECTOR**

Dr. Karen C. Fox  
435 Stoneville Road  
P.O. Box 277  
Stoneville, MS 38776  
Phone: (662) 686-3520  
Fax: (662) 686-3522  
E-mail: kfox@deltahhealthalliance.org

**TOPIC AREAS**

Chronic Disease Management

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Mississippi Primary Health Care Association, Delta State University, and Center for Sustainable Health Outreach at the University of Southern Mississippi

**AREAS SERVED**

Mississippi counties of Bolivar, Carroll, Coahoma, Holmes, Humphreys, Leflore, Panola, Quitment, Sunflower, Tallahatchie, Tunica and Washington.

**TARGET POPULATION SERVED**

Ages 35+ with cardiovascular disease

**PROJECT SUMMARY**

Mississippi's mortality and morbidity rates from chronic illness are the poorest in the nation. In 2006, the state's cardiovascular disease (CVD) mortality rate was 83.5% higher than that of the United States at 403.7 per 100,000, compared to the U.S. rate of 220.0 per 100,000. One out of five Mississippians who die under the age of 65 each year die from CVD, more than from all types of cancer, traffic injuries, suicides, and AIDS combined. Diabetes mellitus was the seventh leading cause of death in Mississippi. The prevalence of diabetes among adult Mississippians has increased from 6.1% to over 10.2% from 1994 to 2004 across the state, reflecting a 67% increase, compared to 49% nationally over a similar period. Incidence of diabetes in the twelve counties targeted by this initiative was 11.5% as of 2006.<sup>1</sup>

Patients with chronic disease from our area have significant difficulty accessing appropriate services in a timely fashion due to a variety of barriers to care. Literacy rates and educational attainment are very low, creating gaps in understanding between physicians and patients. The Delta Community Health Worker (CHW) project focuses on improving our patients' health outcomes through enhanced chronic disease management provided by locally-recruited, trained community health workers stationed at three regional Community Health Centers and their seven satellite locations. These individuals, recruited directly from



# MISSISSIPPI

## *Delta Health Alliance, Inc.*

**Grant Number: D04RH12672**

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the communities to be served, will be trained to provide health information, screening assistance, and supportive services to patients with poorly managed chronic illness. Community Health Workers, also called patient navigators or *promotoras*, have been extremely effective in improving health outcomes for disadvantaged populations in some areas of the nation. This program seeks to replicate that model in a manner culturally appropriate to the Mississippi Delta.

The Delta Health Alliance (DHA) is a non-profit partnership of regional universities and healthcare clinics, united by a mission to improve health outcomes through the development of sustainable infrastructure, patient education, and new research. This project represents a new collaboration that incorporates one new partner (Delta State University, School of Social Work) as well as two existing partners (University of Southern Mississippi, Center for Sustainable Outreach and the Mississippi Primary Care Association) engaged in new activities.

### **ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

## MONTANA

### *Butte Silver Bow Primary Health Care Clinic, Inc. AKA Butte Community Health Center*

Grant Number: D04RH12663

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#### **PROGRAM DIRECTOR**

Michelle Miller  
445 Centennial Avenue  
Butte, MT 59701  
Phone: (406) 496-6013  
E-mail: mmiller@buttechc.com

#### **TOPIC AREAS**

Child Health

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Anaconda-Deer Lodge County Law Enforcement, Anaconda-Deer Lodge Public Health Department, Anaconda-Deer Lodge County Attorney's Office, Anaconda School District, and Department of Family Services (DFS).

#### **AREAS SERVED**

The counties are Beaverhead, Deer Lodge and Madison.

#### **TARGET POPULATION SERVED**

Primary health care services to low-income people.

#### **PROJECT SUMMARY**

The Butte Community Health Center (CHC) located in Butte, Montana is requesting \$375,000 from the Rural Health Care Services Outreach Grant Program to **expand** its Sexual Abuse Prevention Program (SAP) to three rural counties of Southwest Montana. The counties are Beaverhead, Deer Lodge and Madison. The Butte CHC is a private, non-profit organization that has been providing primary health care services to low-income people in Southwestern Montana for twenty-three years. The three counties proposed for expansion are designated rural counties and are eligible, therefore, for Rural Health Care Grants. Through a 2005 Rural Health Services Outreach Grant, the Butte CHC developed a highly respected Sexual Abuse Prevention Program (SAP) in Butte, Montana.

The proposed services support objectives of the Healthy People 2010 Initiative by improving access to comprehensive, high-quality health care services to rural areas and to low-income, uninsured people; by focusing on the special needs of children, particularly in the area of maltreatment; and by increasing quality, availability and effectiveness of educational and community-based programs to prevent disease and improve quality of life.

## MONTANA

### *Butte Silver Bow Primary Health Care Clinic, Inc. AKA Butte Community Health Center*

**Grant Number: D04RH12663**

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The need for SAP services in rural Southwestern Montana is urgent. Underlying the beauty of “Big Sky Country” is a harsh reality. Depression and suicide rates are among the highest in the country and methamphetamine is law enforcement’s greatest challenge. All these conditions set the stage for one of humankind’s most destructive crimes—sexual abuse of children. There are an estimated 1,000 children—one in four—in the Southwest corner of Montana who may need intervention and recovery services. Community groups that serve children are keenly aware of the need. In each community slated for satellite evaluation centers, a consortium of stakeholders has collaborated to plan for development of SAP services. Along with the Butte CHC, consortium members include county attorneys, law enforcement, Department of Family Services, public health departments, hospitals and school districts.

Expanded programs proposed here will focus on prevention, intervention and recovery for children from 0-17 who are at risk for or have been victims of sexual abuse. Prevention will be addressed through a school curriculum called “Talking about Touching”, a nationally recognized approach to helping children keep themselves safe. Intervention will be addressed by creating satellite Child Evaluation Centers in two communities in the region—one in Dillon, Montana to serve children in Beaverhead and Madison Counties and one in Anaconda, Montana to serve the children of Deer Lodge Counties. These centers will provide specialized interviews for child victims as well as forensic medical exams. In the centers, children will have a safe place to talk about and recovery from the terrible trauma of sexual abuse.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

**MONTANA**  
***Cooperative Health Center, Inc.***  
**Grant Number: D04RH16279**

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**PROGRAM DIRECTOR**

Kate A. McIvor  
1930 Ninth Avenue  
Helene, MT 59601  
Phone: (406) 457-8956  
FAX: (406) 457-8990  
E-mail: kmcivor@co.lewis-clark.mt.us

**TOPIC AREAS**

Diabetes, Mental Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Leo Pocha Urban Indian Clinic and St. Peter's Hospital

**AREAS SERVED**

Lewis and Clark County

**TARGET POPULATION SERVED**

Native American health

**PROJECT SUMMARY**

The Cooperative Health Center (CHC), located in Helena, Montana, has provided primary medical care to the target population residing in Lewis & Clark County since its inception as a Federally Qualified Health Center (FQHC) in 1994. The Health Center's parent organization, the Lewis & Clark City-County Health Department, has a history of providing public health services to county residents approaching 70 years.

The service area, Lewis and Clark County, is located in southwestern Montana and is the sixth most populous county in the state, with an estimated 59,302 residents. Helena, the county seat and state capital, has an estimated population of roughly 30,000 and is the largest community in the county. The service area is large, encompassing 3,461 square miles, and is rural with a population density of approximately 17 persons per square mile.

Research suggests that individuals with diabetes are twice as likely to suffer from depression as the general population. For the purposes of this grant application the Health Center, as the applicant, proposes the formation of a consortium including the Leo Pocha Urban Indian Clinic and St. Peter's Hospital. Broadly, the participating parties propose the creation of a joint diabetes registry and specifically, to screen individuals with diabetes for mental health disorders and provide integrated mental health services as the need is identified. The target population will include all patients currently served by the consortium

**MONTANA**  
***Cooperative Health Center, Inc.***

**Grant Number: D04RH16279**

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members with diabetes. The project will employ the use of the chronic care model in improving and expanding current primary care services and integrating mental health services into the delivery model as needed. The project will have a special focus on Native American health.

Fundamental to this project proposal is the belief of leadership and clinical staff in the inherent connection between the health of the mind and the health of the body. Experience at Cooperative Health Center in this field shows that 70% of all CHC patient seeking services from medical providers also have a mental health diagnosis. Over the years the organization has been successful in educating consumers that if one disorder is treated, but not the other, then people don't optimally progress toward good health. In sum this describes the goal of the project; to blend in a seamless fashion mental health services into primary health care for patients with diabetes.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# MONTANA

## *St. James Healthcare Foundation*

Grant Number: D04RH12657

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### **PROGRAM DIRECTOR**

Ida Reighard  
P.O. Box 3300  
Butte, MT 59702  
Phone: (406) 723-2960  
E-mail: ida.reighard@sjh-mt.org

### **TOPIC AREAS**

Diabetes

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,558
- Year 2 – 124,455
- Year 3 – 99,985

### **PARTNERS TO THE PROJECT**

St. James Healthcare, Dr. Pat McGree, private practice, Rocky Mountain Clinic, Express Care, North American Indian Alliance, Butte Community YMCA, and Montana Tech of University of Montana, Nursing Department

### **AREAS SERVED**

Butte, Silver Bow County, Montana

### **TARGET POPULATION SERVED**

At risk for or diagnosed with diabetes

### **PROJECT SUMMARY**

St. James Healthcare of Butte Montana located in Silver Bow County proposes The Butte Community Diabetes Network come together to address diabetes in the county and the surround area. According to the Centers for Disease Control and Prevention count level diabetes estimates, in 2005, 7% of Silver Bow County had diabetes, totaling 2,296 people. (CDC: [www.cdc.gov/diabetes/statistics/index](http://www.cdc.gov/diabetes/statistics/index). 6/6/08) In 2000, 23% of Montana deaths were a result of chronic illnesses. In 2006, the age-adjusted diabetes mortality rate for the state of Montana was 23/100,000. In Silver-Bow County, Montana, it was 45/100,000. This is the highest mortality rate in the state related to diabetes. This rate counts only the number deaths where diabetes was listed as the primary cause of death. (Montana death certificate data, which is maintained by the Office of Vital Statistics analyzed by MT DPHHS)

As the population continues to age in Silver Bow County and the healthcare costs and prevalence of diabetes increases, providers are seeing an amplified need for prevention, education, and care management services; cooperative efforts in addressing problems; and a consistent message throughout the community.

The need for a formal structure, which could develop a program to address the necessity for consistent care, diabetes education and prevention, and a network referral system was identified.

# MONTANA

## *St. James Healthcare Foundation*

**Grant Number: D04RH12657**

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Proposed Butte Community Diabetes Network partners include:

- St. James Healthcare
- Dr. Pat McGree, private practice
- Rocky Mountain Clinic, Express Care
- North American Indian Alliance
- Butte Community YMCA
- Montana Tech of University of Montana, Nursing Department

This Network proposes focusing on service to all those *at risk* for *or diagnosed* with diabetes in the county and secondarily the surrounding counties. Many health care providers in Butte are attempting to provide portions of service to diabetes patients, however they are each falling short of a comprehensive initiative, thus missing pieces of the proverbial puzzle.

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# MONTANA

## *Wheatland Memorial Healthcare*

**Grant Number: D04RH12659**

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### **PROGRAM DIRECTOR**

Scot Mitchell  
FACHE, CEO  
P.O. Box 287  
Harlowton, MT 59036  
Phone: (406) 632-4351  
Fax: (406) 632-3172  
E-mail: scot.mitchell@wheatlandmemorial.org

### **TOPIC AREAS**

Mental Health, Substance Abuse Prevention

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Harlowton Public Schools, South Central Montana Regional Community Mental Health Center (South Central Mental Health, Yellowstone Boys and Girls Ranch (YBGR), and Partners in Health Telemedicine Network (PHTN).

### **AREAS SERVED**

Wheatland, Golden Valley and Meagher Counties of Montana

### **TARGET POPULATION SERVED**

Youth of central Montana in grades 7-12 who is at high risk for mental health problems and substance abuse.

### **PROJECT SUMMARY**

We at Wheatland Memorial Healthcare (WMH) are applying to the Rural Health Care Services Outreach Grant Program to develop and implement a highly replicable service delivery model called “Community Resilience Outreach Program” (CROP) comprising mental health promotion, substance abuse prevention, and early identification, referrals, and treatment services for youth in grades 7-12. WMH is taking the lead in growing a healthy and resilient Harlowton community by serving as primary coordinator and provider of healthcare. Our long term purpose is to build and strengthen a resilient community, defined as one that promotes and embraces a sense of community, responds effectively and appropriately to its members’ needs, seeks to reduce geographic isolation through network and resource development both within and outside the community, and recognizes, develops, and celebrates existing community strengths and resources WMH is located in a frontier community in central Montana and has a strong track record of success. Our diabetes, hypertension, and depression programs, funded by the Rural Health Care Services Outreach Grant Program in 2006 continue to be very successful with excellent results in terms of measurable outcomes, participant satisfaction, and improved self-management behaviors. The replicable health care model we developed can be used in any frontier or rural community.



# MONTANA

## *Wheatland Memorial Healthcare*

**Grant Number: D04RH12659**

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For the past three years, we have worked closely with an advisory council and other community members who have now asked WMH to address the needs of our community youth (grades 7-12) who are at high risk for substance abuse, depression, and suicide. We have identified verified risk factors including geographic and social isolation, depressed economy, very poor access to mental health care, and a frontier 'bootstrap' mentality.

Within the three-year project timeline, we propose to deliver services designed to promote resilience by offering an innovative mental health promotion, substance abuse prevention, and early identification and treatment program for youth. Using a telehealth delivery system, and acting as the service hub, WMH will forge a regional collaboration between Harlowton Public Schools, and providers outside of our community: St. Vincent Healthcare Telemedicine, Yellowstone Boys and Girls Ranch, and South Central Mental Health. CROP's ground-breaking use of telehealth to deliver prevention education and counseling to frontier youth will effectively address Harlowton's geographic isolation by offering services that otherwise would not be available to frontier youth.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

**MONTANA**  
***Granite County Medical Center***  
**Grant Number: D04RH12661**

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**PROGRAM DIRECTOR**

Sharon Fillbach  
310 Sansome Street  
Philipsburg, MT 59858  
Phone: (406) 859-3271  
E-mail: sfillbach@gcmedcenter.org

**TOPIC AREAS**

Oral Health

**PROJECT PERIOD**

July 1, 2009 – June 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,066
- Year 2 – 123,904
- Year 3 – 98,395

**PARTNERS TO THE PROJECT**

Granite County Medical Center, Granite County Public Health (Michele Sare, LPHO), Dr. Lowe, DDS: Missoula, Philipsburg Public Schools, and Drummond Public Schools

**AREAS SERVED**

Granite County

**TARGET POPULATION SERVED**

Health behaviors in children and their families.

**PROJECT SUMMARY**

Eight years ago, a consortium of over 20 community agencies in Pike County, Alabama was formed to promote children's health initiatives. This community partnership resulted in two phases of health promotion and illness prevention programs in school children: Healthy Schools, Healthy Kids. Phase II added an intervention based on a national health program which emphasized proper nutrition and physical activity through educational curricula and through changing environmental conditions in the school. Assessment of children in both phases, revealed risks for future chronic conditions related to obesity. To continue the momentum started by the partnership, a more focused local model which emphasizes continuous wellness promotion in school children is being proposed and if found effective can be replicated in other rural areas both on the state and national level.

A registered nurse will serve as the manager of the wellness program and will coordinate educational activities and assessments, teach and support school staff endeavors, refer at-risk children to proper health care, and work with parents and community members. The nurse will also work to bridge the gaps between mandated wellness policy and the realities of implementation. The consortium members will support the program through man-power and resources. The model: Healthy Schools, Healthy Kids, Healthy Families can demonstrate to school administrators, state agencies, and legislators how a designated health promotion's nurse with community support can ultimately influence health behaviors in children and their families. A local elementary school in Bullock County, Alabama which is in an

# MONTANA

## *Granite County Medical Center*

**Grant Number: D04RH12661**

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underserved rural, poverty area with a large number of minorities will be the site for the model. The health nurse along with help from the consortium members would supply health services to numerous at-risk, culturally diverse, elementary children. Emphasis of this program would be on promoting positive health behaviors in children and their families, to improve future health outcomes.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# NEBRASKA

## *Good Neighbor Community Health Center*

Grant Number: D04RH16345

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### **PROGRAM DIRECTOR**

Heather Elton  
2282 East 32<sup>nd</sup> Avenue  
Columbus, NE 68601  
Phone: (402) 562-8962  
Fax (402) 563-0544  
E-mail: helton@ecdhd.com

### **TOPIC AREAS**

Women's Health, MCH

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Good Neighbor Community Health Center (GNCHC), Four Corners District Health Department (FCDHD) East Central District Health Department (ECDHD) and Columbus Community Hospital Healthy Families Nebraska Program (CCH-HFN)

### **AREAS SERVED**

Boone, Butler, Colfax, Nance, Platte, Polk, Seward and York Counties

### **TARGET POPULATION SERVED**

Pregnant women and newborns

### **PROJECT SUMMARY**

This project is based on a request for expanded linguistically appropriate educational and assessment services from the target population. In two recent focus groups, held with peri-natal women receiving care at Good Neighbor Community Health Center, one of their primary needs was that of increased *face to face* education during both the prenatal and postpartum period specifically related to pregnancy and new baby care. Additionally approximately ten percent of new mothers experience postpartum depression (*Journal Watch Psychiatry, 2002*), left undiagnosed post partum depression can affect the mother-child relationship and impair a child's development, as well as affect the dynamics of the family as a whole.

A consortium consisting of the Good Neighbor Community Health Center (GNCHC), Four Corners District Health Department (FCDHD) East Central District Health Department (ECDHD) and Columbus Community Hospital Healthy Families Nebraska Program (CCH-HFN) have joined together to request Outreach Grant funding to address these issues. The combined service area is 4,300 square miles in rural Nebraska where 1,252 births occurred in 2005. Utilizing an evidenced based approach that both brings prenatal and new parent education into the home and provides screenings including the "parent/family assessment tool", as well as other child development, behavioral health and home physical safety/risk tools, the consortium will improve outcomes through education and early referral. Through Nurse Home

# NEBRASKA

## *Good Neighbor Community Health Center*

**Grant Number: D04RH16345**

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visits, expectant mothers and families will receive both a prenatal and a follow up postpartum visit. The proposed population to be served are pregnant women and newborns residing in Boone, Butler, Colfax, Nance, Platte, Polk, Seward and York Counties. The overall goals of the project are:

1. Reduce preventable safety risks through assessment and education and reduce disparities in available prenatal/postpartum education related to language, cultural and distance barriers.
2. Reduce incidence of complications related to baby blues, including postpartum depression, and family anxiety and stress through early detection screening using the Quick Psycho-Diagnostic Tool (QPD) and early referral to existing community resources
3. Establish and then evaluate the effectiveness of a home visitation program in improving birth and postpartum outcomes and to expand that program to all eight counties serviced by GNCHC and FCDHD by year three.

Funding will go towards; 1) Providing training & ongoing technical assistance support for staff to do home visits utilizing the effective evidenced based tools and trained staff from the CCH-HFN program. 2) In-home education by local nurses to peri-natal families related to pregnancy care, newborn care, child development and safety, 3) Assessment of risk factors for the newborn & family including physical, developmental and behavioral health issues. Services will be offered in both a culturally and linguistically appropriate manner to address the underserved population of Hispanic mothers, newborns and families through support for Spanish-speaking interpreters and purchase of Spanish Healthy Families curriculum materials.

Additionally, this project requests a "funding preference" based upon the following: a) six of the eight counties proposed to be served by this project (Boone, Butler, Colfax, Nance, Platte and Polk counties) are designated as Medically Underserved Area (MUA) b) because of its designation as a Community Health Center, the Good Neighbor CHC is Federally designated as serving a "medically underserved community", c) GNCHC is a Federally Qualified Health Center, and d) three counties (Boone, Platte, and Nance) are designated in whole or part as HPSA for primary medical care.

### **ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# NEBRASKA

## *Saint Francis Medical Foundation*

Grant Number: D04RH07931

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### **PROGRAM DIRECTOR**

Marjorie Jones  
Saint Francis Medical Center  
2126 West Faidley Avenue  
P.O. Box 9804  
Grand Island, NE  
Phone: (308) 398-2601  
Fax: (308)-398-5823  
E-mail: mjones@sfmc-gi.org

### **TOPIC AREAS**

Elder Care

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 145,816
- Year 2 - 123,124
- Year 3 - 95,875

### **PARTNERS TO THE PROJECT**

Saint Francis Medical Center will partners for services with Aurora Memorial Hospital and the Aurora Senior Center in Aurora, NE, Howard County Community Hospital and the St. Paul Senior Center in St. Paul, NE, and Litzenberg Memorial Hospital and the Central City Senior Center in Central City, NE, and the Midland Area Agency on Aging for the May 1, 2007 - April 30, 2010 grant period.

### **AREAS SERVED**

Hall, Boone, Greeley, Hamilton, Howard, Merrick, Nance and Sherman counties, and approximately 553 elderly residents who reside in Buffalo, Madison, Platte, Valley and Wheeler counties.

### **TARGET POPULATION SERVED**

The Central Nebraska Home Services Telecare Project proposes to serve the 15,466 elderly residents (age 65 and older) in nine counties. The Staying Well at Home Coalition works with about 750 patients a year through home healthcare services.

### **PROJECT SUMMARY**

The Staying Well at Home Project, based in Grand Island, NE, includes Saint Francis Medical Center, Aurora Memorial Hospital, Litzenberg Memorial Hospital in Central City, Howard County Community Hospital in St. Paul, the Aurora Senior Center, the Central City Senior Center, the St. Paul Senior Center and the Midland Area Agency on Aging as members. The plan defines three levels of intervention to help elderly residents live independently, avoid frequent re-hospitalization and maintain a high quality of life:

1. *Establish a preventative program for elderly residents at risk for chronic diseases or acute healthcare to live longer independently with a better quality of life through the on-site education and telehealth monitor stations that record vital signs, located at the Aurora, Central City and St. Paul senior centers and Wellness WorWor Su Salud in Grand Island. These stations, available for public use,*

# NEBRASKA

## *Saint Francis Medical Foundation*

**Grant Number: D04RH07931**

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will be able to transmit data to Home Care Services at Saint Francis Medical Center and provide trended data to each participant's local doctor.

2. *Provide collaborative care management through a quantitative patient assessment and a Staying Well at Home plan focused and uniform discharge plan that makes patient-specific referrals to identified community, family and medical resources).* The patient assessment and pathway plan will be developed by the Staying Well at Home Coalition Task Force.
3. *Develop patient participation in the management of disease through prompt feedback from the monitoring of vital signs relevant to a patient's disease process.* The project will include the placement of 28 health monitors furnished through the project and 20 provided by the Saint Francis Medical Center Foundation in the homes of patients identified with the greatest need (provided by scoring from the Staying Well at Home assessment criteria)

The project has identified these key issues: 1) frequent re-hospitalizations and physician visits can be avoided; 2) travel difficulties for aging patients who live significant distances from primary healthcare providers; 3) healthcare provider shortages that threaten the quality of patient case management; 4) chronic disease scores that are higher than the national mean for endocrine, circulatory, respiratory and musculoskeletal categories; 5) an inability of patients to fully understand instruction from physicians and a reluctance to ask questions; and 6) an expressed desire by elderly patients to live independently.

The Central Nebraska Home Services Telecare Project proposes to serve the 15,466 elderly residents (age 65 and older) in nine counties: Hall, Boone, Greeley, Hamilton, Howard, Merrick, Nance and Sherman, and approximately 553 elderly residents who reside in Buffalo, Madison, Platte, Valley and Wheeler counties. The Staying Well at Home Coalition works with about 750 patients a year through home healthcare services.

The use of telehealth monitors will allow more frail elderly residents to: 1) live at home, 2) improve self-management of their chronic conditions, 3) become more aware of changes in their health status resulting in efforts to seek treatment in a timely fashion, 4) become less reliant on emergency care that results in frequent hospitalization.

### **ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

**NEW HAMPSHIRE**  
***North County Health Consortium***  
**Grant Number: D04RH07901**

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**PROGRAM DIRECTOR**

Martha McLeod  
North Country Health Consortium  
646 Union Street  
Littleton, NH  
Phone: (603) 444-4461  
Fax: (603) 444-4460  
E-mail: mmcLeod@nchcnh.org

**TOPIC AREAS**

Oral Health

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

**PARTNERS TO THE PROJECT**

Littleton Community House Annex, Dalton Elementary School, New Hampshire Department of Health and Human Services, Lancaster Elementary School, New Hampshire Community Technical College, National Guard Armory-Berlin, National Guard Armory-Littleton, St Ann's Good Shepherd Parish, Lane House, Littleton Head Start Program, St. Barnabus Church, and Woodville Elementary School

**AREAS SERVED**

Northern Grafton and Coos Counties in Northern New Hampshire.

**TARGET POPULATION SERVED**

The North Country Health Consortium proposes to expand its public health mobile dental service, The Molar Express, to serve a target population of unserved and underserved adults residing in the service area. The Molar Express has been providing preventive, diagnostic and restorative dental care to Medicaid eligible children in Northern New Hampshire since July of 2005.

**PROJECT SUMMARY**

The North Country Health Consortium proposes to expand its public health mobile dental service, The Molar Express, to serve a target population of unserved and underserved adults residing in the service area. The Molar Express has been providing preventive, diagnostic and restorative dental care to Medicaid eligible children in Northern New Hampshire since July of 2005.

The applicant has selected this project to address barriers to oral health care suffered by the target population living in Northern Grafton and Coos Counties in Northern New Hampshire. These barriers include a Dental Health Professional Shortage Area (DHPSA) designation for the entire service area: little or no Medicaid reimbursement for oral health services available to the age 65 and under population, a weekly wage almost 23 percent lower than the state average and access to health insurance that is 20 percent lower than the state average.



**NEW HAMPSHIRE**  
***North County Health Consortium***  
**Grant Number: D04RH07901**

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In addition, surveys conducted by area health care providers indicate that in some communities considerably less than 50 percent of the adult population received regular preventive dental care, over 50 percent indicated that they needed dental work done and that over 30 percent surveyed indicated lack of ability to pay for services precluded access to such services.

To improve the oral health status of unserved and under-served North Country adults through a collaborative program of preventive, diagnostic and restorative care for and education of the population.

- Expand capacity of the Molar Express dental clinic to provide services to the target population through recruitment and credentialing of additional paid and volunteer dentists.
- Improve oral health status and facial appearance of the target population.
- Improve oral health knowledge and behavior through a comprehensive program of education on good oral health.
- Ensure the sustainability of these oral health services by fostering collaboration to determine strategies for long-term viability of all Molar Express services.

The North Country Health consortium members will guide and steer all facets of this project with support from key staff drawn from Consortium personnel and clinical personnel working for the Molar Express.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

**NORTH CAROLINA**  
***Community Health Link***  
**Grant Number: D04RH07925**

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**PROGRAM DIRECTOR**

Lorna Barnett  
538 Scotts Creek Road, Suite 100  
Sylva, NC 28779  
Phone: (828) 587-8224  
Fax: (828) 631-2634  
E-mail: lornabarnett@jacksonnc.org

**TOPIC AREAS**

Comprehensive Health Care

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,906
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Community Health Link (applicant and lead agency); 91% of Jackson County Physicians; the Jackson County Department of Public Health; the Jackson County Department of Social Services; the Good Samaritan Clinic; WestCare Health System; the North Carolina Cooperative Extension Service, and the Medication Assistance Program of Jackson County

**AREAS SERVED**

Jackson County, North Carolina

**TARGET POPULATION SERVED**

Uninsured and very high rates of uninsured among those whose incomes are below poverty.

**PROJECT SUMMARY**

Community Health Link, Inc. (CHL) is requesting \$149,906.00 for the first year of a three year grant to expand and improve Community Health Access Network (CHAN). The request for three years is \$374,906.00. CHAN is expanding and enhancing a program that provides comprehensive health care to residents of Jackson County, North Carolina who are between the ages of 18 and 64, at or below 150% of the federal guidelines for poverty, and have no health insurance. The program provides a medical home to enrolled participants, purchases medications, and makes arrangements for further treatment, lab work, diagnostic tests, physical and respiratory therapy, cardiac services, surgical services, and emergency services.

This grant will provide for **expanded services** which will include **patient assistance** with securing free or low-cost medication from pharmaceutical companies, a **medication safety** component, **a wellness partnership** with the NC Cooperative Extension, basic **health literacy** instruction, **increase the number of patients** served by CHAN by 15% per year to 455 patients over three years and a volunteer component to provide opportunity to patients to give back to the community and to assist CHAN staff with medication assistance.

**NORTH CAROLINA**  
***Community Health Link***  
**Grant Number: D04RH07925**

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CHAN will serve 345 patients in year one, 395 in year 2 and 455 in year 3. CHAN will provide basic health literacy instruction and materials to all patients at Lunch and Learn monthly sessions and when individuals enroll and reenroll every six months. Basic health literacy will provide patients with a sense of control and the knowledge that they can make a difference in their own health.

CHAN will partner with new consortium member, NC cooperative extension to encourage patients to develop healthier lifestyles at Lunch and Learn monthly sessions. As an incentive to attend CHAN will offer to pay the medication co-pays for patients who make use of this training. Partnership with the Jackson County Department of Public Health will continue to provide free complete physicals to CHAN patients referred by CHAN physicians.

CHAN Network members include: Community Health Link (applicant and lead agency); 91% of Jackson County Physicians; the Jackson County Department of Public Health; the Jackson County Department of Social Services; the Good Samaritan Clinic; WestCare Health System; the North Carolina Cooperative Extension Service, and the Medication Assistance Program of Jackson County. Literally the entire medical community is committed to making this program a success.

By following the highly successful Buncombe County model, having extraordinary participation of the entire medical community, and having tremendous community support for Community Health Access Network, we are confident that we will be able to fulfill our goals and objectives for this project. Thank you for giving careful consideration to this worthy and much needed project.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

**NORTH CAROLINA**  
***Tri-County Community Health***  
**Grant Number: D04RH07926**

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**PROGRAM DIRECTOR**

Christopher Vann  
Tri-County Community Health Council, Inc.  
3331 Easy Street  
Dunn, NC  
Phone: (910) 567-7004  
Fax: (910) 567-5342

**TOPIC AREAS**

Safety net-Migrant

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

**PARTNERS TO THE PROJECT**

NC Farmworker Health Project (Satellite Outreach Clinic #1), Lee's Chapel Advent Church (Satellite Outreach Clinic #2), Stewart's Chapel PFWB Church (Satellite Outreach Clinic #3), and the Eastern Carolina Medical

**AREAS SERVED**

Town of Clayton, Town of Smithfield - Site of Johnston Memorial Hospital and Johnston, County Health Department, and Tri-County Community Health Council - Main Site, Newton Grove

**TARGET POPULATION SERVED**

Target \$2,100 uninsured, migrant/seasonal farmworkers and the elderly for outreach and new access to primary medical care.

**PROJECT SUMMARY**

Tri-County Community Health Council, Inc. (TCCHC) is a not-for-profit Community/Migrant Health Center funded under Sections 330(e)(g) of the Public Health Service Act. TCCHC is a corporation of five community/migrant health centers serving southeastern North Carolina. For almost 30 years, TCCHC has provided culturally competent, linguistically appropriate primary medical, dental and behavioral healthcare to vulnerable populations and the community. In response to HRSA-07-005, Tri-County Community Health Council, Inc. (TCCHC) proposes a new Rural Health Care Services Outreach Initiative targeting uninsured and underinsured migrant/seasonal farmworkers (MSFWs) and community members residing in Eastern Johnston County.

The Johnston County Outreach Initiative (JOI), a three-year demonstration project, will provide effective linkages into comprehensive, culturally competent quality health care for those without access. The program plan identifies specific sociodemographic, economic, cultural and geographic barriers characteristic of the area and expands TCCHC's safety net into a region without access to healthcare services. The JOI Team, consisting of a Mid-Level Provider and a Bilingual Outreach Specialist, utilizing

**NORTH CAROLINA**  
***Tri-County Community Health***  
**Grant Number: D04RH07926**

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state-of the art health records technologies, internet access and satellite clinical services, will team with TCCHC's existing care services infrastructure to deliver healthcare to needy communities of Eastern Johnston County. JOI is strengthened by a consortium of local health and service providers by providing access to geographic and socially isolated farmworker camps and communities in Eastern Johnston County, ophthalmology, diabetic education and treatment, HIV treatment and prevention education, referrals for specialty services, including MRI, CAT and physical therapy, and hospitalization. Once fully operational in Year 2, JOI will link healthcare services (general care and specialty/chronic disease care) to 2,100 new patients of any demographic background; however, special emphasis will be placed on migrant and seasonal farmworkers, who face a myriad of health and social concerns, and uninsured/underinsured members of the community - many who have not accessed comprehensive care in years.

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

**NORTH CAROLINA**  
***The McDowell Hospital, Inc.***  
**Grant Number: D04RH12683**

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**PROGRAM DIRECTOR**

Jane Schroeder  
430 Rankin Drive  
Marion, NC 28752  
Phone: (828) 659-5413  
Fax: (828) 659-5428 (Fax)  
E-mail: Jane.Schroeder@msj.org

**TOPIC AREAS**

Child Health, Oral Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 122,623
- Year 2 – 122,533
- Year 3 – 99,808

**PARTNERS TO THE PROJECT**

The McDowell Hospital, Mission Children's Dental Program, McDowell County Partnership for Children and Families, McDowell County Health Department, Children Services Network/McDowell County Childcare Providers, North Carolina Oral Health Section/Division of Public Health/Dept. of Health and Human Services, and McDowell County Schools.

**AREAS SERVED**

McDowell County, North Carolina including City of Marion and surrounding communities Old Fort, Glenwood, Little Switzerland, Pleasant Gardens, Nebo and North Cove.

**TARGET POPULATION SERVED**

Parents and caregivers of children enrolled in 32 regulated day care centers operating in the county. The targeted children range in age from birth to five years.

**PROJECT SUMMARY**

Our overarching goal is to prevent oral disease among young children in McDowell County, North Carolina. To achieve this goal, we have developed a Consortium of interested community and state-based organizations with the same vision of improving oral health among young people in McDowell County. Together we will problem-solve and develop solutions to the poor oral health of preschoolers in our community. We will also take a proactive approach by having a dentist conduct limited oral exams and risk assessments on at least 800 preschool children in regulated childcare facilities and at events in the community geared toward minority communities. Dental Plan with recommendations regarding fluoride varnish and dental treatment will be generated for each child examined. The project coordinator will support parents in accessing care through referrals, assistance in completing forms to enroll Medicaid eligible children, and accessing charitable aid for dental care. The Dental Outreach Program for Preschoolers will also provide assistance when other forms of aid are not available yet are needed. For example, up to \$500 will be available for a limited number of children who meet established financial guidelines, are between the ages of 6 months and five years, have a dental treatment plan, and are

**NORTH CAROLINA**  
***The McDowell Hospital, Inc.***

**Grant Number: D04RH12683**

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approved for services by the Dental Outreach Program's Advisory Board. We will also offer gas vouchers to help defray transportation costs. Finally, education of young parents, new mothers, and pregnant women about the importance of oral health in young children and the safety and effectiveness of fluoride varnish will occur in obstetrical practices, childcare centers, WIC sites, hospitals, and at community events. A system will be developed to track access to oral health services in order to monitor progress toward our goals and objectives. We estimate one major outcome of our McDowell Hospital Dental Outreach to Preschoolers' Program will be a 3% decrease in the number of children entering kindergarten with untreated dental caries within two years of the program's start.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# NORTH DAKOTA

## *Southwestern District Health Unit*

Grant Number: D04RH12748

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### **PROGRAM DIRECTOR**

Carlotta Ehlis  
2869 3rd Avenue West  
Dickinson, ND 58601  
Phone: (701) 483-0171  
Fax (701) 483-4097  
E-mail: cehlis@nd.gov

### **TOPIC AREAS**

CVD, Cancer

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Southwestern District Health Unit, Community Action Partnership, and St. Joseph's Hospital and Health Center

### **AREAS SERVED**

Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope and Stark Counties

### **TARGET POPULATION SERVED**

Healthy lifestyles education and screening for among those 65 years of age and older.

### **PROJECT SUMMARY**

Diet and exercise are directly related to obesity, which is a risk factor for cardiovascular disease and many types of 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 38 members representing over 16 community groups from the eight southwestern counties of North Dakota. Results in 1997, 2002 and data updated in 2007 indicate Areas of Opportunity for Health Action, with cancer and cardiovascular identified as a significant health priority. The Cancer and Substance Abuse Task Force (CSATF) was formed in 1998 creating the Pathways to Healthy Lives (PTHL) program, which became a reality through funding by a Rural Health Care Services Grant from 2000-2003 and an expansion to the current program for years 2006-2009. CSATF identified the need for expansion to cardiovascular screenings with a focus on education, healthy lifestyles and continue the cancer screenings.

PTHL program provides education focusing on healthy lifestyles for cardiovascular health and cancer prevention. Free comprehensive screening events will include cardiovascular, breast, prostate, colorectal, skin, and lung cancers and education. Collaboration between community leaders, providers, clinics, hospitals, and PTHL make it possible to offer services locally where people live, thus increasing accessibility and reducing the amount of distance people must travel.



# NORTH DAKOTA

## *Southwestern District Health Unit*

**Grant Number: D04RH12748**

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The consortium for PTHL 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 PTHL program and to provide advisement and support.

The goals of the PTHL program are to: 1) increase awareness of healthy lifestyles for cardiovascular health and cancer prevention and 2) increase the availability of comprehensive screening events.

The distances to travel with the challenge of harsh climatic conditions have a significant impact on the ability of residents to seek medical services, even further for specialty health care providers. PTHL serves almost 37,000 residents living in a 10,000 square mile, eight county region of southwestern North Dakota. The population density of the eight counties is 3.7 people per square mile, well within the accepted definition of frontier. The 2004 US Census indicates an average annual household income in the counties of \$34,554, (state average is \$39,233). The 2006 US Census also indicated a higher than state average in the number of residents 65 years of age and older (20.1% average for this 8 county area versus 14.6% average in the state and 12.4% national average). This is an important factor supporting the need for healthy lifestyles education and screening in this region since there is a higher incidence of cancer and cardiovascular disease among those 65 years of age and older. Southwestern North Dakota's leading cause of death is cardiovascular disease and number two is cancer.

### **ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

**NORTH DAKOTA**  
***Wishek Hospital Clinic Association***  
**Grant Number: D04RH12730**

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**PROGRAM DIRECTOR**

Trina Schilling  
CEO  
Wishek Community Hospital  
1007 4th Street  
Wishek, ND 58495  
Phone: (701) 452-3125  
Fax: (701) 452-2179  
E-mail: trinas@wiskehospital.com

**TOPIC AREAS**

Primary Care/Wellness, Tribal Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,734.85
- Year 2 – 124,972.95
- Year 3 – 99,801.65

**PARTNERS TO THE PROJECT**

Wishek Community Hospital, Southwest Healthcare Services, Northland Healthcare Alliance, McKenzie County Healthcare Services, Presentation Medical Center, Linton Hospital, St. Andrew's Medical Center, Mobridge Regional Medical Center, Mercy Medical Center, Garrison Memorial Hospital, Community Memorial Hospital, and West River Regional Medical Center

**AREAS SERVED**

Adams, Bowman, Emmons, McLean, McIntosh, McKenzie, Williams & Rolette and Walworth County, South Dakota

**TARGET POPULATION SERVED**

White/non-Hispanic with Native Americans

**PROJECT SUMMARY**

Most would say that North Dakota is doing relatively well in its' efforts to provide healthcare coverage, having a lower percentage of uninsured than the national average. However, research conducted several times over the past five years has shown that there exists a large portion of North Dakota's working population that does not have any healthcare coverage. One segment includes the farmer or sole proprietor organization and another segment includes the rural small business worker. The individuals that comprise these segments would like to have some form of coverage, but according to the surveys, they simply cannot afford to purchase it on their own and the business they work for does not provide it.

**Dakota Cares!** is an effort to ameliorate this problem. **Dakota Cares!** is a three-share type program with a wellness component. A three-share program partners business owners, employees and the community in providing a healthcare coverage product that is both affordable and accessible to the small business owner and their employees.

**NORTH DAKOTA**  
***Wishek Hospital Clinic Association***

**Grant Number: D04RH12730**

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Business owners and employees each pay a small monthly fee, usually between \$35 - \$50 and a third party, in this case the healthcare facility, contributes a portion to the coverage program. Healthcare facilities allocate funds to be used as “charity care” each year and a portion of these allocated funds will be used as a third contribution to the **Dakota Cares!** Three-share Program.

Businesses will qualify, not individual employees, on the basis of number of employees (2 or more), not having offered healthcare coverage in the past 12 months, and having an average hourly wage of \$11.50 or less. In this way, if their business qualifies, all full and part-time employees are eligible for **Dakota Cares!**

The wellness component called **Dakota Healthy Living** is required for participation in **Dakota Cares!** **Dakota Healthy Living** will include initial health screenings, and participate in a wellness education course. The education courses will include: Tobacco Cessation, Hydration, Responsible Alcohol Consumption, Eating for a Lifetime, and Movement Training. Screenings will be required once each year.

This project is unique in several ways. It is the first that will cover many communities at once. Some similar projects have used grant and Disproportional Share Funds to pay for the third share. This project uses charity care funds from the hospitals.

Some work is left to do. The \$149,734.85 in federal monies will provide the necessary funds to complete the organization and pay for start up costs. Each member of this Consortium is contributing significant funds and resources to make this project work. Each group sees this effort as a win-win, and it is because a new segment of the population will now have increased access to primary care services.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

# NEBRASKA

## *Rural Comprehensive Care Network of Nebraska*

Grant Number: D04RH12652

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### **PROGRAM DIRECTOR**

Joleen Huneke, Executive Director  
995 East Highway 33, Suite 2  
Crete, NE 68333  
Phone: (402) 826-3737  
Fax: (402) 826-3746  
E-mail: jthserpa@neb.rr.com

### **TOPIC AREAS**

Recruitment and Retention

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

South East Rural Physician Alliance, Blue River Valley Healthcare Network, and Southeast Nebraska Area Health Education Center

### **AREAS SERVED**

Adams, Boone, Butler, Fillmore, Hamilton, Howard, Jefferson, Johnson, Merrick, Nuckolls, Otoe, Polk, Saline, Seward, Thayer, Valley, York

### **TARGET POPULATION SERVED**

Residents of the rural communities have access to comprehensive, high quality health care

### **PROJECT SUMMARY**

The Rural Comprehensive Care Network of Nebraska is a nonprofit organization consisting of the South East Rural Physician Alliance and Blue River Valley Healthcare Network. The Rural Comprehensive Care Network is the applicant for the outreach grant. The three consortium partners are South East Rural Physician Alliance, Blue River Valley Healthcare Network, and Southeast Nebraska Area Health Education Center.

The target population of this grant will be residents of the rural communities that are served by the rural physician clinics and hospitals in the Rural Comprehensive Care Network service area. The Rural Comprehensive Care Network Consortium's over arching goal is to assure access to comprehensive, high quality health care in our rural area.

The purpose of the grant will be to implement a program to assist in recruiting and retaining the patient care professionals. The consortium defines the patient care professionals as physicians, mid-level practitioners, nurses, lab technicians, x-ray technicians, information technology staff, dieticians, OT and PT therapist and other ancillary providers as needed by hospitals and clinics. The goals of the workforce program are to:

## NEBRASKA

### *Rural Comprehensive Care Network of Nebraska*

**Grant Number: D04RH12652**

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- 1) Ensure an adequate supply of patient care professionals working in the targeted counties;
- 2) Increase the number of young people that choose health care as their career;
- 3) Decrease the turnover rate at Rural Comprehensive Care Network facilities;
- 4) Establish a sustainability plan to ensure that the workforce programs will continue after the grant funding ends.

The consortium will develop programs to recruit the patient care professionals with ties to Nebraska to come back home, design a mentoring program to increase the retention of the patient care professionals, conduct courses to increase the employees' knowledge about management, communication and improve their technical skills. The consortium will also actively recruit junior high and high school students to select health care as their career.

As the current health care workforce get older and "baby boomers" start aging the increased need for patient care professionals will continue to grow within the next five to fifteen years. Everyone needs to have access to high quality health care services in order to eliminate health disparities and increase the quality and years of healthy life. Patient care professional shortages in rural counties create barriers to health care for rural residents. This program will address those workforce issues.

#### **ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# NEBRASKA

## *West Central District Health Department*

Grant Number: D04RH12649

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### **PROGRAM DIRECTOR**

Shannon Vanderheiden  
111 North Dewey Street  
North Platte, NE 69101  
Phone: (308) 696-1201  
Fax: (308) 696-1204  
E-mail: vanderheidens@wcdhd.org

### **TOPIC AREAS**

Oral Health—Children

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

West Central District Health Department (WCDHD), North Platte Public School District, Jefferson Elementary PTA, Mullen Public Schools, Local Dentists, Logan County, and Hooker County

### **AREAS SERVED**

Arthur, Grant, Hooker, Keith, Lincoln, Logan, McPherson, and Thomas Counties

### **TARGET POPULATION SERVED**

Medicaid and low-income, uninsured residents

### **PROJECT SUMMARY**

With fifteen dentists practicing in North Platte, a rural community of 23,878 in the west central part of Nebraska, it should be easy to get dental care. But only one of those dentists accepts new Medicaid patients, so for families on Medicaid, getting dental care has been very difficult. Many Medicaid families traveled 100 miles or more for dental care. Many more did without.

In response to the needs of this underserved population, West Central District Health Department (WCDHD) and its partners opened the West Central Dental Clinic in October 2006, with funding from the HRSA Rural Health Care Services Outreach Grant Program. This clinic serves Medicaid and low-income, uninsured residents of WCDHD's eight-county service area, and has provided basic preventative, emergent, and restorative dental care to more than 3,100 patients since opening its doors. However, access barriers remain for Medicaid and low-income children in North Platte and particularly outside of North Platte. These barriers include a lack of dental professionals outside North Platte, Free and Reduced Lunch rates of 50-70% in targeted schools in the service area, a Medicaid population that is higher than the state average, and the fact that children make up more than 62% of the service area's Medicaid population.

# NEBRASKA

## *West Central District Health Department*

**Grant Number: D04RH12649**

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Therefore, WCDHD and its partners propose to expand its dental services to establish a portable dental clinic, the West Central Smiles Clinic, to serve a target population of underserved elementary-age children residing in WCDHD's service area. The West Central Smiles Clinic will provide educational and preventative services in year one, and further expand to provide basic restorative services in years two and three. WCDHD has selected this project to address barriers to oral health care suffered by the target population living in west-central Nebraska and to better serve this underserved segment of the population.

West Central District Health Department requests a funding preference under provision 1 in the grant guidelines: designation as a Medically Underserved Community and/or a Health Professional Shortage Area. All of the eight counties served by this project have one or both of these designations. HPSA designation applications for dental care were submitted for two of the counties in September 2008 and six of the eight counties have been designated by the state of Nebraska as General Dentistry Shortage Areas.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

**NEW HAMPSHIRE**  
*Trustees of Dartmouth College*  
**Grant Number: D04RH12689**

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**PROGRAM DIRECTOR**

Scott W. Rodi  
One Medical Center Way  
Lebanon, NH 03756  
Phone: (603) 650-3554  
Fax: (603) 650-0473  
E-mail: scott.w.rod@hitchcock.org

**TOPIC AREAS**

Telemedicine, Emergency Services

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Dartmouth-Hitchcock Medical Center, New London Hospital, Upper Connecticut Valley Hospital, and Weeks Medical Center

**AREAS SERVED**

New Hampshire and Vermont

**TARGET POPULATION SERVED**

Significantly older, poorer, and less well educated

**PROJECT SUMMARY**

The Dartmouth-Hitchcock Medical Center (DHMC) and Community and Critical Access hospitals are jointly providing front-line care, Level 1 trauma services, and the other specialized hospital-based services of a tertiary academic facility to some 2 million people scattered across 16,000 square miles of the heavily rural areas of New Hampshire and Vermont. At present, the collaboration is ad hoc, inefficient, duplicative, and frustrating to both patients and providers. The problems undermine the quality of care and exacerbate the disparities that plague rural patients.

The recently established Center for Rural Emergency Services and Trauma (CREST) created a consortium that currently consists of DHMC and three of the region's Critical Access hospitals - Weeks Medical Center, Upper Connecticut Valley, and New London Hospital. Supported by a 2008 HRSA Rural Health Network Planning Grant, CREST has developed plans for a comprehensive, region-wide initiative to better coordinate the emergency services jointly provided by local hospitals and DHMC. This coordinated outreach effort will improve the quality and lower the cost of emergency care across the life span and across this region.

We seek funding to (1) use teleconferencing, telemedicine, and other collaborative, training, and educational tools to improve local emergency care by helping community and Critical Access hospitals



**NEW HAMPSHIRE**  
*Trustees of Dartmouth College*

**Grant Number: D04RH12689**

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adopt and implement evidence-based clinical protocols; (2) develop, test, and disseminate transfer guidelines and templates and substantially improve communication between local hospitals and DHMC, so as to improve the transfer process and thus improve the continuity and quality of care; and (3) broaden outreach efforts and expand the number of rural communities affiliated with CREST to improve the care provided by -- and the transfers to and from -- every community and Critical Access Hospital in northern New England.

The proposal's major innovation is its focus on coordinating the provision of emergency services over large distances, across hospitals with highly asymmetric resources, training, and experience at their disposal. The proposal addresses the need to improve a multi-faceted and much neglected cluster of medical services and logistical challenges that have a major impact on morbidity, mortality, and the overall quality and cost of care delivered to rural and underserved populations.

**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

**NEW HAMPSHIRE**  
***Mid-State Health Center***  
**Grant Number: D04RH12688**

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**PROGRAM DIRECTOR**

Sharon Beaty  
101 Boulder Point Drive, Suite 1  
Plymouth, NH 03264  
Phone: (603) 536-4000  
E-mail: sbeaty@midstatehealth.org

**TOPIC AREAS**

Referral, Case Management

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,694
- Year 2 – 124,550
- Year 3 - 99,394

**PARTNERS TO THE PROJECT**

Spere Memorial Hospital, Mid-State Health Center, Pemi Baker Home Health & Hospice, Genesis Behavioral Health, Plymouth Pediatrics & Adolescent Medicine, Whole Village Family Resource Center, Community Action Program Belknap-Merrimack Counties, Newfound Area Nursing Association (NANA), and Plymouth Regional Free Clinic

**AREAS SERVED**

Grafton and Belknap Counties, NH

**TARGET POPULATION SERVED**

Medically uninsured, underserved and socially vulnerable

**PROJECT SUMMARY**

The Plymouth Regional Outreach for Health (PROHealth) project is a collaborative initiative of the Central New Hampshire Health Care Partnership. The basic goal of the PROHealth project is to more effectively and seamlessly connect medically underserved and socially vulnerable populations with the right set of services at the right time.

Through PROHealth, providers will work collaboratively in an interagency team to assure common assessment, uniform points of system access, efficient referral and information exchange, eligibility assistance, interagency care coordination, and continuous access to care through a medical home. The model integrates community based outreach with clinical case management and interagency care coordination.

PROHealth strategies include the following:

1. Strategy 1: Increase capacity for community outreach, assessment and referral for services.
2. Strategy 2: Increase capacity for clinical case management of medically underserved individuals and families.

**NEW HAMPSHIRE**  
***Mid-State Health Center***  
**Grant Number: D04RH12688**

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3. Strategy 3: Establish the Community Health Access & Resource Team (CHART) to address specific cases and quality improvement of systems and processes of care across agencies.

The goal, strategies and anticipated outcomes of this proposed project will produce important benefits to the individuals and families served including more appropriate and continuous health and social service relationships leading to improved health outcomes.

The project will also significantly advance the Partnership toward our long term goal of strengthening the health care delivery system available to Central New Hampshire residents by enhancing the capacity and viability of Partner organizations and communities through collaborative assessment, planning, implementation and evaluation of integrated services and systems of care that are regional in nature and responsive to the special needs of our rural underserved population.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

**NEW MEXICO**  
***Ben Archer Health Center***  
**Grant Number: D04RH12651**

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**PROGRAM DIRECTOR**

Mary Alice Garay, Executive Director  
P.O. Box 370, Hatch, NM 87937  
Phone: (575) 267-3280  
Fax: 575-267-1747  
E-mail: mgaray@bahcnm.org

**TOPIC AREAS**

Health Wellness, Primary Care Focus, Prenatal, Teen Pregnancy, STDs

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Ben Archer Health Center (BAHC), The Deming Women's Center, Deming Health Center, New Mexico Department of Health, Local Public Health Office Region 5, New Mexico Department of Health/Office of Border Health, Mimbres Memorial Hospital (MMH), Columbus Fire/Emergency Medical Services (EMS), Chihuahua State Health Services Health Jurisdiction #5 and Palomas Health Clinic, Columbus-Luna County-Palomas Binational Health Council (BHC), and Immigration and Customs Enforcement (ICE)

**AREAS SERVED**

Luna County, New Mexico

**TARGET POPULATION SERVED**

Provide primary health and dental care to local residents and Spanish-speaking migrant workers.

**PROJECT SUMMARY**

Ben Archer Health Center (BAHC), a non-profit 501 (C) 3 corporation and has been providing primary care services in the second congressional district since 1971. The organization has eight community health centers that provide primary health and dental care to local residents and Spanish-speaking migrant workers. The eight centers are distributed throughout Southern New Mexico with two sites located in Deming and Columbus in Luna County, New Mexico. The administrative services of the organization are located in Hatch, New Mexico.

The project will address selected elements contained in the *Comprehensive Public Health Management Plan for the Luna County – Palomas, Chihuahua Binational Corridor*, a binational three-year strategic plan developed by local and state government agencies and healthcare provider organizations active in Luna County and Palomas, Chihuahua. BAHC has organized these same organizations into a consortium to implement the project. The project will be focused especially in the areas of health education and outreach, and provision of preventive and primary health care services. The following health issue areas will be directly addressed by the project: prenatal care, teen pregnancy, prevention of sexually-transmitted

## NEW MEXICO

### *Ben Archer Health Center*

**Grant Number: D04RH12651**

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diseases (STDs), and immunizations. Project staff and consortium partners will develop and implement a binational prenatal registry and health card system to improve continuity of care for pregnant women seeking care within the border region. The project will include deployment of a community-based sexual health education and STD prevention curriculum to be applied primarily in the Columbus-Palomas border area. The project approach will catalyze and expand a comprehensive binational community health worker (CHW, known regionally as *Promotoras*) network, including training and develop of a volunteer Promotora Corps in Palomas to improve health education and outreach services to Spanish-speaking only immigrant and migrant subpopulations, and strengthening the capacity of Promotoras. The project will also feature implementation of a culturally-appropriate and innovative immunization methodology in selected Luna County communities employing door-to-door outreach campaigns.

The proposed services for the Rural Health Care Services Outreach Grant Program in Luna County will include the following staff: One project director, a project coordinator and three community health workers and one part time administrative assistant.

Ben Archer Health Center (BAHC) is requesting a funding preference for a Health Professional Shortage Area and Medically Underserved Community (MUC). Ben Archer Health Center is designated as a Federally Qualified Health Center. The Deming site is a Migrant Health Center.

The site is located in a county on the United States/Mexico border which has been identified as an area of high need.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

**NEW YORK**  
***Chautauqua Opportunities, Inc.***

**Grant Number: D04RH16282**

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**PROGRAM DIRECTOR**

Diane Hewitt-Johnson  
10825 Bennett Road  
Dunkirk, NY 14048  
Phone: (716) 366-8176  
E-mail: dhewitt-johnson@chautopp.org

**TOPIC AREAS**

Obesity, Diabetes, School-Based

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Chautauqua County Health Department, Brooks Memorial Hospital, and Westfield Memorial Hospital.

**AREAS SERVED**

Chautauqua County, NY

**TARGET POPULATION SERVED**

Young children, teens, adults, and the elderly

**PROJECT SUMMARY**

Chautauqua Opportunities, Inc. (COI) will operate the Chautauqua County Nutrition Outreach Program for three years with funding from the Rural Health Care Services Outreach Grant Program in consortium with the Chautauqua County Health Department, Brooks Memorial Hospital, and Westfield Memorial Hospital. The program will target residents of Chautauqua County, a rural county in the southwest corner of New York State, and will focus on obesity, diabetes, and school-based programs. The target population will include young children, teens, adults, and the elderly.

The problem of overweight/obesity is one of the leading health indicators identified in the national health objectives of *Healthy People 2010*. Another goal of *Healthy People 2010* is to increase the proportion of persons with diabetes who receive formal diabetes education from 45% to 60%. National progress data relating to weight show a trend away from the 2010 targets for both adults and youth. Health issues in Chautauqua County are reflective of this national trend. Obesity is more common in the poor, as are related chronic diseases such as diabetes, heart disease, cancer, and hypertension.

COI will hire a Nutrition Outreach Coordinator who will acquire certification as a Diabetes Educator in the first year of the program. Services to be provided include nutrition and diabetes education in both individual and group settings at COI offices, home visits, and health fairs. Home visiting will be used to serve diabetic customers of COI's Home Care division. As a result of the diabetes education and counseling, diabetics will be able to better manage their disease and maintain HbA1c levels that are

## NEW YORK

### *Chautauqua Opportunities, Inc.*

Grant Number: D04RH16282

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within the adequately controlled range. The Nutrition Outreach Coordinator, in cooperation with the Chautauqua County Health Department Dietician, will work with Meals on Wheels recipients to educate them about how to fit their delivered meals into their meal plans for the most effective management of their diabetes.

Cors existing after school programs in several county school districts will provide a forum for the Way to Go Kids! nutrition and fitness education program, to be delivered in 8week sessions by Registered Dieticians from the two hospital consortium members. Nutrition professionals will be recruited to serve on School District Advisory Councils with the intention of having a positive influence on school policies regarding nutrition and fitness.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

## NEW YORK

### *Mary Imogene Bassett Hospital*

Grant Number: D04RH12647

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#### **PROGRAM DIRECTOR**

Jane Hamilton  
One Atwell Road  
Cooperstown, NY 13326  
Phone: (607) 746-9332  
Fax: (607) 746-9332  
E-mail: jane.hamilton@bassett.org

#### **TOPIC AREAS**

School-Based, Primary Care, Mental Health

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Schenevus Central Schools, Sidney Central Schools, The Friends of Bassett, and Sidney Area Hospital Foundation

#### **AREAS SERVED**

Sidney (Delaware County), Schenevus (Otsego County), New York

#### **TARGET POPULATION SERVED**

Working poor families which are more common among these rural areas are not eligible for Medicaid

#### **PROJECT SUMMARY**

Delaware and Otsego Counties are part of an economically depressed rural region of south central Upstate New York. These counties are among the most northern edge of Appalachia, as designated by the federal legislation forming the Appalachian Regional Commission. These two counties are home to the communities at the focus of this grant proposal.

This proposal requests funding for the establishment of School-Based Health Centers (SBHCs) in the rural school districts of Sidney (Delaware County) and Schenevus (Otsego County). These services come at the behest of community members and residents in the counties where these two school districts are located. The applicant organization is The Mary Imogene Bassett Hospital (hereinafter cited as Bassett or Bassett Healthcare), a not-for-profit rural health care network of primary and specialty care providers dedicated to patient care, teaching and research. With 13 highly successful School-Based Health Centers (SBHCs) in nine school districts Bassett's School-Based Health Program is the largest rural program of this type in New York State.

Results of the National Survey of America's Families (NSAF) reported by the Urban Institute confirm many disparities in rural health care resulting from low incomes, inadequate insurance coverage, increased health problems, and lower rates of service use. Members of the Community Advisory Boards



## NEW YORK

### *Mary Imogene Bassett Hospital*

Grant Number: D04RH12647

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of Bassett's School-Based Health Program and Consortium partners have specifically identified barriers to primary and mental health care confronting the residents of these geographic areas including:

- Lack of Insurance
- Inability of parents to enroll in public insurance systems
- Limited number of primary care providers in the communities
- Limited number of mental health providers in the region, especially those who care for children and adolescents
- Poverty - agricultural area
- Geography - mountainous terrain, two-lane roads, long distances between villages
- Inadequate public transportation, high fuel prices in the rural region ~ Inclement weather, especially in the winter

**Lack of insurance.** Bassett's experience in other school districts within these counties indicates that in these communities a significant number of students do not have adequate

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

## NEW YORK

### *Newark-Wayne Community Hospital*

Grant Number: D04RH16281

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#### **PROGRAM DIRECTOR**

Emilie Sisson  
Driving Park Avenue  
P.O. Box 111  
Newark, NY 14513  
Phone: (315) 483-3266  
Fax: (315) 483-3270  
E-mail: emilie.sisson@viahealth.org

#### **TOPIC AREAS**

Geriatric Care

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Wayne County Rural Health Network, Wayne County Office of Aging and Youth, Rochester Chapter Alzheimer's Association, Wayne Medical Group – Wolcott Office, and Geriatric Consultive Service, Rochester General Hospital

#### **AREAS SERVED**

Wayne County, New York

#### **TARGET POPULATION SERVED**

Chronic diseases common to the elderly

#### **PROJECT SUMMARY**

Wayne County is located in upstate New York. This 604 square mile county is designated rural in the central and eastern portions of the county. There are over 11,800 persons over the age of 64, and 23% of all households in the county have someone in this age group living with them. Currently, there is an insufficient supply of physicians, and there are no geriatricians to manage the special medical needs of the non-institutional elderly in the community.

In addition to the chronic diseases common to the elderly, there are a set of syndromes that overburden the community (primary physicians and social service organizations) and institutional (hospital/nursing homes) medical systems. Syndromes affecting the elderly are: urinary incontinence, instability and falls, HTN/dizziness, syncope, osteoporosis, pressure ulcers, sleep disorders, failure to thrive, and neuro-psychiatric disorders, including dementia, delirium, depression, substance abuse, nervous system disease, cerebrovascular disease and Parkinson.

Syndrome-Focused Geriatric Assessments, developed by Dr. Steven Rich (Geriatric Consultive Services, Rochester General Hospital, Rochester, NY), have proven successful in addressing the debilitating

## NEW YORK

### *Newark-Wayne Community Hospital*

**Grant Number: D04RH16281**

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syndromes in the elderly. This proposal details a similar program, adapted to the needs of rural communities, and provides for a geriatrician and a nurse/case manager team to complete a structured comprehensive assessment that focuses on dementia, urinary incontinence, falls, polypharmacy, chronic pain, depression, functional decline/assessment, and end of life issues. Included in this model program is the often-lacking component of follow-up case management that assists patients in maintaining protocols put in place to treat the above-mentioned syndromes.

This grant will bring the expertise of Geriatric Consultive Services (GCS) at Rochester General Hospital to Wayne County, thereby increasing access for elders to geriatric specialists. GCS will provide direct clinical service to referred elders in person or via a new telemedicine site in a local Wayne County PCP office. The telemedicine equipment will also link elders to other specialty physicians.

In addition to the direct medical services provided, the grant will subsidize educational efforts of health professionals and care-givers in Wayne County to elevate the skill set of those who work with the elderly. A strong evaluation program and project plan is also included. All of the staff dedicated to this program are contracted. To continue operations in the third year, one third of paid staff will be supported through funding outside of the grant. WCRHN and the local geriatric consortium will work to transition the services to an existing medical practice operating in the county.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

**NORTH DAKOTA**  
***City-County Health District***  
**Grant Number: D04RH16387**

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**PROGRAM DIRECTOR**

Theresa Will  
230 4th Street, N.W., Room 102  
Valley City, ND 58072  
Phone: (701) 845-8518  
Fax: (701) 845-8542  
E-mail: twill@co.barnes.nd.us

**TOPIC AREAS**

Chronic Disease

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

City County Health District (CCHD), Central Valley Health District (CVHD) and South Central Adult Services (SCAS)

**AREAS SERVED**

Barnes, Stutsman, and Logan Counties in North Dakota

**TARGET POPULATION SERVED**

Increase delivery of the specific healthcare services needed by chronic-disease-impaired residents.

**PROJECT SUMMARY**

**The Need:** Many of our chronic-disease-impaired rural citizens are experiencing increased needs for healthcare services that will enable them to most cost-effectively and safely remain in their homes. Over the past 30 years, City County Health District (CCHD), Central Valley Health District (CVHD) and South Central Adult Services (SCAS) have delivered much-needed services to area residents in their homes as well as in the three agencies' offices. However, in recent years, even though the need for assistance has spiked, rising costs and decreasing or flat revenues are forcing all three agencies to actually decrease necessary services. From 2004-07, public health home visits provided by CCHD increased from 800 to 1160.

At CVHD, the documented number of public health home visits more than doubled in one year, from 1,459 in 2006 to 2,929 in 2007. Furthermore, during just the first nine months of 2008, CVHD's number has already risen to 2,325. These increases necessitate increased nursing time to keep up with the demand. Needs for services are rapidly increasing at SCAS, too. In Barnes and Logan Counties alone, the number of rides provided increased by 3,540 from 2006 to 2007.

**NORTH DAKOTA**  
***City-County Health District***  
**Grant Number: D04RH16387**

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The people requiring assistance have most often exhausted other resources, have a minimal or very unreliable support system, and come to Public Health and/or SCAS for numerous services that are not available elsewhere.

**The Proposed Consortium:** CCHD, CVHD and SCAS have already committed to strategize and fill these unmet needs both now and well into the future. All three are eager to formally convene a consortium to mitigate the impact of chronic disease and enable more people to stay safely in their homes in our region. All agree that this new collaboration will financially benefit the agencies, clients and community, while also increasing access to essential healthcare services.

**Goal and Proposed Services:** The three partners will collaborate to boost efficiency and, thus, increase delivery of the specific healthcare services needed by chronic-disease-impaired residents so they can remain in their homes. Specifically, we will: provide in-office and home visits for those with a chronic disease; provide foot care; pre-fill insulin syringes and medication minders; reorder medications; contact physicians; educate clients on self-management of their specific chronic diseases; and provide other ongoing medical/physical/mental health support as needed. In other words, the proposed program will provide comprehensive chronic-disease **case management**.

Overall, the nation's healthcare infrastructure faces serious challenges, and it is imperative that rural providers innovate to deliver the best healthcare by pulling resources together.

**Population to Be Served:** All 33,219 residents in Barnes, Stutsman and Logan Counties will benefit; this includes both the citizens needing services and all others who pay taxes. This program will extend the ongoing ability of individuals to remain safely in their homes, thus avoiding costly premature long-term care placement.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

## NORTH DAKOTA

### *Park River Health Corporation DBA "First Care Health Center"*

Grant Number: D04RH16385

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#### **PROGRAM DIRECTOR**

Louise Dryburgh  
115 Vivian Street  
Park River, ND 58270  
Phone: (701) 284-4538  
E-mail: louise.dryburgh@1stcarehc.com

#### **TOPIC AREAS**

Obesity, Chronic Care

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

First Care Health Center, Walsh County Health District, and Altru Home Services are requesting the Rural Health Care Services Outreach Grant to implement WOW2 (Wellness Outreach Without Walls).

#### **AREAS SERVED**

First Care Health Center service area which includes portions of Walsh, Pembina, Cavalier, Nelson, Ramsey, and Grand Forks Counties in North Dakota. This Includes Park River and nine surrounding communities.

#### **TARGET POPULATION SERVED**

Targeted communities have disabled populations.

#### **PROJECT SUMMARY**

First Care Health Center, Walsh County Health District, and Altru Home Services are requesting the Rural Health Care Services Outreach Grant to implement WOW2 (Wellness Outreach Without Walls). This proposal is a collaborative effort to promote healthy lifestyles and provide wellness services to residents of Walsh County, eastern Ramsey County, northern Nelson County, and southern Pembina County in northeastern North Dakota. Much of the population lives in communities ranging in size from 25-1500 who travel 20-50 miles for healthcare. The Walsh County residents are primarily Caucasian with 1.2% American Indian. Nearly 25% of the population is over age 65, above the state's average. The majority of the targeted communities have disabled populations that are higher than national averages. Area climate factors make it difficult, if not impossible, for residents to be active outdoors 5 months out of the year. (November-March)

Through community forums and surveys, the following needs and concerns were identified: 1. An increase in obesity. 2. An increase in chronic disease conditions. 3. Lack of Mental Health providers. The WOW2's Network goals are to implement WOW2's services to 10 communities which will improve the overall health of the people in northeastern North Dakota.

## NORTH DAKOTA

### *Park River Health Corporation DBA “First Care Health Center”*

**Grant Number: D04RH16385**

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Through implementation of the WOW2 Network goals we will:

- Decrease obesity rates by promoting wellness and lifestyle change programs to improve overall health.
- Increase availability of chronic disease prevention programs and provide health screenings.
- Increase availability of Mental Health Services.

Funding for this project will allow us to directly address 7 of the 28 *Healthy People 2010* focus areas: Objective 3 – Cancer; Objective 5 – Diabetes; Objective 7 – Educational & Community-Based Programs; Objective 12 – Heart Disease and Stroke; Objective 18 - Mental Health & Mental Disorders; Objective 19 - Nutrition and Overweight; and Objective 22 – Physical Activities & Fitness. The WOW2 (Wellness Outreach Without Walls) main office for comprehensive wellness services will be located in Park River, North Dakota with outreach locations providing fitness and wellness activities and chronic disease screenings in 9 other rural towns.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# OHIO

## *Ohio University*

Grant Number: D04RH12664

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### **PROGRAM DIRECTOR**

Jane Hamel-Lambert  
347 Grosvenor Hall  
Athens, OH 45701  
Phone: (740) 593-2289  
E-mail: hamel-lj@ohio.edu

### **TOPIC AREAS**

Mental Health, Workforce

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,999
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Tri-County Mental Health and Counseling Services, Inc. (TCMH-CS), Athens City School District, and Athens-Meigs Educational Service Center (AMESC)

### **AREAS SERVED**

Athens County, OH

### **TARGET POPULATION SERVED**

Improving early childhood outcomes and increasing the capacity of early childhood educators.

### **PROJECT SUMMARY**

Building Capacity – Raising Resiliency will accomplish its goal of *improving early childhood outcomes* and *increasing the capacity of our early childhood workforce* to ensure healthy child development through two objectives. First, we will implement an Early Childhood Mental Health Consultation Program (ECMH-CP), serving preschool-aged children annually in Athens County, OH. The ECMH-CP will offer three tiers of intervention - universal, targeted and intensive - provided by an interdisciplinary team of professionals including the ECMH consultant, the Family Care Navigator, and a pediatric neuropsychologist.

Second, we will implement an Early Childhood Workforce Initiative designed to advance a range of professional competencies through didactic trainings, collaborative peer group supervision, learning communities, journal readings, and program consultation through site visits and videoconferencing with state and national experts. Additionally, the ECMH-CP will deliver on-site training through directed instruction, modeling and coaching to the 19 teachers, 8 aides, and other related school employees serving the 19 Athens City and Athens County public preschool and preschool special education classrooms.

This grant proposal expands the efforts of our rural health network, Integrating Professionals for Appalachian Children (IPAC), aimed at developing integrated health delivery systems (e.g., public pre-schools and mental health agencies) and leveraging the infrastructure established and lessons learned



# OHIO

## *Ohio University*

**Grant Number: D04RH12664**

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through our RHND grant. Our consortium is composed of a subgroup of IPAC, bringing together our community mental health center, Ohio University's College of Osteopathic Medicine and Psychology & Social Work Clinic, public school teachers and administrators, and families in a jointly planned initiative to demonstrate the feasibility and effectiveness of a school-based, early childhood consultation model for integrating education and mental health services.

Because Athens County, OH is a rural eligible community, a mental health and dental professional shortage area (Dental-HPSA, MHPSA), and MUA, we are requesting a funding preference under the first category, health professional shortage areas. Additionally, both the consultation program and the workforce development trainings foster wellness and disease prevention, qualifying the program for category 2 funding preference.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# OHIO

## *Orrville Hospital Foundation*

Grant Number: D04RH16280

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### **PROGRAM DIRECTOR**

Cy Naumoff  
832 South Main Street  
Orrville, OH 44667  
Phone: (330) 684-4711  
Fax: (330) 683-2130  
E-mail: [cynaumoff@dunlaphospital.org](mailto:cynaumoff@dunlaphospital.org)

### **TOPIC AREAS**

Wellness

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Smith Dairy, Dunlap Community Hospital, Schantz Organ Company, and Packship USA.

### **AREAS SERVED**

Orrville, Ohio

### **TARGET POPULATION SERVED**

Medical care for the underinsured

### **PROJECT SUMMARY**

The rapid unraveling of employer-based health insurance has led to a decrease in access to affordable medical care for the underinsured. Strikingly, access to care declined the most for insured individuals between 2003 and 2007.<sup>1</sup> Small to mid-sized employers shoulder a larger healthcare cost burden leading to increased out-of-pocket healthcare expenses for many employees.<sup>2</sup> According to an October 2008 electronic survey conducted by the Orrville Area Chamber of Commerce, 100% of Chamber respondents currently providing employee healthcare benefits are concerned with the rising cost of healthcare. Although 75% percent of respondents did not believe they would cease offering employee health benefits, 60% anticipated raising the cost of employee deductibles while 68% also planned to raise the cost of employee co-pays.

The Orrville Hospital Foundation, dba Dunlap Community Hospital, is a critical access hospital with a service area of 30,000 individuals. Orrville, Ohio is the home to 9,000 residents and 400 area employers, 97% of which are categorized as small to mid-sized. The Healthcare Cost Reduction Coalition (HCRC) project is an innovative, grassroots approach to increasing access to quality healthcare by offering an affordable, incentivized insurance product to healthier employees through partnering with an insurer. *The pairing of an effective healthcare system with an insurance product supporting the healthcare effort is essential.* The purpose of the HCRC is not to realize profit but rather to continually re-invest into the community.

# OHIO

## *Orrville Hospital Foundation*

Grant Number: D04RH16280

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The HCRC consists of eight consortium members. The Orrville Hospital Foundation, the recipient of a 2003 Health & Human Services equipment grant, is the lead applicant. Orrville primary care physician groups have pledged to act as in network providers. The Orrville Area Chamber of Commerce will serve as the liaison between the local healthcare and business communities. During a two-year demonstration period at four beta-site companies, 716 employees will be offered annual health risk assessments, quarterly screenings, personal wellness plans, incentives and wellness classes at no cost. Contingent upon participation in a company wellness program, employees will be eligible for enrollment in an insurance program offering incentivized premium discounts. The correlation between company wellness programs and employee wellness will be tracked and evaluated. Rewards based upon participation, limited (20%) health-related standards and the use of aggregated employee data ensures compliance with HIPAA and the ADA. Trends in employee healthcare costs will be documented by monitoring employee premiums, co-pays, and deductibles. Return on Investment (ROI) will be calculated for each beta-site employer. Finally, underinsured data will be generated.

The ultimate goal of the HCRC project is to encourage employee wellness thereby increasing access to affordable healthcare for the employees of small to mid-sized businesses and their families. By virtue of the project's emphasis on wellness and disease screening as outlined above, **funding preference** is respectfully requested for the HCRC project.

<sup>1</sup>Cunningham, Peter J., and Felland, LaurieE., *Falling Behind: Americans' Access to Medical Care Deteriorates, 2003-2007*, Tracking Report No. 19, Center for Studying Health System Change, Washington D.C. (June 2008). <sup>2</sup>Abelson, Reed, "Small Business Is Latest Focus in Health Fight." *The New York Times*, 10 July 2008.

### **ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# OHIO

## *The Twin City Hospital Corporation*

Grant Number: D04RH12658

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### **PROGRAM DIRECTOR**

Timothy McKnight  
819 North First Street  
Dennison, OH, 44621  
Phone: (740) 922-7474  
E-mail: tmcknight@twincityhospital.org

### **TOPIC AREAS**

Health Behavior—Obesity

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Twin City Hospital (lead agency); Family Practitioner Dr. Tim McKnight; Tuscarawas County Health Department; Carroll County Health Department; Tuscarawas County YMCA; Dr. Nina Kucyk, Psychologist; Dr. Michael Jakubowski, Chiropractor; and Ohio State University (OSU) Extension Office of Tuscarawas County

### **AREAS SERVED**

Village of Dennison, Tuscarawas County and surrounding counties of Carroll, Harrison and Guernsey

### **TARGET POPULATION SERVED**

Overweight and obese community men, women and children of all ages.

### **PROJECT SUMMARY**

The Goal of the Twin City Hospital (TCH) Healthy Community Outreach Program (HCOP) is to provide an innovative multi-agency means to reduce the number of overweight and obese community men, women and children of all ages in Tuscarawas County Ohio and the surrounding counties of Carroll, Harrison and Guernsey. The program allows a consortium of community agencies to pool resources in order to enhance educational opportunities, outreach, facilities and services through a collaborative effort. Program services will be offered to all populations regardless of their abilities to pay or ethnic backgrounds.

The Twin City Hospital HCOP will address the following health and wellness needs: 1) Lack of affordable diet and exercise training; 2) Need for a central location where people can access health and wellness information; 3) Need to provide treatment for obesity; 4) Need for enhanced diabetes treatment and education; 5) Need for fitness programs for all ages; 6) Need to address health concerns of the working poor, and 6) Need to provide local access to these services due to a lack of affordable public transportation.

# OHIO

## *The Twin City Hospital Corporation*

**Grant Number: D04RH12658**

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The Twin City Hospital HCOP provides the following age-appropriate services in order to meet the needs identified: 1) Nutrition and exercise programs for adults of all ages through Fit for Life classes; 2) Special health interventions for adults who are diabetics or are at risk for diabetes; 3) Assistance with school wellness programs; and 4) Nutrition and exercise information on the Hospital's website to improve access to health and wellness information.

To date, more than 350 adults have "graduated" from the Fit for Life classes thanks to funding from a previous Rural Health Outreach Grant. This grant proposal seeks funding to *expand and enhance the scope* of our previous grant activities to include addressing the health needs of the working poor by providing Fit for Life wellness classes for employees at their places of work.

While the program will be administered at Twin City Hospital, services will be offered at various locations throughout the community in order to reach the target population. According to the 2000 Census, 90,914 populate Tuscarawas County. The following consortium member organizations have committed to providing services to assist with the HCOP: Twin City Hospital (lead agency); Family Practitioner Dr. Tim McKnight; Tuscarawas County Health Department; Carroll County Health Department; Tuscarawas County YMCA; Dr. Nina Kucyk, Psychologist; Dr. Michael Jakubowski, Chiropractor; and Ohio State University (OSU) Extension Office of Tuscarawas County. Funding Preference: Funding Preference 2 is requested for this project because the Twin City Hospital HCOP's project focus is to utilize *wellness and disease prevention strategies to promote healthy living and the prevention of disease*.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# OHIO

## *Fostoria Community Hospital*

Grant Number: D04RH12742

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### **PROGRAM DIRECTOR**

Amy Preble  
501 Van Buren Street  
Fostoria, OH 44830  
Phone: (419) 436-6640  
Fax: (419) 436-6671  
E-mail: amy.preble@promedica.org

### **TOPIC AREAS**

EMS, CVD

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,985
- Year 2 – 124,919
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Local Fire Department, Police Department, EMS Service, and Catheterization Lab

### **AREAS SERVED**

Fostoria, Ohio

### **TARGET POPULATION SERVED**

Individuals who present an acute myocardial infarction

### **PROJECT SUMMARY**

The purpose of the Improving Health Outcomes through Telehealth Strategies (IROTT) Project is to utilize community collaboration and telehealth strategies to enhance rural emergency health care services and improve health outcomes for individuals who present an acute myocardial infarction (AMI) or ST-elevation myocardial infarction (STEMI). Fostoria Community Hospital (FCR) has created a Consortium which includes the local Fire Department, Police Department, EMS Service, and Catheterization Lab to implement the project. The Consortium will work together to develop ways to reduce the number of cardiovascular deaths in Fostoria by making sure more emergency response vehicles are equipped with Automatic External Defibrillators (AED) and by reducing the door-to-balloon time in cardiac emergencies. AED's will be installed in both the Fire and Police Department vehicles, in addition to purchasing necessary software and equipment to implement the STEMI management solution. An ambulance will be designated specifically for critical patients who require immediate transfer to tertiary care hospitals and/or a Cardiac Cath-lab.

Physio-Control LIFENET STEMI Management Solution is a secured web-base, early warning system for STEMI patients. While paramedics focus on patients, the STEMI Management Solution securely delivers electrocardiograph (ECG) data when and where it is needed, linking prehospital, emergency room, and Percutaneous Coronary Intervention (PCI) treatment teams, reducing door-to-balloon time and possibly saving lives.

# OHIO

## *Fostoria Community Hospital*

**Grant Number: D04RH12742**

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According to the 2005 Seneca County Health Needs Assessment, major cardiovascular disease (heart disease and stroke) accounted for 49% of all Seneca County adult deaths from 2000-2002, compared to 45% in Ohio and 36% in the U.S. In 2005, 7% of Seneca County adults reported they had a heart attack or myocardial infarction, increasing to 23% of those who rated their health as fair or poor, 19% of those over age 60 and 16% of those with incomes less than \$25,000. It is estimated that each year 1.5 million Americans experience AMI or STEMI. Medicare patients with AMI who were treated in rural hospitals were less likely than those treated in urban hospitals to receive recommended treatments and had significantly higher adjusted 30-day post AMI death rates from all causes than those in urban hospitals.

One reason for the considerable difference in morbidity and mortality rates is the prolonged delays between the incidents and the arrival of the EMS, in some cases eight minutes greater than in urban areas. For individuals suffering from an AMI or STEMI every minute counts. Of the half a million Americans who experience STEMI, one-third of them die within 24 hours of onset if not treated with PCL. Like more than 75 % of U.S. hospitals, FCH does not have the ability to perform PCL. The time it takes to get a patient into the ED and identify problem, coupled with the time and distance to facilitate patient transfer increases the door-to-balloon time for residents within the FCH service area, ultimately decreasing the likelihood of survival.

The targeted population to be served will be residents and visitors within the Fostoria Community Hospital service area who present an AMI or STEMI. This area includes Hancock, Seneca and Wood counties, in Northwest Ohio approximately 40 miles southeast of Toledo and 90 miles north of Columbus. Seneca County statistics are a good representation of the combined 3 county areas. According to the US Census Bureau, the 2006 total population for Seneca County was comprised of 96% White, 2% African American, 0.2% Native American, 0.5% Asian, 3.8% Hispanic or Latino, and 1.2% multi-racial. Patients will enter the program through the local Fire Departments, Police Departments, EMS and/or the Fostoria Community Hospital Emergency Department.

Telehealth strategies can provide a safety net for patients in remote rural areas, providing the opportunity to take advantage of skills and knowledge of those in other locations and allowing Emergency teams to prepare for specific patient needs, reducing door-to-balloon time and avoiding false-positive Cath-lab activations. An onsite emergency vehicle further ensures quicker response times. Because of the high unbillable costs of the LIFENET STEMI Management Solution, Federal assistance for the IROTI project is necessary to improve rural emergency health care services and health outcomes of patients suffering from STEMI in the rural areas of Fostoria, Ohio.

### **ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# OHIO

## *Pathstone Corporation*

Grant Number: D04RH12665

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### **PROGRAM DIRECTOR**

Michal Urrutia  
2-453 County Road V  
Liberty Center, Ohio 43532  
Phone: (419) 875-6654  
Fax: (419) 875-4010  
E-mail: murrutia@pathstone.org

### **TOPIC AREAS**

Maternal/Child Health, Domestic Violence, Diabetes

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Rural Opportunities (ROI), Community Health Services (CHS), that is a migrant health center; and Wood County Health Department (WCHD)

### **AREAS SERVED**

Seneca, Wood, Henry, Fulton, Williams, Ottawa, Putnam, and Sandusky Counties

### **TARGET POPULATION SERVED**

Increase access to primary, preventive services among the farmworker.

### **PROJECT SUMMARY**

Rural Opportunities, Inc. (ROI) respectively request \$375,000, for a three year period, from the Rural Health Care Services Outreach Grant Program. ROI proposes implementing Preference 1. Sandusky County has a Health Professional Shortage Area (HPSA) designation. Additionally our Consortium Members; Community Health Services (CHS) and Wood County Health Department qualify as Medically Underserved Communities. This project also qualifies under Funding Preference 2, because of a focus on wellness and disease prevention through health education, referrals, and other services.

ROI proposes the Promotoras Para La Salud Y Segridad/ Promotoras Health & Safety Outreach Program (PHSOP) to provide outreach, expand, and enhance health care to farmworkers and the rural, at risk Hispanic/Latinos of Northwest Ohio. PHSOP proposes to provide health and safety prevention education, screenings, interpretation, supportive services, case management, referral, and transportation for high risk low income uninsured farmworkers in the counties of Henry, Fulton, Ottawa, Putnam, Wood, Sandusky, Seneca, and Williams.

According to the Ohio Department of Job and Family Services, Farmworker Monitor Advocate Report, (Lucio, 2004), Ohio hosts 15,782 Migrant Farmworkers. USDOL reports document 151 licensed migrant camps in Ohio in 2004. ROI has identified an additional 50 unlicensed camps and other locations where



# OHIO

## *Pathstone Corporation*

**Grant Number: D04RH12665**

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farmworker live. This information alone does not include the poultry or dairy production, National Agricultural Workers Survey, or migrant health statistics. Therefore, it could be estimated that there are anywhere from 20,000 to 40,000 farmworkers in Ohio. Over 99% of the population is Hispanic 80% have limited English proficiency, and over 85% have less than a high school education, earning less than \$7,000 a year (ROI MIS Participant Characteristics, 2007).

The Consortium includes: (ROI), Community Health Services (CHS), that is a migrant health center; and Wood County Health Department (WCHD). Consortium members will help to increase access to primary, preventive services among the farmworkers in Northwest Ohio through referral, coordination, involvement in project activities, project feedback and addressing priorities.

### **ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

# OREGON

## *Three Rivers Community Hospital*

Grant Number: D04RH12753

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### **PROGRAM DIRECTOR**

Debbie Daggett  
2600 Doctors Park Drive  
Medford OR 97504  
Phone: (541) 789-5333  
E-mail: ddaggett@asante.org

### **TOPIC AREAS**

Telehealth/Telemonitoring—Elderly CV Care

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,675
- Year 2 – 124,996
- Year 3 – 99,952

### **PARTNERS TO THE PROJECT**

Three Rivers Community Hospital (TRCH), a community hospital in Grants Pass, OR, serves this project area, along with Rogue Valley Medical Center (RVMC), a Tertiary Care Regional center in Medford, OR.

### **AREAS SERVED**

Josephine County and the cities of Gold Hill and Rogue River in Jackson County, Oregon

### **TARGET POPULATION SERVED**

The special needs of rural, elderly persons with chronic disease.

### **PROJECT SUMMARY**

This rural outreach project addresses an issue of significant public health importance: the special needs of rural, elderly persons with chronic disease whose care is managed across health settings, including, hospital, physician and homecare. Specifically, this outreach program will address the impact on quality of care and cost of care of using telemonitoring and computerized home medication dispensing systems with rural homecare patients for the improved management of their chronic illness.

Three Rivers Community Hospital, operating with partners in a underserved rural area, will demonstrate the value of these homecare technologies toward improved safety and quality care for patients who have chronic heart conditions and whose disease management is experienced across multiple points of care. The homecare telemonitoring and medication dispensing units transport data over simple telephone lines, and that data will then interface with the hospital and physician offices, utilizing a virtual private network (VPN) and secure physician portal as a platform for the improved care of a shared patient constituency. The goals of this project follow:

- Goal I: Rural patients with chronic heart disease will benefit from improved medication management, and quality care through the use of home-based computerized medication dispensing units.

# OREGON

## *Three Rivers Community Hospital*

Grant Number: D04RH12753

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- Goal II: Rural patients with chronic heart disease will benefit from improved quality care through the use of homecare telemonitoring.
- Goal III: Rural patient with chronic heart disease will benefit from increased efficiencies and reduced costs of care through the use of telehealth technologies.

This project will demonstrate the extent to which these technologies contribute to measurable and sustained improvements in quality care. In specific, this project will demonstrate the impact of homecare telehealth technologies, using a centralized monitoring system, deployed across an interagency system of care to: (a) improve medication management of chronically ill homecare patients; (b) improve the quality of homecare, including early identification of heightened health risk status, timeliness of medical response, improved communication among and between the healthcare team, and improved stakeholder satisfaction with care; and (c) reduce overall costs of health care by reducing the number of required visits by homecare staff, as well as reducing the number of emergent care visits and hospital readmissions required by telemonitored patients.

Results from this rural outreach study will inform the Health Resources and Services Administration, providers, patients, payers, policy makers, and the general public about how telehealth technologies can be successfully implemented in homecare settings and lead to safer and better health for rural persons facing the challenges of chronic disease management.

### **ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

# OREGON

## *La Clinica Del Carino*

Grant Number: D04RH12684

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### **PROGRAM DIRECTOR**

Tina Castanares  
849 Pacific Avenue  
Hood River, OR 97031  
Phone: (541) 308-8354  
E-mail: tina.castanares@gorge.net

### **TOPIC AREAS**

Diabetes/Obesity

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Nuestra Comunidad Sana and Providence Hood River Memorial Hospital

### **AREAS SERVED**

Hood River and Wasco Counties, Oregon Klickitat and Skamania Counties, Washington

### **TARGET POPULATION SERVED**

Chronic disease and other health needs

### **PROJECT SUMMARY**

La Clínica del Cariño, a community and migrant health center in Hood River Oregon, in partnership with Nuestra Comunidad Sana, a community health promotion agency and Providence Hood River Memorial Hospital is applying to the U.S. Department of Health and Human Services, Office of Rural Health, for support of a community project entitled ¡*Pasos Adelante!*

The overall goal of the project is to address diabetes, obesity and the role stress plays in our rural residents' ability to make healthy choices for themselves and their families. With our community partners we will provide targeted case management services and implement community programs providing health education, peer support, outreach and connection to resources.

¡*Pasos Adelante* has the following specific five goals:

- Expand a diabetes case management program to Wasco County to improve the self-management and health outcomes of patients diagnosed with diabetes.
- Expand a group program addressing behavior change to Wasco County for community members who want to manage their diabetes and/or weight.
- Initiate a group based Family Wellness Program for families interested in improving the health of their children.

# OREGON

## *La Clinica Del Carino*

**Grant Number: D04RH12684**

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- Conduct outreach activities regarding obesity and diabetes awareness and prevention to those community members most at risk: seniors and migrant farmworkers.
- Build on relationships strengthened during the project to establish a permanent

Consortium to address chronic disease and other health needs of the community.

To accomplish these goals, a comprehensive training strategy will be implemented, utilizing the expertise and resources of consortium members, to ensure that project staff are well versed in diabetes and obesity issues and stress management techniques. Strategies to meet our goals will include: 1) Expansion of an effective diabetes case management program to a satellite clinic in Wasco County 2) Expansion of our effective group program model to an additional rural site in Wasco County 3) Development of parent/child groups to provide information, tools and support for improving family health 4) Provision and expansion of diabetes awareness and prevention outreach to both the Spanish-speaking and the English-speaking community and 5) Development and strengthening of our existing consortium to ensure that successful programs addressing community health continue to be funded.

### **ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

## PENNSYLVANIA

### *Carbon Schuylkill Com Hospital/St. Lukes Miners Memorial Hospital*

Grant Number: D04RH12697

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#### **PROGRAM DIRECTOR**

Karen Smith  
360 West Ruddle Street  
Coaldale, PA 18218  
Phone: (570) 645-8260  
Email: smithk@slhn.org

#### **TOPIC AREAS**

Diabetes, Obesity

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Tamaqua Area Community Partnership and Lehigh Carbon Community College (LCCC)

#### **AREAS SERVED**

Carbon and Schuylkill Counties in the state of Pennsylvania

#### **TARGET POPULATION SERVED**

Medically Underserved Area

#### **PROJECT SUMMARY**

St. Luke's Miners Memorial Hospital, in partnership with the Tamaqua Area Community Partnership and Lehigh Carbon Community College (LCCC), participated in community strategy sessions, gathered data, analyzed and planned to develop a Rural Community Outreach program.

Pennsylvania has the largest rural population in the United States. The project will take place in the economically challenged coal mining and manufacturing Appalachian Region communities in Northeastern Pennsylvania. *My Health. My Community* will provide rural community outreach and case management to the Medically Underserved Area of Schuylkill and Carbon Counties in Pennsylvania (Coaldale MUA), with a primary focus on the Tamaqua area.

Utilizing the successful Community Health Outreach model developed by the Bethlehem Partnership for a Healthy Community, "*My Health. My Community*" goals and objectives are aligned with Healthy People 2010. Activities have been developed to address the specific needs of the community.

Funding from the Rural Health Care Services Outreach Grant Program will provide the start up funding required to allow St. Luke's to implement community outreach in the MUA. St. Luke's will entrench a mid-level practitioner (Nurse Practitioner), ADA Certified Nurse Educator and Registered Dietician within the community to develop and support practices that address three primary local health priorities:

## PENNSYLVANIA

### *Carbon Schuylkill Com Hospital/St. Lukes Miners Memorial Hospital*

**Grant Number: D04RH12697**

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1. Diabetes – awareness, education and management; 2. Obesity – prevention and treatment; 3. Education, Wellness and Disease Prevention.

The program will provide community screenings, support groups, nutrition and exercise classes, support of healthy community events, community education, as well as educational partnerships with the school districts and college. Home visits will be a critical strategy to encourage ownership of treatment and improved self-management of disease.

During the grant program, St. Luke's will aggressively continue its strategy to increase the accessibility and quality of health care by opening two new Rural Health Clinics in the targeted service area. This strategy will dramatically increase the number of patients who receive services, establish a "medical home" and enable the continuation of community outreach programs. Upon completion of the grant funding program, St. Luke's will be poised to continue the rural outreach activities through the support of the three Rural Health Clinics.

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# PENNSYLVANIA

## *Clearfield-Jefferson Drug and Alcohol Commission*

Grant Number: D04RH12695

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### **PROGRAM DIRECTOR**

Susan M. Ford  
104 Main Street  
P.O. Box 647  
Falls Creek, PA 15840  
Phone: (814) 371-9002  
Fax: (814) 371-9055  
E-mail: [suford@cjdac.org](mailto:suford@cjdac.org)

### **TOPIC AREAS**

Substance Abuse

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

DuBois Regional Medical Center, Saint Francis University, the Clearfield County Career and Technology Center and the Jefferson County Vocational Technical School

### **AREAS SERVED**

Clearfield and Jefferson Counties, Pennsylvania

### **TARGET POPULATION SERVED**

Substance abusers who are high risk for Hepatitis C

### **PROJECT SUMMARY**

The Clearfield-Jefferson Drug and Alcohol Commission is applying for the Rural Health Care Services Outreach Grant Program. Grant funds are being sought to expand services to substance abusers who are high risk for Hepatitis C to include vaccine services for Hepatitis A and B.

In Clearfield and Jefferson Counties, fewer economic development opportunities and high unemployment rates all contribute to escalating drug use. Between the years of 2002 and 2005 the use of heroin and other opiates in 18-25 year olds more than doubled in Clearfield and Jefferson counties, according to the PA Department of Health, Bureau of Drug and Alcohol Programs. The CJDAC has shown a 33% increase in intravenous drug use admissions for treatment in the past two years. Also, in the past two years, heroin and other opiates have surpassed marijuana as the number two drug of choice for those entering drug and alcohol treatment services. The changes over time in drug preferences and the increase in intravenous use, both risk factors for hepatitis C, suggest that there is a growing need for effective screening and referral.

The Hepatitis C and Substance Abuse Expansion Project will seek to address the following identified barriers in Clearfield and Jefferson Counties: Perceived stigma towards substance abusers and hepatitis C services; Lack of Transportation; Lack of awareness of service availability and the benefits of those



## PENNSYLVANIA

### *Clearfield-Jefferson Drug and Alcohol Commission*

**Grant Number: D04RH12695**

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services; Lack of education for patients and allied health professionals on hepatitis C and substance abuse. The project will address these barriers by creating a Consortium with the DuBois Regional Medical Center, Saint Francis University, the Clearfield County Career and Technology Center and the Jefferson County Vocational Technical School. This consortium will seek to address these issues by joining forces and expanding the number of sites available for individuals to the more rural locations of the two counties, providing increased numbers of training and education opportunities for patients, medical professionals and allied health professionals and offering Hepatitis A and B vaccine services.

The Clearfield-Jefferson Drug and Alcohol Commission Consortium requests funding preference based on meeting eligibility for both Preference 1 and Preference 2. The project will provide services in a designated health professional shortage area (I-IPSA). Services will expand to the Glendale Medical Center which is a HPSA (Coalport Borough, Clearfield County, PA). In addition, the program requests funding for Preference 2 because the project focus is on Wellness and Disease Prevention. Hepatitis C as well as vaccine services for in addition there will be a health education component that will provide information to patients, community groups, and medical and allied health professionals.

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

# PENNSYLVANIA

## *Cornerstone Care*

Grant Number: D04RH12694

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### **PROGRAM DIRECTOR**

Richard Rinehart  
1227 Smith TWP State Road  
Burgettstown, PA 15021  
Phone: (724) 947-2255, ext. 135  
E-mail: rrinehart@cornerstonecare.com

### **TOPIC AREAS**

Oral Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Cornerstone Care and the Greene County Dental Task Force Consortium

### **AREAS SERVED**

Greene County, Pennsylvania

### **TARGET POPULATION SERVED**

Low-income population

### **PROJECT SUMMARY**

Cornerstone Care has partnered with Community Action Southwest (WIC, Head Start, Family Economic Development and Senior Services) as well as Greene Arc, Greene County Human Services, MAGIC (Making a Great Impact Collectively), SHIP (State Health Improvement Program) to form the Greene County Dental Task Force Consortium to carry out the Greene County Oral Health Improvement Initiative which consists of:

- Providing awareness, outreach and dental care services to underserved, uninsured or low income families, children, senior citizens and individuals with disabilities to address oral & dental health disparities in rural Greene County, PA, where 51% of the 40,133 population is below 200% of poverty
- Increasing awareness in the community and among un-served and underserved populations of the importance of oral health and the relationship of oral health and overall health
- Increasing access to oral health services by connecting target populations with oral health care resources
- Increasing the rate of persons completing a comprehensive oral health exam and treatment plan within twelve months.
- Incorporating the HRSA Oral Health Disparities Pilot and Rural Healthy People 2010 models into our outreach and care model

**PENNSYLVANIA**

*Cornerstone Care*

**Grant Number: D04RH12694**

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**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# PENNSYLVANIA

## *Dickinson Mental Health Center, Inc.*

Grant Number: D04RH12693

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### **PROGRAM DIRECTOR**

Gwen Auman  
110 Lincoln Street  
Ridgway, PA 15853  
Phone: (814) 776-0234  
Fax: (814) 772-6154  
E-mail: aumanweisenterprises@yahoo.com

### **TOPIC AREAS**

Wellness/Prevention, Mental Health, Nutrition and Fitness

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Dickinson Mental Health Center, Elk Regional Health System, Cameron Elk Mental Health Mental Retardation, St. Mary's Area Public Schools, St. Mary's Catholic School System, Johnsonburg Area School District, and Ridgway Area School District

### **AREAS SERVED**

Elk County, Pennsylvania

### **TARGET POPULATION SERVED**

Expectant mothers, children ages 0 to 18 and the parents of those children

### **PROJECT SUMMARY**

The Elk County Wellness Express Consortium, comprised of 8 organizations from Elk County will implement a wellness project aimed at educating the target population on the importance of daily physical activity and healthy eating, as well as collecting important data on the obesity levels of children in the County.

The roles of the project partners are as follows:

- Dickinson Mental Health will serve as the program administrator employing the full time staff, coordinating and conducting the program activities and composing the required grant documentation and follow-up information.
- Elk Regional Health System will provide in-kind office space for the Wellness team; commit the time of their Registered Dietitians and the time of their Women's Health Nurse Practitioner.
- School Districts will provide referrals and host health fairs.
- Cameron Elk Mental Health Mental Retardation will provide referrals through their early Intervention program.

## PENNSYLVANIA

### *Dickinson Mental Health Center, Inc.*

**Grant Number: D04RH12693**

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- Family Resource Network Board will serve as a strong supporter of the project by monitoring and disseminating information gathered from the project and evaluating the program components as they relate to the county wide prevention programs.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# PUERTO RICO

## *Migrant Health Center, Western Region, Inc.*

Grant Number: D04RH12690

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### **PROGRAM DIRECTOR**

Reynaldo Serrano  
Ramon E. Batances Street # 392 South  
Mayaguez, PR 00680  
Phone: (787) 833-1868  
Fax: (787) 832-0740  
E-mail: mhc@migrantspr.com

### **TOPIC AREAS**

Migrant Health Education

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 144,363
- Year 2 – 124,842
- Year 3 – 99,944

### **PARTNERS TO THE PROJECT**

MCH, Inc., Rural Opportunities, Inc., Coordinadora, Paz para la Mujer, Inc. and Community Consulting Group, Inc.

### **AREAS SERVED**

Communities throughout Puerto Rico

### **TARGET POPULATION SERVED**

Seasonal farm workers working that is Hispanic and primary language is Spanish.

### **PROJECT SUMMARY**

On April 1971, Migrant Health Center Western Region, Inc. (herein MCH, Inc.) began its operation serving Migrants and their dependents in two municipalities with a \$125,000 budget and most of its services subcontracted on a fee for service basis. During 1986 the program was incorporated as a non-profit organization under the laws of the Commonwealth of Puerto Rico, with its own Board of Directors. The Center is a Rural Health Clinic and this part of the region has been designated as a MUA's, MUP's, MIA's and HPSA's. MCH Inc. has been a pioneer Community Based 330 (g)(e)(h) program in the quest to meet the target populations' needs. The program's target area is comprised by 45 rural communities throughout Puerto Rico. The principal health issues in the target area are related to HIV/AIDS, Diabetes mellitus and domestic and sexual violence. Farm workers, the target population, in this area have been segregated and set aside by private health organizations due to their socio-economic, educational and health status. Most of this population is conglomerated in remote and isolated areas. This special population needs educational services to prevent health status conditions related to the identified health issues.

In the target area there are 16,000 registered seasonal farm workers working from 2 to 5 months per year in the fields. 100% of the population is Hispanic and primary language is Spanish. 44 % of the target population has experienced unemployment since 2006 as compared to Puerto Rico's average 12.6% on

## PUERTO RICO

### *Migrant Health Center, Western Region, Inc.*

**Grant Number: D04RH12690**

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August, 2008. Their required minimum salary is \$5.25 and the average income is \$7,500 as compared to Puerto Rico's average \$14,412. 78 % of the age of 16 and above of the target population has not reached a high school diploma, in comparison to the 33 % of the general rural population. MHC, Inc., in collaboration with the other six Migrant Health Centers in Puerto Rico serves the target population through clinic sites throughout the island. MHC incorporates an educational rural outreach program on nutrition, immunization, evaluation, referrals, screening and follow-up. MHC Inc.'s HIV/AIDS program in coalition with other organizations is funded through Ryan White.

At present, educational outreach on preventive measures on HIV/AIDS, diabetes and domestic/sexual violence is not fully reaching the target population in the most remote communities. MHC is requesting the amount of \$369,418 in order to serve the target population through the collaborative educational efforts of a consortium of four organizations, namely MCH, Inc., Rural Opportunities, Inc., Coordinadora, Paz para la Mujer, Inc. and Community Consulting Group, Inc. Educational trainings on the identified health issues, clinics and the distribution of information will be provided by the Consortium in 45 most remote rural communities to 675 farm workers, their families and communities throughout Puerto Rico.

#### **ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

**SOUTH CAROLINA**  
***Western Carolina Higher Education Commission***  
**Grant Number: D04RH07905**

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**PROGRAM DIRECTOR**

Camille Nairn  
Western Carolina Higher Education  
P.O. Box 617  
Allendale, SC 29810  
Phone: (803) 584-3446, ext. 124  
Fax: (803) 584-5038  
E-mail: nairncs@gwm.sc.edu

**TOPIC AREAS**

Diabetes

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 149,829
- Year 2 - 124,989
- Year 3 - 99,999

**PARTNERS TO THE PROJECT**

Salkehatchie Healthy Communities Collaborative, Allendale County ALIVE, Inc., Low Country Regional Transportation Authority, Carolina Medical Associates and the Laffitte and Warren Medical Center, Allendale County Office of Aging, and Me and My Sugar Diabetes Support Group/Salk Walk.

**AREAS SERVED**

Allendale County, South Carolina

**TARGET POPULATION SERVED**

Will improve the lives of diabetics in Allendale County, South Carolina, by providing them with the education and tools they need to take control of the disease, instead of allowing it to control their lives.

**PROJECT SUMMARY**

The Salkehatchie NEEDS (Nutrition, Education, and Exercise for Diabetes Stabilization) Diabetes Initiative is a Rural Outreach program that will improve the lives of diabetics in Allendale County, South Carolina, by providing them with the education and tools they need to take control of the disease, instead of allowing it to control their lives.

This outreach effort grew out of ongoing efforts of the Salkehatchie Healthy Communities Collaborative, which works with local and state healthcare providers to improve the quality of healthcare accessible to local residents. Collaborative partners focused on the need to help those non-compliant diabetics in our community understand the disease and how to control it, to reduce the negative impact on their lives and the economic burden to the community. Some of those partners came together to form the NEEDS Rural Outreach Grant Consortium.

Reports from the SC Department of Health and Environmental control indicate that in 2002, diabetes resulted in \$2.3 million in hospital charges for Allendale County patients. In a county of only slightly



## **SOUTH CAROLINA**

### ***Western Carolina Higher Education Commission***

**Grant Number: D04RH07905**

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more than 11,000 people, with the lowest per capita income and highest poverty rate in the state, any disease with that kind of impact is severe. In a county where 74% of people are overweight, about 10% have diabetes, and two local Rural Health Clinics registered 2,210 office visits in 2005 related to diabetes, the need for a diabetes education and intervention program that focuses on self-regulation of the disease was obvious to the grant Consortium.

Salkehatchie NEEDS will provide a Certified Diabetes Educator in the community, housed at the county hospital, who will oversee the NEEDS program and provide both one-on-one and group educational sessions for diabetics referred by local physicians and the ER. Through this grant, the hospital will also be able to provide a Registered Dietitian in the community for one additional day each month, during which time she will work directly with NEEDS participants to customize nutrition plans and increase their understanding of the relationship between food choices and diabetes. These educational and service components will be combined, through Salkehatchie NEEDS, with a fitness component, provided in large part by the University of South Carolina Salkehatchie and the Salkehatchie Healthy Communities Collaborative. The campus currently has the only fitness center in the county, and has agreed to open that facility to NEEDS participants. The Center's manager will work with the CDE to tailor fitness and activity programs to individual participants' needs and ability levels, with a focus on reducing the risk factors that often exacerbate diabetes complications, such as obesity, heart disease, and high blood pressure. Grant activities also call for the creation of a special NEEDS activity class that will allow participants referred by the CDE to do low-impact activities, such as chair aerobics, and resistance training with bands, using video guidance. Additional community partners will provide services such as inclusion of NEEDS participants in a walking program and community aerobics classes, transportation to educational and fitness activities if needed, diabetes medication and supply assistance, and access to an existing diabetes support group.

#### **ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

**SOUTH CAROLINA**  
***Fairfield Memorial Hospital***  
**Grant Number: D04RH07907**

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**PROGRAM DIRECTOR**

Beverlyann V. Austin  
Fairfield Memorial Hospital  
P.O. Box 620  
Winnsboro, SC  
Phone: (803) 712-0375  
Fax: (803) 712-1683  
E-mail: beverlyann.austin@fairfieldmemorial.com

**TOPIC AREAS**

Diabetes

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

**PARTNERS TO THE PROJECT**

The network partners include a Critical Access Hospital, a for-profit hospital, two Federally Qualified Health Centers, a free clinic, a primary health care center affiliated with the USC School of Medicine, Region 3 of DHEC - the state public health agency, CareLINK - an indigent and medically underserved healthcare access program, and a private foundation.

**AREAS SERVED**

Chester and Fairfield Counties

**TARGET POPULATION SERVED**

Middle school students, ages 11-15, with asthma and diabetes are the primary target population for this grant.

**PROJECT SUMMARY**

The Upper Midlands Rural Health Network was a 2006 recipient of a Rural Health Network Development Planning Grant and has been successful in implementing its objectives. The overarching goals of the Upper Midlands Rural Health Network are to achieve efficiencies, to coordinate and improve the quality of essential health care services, to strengthen the rural health care system as a whole and expand access. Access to health care in the two county Upper Midlands region is ranked among the lowest in the state. This Outreach Grant will seek to expand one of the objectives of the Rural Health Network Development Planning Grant that addressed planning for appropriate services for network residents including children with diabetes or at risk for developing it. The primary goals of this grant are 1) To strengthen the Network and its effectiveness in improving the system of health care in the Network region, 2) To reduce absenteeism of middle school students with the chronic conditions of asthma and diabetes, and 3) To increase community knowledge of the risk factors for diabetes and asthma and how to manage them. Middle school students, ages 11-15, with asthma and diabetes are the primary target population for this grant. Asthma/Bronchitis is the leading cause of hospitalization for children under the age of 18 in the two

**SOUTH CAROLINA**  
***Fairfield Memorial Hospital***  
**Grant Number: D04RH07907**

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counties. Seventy-three children under age eighteen visited the emergency room (ER) in Chester County and 106 in Fairfield County due to asthma. Non-white children under the age of eighteen visit the ER more frequently than white children in the same age group. The secondary target population is adults who have asthma and diabetes or who are at risk of developing the diseases. Plans are to hire two school nurses to case manage children with these chronic conditions in each county school district. Also, the grant will implement an electronic school health record system to help the school nurses effectively track and manage these students.

The median household income is less than the state's average \$37,082. The percent of the African American population and the most impacted by health disparities is higher than the state's average of 29.5%. The challenges these communities face in meeting the Healthy People 2010 goals of increasing the quality and years of healthy life and eliminating health disparities are complex and varied. Poverty, lack of education, high unemployment, unhealthy lifestyles and poor utilization of preventive health care all contribute to poor health status and strain the fragile rural health infrastructure.

The Network began the initial stage of its development in 2004 through the assistance of a minigrant from the SC Office of Rural Health in 2004. The network partners include a Critical Access Hospital, a for-profit hospital, two Federally Qualified Health Centers, a free clinic, a primary health care center affiliated with the USC School of Medicine, Region 3 of DHEC - the state public health agency, CareLINK - an indigent and medically underserved healthcare access program, and a private foundation. The SC Office of Rural Health serves in an Ex-Officio capacity and has been instrumental in providing mini-grants of approximately \$65,000 since 2004 and annual technical assistance support by staff of estimated at \$45,000 per year.

The leaders of the Network recognize that funding from the Rural Health Outreach Grant will ensure that the critical building blocks for an effective school nurse chronic disease case management program will be accomplished resulting in reduced absenteeism and improved academic performance of middle school students. It is hoped that this innovative program can be expanded to all grades in the years to come.

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# **SOUTH CAROLINA**

## ***Clemson University***

**Grant Number: D04RH12726**

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### **PROGRAM DIRECTOR**

Cheryl J. Dye  
535A Edwards Hall  
Clemson, SC 29634  
Phone: (864) 656-4442  
Fax: (864) 656-2182  
E-mail: tcheryl@clemson.edu

### **TOPIC AREAS**

Hypertension

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,984
- Year 2 – 124,965
- Year 3 – 99,978

### **PARTNERS TO THE PROJECT**

Clemson University, Oconee Medical Center, CareSouth Carolina, Palmetto Health hospital, the SC Department of Health and Environmental Control and the Center for Disease Control and Prevention

### **AREAS SERVED**

Oconee County, South Carolina

### **TARGET POPULATION SERVED**

Health Coaches for Hypertension Control” (HCHC), patients over the age of 65.

### **PROJECT SUMMARY**

In the proposed project, “Health Coaches for Hypertension Control” (HCHC), patients over the age of 65 years will be referred from family physician practices to receive assistance from trained community members known as “Health Coaches” (HCs). The HC will provide community classes in hypertension control in which referred patients will exercise elements of self-management consistent with the Chronic Care Model by developing their own Individualized Action Plans (IAPs) and monitoring their progress using a Personal Health Diary. After completion of the hypertension classes, referred patients will choose from four types of follow-up assistance: classes on nutrition and/or physical activity focused on skill development; telephone coaching focused on achieving their IAPs; and support groups with fellow patients for discussing challenges to reaching their goals and the solutions they developed. All patient assistance will be provided by HCs who will coordinate their work with Clemson University extension services and the local health department and senior center. HCHC will bridge services offered by the consortium partners which would have not been integrated otherwise.

The proposed project will serve older citizens of Oconee County; a very rural county of South Carolina where, among those over 65 years of age, 42 percent have less than a high school education and an average of 13.6% live in poverty with that rate rising to 27% in some areas of the county. According to

# **SOUTH CAROLINA**

## ***Clemson University***

**Grant Number: D04RH12726**

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the 2005 Behavioral Risk Factor Survey, Oconee County has higher rates of hypertension and heart disease than state averages, and higher rates of risk factors that contribute to these conditions such as smoking, overweight, and high cholesterol. The county's socioeconomic factors along with high risk factor and chronic disease rates create daunting challenges for older Oconee County citizens. HCHC will provide them with the resources and services they need to manage their chronic health conditions in ways that are culturally appropriate and that overcome health literacy limitations. The proposed project incorporates best practices of other lay health advisor programs and tested materials such as CDC's, "Community Health Worker's Heart Disease and Stroke Prevention Sourcebook". This combination of best practices, commitment of numerous stakeholders, and designation of the Project Director's past work with lay health advisors as a "Leading Practice" by the federal Office of Performance Review assures success of "Health Coaches for Hypertension Control".

### **ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

**SOUTH CAROLINA**  
***Caresouth Carolina, Inc.***  
**Grant Number: D04RH12725**

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**PROGRAM DIRECTOR**

Todd Shifflet  
P.O. Box 1090  
Hartsville, SC 29551  
Phone: (843) 857-0111  
Fax: (843) 857-0150  
E-mail: todd.shifflet@caresouth-carolina.com

**TOPIC AREAS**

Behavior, Cardiac Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

CareSouth Carolina, Chesterfield County Coordinating Council, Chesterfield General Hospital, Marlboro County Inter-Agency Council, Marlboro Park Hospital, Northeastern Technical College, South Carolina Department of Health and Environmental Control (SC DHEC) Region 4, Tri-County Community Mental Health Center, and University of South Carolina School of Medicine

**AREAS SERVED**

Chesterfield and Marlboro Counties, South Carolina

**TARGET POPULATION SERVED**

Adults at risk for cardiovascular disease due to a related behavioral health condition

**PROJECT SUMMARY**

CareSouth Carolina, a federally qualified health center, is applying on behalf of the Northeastern Rural Health Network (NRHN), a 9-member consortium serving Chesterfield and Marlboro Counties in South Carolina. The NRHN is a FY2008-2009 HRSA ORHP Network Development Planning Grantee. The result of this funding has led to the development of the proposed project that addresses cardiovascular disease, mental illness, and substance abuse in the target population: CATCH HOPE – Community Action to Create Healthy Hearts, Open-minds & Personal Excellence. The geographic area to be served, Chesterfield and Marlboro Counties, comprise 1,273 square miles of rural South Carolina with total population of 71,586. Rural isolation coupled with poverty, lower than average literacy levels, double-digit unemployment rates, unhealthy lifestyles and lack of access to preventative cardiovascular and mental health services are contributing significantly to dismal health status outcomes, undue suffering and mortality. The target population for the CATCH HOPE project are adults at risk for cardiovascular disease due to a related behavioral health condition. Data revealed during a community-based and statistical needs assessment conducted over the past year, indicate that all adults in the NRHN region are at risk, especially due to disparities in co-occurring behavioral health and cardiovascular disease and rampant substance abuse. The project hopes to achieve four main goals: (1) Support the long term

**SOUTH CAROLINA**  
***Caresouth Carolina, Inc.***  
**Grant Number: D04RH12725**

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sustainability of CATCH HOPE by using the infrastructure, accomplishments, and goals of the consortium (Northeastern Rural Health Network) as a foundation for success; (2) increase community awareness of cardiovascular disease risk factors, especially related behavioral health conditions; (3) improve the ability of people with cardiovascular disease risk factors, especially related behavioral health conditions, to prevent a cardiovascular event; and (4) increase access to health care for people who are at risk for cardiovascular disease, especially due to related behavioral health conditions. By focusing on available resources and project sustainability, the proposed activities represent present and future successful collaboration between the consortium partners.

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

**SOUTH CAROLINA**  
***Clarendon Memorial Hospital***  
**Grant Number: D04RH12727**

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**PROGRAM DIRECTOR**

Scherrie Cogdill, Network Director  
P.O. Box 550  
Manning, SC 29102  
Phone: (803) 435-5246  
Fax: (803) 435-5274  
E-mail: scogdill@clarendonhealth.com

**TOPIC AREAS**

Access, Health Education

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Clarendon Memorial Hospital, Marion County Medical Center, Williamsburg Regional Hospital (Critical Care Hospital), Black River Healthcare, Inc. (federally qualified health center), Regions 4 & 6 of DHEC (public health agency), and Williamsburg Technical College. McLeod Medical Center Dillon and Perdue Farms, Inc.

**AREAS SERVED**

Clarendon, Williamsburg, Lower Florence, Dillon, Marion counties

**TARGET POPULATION SERVED**

Preventive health screening and health care system for Latino population

**PROJECT SUMMARY**

This application for a Rural Health Outreach Grant, *Healthy Families/Familias Saludables*, is being submitted by Clarendon Memorial Hospital on behalf of the Coastal Plain Rural Health Network (consortium). The mission of the proposed *Healthy Families/Familias Saludables* project is to increase access to health care and health screening for Latino families with a particular emphasis on medically underserved Spanish-speaking women in a five-county rural region of South Carolina. The Coastal Plain Rural Health Network members include Clarendon Memorial Hospital, Marion County Medical Center, Williamsburg Regional Hospital (Critical Care Hospital), Black River Healthcare, Inc. (federally qualified health center), Regions 4 & 6 of DHEC (public health agency), and Williamsburg Technical College. McLeod Medical Center Dillon and Perdue Farms, Inc. are collaborating with the Coastal Plain Rural Health Network on this grant.

Healthy Families/Familias Saludables has the following three goals:

- Support the long term sustainability of *Healthy Families/Familias Saludables* through the infrastructure of the Coastal Plain Rural Health Network.



**SOUTH CAROLINA**  
***Clarendon Memorial Hospital***  
**Grant Number: D04RH12727**

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- Increase access to health care and health screening for Latino families.
- Provide culturally appropriate health education and support to Latino families.

Comprehensive strategies designed to meet these goals include strengthening the Coastal Plain Rural Health Network (consortium), establishing a Promotora de Salud Program, providing opportunities for Latino families to access preventive health screening and be assigned to a medical home, and receive culturally appropriate health education and support concerning chronic disease prevention and prenatal care.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

## **SOUTH CAROLINA**

### ***Beaufort Jasper Hampton Comprehensive Health Services, Inc.***

**Grant Number: D04RH12731**

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#### **PROGRAM DIRECTOR**

Roland Gardner  
721 Okatie Hwy 170  
Ridgeland, SC 29936  
Phone: (843) 987-7448  
Fax: (843) 987-7484  
E-mail: rgardner@bjhchs.com

#### **TOPIC AREAS**

Diabetes

#### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

#### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

#### **PARTNERS TO THE PROJECT**

Hampton County Healthcare Consortium, Beaufort Jasper Hampton Comprehensive Health Services, and the South Carolina Department of Health and Environmental Control

#### **AREAS SERVED**

Beaufort, Jasper and Hampton Counties

#### **TARGET POPULATION SERVED**

Access to care for residents

#### **PROJECT SUMMARY**

Beaufort Jasper Hampton Comprehensive Health Services (BJHCHS) is applying for Rural Health Outreach funding to develop the Hampton County Healthcare Consortium (HCHC). The purpose of the consortium is to increase access to care for residents of Hampton County South Carolina, a rural medically underserved area (MUA) in the Low Country region of South Carolina. There are dramatic health disparities documented in Hampton County, especially for the African American population. One of the most striking of these disparities is the death rate for diabetes for African Americans in Hampton County, which is nearly five times higher than that of whites.

The members of the HCHC are BJHCHS, a HRSA Section 330 funded community health center (CHC), the South Carolina Department of Health and Environmental Control, Region 8 office (SC DHEC), and Coastal Empire Community Mental Health Center (CECMHC), the state mental health agency serving the region. Each of the consortium members currently provides services in Hampton County. The members of the consortium will combine their respective strengths in order to make a holistic system of care available to low income residents of the county.

BJHCHS provides comprehensive primary care services to all people regardless of ability to pay. As a CHC, BJHCHS is governed by a Board of directors that includes representatives from all parts of its

## **SOUTH CAROLINA**

### ***Beaufort Jasper Hampton Comprehensive Health Services, Inc.***

**Grant Number: D04RH12731**

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service area (including Hampton County), and maintains a majority of consumer users of its health care services. The BJHCHS service area includes Beaufort, Jasper and Hampton Counties. DHEC is a state agency. The DHEC Region 8 office serves Beaufort, Jasper, Hampton and Colleton Counties. DHEC is charged with conducting periodic needs assessments of the communities in its service areas. These assessments include the health status of community residents as well as the capacity of the local public health system, and its effectiveness in responding to community needs. DHEC provides some health care services with an emphasis on health education and wellness services in support of primary care needs. Coastal Empire Community Mental Health Center is a state funded mental health agency serving Beaufort, Jasper, Hampton, Colleton and Allendale Counties. CECMHC provides outpatient mental health services including life skills counseling.

The services provided by the three agencies are complementary. Each agency in the consortium has collaborated with one or both of the others on specific projects (either currently or in the past). This will mark the first time that the three agencies have entered into a consortium agreement involving all three simultaneously. The process of developing the consortium has revealed opportunities for collaboration between consortium members that will help eliminate duplication of services, increase the number of people served, increase interagency referrals to assure that patients benefit from the full range of health care resources available in the community, and help assure that health care resources are used more effectively.

All three agencies include Beaufort, Jasper and Hampton Counties within their respective service areas. Hampton County was selected as the geographic area to focus on first for several reasons.

#### **ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

**SOUTH DAKOTA**  
***Avera St. Benedict Health Center***  
**Grant Number: D04RH16386**

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**PROGRAM DIRECTOR**

Denise Muntefering  
401W. Glynn Drive  
Parkston, SD 57366  
Phone: (605) 928-3311  
Fax: (605) 928-7368  
E-mail: denise.muntefering@averastbenedict.org

**TOPIC AREAS**

Mental Health

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 98,240
- Year 2 – 98,268
- Year 3 – 88,571

**PARTNERS TO THE PROJECT**

Avera St. Benedict Health Center, Our Home, Inc., and Avera Behavioral Health Center

**AREAS SERVED**

Avera St. Benedict

**TARGET POPULATION SERVED**

Individuals who receive health care in the three-county Avera St. Benedict service area.

**PROJECT SUMMARY**

Mental health disorders in rural populations are under diagnosed for several reasons, including a lack of access to mental health care, rural values of self-reliance and self-determination that are prohibitive to seeking care, and the prevalence of a negative stigma attached to mental health disorders. Overall, rural areas have insufficient services to treat mental and behavioral health problems.

The Avera St. Benedict Mental Health Services Project will take a comprehensive, two-pronged approach to improving mental health and ensuring access to appropriate, quality mental health services. Major project strategies include: 1) add a full-time counselor to the staff at Avera St. Benedict, Parkston; 2) add telepsychiatry services in the Avera St. Benedict service area; and 3) provide community behavioral and mental health education.

The target population for the project are individuals who receive health care in the three-county Avera St. Benedict service area. These counties include: 1) Hutchinson County; 2) Douglas County; and 3) Charles Mix County.

**SOUTH DAKOTA**  
*Avera St. Benedict Health Center*  
**Grant Number: D04RH16386**

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**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

**SOUTH DAKOTA**  
*Delta Dental Plan of South Dakota*  
**Grant Number: D04RH12728**

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**PROGRAM DIRECTOR**

Connie Halverson  
720 N. Euclid  
Pierre, SD 57501  
Phone: 605-224-7345  
Fax: 605-224-0909  
E-mail: connie.halverson@deltadentalsd.com

**TOPIC AREAS**

Oral Health—Mobile Dental

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Delta Dental of South Dakota's mobile dental program, Prairie Community Health Care, Inc., Rural Community Health, Inc., and Horizon Health Care, Inc.

**AREAS SERVED**

South Dakota

**TARGET POPULATION SERVED**

Dental care services via the mobile unit to targeted low income patients.

**PROJECT SUMMARY**

The South Dakota Mobile Dental/Health Center Consortium proposes to develop a long-term collaborative effort between Delta Dental of South Dakota's mobile dental program and three South Dakota community health center organizations: Prairie Community Health Care, Inc., Rural Community Health, Inc., and Horizon Health Care, Inc. The project will deliver essential dental care services via the mobile unit to targeted low income patients in some of the most rural areas of South Dakota.

Over the next three years, the Consortium is looking to use Rural Health Outreach grant funds as bridge funding to allow the Consortium partners time to explore a more permanent funding source that will allow dental services to be offered by the health centers on a long term basis. In the interim, outreach grant funding will allow Delta Dental's mobile program to provide up to 36 weeks of service in 6-8 different health centers that are not currently offering dental services.

South Dakota's dental workforce numbers are lower than in many parts of the country and the service area for this project is even worse off than other areas of the state. According to the South Dakota Vital Statistics Report, not one of the counties identified for this project has a dentist and all but three are listed by the South Dakota Department of Health as a Dental Health Professional Shortage Area. These areas have been without a dentist in private practice or any sort of dental safety net for many years.

## **SOUTH DAKOTA**

### ***Delta Dental Plan of South Dakota***

**Grant Number: D04RH12728**

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The combined structural barriers of geographic isolation, low income and lack of access to care have resulted in an oral disease burden for the target population that is significantly higher than many areas of the country. The statistics from South Dakota's American Indian Reservations, two of which will be included in this grant, are especially startling. The Aberdeen Area Indian Health Service reports caries and untreated decay rates on South Dakota's Indian Reservations among the highest in the country at two to five times the national rate.

The highly collaborative process that developed this comprehensive proposal will be reflected in its implementation and evaluation. We anticipate that with the leveraged funds from the Consortium members and others, combined with Rural Health Outreach grant funds, we will be able to demonstrate significant improvements – both short term and long – in dental access for those with the greatest needs and least current care.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

**SOUTH DAKOTA**  
***Sacred Heart Health Service***

**Grant Number: D04RH12729**

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**PROGRAM DIRECTOR**

Michael D. Larson  
501 Summit Street  
Yankton, SD 57078-3855  
Phone: (605) 668-8148  
E-mail: mlarson@shhservices.com

**TOPIC AREAS**

Telestroke

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 147,746
- Year 2 – 116,553
- Year 3 – 97,782

**PARTNERS TO THE PROJECT**

Avera Sacred Heart Hospital; the American Heart Association- Midwest Affiliate; Avera Health; Avera McKennan Hospital & University Health Center; Neurology Associates; St. Michael's Hospital; and, Wagner Community Memorial Hospital

**AREAS SERVED**

Bon Homme, Charles Mix, Clay, Douglas, Gregory, Hutchinson, Tripp, Turner, and Yankton counties in South Dakota and Boyd, Cedar, and Knox counties in Nebraska

**TARGET POPULATION SERVED**

High stroke incidence including individuals over 65, Native Americans, and low-income populations.

**PROJECT SUMMARY**

**Needs Addressed:** There is an identified rural penalty for stroke care, resulting in increased mortality and long term disability. Because rural stroke patients do not have immediate access neurology support, their diagnosis process often extends past the critical three-hour window for administering lifesaving stroke treatment. This means that fewer than 3% of eligible patients receive the therapy, simply because they do not have timely access to specialty care. In the service area counties, the average crude death rate for cerebrovascular disease between 2002 and 2006 was **103** persons per 100,000. This is more than twice the US rate in 2006 of **48** per 100,000, and larger than the South Dakota rate of **64** persons per 100,000.

**Proposed Services:** Avera eStroke proposes to develop a telestroke system, linking three rural hospitals to neurology stroke support 24 hours a day. The system will provide neurology specialty care to stroke patients seeking care in the three rural emergency rooms, by 1) assisting local staff with assessing the patient, 2) recommending stroke treatment when appropriate, 3) remotely assisting staff in initiating stroke treatment, and 4) assisting with patient transfer if necessary. The provision of neurology expertise through telemedicine will support increased use of stroke treatment therapy, leading to improved outcomes for patients.



## **SOUTH DAKOTA**

### ***Sacred Heart Health Service***

**Grant Number: D04RH12729**

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Additionally, the program will 1) provide end-user staff training to assist in delivery of high quality stroke care; 2) provide outpatient neurology telehealth consults to provide local neurology access to patient that are recovering from stroke; 3) provide community education aimed at identifying individuals at high risk of stroke and teaching the signs and symptoms of stroke.

**Populations to Be Served:** The target population for the Avera eStroke project are individuals at high-risk of stroke, individuals who seek care in the emergency room during a stroke, and individuals recovering from stroke in the service area counties of Bon Homme, Charles Mix, Clay, Douglas, Gregory, Hutchinson, Tripp, Turner, and Yankton in South Dakota and Boyd, Cedar and Knox in Nebraska. Specifically, the project will target populations with high stroke incidence including individuals over 65, Native Americans, and low-income populations.

**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

**SOUTH DAKOTA**  
*University of South Dakota*  
**Grant Number: D04RH07911**

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**PROGRAM DIRECTOR**

Shelly Grinde  
Center for Disabilities  
Sanford School of Medicine of the University of South Dakota  
414 E Clark Street  
Vermillion, SD  
Phone: (800) 658-3080  
Fax: (605) 357-1438  
E-mail: shelly.grinde@usd.edu

**TOPIC AREAS**

Child Health

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

**PARTNERS TO THE PROJECT**

The interagency network is comprised of the Center for Disabilities at the Sanford School of Medicine of the University of South Dakota; Oglala Sioux Tribe Health Administration; Oglala Sioux Tribe Office of Special Education Services; Porcupine Clinic Health Board; Shannon County Public School District; and 123..Hi Baby!, Inc.

**AREAS SERVED**

Pine Ridge Reservation

**TARGET POPULATION SERVED**

To identify developmental concerns in children birth through five years of age.

**PROJECT SUMMARY**

The Pine Ridge Reservation: Creating an Early Health Care Community project proposes to create local access to a comprehensive and culturally appropriate system of health and developmental services on the Pine Ridge Reservation in order to identify developmental concerns in children birth through five years of age and linkage to services. The lead agency for this project is the Center for Disabilities (CD), Sanford School of Medicine of The University of South Dakota. CD is part of a national network of University Centers of Excellence in Developmental Disabilities Education, Research and Service. The Pine Ridge Reservation, located in southwest South Dakota, has been designated as one of the poorest areas in the United States. Over 61% of all children are living below the national averages for poverty and the Reservation, designated as medically underserved, has a health profession shortage for dental, mental health and primary medical care. Lack of trained pediatric specialists currently requires families with young children to travel hundreds of miles to receive these services. In South Dakota, and especially on the Pine Ridge Reservation, the follow-up for most of these children is absent, inadequate or fragmented due to the following five factors that influence rural health care access: availability, accessibility,

**SOUTH DAKOTA**  
*University of South Dakota*  
**Grant Number: D04RH07911**

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affordability, acceptability and accommodation. Early intervention services do exist through the educational system, but young children need to be diagnosed and identified as eligible before these important services can be provided.

An interagency network system was created in order to construct a comprehensive system of services for young children and their families on the Pine Ridge Reservation. Through networking and sharing of existing resources, a public awareness campaign promoting the positive benefits of developmental health and wellness for young children will be developed and implemented in all the local Reservation communities. A Reservation-wide system for developmental screening will be created and maintained with appropriate referral networks established. Pediatric specialists will be brought in on a monthly basis to work in partnership with the local health and educational services to establish a comprehensive developmental evaluation clinic where children can be thoroughly and appropriately evaluated. Linkages to early intervention and other appropriate needed services will be created as follow-up services to the clinic. Tracking and monitoring of children not eligible for services, but considered at-risk will also be created as part of this comprehensive system. The interagency network is comprised of the Center for Disabilities at the Sanford School of Medicine of the University of South Dakota; Oglala Sioux Tribe Health Administration; Oglala Sioux Tribe Office of Special Education Services; Porcupine Clinic Health Board; Shannon County Public School District; and 123..Hi Baby!, Inc. All Interagency Network members have provided a letter of commitment to work collaboratively to meet the objectives of this project.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-1902  
staylor@hrsa.gov

# TENNESSEE

## *Hickman Community Health Care Services, Inc.*

Grant Number: D04RH12765

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### **PROGRAM DIRECTOR**

Dawn James, CNO  
Hickman Community Hospital  
135 East Swan Street  
Centerville, TN 37033  
E-mail: dawn.james@baptisthospital.com  
Phone: (931) 729-4271

### **TOPIC AREAS**

CVD

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 147,594
- Year 2 – 124,656
- Year 3 – 99,720

### **PARTNERS TO THE PROJECT**

Hickman Community Hospital, Henry County Medical Center, and Southern Tennessee Medical Center

### **AREAS SERVED**

Tennessee Counties: Benton, Carroll, Coffee, Franklin, Grundy, Henry, Hickman, Lewis, Lincoln, Moore, Perry, Stewart, Weakley

### **TARGET POPULATION SERVED**

All residents

### **PROJECT SUMMARY**

It is well documented in health disparity research that despite medical advancements, certain populations are more vulnerable to heart disease than others. Among the more vulnerable groups, according to Rural Healthy People 2010, are “rural populations, particularly those in the South and Appalachian region,” which present disproportionately high percentages of social and behavioral risk factors and severe lack of availability of health care personnel, training and equipment. Within the category of heart disease, heart failure in particular poses unique challenges to rural healthcare providers. Due to the multisymptomatic, progressive nature of the disease, heart failure patients require a time-intensive, integrated treatment approach that is largely unavailable in rural areas. Rural heart failure patients therefore either travel long distances to urban tertiary centers or simply do not receive the care they need.

The goal of this project is to implement a standardized approach, consistent with evidence-based protocols, among partnering consortium members for the treatment of heart failure throughout three rural, multi-county service areas in Tennessee. This will be accomplished through the standardization of education and protocol among rural primary care and emergency department physicians, the implementation of outpatient Nurse Practitioner Heart Failure Clinics at each of the three primary consortium members’ rural facilities, and the ongoing engagement of the target population through educational outreach in churches and civic centers. The end result will be improved education, diagnosis,

# TENNESSEE

## *Hickman Community Health Care Services, Inc.*

**Grant Number: D04RH12765**

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and treatment related to heart failure, ultimately slowing the progression of heart failure, improving the quality of life of heart failure patients, and reducing regional heart disease deaths. A number of key elements form the consortium's strategy for accomplishing its goals, including:

- Hiring a Heart Failure Clinic Nurse Practitioner (proposed grant-funded position) to coordinate and implement proposed activities.
- Monthly chart reviews to assess protocol adherence and patient compliance; yearly performance measure reviews to evaluate patient outcomes, i.e., hospital re-admission rates.

The target population is all residents of Tennessee's Benton, Carroll, Coffee, Franklin, Grundy, Henry, Hickman, Lewis, Lincoln, Moore, Perry, Stewart, and Weakley counties. The population size of all 13 counties combined is approximately 400,408. All 13 counties are considered Medically Underserved Areas. Hickman Community Hospital (Hickman County) serves as the applicant organization and is considered one of the consortium's 4 partnering members. The other two primary members are medical centers serving clusters of the targeted counties. Saint Thomas Heart is considered a member providing ongoing expertise and clinical resources.

### **ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# TENNESSEE

## *Ridgeview Psychiatric Hospital and Center, Inc.*

Grant Number: D04RH12764

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### **PROGRAM DIRECTOR**

Stacy Park  
240 West Tyrone Road  
Oak Ridge, TN 37830  
Phone: (865) 276-1219  
E-mail: parksp@ridgevw.com

### **TOPIC AREAS**

Substance Abuse, Referral

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Ridgeview, Methodist Medical Center (MMC), Anderson County Health Council's, TN Department of Children's Services, Local Pediatric Physicians/Women's Care Groups, and the Juvenile Court System of Anderson County

### **AREAS SERVED**

Anderson and Roane

### **TARGET POPULATION SERVED**

Drug exposed infants (DEI) and their mothers as well as admitting alcohol and drug (AOD) pregnant mothers.

### **PROJECT SUMMARY**

In 2006, Tennessee ranked higher at 9.2% deaths per 1,000 live births than the United States at 6.4% for infant mortality rates. Tennessee also ranked higher than the countries of South Korea, Italy, United Kingdom, Canada, Australia, Germany and Japan.

The counties of Anderson and Roane, located in the rural Appalachian region, are historically underserved and face many challenges. The mountainous terrain and sheer size of the region encourages isolation. This sense of seclusion coupled with the high levels of poverty, unemployment, low education attainment, high rates of rural drug use, and poor access to birthing facilities results in a large number of cases reported of drug exposed infants and high infant mortality rates.

Drug exposed infants are believed to be why Anderson and Roane counties have extremely high rates of infant deaths. Locally, Roane County (17%) and Anderson County (13.3%) rank higher than the state's average. (*A Tennessee KIDS COUNT Project, The state of the Child in Tennessee 2005*) Tennessee's goal for 2010 is to reduce the total infant mortality rate to 7% per 1,000 live births.

# TENNESSEE

## *Ridgeview Psychiatric Hospital and Center, Inc.*

Grant Number: D04RH12764

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The **Mothers and Infants Sober Together program (MIST)** will address a significant treatment void for Anderson and Roane Counties drug exposed infants (DEI's) and their mothers and admitting AOD (alcohol and other drugs) pregnant mothers by implementing individualized, community based, integrated treatment services linked with a seamless referral system to vocational rehabilitation programs and other needed physical and social services.

The target population of the MIST proposal will be:

- Drug Exposed Infants (DEI) and their AOD mothers. Infants who, at the time of their birth, tested positive for drugs and were negatively impacted by the mother's chemical use enough to warrant Department of Children's Services (DCS) intervention.
- Pregnant AOD mothers who admit to drug use and/or test positive

The MIST program proposes serving 60 infants/mothers annually for a total of 180 over the course of the grant life. Services that will be provided are: 1) Screening and Assessment, 2) Individualized Integrated Treatment, 3) Intensive Case Management, and 4) Linkage and Referral. The MIST team consists of a clinical therapist and case managers who will conduct assessments and implement treatment plans through a home visitation model. MIST intends to work with each mother and infant for approximately six (6) months to stabilize each family unit and facilitate the family's participation with further treatment and a long-term provider.

### **ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

**TENNESSEE**  
***Community Health Network***  
**Grant Number: D04RH12700**

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**PROGRAM DIRECTOR**

Debra Gott  
P.O. Box 40  
Oakdale, TN 37829  
Phone: (866) 519-2464  
Fax: (866) 523-7527  
E-mail: deb.gott@communityhealth.net

**TOPIC AREAS**

Diabetes—Telehealth

**PROJECT PERIOD**

May 1, 2009 – April 30, 2012

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

**PARTNERS TO THE PROJECT**

Hardeman County Community Health Center, Hardin County Regional Health Center, Perry County Medical Center, Inc., and the Monroe Carell Jr. Children's Hospital at Vanderbilt (hereafter "Vanderbilt Children's Hospital" or "Children's Hospital").

**AREAS SERVED**

Tennessee: Hardeman, Haywood, Chester, Perry, Hardin, Wayne, and Hickman counties.

**TARGET POPULATION SERVED**

Expand the use of telehealth in pediatric and adult specialist care.

**PROJECT SUMMARY**

The proposed South Central Tennessee Telehealth Project is based upon a demonstrable need in the target rural communities for improved access to pediatric specialist services. It is also based upon an opportunity and need for the three health centers to establish and collaborate on a program to expand utilization of telehealth equipment/technology purchased by CHN for the health centers through previous USDA and State of Tennessee grants. This collaboration will allow consortium members to access pediatric specialist services from providers affiliated with Children's Hospital in Nashville and Jackson, Tennessee. Though the project will initially focus on three specific areas of need for pediatric services, the long term goal of the consortium is to expand the use of telehealth in pediatric and adult specialist care to meet a wide range of health needs within these and other rural communities in the state.



**TENNESSEE**  
***Community Health Network***  
**Grant Number: D04RH12700**

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**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# TEXAS

## *H.O.P.E.*

Grant Number: D04RH07902

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### **PROGRAM DIRECTOR**

Fran Daniel  
H.O.P.E., Inc.  
595 Ragsdale  
Jacksonville, TX  
Phone: (903) 565-7781  
Fax: (903) 586-2569  
E-mail: frandaniel@suddenlinkmail.com

### **TOPIC AREAS**

Health Literacy

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 160,000
- Year 2 - 135,000
- Year 3 - 110,000

### **PARTNERS TO THE PROJECT**

East Texas Medical Center, Jacksonville, Cherokee County Health Department, ACCESS, Jacksonville Independent School District, University of Texas at Tyler Nursing Program, Stephen F. Austin University School of Nursing, Trinity Counseling Associates of East Texas, Inc., and Trinity Mother Frances Health System

### **AREAS SERVED**

Cherokee County

### **TARGET POPULATION SERVED**

To provide access to healthcare resources for the uninsured, underinsured, or medically underserved citizens of Cherokee County.

### **PROJECT SUMMARY**

Cherokee County, located in the piney woods of East Texas is a rural county with a population of 48,464. The largest town in Cherokee County is Jacksonville, with a population of less than 14,000. Sixteen percent of the residents of Cherokee County are Hispanic and the number continues to rise. The county covers 1,052 square miles with approximately 44 persons per square mile, compared with the state of Texas, which has almost 80 people per square mile. There is no public transportation in the county or in any of the towns.

The median household income of Cherokee County is just under \$30,000, compared to almost \$40,000 for the state. Eighteen percent of the people in Cherokee County are living below the poverty level, compared with 16% of Texans as a whole.

There are a number of factors that contribute to the need for improved access to health care for the economically disadvantaged in Cherokee County. These include: a large percentage of the population

# TEXAS

## *H.O.P.E.*

**Grant Number: D04RH07902**

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living at or near the poverty level; a large Hispanic population with accompanying language/cultural barriers; and a large rural area with no public transportation.

As a result of the economic, geographic and language/cultural barriers, the unmet needs of our target population include access to the following: primary health care for emergency and ongoing care; health screenings to identify chronic diseases and conditions; health education programs, including disease management and monitoring; free or low cost medications; and transportation to medical appointments and to other programs that promote a healthy lifestyle.

Partners In Health for Cherokee County is designed to provide access to healthcare resources for the uninsured, underinsured, or medically underserved citizens of Cherokee County. The project's goal is improved health of the target population through increased access to primary healthcare, participation in health education programs, and referral for eligible benefits. The project has been developed by a consortium of community organizations interested in providing better health for the underserved population of the county.

HOPE will act as a clearinghouse for the program by providing financial and health screenings and then referring those who qualify to physicians who volunteer to see the patient in their office at no cost to the patient. Hope will also refer clients to other assistance programs and will take the lead in organizing health screenings, health fairs, health education programs, and arrangements for transportation. These activities will continue in the Jacksonville area and outreach efforts will begin to serve all other areas of the county during the three years of the project.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
(301) 443-6884  
lsmetana@hrsa.gov

# TEXAS

## *East Texas Access Network*

**Grant Number: D04RH12691**

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### **PROGRAM DIRECTOR**

Carlene Womack  
117 W Houston Street  
Jasper, TX 75951  
Phone: (409) 384.2099  
Fax: (409) 384.2211  
E-mail: carlene.womack@ethannetwork.org

### **TOPIC AREAS**

Chronic Disease

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

East Texas Health Access Network, Jasper Newton County Public Health District, CHRISTUS Health, Department of Community Health, CHRISTUS Jasper Memorial Hospital, AgriLIFE Extension Office, Jasper County, Stephen F. Austin State University School of Human Sciences, and WellDoc, Inc.

### **AREAS SERVED**

Jasper, Newton, Sabine, San Augustine and Tyler Counties of Northeast Texas

### **TARGET POPULATION SERVED**

Empower and support uninsured, high risk, chronically ill individuals and their families.

### **PROJECT SUMMARY**

The overarching goal of the Community-Based Care Management for the Chronically-Ill Project (CBCMCP) to empower and support uninsured, high risk, chronically ill individuals and their families by developing the requisite skills and behaviors needed to self-manage obesity, diabetes and hypertension through more effective utilization of health care resources, improved adherence to treatment plans and adoption of healthier behaviors. The goal of the CBCMCP will be implemented through a complementary set of strategies: 1) appropriate health resource utilization, 2) adoption of healthy behaviors, 3) improved health literacy, and 4) an innovative, mobile, chronic disease management system.

The program will address the need for more effective control of chronic illnesses, specifically obesity, diabetes and hypertension, which are endemic among the uninsured residents of the five county of Jasper, Newton, Sabine, San Augustine and Tyler Counties of northeast Texas. Participants will benefit from intensive care management by certified community health workers, primary care through CHRISTUS Rural Health Clinics, evidence-based education in chronic disease management provided by AgriLife Extension, and one to one nutrition counseling through Steve F Austin State University Health Sciences. Well Doc's mobile chronic disease management service will facilitate consistent monitoring, nutritional

# TEXAS

## *East Texas Access Network*

**Grant Number: D04RH12691**

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support and real time coordination between participating patients, their community health worker, and primary care providers.

ETHAN is requesting a funding preference based on the region's official status as HPSA's, MUA's and MUP's (Health Professional Shortage Areas/Medically Underserved Areas/Medically Underserved Populations), and a focus on primary care strategies that include routine medical care, vision care, dental care, diagnosis, treatment, and health education, and referrals.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# TEXAS

## *Migrant Health Promotion*

Grant Number: D04RH12667

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### **PROGRAM DIRECTOR**

Phillis Engelbert  
536 S. Texas Boulevard, Suite 117  
Weslaco, TX 78596  
Phone: (956) 968-3600  
Fax: (956) 968-3737  
E-mail: pengelbert@migranthealth.org

### **TOPIC AREAS**

Health Promotion, Access, Prevention

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Hope Family Health Center, St. Marie's Clinic, and ARISE

### **AREAS SERVED**

Hidalgo County, TX Rural colonias on the outskirts of Pharr, Edinburg, and Alamo

### **TARGET POPULATION SERVED**

Low-income Latino residents

### **PROJECT SUMMARY**

*Futuros Saludables* (Healthy Futures) will improve access to primary and mental health care, as well as nutrition and physical fitness education, to medically underserved Latino residents of Hidalgo County, Texas. The program will demonstrate the synergistic effect of behaviors and services that enhance both mental health and physical health, improve overall wellness, and enhance quality of life. By bringing a mobile medical clinic and psychological counselors directly to rural *colonias* of the Lower Rio Grande Valley, the program will overcome transportation barriers that often prevent *colonia* residents from receiving care. Community Health Workers and health care providers will offer community-based, culturally and linguistically competent health care and health education.

Migrant Health Promotion will lead *Futuros Saludables* in a formal collaboration with Hope Family Health Center, ARISE (network of volunteers and community centers) and St. Marie's Mobile Clinic. The Program will draw on the *Futuros Saludables* Consortium to increase access to and utilization of relevant health care services. In addition, the program will employ community-organizing strategies to unite community members in isolated *colonias*, respond to their health challenges with information and resources, and work together to create positive social support and community changes. Residents trained as Community Health Workers 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.

## TEXAS

### *Migrant Health Promotion*

Grant Number: D04RH12667

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The target population for the *Futuros Saludables* program comprises Spanish-speaking Latino *colonia* residents in rural, southern Hidalgo County at the southernmost tip of Texas. All of Hidalgo County is designated a Health Professional Shortage Area, a Medically Underserved Area for primary care, and a Medically Underserved Area for mental health. More than 30 percent of Hidalgo County residents are uninsured. *Colonias* are unincorporated neighborhoods developed outside of city limits and lacking city services such as transportation, utilities and road signs. More than 400,000 Texans live in *colonias*, with the largest concentration in Hidalgo County; an estimated 98-99 percent of *colonia* residents are Latino. Nearly 30 percent of border Hispanics in *colonias* live in poverty; an estimated 50-75 percent of *colonia* residents are, or have been, farmworkers.

By offering peer health education and sustaining a community-based health service and referral network, the *Futuros Saludables* program will increase access to primary and behavioral health care services among the target population; increase participants' knowledge of how to access services; increase participants' understanding of mental health issues and the benefits of good nutrition and exercise; and increase participants' healthy behaviors. Annual, community-based assessment surveys and pre-tests and post-tests administered at the beginning and end of each educational presentation will provide evidence of increasing knowledge of, access to, utilization, and satisfaction with the health services provided. For each year of the three-year program (May 1, 2009 to April 30, 2012), *Futuros Saludables* will provide physical and mental health care - plus education, referrals, and case management - to at least 700 low-income, uninsured individuals previously isolated from appropriate services in targeted *colonias*.

#### **ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# VIRGINIA

## *Shenandoah Memorial Hospital*

Grant Number: D04RH07904

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### **PROGRAM DIRECTOR**

Floyd Heater  
Shenandoah Memorial Hospital  
759 South Main Street,  
Woodstock, VA  
Phone: (540) 459-1100  
Fax: (540) 459-1121  
E-mail: fheater@valleyhealthlink.com

### **TOPIC AREAS**

Elder Care

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 149,914
- Year 2 - 124,999
- Year 3 - 99,999

### **PARTNERS TO THE PROJECT**

Shenandoah Memorial Hospital (SMH), Shenandoah Area Agency on Aging (AAA), Shenandoah County Free Clinic, United Way of Northern Shenandoah Valley, Valley Health Systems (VHS), and Our Health, Inc.

### **AREAS SERVED**

Rural Shenandoah County, Virginia

### **TARGET POPULATION SERVED**

It will specifically serve the health needs of older adults and seniors, children and underserved minority residents.

### **PROJECT SUMMARY**

The “Community Health Connections” project will provide disadvantaged persons in rural Shenandoah County, Virginia with enhanced access to health services utilizing a variety of education, outreach and coordination of care activities. It will specifically serve the health needs of older adults and seniors, children and underserved minority residents. The goals of the project are to: 1) Improve the health of chronically ill older adults living in remote areas through innovative health care delivery methods; 2) Assist low-income and disadvantaged persons living in obtaining access to key health and human services; 3) Make communities in the region more aware of rural health issues through extensive network community outreach/marketing and public relations; and, 4) Stimulate partnership and collaborations among providers so that a well-coordinated approach to meeting rural health needs is in Activities that will be carried to fulfill these goals include: having nurses go into homes of immobile chronically ill seniors to provide treatment; providing case management services low-income persons so they can access affordable health and human services, operating a transportation program that connections citizens with health providers, and conducting a variety of education, public relations and outreach activities so citizens know how to access affordable health care. The project will be operated by a consortium of six partner



## VIRGINIA

### *Shenandoah Memorial Hospital*

**Grant Number: D04RH07904**

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organizations in collaboration with numerous local public, private, non-profit and faith-based organizations. It will serve an estimated 2,475 persons and provide approximately 14,200 health encounters over a three year period. The year one federal budget request is \$149,914, with an estimated \$55,937 in cash and in-kind resources being provided by the consortium members (a 37 percent match).

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

# VIRGINIA

## *Carilion Giles Memorial Hospital*

Grant Number: D04RH08045

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### **PROGRAM DIRECTOR**

Tammy Blankenship  
Carilion Giles Memorial Hospital  
1 Taylor Avenue  
Pearisburg, VA  
Phone: (540) 921-6877  
Fax: (540) 921-6858  
E-mail: thblankenship@carilion.com

### **TOPIC AREAS**

Mental Health

### **PROJECT PERIOD**

May 1, 2007 – April 30, 2010

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

### **PARTNERS TO THE PROJECT**

Carilion Giles Memorial Hospital (CGMH), the Free Clinic of the New River Valley (FCNRV), the Mental Health Association of the New River Valley (MHANRV), and the Virginia Rural Health Resource Center (VRHRC).

### **AREAS SERVED**

Rural Giles County, Virginia

### **TARGET POPULATION SERVED**

Services will be provided to Giles County residents who are low income (at or below 125 percent of the poverty guidelines) and have no health insurance.

### **PROJECT SUMMARY**

Giles County, in far Southwestern Virginia, is experiencing a dire need for health care services, including mental health care and oral care. This need is created by the unusually high number of uninsured, unemployed, and low-income families living in this area, along with significant geographic barriers that make travel difficult. The need is evidenced by the high proportion of emergency room visits for non-emergency medical, dental and mental health issues. Giles County is categorized as a Medically Underserved Population (MUP) and the County is in the process of obtaining designation as a Health Professional Shortage Area (HPSA). The program headquarters and clinic will be located in Giles County which is in an officially designated rural census tract.

The proposed solution, the Giles Community Health Access Project (G-CHAP), will be a new, innovative, and collaborative approach to the delivery of health care for Giles County residents. Comprehensive and holistic care including medical, dental, mental health, and pharmacy services will be delivered collaboratively through four Network Consortium members: Carilion Giles Memorial Hospital (CGMH), the Free Clinic of the New River Valley (FCNRV), the Mental Health Association of the New

## VIRGINIA

### *Carilion Giles Memorial Hospital*

**Grant Number: D04RH08045**

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River Valley (MHANRV), and the Virginia Rural Health Resource Center (VRHRC). Each member will promote rural health service outreach by expansion of existing services, creation of new services, sharing of resources and evaluation of program impact. The G-CHAP Program will coordinate current and new safety net services for individuals previously unable to seek medical treatment because of lack of finances or insurance.

CGMH will contribute the program's clinic building located in central Giles County. The clinic will operate every weekday. A paid staff of a half-time Nurse Practitioner and full-time Program Assistant will be bolstered by the participation of health care student interns from four regional colleges and local volunteers. The G-CHAP clinic will function as a satellite of the FCNRV. Dental services will be provided by the FCNRV's Dental Program. FCNRV will also contribute the use of its licensed pharmacy for free medication access. Mental health services will be provided by the award-winning *ARMS Reach* Project of the MHANRV. Specialty clinics for patients with chronic conditions such as diabetes and heart disease will be established to provide continuity of care with a strong focus on health education/literacy.

Process and outcome evaluation of the G-CHAP Program will be conducted by the Virginia Rural Health Resource Center. Program design will be culturally compatible with the Appalachian heritage of the target population, and service delivery will be culturally informed in all aspects.

Services will be provided to Giles County residents who are low income (at or below 125 percent of the poverty guidelines) and have no health insurance. To assure success of the project, the local community has been highly involved in the planning for the G-CHAP clinic. A local consumer survey was conducted to identify health needs and access issues. Meetings with local government officials, health care professionals, and agency directors were conducted to assure broad input and support for the project.

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

# VIRGINIA

## *Blue Ridge Medical Center, Inc.*

Grant Number: D04RH12653

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### **PROGRAM DIRECTOR**

Margaret Whitehead  
4038 Thomas Nelson Highway  
Arrington, VA 22922  
Phone: 434-277-8234  
E-mail: peggyw@brmedical.com

### **TOPIC AREAS**

Health Promotion, Access, Prevention

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Downtown Family Practice (Charlottesville) Johnson Health Center in Lynchburg, University of Virginia Health System, Nelson Eye Center, and the Departments of Social Services in Amherst and Nelson Counties

### **AREAS SERVED**

Nelson County and surrounding communities

### **TARGET POPULATION SERVED**

Low-income uninsured individuals

### **PROJECT SUMMARY**

The Blue Ridge Medical Center (BRMC), a community health center located in Arrington, Virginia, proposes to expand the scope of a preventive health care delivery model called the “*Wellness Passport*”, a benefits program for low-income uninsured individuals. Target populations include qualified residents of Nelson and Amherst Counties, and the Latino population of migrant and settled laborers in these areas and in neighboring Albemarle County. BRMC’s “Rural Health Outreach Program” (RHOP) has created and piloted the *Wellness Passport*, enrolling uninsured patients under 200% of the poverty level. Services include:

- A comprehensive physical exam including age and gender specific screens as well as assistance setting individual health improvement goals;
- Health coaching through follow-up contacts with enrollees;
- Care management services for enrollees who are in need of access to social, mental health, dental services, or specialty care;
- Minimal office fees for visits with participating primary care providers.

Partnering primary care practices offer a low discounted service fee for enrollees. Joining BRMC are the Downtown Family Practice (Charlottesville) whose bilingual providers accommodate Spanish speakers, and the Johnson Health Center in Lynchburg, which provides convenient and affordable access for rural

## VIRGINIA

### *Blue Ridge Medical Center, Inc.*

**Grant Number: D04RH12653**

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residents in Amherst County. Consortium members also include: University of Virginia Health System providing access to specialty care using telemedicine equipment located at Blue Ridge Medical Center; Nelson Eye Center, Optometrists, providing vision screening for enrollees, and the **Departments of Social Services in Amherst and Nelson Counties**, providing Passport enrollment assistance and referral. BRMC provides supportive outreach activities to serve Passport enrollees and other target populations to increase access to care.

- Through RHOP's school nursing program children are identified who qualify for the state's child health insurance programs. The parents of these children are also a target population for the Wellness Passport.
- Assistance in obtaining free and reduced medications is provided through our "Medication Assistance Program (MAP).
- Latino families are provided with home and work site preventive health care using our mobile clinic. Transportation and medical interpretation are provided for visits to health and human service providers.

The outcomes for all these activities are aimed at improving personal health status by making health care affordable and available; and to decrease the costly hospital-based care through prevention, care management and health education. Because we know that the uninsured are less likely to see a doctor and have a regular source of care, and that they receive fewer preventive services and less care for chronic conditions than the insured, this program targets the most vulnerable populations, those who are low-income and uninsured, including the Latino population. The Wellness Passport program will prepare materials and sustainability plans for replication of the model in other rural areas.

#### **ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# VIRGINIA

## *Appalachian Agency for Senior Citizens*

Grant Number: D04RH12654

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### **PROGRAM DIRECTOR**

Rose Hurley  
P.O. Box 765  
Cedar Bluff, VA 26609  
Phone: (276) 964-7152  
E-mail: rhurley@aasc.org

### **TOPIC AREAS**

Elder Care, Mental Health, Substance Abuse

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Cumberland Mountain Community Services Board, Dickenson County Behavioral Health Services, and University of Appalachian College of Pharmacy.

### **AREAS SERVED**

Buchanan, Dickenson, Russell and Tazewell

### **TARGET POPULATION SERVED**

Health care needs of frail elders

### **PROJECT SUMMARY**

Appalachian Agency for Senior Citizens, a private non-profit corporation, is the designated area agency on aging serving four rural counties in southwestern Virginia. Since 1975, the agency has provided a variety of services to the older and disabled population of this rural area including personal care, homemaker, nutrition, transportation, care coordination, disease prevention and health promotion, medication management, and emergency home repair. In October 2006 the agency was awarded Federal and State funding to develop a Program of All-inclusive Care for the Elderly (PACE). Throughout 2007 and the early months of 2008, the agency completed all the federal and state requirements to operate a PACE program, and in March 2008, the agency was granted permanent provider status as a PACE Organization under both Medicare and Medicaid. This new program added another dimension to the current service structure of the agency. For the first time the agency would be managing and coordinating the health care needs of frail elders as well as the social support services currently in place.

A PACE program provides all needed medical and supportive services for the frail elderly with chronic care needs in community and home-based settings. To be eligible to receive services under the PACE program, an individual must meet the level of care required for nursing home placement. The goals of PACE are to enhance the quality of life and autonomy for frail, older adults; maximize dignity of and respect for older adults; enable frail older adults to live in their homes and their community as long as medically and socially feasible; and preserve and support the older adult's family unit.

# VIRGINIA

## *Appalachian Agency for Senior Citizens*

**Grant Number: D04RH12654**

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- Adult day care that offers meals, personal care, recreation, socialization, and transportation
- Medical care by a primary care physician and nurses
- Physical and Occupational therapies
- Home health care and personal care
- All necessary prescription drugs and over the counter medications
- Social services
- Medical specialists such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

Central to the PACE model is the delivery of most needs in a center setting where participants may come regularly to access primary care and social services. PACE participants can regularly attend the PACE center on an average of three days a week if desired. The center includes a health clinic with a primary care physician and registered nurses, physical and occupational therapy facilities, and at least one common room for social and recreational activities. The center environment, where most staff provides services, is a valuable observation and care environment where providers can call upon other staff members to monitor how participants are faring and how they are responding to different interventions. And because PACE participants have regular contact with primary care professionals who know them well, slight changes in their health status or mood can be immediately addressed.

### **ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# VIRGINIA

## *The Health Wagon, Inc.*

Grant Number: D04RH12777

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### **PROGRAM DIRECTOR**

Teresa Gardner  
119 Number Ten Street  
Clinchco, VA 24226  
Phone: (276) 835-9474  
Fax: (276) 835-1300  
Email: hw@thehealthwagon.org

### **TOPIC AREAS**

Primary Care, Diabetes

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,859
- Year 2 – 122,825
- Year 3 – 99,205

### **PARTNERS TO THE PROJECT**

University of Virginia (UVA) Health System and Mountain States Health Alliance (MSHA)

### **AREAS SERVED**

Virginia counties of Buchanan, Dickenson, Russell, and Wise

### **TARGET POPULATION SERVED**

Primary Care for People with Diabetes

### **PROJECT SUMMARY**

The Health Wagon, Inc., a 501c3 non-profit, is the applicant organization for a Rural Health Care Services Outreach (HRSA 09-002, CFDA 93.912) grant to the Office of Rural Health Policy. It is the lead organization in a consortium with the University of Virginia and Mountain States Health Alliance. The purpose of the **Enhancing Primary Care for People with Diabetes in Southwestern Virginia** project is to improve diabetes-related primary care services to medically underserved and indigent diabetic and at-risk patients of all ages in rural far Southwest Virginia (SWVA) through the use of the chronic care model.

The region served is specifically the southwestern Virginia counties of Buchanan, Dickenson, Russell, and Wise, located in the heart of the Appalachian coalfields. This region is severely affected by high rates of diabetes, with mortality rates that are 81.4% higher than that of the state and 55.4% higher than that of the nation. The Virginia Department of Health reports that the Appalachian region of Virginia has a diabetes prevalence of 10.4%, compared to 6.5% for the rest of the Commonwealth. Of 1381 active patients seen by the Health Wagon, 217 of them are diagnosed diabetics, a prevalence rate of 15.7%.

In partnership with the University of Virginia (UVA) Health System and Mountain States Health Alliance (MSHA), the Health Wagon will provide comprehensive primary care for patients with or at-risk for chronic diabetes in a four county region in Southwest VA. A nurse practitioner will coordinate the



## VIRGINIA

### *The Health Wagon, Inc.*

**Grant Number: D04RH12777**

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implementation of the chronic care model and ensure access without disparity. The Health Wagon will coordinate the delivery of a quarterly UVA endocrinology clinic. Mountain States Health Alliance will provide space for the clinics, and provide training for Health Wagon staff on the implementation of an electronic patient registry and process improvement practices. The net result will be access to improved primary care, with specialist support, for at-risk and diagnosed diabetics in these rural, impoverished areas.

**ORHP CONTACT:**

Karen Beckham  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0502  
kbeckham@hrsa.gov

# VIRGINIA

## *Northern Neck Middle Peninsula Telehealth Consortium*

Grant Number: D04RH12656

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### **PROGRAM DIRECTOR**

Edie McRee Bowles  
659 Hospital Road, Building A, Suite 104  
Tappahannock, VA 22560  
Phone: (804) 443-6286  
Fax: (804) 443-3780  
E-mail: firenz72@yahoo.com

### **TOPIC AREAS**

Telehealth, Chronic Disease Management

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Riverside Tappahannock Hospital, Westmoreland Medical Center, Central Virginia Health Services, University of Virginia Telemedicine Department, Virginia Commonwealth University Telemedicine Department, Bay Aging, Rappahannock General Hospital, Walter Reed Hospital, Northumberland County Economic Development Council, Middle Peninsula Northern Neck Community Services Board, Three Rivers Health District, Rappahannock Rural Health Development Center, and Family Maternity Center of the Northern Neck

### **AREAS SERVED**

Essex, King William, King and Queen, Northumberland, Middlesex, Gloucester, Mathews, Lancaster, Richmond, and Westmoreland

### **TARGET POPULATION SERVED**

Increase access to care for older adults (over 55) with chronic diseases

### **PROJECT SUMMARY**

Bridges to Health is a health education and medical care delivery project that uses telehealth technology to target chronic diseases, especially diabetes, in diagnosed and at risk older (55+) adults. An initiative of the Northern Neck Middle Peninsula Telehealth Consortium, it brings together Network members with five new Partners. The project plan describes three goals to improve access, enhance health care delivery, avoid re-hospitalizations, provide health information, and foster independent living for older adults.

Increase access to care for older adults (over 55) with chronic diseases who reside in the Northern Neck and Middle Peninsula by expanding telehealth capabilities in the region and the number and types of consultations with specialty physicians using telemedicine technology.

Improve diabetes/chronic disease self-management for older adults by collaborating with Certified Diabetes Centers to develop a diabetes education program to be broadcast widely in the region using

# VIRGINIA

## *Northern Neck Middle Peninsula Telehealth Consortium*

**Grant Number: D04RH12656**

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telehealth technology, thereby reducing unnecessary use of higher-cost health care facilities and keeping older adults at home as long as possible.

Enhance provider capacity to meet care needs of patients with chronic diseases by developing and providing continuing medical education for allied health professionals, caregivers, and physicians using telehealth technology.

The service area is home to a sparse and geographically dispersed predominantly lower income, older, and medically underserved population of over 141,000. Due to social, economic, cultural, geographic, ethnicity, age, education levels and health status, many residents have significant difficulty in accessing existing health services and making optimal use of resources to prevent, detect and manage their diseases. Contributing to care barriers are travel difficulties for older patients who live at a distance from specialty providers; provider shortages that threaten the management of patient care; and chronic disease rates at a rate higher than the national and state mean.

The Bridges to Health project proposes to serve over 32,000 older adults who reside in a rural northeastern Virginia (counties of Essex, King William, King and Queen, Northumberland, Middlesex, Gloucester, Mathews, Lancaster, Richmond, and Westmoreland). It targets those who have been diagnosed with and are receiving or should receive education and treatment to manage chronic diseases, especially diabetes; patients who may require care from medical specialists; and health care providers needing continuing medical education. Annually, the project works with an average of 250-275 patients, and an average of 50-70 rural health care providers.

The use of telehealth technology will improve access to health information; increase compliance and self-management of chronic diseases; help patients seek earlier care for complications; support more coordinated information exchange between providers; and reduce inappropriate emergency room use, or reliance on higher levels of care.

**ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov

# VERMONT

## *Bi-State Primary Care Association*

Grant Number: D04RH12687

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### **PROGRAM DIRECTOR**

Kate Simmons  
61 Elm Street  
Montpelier VT 05602  
Phone: 802-229-0002/  
Fax: 802-223-2336  
E-mail: ksimmons@bistatepca.org

### **TOPIC AREAS**

Primary Care

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,983
- Year 2 – 124,987
- Year 3 – 99,994

### **PARTNERS TO THE PROJECT**

The Open Door Clinic (ODC), and the Northern Tier Center for Health (NoTCH)

### **AREAS SERVED**

Addison, Franklin, and Grand Isle counties, Vermont

### **TARGET POPULATION SERVED**

Outreach and primary care to immigrant farm workers

### **PROJECT SUMMARY**

Bi-State Primary Care Association is applying for \$374,964 over three years to implement The Vermont Farm Health Connection in conjunction with The Open Door Clinic (ODC), and the Northern Tier Center for Health (NoTCH). The Vermont Farm Health Connection will provide outreach and primary care services to immigrant farmworkers located initially in Vermont's Addison, Franklin, and Grand Isle Counties; though in Year 2 an additional service area will be selected (depending on results of a Year 1 Needs Assessment). Primary and preventive care services to include health and farm safety education, physical exams, chronic care management, oral hygiene, etc., will be provided in culturally- and linguistically-competent clinics on farms and in nontraditional community locations convenient for farmworkers (e.g. church basements, etc.). Additionally, ODC will establish Vermont's first-ever voucher program for transportation and dental care for farmworkers living in Addison County. All services will be rigorously evaluated and improved upon throughout the project period.

Vermont's immigrant farmworker population is one of the most marginalized and vulnerable populations in the state. Little information is known about their numbers, though a conservative best guess is that Vermont hosts roughly 2,500 farmworkers, mostly from Mexico, dispersed in small numbers throughout the state. A 2007 VT Department of Health report estimates 1,200 live in the rural Champlain Valley (Addison, Franklin, and Grand Isle Counties). These farmworkers are geographically, culturally, and linguistically isolated, have limited access to financial resources, and have little to no knowledge of the

## VERMONT

### *Bi-State Primary Care Association*

**Grant Number: D04RH12687**

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health services available to them. Inperson interviews have found that their health concerns include skin problems, lower back pain, toothaches and other oral pain, depression, and communicable diseases including tuberculosis. Farmworkers and farm owners/operators on their behalf have long advocated for health services available to farmworkers on or close to farms. It has been this repeated request that led to the development of The Vermont Farm Health Connection. The Vermont Farm Health Connection, however, represents just the first step in serving this population; the ultimate vision is for a statewide, sustainable program, operated by a network of Vermont's safety-net providers. HAB is consequently designed to be both replicable and expandable, and "lessons learned" will be shared within the Vermont Rural Health Alliance (VRHA), the VT Farm Health Taskforce and a broad audience of Vermont organizations.

**ORHP CONTACT:**

Valerie Darden  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0837  
vdarden@hrsa.gov

# VERMONT

## *Mt. Ascutney Hospital Community Health Foundation*

Grant Number: D04RH16292

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### **PROGRAM DIRECTOR**

Jill M. Lord  
289 County Road  
Windsor, VT 05089  
Phone: (802) 674-7327  
E-mail: jill.m.lord@hitchcock.org

### **TOPIC AREAS**

Mental Health, Oral Health, Uninsured

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Consortium partners include Mt. Ascutney Hospital Community Health Foundation (applicant), Mt. Ascutney Hospital and Health Center, the Windsor Area Community Partnership (a 51-member collaborative), Windsor Connection Resource Center, Windsor Community Health Center, West Central Behavioral Health, and the Health Care and Rehabilitation Services (HCRS).

### **AREAS SERVED**

Windsor, Vermont

### **TARGET POPULATION SERVED**

Targeting low income, uninsured, underinsured, and underserved residents in Windsor, Vermont.

### **PROJECT SUMMARY**

A consortium of seven health and social service providers are engaged in efforts to create an integrated primary medical, mental health, and oral health service delivery system targeting low income, uninsured, underinsured, and underserved residents in Windsor, Vermont. Consortium partners include Mt. Ascutney Hospital Community Health Foundation (applicant), Mt. Ascutney Hospital and Health Center, the Windsor Area Community Partnership (a 51-member collaborative), Windsor Connection Resource Center, Windsor Community Health Center, West Central Behavioral Health, and the Health Care and Rehabilitation Services (HCRS).

The priority unmet health needs of the service area targeted for this project are dental, mental health, and uninsured. Other priorities addressed by this project include transportation, service integration, and communication across three distinct health care systems, namely primary medical care, mental health care, and oral health care.

Increased access to medical, dental, and mental health care for low income, uninsured, underinsured, and underserved residents in Windsor, Vermont will be accomplished through an interdisciplinary consortium. The overarching goals for this initiative are 1) to expand the delivery of primary health care

## VERMONT

### *Mt. Ascutney Hospital Community Health Foundation*

**Grant Number: D04RH16292**

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services to include mental health, oral health, and access to economic, health, and social services for 4071 low-income, underinsured, uninsured, and underserved residents (2010 improve access to comprehensive quality health care services); 2) increase access to appropriate and quality mental health services for uninsured and under insured individuals (HP2010 – Focus area 18 – MH; and 3) increase access to preventive and restorative oral health care for uninsured and underinsured children and adults (HP2010 – Focus area 21 – OH). To accomplish these goals, the consortium will *create a collaborative that brings together at least ten providers from primary care, social services, mental health, and oral health; create comprehensive mental health and oral health service integration plans; establish a satellite site of the Windsor Community Health Clinic at the Windsor Connection Resource Center; increase by 5%, the number of residents in the MAHHC service area that have successfully applied for health insurance; refer 877 low-income, uninsured, underinsured, and underserved citizens and families to primary care, mental health, and oral health providers and programs established by the oral and mental health collaborative; and assist at least 439 residents in accessing available economic, rehabilitation, and social services.*

**ORHP CONTACT:**

Leticia Manning  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-8335  
lmanning@hrsa.gov

# VERMONT

## *Southern Vermont Area Health Education Center*

Grant Number: D04RH12782

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### **PROGRAM DIRECTOR**

Nancy Lanoue  
365 River Street  
Springfield, VT 05156  
Phone: 802-885-2126  
Fax: 802-885-2128  
E-mail: nlanoue@svahec.org

### **TOPIC AREAS**

Children's Health

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,957
- Year 2 – 124,968
- Year 3 – 99,064

### **PARTNERS TO THE PROJECT**

Springfield Hospital, Windham Northeast Supervisory Union, Cornerstone Pediatrics, Springfield Pediatric Network, Vermont Department of Health, Springfield District, and Southern Vermont Area Health Education Center

### **AREAS SERVED**

Bellows Falls, Windham County, Vermont Springfield, Windsor County, Vermont

### **TARGET POPULATION SERVED**

K-5 children above the 85<sup>th</sup> percentile BMI

### **PROJECT SUMMARY**

The 30+5 school-based project will focus on elementary school students by increasing intake of fruits and vegetables and participating in more physical activity in grades K-5 in Bellows Falls and Springfield, Vermont.

Both are rural towns in particular need of obesity prevention efforts since these communities struggle with poverty, unemployment, and low education levels that put them in a lower socioeconomic group.

“Obese young people are more likely than children of normal weight to become overweight or obese adults, and therefore more at risk for associated health problems, including heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis” (CDC).

The project proposes to improve the activity and nutritional environment at school through local wellness and nutrition committees (WNCs) by recruiting parents and students who have a stake in what food is available during the school day. A consistent involvement with administrators and the school board to keep them abreast of what the WNCs are doing is also imperative.



## VERMONT

### *Southern Vermont Area Health Education Center*

**Grant Number: D04RH12782**

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The proposed project will increase nutrition improvement opportunities by incorporating more fresh fruits, vegetables, and whole foods into school food. To help, the consortium proposes to increase the capacity of volunteers both in school food preparation and donations of fresh fruits and vegetable to the school lunch kitchens. The project plans to increase nutritional skill level for school personnel, volunteers, and parents involved in school food to support food change.

A public information focus on both in-school and community health promotion will be achieved through media coverage of special fitness events for families, community gardening, classroom activities, and volunteer projects.

**ORHP CONTACT:**

Sonja Taylor  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-1902  
staylor@hrsa.gov

**WASHINGTON**  
***Family Health Centers***  
**Grant Number: D04RH07912**

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**PROGRAM DIRECTOR**

Heather Findlay  
Family Health Centers  
716 First Avenue South  
Okanogan, WA  
Phone: (509) 422-5700  
Fax: (509) 422-7680  
E-mail: hfindlay@myfamilyhealth.org

**TOPIC AREAS**

Minority/Cultural/HL

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 144,887
- Year 2 - 113,077
- Year 3 - 99,693

**PARTNERS TO THE PROJECT**

In partnership with Mid Valley Hospital (MVH) and Okanogan County Public Health (OCPH) will form a consortium to provide health education and outreach to the Migrant and Seasonal Farmworker (MSFW) population in Okanogan County, a large rural region in north central Washington.

**AREAS SERVED**

Rural Okanogan County

**TARGET POPULATION SERVED**

Latino residents and MSFW and their families in rural Okanogan County.

**PROJECT SUMMARY**

Family Health Centers (FHC), the applicant agency, in partnership with Mid Valley Hospital (MVH) and Okanogan County Public Health (OCPH) will form a consortium to provide health education and outreach to the Migrant and Seasonal Farmworker (MSFW) population in Okanogan County, a large rural region in north central Washington. The Program will use the promotor(a) model (lay workers) to improve and expand culturally relevant health education for Latino residents and MSFW and their families in rural Okanogan County. Consortium members have worked together for nearly a decade and will use their strong existing relationships to conduct this work. This project was developed with the assistance and input from the Latino and MSFW communities. Family Health Centers 'La Futura Mama y Su Salud' (The Mother to be and Her Health') has been an existing task force program between the consortium members. This pilot project has, on a small scale, done some outreach to the Latino community, and was funded through the local Health Department for two years, which ends in June 2007. This new Program will enable us to provide new and expanded services under the operation of Family Health Centers.

## WASHINGTON

### *Family Health Centers*

**Grant Number: D04RH07912**

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In Okanogan County, an agriculturally-based economy, migrant workers are a key portion of the labor force. 14.4% of the county's resident self-identify as being Latino. This number swells during summer and the fall, with transient migrant workers who come to harvest fruits, nuts and berries. Within Family Health Centers' (FHC's) patient population nearly 50% are Latino and 7% are Migrant and Seasonal Farmworkers. Providing culturally and linguistically appropriate healthcare to Latino patients is an ongoing challenge for local health care providers, because the community has a different language, cultural and religious beliefs that affect willingness to access care and, there are immigration issues that prevent this population from seeking care. This project is designed to address these challenges.

We will: (1) Develop and implement a promotor(a) (lay educators) program so that health education can be taken to the orchards, agricultural camps, and other community events and locations. (2) Develop and broadcast education programs through a local Spanish language radio station. (3) Provide childbirth education by a bilingual certified Lamaze instructor; and (4) Train health care providers and others in the community about cultural competency and the practice of medicine. During this Program we anticipate providing services to 1,939 clients.

#### **ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

**WASHINGTON**  
***San Juan County Public Health***  
**Grant Number: D04RH07913**

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**PROGRAM DIRECTOR**

Beth Williams Gieger  
Compass Health  
4526 Federal Avenue (M/S 19)  
Everett, WA 98213  
Phone: (425) 349-6320  
Fax: (425) 349-6325  
E-mail: bethwg@interisland.net

**TOPIC AREAS**

Telepsychiatry

**PROJECT PERIOD**

May 1, 2007 – April 30, 2010

**FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 - 150,000
- Year 2 - 125,000
- Year 3 - 100,000

**PARTNERS TO THE PROJECT**

The proposed partnership-Inter Island Medical Center, two Compass Health facilities (one in San Juan County), and Regence Blue Shield (which will contribute technical data and consultation regarding service delivery)-will establish, run, and maintain a telemedicine service project that provides psychiatric evaluation and treatment to isolated patients in San Juan County.

**AREAS SERVED**

Rural San Juan County, WA

**TARGET POPULATION SERVED**

The project has two goals: 1) increasing access to psychiatric services for underserved populations, and 2) influencing third party payers to pay for such services in order to sustain services over the long-term.

**PROJECT SUMMARY**

Inter Island Medical Center and its partners request a grant of \$375,000 to establish, run, and maintain a telemedicine project that provides psychiatric services to isolated patients in rural San Juan County, WA. The project has two goals: 1) increasing access to psychiatric services for underserved populations, and 2) influencing third party payers to pay for such services in order to sustain services over the long-term. Telemedicine via videoconferencing has been found satisfactory to both patients and providers, and to be equal to in-person appointments for efficacy. Recent literature has called for initiatives aimed at influencing third party payers to pay for telepsychiatry services in rural areas with significant health care disparities.

San Juan County, consisting of a group of islands off the coast of Washington State, is designated as a rural area. It is medically underserved, has a lack of health professionals, and is isolated and costly to serve. Most full-time residents work in low paying service industry jobs or on farms. The alarming lack of

## WASHINGTON

### *San Juan County Public Health*

Grant Number: D04RH07913

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health services, especially for mental illness, impacts all age categories, including children and older adults.

No psychiatrists or psychiatric nurse practitioners are available anywhere in the island county to provide evaluation and pharmacologic treatment. Patients must travel hundreds of miles and many hours, primarily by ferry, to access psychiatric services on the mainland. Few citizens can afford mental healthcare from their own funds, but neither Medicaid nor most commercial health plans pay for telepsychiatry services that would allow for virtual psychiatric evaluation, diagnosis, and treatment. Even those health plans that do pay for telepsychiatry in some instances do so reluctantly, impose a standard for service approval that is not imposed for in-person services, and allow insufficient fees to cover the cost of psychiatric service and necessary technology.

The proposed partnership-Inter Island Medical Center, two Compass Health facilities (one in San Juan County), and Regence Blue Shield (which will contribute technical data and consultation regarding service delivery)-will establish, run, and maintain a telemedicine service project that provides psychiatric evaluation and treatment to isolated patients in San Juan County.

The project will address high rates of depression, reduce the incidence of untreated psychiatric illness, and examine the cost-offset and community health status effects of psychiatric service delivery. By significantly increasing access to psychiatric services, the project will result in the reduction of Global Health Burden of psychiatric illness in San Juan County - a condition that ranks second only to cardiovascular disease in health burden.

**ORHP CONTACT:**

Christina Villalobos  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0835  
cvillalobos@hrsa.gov

# WASHINGTON

## *Yakima Valley Farm Workers Clinic*

Grant Number: D04RH12750

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### **PROGRAM DIRECTOR**

Vickie Ybarra  
402 North 4th Street, Suite 202  
Yakima, WA 98901  
Phone: (509) 248-3782  
Fax: (509) 494-1049  
E-mail: vickiey@yvfwc.org

### **TOPIC AREAS**

Diabetes-Hispanics

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 149,027
- Year 2 – 124,934
- Year 3 – 99,749

### **PARTNERS TO THE PROJECT**

Morrow County Health Department (MCHD) and Radio KDNA/Northwest Communities Education Center (NCEC)

### **AREAS SERVED**

Umatilla County OR, Morrow County OR, Columbia County WA, and Walla Walla County WA

### **TARGET POPULATION SERVED**

Hispanic and Spanish-speaking

### **PROJECT SUMMARY**

**Needs to Be Addressed:** Compared to national and state rates, one or more of the targeted counties in north-central Oregon and southeast Washington have higher rates of residents with high cholesterol, diabetes, high blood pressure, and being overweight or obese; and lower rates of physical activity and health care coverage. The Hispanic and Spanish-speaking target population faces two primary barriers to accessing diabetes and other nutrition-related services: a shortage of primary care providers and a lack of culturally and linguistically appropriate services.

**Proposed Services:** A Primary Care Registered Dietitian and Physicians will provide medical nutrition therapy for 400 consumers with diabetes and other nutrition-related disease per year. Tomando Control de su Salud (Taking Control of Your Health) Lay Leaders will provide self management education workshops for 72 Hispanic and Spanish-speaking residents with diabetes and other nutrition-related disease per year. Radio KDNA will provide radio public service announcements to market medical nutrition therapy services and self-management education workshops to residents. The Consortium will provide culturally and linguistically appropriate services by providing self-management education curricula that have been adapted for Hispanic and Spanish-speaking populations.

## WASHINGTON

### *Yakima Valley Farm Workers Clinic*

**Grant Number: D04RH12750**

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**Population Group to Be Served:** The Consortium will provide health care services to primarily Hispanic and Spanish-speaking residents with diabetes and other nutrition-related disease in Morrow and Umatilla Counties in north-central Oregon, and Columbia and Walla Walla Counties in southeast Washington.

**ORHP CONTACT:**

Vanessa Hooker  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-594-5105  
vhooker@hrsa.gov

# WISCONSIN

## *Northwest Wisconsin Concentrated Employment Program, Inc.*

Grant Number: D04RH12762

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### **PROGRAM DIRECTOR**

Susan Bodoh  
422 West Third Street, Suite 200  
P.O. Box 616  
Ashland WI 54806  
Phone: (715) 682-9141  
Fax: (715) 682-9181  
E-mail: sbodoh@nwcep.org

### **TOPIC AREAS**

Elderly, In-Home Direct Care Services

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Northwest Wisconsin CEP, Inc., Wisconsin Personal Services Association, Wisconsin Indianhead Technical College, Northwest Family Care Collaborative, Bad River Tribe, Red Cliff Tribe, St. Croix Chippewa Indians of Wisconsin, North Country Independent Living, Indianhead Community Action Agency, Lori Knapp, Inc., Gemini Leasing, Inc., and Ashland County Health and Human Services Department.

### **AREAS SERVED**

Red Cliff, Bad River, Lac du Flambeau, St Croix, and Lac Courte Oreilles.

### **TARGET POPULATION SERVED**

Low income, rural, elderly and disabled people.

### **PROJECT SUMMARY**

Residents of Northwest Wisconsin are facing an acute shortage of in-home, personal care health workers. In the eleven counties that comprise Northwest Wisconsin, several changes will occur over the next year that directly affect the provision of personal care services. First, as a result of the State of Wisconsin's expanded managed long term care options, the number of people eligible for direct care services will greatly increase. Secondly, in March of 2009, all the elderly, adults with physical disabilities, and adults with developmental disabilities who are currently on waiting lists for services must be phased in to managed care organizations and begin receiving direct care services. Within Northwest Wisconsin, this expansion will move over 1,320 people off waiting lists, allow them to obtain personal care services in their homes and avoid costly nursing home care. And while the State's expansion of long-term care programs is increasing the number of residents eligible for home and community-based services, the general population is aging, thereby further adding to the need for personal care workers. Based on information from area service providers, it is estimated that the Northwest region will need at least 300



## WISCONSIN

### *Northwest Wisconsin Concentrated Employment Program, Inc.*

**Grant Number: D04RH12762**

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additional in-home, personal care workers over the next three years, as well as thirty to fifty direct care managers, to meet clients' home health care needs.

Combined with this shortage of skilled workers is a population of untrained citizens with the potential to step into positions as direct care workers and managers. To meet this growing need for skilled, in-home, personal cares, and utilize the local workforce, the Northwest Wisconsin Concentrated Employment program (NWCEP) is requesting a grant from the Office of Rural Health Policy, in the federal Health Resources and Services Administration. This grant will address the need for recruitment, training, placement, and retention of an estimated 300 hundred personal care workers and thirty to fifty supervisors. NWCEP is uniquely suited to this role, with over forty years of experience as the work force development leader in Northwest Wisconsin. NWCEP will recruit participants through a collaborative marketing program. It will fund training and competency certification, through partnerships with area technical colleges, home health care provider agencies, as well as through the College of Direct Support. The project will also address the issues of employee satisfaction and retention with workshops for supervisors and managers.

The grant project's population groups include low income, rural, elderly and disabled people, primarily adults but not limited to only adults. A significant number are Native American, and almost all will have special health care needs.

The recipients of the in-home, direct care services reside in eleven counties in Northwest Wisconsin, a geographical area that meets HRSA preference criteria. According to the HRSA web site, ten of these eleven counties are designated health professional shortage areas (HPSA) and all but one are designated as medically underserved (MUPs). In addition, the grant project's region includes five tribal areas, all Band of Lake Superior Chippewa: Red Cliff, Bad River, Lac du Flambeau, St Croix, and Lac Courte Oreilles.

**ORHP CONTACT:**

Kathryn Umali  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-7444  
kumali@hrsa.gov

# WISCONSIN

## *Western Dairyland Economic Opportunity Council*

Grant Number: D04RH12761

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### **PROGRAM DIRECTOR**

Dan Stickler  
P.O. Box 125  
Independence, WI 54747  
Phone: (715) 985-2391  
Fax: (715) 985-3239  
E-mail: stikwdhs@westerndairyland.org

### **TOPIC AREAS**

Oral Health, Children

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Western Dairyland Economic Opportunity Council, Inc., Buffalo County Public Health, Jackson County Public Health, and Trempealeau County Public Health

### **AREAS SERVED**

Buffalo, Jackson, and Trempealeau Counties in Wisconsin

### **TARGET POPULATION SERVED**

Head Start children and their siblings up to 10 years old, Head Start parents, and Medicaid-eligible pregnant women their children up to age years old.

### **PROJECT SUMMARY**

The Project will encompass Buffalo, Jackson, and Trempealeau Counties, all of which have been designated as rural counties. Western Dairyland will be the applicant agency and fiscal agent for the Project. The Buffalo County Health Office, the Jackson County Health Office, and the Trempealeau County Health Department will be partners with Western Dairyland in the Project.

Western Dairyland will requesting a total of \$375,000 for the three years of the Project's operations: \$150,000 for Year 1, \$125,000 for Year 2, and \$100,000 for Year 3.

The Project will serve a total of 4,057 Medicaid-eligible individuals, including 1581 low-income/Medicaid-eligible Head Start children and their siblings ages 10 years and younger, 1,144 Head Start parents, and 189 Medicaid-eligible pregnant women and their 1143 children 10 years or younger. 100% of the target population will have access to new/expanded services through the Project.

The new/expanded services include: preventative oral health care, oral health education, and restorative dental care.

# WISCONSIN

## *Western Dairyland Economic Opportunity Council*

**Grant Number: D04RH12761**

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The target population of the Project will be Head Start children and their siblings up to 10 years old, Head Start parents, and Medicaid-eligible pregnant women their children up to age years old. Western Dairyland will use its currently funded Oral Health Project to serve Head Start children. Western Dairyland will use the Rural Health Outreach funds to support the provision of oral health services to Head Start children and the siblings of Head Start children 10 years old and younger. The Public Health Offices/Department for Buffalo, Jackson, and Trempealeau Counties will serve Medicaid-eligible pregnant women and their children up to age 10 years old.

The Public Health Offices/Departments will serve additional Medicaid-eligible children as staff availability permit.

Western Dairyland and the Public Health Offices/Department will provide screening, fluoride varnish and oral health education to their respective patients. Western Dairyland and the public health offices/department will be responsible for securing restorative treatment as appropriate for their respective patients. Western Dairyland will purchase five slots per week at Chippewa Valley Technical College for the provision of restorative treatment for those children and pregnant women with the greatest need for treatment for patients of the Project regardless of whether they are patients of Western Dairyland or the Public Health Offices/Department.

The Project will have a Third-Party Evaluation component which will be performed by Dr. David Born, a professor at the University of Minnesota.

**ORHP CONTACT:**

Lilly Smetana  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-6884  
lsmetana@hrsa.gov

# WISCONSIN

## *Marshfield Clinic Research Foundation*

Grant Number: D04RH12696

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### **PROGRAM DIRECTOR**

Nina M. Antoniotti  
1000 N. Oak Avenue  
Marshfield, WI 54449  
Phone: (715) 389-3694  
Fax: (715) 387-5225  
E-mail: antoniotti.nina@marshfieldclinic.org

### **TOPIC AREAS**

Telehealth-Elderly (Chronic Disease-End Stage Renal)

### **PROJECT PERIOD**

May 1, 2009 – April 30, 2012

### **FUNDING LEVEL EXPECTED PER YEAR**

- Year 1 – 150,000
- Year 2 – 125,000
- Year 3 – 100,000

### **PARTNERS TO THE PROJECT**

Marshfield Clinic TeleHealth, Good Samaritan Hospital, Pinecrest Nursing Home, Friendly Village, Nu-Roc Community Healthcare, Park Manor, Heritage Manor, Rice Lake Convalescent Center, and Lakeview Medical Center

### **AREAS SERVED**

Barron, Lincoln, Oneida, Price, and Rusk, Wisconsin

### **TARGET POPULATION SERVED**

Elderly, patients with end stage renal disease, persons of low socio-economic status, and rural populations.

### **PROJECT SUMMARY**

This grant application initiates a consortium of health care organizations linked through common goals of providing services to underserved populations through the use of TeleHealth. The program addresses the needs of the elderly, patients with end-stage renal disease, and populations with special health care needs. Specifically, the program provides primary and specialty health care services by TeleHealth to elderly and special needs residents of rural skilled nursing facilities (SNFs); nephrology and other specialty care to patients receiving dialysis in rural hospital-based dialysis centers; and for hospital patients with unmet health care needs and chronic conditions, who benefit from access to specialist health care services. The program is designed, with community involvement, to provide services to eight skilled nursing facilities, one rural hospital with a dialysis center, and one rural dialysis center in remote North Central Wisconsin. The problems the projects in this grant application intend to resolve are:

1. Lack of access to primary and secondary care for residents of skilled nursing facilities.
2. Lack of access to on-site evaluations by primary and specialty services on-demand for residents of skilled nursing facilities whose condition changes suddenly.

# WISCONSIN

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3. Lack of access to specialty care for patients hospitalized or in the emergency department of a critical access hospital.
4. Lack of access to nephrologists and other specialists involved in the care of renal dialysis patients in a rural renal dialysis center

The areas to be served in this grant proposal include five rural counties in Wisconsin – Barron, Lincoln, Oneida, Price, and Rusk. This grant application serves the elderly, patients with end stage renal disease, persons of low socio-economic status, and rural populations. The specific goals of this grant project are, through the use of TeleHealth 1) to improve access to primary and secondary care for residents of skilled nursing facilities; 2) to improve access to on-site evaluations by primary and specialty services on-demand for residents of skilled nursing facilities whose condition changes suddenly; 3) to improve access to specialty care for patients hospitalized or in the emergency department of a critical access hospital; 4) to improve access to nephrologists and other specialists involved in the care of renal dialysis patients in a rural renal dialysis center; 5) to decrease the number of unnecessary transports from hospitals, emergency departments, and skilled nursing facilities; and 6) to decrease the incidence of transfer trauma on the elderly.

### **ORHP CONTACT:**

Sheila Warren  
Project Officer  
HRSA/ORHP  
5600 Fishers Lane  
Rockville, MD 20857  
301-443-0246  
swarren@hrsa.gov