

OUTREACH SOURCEBOOK



Volume 14 RURAL HEALTH DEMONSTRATION PROJECT

2006-2009

April 2010

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PROGRAM OVERVIEW

In FY 2006-2009, ORHP awarded 65 Outreach grantees across 37 States.

The Rural Health Care Services Outreach Grant Program encourages the development of new and innovative health care delivery systems in rural communities that lack essential health care services. The program is unique due to the fact that it is based on the specific need within each individual rural community. Outreach grantees deliver a variety of health services. These include primary health care, dental care, mental health services, home health care, emergency care, health promotion and education programs, outpatient day care and other services not requiring in-patient care. Actual services include health fairs, screenings, training and education of providers to name a few.

To be eligible, the grant recipient's organizational headquarters must be a rural public or rural nonprofit private entity and be located in a rural county or in a rural Census Tract within a metropolitan county, exclusively provide services to migrant and seasonal farm workers in rural areas or be a Federally-recognized Tribal Government. Applicants must also form a consortium with 2 other organizations, which may be rural, urban, non-profit or for-profit. www.ruralhealth.hrsa.gov



GLOSSARY OF FREQUENTLY USED TERMS

ADA	American Diabetes Association
AHORA	Alliance for Hispanic Outreach and Regional Awareness
BB	Best Babies
BBAHC	Bristol Bay Area Health Corporation
BHN	Behavioral Health Network
BMI	Body Mass Index
CAC	Community Advisory Committee
CCNTR	Caring Community Network of the Twin Rivers
CDSMP	Chronic Disease Self-Management Program
CGSG	Caregiving Support
CHC	Cooperative Health Center
CIMC	Catalina Island Medical Center
CMH	Center for Mental Health
CPA	Competent Professional Authority
CROC	Children's Regional Oral Health Consortium
CVD	Cardiovascular Disease
CVPH	Champlain Valley Physician's Hospital
DCBS	Kentucky Cabinet for Health and Family Services
DCMP	Diabetes Case Management Program
DRE	Digital Rectal Exam
DSME	Diabetes Self-Management Education
ECDHD	East Central District Health Department
ECMT	Electronic Case Management Tool
EMR	Electronic Medical Records
FOBT	Fecal Occult Blood Test

GLOSSARY OF FREQUENTLY USED TERMS

GDPH	Georgia Division of Public Health
GNCHC	Good Neighbor Community Health Center
HABITS	Health Access Barriers in the State
HCA	Hospital Corporation of America
HCIS	Health Care Information System
HCs	Health Coaches
HPSA	Health Provider Shortage Area
HPSAs	Health Professional Shortage Areas
HRAs	Health Risk Assessments
HRSA	Health Resources and Services Administration
HYWPP	Hardrock Youth Wellness and Prevention Program
INS	Immigration and Naturalization Services
IS	Information System
JCEO	Joint Council of Economic Opportunity of Clinton and Franklin Counties
LEND	Leadership & Education in Neurodevelopmental Disability
LIS	Low Income Subsidy
LMHP	Licensed Mental Health Practitioner
Medicare Part D	Medicare Prescription Drug Plan
MHSA	Mental Health Shortage Area's
MIBH	Mary Imogene Bassett Hospital
MSP	Medicare Savings Program
MUA	Medically Underserved Area
MUAs	Medically Underserved Areas
MUC	Medically Underserved Community
MUP	Medically Underserved Population
NTI	Northern Telepsychiatry Initiative

GLOSSARY OF FREQUENTLY USED TERMS

ORHP	Office of Rural Health Policy
PAN	Physical Activity and Nutrition
PAP	Prescription Assistance Program
PAP	Pharmaceutical Patient Assistance Programs
PEAL	Progress Equals Access for Louisiana
PECS	Electronic Care System
PGTF	Palemon Gaskins Trust Fund
PHP	Perinatal Health Partners
PSA	Prostate Specific Antigen
QPD	Quick PsychoDiagnostitic Panel
RAPCS	Rural Assistance Program for Churches and Schools
RBHN	Regional Behavioral Health Network
RHCSOG	Rural Health Care Services Outreach Grant
SBHC	School-Based Health Centers
STEMI	segment elevation myocardial infarction
TCH HCOP	Twin City Hospital Healthy Community/Happy Children Outreach Program
TIP	Texas Independence Program
TRHN	Thumb Rural Health Network
UIC	University of Illinois at Chicago
UMD	University of Maryland
WIC	Women, Infant and Children Programs
YVFWC	Yakima Valley Farm Workers Clinic

ALABAMA—SYLACAUGA ALLIANCE FOR FAMILY ENHANCEMENT, INC.

Community Characteristics

The target population has been identified as residents of Talladega County, Alabama, who are 200% of the federal poverty level, uninsured or underinsured and diagnosed with one or more of the chronic diseases of diabetes, hypertension, chronic obstructive pulmonary disease, or congestive heart failure. In Talladega County, forty percent or 32,128 of the 80,321 residents live at 200% of poverty. Only referrals from Coosa Valley Medical Center (south Talladega County) and Baptist Citizens Medical Center (north Talladega County) who met the defined criteria for inclusion in the target population were enrolled in the program. Once a referral was submitted at the hospital level to the FHA's and the Parish Nurse, the following services were available based on the results of an individualized, comprehensive assessment. Services available to participants included in-home disease/case management, education, disease parameter monitoring, access to needed pharmaceuticals, increased access to other necessary social and health services, compliance monitoring, referrals to medical homes, advocacy, and assistance in goal setting and attainment. During the project period, 118 unduplicated participants were provided 4,702 documented services with a value of those services totaling \$238,235.40. The ECMT provided the capacity to track, monitor and analyze services provided and outcomes attained.

Services Offered

The target population for this project is the uninsured and underinsured populations in Talladega County, Alabama having one or more of the chronic conditions of diabetes, hypertension, congestive heart failure, and/or chronic obstructive pulmonary disease.

Innovative Solutions to Problems

Staffing: Several personnel challenges were encountered over the course of the project. Initially, the Parish Nurse that was employed to develop the training curriculum and implement the disease/case management program resigned within one month of hire. Facing the challenge of recruiting a part-time Parish Nurse to fill the vacated position, a coalition member, Coosa Valley Medical Center agreed to share an RN Case Manager to develop the training curriculum, train the FHA's and initiate the project work plan. This position also served as the Parish Nurse for participants referred through Coosa Valley Medical Center on the south end of the county. Beginning in January 2007, a part time RN Parish Nurse was hired to fill the position of the RN Parish Nurse for Baptist Citizens Medical Center in the north end of Talladega County.

Fortunately, when the Coosa Valley Medical Center RN resigned in June 2007, this Parish Nurse was able to fulfill the job responsibilities through June 2009. Her premature departure from the project challenged a timely close-out, transition and start-up of an expansion project that was funded in May 2009. Based on an analysis of project implementation and with the resources to expand the scope of this initiative, a full-time Parish Nurse position was warranted. That position was filled in August 2009 providing additional support for close-out, transition and start-up. Compounding the issues related to retention of an RN Parish Nurse, were family health issues for both of the FHA's who required prolonged medical leave throughout the final year of implementation.

Formal Consortium Meetings: The DOTCOM coalition members represent agencies that are spread across Talladega County. With challenging economic stressors being faced throughout the region, along

ALABAMA—SYLACAUGA ALLIANCE FOR FAMILY ENHANCEMENT, INC.

with limited leadership capacity to address those challenges, formal meetings, requiring travel and time away from their primary responsibilities led to poor attendance at the monthly coalition meetings. As a result and based on a survey of the membership, conference call meetings were scheduled bi-monthly rather than on a monthly basis. That method of communication has been unsuccessful in improving attendance. In an effort to expand the scope of this project and in order to increase participation the coalition has expanded its membership by 20 people. Meeting agenda and process has transitioned from a reporting format to one that is interactive. Committees have been assigned to address specific work plan strategies. The coalition committees can accomplish their work in both formal and informal settings and at times and locations that are convenient for their membership.

(Electronic Case Management Tool- ECMT): The ECMT is the vehicle for tracking and documenting services, case notes, treatments, goals, case level and status. The original work plan proposed an upgrade to include “Laptops to Go” providing the FHA’s and Parish Nurse the capacity to capture data at either the bedsides or in the homes of the consumers, thus eliminating the need to manually capture data. This enhancement was compromised due to an inability to fund the software upgrade. Another software challenge has been the inability of the ECMT, through software upgrades from the vendor, to track progress toward individual goal attainment and the capacity to report progress related to changes in disease parameter. At this time, evaluation of that data must be manually captured and analyzed through the review of each file. We are working with the software company, Data Futures, to develop a solution.

Time in Program: One of the lessons learned is related to the duration of service provision in program and commitment per participant to the achievement of identified goals and healthcare plan. Data indicates that 62 participants (52.5%) did not participate in the program long enough to rerate goals or to complete a post-test. There were 56 participants (47.5%) who continued their participation for 3 months or more. For the 43 participants who did stay in the program for 6 months or longer, 69.8% of those participants scored lower (less depressed) on the final Beck Depression Inventory with an average decrease of -9.7 points. In response to this data, strategies are being implemented including a pre-test survey to assess a consumer’s willingness for change and a more strengths-based approach to creating in partnership with that consumer goals, action plans and strategies. In other words an approach that places responsibility for change on the consumer rather than a prescriptive, medical model that is defined by the FHA’s and the Parish Nurse.

Disease Parameter collection: It has been difficult gathering data such as AI C test results from the physicians, thus limiting the evaluator’s ability to analyze and compare results. Currently, 39% (46) of Rural Health participants access the Goodwater, Alabama rural clinic 20 minutes, north east of Sylacauga. Test results are available through this clinic, but accessibility for consumers is a challenge.

Results

The evaluation process for this project is multilayered. Dr. Arlene Hayne, the grant evaluator provided technical assistance and worked with the QA Specialist to collect and evaluate the data to make sure it is accurate and to determine that the goals and outcomes of the grant were being met. Dr. Hayne analyzed the pre and post tests as well as the disease parameters which were listed in the previous section.

ALABAMA—SYLACAUGA ALLIANCE FOR FAMILY ENHANCEMENT, INC.

Additionally, through the performance review process we were able to access technical assistance to provide a return on investment study through the ROI Institute. The initial report was completed in September 2009 and the final report will be completed with the return of investment study of the Alabama Network of Family Resource Centers.

Potential for Replication

The Governor’s Task Force to Strengthen Alabama Families has recommended and received endorsement from the Governor that the currently existing “family service center” model embodies best practices and comprehensive solutions for a wide range of issues at both the local and State level. This endorsement includes a commitment to replicate this model in every county in Alabama, thus providing the infrastructure for community based systemic reform. Every level of government has been engaged in the support of this reform.

After the Grant

Yes, based on continued needs assessment through consumer satisfaction surveys and data collection, the coalition applied and successfully accessed funding through the Office of Rural Health Policy to expand the scope of the outreach initiative to include prevention of chronic conditions such as obesity with school aged children. The coalition is currently actively engaged in developing those strategies for successful implementation. Additionally, through the Outreach funding, a detailed training manual was developed for family health advocates. Although it is not yet copyrighted, our goal is to copyright it to allow for continued sustainability of project initiatives.

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Community Characteristics

The Rural Assistance Program for Churches and Schools (RAPCS) provides access to health care for the disadvantaged populations in Greene, Sumter and Marengo Counties. These counties are ranked among the poorest in the State and Nation. They are rural, medically underserved, and have a largely minority African-American population. The prevalence rates of numerous chronic health disorders are higher in this area than other comparable areas in Alabama, which overall has higher rates than other states in the U. S. In addition to higher chronic disorder rates, this area suffers from inaccessibility to health care due to the unavailability of public transportation. There are also major behavioral and societal problems (e.g., teen pregnancy, low birth weight, high tobacco use, and alcohol and drug abuse). The average median household income is 36% of the state average per the United States Census Bureau for the most recent statistical date (Year 2000). These persons are also the ones without health insurance coverage. Those who are covered have government provided insurance such as Medicare and Medicaid. Also according to the United States Census Bureau, individuals in the targeted Counties have a high school graduation average of 67%, which is below the state average. Low education and employment reinforces the economic problems and often results in poor health practices and lack of knowledge about accessing and using health care resources. These factors and others provide insurmountable barriers to healthcare in this area of Alabama.

Services Offered

The Rural Assistance Program for Churches and Schools (RAPCS) provides access to health care for the disadvantaged populations in Greene, Sumter and Marengo Counties. These counties are ranked among the poorest in the State and Nation. They are rural, medically underserved, and have a largely minority African-American population. The prevalence rates of numerous chronic health disorders are higher in this area than other comparable areas in Alabama, which overall has higher rates than other states in the U. S. In addition to higher chronic disorder rates, this area suffers from inaccessibility to health care due to the unavailability of public transportation. There are also major behavioral and societal problems (e.g., teen pregnancy, low birth weight, high tobacco use, and alcohol and drug abuse). The average median household income is 36% of the state average per the United States Census Bureau for the most recent statistical date (Year 2000). These persons are also the ones without health insurance coverage. Those who are covered have government provided insurance such as Medicare and Medicaid. Also according to the United States Census Bureau, individuals in the targeted Counties have a high school graduation average of 67%, which is below the state average. Low education and employment reinforces the economic problems and often results in poor health practices and lack of knowledge about accessing and using health care resources. These factors and others provide insurmountable barriers to healthcare in this area of Alabama.

The purpose of this project was to (A.) Improve access to healthcare by establishing outreach health care sites throughout the counties in schools and churches where people are isolated and without direct access to health care and (B.) Implement a health education campaign that would increase the public awareness of healthcare, and increase the public's awareness of availability of health care services.

The projects purpose/goal was achieved through the provision of: (a) nursing services in local schools and churches, (b) selective primary care in area schools and churches and (c) access to preventive health

education programs. The target population included students in local schools, churchgoers, senior citizens, parents and the working poor.

The project has developed an extensive network of Consortium members. These members include local hospitals, health centers, school systems, churches, and community-based organizations.

Innovative Solutions to Problems

Initially, the project proposed a part-time nurse as the Project Manager and a full time Project Secretary. The proposed manager resigned her position with the organization during the first year of the project. Although extensively advertised, with this Project Manager-RN position proposed as part-time, the present nursing shortage and the size of the counties and their rural nature, it became evident that filling this position was “going to be very difficult. The Project Director, Tri-County Liaison and other consortium members discussed this matter and it was decided to combine the Program Manager and Secretarial position and make the position full time. The position required that the person have healthcare related experience, live in the tri-county area and have a genuine interest in the improvement of health in the areas served.

Results

This project is very suitable for implementation in other rural settings. The program adopted for its target counties (Greene, Sumter, and Marengo Counties) an outreach program that has demonstrated success in other rural and urban areas where access to health care has been a problem. Areas like Troy and Birmingham, Alabama are both consist of rural and urban areas, and have administered this type of outreach program mainly in schools successfully for more that 10 years. The programs demonstrated proven results in the reduction of some of our State’s more prevalent social, behavioral and health program, (teen pregnancy, access to healthcare, etc.) through the provision of activities like health fairs and screenings, health education, and basic health care.

Potential for Replication

The model this project chose to adopt for the rural outreach program is an eclectic blend of the following models used by other programs, which have proven to significantly improve access to health care for disadvantage populations in rural and urban areas. Healthcare agencies in the past like West Alabama Health Services offered comparable with funding from Robert Wood Johnson Foundation. These services were innovative to the community and continue in one church today, even though the agency has closed due to loss of federal funding. HERO, a rural health organization located in an adjacent county to the target areas, was provided through funding from the Department of Human Health Services with a mobile health van. Provision of this Mobile Health Van significantly improved access to health care. This program too, however has been discontinued to loss of grant funding. Other colleagues have addressed similar problems with outreach programs in urban areas (the Kansas City SWOPE program, the Birmingham Alabama School based program). Other programs funded by Alabama Department of Human and Health Services have really been helpful in the development of this application, some have shared their experience with us and have technical assistance with the implementation of this project. These programs are Health Schools-Healthy Kid of Troy, Alabama, Kid Power of Pikesville, Kentucky, Schools Health Network of Fulton County, Canton, Illinois, and the Parish Nurse Outreach project of

Lavem, Oklahoma. Our reasoning for looking at these programs was because of the outcome data shown and the goals reached. We were impressed that obstacles did not discourage the program from reaching the goals. This program, as a blend of these models, proved to be just a successful.

After the Grant

The program will be sustainable once Outreach grant funding has ended. Grant funding allowed the program to function totally independent of other programs within the lead organization. With the loss of grant funding, the program will function as a part of another department within the lead organization. It will function in a scaled down capacity and employ one part-time nurse to perform health education and outreach in the Marengo County area. The program in Greene and Sumter counties will be performed through the health education program consortium member. The scaled down program will provide services in churches and community service areas. The implementation of the Kid Check program in the area schools through the Governor's Office has undertaken the school health portion of the program.

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Community Characteristics

The service area of this proposed project is the 34 rural communities within the Bristol Bay Area Health Corporation (BBAHC) medical care system in Alaska. Some 8,072 people live in the area, of whom 6,865 are all or part Native. The target population is the 555 persons over the age of 62 that reside in the region. The most significant barriers to care for the elderly are language and travel to advanced medical care. Some 62 percent of elders in the service area speak a language other than English. Of those, 9 percent do not speak English at all, and 19 percent do not speak English well. There are no connecting roads or bridges between any of the villages either intraregional or to the hospital in Dillingham.

Services Offered

The overall goal of this proposed project is to meet the healthcare needs of elders so they can remain in their communities and stay connected to their homes and families for as long as possible. There are five program goals used to describe the approach more specifically. They are to: A) Increase access to specialized medical care for persons over the age of 62; B) Increase patient translation and advocacy services for persons over the age of 62; C) Increase provider staff knowledge of geriatrics; D) Increase public awareness and knowledge of geriatric issues; and E) Increase Medicare enrollment in the target population. Strategies for goal A includes contracting with an itinerant physician specializing in gerontology or internal medicine; referring elders for assessments and treatment; providing transportation for elders to the specialty clinic; and using telehealth capabilities to provide services to elders in the remote villages. Goal B will be accomplished by hiring one FTE Patient Advocate/Translators to assist elders in accessing care. Strategies for goals C and D will involve the provision of staff in-service training and community education regarding geriatric issues. The strategy for goal E is to provide education to identified patients regarding the benefits of applying for Medicare benefits.

Innovative Solutions to Problems

The most significant problems encountered in the project implementation were our inability to contract with a gerontologist to travel to Dillingham and provide the training, evaluation and treatment of elders. We hired one gerontologist the second year of the grant that traveled here once but because he would not comply with our credentialing and background check process he was unable to see patients. We hired a second gerontologist the last year of the grant and she traveled out twice. Not being able to hire the gerontologist as planned limited the training we planned as well as the evaluation's how we serve elders. We were not able to overcome the problem completely because of the inability to contract for the position.

The project manager worked closely with the consortium and included them in training that the gerontologist provided as applicable. The gerontologist also visited MEAL and evaluated the program there. The patient advocate/translator hired by the grant was available to provide translation services to the consortium when needed and if available.

The innovative method of service delivery was the hiring of the patient advocate/translator and employing her to work closely with the elders accessing medical services at the Bristol Bay Area Health Corporation. This individual made a point of meeting and greeting elders as they accessed the BBAHC services and made sure that all their needs were met and they understood what they were.

Results

The successful outcome of the grant was the patient advocate/translator hired from the grant as well as the training that was provided to staff of BBAHC as well as the consortium.

The consortium was able to function as planned and will continue after the grant ends.

MEAL referred patients needing geriatric health care to BBAHC, provided transportation for the elders, participated in the training provided by the geriatric physician and also trained local residents while working in their facility on caring for elders. At least 3 caregivers [from MEAL] have received their Certified Nursing Assistant certification while working at MEAL.

As indicated above the only problem and barrier of the total implementation of the project was the inability to hire a geriatric doctor as planned. The area that was not completely fulfilled because of the lack of hiring was the on-going training to the medical staff.

We successful recognition or acknowledgements were received from the project.

Potential for Replication

A similar project could be implemented in other rural settings if funding was available and access to a geriatric consultant.

Funding special projects such as these would be problematic. We would not have had the ability to fund the translator, trainings or hiring the consultant without this grant.

Hiring the specialized provider would also be an issue for rural settings. Our organization has a stringent credentialing and background check requirements. Getting the providers to fill out all the documents and turn them in is a barrier for recruitment.

After the Grant

This program will be sustained, at least the patient advocate/translator component through the acquisition of our HRSA New Access Point. We were successful in getting a Community Health Center grant for our hospital and the patient advocate/translator position was one of the funded positions through the grant.

Through the Community Health Center grant the services provided by the patient advocate/translator will continue. If we did not receive this grant this position would have sunset when the grant ended.

I don't think the grant is a best practices model because it basically was hiring additional staff and providing training.

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Community Characteristics

Colorectal cancer is the second leading cause of death among Alaska Natives. We provide Colorectal screening to Alaska Native to provide preventative measures to our patients. Alaska Native Tribal Health consortium provides training to our medial staff on the procedure. They also helped us set up a referral process to get out patients to ANMC for a colonoscopy if precancerous polyps are found. Patients were screened by age and once identified patients were scheduled for a sig. Information was sent to ANMC. Dena'ina Health Clinic and ANMC tracked the screenings. The majority of our patients are Alaska Native and American Indian, but did have several Non- Native patients.

Services Offered

Patients were screened by age and once identified patients were scheduled for a sig. Information was sent to ANMC. Dena'ina Health Clinic and ANMC tracked the screenings. The majority of our patients are Alaska Native and American Indian, but did have several Non- Native patients.

Innovative Solutions to Problems

One of our biggest problems was the stigma attached to the procedure: Patients were afraid to have the procedure done. In order to help them overcome their fear, patients received a tour of the room prior and ask questions. They are also pre-screened and our nurses are ready to discuss colorectal screening at clinic visits.

Results

Patients were screened by age and once identified patients were scheduled for a sig. Information was sent to ANMC. Dena'ina Health Clinic and ANMC tracked the screenings. The majority of our patients are Alaska Native and American Indian, but did have several Non- Native patients.

Potential for Replication

Yes, patients fine the option of being able to receive procedure/screening locally instead of traveling. Good accessibility.

Misinformation regarding what is expected during procedure or that it may be “uncomfortable”. Truth is, the procedure is well tolerated. Providers should also be having colorectal screening discussion at annual exams.

After the Grant

Yes, the program will be sustainable. Advertisement, trained providers to do the procedure will still continue. We would like all our providers trained on the procedure so we can have daily procedures done.

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ARIZONA—HARDROCK COUNCIL ON SUBSTANCE ABUSE, INC.

Community Characteristics

The community of Hardrock lies in the center of the Navajo Nation, a land base the size of West Virginia. In this massive space of over 27,000 square miles there are a total of 5 major Health Care Centers. There are a few more clinics located in between these health care center locations. For the residents of Hardrock Chapter, we have access to 2 clinics and 3 major health care centers. The nearest clinic is located 5 miles away and it is only open 1-day a week. The other two are about 25 miles away and one of them is paved and the other is a wash-board like road which can take up to an hour of traveling. The other major hospitals are 65 miles away. It is very much the same with all other major services which include social services, behavioral health, mental health, youth programs, public assistance programs, etc.

As we have stated in our grant application even in our remote location we were self-sufficient in our daily lives regarding our physical, mental, emotional and spiritual health. In the 70's a major disruption took place which was the Navajo-Hopi Land dispute. The end result was the relocation of almost 2/3 of our population and the loss of land base. This situation created many issues and as the years progressed we found ourselves in need of a lot of outside services. As such the leaders of our community advocated and pleaded with our Navajo Nation government. Every once in a while a program such as social services would send a worker to be stationed in our community only to re-station them a few months later. In 1999, after a tragic year the community members and leaders got together and created a task force which later became a nonprofit organization. With this organization, we were able to identify various funding sources outside of our Navajo Nation and implement some very much needed programs. As such, we created the behavioral health program and the youth program.

We are now able to provide some services within our own community without having people travel over 65 miles.

Services Offered

The Hardrock Youth Wellness and Prevention Program was designed to increase access and participation of youth to substance abuse prevention education and overall wellness activities that encompasses the Dine traditional philosophy. Secondly, to increase participation of youth and their families in substance abuse intervention and treatment programs as well as in traditional healing modalities. In our grant period we were able to hire a youth coordinator and a behavioral health specialist who accomplished much of the activities specified in the program goals and strategies.

Innovative Solutions to Problems

One of the major areas of difficulty was hiring the right project director. We went through two project directors before we could place the person who could really oversee the project. The other problem area was getting the youth program coordinator hired immediately. Because this was a task of the U of A, the process was prolonged and we finally got our coordinator until March of 2007. This is also the length of time the youth programs were delayed.

Results

Outcomes for the youth program portion of the project funded by grant monies are as follows: There was a ten-percent (10%) increase in attendance for each consecutive year during the funding cycle. There

ARIZONA—HARDROCK COUNCIL ON SUBSTANCE ABUSE, INC.

also has been a general increase in the amount of younger students who participate in the HYWPP (Hardrock Youth Wellness and Prevention Program); this would include youth from ages four through seven years of age. Since 2006, the project has hired a permanent youth program coordinator, who has authored the curriculum framework which guides all HYWPP activities. The HYWPP has also since developed the informal partnership with the local school, Rocky Ridge Boarding School. The development and sustenance of this informal partnership is critical for the success of the summer program portions of the implementation of the HYWPP.

With the behavioral health program the evaluation was done through collected data of each visit, progression as evident by narrative progress notes. Routing consultation with direct motivational type dialogues. The Dine scripted of healing for stages of changes completed at each 11 encounters, either at home of origin or office visits.

Potential for Replication

I do whole-heartedly believe this program can be successful in other rural settings. There could be numerous programs such as ours on the Navajo reservation, however what makes the program this successful is the community leadership.

After the Grant

We successfully applied for another Rural Health Outreach Program. We have an excellent technical assistance through Georgia Health Policy and we have been communicating on finding technical assistance grants that would assist us in moving towards a telehealth program.

I do consider our program to be a best practice model, we are the first community on the Navajo Nation to develop a youth program and we have been recognized both locally and nationally for a lot of our efforts pertaining to community wellness.

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Community Characteristics

The rugged West End of Catalina Island has never had local primary medical care services available to its 493 year-round residents, 1,648 summer residents, and hundreds of boaters and divers. To reach CIMC for primary care, residents of the West End must travel the 23+ miles, 1.25-hour trip over mountainous terrain and partially paved roads, or must travel at least one hour by boat to Avalon or a mainland facility. To improve access to primary health care services for these island residents and visitors Catalina Island Medical Center (CIMC) opened a satellite clinic at the West End of Catalina Island.

There is a lack of specialty services on the island. CIMC's medical providers refer patients in need of specialty care to the mainland, but compliance with these referrals is poor, particularly for the low-income population. To address this access issue CIMC and consortium partners initiated a telemedicine program, with a specific focus on psychiatry services, ophthalmology services, and diabetic education, to bring these needed specialty services to the island population.

Drug and alcohol dependencies are a large problem in our community, but there are no local chemical-dependency treatment facilities. A study was conducted to determine if it would be financially feasible for CIMC to develop and implement a chemical dependency treatment services program. Although the study determined that it would not be feasible for CIMC to undertake development of such a program on its own, CIMC provides staff resources to a community collaborative that provides substance abuse prevention and treatment services.

Services Offered

West End Clinic: CIMC, located in the City of Avalon, is approximately 23 miles from the island's other popular tourist attraction, the community of Two Harbors, located at the island's West End. At least 493 people are residing on the island's West End on any given day during the winter, a number that grows to approximately 1,648 in the summer. In addition, there are a total of 628 moorings in the West End cove that average 4 persons per boat, for total of 2,512 additional people at the West End during the busy summer months. Hundreds of additional boats anchor off shore at the various coves.

The West End Clinic was established to provide primary medical care services to this population.

The monthly satellite clinic now provides general preventive care, well-child checks, treatment of acute and chronic health conditions, minor wound care and sutures; limited on-site lab work: Urinalysis, Hemoglobin counts, pregnancy tests, blood glucose testing, rapid strep tests; and phlebotomy (blood draws) with specimen transport to CIMC for all other lab tests.

Telepsychiatry services are provided to those patients who have private insurance through a contracted private psychiatrist. For those patients who are uninsured, services are provided through a contract with the Los Angeles Department of Mental Health, by doctors from the San Pedro Mental Health office. Patients who have Medicare and/or Medi-Cal insurance can choose the telepsychiatry provider they wish to see.

Retinal Imaging Screenings are conducted by medical assistants who have been specially trained in the procedure. The images are transmitted digitally to the ophthalmologists at LLUMC who interpret the images and transmit a report back to CIMC. The patient is then scheduled for a follow-up visit with his/her primary care physician to discuss the results. CIMC services have been provided to those patients who identify themselves as primarily Spanish speaking by bilingual staff, or through use of a Spanish interpreter. The distance-learning diabetic education classes were taught by a pharmacist at LLUMC who

is a certified Diabetic Educator. Classes were held separately for patients in English and Spanish. Staff also received special training in use of a “Diabetic Map” to increase the Educator’s interaction with patients during classes.

Innovative Solutions to Problems

By far the most significant problems encountered in the Island Outreach Project were the unexpected delays in receiving the required permits for implementation of the West End Clinic. The permitting process to allow CIMC to obtain a Certificate of Occupancy to add the outpatient service to the CIMC facility license was extremely complicated and much more time-consuming than was originally expected. The delays continued into years two and three of the project, with the Conditional Use Permit from the L.A. County Zoning and Planning Department taking much longer than expected. With advocacy on our behalf from our County Supervisor’s office, the permit was finally granted. The L.A. County Building and Safety Department finally inspected the site, and after additional delays a Certificate of Occupancy was received. The original lease agreement (a 3-year agreement) for use of the clinic building expired during this process and had to be renegotiated with Los Angeles County Fire Department. The Certificate of Occupancy and renewed Lease Agreement were forwarded to the L.A. County Licensing and Certification office with an application to add the West End Clinic service to our facility operating license as an Offsite, Outpatient Service. The license was finally received in March, 2009, and services began at the site in April, 2009.

Telepsychiatry services are running well at CIMC. The biggest issue encountered in this program was finding an alternative provider when LLUMC was unable to recruit psychiatrists into the program. This was resolved with the help of another Critical Access Hospital was able to provide referrals of alternative psychiatrists. Billing issues with Medicare and Medi-Cal were also resolved with help from the California Technology and eHealth Center, and from the California Association of Rural Health Clinics.

Teleophthalmology Services were delayed initially because of changes in desired equipment that necessitated an unexpected fundraising effort, and because of delays in coming to an agreement with Loma Linda University Medical Center on language for the professional ophthalmology services agreement. Once these issues were resolved, issues of reimbursement for professional ophthalmology fees were re-visited, and a professional services contract that had expired between LLUMC and CIMC was re-negotiated. Services have been interrupted intermittently throughout the project due to staffing changes. The person holding the position of Telemedicine Coordinator changed four times over the course of the project, and additional turn-over in medical assistant positions necessitated re-training staff to conduct the retinal screening exams. During year three technical difficulties in transitioning to new T-1 lines caused further delays in patients receiving needed screenings. Patient scheduling issues are currently being addressed by having retinal screenings conducted one or two days per month in the clinic, with a trained Medical Assistant assigned only to this service. Diabetic Education Distance Learning classes have been stalled due to difficulty recruiting patients to attend classes at the time the Diabetic Educator is available. Dialog is now being held with the Diabetic Care Department of LLUMC to try to recruit a new educator who has a more flexible schedule. We now have a physician champion for CIMC’s diabetic services, which is helping to move these services forward.

Results

West End Clinic: Process goals for patient encounters initially established for this objective were not met due to the severe delays in receiving required permits to initiate services. Services have now been initiated and patient statistics volumes are being monitored by the Program Director and the Clinic Manager. Medical Outcomes Study short form 12 (SF-12) surveys and patient satisfaction surveys are completed by all patients at initial visit and every 6-months thereafter. Statistical analysis will be conducted of the results of these surveys by the contracted professional evaluation company (CoBro Consulting, San Diego, CA) and a final report will be generated.

Telepsychiatry: Patient volume goals (at least 12 patients receiving telepsychiatry services each month) were not met during years one and two, and were consistently met during year three. CoBro Consulting has analyzed survey data generated by the telepsychiatry program since initiation of the service in August 2006. The most recent data evaluation report is summarized as follows: “This study reveals measurable improvements among patients of the CIMC telepsychiatry program. Most notably, patients entering with the most severe impairments consistently showed improvement over time. There is also some evidence that ongoing visits are associated with increased improvement over time. In summary, although the small number of patients participating in this program warrants caution in interpreting these results, the overall consistency of the findings across analyses presented here suggests positive program effects.” In terms of patient satisfaction, 90% of all telemedicine patients report being “satisfied” or “very satisfied” with their telemedicine visit, and 91% report they will use the service again.

Teteophthalmology and Diabetic Education: Due to the delays-and service interruptions described in section II. A above, patient volumes under the teleophthalmology service did not meet the volume goals originally established (12 screenings per month). The total number of eye screening visits during years one through three was 41. The Diabetic Education goal was added to this objective during year two, and 12 patients received Diabetic Education classes.

Potential for Replication

West End Clinic: Satellite Offsite Outpatient Clinic development in other remote rural areas can definitely be successful. Small rural communities can be very grateful when needed services are brought into their communities.

Telepsychiatry: Absolutely. Telemedicine is an ideal solution for rural areas that struggle to recruit and/or retain specialists such as psychiatrists.

Teleophthalmology and Diabetic Education: Both these services can be successful in other rural settings, particularly other rural areas with large Hispanic populations.

After the Grant

West End Clinic: Although it is too early to know for sure, financial models look promising. Sustainability depends on generating a minimum level of patient volumes. Since grant funding has paid for all start-up costs, patient revenues for medical services provided are anticipated to cover the ongoing costs of running the part-time clinic. If clinic volumes are low, promotional activities will be implemented by the CIMC marketing director.

Telepsychiatry. Yes. Professional services fees are-paid to the private practice psychiatrist contract, at a rate lower than that typically received from third party payors. The Department of Mental Health

CALIFORNIA—AVALON MEDICAL DEVELOPMENT CORP.

psychiatrists are paid by the County of Los Angeles; no money changes hands between CIMC and the psychiatrists for the services provided. Support staff time needed to continue these services will be donated by CIMC as a community service. CIMC participates in discount programs available to rural hospitals for telecommunication charges.

Teleophthalmologists are covered by the reimbursement CIMC receives for patient visits in the clinic. It is probable. To date, Diabetic education instructor has been a volunteer position. For this program to be sustainable this will need to continue to be a volunteer position

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Community Characteristics

The focus of the project was to increase the number of children with health insurance and to increase access to and utilization of dental treatment and health care. In Tulare County, about 10% of the children are uninsured, however, in Lindsay about 27% of the migrant children who received oral health screenings were without insurance while in Woodlake about 12% of those screened were without insurance. In addition, the eHealth dental program through Children's Hospital Los Angeles was developed at the same time. In order to participate in this teledentistry program, participants had to be insured.

Services Offered

Each community hired a CAAICase Manager to enroll children initially into one of three insurance programs: Medi-Cal, Healthy Families, or Healthy Kids. In addition to enrollment, the CAAICase Manager facilitated health and dental care utilization by follow-up contacts with each family to ensure that they actually received the medical/dental care needed, used their new insurance card and felt confident in accessing health care in the future. These CAAICase Managers also provided traditional case management services alongside other case managers in their local family resource centers. For example, the CAAICase Manager would make arrangements for the family to be seen at Valley Children's Hospital for specialty care, sort out their welfare status, set up counseling appointments, arrange for donated car seats, etc.

For approximately 1½ years, we were able to insure undocumented 0-18 year old children with the Healthy Kids Program funded through First 5 Tulare County. Unfortunately, that program was no longer available to 6-18 year olds because First 5 was unable to raise the necessary funds to sustain premium costs for children beyond five years old. As a result of this change in scope, HRSA authorized us to use the funds originally allocated for Healthy Kids premiums for 6 to 18 year olds for dental vouchers so that undocumented children could receive primary dental care in their local community.

Innovative Solutions to Problems

Because the program existed in the context of family resource centers, we were able to readily respond to the changing landscape in our communities. The first example is when our community went through a freeze affecting the orange industry. Several of the large packing houses eliminated dependents from their employee insurance packages. We were able to connect with these packing houses and offer our services to families looking for insurance for their children. The second example was when California was threatened with the elimination of Healthy Families. We quickly sent notices home with children through the schools and as a result enrolled 57 children in Healthy Families in one month (average enrollees per month = 16).

We also learned how important it was to follow-up with those enrolled families to ensure that they truly understood the benefits of using their insurance card for services as opposed to using the emergency rooms of hospitals or walk in clinics. The CAA/Case Managers also actually called the insurance help lines with the clients in an effort to improve their comfort level with this new system.

Results

The data we collected was derived from our work plan. The most important data to us included the number of children actually enrolled into insurance plans, the number of follow up contacts necessary to ensure that families kept their appointments and used their insurance, and the number of medical and dental appointments actually kept as a result of our efforts. Following is chart of the data collected on a monthly basis from May 1, 2006 through April 30, 2009.

Potential for Replication

I think that there would be very few problems inherent in this model of service delivery. The problems of insuring the undocumented is a present reality that is a challenge outside of the service delivery model supported by this Outreach Grant. The CAA/Case Manager must not only be an expert on the various insurance programs but must be knowledgeable about ways to receive health care without insurance, for example, the location of county and other clinics and their sliding fee scales, availability of support from local churches, etc. With the potential changes in our health care system, trained staff will need to be poised to translate new systems of care to families in rural settings.

After the Grant

Yes, the program will be sustainable. The program will be funded in Lindsay for one more year through carry over funds from the HRSA Outreach Grant, a contribution from our local District Hospital Board, and funding from First 5. The position will not be funded in Woodlake.

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Grantee did not submit information

FLORIDA—RURAL HEALTH NETWORK OF MONROE COUNTY FLORIDA, INC.

Community Characteristics

The project was design to enhance the relationship between the collaborating partners and additional members, to create service access where is was lacking, without duplicating services, offering enhanced primary care and oral health care, coupled with mental health and substance abuse services.

Services Offered

The services were primary care and oral health care and treatments, mental health and substance abuse treatments to the indigent/homeless population, the uninsured population, and the many under-insured.

Innovative Solutions to Problems

The main problem came after the first year when we lost use of the primary care facility provided by the LKHC. We immediately switched facilities to our RHN mobile medical van and to our medical director's private office location (literally walking distance from the Depoo hospital where we were before). The other issue was what to do with a primary care patient that is in need of secondary care. There was not enough funding to cover treatments of issues once discovered through the primary care process. We were able to provide some outlets through additional partners and sources, but only a fraction of what was needed.

Results

Referral forms were used (from the patients) to understand their perspective. Measurements were made of the number of patients seen, number of visits made and number of services, as well as the referral source. (Mostly performance measures.) Lacking were the true outcome measures that should have been made. I believe that a better data management system between the organizations for collecting "outcome measures" should have been implemented from the onset.

Potential for Replication

I believe with fine tuning and slight tweaking it could be.

After the Grant

We are actually meeting next week (mid December 2009) to map out our new strategies for continuing the services we started through this grant. Our original member, the Lower Keys Hospital Center is back in the plan and wanting to move forward on establishing a permanent solution.

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Community Characteristics

Every time a high-risk pregnancy in South Georgia results in the delivery of an infant weighing 1500 grams or less, the cost is approximately \$156,000 for the initial care. This does not include the cost of the mother's medical care (sometimes extensive prior to delivery) or long term costs of maternal and infant morbidity/mortality. Social workers and hospital case managers consistently identify the psychosocial stress that families endure when they experience adverse pregnancy outcomes. Recent studies imply a difference in academic achievement, professional attainment and weekly income levels of adults who were low birth weight. To address the need for intensive health services for medically fragile pregnant women, many of whom face significant barriers to care, Best Babies (BB) combines in-home case management with nursing assessment and care coordination for the high-risk pregnant woman and her infant.

Best Babies was created to address needs identified through a regional planning process to study perinatal health in 24 southeast Georgia counties. This large scale planning effort reviewed population needs of these communities and perinatal health data, interviewed community leaders, private providers and consumers as well as representatives from local agencies and hospitals and investigated model practices across the country. The process culminated with the development of the Southeast Regional Perinatal Health Strategic Plan. Best Babies, a sister program to Best Babies, was created to respond to the needs identified in the strategic plan. In 2006 the Evans County Board of Health applied for this grant to duplicate the Perinatal Health Partner program in not only their county but 3 surrounding counties as well.

Services Offered

Best Babies provides high-risk pregnant women with intensive medical case management, utilizing a home visiting model. Women are also offered one-on-one education to meet their specific needs. Services are provided by a team of dedicated nurses and interpreter who work in concert with the woman's OB/GYN. Supports such as child care and transportation vouchers are available to help women keep their prenatal appointments. Case management is also offered to medically fragile infants discharged from tertiary care centers.

Innovative Solutions to Problems

The greatest problem encountered was convincing physicians of the value of BB and demonstrating that BB was not competing with them. Once physicians understood the role of BB in relation to their practice, they began to embrace the project. The Consortium was valuable in educating local physicians about BB. Local *OB/GYNs* were invited to attend Consortium meetings and become part of the group. Members also championed the project with local physicians, sometimes providing updates at local hospital staff meetings. Another factor that helped overcome initial resistance on the part of some physicians was the fact that only the local physician can enroll a patient in BB. This gave physicians the decision-making power of whether or not to enroll one of their patients.

Another problem was finding qualified nurses to staff the program. Ideally, nurses needed prior experience working in labor and delivery and prenatal care as well as knowledge of appropriate interventions for high-risk prenatal patients and newborns. Finding nurses with the background and experience necessary for the job was difficult in our rural area. The targeted counties are Health

Professional Shortage Areas (HPSAs), and nursing shortages of all types are widespread. This continues to be a challenge.

Results

Evaluation was conducted by the Center for Rural Health and Research, Jiann-Ping Hsu College of Public Health, at Georgia Southern University in Statesboro.

Methods included the following: Analysis of work plan activity, which included network composition and performance; Provider, patient and staff satisfaction surveys; Descriptive analysis of patient data including generation of frequencies, means, standard deviations and percentages; Inferential analysis to compare previously recorded birth outcomes to outcomes following enrollment in BB; Analysis of four birth outcome variables: birth weight, gestational age, proportion of low birth weight births; proportion of infant mortality.

BB program personnel capture client data in a Microsoft Access database. This database was sent electronically to the evaluator. Data were then analyzed using SPSS for Windows. Provider, patient and staff satisfaction was assessed using three separate surveys. Completed surveys were mailed to the evaluator where they were entered and descriptively analyzed using SPSS. In addition to client data, program narrative reports provided information on network function and work plan activity.

Potential for Replication

BB is a sister program to another successful program in the Southeast Health District. That program is known as Perinatal Health Partners (PHP). PHP is making a difference in the lives of southeast Georgia's families and has been in operation since July 1, 2001. PHP and BB's proactive versus reactive approach set them apart from other efforts to reduce adverse pregnancy outcomes. Ultimately, these programs can and should serve as a model for other communities throughout the state, and possibly in other parts of the country, in improving birth outcomes. PHP and BB's intensive in-home nurse case management model makes these programs especially suitable for rural women who are geographically isolated and often lack transportation. By providing one-on-one health education that is specifically tailored for each woman's specific medical needs, BB and PHP addresses the unique needs of so many of their clients with low educational attainment. These women often need more frequent, individualized education on how to reduce their risk for a poor birth outcome. These programs could be successfully duplicated in other rural settings.

After the Grant

We have been able to continue BB services after the end of Rural Health Outreach funding, primarily through funding from three sources. The Georgia Division of Public Health (GDPH) funding and additional grant funding. The GDPH provided seed funding to Perinatal Health Partners, Best Babies sister program in 2002. This funding has continued yearly and is utilized in both programs. GDPH continues to provide support to BB and PHP. GDPH funding is year-to-year, depending on availability of funds. The Women's Health Branch of GDPH has been closely watching PHP and BB to determine its effectiveness in reducing costs while improving perinatal outcomes and, perhaps ultimately, to use it as a model for perinatal care throughout the state. We have also earned some dollars through third party billing for case management services. However, at the current rate of reimbursement for these services

GEORGIA—EVANS COUNTY HEALTH DEPARTMENT

BB can never be able to bill enough to sustain the program. Our third source of funding is a new *ORH/HRSA* grant that focuses on expanding patient services. With the new grant eligible mothers and babies will be tracked and monitored for a full two years after delivery.

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Community Characteristics

In 2000, Washington County Community health needs were assessed in interviews, meetings and group work with members of the medical community health care and social service providers including Public Health, public officials, business leaders and concerned citizens. The results of the process emphasized health problems, as well as recognition that diabetes, especially DM II was at a crisis proportion in the county.

Obesity among county residents and the surrounding area population was cited as the primary problem, with poor diet and lack of exercise leading to the escalating number. The poorest and most rural of children lacked resources, health and wellness education, information and transportation to participate in activities.

Services Offered

Taekwondo Training with the possibility of reaching Black Belt, Nutrition Component, Psychological Testing, Fitness Testing, Life Skills such as courtesy, respect, discipline and attitude, and Candidates that participated in the program were age four through age fifty nine.

Innovative Solutions to Problems

A major problem encountered in the project's implementation was retaining the goal of 60 obese and overweight students. Some felt three to five days was too much. Some participated in other available sports, and some lost interest after four to six months. In response to this problem, TWW implemented healthy fun competitions, late night fun and reduced the training days to two days a week. This helped, but only a little. Another problem encountered was inconsistencies on data collected. Too many influences were involved in the data collection which in turn created problems. TWW centralized everything in one location with the same personnel performing the same task each time. This reduced errors. Lastly, a high staff turnover rate and resignation of board members had a huge impact on the program, especially outreach possibilities. However, the board members and staff came together, reassigned responsibilities and worked everything out.

Results

The project was evaluated by Georgia Southern University, Statesboro, Georgia. Students gained knowledge about nutrition. They became more aware of reading labels, counting calories, and goal setting towards weight loss. Some students lost weight or body mass, some did not. However all students were equipped with the knowledge to change their lifestyle to become a better person, and to pass that knowledge on to friends and family members.

The consortium did function as initially planned, however, some consortium members left. Openings were filled as quickly as possible and the new members picked up the slack. The consortium made a huge difference in the outcome of the project. Their support and network with the community gave the new program a major boost in the right direction.

The two main problems for the program were high staff turnover rate and sustainability of students in the program. TWW had a total of four directors since the start of the program and is currently on the fifth. One moved away, two received other job offers, and one ended with the end of the grant period. Keeping

students interested in the program for the full three years has been a tremendous challenge. Too many influences dictated the student's decision to stay such as church activities, other sports, and school activities.

TWW has constantly been involved in the community newspaper announcing results of student testing, students receiving black belts, and students attending and receiving awards at state level tournaments.

Potential for Replication

This project could definitely be successful in other rural areas. Of course, as with almost everything, obstacles would have to be overcome, but to be able to provide on-going training to children and parents about health issues is always a plus. Add in a program that teaches life skills in a fun environment and you are well on your way to a healthier wiser community. B. The main issues and problems that other communities might face with a project such as this would be 1) Keeping the project interesting enough to keep the students coming back. It's too easy to sit at home and watch television or play video games instead of exercising the body, which in their mind is too much work. 2) Being mindful of the amount of time expected of each student per week. Too much time and they may not come; too little time and you may not accomplish the goal. 3) If it's a program that will require staff certification, maintaining qualified personnel may become a problem in a rural environment.

After the Grant

The program will hopefully be sustainable once grant funds has ended. The program's new partner, The Washington County Community Mission, has taken an interest in the program and is helping with funding projects such as summer camp and sponsorship of low income students.

We do consider this program to be a good practice model. As with most new programs, we did have our share of ups and downs, however, we did accomplish setting up a unique situation that resulted in children wanting to learn how to be healthier one step at a time. We combined that with a taekwondo program that taught life skills such as self-esteem, confidence, discipline, and goal setting to name a few. We even had a total of twelve students that tested and received their black belts.

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Community Characteristics

Diabetes is one of the most common chronic diseases in the United States and was the eighth leading cause of death in Georgia in 2001. Unfortunately, the 2000-2001 prevalence of diabetes in two rural southern Georgia counties - Ben Hill (13.2%) and Irwin (14.7%) - was more than twice that of Georgia (6.9%) and the United States (6.2%). According to a 2002 publication by the Georgia Hospital Association Research and Education Foundation, Ben Hill and Irwin Counties fall in the top 50% of counties in Georgia with the highest hospital admissions for uncontrolled diabetes. This prevalence data, in addition to related health indicators such as high rates of obesity and little physical activity, high poverty levels, and the racial makeup of the populations, illustrate the severity of diabetes in these counties. This area like many is designated as medically underserved and did not offer any type of diabetes education program prior to Sweet Dreams.

Services Offered

The target population included individuals who were diagnosed with type 2 diabetes, with an emphasis on those who do not have insurance and/or who live in poverty; middle school children who needed to develop healthy lifestyle behaviors to lower their risk of becoming diabetic; and the general public. Services provided include self management education classes; dietitian counseling; diabetic medication and supply assistance; community education through health fairs; community meeting presentations; health screenings; newspaper articles; and the distribution of brochures and other education material; middle school education; provision of physical activity equipment and nutrition education material; assessments of middle school students body mass index; and an afterschool Taekwondo program.

Innovative Solutions to Problems

The significant problems encountered during project implementation included finding and hiring a dietitian for Sweet Dreams. Originally the plan was to partner with Dorminy Medical Center and split the salary and time of the dietitian in half between the two agencies; however, due to billing and employee benefits concerns, this decision was reconsidered. As a result, the Irwin County Hospital provided the services of a dietitian as in kind initially and then the dietitian was hired and paid hourly for the self management education classes and individual counseling to expand the programs billing options.

Another problem encountered also pertains to billing for the services of the dietitian. The process for applying and receiving a Medicare billing number for the dietitian took almost two years. This problem was eventually resolved with persistence from the billing department of the South Health District and the assistance of the HRSA OPR team assigned to Sweet Dreams. Six months before the end of the grant period, the application to bill Medicare was approved and Sweet Dreams began billing for dietitian services.

Results

One of the services provided by Sweet Dreams is medication and diabetic supply assistance given to those who qualify financially. Ben Hill and Irwin Counties are very fortunate to have a local trust fund dedicated to assisting low income uninsured diabetics to get their medications and testing supplies. Many

rural communities do not have this luxury and would therefore have to find other funding sources to provide these same services.

Although the consortium provides a variety of medical expertise, the number of specialist including ophthalmologist, podiatrist, and endocrinologist who are necessary to provide adequate care to many diabetics is limited in the area surrounding these two counties.

This may also be an obstacle for other communities implementing a similar program.

Potential for Replication

Although Sweet Dreams has encountered a few barriers especially in the area of sustainability, it continues to provide needed services to diabetics in this community and will continue to make necessary changes to overcome them. The project continues to learn from trial and error and as it becomes more efficient, it may one day be considered a best practice model.

After the Grant

Yes, the program will be sustainable. Sweet Dream has begun billing for some of the services provided to diabetics. It is anticipated that this revenue will increase to a level sufficient enough to sustain a portion of the dietitian and nursing services. The local trust fund, Palemon Gaskins Trust Fund (PGTF), will continue to provide short term assistance with medications and supplies to diabetics in Ben Hill and Irwin Counties through the health departments. The success of Sweet Dreams lead to the expansion into the neighboring counties of Berrien and Cook and is supported by a new HRSA outreach grant. In addition to these funds, the Project Director will work with local businesses and physicians during the next project period to develop an on-going disease management program for high-risk patients/employees that can be funded by the businesses and/or Medicaid billing. It is a proven fact that control of diabetes and other chronic diseases will decrease medical costs for employers and improve employee productivity. This will help sustain the project and provide funding for continued education to increase awareness of the importance of preventing and early detection of type 2 diabetes in these communities.

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Community Characteristics

Patients were screened by age and once identified patients were scheduled for a sig. Information was sent to ANMC. Dena'ina Health Clinic and ANMC tracked the screenings. The majority of our patients are Alaska Native and American Indian, but did have several Non- Native patients.

Services Offered

Project ACCESS provided services for seniors (60+) in rural Latah County, Idaho and Whitman County, Washington in four primary areas:

Transportation needs were addressed by a) recruiting volunteer drivers to provide seniors with transportation services, and b) raising awareness of transportation resources provided by ACCESS in our rural communities. Project ACCESS reimbursed COAST Transportation who in turn reimbursed volunteers for mileage. Transportation services have been provided for medical and social services appointments as well as social visits that improve morale and quality of life.

Community Education was provided by purchasing books and DVDs for the county libraries and the libraries of the consortium members. These materials are available through the libraries and travel from main branches to the rural libraries on a revolving schedule. By partnering with the Inland Northwest Alzheimer's Association we were able to bring monthly educational seminars to the area on topics relating senior health, Dementia, and aging.

Recording equipment was purchased for the consortium members to make recording and duplicating these classes possible. Recordings are available the country libraries as the 5 other consortium libraries.

Grant funding provided support for a part-time licensed social worker to assess need, establish and facilitate Caregiving Support (CGSG) in the designated community clusters. ACCESS is working to identify and train a qualified community member in each town to "take over" the group to make these groups community sustained.

The Gatekeeper Program is a nationally recognized program developed in 1976 designed to train community members to identify potential warning signs and symptoms that a person might be experiencing a crisis. The program emphasized awareness of others and provides appropriate professional referral protocol strategies. After the Gatekeeper Program was offered to each town the manual and training materials were reproduced for each town and are currently housed in the City Hall offices for future community lead trainings.

Innovative Solutions to Problems

Even the most significant problem was relatively easy to overcome. I attribute this to the cooperative nature of our group. The most significant problem we encountered was with the 211 information system. Our goal in the original proposal was to purchase a "data bridge" to link the Washington and Idaho 211 systems. We were partnering with both states to develop the software necessary to share resources (this is very valuable in a region that encompasses 2 states) between states. Washington 211 was prepared to match our funds to start software development.

However, we learned that the software would actually serve as a way for Washington to get Idaho's resources list, but the system could not be bi-directional. Also, the "data bridge" would only link WA and ID, not OR or MT or any other state in the country. The "data bridge" would also become antiquated technology with any software updates by either state. We considered our options and after thoughtful

discussion it was decided that we would focus our efforts and funding elsewhere. This is outlined in the Year I - Year 2 carry over application.

Results

The program was evaluated through two methods. Process data were collected through two waves of qualitative interviews with the grant director, grant manager, Gatekeeper trainer, transportation and care giver support group coordinators. The interviews gave information valuable to make in-progress changes in the program to increase efficiency and effectiveness. Outcome data were collected through pre and post training surveys to measure retention and utilization of the Gatekeeper training.

Potential for Replication

The Outreach funding ended May 1, 2009, with a no-cost extension till April 1, 2010. During the extension period we are focusing attention and funds on Caregiver Support Groups and volunteer driver reimbursement. Project ACCESS was designed to accomplish certain tasks with the three-year grant period and become community sustained. To date, the project is sustainable as intended. We continue to seek foundation funding to continue purchasing educational materials, match funds for COAST Transportation volunteer driver reimbursement.

After the Grant

The project is closing out at the end of the extension period. It was designed to become community sustained without the need for further efforts and we have been successful in becoming so. The difficulties in developing a sustainability plan were addressed in the proposal development stage, and therefore, we avoided sustainability planning issues during the grant funding period.

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ILLINOIS—COLES COUNTY MENTAL HEALTH ASSOCIATION, INC.

Community Characteristics

While depression is one of the most common health disorders in women, few access services or receive adequate treatment. Nearly one-fourth of all women experience a major depressive disorder in their lifetime, and the risk for depression increase during pregnancy. The risk of suffering post-partum depression increases if the woman has had prior episodes of depression. In our communities, there had been no specific training on screening for or treating post-partum depression. While staff from the county health departments may have utilized the Edinburgh Post-natal Depression Scale with some of their clients, where and how to refer for services was not known. Similarly, if women were administered this screening tool by their physician or nurse, addressing the mental health aspect of the disorder was not happening. Additionally, if the woman reported more imminent risk issues such as suicidal ideation or thoughts of harming her child, there was no mechanism in place to access immediate care. Women did not receive accurate or timely assessments of their mental health needs or the risk factors to their safety or that of family members.

Services Offered

Services established and delivered with these outreach grant funds to address post-partum depression include: 24-hour referral system, 24-hour availability to screen/assess, 24-hour immediate in-person response for high risk referrals, case management, service referral and linkage. Utilizing the RBHN's established 24-hour crisis line, referrals from any source were made. The majority of referrals came from physicians and the public health departments. Acuity was assessed over the phone and an in-person assessment time and location was set based on risk and client preference. The Edinburgh screening tool was administered to each client as well as a mini-mental status exam. Results of these directed what interventions were provided and what follow-up services were arranged. The population served was women. The majority of them in their 20's and 30's who were Medicaid recipients. While the clients were the direct service recipients, referral sources also benefited in now having immediate access, 24-hours a day to qualified mental health professionals. Professional and community education services were also delivered via this project. A 1-day workshop for clinical professionals was provided by staff from The University of Illinois at Chicago (UIC). Approximately 40 persons attended this training and were able to earn continuing education units. General community education and awareness was provided by way of newspaper articles, brochure distribution, health fairs and local presentations.

Innovative Solutions to Problems

We did not encounter any significant implementation problems in regard to clinical service delivery, although we did not see as many women as we had anticipated. We were unable to provide regional conference in year 3 as we had hoped. Additionally, we were not successful in providing specific training to physicians on this topic. In regards to the conference, we did not have adequate personnel to organize an event of this size. With multiple staff off on medical leave in year 3, we had to struggle to provide our clinical services. Regarding physician education, the main barrier was UIC's inability to travel to our region followed by difficulty finding time in the physicians' schedules.

ILLINOIS—COLES COUNTY MENTAL HEALTH ASSOCIATION, INC.

Results

The main problems that might be faced by other communities emulating our service model would be those common to any change; turf issues and trust and insecurities in doing business a new way. Also, providing mobile services and providing them 24-hours a day comes at a cost. With today's economic crisis and health care worker shortage, this may be seen by some as insurmountable. On the positive side, if a community can identify a "cause" and obtain buy-in more options may come to light and/or seem possible. Being able to build on the shoulders of previously established relationships and network structure would be a valuable cornerstone for a community to then model this outreach project.

Potential for Replication

Yes, in regard to structure, training and improved access to care.

After the Grant

Yes, the program will be sustainable. From the start of this Outreach Project sustainability was considered. Training, supervision, and service delivery were intentionally rolled into the existing structure of the network (RBHN -Regional Behavioral Health Network). This has allowed for these specific services to not have to "stand alone", but be 1 of the numerous services delivered by RBHN. By building this into an already established successful system, we are able to support this project's services by reduced overhead and utilizing surplus revenue from other service lines.

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Community Characteristics

Local research through community forums, surveys, needs assessment, occupational status, poverty and social problems identified three obstacles preventing residents with mental illnesses in the targeted communities from getting the excellent care they deserve: 1.) Stigma that surrounds mental illnesses, 2.) Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and 3.) The fragmented mental health service delivery system. The evidence from the target communities, Rush, Fayette and Franklin counties, identifies specific areas related behavioral health concerns surrounding community issues such as a growing indigent population, addiction, unemployment, and many other indicators.

Services Offered

The goal of the grant was to improve the health and wellness of people living in the rural communities of Fayette, Franklin and Rush counties in Indiana, especially the low income and elderly, by 1) focusing on decreasing barriers, 2) providing prevention and early intervention education, and 3) increasing treatment effectiveness. The target counties have added barriers as they have been designated by The Indiana State Office of Rural Health: Fayette County as a partially medically underserved area (MUA), Rush County is a health care professionals shortage area for members 200% or below of poverty, Franklin County is a whole county health care professionals shortage area (I-IPSA), a whole county medically underserved (MUA) and Mental Health Shortage Area's (MHSA) as well.

Innovative Solutions to Problems

The project had multiple challenges relating to personnel. From the time of grant submission to the end of the grant period, all but three persons on the Advisory Committee changed, thus creating some difficulty in maintaining momentum and continuity of information. The Licensed Clinical Social Worker initially identified was unable to fulfill the role, thus creating an opening that was difficult to fill in a rural area. The hiring gap created a six-month delay in start-up of services. In addition, Family Health Services closed a satellite clinic during Year Two, affecting access for clients and clinical impact.

Payment for services was also problematic. When the grant was submitted, the program was based on the premise of Medicaid payment fee for service. The year the grant was funded, Indiana went to managed care Medicaid with three different providers. This required reeducating clients, having the clinical providers to apply for three different panels, and then retraining office staff to obtain authorization on the three programs. This delayed Medicaid payment, which was presumed to be the predominant payor for this program. However, the most dominant pay or for this and all services within Family Health Services were the unfunded client. This fact created a revenue generating challenge.

In the ongoing evaluation of the progress of the program, barriers previously identified seemed less inhibiting and others presented themselves. Elderly persons were not accessing the program as projected because of age specific belief systems and the fact that many elderly had a wide range of expensive wellness issues which had already consumed multiple Primary Care visits. Therefore, many elderly who were referred to the program through primary care did not choose to come to the program. Primary Care providers believed that the elderly population sought faith based services before mental health services, a choice in alignment with their beliefs and existing support systems. Costs related to the transportation and pharmacology could have also been a factor. Primary Care Plus staff attempted to inform local clergy

about the program in order to gain their support for referrals. In addition, other marketing efforts included a community breakfast, articles published in area papers and white papers related to changing the stigma attached to the term “mental health” which reached several thousand readers. Flyers and information posters were posted in primary care offices, churches, Bingo areas, etc. related to the elderly population. A community education event held by the Family Health Services group allowed for all participants to learn of the services and that the health center was indeed becoming a one stop shop which was integrating primary health care and mental health.

A second barrier determined by the post referral phone survey and other related tools, was the fact that clients being referred to the program were not making it or not choosing to come to the program for even an initial assessment. Calls to those referred, were made to determine the reason for no-shows which determined various issues but the top three were: no gas money, home crisis, belief they could not afford to pay. In this rural community, multiple trips to a facility were not an option with prices of gas and distance. If a client was referred and could not be seen the same visit or on a subsequent visit for multiple services, the client would choose not to go. A focus to make appointments for Primary Care Plus + program services at the health center during visits for other regularly scheduled medical issues was made to decrease those barriers.

The recognition that paper work for clients was initially cumbersome, tedious, and repetitious in order to abide by multiple regulations, making it difficult for collaborating organizations to utilize a single point of contact and to maintain shared record keeping. Through collaborative efforts, we were able to refine the paper work in ways that allowed patient information to be protected and yet accessible for all necessary staff.

Results

1. Increase the number of community health patients receiving behavioral health care by 20%.
2. Decrease the number of psychiatric and drug and alcohol visits to the county emergency rooms by 2%.
3. Improve the health status and wellness of people living in the Fayette, Franklin, and Rush Counties of Indiana particularly the indigent and elderly.
4. Replicate the successful program to 8 additional rural designated counties in Indiana.

Evaluation systems of process and outcome measures initially revolved around the achievement of these goals. However, it was discovered that the local emergency rooms were unable to develop baseline or on-going tracking of utilization related to psychiatric and/or substance abuse visits. Another consideration was the lack of definition of parameters to measure “improved health and wellness”. This may have been the result of abandoning the use of a standardized mental health screening tool for the medical providers. Thus, after discussion with technical assistance personnel in Year Two areas for evaluation were adjusted.

It was possible to measure program utilization and patient and provider satisfaction with the program. Standard demographics on clients served were gathered. Documentation of dissemination efforts was noted.

Potential for Replication

This model evolved over time. By the end of the grant period, many of the original difficulties were resolved. Recommendations for other program initiatives can be made with firm experience behind it. The program could work in other places with recommended advanced planning addressing the barriers that this program encountered. It is feasible that propagation with conviction can occur. However, the program as conceived and originally submitted would not be universally applicable to other programs with the anticipation of equal or better results. The model is a best practice model for a FQHC, because they are cost reimbursed. Our two partners a rural health clinic and a community mental health center are reimbursed at much lower rates, so the program cannot sustain itself due to the lack of volume and the poverty that is associated with the rural area.

After the Grant

Yes, the approach will continue with some variation. The Licensed Clinical Social Worker will come on as a full time staff member of the Family Health Services Clinic. The clinic staff was adamant regarding the value of therapy access for patients. The paperwork flow and billing procedures will follow Family Health Services internal protocols. The clinician will continue to refer to Dunn Center when patients need prolonged and intensive treatment.

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Community Characteristics

The Lifestyles Diabetes Project has two primary goals. First, we aimed to reduce long term and short-term diabetes, related complications for as many residents as possible who have already developed diabetes. To reach this goal, the project provided diabetes self-management education following recognized national standards at the project's clinic and at key outreach locations. Second, we aimed to promote awareness and prevention of diabetes to as many citizens as possible in the two-county area. To achieve this goal, we reached out to conduct awareness, assessment, and education sessions at senior citizens' centers, schools, churches, and health fairs, and we conducted a diabetes awareness and prevention marketing campaign.

Services Offered

Diabetes Self-Management Education (DSME): designed to achieve diabetes awareness and prevention for citizens in Gibson and Pike Counties and to provide education and support on self-management for many who have already developed diabetes. According to the 2003 Indiana Behavioral Risk Factor Surveillance Systems, 7.8% of adults 18 and over in Indiana have been diagnosed with diabetes. The project provided diabetes self-management education following the recognized national standards at the project's clinic.

Promote awareness and prevention of diabetes to as many citizens as possible in the two county area. We reached out to conduct awareness, assessment, and education sessions at senior citizens' centers, schools, churches, and health fairs. We conducted a diabetes awareness and prevention marketing campaign. Success of the project will result in healthier communities in Gibson and Pike Counties, more effective use of existing healthcare resources, and a lowering of community healthcare costs.

Innovative Solutions to Problems

1. Diabetes Self-Management Education (DSME):
 - a. Acceptance by physicians
 - Luncheon/education visits with physician and key staff
 - Baskets with educational information given to key staff
 - b. Community awareness
 - Marketing: billboards, newspaper, radio, flyers, etc.
2. Outreach
 - a. Acceptance into school
 - One-on-One meetings with key personnel provide information on program.
 - Started with contacting school nurses per instruction of superintendent. When that was determined unsuccessful, we contacted school principals, which proved to be our most successful avenue.
 - b. Acceptance into senior centers, went from trying to set up visits with Executive Director to calling the Activity Director
 - c. Poor participation from senior citizens in centers:
 - New program ideas: We would go into the senior centers to speak on nutrition, diabetes awareness and prevention. There might be 4-9 participants. So drawing from 25 years experience in geriatrics, we scheduled Bingo with healthy prizes followed

by an educational speech by the nurse or registered dietitian: we had from 48-56 participants for Bingo and all stayed for the speech. The other idea we tried was the Foot Clinic. We had several elderly patients report that if they could reach their feet they could not see well enough to care for their feet. So the nurse examined their feet and provided instruction on good foot care. Podiatry referrals were given if needed. Nurse would trim non-complicated toenails. Each participant was given a goody bag which contained a long-handled shoe horn, mirror, nail clippers, samples of lotion, etc. Another success, there would be 15-20 participants for foot clinic.

d. Acceptance into churches:

- After many attempts trying to set up events with local churches, we contacted the person responsible for parish nurse training in the area who introduced us to local nurses who partner on a couple events.

Results

The consortium did not function as we thought. It was difficult to get the members together for a meeting. The consortium preferred to participate through email. The existence of the consortium assisted us with referrals, with contacts for our outreach and as a sounding board when we needed support.

There were no barriers that were not resolved. When we met with a road block, the LDC staff just found another avenue to meet our goals. The barriers were frustrating but with perseverance we succeeded. The churches are one aspect we are still working on. We partnered with two in the 3 years.

Potential for Replication

LDC is committed to using the best practices in the diabetes field to ensure success. LDC has been very successful in our Outreach as shown by the attached work plan.

After the Grant

The Diabetes Self-Management Program is not self-sustainable. Gibson General Hospital supports the diabetes center.

The program will not be closing. We are developing a Pro Forma for a wound clinic. We felt the diabetes program and the wound clinic would complement each other, and the wound clinic would offer additional revenue producing opportunities. Gibson General Hospital is very supportive of our diabetes center and the Pro Forma for the wound clinic. Gibson General Hospital will be supporting the Outreach activities. The Outreach will be limited in the amount of hours that can be allotted for that service.

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Community Characteristics

Marshall County, Iowa has experienced a dramatic shift in the demographics of its population in recent years. This shift is resultant of a 480% increase in the minority population which includes an 1106% increase in the Hispanic Community in the past ten years. New immigrants recruited to the community by the meat packing industry have driven these changes. This industry is the largest private employer in Marshall County with pay ranging from \$9-\$11 an hour.

The low pay and larger family size of immigrant families has resulted in an increase in the number of people living in poverty and an upsurge in the number of un or under-insured residents. For economic reasons, Marshall County is designated as a Health Provider Shortage Area (HPSA). Further, the county has been designated a Medically Underserved Community (MUC) and the immigrant population has been designated as a Medically Underserved Population (MUP) due to language and cultural barriers in accessing health care services.

Services Offered

The Building Healthy Families project is designed to decrease the disparities in health and social services available to our target population of all pregnant Hispanic women residing in Marshall County, Iowa. The BHF project's goal is to improve prenatal health outcomes through the strategies of identification and assessment, provision of family support and health education services and incentives to increase participation in health care and educational opportunities in the community. The project will address the severe lack of services to Hispanics due to cultural and language barriers.

Innovative Solutions to Problems

This project was implemented in April 2006, and on December 12, 2006, Marshalltown was the site of an ICE Raid at the local meat packing plant. As a result, more than 90 Hispanic workers were detained or deported. Immediately during and following the raid, Hispanic families went into hiding due to fear of additional raids. Many Hispanic families left our community to relocate in other states Or began co-habiting with other family or friends due to lack of resources from lost jobs.

Although our program had only been operational for a few months, our program staff were some of the very few people in the community that were trusted enough to be allowed into homes. Because of this relationship of trust, we were instrumental in providing support and accurate information to these families.

Consortium member, St. Mary's Hispanic Ministry became the central point of coordination in the community and coordinated community fundraising and awareness efforts to assist the families impacted by the raid.

For several months, our target population was overwhelmed with survival and our efforts focused on providing information and referral services and family support. Over time, we were able to focus more on the outcomes identified in the grant.

Results

The various tools were used and developed to evaluate this project. Edinburg Depression Screening tool was used to assess maternal depression. A safety survey, modified post-test, and client satisfaction

survey were developed at the beginning of the project. Due to the education level of our target population, all tools were developed with this in mind.

Potential for Replication

Yes. The BHF project combines the research and strategies of three successful model programs; Healthy Start, Healthy Families Iowa and Parents as Teachers. According to the Promising Practices Network (www.promisingpractices.net). Parents as Teachers is a “Promising Program” utilizing their national evidence criteria.

After the Grant

Our sustainability plan included an agreement among consortium members to begin to integrate the cost of some services into their core operating budgets. The program outcome data was used to demonstrate the need and the benefits of the project and to seek community support for such services. As a result, we secured a commitment from a local foundation to provide significant funds to continue this project. However, due to the recent economic downturn, the foundation announced that they are not able to honor their commitment. We have secured a state grant to continue some components of the BHF project and are in the process of writing additional grants to sustain the program. We will revise the strategic plan to meet the funding needs of this project in the future.

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Community Characteristics

The Wayne County Multi-Generational Behavioral Health Project serves one of the state's most poor, isolated, and distressed areas with the greatest percent of population over age 85. Located in southern Iowa along the border with Missouri, Wayne County suffers troublesome economic, educational, and environmental problems that have damaged for years the mental and behavioral health of its children and youth, families, schools, and communities.

All four of these strata of life have been integrated into this project by increasing access to behavioral health care for children, youth, and the isolated elderly through outreach, education, and community involvement. This project represents a transition from mental health to a broader, more pervasive behavioral health condition that has emerged as the county's most telling unmet need. Fifteen hundred Wayne County children and elderly persons comprise the target population, but in the context of their families, schools, and communities.

Services Offered

The school-based services included: 1) school and home-based counseling for approximately 65 children and their families. 50% of these cases had parental involvement, meaning that parents either participated in family counseling or received their own, individual services. 2) Approximately 80 elementary students/year participated in guidance during the After School Program. This involved a 30 minute character building group based on Capturing Kids' Hearts. 3) Five junior high and high school students and twelve Alternative program students received Aggression Replacement Training co-facilitated by school-court liaison. 4) Eleven junior high girls received gender-specific support group based on the University of Minnesota Circle of Support. 5) Families attended the summer school activities that included an Iowa Cubs baseball game and water activities at Corydon Lake Park.

Innovative Solutions to Problems

Some of the problems faced when implementing the project included episodic client participation, turnover of project staff (management issue), misinterpretations, and fear of the system. Clients often failed to keep appointments or did not call to cancel, while the participation of others declined to the point of no longer attending sessions. This made it difficult to collect accurate data, potentially increased future work, and made ineffective and inefficient use of resources. The inconsistencies did not help those involved, especially the children.

The turnover of Project Staff, especially the project director, was an ever pressing issue. When project staff members became disconnected from the project; valuable information was lost, and the project lost some of its resourcefulness. Lack of continuity and investment inhibited progress and added stress to other staff.

Results

The following is an example of high school student data, which was collected over a period of two years. On the category "Behavior Toward Others", the specialist utilized the CAFAS scale over a period of time to determine a beginning or "intake" score and a current/ending "discharge" score to help evaluate the effectiveness of the mental and/or psychological services provided. An average percent of change was then calculated to determine overall positive or negative growth. Many factors are considered

when assessing the negative fluctuations on the graph, such as home instability, disabilities, sexual abuse, substance abuse, divorced parents, peer pressure, personal relationships, etc.

Potential for Replication

This program can be successful in other rural settings if the community and family have ownership, want to have a program exist, and are willing to provide input and assistance for success. The program can be successful in other rural settings if recruitment and retention of staff is fully developed and planned prior to implementation. As with many organizations in rural settings, individuals fill many roles and wear many hats. If there isn't a perceived need or positive outcomes are achieved, the program will be difficult to maintain in the current economy.

After the Grant

The Wayne County Multi-Generational Behavioral Health Project is still seeking funding to continue services across the county. As with any grant-funded program, the greatest challenge is identifying continuation funding, while the greatest assets are the collaborative relationships that were developed and strengthened through the program and that will continue to support collaborative efforts in the future. The agreement with the Wayne Community School District and Rathbun Mental Health will continue through the 2009-10 school year through an At-Risk levy supported by local tax payers.

To continue some of the services, the staff at the different consortium member's organizations will continue the implementation of practices, procedures, evaluation, and the self management education. This "train the trainer" concept works well for continuation of the program and staff resources.

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Community Characteristics

The PrairieStar/Health Ministries Dental Project focused on the inadequate dental access, lack of awareness of the importance of oral health, and no continuity of care between medical and dental services among low-income residents of Reno and Harvey Counties in Kansas. The project was designed to address the lack of access to dental care by the 26,767 low-income residents and the 15,237 Medicaid beneficiaries of Reno and Harvey Counties. Access to dental care was anticipated to reduce the high cardiovascular mortality rate, high percentage of low birth-weight babies and high diabetes hospitalization rates present in the two counties.

Services Offered

The scope of the PrairieStar/Health Ministries Dental Project was the residents of Reno and Harvey Counties without access to dental care. Reno and Harvey County low-income children and pregnant women were the target populations of the project.

Innovative Solutions to Problems

The most significant problem encountered by the project was the low numbers of Harvey County residents accessing dental care at Health Ministries Clinic. Productivity at that Site was substantially lower than at the PrairieStar site throughout the project. Public awareness of the project was provided by the health department and Health Ministries Clinic staff. The hygienist hired to provide services at that location attended community meetings and provided presentations to encourage participation in dental services at HMC. She also was the hygienist who provided fluoride varnish through the health department; she made referrals to the dental clinic through this resource.

Throughout the project, the Project Director encouraged double and triple booking appointments to overcome no shows and last minute cancellations. By year three of the project, a reduction of provider time at that clinic was recommended by the Project Director to reduce the loss of project revenue due to low productivity at the HMC site and ensure sustainability of the project.

Results

The project was evaluated based on its ability to be sustainable after the grant period. Outcomes achieved with grant funds were the successful initiation and implementation of dental services at two safety net clinics in South-Central Kansas, and sustained dental service provision at the two clinic sites by the separate organizations housing the project.

Potential for Replication

Yes, PrairieStar Health Center is responsible for maintaining their dental clinic and Health Ministries Clinic is responsible for maintaining their dental clinic. Both clinics report that they are committed to the continuation of dental services in their communities.

After the Grant

Both clinics will continue providing dental services. Ensuring that program sustainability and the project as a whole is more important than any of the consortium members' goals is key to making a consortium such as this effective and efficient.

KANSAS—PRAIRIE STAR HEALTH CENTER

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KENTUCKY—MONTGOMERY COUNTY KENTUCKY HEALTH DEPARTMENT

Community Characteristics

The mission and function of the Montgomery County Health Department, the applicant agency, is to provide programs and activities for the prevention, detection, care, and treatment of physical disability, illness and disease for the residents of the county. The Health Department has a well established record of planning and implementing grant-specific projects that complement its public health responsibility. The health department receives money from a variety of funding streams, including state and federal allocations, Medicaid and Medicare reimbursement, fees and grant funding.

Services Offered

We proposed 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 three years of the grant the Consortium planned to provide 540 primary care visits and 600 dental visits as well as outreach, transportation and other services.

Innovative Solutions to Problems

Problems experienced with the implementation of this project were unanticipated. Shortly after the initial award of the grant, the media increased the fears of Immigration and Naturalization Services (INS) to a degree where some of the project planning needed to be changed. Utilizing Hispanic focused job fairs seemed to be a counter productive move for this project. At that time in Montgomery County, immigrant workers were unlikely to gather in any large group and therefore publicizing the project and such job fairs were removed from the overall outcome plan. Instead, the project relied much more heavily on the one on one relationship between prospective program participant and the Promotoras and word of mouth within the community itself.

Other problems encountered were issues that required other agencies to provide data that support the work of this project. EMS and 911 services did not collect data in a way that would support our desired outcome that program participation would reduce the need for emergency calls for this particular population. Further data is not kept on completion of ESL coursework, but rather data is kept on individuals signing up for the courses. Completion rates of ESL in this area appear to be low, however sign ups are higher.

Results

Evaluators for this project changed midway through implementation and at that time evaluation strategy did change somewhat. After thorough review of all measures, it was determined, that there was no supporting data currently collected to address some measures specified within the grant. Further, after discussion it was determined that though this project could be supportive of increasing numbers in ESL course Vi/ark arid supporting health care providers in meeting Full Compliance for Title; VI the project itself could not be fully responsible for ensuring each of these measures was met as initially written. The Project Director and the evaluator then sent a request to the program officer requesting minor changes in the wording of the measures initially agreed upon. Those changes are noted in the

KENTUCKY—MONTGOMERY COUNTY KENTUCKY HEALTH DEPARTMENT

Performance Measures section. Since it was critical to the project that a targeted population engaged in seeking and obtaining medical care, the critical questions became: what strategies could be employed to more readily engage the target population: what are the barriers to accessing health care; and once health care had been accessed: what worked and what could be improved. The evaluator also worked with the project staff to create surveys that gathered changes in participant opinions and ideas about the project over time. Surveys were created to ask providers their thoughts specific to critical performance measures and project components. The evaluation strategy was participatory and driven by objective pre and post data as well as subjective information given in the open response portions of the surveys. In many cases it was the open responses that brought about minor changes in implementation and gave the project staff encouragement that they were implementing a critically needed program.

Potential for Replication

Community “buy in” is critical and the sponsoring organization would need to have the kinds of relationships already established by the Montgomery County Health Department. The Local Director of Public Health and the Project Directors have tremendous credibility in the community and there is trust with the sponsoring organization. Further, program participants must have a clear understanding from the beginning that this is not “permanent” insurance for them, and they will need to learn how to become independent of this program.

After the Grant

Often smaller communities are envious of the service arrays in more populous areas, however the personal relationships developed and nurtured in small communities are a tremendous asset to projects such as this. Best Practice models are not built overnight, rather they are often based on the social capital of those who are involved in the implementation of such programs. Going to church or to the grocery with health care providers gives program implementers an opportunity to engage providers in a way that is more expedient and based on a trusting relationship, therefore expediting implementation and opening lines of communication that are vital to such a program’s success. With a trusted Public Health system in the lead on such a project immediate viability occurs, because both providers and potential participants know they will receive the best possible services. When the project hires a first generation Spanish speaking immigrant as a care coordinator the project gains increasing credibility; and finally when the project engages numerous popular opinion leaders from the community being served it becomes optimal.

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Mt. Sterling, KY 40353

Community Characteristics

The Connections Program focused on addressing the health care needs of low-income residents of Madison and Anderson County, and assisting them in locating and utilizing their community health care resources. The needs were identified through a public needs assessment administered to random members of these communities. Many of these individuals face serious limitations in their ability to access health care. The program expanded the delivery of rural health care by providing referrals to community resources and direct services, including in-home assessment, case management (up to 90 days, unless extension is necessary), transportation to/from appointments, psycho-educational tools/information, and mental health/family support services. The Connections Program used a comprehensive approach that promotes self sufficiency by, providing the client with educational tools that address their specific health care needs, increasing the client's knowledge about existing resources and how to access them in order to reduce future barriers and disparities they may face, and for the client to foster their own health. The Connections Program also provided psycho-educational programs covering content areas we know significantly impact health such as, tobacco, diet/nutrition/exercise, substance abuse/mental health, diabetes, arthritis, self esteem, among other health related issues, in the county schools and other community establishments.

Services Offered

Services were provided through a partnership in cooperation with The Kentucky Cabinet for Health and Family Services (DCBS), and the public schools/family resource centers in Madison and Anderson County Health Departments.

The following services were provided through DCBS:

- Identified appropriate clients for referral
- Assisted by providing collateral information when available
- Advised on the need of participating youth and families
- Assisted with the preparation of evaluations and quarterly reports
- Designated a contact person for the collaborative
- Participated in program evaluation and cooperated with the project evaluator
- Youth education programs and materials
- Services through the school nurses
- Family resource centers supportive services and counselors

Innovative Solutions to Problems

The most significant problems encountered in the project implementation were, establishing the program services throughout the communities, and offering a broad range of services rather than focusing on specific areas. Efforts to resolve the issues in publicizing the program, included but weren't limited to, attending community-wide networking/collaborative meetings for various service providers, to share and discuss the services provided by programs represented, setting up tables/booths at community health events, assisting in the delivery of community health events, designing a program brochure, and continuously making efforts in building relationships in the communities.

Results

Innovative methods of services that were implemented in this project included, offering case management, in-home visits, transportation to and from health related appointments, the ability to offer a range of services to address various needs of the individual, and delivering services through active participation in various community events/settings.

Potential for Replication

We believe that similar projects would be beneficial and successful in other rural settings, considering that various domains of access to health care appear to be a presenting concern in other rural areas throughout the nation. However, it is crucial that there are strong supportive partnerships built within the communities, on a fiscal, political, and community wide level, that will explore innovative methods of reducing these barriers, and combat the critical issues that currently exist.

After the Grant

The program recently received funding through a foundation grant, which will allow sustainability for the program. Additional sources of potential funding will be continuously sought, to secure the program's sustainability for future preservation.

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LOUISIANA—BAYOU TECHE COMMUNITY HEALTH NETWORK

Community Characteristics

ByNet's St. Mary Parish (County) Chamber of Health Coalition comprised of over 70 representatives of healthcare, social service, consumer, faith-based and governmental entities, identified five key areas of need to improve healthcare in St. Mary and surrounding Parishes. Focus groups and committee research led the coalition to identify education, consumer finance, transportation, access to medication and primary and specialty care as key barriers to healthcare access for residents. In addition, the Health Access Barriers in the State (HABITS) Survey was conducted for the three project target counties. The University of Louisiana at Lafayette's Health Informatics Center conducted the surveys used as baseline data for network program evaluation. Emergency room usage, lack of health insurance, transportation and inability to afford needed medications were identified as key concerns for all three target areas. Beginning in 2001 the network's consortium of members began to implement programs and services to address identified needs. In the aftermath of the September 2005 Hurricane Katrina devastation experienced in the southern coastal region of the United States, the previously identified needs have significantly enhanced to an insurmountable level. St. Mary, Iberia and Terrebone Parishes have now become home to thousands of survived families requiring these services.

Services Offered

The ByNet CEI Project Outreach is working to expand the Bayou Teche Community Health Network's Information and Help Center, Medication Assistance Program, Telehealth Project and Chronic Disease Management/Prevention Outreach Programs. Expected results are:

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

Innovative Solutions to Problems

In the early implementation of the project ByNet noted challenges in several key areas including the following:

- The most significant factor restricting progress toward the achievement of Goal 1 was the absence of a finally shared vision among the network member organizations.
- With the advent of Medicare Part D,⁷ ByNet observed a decrease in the number of users of its Prescription Assistance Program (PAP),⁸ with a corresponding decrease in its program income. ByNet has not developed a written sustainability plan.
- The availability of health services is restricted by: 1) difficulty recruiting provider staff; 2) reluctance of member organizations and partners to assume risk, such as the liability issues

LOUISIANA—BAYOU TECHE COMMUNITY HEALTH NETWORK

involved with the faith-based volunteer transportation system; and 3) the impact of Hurricane Katrina which extended throughout Louisiana and adversely affected many aspects of service systems, while causing major population migrations. In particular, the delivery of health provider continuing education courses and TeleHealth support received from Tulane University was terminated due to the storm.

Results

Project Outreach's evaluation demonstrates positive community impact due to greater efficiency in coordination and collaboration among existing social service, healthcare and faith-based organizations in the parish. Positive impact includes:

- increased enrollment in local, state and national programs (i.e., LaChip/Medicaid/Medicare Savings/Care for the Caregiver);
- continued decrease in non-emergency ER utilization;
- increase in outreach partners comprising Community Health Teams; increase in number of comprehensive screenings (i.e. diabetes/blood pressure and service eligibility);
- establishment of single points of entry for patient mapping; leverage of state (\$50,000) and federal funds (\$200,000);
- increase in number of residents with identified medical home; increase in number of churches providing transportation to medical care;
- consortium access to state-wide meetings and seminars through coordination of teleconferencing equipment and “ accumulation of additional data on the target population through service point customization and expansion.

Potential for Replication

We do feel strongly that our program has the potential to become a best practices model.

After the Grant

We strongly believe that some components of our project will continue to be sustained outside of the Outreach funding, but at a very limited scope.

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LOUISIANA—FRANKLIN PARISH HOSPITAL SERVICE DISTRICT, No. 1

Community Characteristics

Franklin Parish Hospital Service District I is a service district hospital facility dba Franklin Medical Center. In 2006, the hospital was awarded a HRSA. ORHP awarded Franklin Medical Center a Better Health for the Delta Grant in 2003 and a Network Planning Grant in 2004. Franklin Medical Center created the Franklin Parish Health Coalition to serve as the community planning group for the Better Health for the Delta Grant. Sheila Mason, RN, program director served as the "community encourager" and the HRSA project director during all of the Better Health for the Delta grants. Currently, the coalition has been expanded to the Franklin-Tensas HealthCare Coalition and serves as the advisory consortium for the outreach grant program.

Services Offered

Franklin Medical Center administers outreach grant funds for the provision of behavioral health services, which are integrated with the medical center's primary care services to provide a multidisciplinary approach to care. The grantee's outreach program serves Franklin and Tensas Parishes located in northeastern Louisiana. The grantee's service area is part of the Mississippi River Delta Region.

Innovative Solutions to Problems

Innovative methods of delivery evolved over trial and error periods during the grant's cycle, but the overall result has been a sustainable, primary care based program that reaches to all populations - specifically targeting the school aged child at this present time. Over the years, the grantee acquired Technical Assistance from the Office of Rural Health Policy for pending removal of the program from the hospital's Administrator due believed sustainability issues from Louisiana state funded mental and behavioral health reimbursement programs, such as Medicaid and LaChip programs.

Results

Franklin Medical Center established the rural health outreach program in response to the limited access to primary health care and behavioral health services for residents of Franklin and Tensas Parishes. Both parishes are designated as MUA and HPSA areas for primary medical care and mental health services. The grantee's outreach program is a component of the services provided within a rural health centers. This common site provides physicians and mid-level practitioners an opportunity to make immediate referrals for behavioral health assessment and treatment.

Potential for Replication

Grantee did not submit information.

After the Grant

Franklin Medical Center, along with consortium members, has developed a sustainable mental/behavioral health program that has increased and made access to care for individuals living with co-occurring chronic medical conditions and mental illness a success.

**LOUISIANA—FRANKLIN PARISH HOSPITAL SERVICE
DISTRICT, No. 1**

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LOUISIANA—HOSPITAL SERVICE DISTRICT NO. 1-A OF THE PARISH OF RICHLAND

Community Characteristics

The “*Richland Healthy Heart Consortium*” was first organized with a group of people who had previously been a part of a group of community members that had been meeting to discuss the possibility of constructing a Community Wellness Center. The Richland Parish Hospital Administration first began meeting with this group in June 2004. The group was formed as a result of community assessment activities performed by the Richland Health Coalition, which began in the Fall of 2003.

The *Richland Parish Hospital* has served as the Lead Agency for the grant and as such, has taken the lead role in developing and conducting the project activities. RPH employs the Project Staff and has provided the facility and additional project personnel as Inkind Contributions. The Inkind Contributions provided by RPH over the three year grant period are calculated to be an estimated \$151,000. RPH Administration has assumed the responsibility for meeting all HRSA/ORHP requirements.

Services Offered

The primary needs addressed through the Rural Health Care Services Outreach Grant were:

- a. The need to increase the quality, availability, and effectiveness of community-based programs designed to prevent cardiovascular disease and improve health and quality of life
- b. The need to expand the availability of health education resources to underserved, vulnerable and special needs population to reduce cardiovascular disease in these populations.
- c. The need to decrease the risk factors and the *resulting* high incidence rate of cardiovascular disease and correlating chronic diseases 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 management and treatment of cardiovascular disease and correlating chronic diseases.

Innovative Solutions to Problems

The primary problems, circumstances and opportunities addressed through the Rural Health Care Services Outreach Grant included: a) high poverty, poor outcomes and disparity within the target area; b) increased incidence of cardiovascular disease and the correlating chronic diseases; and c) an opportunity to benchmark a successful Community Wellness & Prevention Program and leverage use of state grant funds which allowed the purchase of the start-up equipment and software for the CW&P Program

Results

We do not know of any problems or barriers that were not successfully resolved in the implementation of the project. The TRAC Program Staff was extremely fortunate to have the guidance of not only Dr. Labrentz, but also Karen Wakeford of the Georgia Health Policy Institute. Ms. Wakeford served as the *HRSA/ORHP* Technical Assistance Provider for the TRAC Program and was also an invaluable resource. We greatly appreciate her additional assistance that was provided by HRSA/ORHP.

LOUISIANA—HOSPITAL SERVICE DISTRICT NO. 1-A OF THE PARISH OF RICHLAND

Potential for Replication

The biggest hurdle that must be overcome is finding the right leadership team for the project. It is without doubt that the TRAC Program would not have been as successful without the help of our Physician Champion, Dr. Paul Grandon. It is also important that the project have the backing of a primary health care provider in the community - in our case it is the Richland Parish Hospital. The RPH Administrator, Michael Carroll, is both a community leader and a strong advocate for Wellness & Prevention. While the project can definitely be implemented without these two components, it is our opinion that it will be much more difficult to gain the credibility and trust of the community that is necessary to be successful.

After the Grant

During the Outreach Grant period, funding was secured from other sources to contract with Labrentz & Associates to study the region and develop a Sustainability Plan. As part of this plan, a Business Plan was also developed for a Regional Corporate Wellness Model. RPH was subsequently awarded a HRSA/ORHP Network Development Grant to implement this regional business model throughout the Northeast Region of Louisiana through the North Louisiana Regional Alliance. It is our belief, that we can also continue our Community Outreach efforts through the program revenue to be earned from the Corporate Wellness activities.

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Community Characteristics

The Progress Equals Access for Louisiana (PEAL) program was designed to provide outreach and education services in conjunction with the implementation of the Medicare Prescription Drug Plan (Medicare Part D). The program was originally designed to provide education and enrollment services for Medicare beneficiaries residing in the identified delta parishes stated in the grant application. The program was designed to target beneficiaries in rural and underserved areas that are not aware of the benefits of Medicare Part D and the low income subsidy (LIS).

Services Offered

The PEAL Program focus on providing education and enrollment specific to Medicare Part D, low income subsidy (LIS/extra help). Specific services provided by the PEAL Program as follows:

- a. Education beneficiaries about Medicare Part D
- b. Direct assistance with comparing Medicare Part D drug plans
- c. Direct assistance with selecting a Medicare Part D drug plan that best met their needs and enrolling
- d. Screening for LIS and applying for LIS if applicable
- e. Screening for Medicare Savings Program (MSP) and applying for MSP if applicable
- f. Screening and enrollment for prescription assistance programs
- g. Ongoing assistance and follow up with Medicare beneficiaries to answer questions
- h. regarding their new Medicare Part D plan
- i. Providing train-the-trainer workshops to teach health care professionals, social service providers and volunteers how to assist Medicare beneficiaries with Medicare Part D education and enrollment as well as LIS screenings and applications.

Innovative Solutions to Problems

The scope of the program broadened to become statewide; therefore, the most significant problem encountered during project implementation resulted from limited staff to travel statewide. Another significant problem revolved around the limited open enrollment period for Medicare Part D. The demand for educational events is strongest during the open enrollment period, November 15-December 31. With limited staff, and a month and a half open enrollment period, the PEAL Program utilized the train-the-trainer concept to overcome this barrier.

Results

In the beginning, the Project Director and consortium partners evaluated the success based on the amount of positive feedback received from clients, family members, and rural health care facilities.

As the project began to grow due to popularity and referrals, the Project Director collected the number of duplicated and non-duplicated encounters as well as the number of train-the-trainer workshops held each year. The following year after a beneficiary was enrolled into the Medicare Part D plan, they would call or come to visit to reevaluate their plan for the upcoming year. The data collection provided a means of evaluating the success and outcomes achieved by the percentage of beneficiaries who returned for services.

Potential for Replication

As aforementioned, the only barrier that other communities may face revolves around the short open enrollment period; however, you're constantly busy after the enrollment period assisting others who are not eligible for Medicare Part D.

After the Grant

Due to the outstanding outreach services PEAL provides, the Louisiana Department of Insurance SHIIP has renewed their contract (\$40,392) with the Louisiana Rural Health Association's PEAL Program. The contract will allow PEAL to continue carrying out the program activities and provide on-going assistance to Medicare beneficiaries.

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Community Characteristics

Health centers throughout the United States are challenged to serve an increasingly aging population. Between 2005 and 2030, the over-65 population will double from 35 million to over 70 million and the oldest old, those 85 years of age and older, will grow from 2% of the population to 5%, according to the Administration on Aging. According to recent reports, Maine's elderly population continues to increase. Maine's population 65 and older is now at 15%, compared to 12% for the nation. The state's near-elderly and elderly population faces significant barriers in access to quality health care and supportive services including geographic isolation, lack of transportation, limited financial resources, lack of insurance coverage for many services (even for those on Medicare), and an insidious cultural bias against the elderly, promulgated by a youth-obsessed society. Additionally, as a number of needs assessments, discussions and meetings determined, there is often a "disconnect" between providers of health care and social services leading to acute fragmentation of care within the health care and social service system. These access issues coupled with the fragmentation of services, result in poor health outcomes, lack of attention to preventive care and lowered quality of life for the area's vulnerable elderly population.

Services Offered

The major goals of the Rural Maine Healthy Aging Program embrace the following: developing communication mechanisms among service providers; improving access to high quality, locally coordinated, multi-specialty and integrated health care; expanding preventive services emphasizing specific concerns for older adults substance abuse, tobacco use, injury prevention, obesity, physical activity, mental health and immunizations and expanding mental health awareness and services. The proposed activities include: expanded case management with a geriatric focus; vigorous community outreach and education; improved preventive care and screenings; and the promotion of higher education in rural geriatrics.

Innovative Solutions to Problems

Every provider and community member interviewed stressed the importance a senior center for a variety of purposes. A community recreation center is currently in the planning stages in Lincoln, but completion is at least another ten years away; and all agreed that an area specific to seniors is needed before this time. Most providers agreed that the best location for a senior center would be in a nearby town that would be equally accessible to both the Lincoln and Millinocket residents. While locating the appropriate space for a senior center proved to be a barrier. Participants also note that although Lincoln and Millinocket are not geographically distant, they are often considered to be culturally distinct which causes additional barriers.

Results

As a result of this grant program within Health Access Network sustainable changes have been made to rural health care practice that will benefit the rapidly aging population residing within HAN's service area. As a result of the grant, Health Access Network will be implementing components of the MatureCare model which will ensure that nursing home coverage by physicians is responsive to patient needs and is efficiently coordinating among healthcare staff. Nursing home social worker visits are now a self-sustaining component of the program providing critical support services to those patients who are

most in need of this support. The Northern Maine Rural Geriatric Coalition is also another long lasting component that will provide a forum for future healthcare planning in the Lincoln/Millinocket region that did not exist prior to this grant. This coalition brings together experts and professionals from throughout the state to brainstorm and discuss issues that impact some of the most rural regions of the HAN service area. Older adults will also continue to benefit from the outreach activities, support groups, and prescription assistance program into the future.

Potential for Replication

Through this grant great strides have been made to enhance the patient experience at HAN. However, there remains a need to continue project activities to ensure that the achievements made under this grant are maintained. These activities include on-going staff training regarding healthcare for older adults and on-going outreach to providers, caregivers and older adults regarding the needs of older adults and the specific services and supports available both within the community. HAN has not acquired any new funding other the relationships that they have formed with other agencies and the community so there needs to be a commitment to continue to support older adult patients and their caregivers in order to sustain the momentum of this project.

After the Grant

To help support the sustainability of the geriatric program, HAN and other program partners strive to promote continuation of Northern Maine Rural Geriatric Coalition. For example, participants attending the educational programs were offered the opportunity to join the coalition. At present, there are 20 members representing 15 agencies in the region. They will meet approximately 4 times per year to discuss possible training opportunities for local providers and/or community members.

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MARYLAND—EASTERN SHORE AREA HEALTH EDUCATION CENTER

Community Characteristics

This report summarizes the outcomes of the Children's Regional Oral Health Consortium (CROC) evaluation conducted from 2007-2009. The CROC was awarded a Health Resources and Services Administration (HRSA), Office of Rural Health Policy (ORHP), Outreach grant in late July, 2006. The purpose of the CROC grant was to: (1) develop a comprehensive dental center in Dorchester, Maryland; (2) develop a regional hospital-based pediatric dental program for the six mid and lower Eastern Shore counties; and, (3) develop community-based clinical and educational training opportunities for dental hygiene students on the entire Eastern Shore of Maryland. This report presents favorable outcomes for all the original CROC objectives and finds that the CROC staff and project management did an outstanding job of implementing the Project-the first of its kind and a success in providing dental services to Medicaid children in Dorchester and surrounding counties on the Eastern Shore of Maryland.

Services Offered

Objective One: Increase access of and availability to comprehensive primary oral health care services to low income children in Dorchester County. This outcome measure will be evaluated through a record review of Medicaid children receiving dental services before and after CROC, and evaluation of patient/family satisfaction. Patient record review is a long-term strategy and will begin in the second grant award of the CROC Project. Patient and family satisfaction is reported in this report

Objective Two: Increase availability of and access to oral rehabilitative services requiring sedation for children on the Eastern Shore. Measurement of this objective will also begin during the second grant period and through a record review of child dental patients at Dorchester Hospital for services that require sedation. In addition, patient/family satisfaction will be conducted.

Objective Three: Increase clinical and educational services for the dental hygiene workforce on the Eastern Shore-this outcome measure will be evaluated through the number of clinical and educational events, and number of participants involved.

Innovative Solutions to Problems

The entire CROC staff had input in the development of the evaluation tools and was trained in their administration, but the task of administering the seven various tools fell to the CROC Dental Receptionist. While a dedicated and willing partner in the evaluation process, the demands of her own job, and the fact that her work area is separated from the patient/parent waiting area by a glass enclosure, prevented her from getting a larger evaluation sample.

Results

Objective One: Develop a comprehensive dental center in Cambridge, MD-this was evaluated through the following:

- Renovation to temporary facility to house the dental center--This was accomplished within the first quarter of the project.
- Purchase and installation of office equipment-This was accomplished within the first quarter of the project.
- Hire of new dentist and office staff-This was accomplished within the first quarter of the project.

MARYLAND—EASTERN SHORE AREA HEALTH EDUCATION CENTER

Objective Two: Expand oral restorative and rehabilitative services at Dorchester General Hospital- this was evaluated through the following:

- Agreements reached with Dorchester General Hospital for scheduling the OR for oral *surgeries- This was accomplished within the first six months of the project.*
- Development of referral system for patients in need of pediatric specialty *care- This was accomplished within the first six months of the project.*
- Objective Three: Develop training opportunities for dental hygiene students- this was evaluated through the following:
- Hire of a CROC Dental Hygienist *Coordinator- This was accomplished within the first six months of the project.*
- Development of clinical and educational events for dental hygiene students on the Eastern Shore- *This was accomplished within the first year of the project and is on going.* The Dental Hygienist Coordinator reported the following clinical opportunities developed during CROC 1:
- Four University of Maryland (UMD) Dental Hygiene students participated two times (for a total of eight events) with the Holly Center, Urgent Care and Community Dental and Village during 2006-2007.

Four UMD Dental Hygiene students participated two times (for a total of eight events) with the Holly Center Urgent Care, and Community Dental and Village Dental during 2007-2008 Eight UMD Dental Hygiene student participated two times each (for a total of 16 events) with the Village Dental Choptank Community Health Systems School-Based Program during 2008-2009 Four UMD Dental Hygiene students participated in Children's Dental Health Month Presentation for Pre-K and first grade Title 1 schools during 2008-2009.

The following data was collected and analyzed from the seven evaluation tools used for the CROC Project. The data is presented according the evaluation form and questions asked of the patient and/or their parent/guardian.

Potential for Replication

Develop partnerships with others (individuals, organizations, etc.) who are compatible with program objectives and bring to the effort programs, services, or resources necessary to achieve success.

To illustrate this in action, our Children's Regional Oral Health Consortium (CROC I) involved partnerships with our AHEC Center, acute Community Hospital, the University Dental School, and two (2) federally qualified community health centers. The AHEC for the project brought administration and management; the hospital and University, guidance and operating room availability; while the federally qualified community health centers brought their experience and personnel in delivering clinical services. In my view the end result was most successful in developing a program meeting project objectives. Further, with the involvement of the federally qualified health centers, the clinical element of the project and most of the educational components remain operational and sustainable.

Overall, developing partnership with others who can assist in achieving program success.

After the Grant

During the project's 3-year time frame a total of \$844,935 was received for services provided- \$684,576 from the dental clinic and \$160,659 from hospital service.

MARYLAND—EASTERN SHORE AREA HEALTH EDUCATION CENTER

Sources for most of this revenue was the Medicaid Program. There was also a very small percentage of private insurance payers.

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Community Characteristics

Michigan has the third highest obesity rate in the United States, with 62% of adults overweight or obese. Our children are following in our footsteps. Eleven percent are likely to become overweight adults with all the serious health conditions, psychological issues and health care costs that arise with excess weight and energy imbalance.

Services Offered

The target of 799 children screened, was exceeded as 2,183 children were screened within the Consortium area. Screenings were mostly done in local schools, and at local health fairs.

Innovative Solutions to Problems

Initially the Shaping Our Children's Future program was designed to provide fitness classes on site at each facility, but provide nutrition education via teleconferencing to maximize resources. However, it was noted with the first class, the kids and parents in the off-sites had difficulty paying attention, and in active participation, so it was decided by the grant committee and the Principal Investigator to provide all classes on site. This made the nutrition education much more inter-active with the Dietitian and the class participants.

The initial classes were scheduled for 12 weeks. It was found, the participants were diligently attending classes for 6 to 7 weeks, and then attendance greatly decreased. It was then decided to make the classes 6 weeks in duration, which kept attendance 100%.

The initial class consisted of:

- Initial BMI
- Lab values to determine Metabolic syndrome or other underlying medical issues
- Behavioral Health Survey
- Nutritional Assessment
- Behavioral Modification Education
- Fitness Classes
- Final BMI after 1 year

However, insurance reimbursement proved difficult for labs, and kids did not want to get a blood draw. Changes to the program consisted of dropping the blood draw, thus not having to worry about receiving reimbursement for services. Curriculum changes were made, the Nemours 5-2-1-Almost none model was adopted, proving to be a simple, and effective teaching tool. The Nemours model is a non-profit organization with the goal to drive long-term changes in policies and practices that promote child health and to leverage community strengths and resources to have the greatest impact on the most children. Based on the concept of 5- Fruits and vegetables per day, no more than 2 hours of screen time per day, 1 hour of physical activity per day, and almost none sugary drinks daily, this model has had a great impact on the success of this program.

In the first year of the grant, screenings were primarily performed via health fairs and Provider Well visits thus decreasing numbers screened. In the second year, it was decided to partner with local schools, train local Physical Education Teachers to screen and when to refer, with site coordinators overseeing the process. Screening numbers greatly increased, and continue in the sustainability process.

Results

The project was evaluated by the formal Evaluation Team on a yearly basis. The Principal Investigator monitored the program and the funding in relation to the outcomes on a monthly basis.

The consortium partners of Mackinac Straits Hospital and Helen Newberry Joy Hospital functioned as initially planned. Marquette General Hospital required constant re-direction in the first 2 years, the last year they functioned as initially planned.

All barriers to the success of this project were successfully resolved by the management, advisory and evaluation teams.

Potential for Replication

Sustainability of the grant will also be accomplished by modifying the classes to provide individual educational sessions by the Nurse Practitioners who participated in the grant over the past 3 years, and have obtained additional education on weight management. Re-imbursement will be done by billing private insurances. This will ensure the educational sessions continue on a long; term basis.

Reimbursement for services was the main challenge faced in developing and implementing a sustainability plan. This challenge was resolved by utilizing the school personnel to do the screening, and the Family Nurse Practitioners to do the education and classes.

Based on the success of our program, we consider our program a best practices model.

After the Grant

Sustainability of the grant will also be accomplished by modifying the classes to provide individual educational sessions by the Nurse Practitioners who participated in the grant over the past 3 years, and have obtained additional education on weight management. Reimbursement will be done by billing private insurances. This will ensure the educational sessions continue on a long term basis.

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Community Characteristics

The *Nuevas Avenidas* (New Avenues) Program established new routes to primary, preventative, and behavioral health care for medically underserved residents of Hidalgo County, Texas. The program combined the work of Community Health Workers (*Promotoras*) with accessible health care services, case management, grassroots organizing and service agency coordination. The program was designed to address the range of mental and behavioral health issues confronting community residents, as well as the lack of access to primary and preventative health care.

Nuevas Avenidas took place in 14 *colonias* of rural, southern Hidalgo County, Texas, on the border with Mexico. Hidalgo County is home to over 600,000 people. *Colonias* are incorporated neighborhoods developed outside of city limits and lacking city services such as transportation, utilities and road signs. Federal government data in 2001 stated that an estimated 98-99 percent of *colonia* residents were Latino. The Texas Secretary of State in 2004 found that many *colonias* lack clean water and adequate sewage and drainage. Half of rural *colonias* lack complete plumbing, as well as garbage collection and improved roads. Additionally many *colonia* families do not have telephones, making it very difficult for health and social service providers to communicate with them. The Housing Assistance Council reported in 2005 that nearly 30 percent of border Hispanics in *colonias* lived in poverty. According to 2000 U.S. Census data, a language other than English is spoken at home in 83.1 percent of Hidalgo County households. Texas Secretary of State in 2008 reported that more than 400,000 Texans lived in *colonias*, with the largest concentration in Hidalgo County. Almost 1,000 unincorporated rural settlements, or *colonias*, exist outside of city limits. *Colonias* attract low-income families, about one-third of whom migrate for agricultural work in the summer months.

Services Offered

The target population for the *Nuevas Avenidas* program comprised Spanish-speaking Latino *colonia* residents in rural, southern Hidalgo County, Texas, on the border with Mexico. The program established new routes to primary, preventative, and behavioral health care for medically underserved community members. The program helped uninsured *colonia* families in the target area to improve and care for their health and take collective action to promote health in their communities.

The community-based education, advocacy and organizing was led by community members trained as *Promotoras*. The *Promotoras* went door-to-door in the *colonias* and spoke to families about health concerns and provide information and referrals. provided individual health education and referrals to health and social services (primarily to Hope Family Health Center for medical care and/or counseling) and social support. The referred individuals received follow-up visits from the *Promotoras* or the Program Coordinator/case manager.

Innovative Solutions to Problems

The three most significant problems encountered in the project implementation were: transportation of referred individuals to medical and counseling appointments at Hope, getting Hope to schedule appointments in a timely manner, and the stigma surrounding mental health issues and care.

The project took place in 14 *colonias* in Hidalgo County, some of which were up to 40 minutes away from Hope Family Health Center, a grant subawardee. Even when program participants were referred and had appointments scheduled, they often couldn't make it to their appointments. Many participants either

had no car, had an unreliable car, or had no money for gas. And most of the *colon/as* in the project area are not serviced by public transportation lines.

The program had not budgeted money for taxi vouchers and had no way to get people to the clinic. In addition to transportation, child care posed an obstacle for some participants. For these reasons, the numbers of people referred to appointments was significantly larger than the number receiving services. This problem was never adequately resolved, however it led to efforts to provide on-site services in subsequent Migrant Health Promotion programs.

Results

The project was evaluated using process and outcome measures, all of which were analyzed throughout the project period to both make improvements to the program and to assess the program's effectiveness. For instance, at least 100 needs assessments were administered at the start of each program year in order to determine the needs, strengths, and topics of interest to the community. The results of the needs assessments were used to determine the content of the educational programming for the upcoming season. In the first two years, pre-tests that measured participants' knowledge of mental and behavioral health topics were administered before the first presentation of the series and post-tests were administered after the final presentation. In the third year, after determining that the participant pool shifted throughout the season and participants did not attend all presentations, the decision was made to administer pre-tests and post-tests at every presentation. Throughout each of the program seasons, *Promotoras* conducted individual; encounters in which they collected demographic information, provided health information, and made referrals to health and social services as necessary. In year 3, participants were asked both before and after the program season about their understanding of mental health issues and their knowledge of/access to mental health services.

Potential for Replication

Yes. Migrant Health Promotion is a nationally recognized expert on community-based peer health promotion programming, innovation and implementation. The agency is a winner of the 1996 national Models That Work Competition, sponsored by the Bureau of Primary Health Care. The Competition honors unique community-based programs that improve access to and appropriate utilization of primary health services for vulnerable populations.

The program is closing out in one sense, but the same staff and some of the same partners are continuing in *Futuros Saludables*. That said, Migrant Health Promotion has taken the appropriate steps in terms of financial and programmatic reporting for the end of *Nuevas Avenidas*. Migrant Health Promotion worked intensely during the 3 years of the program to leverage new public and private grant funding, both to expand *Nuevas Avenidas*' scope and to sustain it at the conclusion of the project period. In particular, Migrant Health Promotion submitted grant proposals to the Meadows Foundation and the American Psychiatric Foundation; both proposals were rejected, though one made it to the final round of the Meadows Foundation's process. Migrant Health Promotion also sent a letter of interest the Houston Endowment upon the recommendation of one of their staff members as well as a Consortium member (we were ultimately rejected for being outside of their geographic scope). We also worked on a proposal to the National Institute of Mental Health, Center for Mental Health Services, but our research partner became ill during the process so the grant was not submitted.

After the Grant

Nuevas Avenidas ended without attaining sustainability, however a new Outreach grant enabled Migrant Health Promotion to begin a program called *Futuros Saludables*. The new program is similar to *Nuevas Avenidas* in that it highlights educational programming on mental and behavioral health topics and provides access to primary and preventative care. *Futuros Saludables* improves on *Nuevas Avenidas* by providing mental and physical health care on-site (removing the obstacle of transportation to an off-site clinic) and by incorporating nutrition and physical fitness into the curriculum.

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Community Characteristics

The Thumb Area Nutrition and Physical Activity Campaign was a result of a community health assessment conducted by the Thumb Rural Health Network (TRHN) in 2004. The (TRHN) identified obesity as the underlying factor influencing the development and progression of chronic disease in the Thumb Area of Huron, Sanilac, and Tuscola Counties.

Results indicated that the overarching issue related to death rates from heart disease, diabetes, and other chronic disease was obesity. Despite numerous health education program³ that addressed nutrition and physical activity, 66.5% of adult residents and 40% of youths were overweight or obese. The project was the result of 15 months of research and planning by the task force. The Task Force had four long term goals: 1) Increase the proportion of adults who are at a healthy weight (BMI) from 33.8% to 38.8% by 2015; 2) Reduce the proportion of adults who are obese (BMI) from 28.8% to 26.8% by 2015; 3) Reduce the proportion of children and adolescents that are overweight or obese from 40% to 30% by 2015; and 4) Increase the proportion of children and adolescents ages six to 19 years whose intake of meals and snacks at school contributes to good overall dietary quality.

Services Offered

The “Thumb Steps Up Program” is located in the ‘Thumb’ of the mitten shaped state of Michigan. The Thumb is a sparsely populated area covering three counties: Huron, Sanilac, and Tuscola. The Thumb Steps Up Task Force service area includes three counties: Huron, Sanilac, and Tuscola. The consortium members include county Michigan State University Extension Offices, the three County Health Departments, and five rural hospitals that include Harbor Beach Community, Scheurer, Deckerville Community, Hills and Dales General Hospitals, and the Huron Medical Center.

All three counties are designated in part as Health Professional Shortage Areas (HPSA) for primary care and mental health. Huron and Sanilac counties are designated HPSAs for dental care for the low-income population and both have a portion of their counties designated as Medically Underserved Areas (MUAs).

Innovative Solutions to Problems

There was an unequal-distribution of resources to each partner and they were not proportional to the targets or expectations for each organization. These decisions had been made by when the grant was originally submitted. Once the grant actually was awarded the original persons who committed to the targets and budget were no longer involved or no longer employed with the hospital. Solution: The members all decided to pool resources and do a redistribution of the target numbers and also redistributed the supplies such as pedometers and exercise bands. We ended up purchasing cheaper pedometers for the hospitals and health departments who focused on children walker and then we saved the more expensive pedometers for the adult walkers. As consortium members we also pooled resources to purchase the educational materials.

Staff members or administrators who helped plan the project and wrote the grant were not those who actually implemented the project. This was in part due to staff turnover at organizations. We had a half hour set aside at each quarterly meeting to discuss program specific challenges that each group was having and then as group we developed strategies to rectify those challenges. The coordinator has put

together a guide to doing programming for each entity and this served as a reference for the new employees.

Multiple project components combined with eleven diverse partners made coordination of interventions and evaluation activities difficult. Emails and monthly meetings the first year really helped keep things organized. These partners all had some working relationships prior to this grant which did assist us in accomplishing our tasks. Trust issues and crossing county lines was an issue in the first six months, but those barriers were quickly tore down once the program partners actually started working together.

Having no out of the box programs, created a learning curve which caused frustration as interventions, reporting, and evaluation was tweaked to better meet needs. With eleven partners in the program we needed to develop timelines and reporting formats that each partner so the data was being gathered the same way from partner to another.

The first pedometers we purchased was based on the lowest cost, this was not a good idea! The pedometers were not accurate and they broke within a week or two of use. As a result, we did our homework and found resources that rated the pedometers and we also called people who had experience in conducting pedometer walking programs. We ended up spending \$1.50 more per pedometer and what a difference it made, we had happy walkers.

Results

Of the program participants who indicated that they finished the program, 88% of them indicated that the walking program impacted their thoughts and/or intentions about physical activity and nutrition. Attached tables illustrate the level of attitude change toward eating better and being more active. Program satisfaction was high. None of the participants that did not complete the program said that they didn't like the program. Overall, 82.4% rated the program as a 4 or 5.

Potential for Replication

Yes, it is a common sense approach and easily sustainable. It does not take a lot of financial resources to walk. It also encourages you to look at affordable and free recreational and exercise opportunities that are within your own community.

After the Grant

Yes, the program will be sustainable. Some of the partners will be charging a fee to cover the cost of the pedometer.

Of the project components members would like to continue, Partner Networking and sharing ranked number three. Pedometer walking programs and outreach to schools ranked one and two respectively.

We conducted a partner survey at the end of the project to assess our grant process and also as a starting point for the sustainability plan the results revealed the following: 5 out of 10 organizations indicated they would definitely like to continue the project, 4 out of 10 said they would maybe like to continue, and one said they would not like to continue. When discussed during strategic planning, all present agreed that if there were not reporting and evaluation requirements they would like to continue the project.

MICHIGAN—TUSCOLA COUNTY HEALTH DEPARTMENT

It was agreed upon that we could continue with at least one walking program each hand we would continue with our outreach efforts to worksites. Worksite programs are where we could reach the largest populations and business were supportive of their employees' efforts. Church congregations would also be an area where we felt we could have the most impact.

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Community Characteristics

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

Services Offered

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

Innovative Solutions to Problems

The most significant problem encountered in the project was completing the fund raising to open the facility in a timely manner. The Rice Hospital Board of Directors very wisely refused to begin construction until all funds for construction and a minimum of three years of operating revenue were secured. Many grants were written, presentations given, town hall meetings were held, and by summer 2007, architectural plans were drawn up and construction began. The facility, Rice Regional Dental Clinic (Dental Clinic) opened its doors to patients December 5, 2007 and began serving low income uninsured and underinsured residents of a twelve county area.

The combined skills and resources of the consortium members strongly illustrate the components necessary to successfully meet the needs of this project. The consortium brought together the critical elements for addressing the needs of the dentally underserved people of the target region. Rice has extensive experience partnering with other organizations on projects in the community and region, administering grant dollars and delivering a wide variety of services. All individuals needed to initiate project activities at the start of this grant were paid staff through the Consortium. Open participation was encouraged among all five partners so decision-making and problem solving could be accomplished successfully. This group continues to meet on a regular basis to assist in guiding not only future growth but also day to day operations.

The main innovative methods of service delivery include allowing fourth year dental and dental hygiene students provide oral health care services and the recruitment of area dentists to not only support the project but also volunteer and assist in overseeing the dental students at work in the clinic. Patients are assigned to a dental or dental hygiene student who performs their care. The dental students treat patients under the direct supervision of a faculty dentist or faculty hygiene instructor. There are currently twelve area dentists who have been trained as adjunct faculty who volunteer eight hours per month in the clinic. This collaborative effort not only allows the Dental Director a reprieve to do the necessary administrative tasks of his job but also allows the students direct exposure to other rural oral health care professionals.

Results

- Provide dental care for uninsured and underserved resident in the service area.
- Promote Careers in dentistry among people living in the area through education and public service.
- Engage area dentists and dental hygienists in public service.
- Increase the number of dentists and dental hygienists choosing to practice in the service area.
- Provide opportunities for inter-professional education.
- Continue to develop and strengthen Dental clinic infrastructure.

Potential for Replication

Yes, I do believe this program is a best practices model - from holding area town hall meetings to gather support in the planning process to construction of a state of the art facility to excellent operations and business practices to ongoing program evaluation and strategic planning for the future. This program has what it take to be successful at helping address the access to oral health care shortages in rural Minnesota.

After the Grant

Based on the feedback from all the students who have worked in the Dental Clinic, this program will go on for a long time. They not only learn a tremendous amount of dentistry, they also see what the underserved struggle with every day. As public awareness that oral diseases have an enormous impact on the lives of underserved Americans, it will become vital for this service area to address the needs of their residents. The reputation of the clinic and its impact on the health of area residents will be an attractive recipient for local foundations as well as future endowments. Local city and county governments have already stated they will be supportive of the clinic operations.

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Community Characteristics

Since 1994 the Cooperative Health Center, based in Helena, Montana has provided primary medical and dental care to anyone needing those services, and without consideration of their ability to pay for those services. But with 19% of the population in the service area and half of all CHC patients living below the federal poverty level (and 30% living at or below 200% of the federal poverty level), combined with a weakening economy, Lewis and Clark County experienced a large and rapid increase in the number of uninsured patients. The links between down economic times and increased episodes of emotional illnesses and substance abuse are well documented. 70% of CHC's patient population seeking primary health care has a mental health diagnosis; some have a substance abuse diagnosis, and some have both. Access to community based mental health and substance abuse providers was severely limited, with waiting lists for intake appointments at the local Center for Mental Health ranging from 5-8 months. CHC leadership recognized correctly that even though it was a primary health care clinic and not a mental health center, it was, in fact, in the mental health business.

So CHC's project began with the goal of improving mental health and substance abuse services at the Cooperative Health Center by integrating mental health and case management services with primary health care, providing short term, evidence-based strategic interventions; by hiring additional service providers; and strengthening partnerships and improving access to our community's mental health center and chemical dependency services agency.

Services Offered

Psycho education, along with brief, strategic counseling is available to all established patients of the Cooperative Health Center. Many people the consortium members serve have multiple psychosocial or environmental problems, and our case manager helps link people to the community based resources they need to better manage their lives. An informal system of curbside consulting already existed among consortium members (i.e., CHC medical practitioners already worked closely with psychiatrists at CMH.) The creation of the consortium turned that into a more formalized system in which CMH and BA agreed to set aside a number of appointment slots specifically for CHC patients.

Innovative Solutions to Problems

The grant stated that the Center for Mental Health would be charged with advertising for, interviewing and hiring the full-time case manager. It became apparent early on that the wage disparity between the Center for Mental Health and the Cooperative Health Center would create an on-going problem. It was decided that the Cooperative Health Center would employ the full-time case manager and house the case manager on site, at the clinic. The Cooperative Health Center assumed the management of the case manager.

Results

The CHC will integrate mental health services with primary health care visits.

Goal 1 has been met. For the past 3 years, a counselor and a case manager have been located on the primary care hallway at cooperative Health Center. Counseling and case management services have been integrated with primary care services.

The CHC will provide evidence-based mental health and substance abuse interventions.

CHC provided the following evidence-based interventions: solution-focused brief counseling; case management; individual psychotherapy; and psychotropic medications.

Potential for Replication

The process of building a consortium to address Behavioral Health Issues is vital to the quality of health care provided in any given community. Similar projects could be successful in creating a consortium to improve access to mental health and substance abuse services for their consumers. The difficulty lies in providing the direct services to patients once the grant funding comes to an end. Having a strong consortium does not mean you will have the ongoing funding needed to provide direct services. On one hand, our project was very successful; we developed a consortium, we increased access to services for our patient's, we provided quality behavioral health care to 898 patients during our three year grant- But, on the other hand; we haven't been successful in securing ongoing funding for these services.

After the Grant

Yes, we consider ourselves a best practices model. Patrick Frawley, Cooperative Health Center's counselor, has spoken at national conferences about the success of using a QPD panel in a primary care setting.

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Community Characteristics

Mental Health - Installation of tele-health communications equipment has been completed at all locations. There were however some problems with connectivity to the Harvard Medical School, Department of Psychology that were worked through and it is anticipated that these problems will not be a factor in the continuation of the project.

Services Offered

The target population of the project is school age American Indian children and youth, ages 5 to 18, which are referred to the project by school district personnel, and individual family requests. Meetings with school administrators, i.e., Superintendents and principals, as well as teachers, counselors, and nurses have been conducted at each of the four school districts identified in the application. These meetings have included Indian Health Service personnel, and have been both informational and educational. They have served to gain the support of all affected personnel, as well as to develop reporting and information sharing systems. This includes confidentiality requirements, and need to know procedures.

Innovative Solutions to Problems

The Fort Peck Tribes under the authorities of P.L.L. 93-638 have contracted portions on the Indian Health Service programs that allow the Tribes to obtain reimbursement for services from Medicaid patients at an all inclusive rate (\$268 in 2009). There is currently a high unemployment rate of 65% on the reservation with most residents qualifying for Medicaid and SCHIPs, making this program sustainable. Fiscal sustainability projections in the current Fort Peck Tribal School Health Center program indicate annual revenue equal to an amount that will sustain the salaries, supplies and administrative support of the program. Additional revenue will offer expanded health services.

Results

The present Fort Peck Tribal School Health Center project generates reimbursement for services rendered to students in the schools who have third party coverage. On the Fort Peck reservation the high poverty rate results in most students being eligible for SCHIP or Medicaid. Projections of revenue for the current program are such that it is expected the program will have a positive cash flow. The expansion of staff in the school health center will allow a long term program in the schools because it is planned that the revenue will be enough to maintain the professionals in the program beyond the funding period of this project.

Potential for Replication

Replication of this project has a high probability on any reservation with high unemployment and enrollment of its members in the SCHIPs and Medicaid programs.

After the Grant

The Rural Access: Mental Health Care Project is viewed by the Fort Peck Tribal Executive Board as one of the most critical health care projects ever initiated for the benefit of school age children and youth. As such, every effort was made to successfully develop and implement a third party billing system for mental health services provided through this project. A Memorandum of Agreement was approved, which

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allows billing the Indian Health Service, and Medicare, as well as other third party insurers for the provision of professional mental health services to the target population. It is estimated that at the current allowable billing rate of \$253 per encounter, for mental health care services, and based on the number of estimated encounters (1,440), the project would generate \$288,000 over a period of nine months. As of April 30, 2009, there were 740 encounters, which have generated approximately \$75,000 in the third year of the grant. This method of billing will provide sustainability of funding for at least two psychologists/psychiatrists annually, and create a sustainable monetary generating relationship for mental health services.

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MONTANA—WHEATLAND MEMORIAL HOSPITAL & NURSING HOME

Community Characteristics

Chronic disease management in rural communities is extremely difficult due to the vast geographic barriers and resource limitations regarding accessing disease management education, preventive care education, and ongoing care management services. Diabetes is one of the most common chronic diseases among American adults, accounting for nearly 20% of Medicare healthcare expenditures. These expenditures can be attributed to long term complications resulting from diabetes.

Services Offered

Diabetes is the 6th leading cause of death in Montana versus the 8th leading cause of death in the U.S. Complications of diabetes include heart disease (the number one cause of death in Montana), stroke, high blood pressure, blindness, kidney disease, nervous system damage, amputations, dental disease, depression and increased susceptibility to many other illnesses. (Montana Department of Public Health and Human Services).

Innovative Solutions to Problems

The placement and operation of equipment during the first year was the greatest obstacle we faced during the 3 year period. The infrastructure simply wasn't in place sufficiently before we began our first Diabetes Education class. Participants expressed concern over being able to communicate and feeling comfortable with the room and set up. Nevertheless, participants were still very satisfied with the intervention even though the technology presented communication problems. However after phase one, Wheatland Memorial Healthcare utilized other grant funds and through in-kind donations was able to remodel the teleconference space, installing a large screen with comfortable chairs and table. Future classes were very pleased with the new arrangement and with the telehealth intervention in general.

The other problem that hampered the development of ongoing oncology consultations and therapeutic counseling efforts was the need for credentialing for each doctor who uses the telehealth system. All doctors are credentialed in their own facility and many do not feel they should need to go through the laborious process of becoming credentialed in each remote location where they may see only one or two patients. We are still working on streamlining the credentialing process through a central hospital that can be used by all remote sites.

Results

A conceptual model was used to guide and interpret the study, resulting in a more complete understanding of implementation, results, and recommendations for future telecommunications interventions. The CCOP project concerned three areas of health self-management: Diabetes, Hypertension, and Depression. In the Diabetes group, pre and post measures were taken and indicated significant positive differences for weight, HbA1c and BMI. All members who completed the exit physical exam recorded a healthier weight and BMI. Participants also were measured on depression, empowerment, attitude, knowledge, and understanding of self-care. Their scores improved in a statistically significant way in their understanding of diabetes self care and in their attitude toward diabetes. While their scores also improved as far as knowledge and

Potential for Replication

Absolutely, yes.

After the Grant

Yes, the program will continue to exist in an altered format. The data we collected during the grant period has convinced us that our approach works, and so we will no longer be studying the efficacy of our technique. Because there is no need to collect the large amount of data we have in the past, the expense of staff time dedicated to data collection and verification is greatly reduced. We will continue to offer diabetes and hypertension education and support for local residents through telehealth, and will continue to use the equipment purchased during the grant period for educational purposes. A Rural Health Quality Improvement Grant is funding a staff person at WMH to increase the tracking of patients with chronic illness. This employee will also coordinate educational support similar to that which we have learned increases positive self-management of chronic disease. This program will also track physical measures for patients with diabetes and hypertension. Because of a great need identified for mental health services during the CCOP study, WMH received a HRSA grant to expand these services through telehealth as well. Therefore all aspects of the CCOP project will be sustained.

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NEBRASKA—GOOD NEIGHBOR COMMUNITY HEALTH CENTER

Community Characteristics

The need for increased numbers of behavioral health providers in rural areas in Nebraska is significant. Health Professionals Shortage Areas (HPSAs) in the State for mental health services at the onset of the grant were significantly above the national average and continue to be so (Bureau of Primary Health Care Database). At the onset of the grant 88 of 93 counties in Nebraska had been designated by the Nebraska Office of Rural Health as either total or partial Health Profession Shortage Areas in psychiatry services provision (Nebraska Office of Rural Health). Additionally data from the State Licensing Information System in 2004 indicated that 23 counties in Nebraska had no mental health providers and 15 other counties had only one licensed provider of any type (psychiatrist, psychologist, or licensed mental health practitioner).

Services Offered

The original overall goals of the project were to: 1) reduce discrepancies in the availability of outpatient behavioral health care to the rural, underserved population of East Central Nebraska through the provision of expanded services and increased numbers of BH providers; 2) reduce the number of inappropriate out of home placements for children and adolescents through the provision of integrated BH team evaluations for juvenile justice and child protective service agencies in East Central Nebraska; and 3) evaluate the effectiveness of an integrated behavioral health program in the primary care Good Neighbor Community Health Center and replicate the program in at least one additional site in Nebraska by the end of the three year grant.

Innovative Solutions to Problems

Two problems were encountered during implementation of the project. The first being the inability to obtain a court ordered evaluation contract with the State of Nebraska which would provide both a needed service for area residents and sustainability for the Boys and Girls Home.

Despite multiple attempts to secure the contract both with the State and court system this attempt was unsuccessful. The objective relating to this contract was dropped for the third year of the grant as it was outside the control of the grantees. Fortunately, the therapy program at Boys and Girls home has proven to be self sustaining through Medicaid, private insurance funding and support from the UNMC program.

The second issue came in the form of a staffing change related to the original psychiatrist providing services at GNCHC. At the time of writing the grant, both the psychiatrist and staff felt that increasing his hours from 16 to 20 per week was a reasonable, doable solution to increasing medication management availability within the program. By October 2006, our psychiatrist had decided that due to the great amount of travel (200 miles round trip), gas prices and lack of reimbursement of his time during travel, that he would prefer to stay near his home in Omaha. The clinic was able to replace part of the psychiatrist's time with another psychiatrist, but was left with only 10 of the original 16 hours rather than an increase to 20. Due to GNCHC being located in a severe mental health shortage area, recruiting and training someone from outside the area had proved difficult. After advertising for most of 2006 for a psychiatric APRN without success, it was decided to develop the resources within GNCHC, in cross training an existing APRN to provide behavioral health services. A bi-lingual APRN who had been with the agency for some time was ready and willing to complete the 10 hours of classes and practicum to obtain the certification he needed. Unfortunately a second barrier was encountered when the APRN's

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father became gravely ill and he was unable to start the training. After advertising again for a psychiatric APRN, in June 2007 we were successful in hiring a dual program APRN certified in family and psychiatric advanced nursing. She remains with the program to date and provides 30 hours of medication management and therapy, in addition to 10 hours of services within the medical clinic. This solution not only provided hours beyond the original goal, but served as a more financially viable alternative to increasing psychiatry hours.

Results

The project was evaluated initially with the use of an outside evaluator, by the third year it was felt the evaluation could be completed adequately by the oversight of an internal staff member who had multiple years of experience managing and evaluating grant funded programs.

The second objective was to maintain the numbers of BH providers in rural areas by recruitment, training and retention of BH specialists in community and primary care settings.

The next objective was complete screenings on at risk adolescents and families and provide therapy sessions with input from psychologists, social workers, primary care providers and educators, this was related to the goal of reducing the number of out of home placements for children and adolescents.

The fourth objective of reducing the number of negative behaviors and increasing the number of positive behaviors in adolescents was related to the goal of evaluating the effectiveness of integrated BH services in the GNCHC primary care setting and community programs.

Potential for Replication

Throughout the program UNMC has maintained a third party billing system that will cover the cost of the therapist employed by the program. Faculty and student time will continue through third party billing, supplemented by funding AmeriCorps and Leadership & Education in Neurodevelopmental Disability (LEND). *GNCHC/ECDHD* has also developed and maintained a third party billing system that is currently covering the cost of the expanded provider services within this grant. Bi-Lingual Support staff, transportation, and QPD screening will be maintained with third party billing, client fees and supplemental grant applications including a current application in place to HRSA for expansion of Mental Health services and a pending application to Region IV Behavioral Health Services in Nebraska.

After the Grant

Yes the program will be sustained. Although the consortium meetings will roll into a larger community group known as the Behavioral Health Consortium, the individual aspects of the consortium will continue. UNMC plans to continue and expand the therapy and evaluation programs instituted at the Boy's and Girl's home. Currently there are plans to add a male therapist (LMHP) to provide more gender sensitive therapy services for the male residents. Boys and Girls home will continue to provide space for the therapy to continue and maintain a relationship with UNMC faculty and staff. Good Neighbor Community Health Center plans to continue with the expanded behavioral health services, providers and hours established during this project. The QPD screening tool will continue to remain an integral part of the clinic to screen for behavioral health issues and promote integration between BH and primary care services. Additionally, QPD screening will be assessed for continued usage in the outside community and continued in areas where adequate screening is being completed. Bi-lingual support staff will be

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maintained to continue to reduce barriers for non-English speaking clients and transportation will continue to be available to reduce barriers caused by distance and finance. Columbus Community Hospital plans to continue to use the QPD in the Emergency Room to screen for underlying Behavioral Health Issues, intervention and referral as well as continue to screen within it's healthy families program for families new the program.

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NEBRASKA—WEST CENTRAL DISTRICT HEALTH DEPARTMENT

Community Characteristics

The West Central District Health Department applied for and received the Rural Health Outreach Grant on behalf of the West Central Dental Clinic. The West Central District Health Department had recognized a need for access to dental care among residents of its service area who either rely on Medicaid or who self-pay for dental care. A survey of residents in the eight counties served by the West Central District Health Department confirmed that Medicaid and self-pay residents forego dental care at much higher rates than their privately insured counterparts. Therefore West Central District Health Department and their partners proposed to establish a permanent dental clinic in North Platte, Nebraska to serve these patients. A steering committee was developed and comprised of West Central District Health Department staff, a school nurse, an administrator in the public schools, three local dentist, two parents, a representative from the NAF Multicultural Human Development (a Nebraska non-profit originally founded as the Nebraska Association of Farmworkers that represents the views of minority residents), a representative from the North Platte Community College, an early childhood advocate, and two local dental hygienist. Their primary focus was to set in motion the initial development and operation of the West Central Dental Clinic.

Services Offered

The West Central District Health Department established the West Central Dental Clinic to serve Medicaid recipients and low-income self-paying residents in this area. During the first year of operation, the clinic was open half time and the staff included a dentist, a dental assistant, and a receptionist. Dental health education and dental services were available to children and adults. Services included preventative, restorative, and emergent care. Near the end of the first year, the clinic gained a student dental assistant from the North Platte Community College, as well as a half-time dental hygienist. Through the addition of staff, the clinic was able to accommodate more patients in the second year. During the third year of operation, the clinic grew from being a half-time clinic to being open full-time, continuing to offer the same services.

Innovative Solutions to Problems

One of the first issues encountered in implementing the project was taking the clinic from a limited youth focused clinic which previously existed in the area, to a permanent dental clinic, and where to locate the clinic. Experience with the youth focused clinic convinced the West Central District Health Department and its partners that a permanent clinic needed to serve both adults and youth of the Medicaid and low income families. West Central was given the opportunity to rent a space near the North Platte High School in the central part of the city. This space had been used as a dental office in the past and would not require any renovation or construction. However this space was no longer an option when the grant was received, so West Central was forced to look into other locations. The Health services portion of the West Central District Health Department already had a location in the downtown area of North Platte, so locations surrounding the current office were considered. Finally an option became available to rent the location directly next door to the Health Services location. A few minor construction adjustments needed to be made, such as adding adjoining doors to connect the two offices, as well as purchase the

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operatory furniture and equipment for three rooms. This allowed the West Central Dental Clinic to become established in the fall of 2006 and stay better located with the West Central District Health Department.

Another problem encountered involved the plan for sustainability for the dental clinic. A sliding fee scale for the uninsured patients was set up in such a way that, if a patient qualified for what was called “Fee Scale A”, they would receive all of their dental services during an appointment for a total fee of \$25. While the \$25 fee was great for the patient, the clinic would not be able to sustain itself due to a rising cost in material and utilities. Therefore administration reviewed the fee schedule at the end of year two, as well as the accompanying policies. West Central was able to visit with like clinics, as well as some private practices in the area and even some from surrounding states. A template was developed for a new fee scale to utilize, based off of the Federal Poverty Guidelines. This allowed the necessary income to develop a plan for sustainability for the clinic. The fee scale will continue to be reviewed annually as new Federal Poverty Guidelines are released.

Finally, one of the largest issues for the clinic was the management of the consortium. Initially, the dental steering committee was available to meet once a month and discuss any evaluations or issues that developed, as well as the general operation. After the grant was received, the consortium seemed to dissipate, so a local dentist and board member took over the monitoring of the clinic, along with an additional board member for assistance. Together, they comprised a small consortium to assist the dental clinic with their needs. Frustration arose with the lack of communication between the dental staff and board members as their approval and input was not sought after in any of the clinics processes. It was then that the dental clinic was asked to review their procedures and policies so that the two consortium individuals may be kept involved with all aspects of the clinic. With new policies and procedures in place, the board members were able to stay involved and communicate better with the dental clinic.

Results

Project evaluation was completed by the West Central District Health Department staff. The receptionist kept track of the number of patients seen and their age, as well as their insurance status. This information allowed West Central to continually make sure they were reaching the target populations with the grant. The Dental Coordinator also evaluated the financial component of the program by editing and revising the fee scale and policies. The program income as a whole was taken into consideration to make sure that the grant dollars were being put to use in such a way that by the end of year three, the dental clinic would be able to sustain itself. The fee scale was adjusted and revised at the end of year two as a direct result of the financial evaluation.

Potential for Replication

We consider our program to be a best practice model.

After the Grant

The HRSA outreach grant funding period came to an end in April of this year. Since then, the West Central Dental Clinic has been in full operation five days a week, with the number of patients seen as well as the amount of revenue being generated continually increasing. Some policies and procedures that have been developed and implemented since the beginning of the grant are that we now complete an annual

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revision to the policy for the dental clinic, as well as the fee scale to accompany it. Getting the opportunity to benchmark with like facilities aided tremendously in getting the clinic set on the right track financially.

In addition to the evaluations that take place, communication with the board of directors for the West Central District Health Department has increased and allowed for some very valuable insight from key community members in our area. With all of the continued hard work to our program, we intend to keep the West Central Dental Clinic in operation for years to come.

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Community Characteristics

The goal of the project is to establish a long-term, sustainable method of service delivery to Alzheimer's dementia patients, caregivers and health care professional invoiced in the delivery of diagnosis, disease management and treatment in rural and underserved communities of Nevada and other western states via telemedicine.

Services Offered

Caregiver and professional classes on all aspects of Alzheimer's disease, diagnosis, treatment and caregiver issues were taught via the telemedicine technology throughout Nevada, rural Oklahoma and frontier Alaska. Patients were seen in their own rural communities (6 total) for memory screening, diagnosis and treatment as well as caregiver counseling and behavioral assessment, treatment and followup.

Innovative Solutions to Problems

The most significant problem dealt with finding sources and resources to sustain the program. Following the final grant year, the program will transition to a new provider group, Cleveland Clinic Lou Ruvo Center for Brain health, which will continue the dementia telemedicine program.

Results

Project evaluation tools were developed by the consortium to address Clinical Appointments, Educational and support Sessions, and Program Grant Reporting. Clinical Consultants, Clinical Facilitator, patients/patient advocates, and health professional all participated. Each person participating in a clinic or educational offering was asked to complete an evaluation of their experience indicating agreement or disagreement with questions to elicit their level of satisfaction with the clinic or course. Data was gathered and summarized and information was utilized to improve the program.

Potential for Replication

A partnership among the Lou Ruvo Brain Institute, Cleveland Clinic, and Cornerstone Care Consultants has formed including the clinical participants who directly involved in the RDTI project. The program will be funded in part by these partners and will continue to serve rural communities. The program is expected to expand further in the western states as this new partnership matures.

After the Grant

The RDTI program will be sustainable depending upon the anticipated partnership with the Lou Ruvo Brain Institute and the Cleveland Clinic. The original partners for the project will continue to be central to the program to maintain the continuity for their patients and others who may be served by the program.

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Community Characteristics

The School-Based Consortium in Upstate New York was designed to address needs identified in several upstate New York rural communities. The Mary Imogene Bassett Hospital (MIBH) at that time operated 8 school-based health centers (SBHC) in 6 rural school districts located in 3 rural counties. Each of the SBHCs regularly met with their Community Advisory Committee (CAC) to seek advice, direction and impressions. The CACs typically included school community members, students, SBHC staff, faculty, administration, and parents.

Services Offered

The Great Basin College service area residents face many health issues including but not limited to:

- high numbers of Medicare and Medicaid recipients,
- high numbers of uninsured residents,
- high percentage of residents aged 65 or older,
- relatively few health care providers, and
- limited mental health care resources.

These issues all contribute to limiting access to health care. With many of GBC's service area counties receiving MUA and MHPSA designations, the need for a more highly skilled human services workforce was evident to help maximize the resources that were already available. GBC has learned that, through its 40+ years of serving rural Nevada, training students who are from rural Nevada, often leads to a high percentage of those students staying and working in rural Nevada. Providing trained professionals with the ability alleviate the burden of non-medical, but still necessary tasks such as patient in-take, determining client needs and where to find appropriate services, and other related client services, allows medical providers to spend more time providing medical care.

Innovative Solutions to Problems

New programs must be approved by the Nevada State Higher Education Board of Regents. This process, and a difficulty in locating/recruiting a program director who could write the program proposal, coordinate the curriculum with other institutions of higher learning in the state, and write/teach the courses delayed the implementation of this project. Once the coordinator was hired, the program was developed, Regents' approval was obtained, and student recruitment began. The program is now entering its third academic year, and student enrollment/participation has grown from zero to nearly 200 in the eight new human services courses which have been developed.

Results

The grant proposal involved the creation of human service education and training programs at GBC. The outcomes of the project included:

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

There was also anticipated to be indirect impact on residents in the target area through providers' direct services that were assisted by practicum/clinical students from the human services

program. Each student in either the certificate or AAS degree track, was to provide 180 total contact hours with service providers.

Potential for Replication

This is primarily an educational program model geared toward other colleges or universities. It has been effective for an extremely rural area and could be easily replicated.

After the Grant

This program has been implemented, and has been included in the GBC catalog. There is a plan to continue to fund human services courses at GBC over the next two fiscal years; currently GBC funds the program coordinator/instructor at 35% and once the HRSA funding stops (we currently have a one-year, no-cost extension), GBC will fund the coordinator/instructor at 100%. The HRSA continuation grant funds will end at the completion of the 2009-2010 school year.

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Community Characteristics

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

To counter this, the Caring Community Network of the Twin Rivers (CCNTR) has been working as a collective to create a coordinated, accessible system of care across the region. This project has enhanced mechanisms and expanded the capacity of the network to provide effective, coordinated, and accessible services throughout the region that improve health outcomes of clients with chronic illness and provide appropriate services in the primary care setting.

The proposed project positively impacted service delivery in the region. It: (1) identified best practices and evidenced-based disease management, planned care visits, and coordination currently used by medical providers to implement them region-wide through use of the Chronic Care Model for improved clinical efficiency and effectiveness, (2) incorporated the use of electronic tools to use a shared client data based for health education, coordination, referral, and chronic disease registry (3) enhanced client access to the above services and to other services available in the region, and (4) increase the level of disease and care management available, resulting in improved patient health outcomes.

Services Offered

There are three target populations who received the above mentioned services to coordinate care for improved health outcomes and access to care: (1) low-income and uninsured adults, (2) low-income, uninsured and underinsured elderly, and (3) individuals with chronic illness such as diabetes and hypertension. These populations overlap and are inter-related, but experience the greatest barriers to care resulting in the greatest cost and resource allocation. Funding from this grant supported the infrastructure of the Care Model element for a comprehensive chronic disease management education program. As the program continued to be implemented, additional curriculum and telehealth tools expanded access to clients and healthcare delivery support staff specific to the above populations, This program moved from an initial focus on diabetes to other chronic conditions including cardiovascular disease, allowing the services to be customized to reach the needs of a much larger population that currently does not have access to focused specialty services to improve their health outcome and life expectancy.

Innovative Solutions to Problems

As development of the Care Model components within Health First Family Care Center took precedence, efforts were being made to combine disease registry reports into one consistent outcome measure report throughout five separate primary care practices working within the consortium. The long range goal was to have this evolve into a full-scale disease specific registry by the end of the three-year project. A major component of the development into a Chronic Care Model throughout both Health First and LRGHealthcare included the creation of a regional chronic disease specific population registry

reporting on health outcomes for diabetic patients including most recent HbA1c, cholesterol, blood pressure and other disease specific health indicators.

Results

The CCNTR RHO program evaluator held quarterly Diabetes patient chart reviews with Health First Providers to identify missed opportunities for care delivery specific to diabetes planned care model to evaluate the short and long term success of the project. These meetings were a joint effort to discover causes and take action to promote increased compliance with recommended testing, prescribing, and behavioral intervention. This effort identified a number of issues related to key measures including data entry problems, data extraction problems, and provider approval or disagreement with program goals. When these issues are taken into account, the actual compliance with recommendations is better than the registry implies. However, there remain many areas still in need of improvement.

Potential for Replication

Yes, we truly believe that the Chronic Disease Care Management Model that we have utilized and developed under this grant and through participation of the National Diabetes Collaborative have worked diligently to spread and integrate into other practices in the region, is a best practice model, We believe that it directly prepared us for work as we continue to evolve our practice model to become a Health Care Home and that the other practices of the local healthcare system are going to be positioned for better opportunities to move in that same direction, We anticipate a great deal of improvement related to reduced ED visits for chronic disease related episodes, more direct supervision to the patient by the clinical team associated with the patient's PCP as well as reduced morbidity and mortality from cardiovascular diseases in the region including heart attack, stroke, lower leg amputation, kidney disease and blindness among others, These are all complications that are contributed to poor chronic disease management, which is now among the top priorities in bringing together care coordination, chronic disease management and prevention focused clinical measures that impact and hopefully reverse these debilitating and expensive health outcomes.

After the Grant

The initial design of the program was to develop and implement a model that would be integrated into the practice of primary care using these new methodologies within Health First Family Care Center and the other practices of LRGHealthcare, local Visiting Nurse Agencies, Lakes Region General and Franklin Regional Hospital. One of the key indicators that we have been successful is that all of the programs modules that have been implemented in these agencies have now been adopted into the regular operating budgets and procedures of the program and will continue beyond the end of the grant project funding. Additionally, the implementation and ongoing operation of the model has led to a much closer collaborative effort and understanding between the agencies around other clinical issues that has positioned us well for discussions and project planning on other joint efforts that will help us continue to improve the overall healthcare delivery system in our region through continued collaborative efforts. This is evidenced by the successful efforts of the group at working together to develop a Healthy Eating Active Living community education project. We are receiving a new grant for \$150,000 to develop these program materials and special community education efforts. Additionally, the same major players from

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the agencies who have worked together as part the RHO project also participated in a MultiState Learning Collaborative Project to develop quality indicators around the related issues of childhood obesity and body mass index across three Primary Care Practices in the region. The Inter Agency Care Coordination Outreach Teams remain strong and have a dedicated following of representatives from the various agencies whose upper administration now on a regular basis includes it in the job descriptions of the individuals in positions that in some cases were created under grant funded programs, but are now ongoing agency funded positions. We have also made considerable progress, as was one of the initial efforts throughout this program to work with the State of New Hampshire Medicaid Office to try to get them to catch up with other neighboring states in providing same type of reimbursement for Care Coordination and Outreach Activity in the community. We are pleased to say that as of this writing, the proposed rules for adding these Medicaid codes to the approved list in New Hampshire are nearing completion despite the major budgetary issues in the state and the country at large.

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Community Characteristics

There are unique barriers to providing access to high quality, effective and affordable health care in northern New Hampshire. The Northern Telepsychiatry Initiative (NTI) established a creative model for youth to access child psychiatry in the region. The proposed service area, known as The North Country, includes communities throughout the northern half of NH. It encompasses seventeen communities in Grafton County and all of Carroll and Coos County. The North Country spans 4,447 square miles comprising 43% of the total land mass of the State. The region includes 57 small towns with a total population of 105,870 and a density ranging from 18.4 to 47.7 people per square mile.

Services Offered

The goal of the NTI was to provide access to child psychiatry through telemedicine and establish the necessary policy and legislative changes to ensure the success and sustainability of the initiative. With the funding provided a network of members worked to:

- Enhance the consortium of Northern Human Services, New Hampshire Department of Health and Human Services, Bureau of Behavioral Health, NAMI New Hampshire (NAMI) and the Behavioral Health Network (BHN)
- Start up a teleconferencing network among five Northern Human Services office locations and a child psychiatrist
 - Advocate for the inclusion of telemedicine in the New Hampshire Medicaid state plan
- Examine legislative options for private payer coverage of telemedicine, and specifically telepsychiatry, in NH.
- Promote the utilization of child telepsychiatry through advocacy among community leaders and family members of children needing psychiatric evaluations
- Develop and implement satisfaction and outcome studies of the child telepsychiatry initiative
- And, as a side benefit, develop an effective model for child telepsychiatry for replication among the mental health care providers in NH.

Innovative Solutions to Problems

As the consortium began planning this initiative many potential problems were identified. They included: provider and consumer resistance to the new delivery model, the recruitment and retention of a child psychiatrist and the fear that reimbursement for services would not become a reality. In fact, many of the barriers that were predicted were not an issue. The community (providers, clients and the NH legislative body) all embraced the initiative. The consortium did experience significant difficulty in recruiting a child psychiatrist however the arrangement that was created with Dartmouth have proven to be an incredible asset to the project.

An additional and unforeseen problem was the complexity and cost of the technology. These related problems were solved with the investment in staff development and an aggressive effort to pursue options to decrease the cost of connectivity. These options have included other grants (FCC's regional project and USAC) as well as a restructuring of the physical network.

Results

In addition to the 360 degree evaluation which was discussed in Section II members of the NTI monitored the overall project work plan. Members made adjustments to the plans as progress was made or the needs of the project changed. The adjustments in the work plan regarding the recruitment of a child psychiatrist is just one example of the NTI's demonstrated ability to adjust as needed. The outcomes achieved by the NTI have secured a strong foundation for continued growth of telemedicine in NH. Through their efforts the NTI has minimized barriers to service for families as discussed in detail above. In addition, their efforts have contributed to a culture of readiness in northern NH for the adoption of other telemedicine applications. For example, their efforts have secured financial support for telemedicine through the State Medicaid plan and mandatory 3rd party reimbursement. In addition, the technical capacity and infrastructure that was built for the project will remain a vital component for future telemedicine efforts among partner organizations. Finally, through outreach efforts the NTI has contributed to an increased desire to explore the use of technology and to expand access to health care across many disciplines throughout the State.

Potential for Replication

Although it is too early to define the NTI model as a best practice, the initial evaluation of the project was very positive and suggests that we were able to identify elements critical to creation of best practice model.

After the Grant

While the NTI will not continue to be a formal relationship the work of the individual members and the foundation that has been set will ensure that provision of child psychiatry via telemedicine will continue in the North Country. Northern Human Services will take financial responsibility for program costs with hopes that they will be offset by reimbursement for services and additional grants. They also hope to decrease the overhead cost burden by restructuring their network to leverage newer technologies.

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Community Characteristics

Taos County is comprised of several small villages scattered throughout the mountainous region, the Taos Pueblo, and the Picuris Pueblo, both inhabited for over 1,000 years. The County is spread out over 2,203.17 square miles with a density of 13.6 persons per square mile. Current population is 29,979 people with 12,675 households and 7,757 families. (U.S. Census Bureau) Taos, the largest city with a population of 4,700 is located just 75 miles south of the Colorado border, about 60 miles north of Santa Fe, and approximately 130 miles from Albuquerque. The County itself lies between Rio Arriba County to the south and west, Colfax County to the east, Mora County to the southeast and the Colorado border to the north. The major road from Taos to Santa Fe and Albuquerque begins as a narrow two lane road through a canyon which is often icy in the winter and subject to heavy rains during the monsoon season of July/August.

Services Offered

The need for the health outreach grant addressed HRSA's long term goal of reducing health disparities by expanding the availability of rural health care resources to the underserved, vulnerable and special-needs population. The three-year outreach grant was focused on defining and delivering a Single Point of Entry, a Promotora Program and delivering Prescription Assistance to adults with diabetes.

Innovative Solutions to Problems

The three-year outreach grant was focused on designing and delivering a Single Point of Entry, Promotora Program and delivering Prescription Assistance to adults with diabetes. There were many challenges in implementation of these deliverables. Although after three years, the lessons learned during these challenges are valuable in the implementation of the Network Development and Small Provider Quality Improvement grants, as well as the other community partnership initiatives that continue within Holy Cross Hospital and across the community.

This grant initiated the dialogue between medical and social service providers to design a new Model for serving our rural and low income community. The nature of this dialogue was a surprise to some stakeholders, and to others it was a dredging of territory and positioning that has existed for decades in our community. The beauty within this grant was that our Technical Assistance providers, and more importantly our Office of Performance Review consultants continued the dialogue. Significant problems: some folks left the dialogue and others made it personal. But one of the best outcomes of this grant was that the dialogue continued for three years in many forms with folks who stayed at the table, and this caused shifts in our community.

Results

The information from the SF-12 Health Survey was collected for 18 months at Holy Cross Hospital from patients involved in the SPE. As mentioned above, it contains the responses of 251 individuals. All participants took the pre-test survey. At the six month post-test 143 follow-up surveys were received, while 54 were received at 12 months. In this population, there are 8% more men than women who participated in the survey. Most were of Hispanic descent (76%) and White (23%). Thirty-six percent of the population was between 35 and 54, while close to 60% of the population was 55 and older. More than 90% of the individuals in this study had yearly household incomes of less than \$50,000. Data was also

available for a patient's insurance type and their referral agency. The largest percentage of individuals were Medicare recipients (35%), while a good portion were either uninsured (26%) or had commercial insurance (24%). Close to 80% of referrals came from three sources: Taos Medical Group (46%), Family Practice Associates (21%), and HCH Diabetes Case Management Program (DCMP) (12%).

Once patients had been referred from the originating agency or group, further follow-up or referrals for the patient were obtained. Information was collected on whether patients were followed up with Holy Cross Hospital's out-patient diabetes self management program (HCH DSMP), prescription referrals, or pharmaceutical care. Almost all of the patients in the SF-12 database were followed-up by HCH DSMP (81%). Smaller percentages of patients were given prescription referrals and pharmaceutical care, 38% and 21% respectively.

Further analysis was conducted on two specific groups from the Holy Cross Hospital population, the only groups who showed statistically significant changes in survey results. These groups were the uninsured population and the population that was referred from the diabetes case management program (DCMP). The DCMP population was a small subset of the population in the Holy Cross Hospital SF-12 study.

Potential for Replication

We are working within a Kellogg Foundation-funded network called Rural People Rural Policy that includes rural organizations across the country who are applying best practice research for network development in rural areas. We know from our participation in this network that similar projects can and are happening. Network work requires innovation, tenacity and constant reevaluation of methods and approaches to move forward efficiently and effectively. We are working to bring together our learning from HRSA Office of Rural Health Policy with this Network.

After the Grant

All component programs started under the Outreach grant will be continuing. The Promotora Program is part of the Small Provider Quality Improvement Grant funding, and other programs are now Departments of the hospital and developing funding models that include reimbursement. We also continue to grow the consortium through a Network Development Grant.

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NEW YORK—CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER

Community Characteristics

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

Services Offered

The North Country Diabetes Project built community collaboration among core health care providers to increase access to diabetes care through the development of a physician referral network and established an American Diabetes Association (ADA) recognized diabetes self management education program. As a result of ADA recognition, services could be reimbursed by third parties making the program more viable. Medical Nutrition Therapy was provided by a registered dietitian. Other diabetes self management education efforts included insulin training, insulin pump training, and blood glucose monitoring. A unique community health approach was executed including screenings, risk awareness and education sessions, creatively using a Registered Dietitian at the Health Department, home health care Registered Nurses, JCEO case managers and community outreach workers. JCEO volunteers provided transportation to medical appointments for homebound seniors.

Innovative Solutions to Problems

Reimbursement and Program Income: Bills were sent to Medicare, Medicaid, and private insurance companies when Diabetes Self Management Education (DSME) services were eligible for reimbursement as of July 13, 2007 - the date the successful American Diabetes Association (ADA) application was submitted. Since this was a new service, we worked through claim rejections and negotiated credentialing with insurance providers in the area. Available staff time was limited. In year two of the project, the program continued to have significant issues with respect to coding and billing, which inhibited the generation of revenue. A consultant, an expert in reimbursement for diabetes programs, was brought in to speak with key individuals. Contacts were made at other like institutions to determine their billing process. This issue was the primary concern in year two, since diabetes education needed to be sustainable at the end of year three. A concentrated effort followed, both by the Diabetes Project team and reimbursement people. A new reimbursement director had some insight into ways to resolve some of these issues. Her team was diligent, as was the accounting department, to identify billing opportunities and to ensure that we were capturing revenue appropriately. Monthly reports were reviewed to identify patterns and potential consistencies for revenue streams. Ultimately, enough revenue was being produced to support the continuation of the diabetes self management program at CVPH Medical Center. Tracking revenue has also identified months where referrals have dipped and successful efforts by the Diabetes Education Team have been made to seek out the reasons for the decline and identify an effective means to correct them.

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Space: CVPH Medical Center underwent a major construction project to revamp its forty year old surgical department. This affected entire sections of the Medical Center and space was scarce. These space restrictions, which were not anticipated at the time of writing the grant, inhibited class sizes and the number of individuals that could be served by the diabetes program team. In the end, office space was assigned to diabetes outpatient services. This has enabled us to increase class size, hold individual DSME and MNT appointments, as well as run the support systems with the office coordinator.

Competition: At the writing of the grant, there was a lack of providers for diabetes self management. Since the grant award, a private physician has opened up an Urgent Care Center and provides diabetes counseling in his office through referrals from local providers. The Project Director is attempting to identify ways for the North Country Diabetes Education Center can complement the services provided by this doctor, rather than compete with him. Another physician in the community now provides diabetes counseling in his office as well and attempts to partner with this physician are being made as well. The North Country Diabetes Education Center remains the sole provider of ADA recognized diabetes self management education.

Transportation: Transportation by JCEO volunteers was not used as extensively as expected.

Demand for services increased significantly in year three. This is believed to be due to increased awareness of the service.

Results

The Technical Assistance Center at the State University of New York at Plattsburgh was contracted by the Champlain Valley Physician's Hospital (CVPH), within the scope of their North County Diabetes grant project, to act as an independent data evaluator. This role was carried out for both the Department of Health's self risk assessment data collected, and for CVPH's Diabetes Self Management Education (DSME) program. The data included below is a summary of the information collected and analysis of the CVPH DSME program. This assessment was based on patient information provided in three major evaluating forms: 1) blood glucose patient lab results 2) results of a "quality of life" survey and 3) results from a patient "self assessment" (behavioral analysis) survey.

Potential for Replication

The Project Director developed a business plan and various scenarios were explored (given the best case scenario and worst case scenario). Staffing needs and expectations on service availability were assessed. Program income was monitored carefully to ensure we were maximizing opportunity for reimbursement and that sufficient revenue was projected to sustain diabetes self management education and medical nutrition therapy. CVPH Medical Center has significant experience in designing and implementing new health care services. CVPH Medical Center's Vice President of Planning and Professional Services offered guidance and input. Meetings were held with the Clinton County Department of Health to assure community commitment. Also, outreach to physicians, workplaces and other organizations was a key objective for year three of the grant to ensure continued referrals to the program.

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After the Grant

Yes, the program will be sustainable. 1) CVPH Medical Center intends to sustain Diabetes Self Management Education and Medical Nutrition Therapy through program revenue that is generated by third party reimbursement. Recertification by the American Diabetes Association for Diabetes Self Management Education will be sought in 2010. The hospital has two certified diabetes educators to provide services. The hospital has documented this intent with a letter to the health department. 2) Clinton County Health Department is committed to continuing to offer referral services throughout the Department's many programs and to continue dialogue with staff at the North Country Diabetes Center to work together to assure the community has the services it needs. Data compiled through the project will be used to create pertinent community based programs to address the associated risk factors contributing to the rates of diabetes in the North Country. The Health Department has documented its intent with a letter to CVPH Medical Center. 3) Joint Council of Economic Opportunity will continue to inform local residents about the diabetes education services through its case workers and outreach workers. Transportation can continue to be provided by JCEO through other funding for individuals over the age of 60 to medical appointments. JCEO is researching to determine if these funds may be used for individuals over 60 for transportation to and from diabetes self management education sessions.

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Community Characteristics

The School-Based Consortium in Upstate New York was designed to address needs identified in several upstate New York rural communities. The Mary Imogene Bassett Hospital (MIBH) at that time operated 8 school-based health centers (SBHC) in 6 rural school districts located in 3 rural counties. Each of the SBHCs regularly met with their Community Advisory Committee (CAC) to seek advice, direction and impressions. The CACs typically included school community members, students, SBHC staff, faculty, administration, and parents.

Services Offered

Based on input from the community advisory committees and residents in the three counties, this project addressed three areas: Dental, Mental and Behavioral Health and Social Services. The need for dental health services was critical, given the reality that many of the children living in these rural areas do not have access to fluoridated water or regular dental care. The lack of mental health services for children in this upstate area was remarkable and compounded by the fact that shortly after this project started the local "Crisis Unit" and sole in-patient adolescent psychiatry unit, located at the A.O. Fox Hospital in Oneonta NY, serving this entire region, closed! The availability of mental health services in general are limited in rural upstate New York and lacking even more are mental health providers able and interested in caring for children and adolescents. Based on the workload, at the time, of the part time SBH social worker, mental health issues included personal or family substance abuse issues, domestic violence and child abuse circumstances and depression were prevalent. The last area to be addressed was the need for a community outreach worker known as a "Patient Navigator", to assist families in accessing needed health and human services. Many of these families had low incomes, were uninsured, and in general lived in chaotic situations. They needed someone who could "hold their hand" and help empower them to seek needed services.

Innovative Solutions to Problems

Some of the challenges we encountered even though not major, were the lack of clear communication within our organization of the financial commitment of the organization. This information eventually disseminated to all necessary administrators however this did delay staff recruitment. It would also be recommended that anyone that is going to be involved in the program even if in only a small way be included in the early planning, this may have helped us with the resistance we experienced from the dentist.

Results

The consortium was very involved in identifying the needs of the school communities however involved in varying levels in the planning. They were very responsive to any needs or requests during the implementation of all components of the program. There were no true problems or barriers that were not successfully resolved. In the implementation of the project, just some slight delays.

Potential for Replication

This program initiated with the HRSA funds could easily be replicated in other rural communities with School-Based Health Centers. Early engagement of community stakeholders is critical. We have

found our Community Advisory Committees to be invaluable. We regularly engage them in "brain storming sessions" asking how can we improve services of the SBHC, what are other needed services, and most importantly "what do the kids need?" The years of documentation of these meetings have been a great platform for us to use when seeking outside funding. We would also encourage other communities to tap into area institutions of higher learning, graduate students are wonderful resources of energy and knowledge and SBH provides them with a wonderful learning laboratory.

After the Grant

The dental and mental health components have continued since the end of the April 30, 2009. We actually hope to the expand these services within the next few years. The Bassett organization has absorbed the expenses of these programs into the general operating budget. This was possible due to good expense management and aggressive reimbursement recovery. (please note there is never any out of pocket cost to any family at any time) Additionally Bassett HealthCare's organizational commitment to meet the health care needs of the residents of the communities where they provide services is great and they are committed to the continuation and growth of the School-Based Health Program. Some of the dental expenses will be covered by the NYS Preventative Dental Grant.

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NORTH CAROLINA—ALBERMARLE HOSPITAL FOUNDATION, INC.

Community Characteristics

The main members of the consortium were the Albemarle Regional Health Department and the Albemarle Regional Mental Health Department. The Health department worked through its case managers to refer patients to our clinics. The Health Department was thy controlling entity for the Jeff Jones consortium which funded various HIV/AIDS services. Albemarle Mental Health (which had a number of patients with HIV) was instrumental in assisting our efforts to start the clinic and originally helped pay to bring the Infectious Disease physician to our clinic, prior to our HRSA grant.

Services Offered

Albemarle Hospital Foundation operates an indigent care clinic in Elizabeth City. We are located in the rural northeastern comer of North Carolina and have approximately 66 known HIV patients. Those patients must travel great distances (2 hours) in order to see infectious disease physician and to get lab tests done. By starting an HIV clinic within our Community Care Clinic, we were able to see most of the uninsured HIV positive patients locally. This saved them taking a day off from work to travel to Greenville N.C. and also made patients more compliant in seeing their specialist.

Innovative Solutions to Problems

Initially, we encountered very few problems other than compliance issues and some medication problems related to ADEP. We attempted to have better communication with the case manager and with state providers resulting in a reduction of problems.

Results

We performed a case management analysis on patients since we only saw a limited number. We had monthly staff meetings to see how we could improve the process. The grant funds paid for the ID physician.

The consortium was the glue that held the project together. We evaluated the process regularly and strengthened the process along. The initial year was very productive and also enjoyable because we were actually making a difference in the lives of these patients.

The barriers did not occur until the beginning of year two, when the State decided to disband our local consortium and make us be a part of a 26 county consortium which was created to save state money' and give better scope of services. The move was a disaster. It became a political football, in which politically connected counties received the lion's share of funding. Our local health department had to eliminate their AIDS program due to funding cuts and then we lost our referral base. The numbers started dropping as these patients had no case managers to direct them to services.

Our Community Care Clinic became accredited by the BC/BS of NC and we were recognized as a model clinic for the state in our technology advances (EMR).

Potential for Replication

We definitely consider our clinic a best practices model. AS stated earlier, we were one of the first free clinics in the state to earn accreditation. We have been first in technology, with the implementation of our Electronic Health Records system.

NORTH CAROLINA—ALBERMARLE HOSPITAL FOUNDATION, INC.

After the Grant

Because we will not be able to continue this program, the issue of sustainability is moot. However, I know in our community we had very strong support from the other safety net providers, as well as, state foundations.

The program will be closing out. I do not think long-term sustainability would be an issue in our community. We have fundraising capabilities with our Foundation. We also have great community support.

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Community Characteristics

The health care needs for southwestern North Dakota 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 eight southwestern counties in North Dakota. Their mission is “to assure a healthy community for all people by empowering the community to take responsibility for health through on-going assessment; education, advocacy, intervention, prevention, cooperation, and collaboration.”

Services Offered

Free Comprehensive screening events are held within different communities in our eight county regions. Our screenings involve: comprehensive breast exams with referral for a mammogram if needed, prostate exam which include a digital rectal exam (DRE) and prostate specific antigen (PSA), colorectal exam, fecal occult blood test (FOBT), skin exam, and lung cancer risk assessment. Since the beginning of the grant in May 2006, Pathways to Healthy Lives has screened 1117 residents and has found 262 abnormalities. PTHL also incorporates cancer prevention education at each screening event.

Innovative Solutions to Problems

One barrier that Pathways faced was the Minnie-Tohe screening. Our participation numbers drastically decreased from the previous year. We utilized equivalent advertising strategies as in the past and we employed the same health care providers.

Results

An outside, independent evaluator was contracted to conduct the evaluation. Brad Gibbens, Associate Director, UND Center for Rural Health, School of Medicine and Health Sciences was the evaluator. The Center is the State Office of Rural health for North Dakota. The evaluation method relied on qualitative and quantitative techniques (e.g., personal key informant interviews and numerical tracking of activities). A Logic Model was developed and followed to assist in identifying measures and outcomes associated with program goals. The midterm evaluation (April 2008) served as a tool to help the program better understand the status and measurable outcomes of the program. Analysis was conducted and a series of recommendations were issued addressing sustainability, funding, marketing, network development, education, and screening.

Potential for Replication

Yes, Pathways to Healthy Lives is a best practices model. Pathways practices and strives to find the most effective and efficient way to achieve optimum results. Pathways keeps consistent and complete evaluations of all our screenings, public events, and educational presentations. AS stated by Pathways evaluator, Pathways to Healthy Lives is a model network.

After the Grant

Addressing a population health issue, both from a preventative focus and through health assessments such as cancer screenings can help a rural and frontier population to better understand factors they can control to lessen or prevent the occurrence of a condition. Screenings with referrals offer people the opportunity to be forewarned by seeking further assessment and if necessary care. The nature of the

NORTH DAKOTA—SOUTHWESTERN DISTRICT HEALTH UNIT

network is pivotal in community and multi-community programs. A network does not assure that positive results will develop; however, careful development and management of a network is essential. Having the right organizations involved is only half the product as it is critical to have people working together in leadership positions who have shared values, commitment to a goal, and just as importantly an ability to get along with little regard for who or what agency receives credit.

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Community Characteristics

The SRST Indian Reservation is located in south central North Dakota and north central South Dakota and the total land base is 2.3 million acres of which 1,408,061 acres are total tribal owned. The reservation is located in five counties; Sioux County in North Dakota and Campbell, Corson, Perkins and Walworth Counties in South Dakota. There are eight isolated reservation districts of Long Soldier, Cannonball, Kenel, Rock Creek, Bear Soldier, Running Antelope, Porcupine and Wakpala. The reservation towns are Cannonball, Shields, Solen and Selfridge in North Dakota and Wakpala, Bullhead, Little Eagle, McIntosh, McLaughlin, and Mobridge in South Dakota. The SRST Reservation is located thirty-four miles south of Mandan, North Dakota with the largest land base being on the South Dakota side of the reservation. Transportation to and from services continues to be a great need although this was somewhat alleviated through the reservation suicide prevention project known as the Oniyapi program.

Services Offered

The first objective was to provide Lakota Mental Health general training in the eight (8) communities located throughout the reservation. This was done to provide a skill-set to SRST community members in the life-ways of the Dakota/Lakota peoples. To many people this served as a “booster” type training where although the community may have already known how to alleviate mental health needs using Dakota/Lakota teachings passed down through generations, a catalyst may have been needed to jump start or “bring back” those things taught by ancestors. Essentially, to reconnect the contemporary life-ways with the traditions and values passed down through the generations in order to help those in need today. The second objective was to develop a Lakota First Aide curriculum that provided primary caregivers such as Community Health Representatives, school counselors, mentors, and other paraprofessionals who interface with youth with information on how to recognize high risk mental health needs in youth, and second how to help the youth seek and obtain help. Prior to this effort no “First Aid” curriculum existed to guide what service providers should do when confronted with a family involved in a catastrophe, death of a loved one, or other tragedy. This in a sense created a vacuum which may have lead to further trauma since no formal guidance based upon the unique cultural ways of the Dakota/Lakota existed to govern actions of first responders upon arrival at the scene of a traumatic event. The third objective of this grant was to provide a train-the-trainers training to local individual trainers and provide on-going coaching and mentoring to those individual trainers. Training was needed to pass-on what was learned over the project period. Therefore, once the information was collected from the eight districts and a curriculum developed, it was important to disseminate this information to those first responders in a forum where learning could occur. The fourth objective was to develop a comprehensive strategy for the Standing Rock Sioux Tribe Mental Health. This strategy came to be known as the Tawacin Oгна Otokaheya Owicakiya Pi. The final objective is to provide social marketing on mental health information for the Standing Rock Sioux Tribe. Getting the word out is extremely important for any new idea, concept, or training. Otherwise the populace will not know what had been created to assist them in alleviating needs in their lives or where to go for help.

Innovative Solutions to Problems

The SRST reservation suffers the fate common to most, if not all, of the reservations areas in North and South Dakota. Geographic isolation of communities within the SRST reservation plagues service

provision and in this case training timeliness due to the extreme distances agency personnel, families, and stakeholders have to travel to get to the training site. Although training was taken out to the districts, many stakeholders live in the outlying areas associated with the primary town within that district. Several agencies alleviated this condition through the provision of in-kind services by transporting youth, young adults, and families to the training site. One major concern was the receptiveness of the community to the teachings provided by Richard Two Dogs and Ethleen Iron Cloud Two Dogs. How receptive would the Dakota/Lakota people be to discussions involving their own traditional/cultural life ways? Concern was alleviated during the first training session when attendees became actively involved in discussions about Dakota/Lakota mental health issues and stated the need for these types of trainings and discussions to occur frequently. As illustrated by the graph, on average 98.7% of all training respondents were either satisfied or very satisfied with the trainer's knowledge, trainer's presentation, the building where training was held, location of training, and their overall training experience.

One barrier which could have undermined the entire effort was getting all of the 1st responders together for training. This proved difficult because each had their own schedules/needs and they work on a 24 hour shift-work schedule, etc. Those people who did not attend the live training can use the DVD and then their supervisor would authenticate their completion of the training, then let Randy know then certificates would be issued to the person.

Results

Since training played a key role in the success of this initiative the consortium realized the project needed a way to capture the essence of the discussions occurring in each district as well as training effectiveness. Therefore it was decided that notes capturing all of the comments, suggestions, and ideas would be taken during the training sessions. Upon completion of the last day of training, the Training Effectiveness Survey was administered which provided information on the number of training activities, number of participants, and individual level information related to the training experience (See Evaluation Report in Appendix). This information was used to inform the creation of the Tawacin Oгна Otokaheya Owicakiya Pi. In addition to community training, group interviews were held to ensure adequate information was collected from as many SRST stakeholders as possible. These group interviews occurred over a three-day period and included Elder, Community/Service Provider, and Youth groups (See Report of Findings of Group Interviews in Appendix). Once all of the information was collected, analyzed, and interpreted, the Tawacin Oгна Otokaheya Owicakiya Pi was created and a 1st Responder Training held to disseminate the knowledge and wisdom collected through the various trainings and group interview sessions. Pre/post surveys were created to ascertain learner outcomes related to this training

Potential for Replication

Depending on the source of information, best practice is occasionally described as a process or activity that is believed to be more effective at delivering a particular outcome than any other related process or activity. If this is indeed the case, it may be too early to make a determination whether the Tawacin Oгна Otokaheya Owicakiya Pi is a best practice. More training and pre/post testing will need to occur in order to arrive at this conclusion. However, during the eight district trainings, trainees often stated this is what should have been constantly occurring throughout the reservation for all age groups, agencies, and organizations. In addition, all trainees responded positively to the training they

received and the pre/post survey developed specifically to measure learner outcomes proved, at least for the one training provided, that first responders knowledge increased from pre testing through post.

After the Grant

Yes, the program will be sustainable. The program is currently owned and sustained by the SRST. The Internship Program continues as designed, training in the Tawacin Ogná Otokaheya Owicakiya Pi continues, and the concept and the values shared with communities continue to thrive throughout the SRST reservation. The creation of the DVD and the ability of the training to be downloaded through the World Wide Web guarantees sustainability. The curriculum was bound and disseminated to first responders and other stakeholders and is readily available when needed. In addition, Native Aspirations and the Tribal Chairman's Health Board are currently reviewing for possible use.

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Community Characteristics

This project addressed a lack of medical care, OB/GYN and prenatal services as well as oral health care access within Willard, Ohio area in southeastern Huron County, particularly a deficiency of accessible care for uninsured and Medicaid populations. Within the city of Willard, 16.5 percent of the population lives with incomes at or below the federal poverty line, and overall 10.4 percent of the population of the service area lives below 100 percent of poverty. The overall service area includes Willard, four surrounding townships within Huron County and adjacent townships within Seneca and Crawford counties.

Services Offered

- General primary care services (including adult and pediatric acute and preventive/wellness services)
- Chronic disease management, particularly focused on diabetes and hypertension
- Prenatal care/OB/GYN
- Oral health care

Innovative Solutions to Problems

The perceived isolation of the CHS Willard site on Buurma Farm seemed to limit the number of area residents who found the site accessible, even though it is located only two miles south of Willard. The health department's decision to open a clinic on a major thoroughfare in Willard also may have drawn patients from the CHS clinic. Eventually the consortium determined the health department clinic would be the preferred location to serve area residents. Based on this conclusion, the consortium members decided to restructure the project and have the health department become the lead agency.

It was determined a new RHO grant was needed to grow the new clinic, and to add behavioral health services, another major deficiency identified. However, the health department was not funded in the last round. Another issue emerged in the 2008-09 budget year when the private dentist declined to continue participation in the RHO and stopped accepting patients CHS patients through the voucher program. The dental voucher money was reallocated for OB/GYN visits at Mercy Hospital, and patients who needed dental care were directed to the CHS main office in Fremont where the organization's own dental center is located and a sliding fee offered for medical and dental.

Results

- Diabetes: Patients (adults) with diabetes: Tracked through the Patient Electronic Care System (PECS)/diabetes and chronic care management:
- Hypertension: 76 percent of adult patients with hypertension were able to maintain adequately controlled blood pressure
- *OB/GYN*: CHS RHO patients received *OB/GYN* care through Mercy Hospital of Willard *OB/GYN* clinic. Most of the CHS RHO dollars (in the form of vouchers) allowed patients to receive lab tests, ultrasounds and Pap smears. Most CHS patient deliveries were done through Mercy, although the hospital directly recorded and billed for these services.
- Children and youth
- Oral health: five patients received extensive comprehensive oral health care during year's one and two of the project period.

Potential for Replication

Although sustainability funding remains an issue and will continue to be sought, the model itself has value for other communities. One critical element is to ensure the participation and commitment of all the entities involved from the public, nonprofit and private sectors, and to maintain optimal communication to address issues and maintain continuity of care for the target population.

After the Grant

RHO services for the Willard area will be partially sustained by the Huron County General Health District, which applied for new RHO grant to become the lead grantee and project manager under a restructuring. The organization will operate a small, part-time clinic but will not sustain the level of services desired as the agency did not receive an award through the most recent RHO funding cycle.

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Community Characteristics

The Twin City Hospital Healthy Community/Happy Children Outreach Program, which was shortened to TCH HCOP for public relations purposes later, was designed to address the needs identified above. Specifically, the TCH HCOP addresses the following needs: lack of affordable diet and exercise training, need for a central location where people can access health and wellness information that is appropriate for all age levels, ... need to provide treatment for obesity amongst all age groups; need for enhanced diabetes and treatment and education, need for fitness programs for all ages, need for childcare to allow busy parents the time to participate in TCH HCOP services, and the need to provide local access to these services due to a lack of affordable public transportation in Tuscarawas County.

Services Offered

The Twin City Hospital Healthy Community/Happy Children (TCH HCOP) Outreach Program provides the following services: nutrition and exercise training for adult men and women through Fit for Life Classes that meet weekly for three months, nutrition and exercise training to children through Fit for Fun classes (these classes were suspended during the last year of funding due to lack of participation), nutrition and exercise training to schoolchildren through school-based wellness programs, nutritional counseling to adults and children who have diabetes and/or are at risk for diabetes, nutrition and fitness information on the Twin City Hospital website, and monthly support group meetings for “graduates” of Fit for Life to keep them on the path of good health.

Innovative Solutions to Problems

Initially we found that getting adult participants for our first Fit for Life session was challenging. We expected to have at least 50 in the first class but ended up with around 30 participants during the fall of 2006. However, what initially seemed like a problem ended up being a huge benefit because the 30 graduates of the fall class experienced such huge success that they promoted the class to their friends and family members. Also, we got a feature story about our program and their success in a local newspaper in December 2006, and we ended up having to create a waiting list for our Winter 2007 class. Within a short amongst of time, our Fit for Life classes became so popular that we always had a lengthy waiting list. We reduced the size of our waiting list by offering more classes. While there are still names on our waiting list; generally those are names of people who waited until the last minute to try to register for classes.

Another problem that we encountered was that one of our consortium members did not participate in any of our consortium meetings despite repeated e-mail and phone messages and even a couple personal visits. The member indicated that he was still interested in supporting us but just couldn't attend meetings. We continued to send him all program materials throughout the entire three year project period, and he finally invited us to come to his school in the spring of 2009 to present a program to teachers and students.

Third, we noticed that our initial goal of seeing Fit for Life participants lose at least 10% of their body weight was an unrealistic expectation. While many participants did lost at least 10%, most fell short. For years two and three of the grant, we adjusted the goal to 5% and achieved a better success rate from participants.

Fourth, we found it was difficult to get participants for the Fit for Fun classes for children and their parents. After repeatedly trying several different approaches to encourage participation, we decided to discontinue the Fit for Life program for year three of the grant project.

Finally, our free nutritional counseling for obese children at risk for diabetes was not received as well as we thought. Although doctors and nurses provided numerous referrals to our counseling sessions, many parents were simply in denial about their children being obese. While we were successful in reaching 42 children and their parents, we wish there had been more we tried many different incentives encouraged participation with little to no response. We now make pediatric nutritional counseling available upon request as the counseling is most likely to be successful when the parent is actively engaged and participates in improving his/her child's health.

Results

Results achieved by adults in our Fit for Life classes (across seven three-month sessions and 602 participants) are as follows: Each session lost an average of 539 pounds; Each participant lost an average of 7.34 pounds; Each participant lost an average of 3.51% of weight; Each participant lost an average of 1.31 points of BMI; Each participant lost an average of 2.13 inches off waist circumference; Each participant lost an average of 3.88 points off systolic blood pressure and 2.87 points off diastolic blood pressure; Each participant lost an average of 11.06 points off total cholesterol and 20.38 points off triglyceride levels; The average participant saw no change in his/her HDL level and lost 6.66 points off the LDL level.

Potential for Replication

Other rural communities may find the replication of our program difficult for the following reasons: they may not be able to obtain the seed money to start the project; they may have difficulty finding a trusted health professional of Dr. McKnight's caliber to lead the program; they may have some challenges in forming a consortium of community organization's that work well together; and they may have difficulty initially promoting their program.

After the Grant

Sustainable: The program is sustainable; however, in the current depressed economy it is likely that all components of the program may not be sustainable. To cover program costs, we will have to raise participant fees which may make it even more unlikely to accommodate lower income community members; however, we will still make every effort to have scholarships and a sliding fee scale available.

Sustainability Methods: We are working to sustain the program by taking the following measures: raising participant costs slightly to cover the cost of program supplies and blood tests, expanding the scope of the project to go into the workplace to provide programming for the working poor (this aspect is being funded by a new HRSA Rural Health Outreach grant), talking with local insurance companies to get them to cover the program cost for their enrollees, beginning an annual fundraiser to collect money for program scholarships, and applying for other grant funding and donations through foundations and private sources.

OHIO—THE TWIN CITY HOSPITAL CORPORATION

Closing Out: The program will not be closing out. Carrying out our sustainability plan has been challenging thus far due to the depressed state of the current economy. Our program could easily be a best practices model for rural communities.

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OHIO—ZAINESVILLE-MUSKINGUM COUNTY HEALTH DEPARTMENT

Community Characteristics

There were over 2,200 people identified in Muskingum County, OH, who could not afford the medications they needed. To address this problem, RxCUE (located in southeastern Appalachian Ohio - Muskingum County) is a group of nonprofit agencies that have come together to assist those residents in the County who suffer health care problems as a result of the high cost of medications and their subsequent lack of resources to obtain prescribed medicines. Based on local statistics, the greatest needs of this target population include medications for diabetes, hypertension, pulmonary, cancer, and respiratory conditions.

The RxCUE Group has adopted the following Mission Statement: “To ensure that residents of the Muskingum County area who cannot purchase their required prescription medications are provided with those medications and other medical supplies consistent with physician orders.”

Services Offered

Tier I links individuals with free pharmaceutical sponsored programs.

Tier II fills prescriptions from the RxCUE Charitable Pharmacy. The State of Ohio passed House Bi11221, which provides for the development of a State Pharmacy Repository for collection and redistribution of surplus medications from individuals and agencies.

Tier III uses the stopgap approach to filling medications through outright purchase. The purchase of medications is done through a cooperative agreement with consortium members that utilize volunteer pharmacists to fill prescriptions at hospital costs. Grant money funds the purchase of medications in this tier only. The result is an average savings of 50% over purchases from a private pharmacy.

Innovative Solutions to Problems

One of the initial goals was to create a medicine donation system for doctors, nursing homes, and hospitals. The project has had success getting doctors to donate sample medicines they receive from pharmacy representatives (which have been substantial). It has not been successful getting the hospitals and nursing homes to donate unused or extra medicines to the pharmacy, mostly due to economics and regulations. There has not been a solution to this issue to date.

Results

The project was evaluated each year with continuous improvement implemented based on the annual reviews. Copies of these annual reports were used internally by the consortium and submitted to HRSA. Specific activities were also justified against the detailed RxCUE Work Plan matrix, which was reviewed and revised annually. Finally, a revised, detailed budget was submitted annually to HRSA which was aligned with the activities required to implement the program each year. See Chart 2 above for outcomes achieved.

Potential for Replication

A community pharmacy program like this could be replicated in other rural communities. The need most certainly is there. The key factors for success are the support of volunteer pharmacists, the legal

OHIO—ZAINESVILLE-MUSKINGUM COUNTY HEALTH DEPARTMENT

creations of the charitable pharmacy structure with a computer software system to monitor the medications, and appropriate staffing to administer the pharmacy.

Getting the word out and marketing is the least of the problem. Also, the actual cost of the medication was considerable more affordable than was initially budgeted. For such projects, there are increasing ways to purchase lower cost medications for distribution. Securing doctor's donations has not been that difficult either, once the structure was in place. The consortium is certainly willing to share any of the materials or experiences with any community interested in such a project.

After the Grant

Yes, the program will be sustainable. This project has requested a No Cost Extension of the existing grant to use remaining funds into the next fiscal year. This \$21,733 could fund staffing and/or medicine purchases. All of the RxCUE clients who are not MVHC patients were turned over to Rambo Health Center. They will continue to maintain their enrollment in the Pharmaceutical Patient Assistance Programs (PAP). Any new client is supposed to be referred to Rambo, only if they have a breathing condition, or to Genesis Senior Opportunities. These two agencies will continue to enroll patients into the PAP's. The MVHC will be referring anyone that needs medications paid for back to the Health Department.

At this time, the community is working to sustain the PAP component of the program, but the consortium is struggling as to how to maintain the Charitable Pharmacy operation.

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OKLAHOMA—NORTHEASTERN OKLAHOMA COMMUNITY HEALTH CENTERS, INC.

Community Characteristics

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

The target population of the health center are the uninsured and underinsured residents of Cherokee County, Oklahoma; however, health center patients come from across the multi-county region of northeastern Oklahoma, some driving as long as two hours to reach the health center. Needs to be addressed in this project include providing information and education to individuals who are caregivers to those suffering from Alzheimer's disease. Topics of education will include issues such as medications and treatments available, legal and financial concerns, as well as the care givers' high risk for stress-related illness and coping mechanisms that can be utilized to reduce stress induced health risks. A needs assessment was conducted as part of Year 1 grant activities, through which community-specific needs were identified as well as resources available. During Year 2, project partners were expanded and information about the project distributed across a multi-county area; in addition, training of caregivers was begun. For Year 3, the grant conducted caregiver educational sessions, telemedicine to caregivers and providers. The consortium meetings were held bi-monthly and health fairs were used to increase awareness of Alzheimer's disease. The activities took place in Cherokee, Adair, Wagoner, Muskogee and surrounding counties of Oklahoma.

Services Offered

The Goals of this project were to 1) Improve the ability of area organizations to better meet the mental and physical needs of caregivers; 2) Improve the ability of care giving families to utilize health care and support services in their communities; 3) Support the mental and physical health of caregiver; 4) Educate area residents about maintaining brain health and decreasing impact of Alzheimer's disease; 5) Use advanced communication tools, including the Internet, to achieve goals more efficiently; and 6) Develop a plan for sustainability.

Innovative Solutions to Problems

As the project was originally designed, two registered nurses with substantial training in mental health were to be deployed in five different physicians' private practices for the purpose of field-testing a model of integrated primary and behavioral health care services within those practice settings. At the outset of the project, and in consultation with the federal Program Officer, substantial changes were made to the original project design. Instead of employing two registered nurses, the project instead employed a single licensed clinical social worker. And, instead of deploying the project's staff at five different physician practices, the clinical social worker was deployed at a single five physician group private practice. By enacting these changes, the project was able to provide greater behavioral health expertise and to concentrate its efforts in a single practice setting where the clinical social worker could be continuously available to physicians and patients, rather than episodically available according to some schedule of rotation. While these programmatic revisions were not necessarily classified as *significant*

OKLAHOMA—NORTHEASTERN OKLAHOMA COMMUNITY HEALTH CENTERS, INC.

problems, they did comprise a change in design. With this single exception, the project did not encounter any significant problems and unfolded *very* much as originally planned and envisioned.

Results

All project partners are either local, or have local contacts. While this is an advantage in marketing the project, it means that we do not have access to resources that may be found in larger urban areas. In addition, the project has had to refocus on curriculum and other local resources giving it a more rural perspective. Ten televised training “Savvy Caregiver Series” seminars were present, with 3,248 encounters in year 3 of the grant. This number far exceeds the projected 500 persons for year three.

Potential for Replication

Project partners have been encouraged to take ownership of the project so that it takes on a life of its own as a community entity. The Area Agency on Aging, and Oklahoma Area Health Education Center will continue to provide programs for caregivers of Alzheimer’s disease on an ongoing basis. The impact of this project has been to refocus some of that effort toward rural areas, to forge new pathways, and new associations for the benefit of rural families in need of help. The end of year three concluded with integrated into Northeastern State University Social Work curriculum, local retirement communities, clinic programs, a couple churches and a mechanism put in place to cover expenses that occur outside of the community health center entity. Once the project is complete, these new associations will be strengthened through the work of the grant, which will enable continued work and collaboration.

After the Grant

Sustainability of the Northeastern Oklahoma Alzheimer Awareness Project are crucial because of the need of this type of services in this area. Northeastern Oklahoma Community Health Center will determine arrangements for part-time staffing to manage the Telemedicine Alzheimer’s classes’ coordination with the Elko, Nevada group and continue with local community presentations, scheduling and data collections.

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Community Characteristics

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

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

Normed, standardized, and validated results from the *Oregon Youth Behavior Risk Survey* (2004) found that fully 38.0% of Douglas County's eleventh-grade students had engaged in the use of intoxicating substances during the past thirty days (compared to an Oregon statewide rate of 29.6%, and a national rate of 21.0%). The early initiation of problematic substance abuse sets the stage for a lifetime of addictive disorders.

The median age at death for Douglas County residents in 2002 was 75 for males and 79 for females, which compares quite negatively against national life expectancy ages of 79 for males and 83 for females. At least a portion of potential years of life lost prior to the age of 65 in Douglas County is attributable to alcoholism (including alcoholic psychosis, dependence syndrome, alcoholic gastritis, alcoholic cardiomyopathy, alcoholic polyneuropathy, and alcoholic diseases of the liver). On an annual basis, 96 years of lost life, and 18 deaths are attributed to alcohol in Douglas County. The alcohol-related death rate in Douglas County is 18.0 per 100,000 persons, compared to an Oregon statewide rate of 11.9.

Many believed that Douglas County's extremely high rates for deaths by suicide are also attributable to addictive disorders. At the time that the grant application was originally submitted, the suicide death rate in Douglas County stood at 21.0, which compared quite negatively to an Oregon statewide suicide death rate of 16.7. It is to be noted that the suicide death rate in Douglas County peaked in the late 1990s, and was among the highest in the nation, prompting an epidemiological investigation by the Centers for Disease Control.

Studies conducted by the Center for Oregon Health Plan Policy and Research concluded that fully 25% of all Oregon Health Plan enrollees in Douglas County received prescriptions for Vicodin. Primary care physicians, confronted with the need to expeditiously care for those with chronic pain and a paucity of resources, simply overprescribe an effective, yet addictive, substance. As the benefits of the drug weaken over time, patients request higher doses, leading to a slippery slope of prescription medication addiction. Similar patterns are seen in the elderly who present with multisystemic complaints, many of which involve the need for careful pain management or the management of multi-pharmaceuticals.

There are elements of addictive disorders seen in virtually every primary care practice in Douglas County, yet it was the consensus of the medical community that there few resources were brought to bear—either to assist physicians or their patients. As physicians spend more-and-more time treating symptoms and complications that arise from addictive disorders, they have less and less time to spend in serving the county's 14,345 medically-underserved residents who lack access to a permanent medical home.

Services Offered

The project embedded a clinical social worker in a five-physician private practice setting for the purposes of providing integrated primary and behavioral health care services. The specific services provided included: informal *meet and greet* sessions to let patients know that behavioral services were available to them; formalized behavioral health assessments; consultation with primary care providers; and brief psychotherapeutic interventions.

Over the course of the three-year project period, 1,750 unduplicated adult patients participated in the integrated primary and behavioral health program. Of these: 35.7 percent were medically uninsured; 32 percent were enrolled in the Oregon Health Plan (Medicaid); 20 percent were privately insured; and the remaining 12.4 percent were enrolled in Medicare. More females than males participated in the program (69.3 and 30.7 percent, respectively). The project primarily served Caucasians of European ancestry, with only 9 patients reporting Hispanic origins.

Innovative Solutions to Problems

As the project was originally designed, two registered nurses with substantial training in mental health were to be deployed in five different physicians' private practices for the purpose of field-testing a model of integrated primary and behavioral health care services within those practice settings. At the outset of the project, and in consultation with the federal Program Officer, substantial changes were made to the original project design. Instead of employing two registered nurses, the project instead employed a single licensed clinical social worker. And, instead of deploying the project's staff at five different physician practices, the clinical social worker was deployed at a single five physician group private practice. By enacting these changes, the project was able to provide greater behavioral health expertise and to concentrate its efforts in a single practice setting where the clinical social worker could be continuously available to physicians and patients, rather than episodically available according to some schedule of rotation. While these programmatic revisions were not necessarily classified as *significant problems*, they did comprise a change in design. With this single exception, the project did not encounter any significant problems and unfolded *very* much as originally planned and envisioned.

Results

At the outset of the project, and included within the original competing application for federal assistance and project proposal, ADAPT identified a series of six process, performance, and outcome measures. In the following narrative, each outcome measure is re-stated, relevant raw data is presented, and a discussion ensues as to the degree to which the project did or did not attain its original objectives.

The overarching goal of the project was *to alleviate human suffering and conserve scarce fiscal and health professional resources through the development and implementation of an effective program of integrated primary and behavioral health care.*

Potential for Replication

The program, as implemented by ADAPT, is a version of the *Four Quadrant Model* for the bio-psycho-social integration of primary, mental, and behavioral health care services. Elements within the *Four Quadrant Model* have been deemed to be evidence based best practice models by the National Institutes of Health, National Institute on Drug Abuse, Health Resources and Services Administration's Bureau of Primary Health Care, and the Substance Abuse and Mental Health Services Administration.

After the Grant

Yes, the program will be sustainable. The project is working at two levels to assure the long-term sustainment of the program. At the first level, ADAPT, along with the Oregon Primary Care Association, continues to work with Oregon's Department of Medicaid Assistance Programs to seek federally required reimbursement for mental and behavioral health services. Some positive movement is being made in this regard, and Oregon's legislative assembly is currently reviewing whether or not mental health services should remain a *carve out* within the state's Medicaid program, and whether or not county public mental health programs should be the only entities to provide mental health services to the Medicaid population.

At another level, the project initially hypothesized that medical cost savings would be the best argument for the sustainment of the program. Of the 1,750 patients who were served by this project: 35.7 percent were low-income, self-pay patients who were seen on a sliding fee schedule, and for whom the provider did not receive full reimbursement for the costs of care; and 44.2 percent were enrolled in the Medicaid and Medicare programs where, once again, reduced payment structures do not cover the provider's full costs of care. The project demonstrated that it had the capacity to reduce the number of inappropriate primary health care encounters for behaviorally-involved primary health care patients by 3.6 visits per year. If it is assumed that the cost of each primary health care encounter is \$100, and that the provider is paid 40% of this amount (either through Medicaid, Medicare, or a fee-adjusted scale), then the provider will lose \$60 per inappropriate medical encounter. With a reduction of 3.6 visits per annum per patient, the integration of behavioral health care services stands to save the provider \$216 per patient. With a caseload of 400 behaviorally-involved patients, the cost savings would mount to \$86,400 per year, which is sufficient to offset the project's costs associated with retaining the services of a licensed clinical social worker.

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Community Characteristics

The Mid Columbia area is famous for fruit production that is heavily dependent upon the region's large Hispanic population of seasonal farm workers and migrants. In 2003, the median per capita personal income in Hood River County and Wasco County was \$23,676 and \$23,516, respectively, well below those for the state of Oregon (\$29,175) and the United States (\$31,487). Poverty in Hispanics is merciless with an annual per capita income of \$7,630. Fifty percent of Hood River's and 24% of Wasco's Hispanic families are living in poverty compared to 14.2% for non - Hispanic families.

Services Offered

Hood River and Wasco Counties have both been designated a Medically Underserved Areas (MUAs). They also have designation as a Health Profession Shortage Area (HPSA) for migrant seasonal farm workers, mental health and dental. Both counties are also considered "Critical Access Areas" in terms of medical care with the nearest metropolitan being Portland, Oregon. Skamania & Klickitat County residents are separated from Oregon by the Columbia River. Many cross the bridge to work and seek healthcare in Hood River or Wasco County.

Innovative Solutions to Problems

Although it is inevitable that challenges arise with the implementation of any project, our consortium successfully met those challenges and implemented effective solutions. The loss of one of our co-directors, the difficulty with implementation of the dialysis program and a case management program that unfolded differently than visualized were all challenges that required creative responses. In each case the consortium was able to meet the challenge and respond successfully.

Results

The first goal of the *Steps to Wellness* plan was to address mental health issues that impact patient self management of diabetes and/or obesity. The health promoters implemented a 15 week healthy living curriculum developed by program staff that provided information on mental health issues and coping strategies to improve patients' ability to manage their weight and/or care for their diabetes in addition to presentations on nutrition, diabetes and exercise. The curriculum was provided twelve times over the course of the three year project, six times in English and six times in Spanish. During the three years it was regularly evaluated and revised to better meet the needs of the participants. It is now in its final edit and will soon be available at the La Clinica web site, www.lcdefh.org.

Potential for Replication

There are a number of challenges that another community may need to address. First, if the community has little or no experience working with the lay health promoter model, intensive education will need to be provided to the community at large as well as the health care community. In our experience, the community at large is more than ready to accept the health promoter role but the health care community struggles to understand the role and how to work with health promoters. Secondly, if health promoters are providing direct services and education it is vitally important that they have sufficient education and guidance from clinical staff to support them in that role. Finally, offering a 15

week curriculum using Popular Education methodology, while highly effective, is also very labor intensive and will require commitment and energy on the part of staff to ensure that it is successful.

After the Grant

Our intent in the absence of ongoing funding was to continue to offer groups as part of the Salud program at the clinic but with less frequency and fewer group materials. It would have been difficult for our partner, NCS, to continue to participate in this effort due to their program funding. The Georgia Health Policy Center created an attractive prospectus to use in our efforts to recruit community support to sustain the program. We will continue to offer weight management counseling in the clinic setting as part of our diabetes management program. PHRMH invited us to submit a proposal to their hospital foundation to continue the lay counseling in the dialysis unit. A proposal has been submitted and is awaiting approval. The Office of Rural Health has funded a three year grant that will enable us to expand the group series to Wasco County as well as continue to offer them in Hood River County. We are presently recruiting staff and will begin training when they are in place.

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Community Characteristics

Heart disease, both in Oregon and across the nation, is the number one cause of deaths. In 2001 in Oregon, heart disease accounted for 23% of the state's deaths; and stroke, as the third leading cause of death in the state, accounted for 9% of deaths. Residents in Josephine County have among the highest rate of deaths from heart disease in the state; and rates of stroke in this county significantly exceed national rates.

The high incidence of cardiovascular disease and stroke, coupled with the growing over-65 population in Josephine County support the critical need for this rural heart health outreach project.

The goals and strategies of this outreach project were designed to improve treatment of rural residents with cardiovascular disease and stroke implementing three key goals; 1) to improve the capacity for rapid transport and treatment of Josephine County STI segment elevation myocardial infarction (STEMI) patients; 2) to reduce risk-adjusted rates of cardiovascular disease morbidity and mortality by increasing the use of evidence-based practices in the prevention and treatment of Josephine County men and women; and 3) to improve the capacity of Josephine County men and women at high-risk of cardiovascular disease (CVD) to manage their health and receive seamless care across the continuum of heart related care.

Services Offered

Community education and awareness materials and a resource directory were developed in years one and two, and disseminated. Two community based provider seminars were held in years one and two as well as multiple educational workshops for the public, educating the community about the risks of heart disease and a special women heart health class was held as well. The target population for these services was men and women at risk for heart disease or stroke in Josephine County with a special emphasis on persons age 65 and over.

Any man or woman that had a cardiac event had the opportunity to receive timely transport to the appropriate hospital, cardiac rehabilitation services, cardiac education, a Heart Health resource directory, the Living Well training and Home Health telemonitoring upon discharge from the hospital.

Innovative Solutions to Problems

The first challenge occurred in the first month of the grant when the original project director was no longer able to serve in that capacity. Erva Zabel, RN, was recruited as project director and Case Manager for TRCH, along with Theresa Johnston as Case Manager for RVMC. Ms. Zabel quickly pulled together the cardiac team to ensure success of the project and through her diligent efforts; we either met or exceeded the planned goals.

The Josephine County Health Department also lost their director in the first few months of year one of the grant. They remained committed to the project and quickly appointed Cat Metz as the person to represent the health department in their role. Ms. Metz worked with Ms. Zabel and the directory was completed in year two and dissemination began immediately to ensure every heart patient in Josephine County had access to this resource.

Changes in the plan for a self-management intervention delayed its implementation but once it was deployed the classes were scheduled and no more problems were encountered. Initially it was difficult for the Cardiac Case Managers to find the time to recruit participants for the classes. We sought and received

approval to hire a part-time administrative assistant to assist with phone calls and mailings. This greatly improved the process and was an integral part of the success of the recruitment.

When implementing the new best-practice protocols for patients with CVD, the biggest challenge was changing the culture. It is important to allow open communication that maintains the opportunity for feedback which in turn gives the freedom to create change. The project had the support by top leadership to redesign and find the right champion to help implement, develop, and sustain the goals internally and externally.

In the beginning each goal of the project was met with resistance until the champion was identified and thus using that persons leverage to create positive change across the landscape. Some provider's were knowingly targeted for their resistance and asked to assist and be a resource in the development. When implementing the Core Measure Real-time concurrent review, our biggest adversary became our biggest advocate when he realized how we valued his input and then he was able to see the positive results of implementing this change. Again with the training in the "Living-Well" 6-week workshops, providers learned through their patients the value in adopting skills to deal with many chronic conditions and began to recommend patients to the workshops.

When the institution and collaborating partners responded to the economic downturn, the project maintained the goals due to the over riding commitment by all involved to reduce cardiovascular risk factors in Josephine County and help people to be successful in surviving, living healthier lives, and managing their chronic conditions.

Results

Grant funds supported over 455 local providers, allied health professionals receiving education concerning the ASSET program and the community receiving education about the importance of calling 911 and gender specific symptoms of heart attacks. Sign-up sheets were utilized to count participants and evaluations were available afterwards for feedback. 1,000 Community Resource Directories were completed and distributed through provider offices, the health department and cardiac rehabilitation. Evaluation was achieved through customer feedback and number distributed vs. number printed.

Grant funds were the impetus to implementing a cardiac case management team which enabled our organization to achieve positive outcomes for this project and ongoing for our patients with CVD.

Cardiovascular Clinical Core Teams were developed. These teams were comprised of physicians, RN's, cardiac rehabilitation educators and the cardiac case managers. New protocols for CHF patients was developed using new clinical pathways for nurses to follow complementing best practice order sets. New physician order sets were established for patients with AMI, CHF and unstable angina which complemented the nurse clinical pathways. A new process for discharge planners was implemented to ensure discharge instructions were given and documented.

Potential for Replication

Yes. The multiple facets of this rural outreach project have proven a best practice model through improved patient outcomes, reduction in mortality and readmissions, and increased compliance through best-practice CMS core measures, transparency and partnered collaboration in maintaining the gains.

After the Grant

The key elements of the grant will all be sustained upon completion of the grant funding. As stated earlier, Dr. Gross is already moving forward with ASSET program statewide.

The success of the Cardiac Case Management portion has been proven through improved patient outcomes and will continue. A new measure of patient satisfaction has been added which will hopefully show heart patient satisfaction has improved through the case management mechanism. The Living Well self-management classes are continuing and will be available to all heart patients of Josephine County through RVCOG and OSUE. The case managers will continue to refer patients to cardiac rehabilitation, home health for possible telemonitoring, and Living Well classes for a full continuum of care.

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Community Characteristics

The premise of the proposed project was that a significant aspect of patient safety could be improved in the realm of medication safety - including prescription, transcription, validation, documentation, ordering, dispensing, administering, and usage of drugs and other pharmaceuticals. Wayne Memorial Hospital, a 98-bed community hospital in rural Pennsylvania, and its consortium of primary care practices throughout Wayne and Pike Counties, Pennsylvania and portions of Lackawanna County, Pennsylvania and Sullivan County, NY would implement an integrated medication safety program called the IMAPS Project, or Improving Medication and Patient Safety.

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

Services Offered

The Work Plan and Timeline provided with the original Rural Health Care Services Outreach Grant (RHCSOG) application indicated a timeline beginning in January 2006 with an anticipated completion date in September 2008. The population most affected by the project are the inpatients and outpatients of Wayne Memorial Hospital, most of whom are patients of the other consortium members - the primary care practices in the community.

Anticipated at the time of the RHCSOG application was the completion of a new 5-Year Hospital Information System (IS) Strategic Plan that was initiated prior to applying for the Grant. The first steps in this Hospital Pharmacy System upgrade project were to be the replacement of the Hospital's legacy Health Care Information System (HCIS), including the Pharmacy Information System. A new core vendor was selected (Meditech), contracts were signed and the purchase, installation, and implementation of the new HCIS was completed prior to the 3rd year of the grant with the exception of BMV and CPOE that were implemented in the 3rd year. The effect of the new HCIS selection on the IMAPS project was to delay the start of the project by about one year. However, that delay did not change the goals, strategies, or outcomes related to the RHCSOG project. Installation of pharmaceutical barcoding equipment, automatic dispensing units, secure wireless LAN equipment, training of pharmacy and nursing staff and implementation of usage of the system had all taken place by the end of the 2nd year of the Grant. Medication reconciliation for patients was in place by that time, resulting in improved medication inventory control, record keeping, and reduction in medication errors.

Innovative Solutions to Problems

The most significant challenges of the project were completion of a new Hospital Information Systems Strategic Plan and replacement of the Hospital's HCIS. Once this phase of the project was accomplished, the next significant challenge was employing adequate nursing staff necessary to implement fully the BMV and CPOE phases of the IMAPS project. Both BMV and CPOE, especially as

related to the new Hospital HCIS, required significant training. The nursing shortage that has been affecting every part of the nation affected the Hospital and the IMAPS project. The Hospital needed to shift priorities to ensure necessary delivery of care, which made it difficult to free a sufficient number of nurses to attend the required training for implementation of BMV and CPOE. Renewed emphasis on nurse recruitment and scheduling efficiencies improved the situation sufficiently to complete all necessary trainings in the 3rd year of the grant. Finally, the most recent challenge related to protection of data and the new Meditech Health Information System in the event of an unforeseen disaster to that system. Modification of the 3rd year of the grant budget allowed for HRSA funds to help purchase contractual off-site disaster recovery protection.

Results

From the beginning, the IMAPS Project utilized a Logic Model, developed by the Project Team for project planning purposes and program evaluation. The Logic Model, as presented in the original RHCSOG application formed the basis for the Evaluation Plan. Read from right to left, the document describes the basic plan for accomplishing the two primary goals, what project outputs are necessary to yield the outcomes anticipated to accomplish these goals, and what specific resources and activities are necessary to produce the outputs.

The Logic Model read from left to right becomes an evaluation tool. The evaluators can determine if the resources and activities were appropriate to the plan, whether they were indeed used, whether they produced the output that yielded the outcomes that produced the ultimate desired impact on the target population. The process measures and indicators are defined in the Logic Model. Use of the Logic Model fosters coordination, assures and documents accountabilities, and entails participation at all levels throughout the project. Outcomes measures were determined through focus groups and system user satisfaction surveys. The evaluation of medical error reduction will include the various disciplines involved in the project and includes the data collection and reports described in Section II-D above. The project is evaluated both internally and formally by an independent contractor. In November 2008, the project was selected for an HHS, HRSA Performance Review. The Performance Report was completed in January 2009 and is available from Dennis R. Dey, Review team Leader, OPR, Philadelphia Regional Div., 150 S. Independence Mall West, Philadelphia, PA 19106. The results of the Review were very positive and helpful with regard to development of the IMAPS Project going forward.

Potential for Replication

In our opinion the IMAPS project is representative of a best practices model, however, we will leave that judgment to those with a broader perspective of such assessments.

After the Grant

Yes, the program will be sustainable. Wayne Memorial Hospital and its consortium members are fully committed to continuing the IMAPS project far into the future.

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Community Characteristics

The project was developed to help reduce emergent care of discharged home health patients over the age of 65 years with diabetes, congestive heart failure or other heart disease. In order to reduce emergent care, community members were trained as “Health Coaches” to mentor discharged patients in chronic disease self-management and to assist them in accessing needed community resources. Health Coaches also reduced falls by discussing fall prevention strategies with their clients, through conducting home safety checks, and through facilitating home modifications provided by community groups.

Services Offered

Funding from this grant application supported the training of 43 Lay Health Educators, called “Health Coaches” (HCs), who then provided mentoring and education to discharged home health patients over age 65 years in order to enable them to manage their chronic health conditions (i.e. diabetes, cardiovascular disease, and congestive heart failure). The training focused on: (1) Role of Health Coach, (2) Safety and Fall Prevention, (3) Communication Skills, (4) Psychosocial and Physical Aspects of Aging, (5) Heart and Circulation, (6) Stroke and Congestive Heart Failure, (7) Diabetes, (8) Pneumonia and Flu, (9) Medications, (10) Health Behaviors (Nutrition, Physical Activity, and Tobacco Use), (11) Changing and Maintaining Health Behaviors, (12) Human Subjects Protection, (13) and Community Resources. To date, 62 individuals have been served.

Innovative Solutions to Problems

Challenges remain in developing a sustainability plan after April 2010 due to the economic downturn. The Wellness Center Director for our hospital partner indicated the most interest in continuing the program under the leadership of one of their health educators. However, in spring 2009, this health educator position had to be eliminated to meet budget constraints. The hospital partner has indicated on more than one occasion their support of the program and the belief in its effectiveness, and we are hopeful that when it can return to full staff, the implementation of the program will be revisited.

Results

Other communities can successfully replicate this program if they have satisfactory referral protocol adherence. We found that busy Home Health Services nurses sometimes forgot to add a referral to our program in their hectic home visit schedule.

Potential for Replication

After their site visit, Office of Performance Review staff deemed our program a “promising practice”. We believe after peer-reviewed publications about the current project and replication of the Health Coach model in our new outreach project, our program will achieve status as a best practice.

After the Grant

This grant program assisted in developing insight and deeper understanding of the health care needs of rural elderly residents of upstate South Carolina. This insight stimulated several conversations with the hospital partner CEO and various VPs on how to continue with the program. As the project has been granted a no-cost extension until April 2010, sustainability planning is still underway. With the dedication of the partners and the feedback of the lay health educators, home health services RNs, clients,

SOUTH CAROLINA—OCONEE MEMORIAL HOSPITAL, INC.

principle investigator(s) and the co-investigator(s), this program proved the importance of lay health educators / health coaches/community health workers in improving quality of health care at both organizational and individual levels.

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SOUTH DAKOTA—SOUTH DAKOTA URBAN INDIAN HEALTH, INC.

Community Characteristics

The project's aim was to increase the quality of years of a healthy life and to eliminate health disparities among rural South Dakota Urban Indian Health clients at risk of diabetes development or who have diagnosed diabetes, by 1) preventing and reducing overweight and obesity; and 2) establishing a sustainable program to continue to address the unmet health needs of the target population. Aside from the expected medical impact, the program was to give Native American participants a defined way they could meet their medical provider's health plans, i.e. get more exercise and eat healthier. Many times medical providers simply tell patients what to do, but do not give them a path to complete the medical orders. The goal was to provide a hands-on approach to physical activity and nutrition education that would be comfortable and interesting and flexible to improve the health disparities of Native Americans.

Services Offered

Through this grant SDUIH purchased PRECOR treadmills and ellipticals, recumbent bikes, Nu-steps and a weight machine so our Native American patients had access to an exercise room. SDUIH also provided nutrition services through a "Teaching Kitchen" in the Pierre clinic. The "hands-on" Teaching Kitchen related to nutrition planning, shopping and meal preparation to address obesity and overweight issues to our Native American patients.

Innovative Solutions to Problems

Karla Abbott from Avera McKennan resigned during the first year therefore Case Management/Health Education coaching was done minimally due to this change. The resolution to this problem was that Avera McKennan agreed to continue with this component and patients began to receive health coaching to assist them with their progress in year two and also Karla Abbott would train a CNP from each clinic to provide this service in year three.

In this first year it became apparent that the Trainer/Exercise Physiologist did not have a lot of patient contact but most of his time was dedicated to choosing the equipment and installation. SDUIH utilized more of the Trainer/Exercise Physiologist (Joe Dudley) in year two and year three with the addition of a new site in Pierre. A regular schedule was developed for Mr. Dudley to meet with patients at both clinic sites that increased patient connection and tracking.

Results

Once the problem with the Avera McKennan internal computer system was discovered they were not sure how to proceed with their obligation (described below in C). SDUIH explored using BSDI Fitness software, which is an exercise tracking system that is used by Indian Health Service/Tribal diabetes programs. SDUIH received quality reports from the Aberdeen Area Office of Indian Health Service on the system, and reviewed and used a demo of the project. It was discovered to be a user-friendly and captures clinical/medical base line information, is able to establish unique/individual exercise plans, tracks number of days exercised, type of exercise (cardio, strength, core etc.), and provides detailed reports on individuals as well as groups. SDUIH purchased the program through this grant and used it throughout the rest of the grant and will use it to track patients who continue with the program or begin an exercise program in the future.

Potential for Replication

Yes, South Dakota Urban Indian Health would consider this program a best practice model. First of all the co-location of medical, physical activity and nutrition programs is a creating of a *hybrid healthcare model* that actually allows the patient to get medical advice/plans and within the same facility meet with a nutritional educator and physical activity trainer. This is one step further than simply telling or advising a patient to get more exercise and eat healthier. A learning process for most Native American is better with “hands-on” approach; rather than sending lots of written material/brochures home with them to read and study. The multi-discipline approach is also very effective in that different factors improve patient health care and the more involved the “multiple-providers” are the better the results are for the patients. The national Office of Urban Indian Health Programs at Rockville, MD selected SDUIH Keya program to be presented to Canada Health (Internal Diabetes conference) in November 2008 as a Best Practice Model for diabetes programs.

After the Grant

Yes, the program will be sustainable. Once the physical equipment was purchased and staff was training (as well as patients), the process for continuing the program was significantly in place. The facilities are forming ways to open up the exercise room to all active patients with a minimum monthly fee to use the equipment.

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Community Characteristics

The Family Outreach Program was designed to work with drug exposed infants and their mothers. Goals included providing assessments and interventions to help ensure that these clients had a stable environment and one that addresses the physical and emotional well-being of infants with these special needs. The goals were also to ensure that the parents had the skills and resources to provide positive parenting in a drug free home environment. Program staff knew to assess and implement a drug treatment plan for the substance abusing parents or in some cases to work toward assisting the parents in a plan toward regaining custody of their infant.

Services Offered

Services provided included in-home mental health and substance abuse treatment, relapse prevention, parenting education, supervised visits with mothers who did not have custody of their children, education re: infant care and emotional/physical development, and case management services-including assisting the mother's in accessing community resources. The population serviced included mothers who tested positive for substances during the pregnancy or at the time of birth and/or admitted to using drugs during the pregnancy. The mothers ranged in age from 17 to 35+ years old with 90.2% being Caucasian, 9.8% African-American, and 0% Hispanic/Latino. All the program participants were at or below poverty level, most were insured through TennCare, and several had no insurance at all. The goal of the program was to help ensure a stable environment for the infant, to ensure that the mothers had the skills and resources for positive parenting, and to implement a recovery treatment plan for the substance abusing parent(s).

Innovative Solutions to Problems

A three month delay in hiring program staff resulted in zero clients being served during the first quarter (May-July 2006). Staff turnover in the nursing position was also a barrier, with four different individuals hired to fill that role during a three year period. Another problem encountered during the first quarter of the program was conflict with the newly appointment Juvenile Court Judge. The Family Outreach program began with the arrival of a new juvenile court judge due to an election year. As a new judge took office in the beginning stages of the implementation, the program faced some issues in forming collaborative efforts between the courts, the protection agency, the medical facility and the mental health facility. The Juvenile Judge at first was very leery of this program. She quickly ordered that all babies born drug positive would not go home with their mom, but would need to be placed with family member or in state's custody. The protection agency faced challenges with finding alternative foster care or other family placements. The medical facility found that the delays in simply allowing the infant to return home impacted their care efforts as well. The mental health staff found that the distance between the infant and the parent when the baby was placed in another setting was a barrier too but it was one that could be coordinated so that it would allow the mother visitation with the infant and an ability to begin bonding with her baby. Despite the barriers to providing the care, there is still success stories related to the mother gaining the ability to be reunited with her child after a period of time that she was able to "prove" her sobriety. However, these barriers were eventually what helped to develop a very strong working relationship with the Judge. The "barrier" became a strength of the program because the program became a new way for the mother to be in contact with her infant when previously she would have been

TENNESSEE—RIDGEVIEW PSYCHIATRIC HOSPITAL AND CENTER, INC.

restricted from seeing the infant at all. The feedback that the program staff could then offer to the Judge became valuable in helping her determine when and if it was safe to return the child to the mother's home. There were two realignments in staff positions. Due to her experience, knowledge and collaborative efforts of treatment needs in the field, the program therapist was moved to an administrative role of program manager as well as keeping the duties of behavioral health specialist. The nurse position was decreased from 1 FTE to .5 FTE. This decrease did not affect program quality and helped to realign the program position with the grant funding decreases in year two and three.

Results

The program was evaluated using the aforementioned assessments: On the KIDS, 63% of the clients showed an increase in their knowledge of developmental stages, 61% showed an improvement in their quality of life as measured by the CA-QOL, and 62% of the clients reported an improvement in mood as evidenced by their scores on the EPDS. Of the 715 total drug screens administered throughout the course of the grant, 566 (79%) were negative for all substances and 149 (21%) were positive for drugs. Of the 149 positive drug screens, 90 (60%) were the result of prescribed medications. Another basic outcome was the fact that the number expected to be served (i.e. 72) was both met and exceeded during the grant life.

Potential for Replication

Sustainability of the program became the biggest barrier during the program implementation. Because the model was innovative and was "not provided in a licensed center" the managed care companies did not have interest. Coupled with the barriers to sustainability that already existed for an innovative program, the national economic situation hit bottom and the key players that we had leaned on to help develop our program had to deal with their own reductions in force and budget cuts. Tennessee as a whole had a state wide change in our Medicaid/TNcare system and the new companies and contracting was difficult and tense.

After the Grant

Very sadly, all efforts to sustain this program failed. Meetings were held with Board members in appeal for their thoughts/support, and with consortium members for theirs as well. Individual meetings with Managed Care Companies, Juvenile Court, DCS, Healthy Starts, United Way and more were held in efforts to underline the value of the program and no one ever argued that the value didn't exist. But during the time that the grant was ending was also a hard time for the community and the nation due to the economic recession. Most of the players who historically might have given the financial support needed to sustain the program were having to face their own budget cuts and layoffs as well as some program closures and mergers.

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TEXAS—LAVACA HOSPITAL DISTRICT/ LAVACA MEDICAL CENTER

Community Characteristics

The Texas Independence Program (TIP) was designed to reduce the need for long-term institutional placement (caused by preventable medical complications and/or chronic diseases) for the frail elderly, aged and disabled residents of Colorado, Jackson and Lavaca counties. Enhanced case management integrated primary medical care with home and community-based services.

Services Offered

TIP's primary goal when providing services to potential clients was to connect them to a resource that is already available in order for them to be able to live in their home versus the nursing home. Services offered by TIP included: developing a Plan of Care, assessing the needs of the client in order to coordinate/locate available services and electronic (paperless) case management. Local services offered to clients included: meals-on-wheels, food banks, bill assistance, wheelchair ramps, air conditioners, durable medical equipment (walkers, canes, etc.), minor home modifications, medication assistance, Lifeline (emergency response systems), transportation, etc. TIP services were offered to all residents requesting assistance that resided in the three participating counties- Colorado, Lavaca and Jackson. Occasionally, TIP staff worked with clients in neighboring counties. When this happened, staff connected those clients with services offered in their respective communities.

Innovative Solutions to Problems

The most significant problems related to the implementation of TIP were the heritage and education levels of the residents in the participating counties the limited availability of resources. The outreach grant was written with the intent to provide assistance to frail elderly, aged and disabled residents. Based off of the baseline data that was submitted when the grant was written, Colorado, Lavaca and Jackson counties showed large numbers of elderly residents versus the national average. The premise of the grant was directed at establishing a support network that allowed elderly residents to reside within their homes versus a nursing home.

Staff and participating grant members eventually learned that the need for such assistance does not exist within the participating counties. The strong German and Czech heritage within all three communities provided a "we take care of our own" mentality. This mentality proved difficult for TIP staff when wanting to provide assistance.

Another problem TIP experienced dealt with "one hit wonders," These were requests for assistance that resulted in the client asking for a particular item or directions to certain available services. These people did not require ongoing case management services. In any case, the request was fulfilled and assistance was provided.

Results

The consortium recognizes the value of evaluation with any grant. TIP utilized the services of Dr. Larry Gamm (Texas A & M Health Science Center-School of Rural Public Health) as evaluator. The outcomes of the grant are still being measured due to a "No-Cost Extension".

The consortium has functioned according to the guidelines written into the grant. The existing relationship between STHS and the consortium members proved positive when establishing consortium

TEXAS—LAVACA HOSPITAL DISTRICT/ LAVACA MEDICAL CENTER

members for the TIP grant. Monthly board meetings provide peer review and support along with grant evaluation and direction.

Additional work load concerns and connectivity proved to be problems with TIP. Clinical staff and physician schedules do not allow for an additional “log-on” or email. Clinic staff was not interested in having to check an additional website or e-mail throughout the day and then have to add patient data into the website. As more facilities become electronic, TIP’s electronic case management program will be more acceptable. With the addition of electronic medical records (EMR), data can be shared without requiring an additional “to-do” in the workload.

Potential for Replication

It is reasonable to consider that replication of the TIP project would be possible. The infrastructure is sound; the success of the program is defined by the availability of resources within the participating communities.

However, given the current economy, it proved difficult within TIP’s participating counties to find members to enroll and once they were enrolled, finding a funding source to support the service requested. Many of the services provided through TIP are from non-profit organizations, churches and generous individuals; groups that have had their own budgets reduced.

Based off of TIP staff experiences, there are areas of concern (specific to the TIP service area) that must be addressed before a project similar to TIP can be established. The first is transportation. While each participating county offered transportation, clients were met with too many rules and stipulations. The most common were the hours of operation, limited service area (with regard to number of miles from base), imposed fees versus reimbursed Medicaid rates and availability of routes/schedules. Since the premise of TIP is to encourage proactive healthcare in return for remaining at home versus a nursing home, transportation to and from the medical home is extremely important and needed.

Another area of concern is funding sources. Most clients that are referred to TIP come from households at or below the poverty limit and do not currently qualify for State assistance. In the meantime, their direct needs are forwarded TIP. Funds are already extremely limited so asking for reimbursed or payment for a service from the client was not an option. Many of the services provided to TIP were completed by organizations looking for community service projects or wanting to assist a fellow church member.

After the Grant

The TIP project will be continued post grant but in a different way. TIP will continue to offer the local residents the toll free number when requesting information or when being referred by the State for assistance or direction for assistance with staff connecting them to that service. Due to the education levels of many of the elderly residents in the service area, TIP is working to create an education program that will assist in directing potential clients to available resources.

Since diabetes is very prevalent in the participating counties (along with all neighboring counties), a “user-friendly” diabetes education program is currently being established as a joint venture between TIP and the hospital facilities that were grant recipients. By stating “user-friendly”, this education program will include “hands-on” cooking classes, in-depth glucometer testing, education and additional self

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management training. HB 1990 was passed in the 2009 congressional session and this bill focuses on pilot programs for Diabetes Self-Management Training Programs. STHS is positioning itself to be one of the pilot programs chosen to represent rural Texas.

If STHS is selected as a pilot program for Diabetes Self-Management Training Program, the web based services offered through TIP's electronic case management system will be offered to pilot participants. Blood sugar monitors within the electronic case management system are capable of graphing the sugar levels and sending alerts to the physician should a patient's blood sugar fall above or below a predetermined number that is specific to the patient. This type of "electronic" education allows the medical home to gain control of the patient's diabetes while providing quality patient care.

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TEXAS—MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM

Community Characteristics

Matagorda County and Wharton County are both designated as Medically Underserved Areas. The population of Matagorda County is 37,957 and that of the city of Wharton is 9,323 (with Wharton County's population at 41,188). There is extensive need for improved access to health care and dental services in the area. Matagorda County is a Primary Care Health Provider Shortage Area (HPSA) and a Dental HPSA. Wharton is also a Dental HPSA.

Services Offered

The target population for this project is comprised of a subset of low-income individuals in Matagorda County and the Wharton city area of Wharton County who are in need of medical or dental services but who are underserved, isolated, or underinsured or who cannot otherwise find access to needed care.

Innovative Solutions to Problems

The problems this project was designed to address are as follows: 1) improve oral hygiene among low income residents in the proposed service area by expanding dental care services to include dental hygiene for the target population in Matagorda and Wharton counties and a Tooth Fairy program in Wharton city; 2) improve understanding and treatment of diabetes and other chronic conditions and the ability of patients to self manage care through expansion of interactive telehealth services for consumers and their families and continuing education providers; 3) improve continuity and decrease financial barriers to care through the establishment of comprehensive case management services for all clients seeking medical, dental, or social services; and 4) advance public policy agenda regarding dental care, patient education, and case management services for low income and uninsured rural resident in Texas by sharing outcomes of program activities with selected state and professional agencies and with health profession educators.

Results

1. Tooth Fairy Program. Evaluation forms were completed by the teachers of each class which had a Tooth Fairy presentation. The response was overwhelmingly positive from all teachers. Most of the teachers expressed a commitment to review the information with their classes to reinforce it. They all expressed the desire to have the Tooth Fairy come annually to their classes.
2. Diabetes Self Management Education. Evaluation for the diabetes education classes was comprised of a knowledge component (pre- and post-tests) and a clinical component (HbA1c values). Based on the pre- and post-test scores, it appears that the teaching methods and tools were effective. Preeducation testing scores averaged 63.9% while post-education results showed an average of 91.5%. This represents a 54.7% increase in self care knowledge which ultimately contributes to healthier patients and increased quality of life. The average HbA1c results fell by an average of 8.0% over the 8 week class period for the 147 students that participated in the classes. Pre-education HbA1c results show an average value of 7.5, falling to 6.9 eight weeks later. Marked improvement was seen in HbA1c values by all students regardless of race, sex, or age. Based on these statistics, the diabetes self management classes are continuing even now that the grant period has ended and we hope to offer them far into the future.

TEXAS—MATAGORDA EPISCOPAL HEALTH OUTREACH PROGRAM

Potential for Replication

Our program is working fairly well in our community; however, I would not consider it a best practices model.

After the Grant

Yes, the program will be sustainable. At this time, the non-consumable teaching supplies that are being used will continue to be used in the diabetes education classes and in the Tooth Fairy program. Other grant monies have become available to help these programs go forward for the present time. We are exploring the possibility of asking participants to pay a nominal fee to take the diabetes classes in the future.

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Community Characteristics

Project Outreach was designed to deliver integrated primary and mental health care to low income adults and children with unmet health care needs, especially those with both chronic conditions (diabetes, hypertension, respiratory illnesses) and mental health issues.

Services Offered

1. Health Screenings, including depression and substance abuse at community locations and events.
2. Mental Health and Substance Abuse counseling
3. Referrals to primary care providers
4. Health education on a variety of health issues and numerous locations and events.

Innovative Solutions to Problems

The most significant problem encountered in the project implementation was the recruitment of a mid-level provider to perform the services. The grant was initially written that a Nurse Practitioner or Physician Assistant perform the health care services within the communities. ETBHC was not able to recruit a mid-level and the individuals who interviewed did not want to practice outside of the clinic setting. The second issue that ETBHC encountered was that if healthcare services were not provided at the clinics, a home health license would need to be secured. To resolve these issues contact was made with our project officer, and permission was given to hire a nurse to perform outreach screenings. ETBHC was able to hire a Registered Nurse with many years of experience in performing health education and capable of performing screenings in the outlying area. ETBHC did not seek a home health license and the Outreach Nurse performed screenings, education, and referred into appropriate primary care physicians for treatment of identified high risk individuals.

An issue regarding the original tool used for screenings for mental health and substance abuse developed because it was too lengthy and consumers refused to complete and stated it was too invasive. The screening tool was changed to a stress/depression questionnaire and the PHQ9 that was completed with the assistance of the nurse or the case manager. Individual attention provided by the nurse, developed a relationship with the interviewee and screenings increased along with the identification of the risk for substance abuse and depression. Within the community a residual negative stigma of seeking mental health counseling exists and the relationship that was developed during the screening process further allowed the individuals to receive individual education regarding the prevention and treatment of mental health and substance abuse issues.

Results

During the three years, Project Outreach continued to increase its outreach activities. Four thousand, three hundred thirty-three unduplicated individuals receive primary healthcare services; 6 locations provided screenings and education on a regular basis; 235 referrals were made to providers for mental health and substance abuse services; approximately 5,500 health information fliers were distributed across the counties; 44 group education events occurred; and 3,044 individuals received risk reduction education related to diabetes, hypertension, obesity, and substance abuse. This project was received well by the

TEXAS—SABINE VALLEY CENTER PRIMARY HEALTH CARE, INC.

community and at the end of the three years, East Texas Border Health Clinic was asked to provide more educational events than it had the capacity to provide.

It is inconceivable that this project would have been successful without the support of the consortium members. Besides the key consortium members, the group grew from 4 to over 16 members in regular attendance at monthly meetings. The resources provided by all of the members, allowed each member to better utilize their own resources.

The initial staffing barrier was remedied by the hiring of a nurse and no significant barriers prevented the successful completion of this project.

Potential for Replication

I believe that this program can be replicated in any rural area that resources are limited and community involvement is high. Educational materials and handouts were used the diabetes coalition and other state and federal best practices resources that have already been proven to be effective. Little, if any, modifications were made to the curricula and handouts provided to the consumers. The ability to perform mental health screenings with a healthcare professional reduced the stigma of “going to a counselor” and the number of individuals seeking help within the primary care facility continues to rise.

The only barrier another community may have is the recruiting of a qualified provider.

After the Grant

Project Outreach will continue past the grant. East Texas Border Health Clinic continues to meet with the consortium members on a regular basis addressing the issues of the community. We were awarded two grants, during the three years that included the continued activities of outreach past the three year outreach grant. We became a FQHC and the resources from the State of Texas Primary Health Care grant continues to provide support for a community outreach program. Along with the grants received, ETBHC will also have in place a Medicaid Outreach/Eligibility Worker to assist our patients and the community in accessing the available funding to meet their behavioral and physical health needs.

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VERMONT—SOUTHERN VERMONT AREA HEALTH EDUCATION CENTER

Community Characteristics

The Precision Valley Physical Activity and Nutrition (PAN) Consortium chose middle school youth and their families in two neighboring communities, Springfield and Windsor, Vermont to design an intervention to address growing obesity in the population by increasing opportunities for physical activity and access to fruits and vegetables. The program was named 30+5, meaning at least 30 minutes of physical activity and five fruits and vegetables daily.

Access to fresh fruits and vegetables is limited by the cost and availability. There was no farmer's market in Springfield or Windsor. Winter poses another barrier. Fruits and vegetables are very expensive because of shipping costs.

There was also a *lack of nutrition services* in this area. There was one dietitian at Springfield Hospital and one at Mt. Ascutney Hospital in Windsor who were overwhelmed with patients. These dietitians are doing primarily diabetes education, in other words, *treatment as opposed to prevention*. Because the dietitians are so busy with these duties, there was no time to devote specifically to prevention in the pediatric population.

Opportunities for physical activity were also limited by the available services, their cost, and the populations they serve. There was a general lack of knowledge about when these activities occur and how to become involved.

In the targeted communities, there was *not enough adult supervision* for kids to be able to use the gym and weight room as much as they would like. There are *few indoor options* for the winter months.

Services Offered

Our strategies for the grant involved implementation of activities that would increase access to physical activity and increase opportunities to include fruits and vegetables in the diet through a multi faceted approach to and parent outreach through school events, classroom activities, professional education, community education, and clinical services

Innovative Solutions to Problems

We had a disappointment around a family education series that one of the hospital partners put forth as a strong program for families involving interdisciplinary units aimed at the psychological as well as the physiological aspects of changing behavior around food intake. After much was spent advertising the program we found out that the second offering after the pilot failed to attract one person after they went door-to-door to promote it. We had a problem solving meeting with the consortium members and decided to take a more informal approach to dietary changes by promoting fresh fruits and vegetables and recipes at school events and working more closely with the school food service. The consultant dietitian in this community was an invaluable asset to these projects.

One community seemed to have a very unusual way of funding school nurses, which was through the hospital. The school nurses were employed by this entity. We could not get any traction with the school nurses because the supervisory role was never clear- whether school or hospital. We hired a very part time school liaison who could be in the schools more and talk directly with teachers and administration to let them know what programs available to youth (such as trips to go swimming, contests, information to parents). This did not impair our ability to get the BMI results for the target group all three years. We got

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cooperation from the school, but the other community soon outpaced this community in enthusiasm and participation in activities and events.

Results

1) The project recorded numbers of children involved in classroom activities and physical activities out of school that were new. In-school physical activities counted when 30+5 was involved. 425 students, or 100% of the enrollment in the target middle schools participated in at least one fitness or nutrition event. 65% of these students signed up for the PAL (physical Activity Log) Challenge.

2) The food and physical activity behavior survey was administered to 425 students. The major outcome was that the students knew what foods were healthy but did not indicate a healthy choice for a cafeteria meal when both nutritious and non-nutritious foods were presented to them.

3) The Prescription for Wellness youth fitness referral program involved a pre and post evaluation. There were documented changes in number of repetitions completed on fitness machines and the dietitian recorded positive changes in food choices, mood, and concentration.

4) During classroom taste-testing and cooking activities students were given a quick survey about what they thought of the food and would they eat it again.

5) The project tracked changes in school lunches starting in year 2 after more activity was started to increase participation in school wellness committees. By year three, french fries were offered only once a week instead of every day. Local produce was featured by the food vendor. The vendor began attending consortium meetings and implemented suggestions made by the group. A community garden was planted with a system put in place to get fresh produce to the school from the garden in the 2009 growing season.

6) The number of media stories and events advertised in the community were recorded. In addition to over 1,000 parent letters being distributed there were 17 press releases published and 3 features with photos written in major daily newspapers.

7) We counted physical activities brochures distributed. For three years 30+5 updated and distributed a grant-funded (Blue Cross and Blue Shield of VT) brochure called “Physical Activities Options” widely distributed in both communities. 2,000 were distributed annually through such venues as health fairs, workplaces, physicians offices, and public places.

8) In year one, 30+5 facilitated a walking map for Springfield and Windsor that was designed by local committees and printed by Blue Cross and Blue Shield of VT. Over the three years, 2,000 maps were distributed.

Potential for Replication

Yes, to the extent that we have had an impact on the school community and the steps they have taken to improve school lunches and get more active in seeing the lunches and fresh foods in the schools as part of the health of the community. We like to think that being chosen to report to fellow HRSA grantees gives us status as a best practices model. Also, we found out that a program in New Jersey was funded by Robert Wood Johnson and the only one of its kind funded by this organization mirrored our program, which validates what we are doing as well. This is tempered by the fact that this type of change happens very slowly and there are so many variables that it is difficult to say that because of our project certain things happened. We think that implemented best practices in community norm and environmental

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change but in terms of health outcomes, there is a long way to go because of the lifestyle factors and clinical needs of overweight and obese children and their parents.

After the Grant

Parts of the program will be sustainable. We used the model of embedding several of the programs in the community.

- School Wellness Committee meetings attended by consortium members.
- School food improvements and changes happened faster after the school lunch summit and the School Lunch Forum (stakeholders) and the vendor became engaged in the process and will continue to be in both communities.
- The community garden that 30+5 started was taken over by a volunteer group of Master Gardeners.
- A garden has been started at schools in both communities and a system has been developed to get fresh donated produce to the school
- The community recreation center has been completed which was not there when the grant started and will be a regular focal point for after-school swimming with youth as long as it involves a large school group with adult supervision.
- The local food co-op has volunteered to do cooking whole food programs in one of the schools.
- Springfield Hospital has taken over printing and publishing the Physical Activities Options brochure.
- Teacher in-services have been used to leave the teachers with tools to use in order to promote more physical activity at school.
- Raised funds and set up a food service staff workshop to prepare whole and fresh foods in the summer following the close of the grant.
- The Consortium has formed a mission statement and has determined that it will function as an entity separate from 30+5 and will work together on an action project to improve family nutrition.
- A brochure was created to promote 30+5 classroom presentations for schools and worksites.

The biggest challenge in implementing the sustainability of the consortium was leadership and the massive momentum needed in order to create a health promotion product in the tough financial times that evolved in the final year of the grant.

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Community Characteristics

A consortium of health and human service agencies in Bath County, Virginia has formed for the purpose of sponsoring a community wellness program for county residents. Bath County is a rural, sparsely populated county of 5,073 people nestled in the Alleghany Mountains on the western boarder of central Virginia. By providing free access to health screenings through community-based and employer-based HealthConnection Screenings, the program reaches out to those whose access to health care has been limited by geographic isolation, costs of health services, and fear or difficulty in seeing a physician. A health care team of four - Nurse Practitioner, Nurse, Medication Assistance Coordinator, and Program Coordinator - will visit employer sites, and community centers where neighbors, fire and safety volunteers and community leaders gather to learn their “health numbers”. These numbers are blood pressure, blood sugar, cholesterol, height, weight, and body mass index. Patients are advised of appropriate follow-up to primary care providers and can come back to the next HealthConnection Screening to check their progress. All tests are provided by the Bath Community Hospital and are free to the participants.

Services Offered

HealthConnection Screening, HealthConnection Prevention, free dental health care clinics, and community health education sessions. The community wellness program offered to Bath County residents includes: free access to health screenings; the community and worksite based HealthConnection Screening; ongoing wellness care offered through HealthConnection Prevention (individuals enroll and receive a preventive health care package which provides physical examinations, mammograms and follow-up care); dental care is also offered four to eight days per year by a volunteer dentist. Health education is an integral part of this grant and is offered to community groups and at worksites during HealthConnection Screenings. Health education is also an integral component of the Health Connection Prevention which is presented by the physician and nurse practitioners. Depending on the needs of the patients, some are referred to the community health education events primarily for tobacco cessation and diabetes education.

Innovative Solutions to Problems

Our biggest challenge with the Outreach grant was retaining a Project Coordinator.

Results

HealthConnection Screening offers free health screenings and education sessions at community centers and at the work sites of the largest employers in the county. Community health education programs are provided upon request and also in conjunction with screening events. A major topic of interest for education sessions is smokeless tobacco cessation. BCCH has partnered with Alleghany Regional Hospital for the health care screening effort; they are an affiliate of the Hospital Corporation of America (HCA). HCA provides a screening tool and booklet to affiliates. Following screening events; HCA compiles the data collected from the participants at the event. An aggregate data report is provided to BCCH after each event. BCCH has used this tool in their community screenings in conjunction with the completion of lab work at their own hospital lab. At worksite screenings, the per-person cost associated with use of the screening tool has been paid by employers (-\$25 per person).

For ongoing wellness care, residents are encouraged to enroll in HealthConnection Prevention. Individuals without an established source of primary care are referred to local providers who provide care at discounted rates. A preventive health care package is provided for minimal fees; the package includes physical examinations, preventive care screenings (mammograms), and follow-up care.

In addition to these community wellness efforts, BCCH and the consortium support several other activities in Bath County. Free dental health care clinics have been initiated. A local dentist provides the use of office space at no cost for one to two days quarterly (a total of four to eight days per year); two dentists and an oral surgeon donate their services.

Supplies are donated, as well. The dental hygienists are paid for their services during these clinics. At this time, approximately 145 patients have been served during four days of dental clinics in 2008. The value of dental care services donated at these clinics is estimated to be worth \$45,000. The Bath County Board of Supervisors believes that this type of dental care is an important service, and a line item (\$4,000) has been included in the county budget to support future clinics of this kind.

Potential for Replication

Yes.

After the Grant

Our programs will all be sustained through Bath Community Hospital community services and Bath County Board of Supervisors.

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Community Characteristics

Yakima Valley Farm Workers Clinic (YVFWC) patients with diabetes, obesity and other nutrition-related medical conditions in a pilot project (2004-2005) had the following indicators of poor health status: 70.4% had Hemoglobin A_{1c} >7, 46.5% had total cholesterol >200, 51.5% had total triglycerides >150, 39.4% had high density lipoprotein cholesterol <40 (male), 67.7% had high density lipoprotein cholesterol <50 (female), 60.9% had low density lipoprotein cholesterol >100, and 84.6% had body mass index >25. Limited access to culturally and linguistically appropriate health education programs (70% of these patients are Hispanic, Spanish is the primary language of approximately 50% and 85% are low income; less than 200% of federal poverty level) lessens the patient's ability to make dietary and lifestyle changes to improve their health.

Services Offered

The activities of the Salud en Sus Manos Project were designed to address these problems by:

1) providing medical nutrition education and nutrition self-management education, for outpatient users with diabetes, obesity, and other nutrition-related diagnoses; 2) increasing the sustainability of these efforts by recruiting, training and mentoring Lay Leaders who will provide Tomando Control de su Salud (Taking Control off Your Health)/Chronic Disease Self-Management Program (CDSMP) workshops for community participants; 3) reaching out to rural Spanish-speaking community members through the provision of weekly diabetes, obesity and other nutrition-related medical condition self-management education radio shows on Radio KDNA; and providing diabetes self-management education for community members.

Innovative Solutions to Problems

During the initial project year, recruitment of the Nutrition Assistant/ Tomando coordinator was a challenge. This position is vital for recruiting and organizing Tomando classes and providing language translation and scheduling assistance for the Primary Care Registered Dietitian. The position was initially listed as 0.7 FTE (which does not include full benefits); after being increased to 0.8 FTE (with full benefits) the position was filled by an experienced local bi-lingual Hispanic WIC certifier who remained with the project to completion.

Recruiting and retaining sufficient participants in the Tomando classes was another challenge during implementation. The initial goal was to provide Tomando training to 60 - 80 participants each year of the approval ratings for the way the consortium functioned, with the exception of one item. Only 42% agreed with the statement 'The Salud en Sus Manos Consortium has mechanisms to deal with barriers such as turf issues.' The consortium addressed this issue at the next meeting and after discussion with members developed a procedure for addressing these concerns.

Results

Prosser Memorial Hospital Diabetes Education was initially planned for a classroom setting, but space limitations at the hospital and patients' transportation problems lead to moving the program out into the community. For meeting sites they used church halls, schools, senior centers, the Radio KDNA building and community centers in Benton City, Sunnyside, Grandview, Mabton, Granger and Prosser. Decreased travel costs for the patients were an additional incentive for participation. Most patients were

seen one-on-one by the bilingual Hispanic diabetes educator for a series of 4–6 sessions. These one-on-one lessons in the community provided a non-threatening atmosphere for the patients, many who have had poorly controlled diabetes for several years.

The Primary Care Registered Dietitian with the assistance of the Performance Improvement Team developed and implemented innovative techniques for improving patient show rates and provider satisfaction with services. The main innovations were shorter visits (20 minutes maximum), reserving appointment time for walk-ins, pre-screening patients with the provider, using Motivational Interviewing to assist patients in developing health goals and development of an abbreviated chart note which increased both time for patient care and likelihood of the note being read by providers.

Potential for Replication

Our project is replicable to other rural communities where they are co-located with a medical facility and there is a public health challenge surrounding nutrition-related medical conditions requiring behavior change, e.g., diabetes, obesity. Our model addresses common barriers like limited transportation and fear of talking to a nutritionist. This model may also have application to other disciplines outside of nutrition.

After the Grant

To provide sustainability, grant funding is pursued on a continuing basis. Collaborative work with other agencies in the communities is also important for sustainability. In addition outcomes data continues to-be-collected on past participants of Tornado and the PCRD program to document of efficacy. This data will be used as the model is developed into a best practice.

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WISCONSIN—NORTHEASTERN WISCONSIN AREA HEALTH EDUCATION CENTER, INC.

Community Characteristics

Wisconsin State Statute requires local health departments, in cooperation with the community, to regularly assess health needs and develop community health improvement plans. Manitowoc County's assessment addressed the status of the eleven health priorities identified by Healthiest Wisconsin 2010 in our community. Sources of information for the local assessment included health statistics published by the Wisconsin Department of Health and Family Services; two countywide telephone Health Risk Behavior Surveys (using questions from the CDC Behavior Risk Factor Surveillance System) and a Youth Risk Behavior Survey conducted in all school districts of the county. The Wisconsin Youth Risk Behavior Survey is conducted as part of a national effort by the U.S. Centers for Disease Control and Prevention. Through assessment of the data collected six health priorities were identified: physical activity and nutrition; tobacco use; teen pregnancy and risky sexual behaviors; dental health; injury prevention and alcohol and drug abuse. The Healthiest Manitowoc County 2010 Steering Committee then assessed how the HRSA dollars could help address the health priorities identified. This project provided four initiatives: Know Your Numbers (to address physical activity and nutrition); Healthy Teeth Healthy Kids (to address access to dental care for uninsured and Medicaid-eligible children); Manitowoc County Network for Child Passenger Safety (to address injury prevention); and Peer Health Education (to address tobacco, risky sexual behaviors, alcohol and drug abuse and physical activity and nutrition among youth).

Services Offered

Our grant provided funding for four initiatives. 1) Know Your Numbers. The original plan was to provide a media campaign to encourage citizens to find out their numbers (cholesterol, blood pressure and body mass index). After receiving the grant, it was realized how difficult it would be to track the success of the media campaign and instead implemented a county-wide health challenge that encouraged members to get their numbers checked, but to also eat better and increase activity to have better numbers. Over the three years we had approximately 1,700 participated. As part of this initiative we also tried to provide free health risk assessments (HRAs) to underserved individuals. We provided approximately 45 of them, primarily to women age 20-65. 2) Healthy Teeth Healthy Kids. We provided comprehensive dental services to approximately 725 children who were either uninsured or covered by Medicaid. Students were between the ages of 5-15. 3) Manitowoc County Network for Child Passenger Safety. 95% of child seats were noted as being installed correctly, however our county lacked the number of technicians who could provide correct education and installation. Through the grant dollars we were able to have seven people trained to provide the services to approximately 900 families in the county. 4) Peer Health Education. We have a high rate of underage drinking, tobacco use, risky sexual behaviors and other risky behaviors. Grant dollars allowed us to provide education to students and support for students to reach out to their peers to encourage positive choices. Over the three years 325 students in Jr. High or high school have been trained as peer mentors. Their efforts reached approximately 5,600 students.

Innovative Solutions to Problems

1) Know Your Numbers. We struggled to find underserved individuals to take advantage of the free health risk assessment (HRA). The feedback we obtained after making several attempts to various target audiences was that the time required to the HRAs was a major deterrent, especially for a service that falls

WISCONSIN—NORTHEASTERN WISCONSIN AREA HEALTH EDUCATION CENTER, INC.

under the rubric of prevention. We were able to reach a small group that we could take the program to the homes of the population we served and that is how we were able to accomplish the majority of HRAs that we did. This was a unique low-income housing unit, however, so could not duplicate the program throughout the rest of the county. 2) Healthy Teeth Healthy Kids. During our first year of the grant we had a difficult time funding the dentist to provide the services. Our original plan was to partner with a similar program in a neighboring county by sharing dental staff. This did not come to fruition as the other project grew too quickly and could not afford to share staff. We did many outreach efforts to the local dentist community to serve at the clinic. Fortunately one dentist finally agreed to help with the program.

Results

Each initiative had its own evaluation component. The evaluation was structured by a mix of formative and outcome measures. Both quantitative and qualitative data were collected. The purpose of the evaluation was to monitor progress in meeting project goals and to improve the quality of programming as the initiative developed. Outcomes achieved include: 45 underserved or uninsured individuals received an HRA; 1,634 community members participated in a local health challenge and lost approximately 7,100 pounds; 8 schools hosted a mobile dental clinic and 727 children received comprehensive dental care; 7 new staff were trained as a car seat technician and 905 car seats were checked since the new members were trained; 325 students were trained as peer mentors and approximately 5600 students had been reached via different educational approaches about the consequences of risky behaviors.

Potential for Replication

The Healthy Teeth, Healthy Kids I would consider a best practice model.

After the Grant

The Health Challenge, Healthy Teeth Healthy Kids program, and Peer Health Education program will continue. During our second year, we partnered with a state run health challenge program. This allowed us to streamline our process. Because of the success of the program we have received financial support from business to provide funding and door prizes for the challenge. For Healthy Teeth Healthy Kids we were able to secure state prevention dollars for the program and are seeking funds from local community leaders to sustain the program. We have had a good response and believe we will receive the funding needed to continue the program for another three years. The Peer Health Education program will be sustained and expanded through a SAMSHA Drug Free Communities Grant that was received, The Manitowoc County Car Seat Passenger program will have one of the seven technicians trained continue in his service. The others who were trained will not be recertified, because of schedule conflicts or increased workloads. Plus funding for the program from the state is also in question due to the economic times.

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Community Characteristics

The consortium Alliance for Hispanic Outreach and Regional Awareness (AHORA) is a coalition formed in September 2003 to assemble service providers for discussion on regional strengths and weaknesses in meeting the needs of the rapidly growing Hispanic community in central Wisconsin. AHORA includes representatives from the counties of Clark, Lincoln, Marathon, Portage, and Wood. It currently has representatives from 72 medical and service providers, non-profit organizations, faith-based groups, Hispanic/Latino service providers and community volunteers both Hispanic/Latino and non-Hispanic. Local service providers were challenged with meeting the needs of Hispanic/Latino immigrants, many of whom do not qualify for traditional resource programs.

Services Offered

- Providing health information and referral assistance through a bilingual toll free telephone help line connecting the Spanish speaking community to local resources.
- Providing a bilingual home visitation program following the *Promotora Model*, providing a health prevention curriculum and addressing individual unique support needs.
- Train bilingual Competent Professional Authority (CPA) nutrition educators to increase the capacity of regional Women, Infant and Children Programs (WIC) to serve the Hispanic community.
- Provide occupational health and safety information to Hispanic workers and their employers.
- Develop a coordinated system to assess needs and identify priorities for future systems and quality service development.

Innovative Solutions to Problems

Lack of Hispanic/Latino community leadership has proven to be a major obstacle in addressing the needs in this community. Several factors influence this population:

- Central Wisconsin has seen a dramatic increase in this population in the past 10 years.
- Census figures are inaccurate do to the rapid rise in immigration which influences funding services for this population.
- Immigrants are no longer migrating through the area but are finding permanent employment.
- Primarily migratory males farm workers in the past, current trends with stable employment opportunities have families joining their spouses, increasing the need for Spanish services for women and children.
- The immigrant population is illiterate even in their native Spanish.
- The Hispanic/Latino immigrants are coming from many countries and do not hold a common history, culture, or language dialects and there is no inherent trust between these groups.

Results

Evaluation and Outcomes: The overarching goal of our grant to reduce health disparities in the Latino/Hispanic population in a four county area in Central Wisconsin by increasing access to health care, providing health information and education, increasing direct health care services, improving occupational health and safety and developing community capacity and infrastructure to deliver culturally competent health care services. The focus of this grant was holistic, preventative and proactive; building

the capacity of individuals to care for their health and strengthening the target area's ability to serve the Hispanic population.

Describe the Consortium's Functions: The consortium's ability to function was key to the success of our grant project. Monthly meetings and constant communication via email made it easy to implement and maintain a project of this size without a coordinator or director despite the large geographic area served. All steering committee members, their supporting agency in kind contributions, and overall commitment was instrumental in achieving the grant goals and intended outcomes.

Barriers Not Resolved: There were three unresolved barriers related to building community trust and leadership during the course of the grant project. These were influenced by the vast cultural differences in heritage, isolated rural populations and the political climate surrounding undocumented immigrants.

Describe Any Successful Recognition: Due to the sensitive political nature of working with undocumented populations, especially with government funded agencies, discretion had to be shown when promoting grant activities and events.

Potential for Replication

Grant outcomes demonstrated the "*Promotora*" or healthcare navigator model, previously successful in migrant camps or neighborhood settings, worked well in rural settings with dispersed populations. Another key piece to replication would be community resource agencies internally prepared to meet the needs of a new culturally and linguistically diverse population. Given committed consortium partnerships and available community resources we do think the methods used in our outreach grant would be able to be replicated in other rural settings with similar populations.

Yes, we do consider ourselves a best practice model. We took on a large geographic area with a rapidly growing, predominantly undocumented, non-English speaking population as our target audience. We had over 70 agencies involved with the grant and coordinated the grant without a paid director or management position.

Despite the strong negative political climate around this population in Wisconsin as well as the nation, during this grant cycle, we were able to document sufficient need and impact so that all the positions hired or projects started through the grant were sustained after federal funding ended.

After the Grant

Yes, we are proud to say that ALL positions hired or projects started as a result of this grant funding will continue in some form.

From the beginning of the grant cycle all partnering agencies worked diligently to increase agency awareness of the importance of the programming being initiated with the grant funding. Throughout the three year grant cycle, community partners, agencies and county government have learned to appreciate the value and return on investment gained through outcomes achieved. Outside funding and support through those agencies began to trickle in and systemic changes took place. The grant allowed us to show a need and ways to address those needs. At the end of the grant cycle all agencies involved had agreed to continue their programming efforts started by the grant through their internal or other funding sources.

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