

Delta States Rural Development Network Program Sourcebook

August 2023



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Introduction

The purpose of the Delta States Rural Development Network Grant Program is to fund organizations located in the eight Delta States (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee) to address unmet local health care needs and prevalent health disparities through the development of new and innovative projects. Due to the vast geographic reach of the Delta States service area, programs must partner and collaborate to implement their initiatives.

The Delta States grant program promotes collaborative efforts among rural providers, as many of these disparities could not be solved by single entities working alone. Grantees were funded to implement programs with a primary focus on diabetes, cardiovascular disease, obesity, acute ischemic stroke, or HIV/AIDS. Grantees can select no more than two of the focus areas. Programs will address the delivery of preventive clinical health services in their multicounty/multiparish region. Chronic disease initiatives can be in programs focused on prevention, self-management, care coordination, or clinical care, but must be outcomes oriented. The funded programs include activities focused on producing changes in one or more of the following areas:

- Knowledge and understanding
- Attitudes of consumers
- Behaviors of consumers
- Clinical biometrics (e.g., body mass index, weight, A1c, blood pressure)
- Policies and procedures
- Systems (i.e., improved coordination among health and social service agencies)

In addition to the required key focus areas, grantees were permitted to devote a percentage of grant funds toward another issue that may be of need in the service area. This other issue area may or may not be clinically focused and may include areas such as pharmacy assistance, electronic health record management (with funds supporting the enhancement of systems already in place), oral health, cancer screening, women's health, and so on.

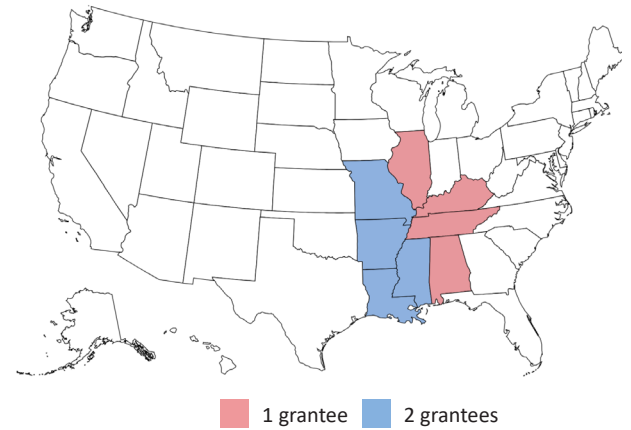
This *Sourcebook* provides a summary of the 12 Delta States Rural Development Network grantees funded during the 2020-2023 grant period. Following the introduction, cohort snapshot, and a summary of key project impacts, the reader will find profiles for each of the 12 funded projects. The reader may search grantee information by grant organizational type and by grant focus area(s).

The Delta States programs addressed the delivery of preventative clinical health services in their multicounty/multiparish region. The chronic disease initiatives focused on prevention, self management, care coordination, or clinical care.

Cohort Snapshot

Reach of Program

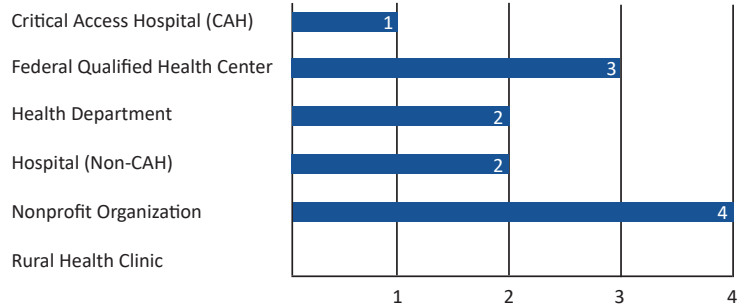
During the 2020-2023 funding period, the Federal Office of Rural Health Policy funded 12 rural health entities across eight states and 194 counties/parishes with \$662,644 to \$1,188,684 per year to implement their Delta States programs.



Funded Entities

The 2020-2023 cohort consisted of lead agencies representing a cross section of rural health care providers. Several agencies partnered with other provider agencies, health and human service entities, and local government agencies, like health departments, to implement funded Delta States initiatives.

Grantee Lead Agencies



Targeted Measures

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

Common outcomes included:

- Expansion of programs into new areas.
- Implementation of new programs.
- Increased patient referrals, access to care, and health insurance enrollment.
- Increased services to youth in school and national recognition for programs.
- Increased membership and strengthened networks.
- Increased workforce capacity through training and professional development.
- Decreases in body mass index, A1c, and blood pressure levels.

Impacts Achieved

Over the three-year grant period, Delta States grantees implemented a range of initiatives aimed at improving and expanding access to preventive and quality care using evidence-based or promising practices to guide their work. Despite the COVID-19 pandemic starting eight months after the grant began, grantees were able to achieve some sustained impacts. The funding provided through the 2020-2023 grant program resulted in improved chronic disease management through better coordination of care and support across health and nonhealth agencies and increased workforce capacity through trainings and professional development, and this improved quality of care and patient outcomes. Some of the key impacts achieved are described below.

Improving Chronic Disease Management

Grantees strengthened clinical service delivery and improved care for patients with chronic diseases including diabetes and cardiovascular disease. Delta States programs such as remote patient monitoring programs, social determinants of health screenings, and health coaching/community health worker programs provided structure to the delivery of clinical care and ensured that patients were receiving necessary educational, navigational, and other supports to remain engaged in their own care. Impacts included:



- Improved knowledge, skills, attitudes, and health behaviors.
- Enhanced patient self-efficacy and engagement in managing their own care.
- Lower health care spending due to reduced hospitalization.

Building Workforce Capacity

Grantees provided training (continuing education via distance learning and in person) and other professional development. This resulted in:



- Establishment of community health worker training sites.
- Improved and holistic care for patients.
- Expanded access and opportunities for professionals (e.g., nurses, teachers) that would otherwise not receive specialized trainings.

Grantee Organization Type

Grantee Organization	Critical Access Hospital (CAH)	Federally Qualified Health Center	Health Department	Hospital (non-CAH)	Nonprofit Organization	Rural Health Clinic	School
ARcare		•					
Arkansas Rural Health Partnership					•		
Baptist Health Madisonville				•			
Big Springs Medical Association		•					
Delta Health Alliance					•		
Egyptian Public & Mental Health Department			•				
Health Enrichment Network					•		
Jefferson Comprehensive Health Center		•					
Mississippi County			•				
Paris-Henry County Health Care Foundation				•			
Richland Parish	•						
Rural Alabama Prevention Center					•		

Grantee Profiles by Grant Focus Area

Focus Area	ARcare	Arkansas Rural Health Partnership	Baptist Health Madisonville	Big Springs Medical Association	Delta Health Alliance	Egyptian Public & Mental Health Department	Health Enrichment Network	Jefferson Comprehensive Health Center	Mississippi County	Paris-Henry County Health Care Foundation	Richland Parish	Rural Alabama Prevention Center
Behavioral/Mental Health				•			•		•	•		•
Cancer Care Management												
Cardiovascular Disease Care Management									•			•
Case Management										•		•
Chronic Disease Management	•	•		•	•		•		•	•		•
Chronic Obstructive Pulmonary Disease (COPD) Prevention												
COPD Treatment and Management												
Community-Based Care Coordination				•	•				•	•		•
Diabetes Care Management				•				•	•	•		•
Health Education/Promotion and Disease Prevention		•	•	•		•	•	•	•	•	•	•
Health Improvement Special Project												
Health Screenings					•			•	•	•	•	•
HIV/AIDS												
Maternal and Child Health				•								
Oral Health				•			•					
Pediatric Care				•						•		
Pharmacy Assistance		•		•				•	•	•		
Primary Care Services		•		•					•			
Population Health		•							•			
School-Based Care Coordination							•					
Telehealth/Telemedicine		•								•		
Transitions of Care												
Women's Health				•								

Other Focus Areas

Grantee Organization	Community Health Worker Services	COVID Education, Testing, and Vaccinations	Health Workforce Education	Medication Optimization	Obesity Prevention	Prescription Drug Assistance	Workforce Development
ARcare							
Arkansas Rural Health Partnership			•				
Baptist Health Madisonville							
Big Springs Medical Association							
Delta Health Alliance							
Egyptian Public & Mental Health Department					•		•
Health Enrichment Network							
Jefferson Comprehensive Health Center							
Mississippi County	•			•		•	
Paris-Henry County Health Care Foundation							
Richland Parish							
Rural Alabama Prevention Center	•						

Grantee Profiles

The following section contains contact information and brief descriptions of the 12 Delta States program grantees funded during the 2020-2023 grant period. These descriptions may include areas served, target population, project goals, and key activities for project and program implementation, including the evidenced-based or promising practices utilized, key outcomes and impacts, sustained impacts, lessons learned, and implications for other communities.

ARcare

Focus areas:
Chronic Disease Management

Federally Qualified Health Center

D60RH36758

Target Population and Needs Addressed

The target population for this project was adults aged 50-74 with cardiovascular disease or obesity-related health issues. Community needs assessments were conducted by local/regional hospitals, which allowed the members of the coalition to determine the needs to be addressed through this funding opportunity: cardiovascular disease and obesity, and behavioral/mental health (a secondary focus).

Area Served

Arkansas Service Region B: Baxter, Clay, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Marion, Mississippi, Poinsett (only rural areas of the county), Prairie, Randolph, Searcy, Sharp, Stone, Van Buren, White, and Woodruff counties.

Project Goals

Goal 1: Maintain and strengthen the Arkansas Health Improvement Coalition initiatives through increased marketing and community awareness/education opportunities to develop a sustainable service within Arkansas Service Region B.

Objective 1.1 — Within six months of receiving the notice of award, the coalition will develop a communication and outreach plan and a logo for the Health in Action Program.

Objective 1.2 — By the end of Year 3, the coalition will develop a plan for long-term sustainability.

Goal 2: Improve care coordination methods among health care and social service providers within Arkansas Service Region B.

Objective 2.1 — By the end of the three-year project, increase access to evidence-based model programs that focus on cardiovascular disease, obesity, and mental/behavioral health issues for the population aged 50-74 residing in the proposed service area.

Goal 3: To increase behavioral/mental health training and educational opportunities for health care and other professionals within Arkansas Service Region B resulting in improved holistic and coordinated care for patients.

Objective 3.1 — By the end of Year 3, reach 250 health care and other professionals through behavioral health training and education, resource development, and service delivery collaboration.

Network Partners

Partners included 1st Choice Healthcare Inc., Boston Mountain Rural Health Care Inc., Unity Health, White River Medical Center, and Crowley's Ridge Development Center Inc.

Evidence-based Model or Promising Practice

Evidence-based models/promising practices for the project included:

1. Remote Patient Monitoring — a subcategory of homecare telehealth that allows patients to use mobile medical devices and technology to gather patient-generated health data and send it to health care professionals.
2. Transition of Care Management — a service in which, after a patient is discharged from hospital, registered nurses contact patients within 48 business hours of discharge to provide a medication review and ensure the patient is scheduled for and attends their follow-up visit with their provider to ensure there are no gaps in care.
3. Medication Therapy Management — range of services provided to individual patients conducted by a clinical pharmacist to optimize therapeutic outcomes (help patients get the most benefit from their medications) and detect and prevent costly medication problems.
4. Social Determinants of Health Assessments — integrate PRAPARE (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) screening tool within an electronic medical record to collect information from patients.

Services and Activities

Activities included:

1. Developing a communication and outreach plan that includes a new logo for the coalition.
2. Creating a long-term sustainability plan for the coalition.
3. Implementing remote patient monitoring, transitional care management, and medication therapy management.
4. Expanding preventive care visits and annual wellness visits for this population, and
5. Implementing a social determinants of health assessment tool.

Outcomes

The first two years of the project were extremely difficult. COVID-19 put a halt to coalition meetings and training for providers, staff, and partners, and all partners were focused on providing COVID-19 care to their patients and clients. Hospitals and the Federally Qualified Health Center (FQHC) partners had staff shortages,

and all clinical staff that were available were exhausted and burnt out. Social service agencies were seeing a significant increase in people requesting assistance for utilities, mortgage and rental assistance, food, and everyday necessities due to the closing of businesses and people losing their jobs. Due to COVID-19, the outcomes were not as projected. However, there were some highlights from the project. These included completion of a communication and outreach plan for the coalition, logo created for the coalition, sustainability plan completion, medication therapy management provided to 479 patients, remote patient monitoring implementation at two FQHCs, four hospitals utilizing transitional care management with the FQHCs, and two partners starting to collect social determinants of health data.

Sustained Impacts

Sustained impacts for the three-year project included implementing, expanding, and enhancing specific services related to cardiovascular disease, obesity, and mental health. These services have had a significant impact on many patients and if continued, can make a lifelong impact on their quality of life.

The services implemented through this project have allowed patients to remain in their homes (at a time when it wasn't safe to leave) but still receive the quality care they need. The nurses and staff that led and worked on the remote patient monitoring (RPM) and targeted case management programs were the true heroes. They showed up for these patients to ensure their blood pressure was under control, that they attended their appointments, that they understood health status, and simply to listen to the patients' needs.

Crowley's Ridge Development Center implemented monthly Community Set Up Days within the counties of Arkansas Service Region B that they serve. Coalition partners are invited to attend, along with other community organizations and agencies, to provide program and service information to families and individuals in each community. Partners are also allowed to set up a place to conduct blood pressure and HbA1c checks, diabetic eye and foot exams, COVID-19 tests, and vaccinations.

Lessons Learned and Considerations for Program Replication

The most significant lesson learned was implementing RPM for the patient population. It is critical that the vendor selected can demonstrate how the software is integrated into an electronic medical record system and how data collection is executed. This was a major challenge for the coalition members. In addition, the program would need to determine whether RPM is a cost-effective service to offer patients. The reimbursement rate for RPM alone for FQHCs is not optimal. A program would need to combine it with other services to ensure the program can receive the maximum reimbursement. These aforementioned factors should be considered before attempting to replicate the program.

Grantee Contact Information

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Arkansas Rural Health Partnership

Nonprofit Public Organization

D60RH36759

Focus areas:

Chronic Disease Management, Health Education/Promotion and Disease Prevention, Health Workforce Education, Pharmacy Assistance, Primary Care Services, Population Health, Telehealth/Telemedicine

Target Population and Needs Addressed

The project addressed providing the primary target population, adults (aged 18-64 years) diagnosed with a cardiovascular disease and/or diabetes at one of 15 partner primary care clinics (more than 1,500 patients per year) with patient assistance, navigation, and access to telehealth services. The secondary target population, the health workforce in participating health care organizations (approximately 6,700 health workforce per year), received access to training, certification, education, and linkage to resources to better serve their patients (primary target population).

Primary consortium/network partners included all member Arkansas Rural Health Partnership (ARHP) health care organizations including eight Critical Access Hospitals (DeWitt Hospital and Nursing Home, Ashley County Medical Center, Bradley County Medical Center, Chicot Memorial Medical Center, Dallas County Medical Center, Delta Memorial Hospital, McGehee Hospital, and Medical Center of South Arkansas); five acute care hospitals (Baptist Health Medical Center, Drew Memorial Health System, Jefferson Regional Medical Center, Helena Regional Medical Center, and Ouachita County Medical Center); two Federally Qualified Health Centers (Mainline Health Systems and Mid Delta Health Systems).

Area Served

The project served 18 counties in the Arkansas Delta Region A: Arkansas, Ashley, Bradley, Calhoun, Chicot, Dallas, Desha, Drew, Grant, Jefferson, Lee, Lincoln, Lonoke, Monroe, Ouachita, Phillips, St. Francis, and Union.

Project Goals

The ARHP Delta Cares project goals included (1) strengthening the organizational and infrastructural capacity of hospitals and primary care clinic partners to improve the quality of care and (2) addressing social determinants of health through patient assistance, navigation, and telehealth resources to improve the delivery of preventive and clinical health services for patients with chronic disease in the Arkansas Delta region by 2023.

Network Partners

Arkansas Rural Health Partnership (ARHP) health care organizations including eight Critical Access Hospitals (DeWitt Hospital and Nursing Home, Ashley County Medical Center, Bradley County Medical Center, Chicot Memorial Medical Center, Dallas County Medical Center, Delta Memorial Hospital, McGehee Hospital, and Medical Center of South Arkansas); five acute care hospitals (Baptist Health Medical Center, Drew Memorial Health System, Jefferson Regional Medical Center, Helena Regional Medical Center, and Ouachita County Medical Center); two Federally Qualified Health Centers (Mainline Health Systems and Mid Delta Health Systems).

Evidence-based Model or Promising Practice

Evidenced-based models/promising practices included (1) The Community Organizer and Capacity Builder Model, which focuses on the skills and roles of a community health worker including the ability to provide support to individuals and communities by identifying and prioritizing needs, using available resources by offering information and support, providing advocacy services, collaborating with community partners, and building coalitions; and (2) the Simulation-Based Healthcare Education (Simulation-Based Mastery Learning) model, which teaches cognitive, psychomotor, and affective skills to individuals and teams to improve skills for all participants leading to skill retention. This model has proven to be very successful in health care provider and worker training and allows for practiced skills.

Services and Activities

The services and activities during the project period included the following:

- Provided health workforce training (virtually and on-site) to health care providers in participating hospitals and clinics.
- Evaluated the benefit of transitioning to value-based payment programs for member organizations.
- Promoted the availability of remote patient monitoring devices for chronic disease patients to health care providers in the primary care setting.
- Conducted telehealth assessments and billing/coding education for telehealth and remote patient monitoring services for patients with chronic disease.
- Provided patient and community assistance services (insurance enrollment, prescription assistance, housing assistance, food assistance, and patient navigation) via certified community health workers.
- Expanded communications and marketing of available health resources to residents (health care resource directory, website, social media campaigns, and community presentations).
- Promoted available jobs and workforce initiatives for health care careers in Arkansas Delta.
- Developed organizational capacity to increase efforts to improve the stability of rural hospitals.
- Formalized a certified community health worker training program.
- Organized and facilitated 16 professional roundtables for leadership in participating health care organizations.

Outcomes

Project outcomes included:

1. Health Care Provider Education: (1) Over 25,000 distance-learning modules were completed by participating health care organizational workforce, (2) over 2,800 total continuing education units (CEUs) were awarded, (3) over 1,600 in-person certifications were awarded, and (4) the ARHP educator provided training (Advanced Cardiovascular Life Support (ACLS), Basic Life Support (BLS), Heart Saver, Pediatric Advanced Life Support (PALS), and Stop the Bleed) to over 1,600 health care workers in the service area.
2. Hospital/Clinic Infrastructure Training and Support: (1) There were 14 telehealth assessments conducted with member hospitals and 11 conducted with rural health clinics to determine their capabilities and greatest needs; (2) 11 Critical Access Hospitals (CAHs) were educated on and assisted with implementing Pulsara, a communication network and mobile app that helps facilitate and streamline care coordination across interorganizational care teams; (3) all participating hospitals were educated on the value of the National Health Service Corp. (NHSC) Loan Repayment Program (five CAHs) and two Federally Qualified Health Centers (FQHCs) are official NHSC sites; (4) 11 hospitals, two FQHCs, and 84 clinics were provided with telehealth/distance learning support; and (5) over 95 professional roundtable discussions were held (with 280 attendees) throughout the duration of the project.
3. Patient and Community Assistance Services: (1) Over 1,900 individuals were enrolled in insurance (Medicaid, Marketplace, or Medicare), (2) over 160 individuals assisted with rent, (3) over 420 social determinants of health screenings were performed, (4) approximately 75 Medicare trainings were conducted, (5) over 7,600 individuals were educated on community health worker (CHW) assistance, (6) over 600 community health needs assessment surveys were completed by assisters, (7) over 1,700 individuals were assisted with prescription needs with a cost savings of approximately \$3.5 million, and (8) over 45 community events were held.
4. Health Care Workforce Recruitment/Education: (1) Over 4,000 individuals were educated on rural health care opportunities, and (2) ARHP participated in over 66 workforce education events.
5. Organizational Capacity: (1) ARHP grew its membership over the grant period to include three additional hospitals and three FQHCs, (2) ARHP hosted an annual strategic planning meeting and was able to accomplish all annual goals each year, and (3) ARHP doubled its annual budget over the grant period.

Sustained Impacts

Sustained impacts that will continue beyond the project period include these:

- Upon completion of the project, ARHP will be fully certified as an approved Arkansas CHW training program. Having the ability to provide approved, standardized CHW training will allow ARHP to continue to expand training to hospital and clinic personnel.
- The project provided access to the University Arkansas Medical School (UAMS) Learn on Demand distance-learning platform, which will continue to provide distance learning, compliance training, and an opportunity for continuing education opportunities at no cost to 16 health care organizations and more than 4,400 health care providers and workers, with an estimated cost savings valued at \$100,000 a year.
- ARHP has a contract with the Arkansas Insurance Department that will provide funding to assist with counseling and enrolling qualifying individuals for Medicare.
- Partnering health care organizations will be engaging in value-based payment programs with the support of infrastructure in place to assist these organizations with their success.
- ARHP partnership continues to grow and expand and now includes 17 hospitals, two FQHCs, and three medical school partners. ARHP continues to provide its members with valuable resources.

- Professional roundtable discussion led to collaborative contracting, member partnerships, and additional ARHP projects.

Lessons Learned and Considerations for Program Replication

Considerations for program replication include these:

- Spend time and effort understanding the needs of the rural partners. Rural hospitals, specifically, are experiencing financial difficulties and transition more than ever. Trying to engage these organizations without providing them with all the necessary resources is futile. Rural hospitals are looking for partners that can support them with programs that address their bottom line and do not require much effort on current staff and expense on their part. Rural hospitals do not have these resources and are focused on trying to survive. Spending time to understand how to assist these organizations and including their staff and leadership (even board of directors) can ensure value and success.
- Collaborate and do not replicate. There is enough work to be done to improve health disparities, especially in the Arkansas Delta. Research and learn what is currently available, and reach out to organizations that are already doing the work that is needed by organizations/members that you are serving through the project. University partners can be extremely beneficial partners with resources that are often not available in rural communities. Spend time gathering available resources, and if it exists, offer to promote it. If it doesn't exist, then you know where your next move needs to be.

Grantee Contact Information

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Baptist Health Madisonville Inc.

Hospital (non-Critical Access Hospital)

D60RH36760

Focus areas:
Health Education/Promotion
and Disease Prevention

Target Population and Needs Addressed

The target population included over 65,000 students and over 9,500 teachers throughout 25 school districts that include approximately 130 public elementary, middle, and high schools in Kentucky's 20 rural Mississippi Delta region counties. The Baptist Health School Wellness Initiative (BHSWI) was designed to address the obesity epidemic in western Kentucky through creating a culture of wellness in service area schools.

Area Served

Ballard, Caldwell, Calloway, Carlisle, Christian, Crittenden, Fulton, Graves, Hickman, Hopkins, Livingston, Lyon, Marshall, McCracken, McLean, Muhlenberg, Todd, Trigg, Union, and Webster counties.

Project Goals

The goal of BHSWI was to enhance the culture of wellness in service area schools by involving school staff, students, parents, and community organizations. The initiative was designed to be an anti-obesity wellness promotion program. The initiative has served, to date, Western Kentucky's 20 rural Mississippi Delta region counties and aided public service area school districts, and elementary, middle, and high schools with:

- Establishing sustainable school wellness leadership groups to assess and address health and wellness needs.
- Retention of classroom-based physical activity beyond required physical education.
- Providing professional development training for school staff.
- Healthy lifestyle activities and presentations for students and residents.

Network Partners

Primary partners were a wellness promotion network/consortium comprised of lead agency Baptist Health Deaconess Madisonville Inc., formerly Baptist Health Madisonville Inc. (health care agency in Kentucky); the Alliance for a Healthier Generation (health promotion program in Oregon); and the West Area Health Education Center (West AHEC; health promotion program in Kentucky).

Evidence-based Model or Promising Practice

The BHSWI school leadership group framework is modeled from the Alliance for a Healthier Generation's Healthy Schools Program Framework, and the coordinated school health program promising practice model was "to assist installation of sustainable school wellness leadership groups to assess and address health and wellness issues." The BHSWI also utilized GoNoodle® sponsorships to service area elementary schools. GoNoodle® is a suite of online movement-based videos and games designed to bring movement and mindfulness into elementary classrooms and homes to get kids moving. Middle and high school wellness leadership groups were assisted in working with principals and staff to ensure students receive the opportunity for 60 daily physical activity minutes (best practice) and incorporate age-appropriate school and classroom physical activity programming such as such as classroom movement breaks and physical activity clubs.

Services and Activities

Activities focused on a school wellness leadership group framework. Participating elementary, middle, and high schools were assisted with wellness leadership group development, activity assessment, action planning to address issues, action plans and implementation of plans, as well as anti-obesity programming retention. Schools utilized the Alliance for a Healthier Generation's Healthy Schools Program, an online wellness committee development tool, and Thriving Schools Integrated Assessment online school wellness apparatus. Wellness leadership groups involved a minimum of six members from school administration, school staff, students, parents, and community organizations. Each was required to meet bi-monthly, four times per year; assess wellness activities annually; develop an action plan to address issues, implement activities, submit health and wellness data, apply for Alliance for a Healthier Generation national recognition program; and, last, hold school-based physical activities beyond required health and physical education standards. In addition to these activities, the project hosted school staff professional development and community wellness presentations.

Outcomes

Outcomes as of March 31, 2023 (when this reporting was due):

1. To verify involvement and promote sustainability, written support was obtained for all 25 school districts covering all 130 service area schools.
2. One hundred twenty-three schools participated.
3. There were 25 school district presentations with 298 attendees.
4. Project specialists completed 5,922 school contacts, with 7,520 total attendees.
5. One hundred twenty-six schools utilized GoNoodle® or similar programming (e.g., TAKE 10!®, Brain Breaks, Movement Breaks, Spark, etc.) in academic classrooms beyond required health and physical education (73 elementary, 28 middle, 25 high).
6. Total GoNoodle® student activity minutes: 12,262,322 by 140,392 students.
7. GoNoodle® average video completed rate: 71%.
8. There were 42 attendees at annual professional development events in Year 3, held Oct. 18 and Nov. 4, 2022. Events were canceled years 1 and 2 due to the COVID-19.
9. Five hundred five consortium contacts were held discussing current programming, improvement strategy, and future plans to assist school wellness policy and staff wellness.

10. Forty-one wellness leadership group meetings drew 253 attendees, and 1,450 sets of meeting minutes were submitted.
11. One hundred thirty service-area schools have formed wellness leadership groups and completed Healthy Schools assessments, Thriving Schools Integrated Assessments, and action plans to address issues. Fifty-one schools were awarded National Healthy Schools Award recognition (31 elementary, eight middle, and 12 high). The project was retitled the Healthier Generation Award for 2021-2022, and seven schools received designations (six elementary, and one high). It was rebranded the America's Healthiest Schools Award in 2022-2023, and there were 107 submissions (62 elementary, 23 middle, 22 high).
12. There were 1,913 activities initiated or renewed by wellness leadership groups.
13. Project specialists conducted or attended seven other school-based events with 1,156 attendees: 25 community events with 2,861 attendees.
14. For meeting participation requirements, \$880,000 was granted across 238 incentives to 130 schools.

Sustained Impacts

School Wellness Leadership Groups: Groups were developed through the Baptist Health School Wellness Initiative are designed to be sustainable and positioned for continuance. Groups trained to update rosters as needed, retain school and classroom physical activity opportunities, and utilize the online Healthy Schools Program for annual required Kentucky Department of Education wellness reporting.

GoNoodle®: GoNoodle® sponsorships were purchased for participating elementary schools. Teachers are equipped to continue GoNoodle® usage, as no training is required. Beyond grant funding for annual sponsorships, basic GoNoodle® online classroom physical activity video suite is available to schools free of charge.

School Wellness Policy: Though not an initiative objective, school wellness policy improvement strategy and model templates received from the Kentucky Department of Education, along with policy review, were provided to service-area schools. Assistance strengthened schools' policy efforts to follow state alignment standards and to be realistic, feasible, and structured guidance models for sustained wellness activity, opportunities, and integration into school culture

Lessons Learned and Considerations for Program Replication

Meeting Flexibility: The COVID-19 pandemic drastically shifted access to schools. Due to the contagious nature of the virus, schools removed access to their facilities beyond essential personnel. Schools enacted nontraditional instruction for students via virtual learning. When traditional classes resumed, access was limited to essential school staff and partners. To assist and support wellness activities and wellness leadership groups, project staff had to shift to support via telephone or electronically; this was a new way to work with schools. COVID restraints led project staff to suspend plans to require schools to submit annual wellness recognition applications with evidence to verify activity. The initiative shifted to having schools submit wellness policies to verify some form of wellness activity guidelines. A need to assist school wellness policy was discovered, as many policies were outdated. All are required to be adopted, reviewed, amended, or modified within every three school years; 124 policies were reviewed. Staff utilized policy guides from the Kentucky Department of Education to assist review with plans to continue and expand in future funding cycles

Grantee Contact Information

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Big Springs Medical Association Inc.

Federally Qualified Health Center

D60RH25755

Focus areas:

Behavioral/Mental Health, Chronic Disease Management, Community-Based Care Coordination, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Maternal and Child Health, Oral Health, Pediatric Care, Pharmacy Assistance, Primary Care Services, Women's Health

Target Population and Needs Addressed

Infants, preschool children, school-age children—elementary, school-age children—teens, adults, the elderly, pregnant women, African Americans, Caucasians, Latinos, native Americans, those needing patient prescription services, the underinsured, and the uninsured.

Area Served

Missouri Service Region A: Butler, Carter, Crawford, Dent, Douglas, Howell, Iron, Oregon, Ozark, Phelps, Reynolds, Ripley, Shannon, Texas, Wayne, and Wright counties.

Project Goals

Goal 1: Improve health outcomes for persons at risk of, or diagnosed with, diabetes in Missouri Delta Service Region A.

Goal 2: Improve women's health and prenatal outcomes in Missouri Delta Service Region A.

Goal 3: Improve network collaboration, communication, action planning, and sustainability.

Network Partners

Butler County Health Department, Reynolds County Health Center, Carter County Health Center, Ripley County Health Department, Douglas County Health Department, Shannon County Health Center, Howell County Health Department, Texas County Health Department, Iron County Health Department, Wayne County Health Center, Oregon County Health Department, Wright County Health Department, Ozark County Health Department, Whole Health Outreach, Parkland HealthMart, and Whole Kids Outreach.

Evidence-based Model or Promising Practice

Chronic Disease Self-Management: Chronic disease self-management was used to address high-risk patients with diabetes. Community health workers were deployed throughout the region and provided supportive services to improve health outcomes. Telehealth and Show-Me ECHO: Via Show-Me ECHO, Missouri Highlands Healthcare (MHHC) providers had access to endocrinology and obstetric/gynecological specialists. PRAPARE (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) tool: PRAPARE is a social determinants of health (SDOH) screening tool. And Prevent T2 Curriculum: Health department network partners utilized this evidence-based curriculum to educate and engage residents in lifestyle modifications.

Services and Activities

Activities included:

- Outreach and education to promote healthier lifestyle.
- More effective communication among consortium partners.
- The establishment of hospital partnerships and care coordination of pregnant patients.
- The provision of prenatal care services on site at MHHC clinics.
- The provision of age-appropriate women's health screenings and services (e.g., cervical and breast cancer).
- Increased access to primary, behavioral health, and nutritional services.
- Increased access to obtaining SDOH needs and resources.
- Effective diabetic monitoring strategies and methods were identified, and the region's access to service delivery was expanded.

Outcomes

- There was improved health for persons at risk of, or diagnosed with, diabetes in Missouri Delta Service Region A. As part of the CDC's Prevent T2 curriculum, nine of 20 participants had a significant reduction in A1c, four participants tested the same, while three had a higher A1c post the program. These results have inspired the four participating public health departments to initiate a new round of educational programs including a six-month follow-up testing on participants.
- There were improved women's health and prenatal care outcomes in Missouri Delta Service Region A. Strategies for this goal included improving access to gynecological and obstetric care and improving women's health preventive screening services.
- There was improved network collaboration, communication, action planning, and sustainability. Strategies for this goal include engaging network partners in focused initiatives for improvement.

Sustained Impacts

Care Coordination: Community health workers will continue to identify patients' SDOH needs by utilizing PRAPARE tool.

Diabetes Education and Monitoring: Adults who are at risk of diabetes, who have been diagnosed as prediabetic, or have diabetes diagnoses will be connected with affordable A1c screening services at MHHC.

Women's Health Services: Prenatal care services will continue to be provided on site at MHHC clinics. Clinical and community outreach staff will continue to provide outreach and education regarding women's health services.

Lessons Learned and Considerations for Program Replication

There are many challenges in engaging underfunded rural public health partners in collaboration with many unfunded mandates. It is always an issue in working with rural public health and human service partners. This will be a continued challenge until a reasonable and equitable funding approach is adopted for rural public health nationally. The resources an outside grant can provide as incentive to collaborate require finding best practice opportunities that can fit within the current realm of existing mandates. The focus on public health's role in health literacy and health education is an example of how the Delta Project has approached this challenge to impact those with diabetes. The significant role the community health worker movement can contribute to population health improvement is another opportunity for program replication. Applying the SDOH and a population focus has created opportunities to engage the human services element throughout the region through care coordination functions, an asset to aiding population health access to services and coverage.

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Delta Health Alliance Inc.

Nonprofit Organization

D60RH36762

Focus areas:

Chronic Disease Management,
Community-Based Care Coordination,
Health Screenings

Target Population and Needs Addressed

The Delta Stroke Initiative served a population of nearly a half-million people, 27.8% of whom live in poverty, and 51.6% of whom are African American. In a state that is often ranked last in the nation for many economic and education factors, this 18-county area of Mississippi stands out as having significantly worse outcomes than state and national averages. One in five adults do not have functional basic literacy skills, making it difficult for patients to understand complicated health care advice or medication instructions. In 2016, stroke was the sixth-leading cause of death in Mississippi, and the statewide death rate is 1.4 times greater than the national rate.

Area Served

Eighteen rural counties in Mississippi: Attala, Bolivar, Carroll, Coahoma, Grenada, Holmes, Lafayette, Leflore, Montgomery, Panola, Quitman, Sunflower, Tallahatchie, Tippah, Tunica, Union, Washington, and Yalobusha.

Project Goals

The goal of the Delta Stroke Initiative was to provide stroke education and prevention through a series of coordinated activities designed to dramatically improve residents' outcomes by improving care coordination post-discharge for patients diagnosed with ischemic stroke in our 18-county rural region. It emphasizes care transitions with a focus on preventing stroke recurrence. Hospitalization may serve as a wake-up call for an individual who has suffered a stroke, but if they do not receive appropriate post-discharge follow-up care, patient education, empowerment training upon returning to their community, and family caregiver support, they often soon end up back in the hospital.

Network Partners

Primary project partners include a hospital consortium comprising following organizations in Mississippi:

- Baptist Memorial Hospital–North Mississippi — hospital
- Bolivar Medical Center — hospital
- Delta Health Alliance — fiscal agent, nonprofit organization
- Social Services Collaborative (provides patients with services such as transportation access and enrollment in programs such as the Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families — nonprofit organization
- Leland Medical Clinic — Federally Qualified Health Center

Evidence-based Model or Promising Practice

Two evidence-based models have been utilized to achieve this purpose, including (1) the community health worker model promoted by the Office of Rural Health Policy and (2) Dr. Eric Coleman’s Care Transitions model for improved care coordination.

Services and Activities

The Delta Stroke Initiative consisted of a network of local partners. The success of the project involved collaboration with multiple community entities that all work together in a collective effort to provide services to individuals in the Mississippi Delta. These resources included health education, blood pressure screenings, resource navigation, and referrals to social services. All 18 counties received health education, health screenings, obesity-prevention programs, and local outreach at community events by our network of community health workers (CHWs) that worked directly with area churches, businesses, grocery stores, community gardens, and other public settings to improve access to information and services related to stroke prevention.

Working directly with the case management departments, the CHWs were able to find those patients suffering from stroke-related diagnoses. If interested, the patients consented to be a part of the 45-day post-discharge program, which like the Coleman Care Transitions program, included both phone calls and home visits. These phone calls and home visits were aimed at educating the participants about their conditions, thereby decreasing the risk of hospital readmission.

Outcomes

There was improved health for persons at risk of, or diagnosed with, diabetes in Missouri Delta Service Patients enrolled in the program have had changes in their diets (reduction in salt and sugar consumption, and increased vegetable consumption).

Some of the key outcomes resulting from the Delta Stroke Initiative include these:

- There were 348 community events where screening and education were provided to people on risk factors and risk-reduction strategies for stroke.
- One hundred forty-seven community partners engaged in collaborative community events.

- The Delta Stroke Initiative has increased awareness by distributing 18,021 fliers/educational material (topics included stroke prevention, healthy eating, hidden sugars, decreasing salt intake, managing stress, physical activity, and medication adherence).
- Event attendees (36,723) received information about reducing stroke risk.
- One hundred fifty individuals were enrolled in the care transitions program.
- Of 116 care transitions program participants, 77.3% completed the program without being readmitted to the hospital.

Sustained Impacts

COVID-19 was a significant challenge for rural hospitals, and the service region has witnessed several hospitals close and struggle to meet demands of stroke program participation. Moving forward, the Delta Stroke Initiative will focus on partnering with local clinics to increase awareness around stroke prevention and educate the public about stroke risk factors.

The care coordination services performed by CHWs helped program participants adopt healthier lifestyles to prevent future strokes, receive access to social services, as well as make healthier food choices, which aid in overall well-being. Providing the program participants with blood pressure cuffs and digital scales has allowed the residents to take charge of their health to prevent high blood pressure and obesity, which are both risk factors of stroke. As a result of the program, participant hospitals decreased stroke hospital readmissions by 12%.

This program has also built sustained relationships with adult daycares and faith-based organizations to host stroke-prevention workshops.

Lessons Learned and Considerations for Program Replication

During the project period, a significant challenge was navigating through the impacts of the COVID-19 pandemic. Area hospitals opted out of partnership, and multiple hospitals shuttered over the grant period. One of the Delta Stroke Initiative partner hospitals deemed program staff as unessential, which meant they could not enter the hospital to recruit participants. The staff had to pivot and recruit patients by phone. The project management and staff learned to be innovative and prepared for sudden change. Rural hospitals have other priorities that may compete with the program; therefore, developing strong communication and open pathways with hospital partners has been very important to the success of the project. And the staff's ability to be innovative and adaptable to sudden shifts in context was also vital to success.

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Egyptian Public & Mental Health Department

Health Department

D60RH36763

Focus areas:
Health Education/Promotion and
Disease Prevention,
Obesity Prevention,
Workforce Development

Target Population and Needs Addressed

The population served with Delta States funds are children prekindergarten–12th grade in the Illinois Delta Region. Illinois Delta Region youth face worsened health outcomes due to poverty, infant mortality, low birth weight, and teen pregnancy than those in other parts of the state. They exhibit high rates of sadness, hopelessness, and bullying. Physical inactivity, poor eating habits, and obesity are also high among Illinois Delta Region youth. Furthermore, Illinois Delta Region adults exhibit higher rates of obesity, diabetes, smoking, and physical inactivity than their counterparts. Working with Illinois Delta youth can help break this multigenerational cycle.

Area Served

Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Perry, Pope, Pulaski, Randolph, Saline, Union, and White counties.

Project Goals

Long-term outcome goals:

1. Decrease health disparities among children in the Illinois Delta Region.
2. Improve the quality of life of children in the Illinois Delta Region.
3. Decrease the percentage of children in the Illinois Delta Region who are overweight or at risk of becoming overweight.
4. Improve health literacy among children in the Illinois Delta Region.
5. Decrease age-adjusted suicide rates in the Illinois Delta Region to the Healthy People 2020 goal of 10.2 per 100,000.
6. Reduce the prevalence of chronic disease among school-age children in the Illinois Delta Region.
7. Improve student connectedness and academic performance through the creation of a school climate that is engaged, safe, supportive, and healthy.

8. Improving overall health status of counties in the Illinois Delta Region has been determined by the County Health Rankings.

Intermediate outcome goals:

1. Increase the duration and intensity of physical activity among school-age children in the Illinois Delta Region.
2. Improve the nutritional environment, knowledge, and behaviors of children in the Illinois Delta Region.
3. Improve health literacy related to nutrition and physical activity among children in the Illinois Delta Region.
4. Improved adherence to chronic disease–management protocols.
5. Develop school wellness policies with provisions related to physical activity, nutrition, and social-emotional learning.
6. Improved communication between parents and youth concerning health behaviors.
7. Increased capacity of school staff to refer at-risk students to appropriate mental health resources.
8. Reduce the incidence of bullying among school-age children in the Illinois Delta Region.
9. Develop best practices for promoting healthy social-emotional climate at schools in the Illinois Delta Region.

Network Partners

Primary project partners include a community consortium comprising the following eight organizations: Egyptian Public & Mental Health Department (health department), Franklin-Williamson Bi-County Health Department (health department), Jackson County Health Department (health department), Perry County Health Department (health department), Southern Seven Health Department (health department), Southern Illinois Healthcare (hospital system), Southern Illinois University School of Medicine’s Center for Rural Health and Social Service Development (university), and University of Illinois Extension (university).

Evidence-based Model or Promising Practice

The following evidence-based models were utilized during the grant period:

Whole School, Whole Community, Whole Child (WSCC) model — The project is guided by this coordinated school health model put forth by the Centers for Disease Control and Prevention. WSCC focuses on a coordinated approach of several components including (1) health education; (2) physical education and activity; (3) nutrition environment and services; (4) health services; (5) counseling, psychological, and social services; (6) social and emotional climate; (7) physical environment; (8) employee wellness; (9) family engagement; and (10) community involvement.

Coordinated Approach to Child Health — The primary program used within the project is the Coordinated Approach to Child Health (CATCH). CATCH is designed to include teachers, school administration, faculty and staff, students, and families in the facilitation of the program. The coordination among these components designates it as a CSH program.

Mental Health First Aid — Mental Health First Aid aims at equipping individuals with the skills and education to assist someone experiencing a mental health/substance use-related crisis.

Signs of Suicide — Signs of Suicide is a school-based depression awareness/suicide prevention program designed for middle school and high school students. The goals of the program are to decrease suicides and suicide attempts, promote help-seeking, reduce stigma, engage parents and school staff, and encourage schools to develop community-based partnerships to support mental health.

Services and Activities

The Illinois CATCH on to Health Consortium (ICHC) established and maintained itself as an active and functional consortium, despite the COVID-19 pandemic. The consortium was able to quickly adapt to the virtual world, be flexible, and meet schools where they were. ICHC implemented the CATCH curriculum, including vaping-prevention program CATCH My Breath. Furthermore, through the application of CDC's WSCC model, ICHC piloted implementation of Illinois social-emotional learning standards into pre-K–12th grade in its schools. The consortium also conducted Hidden in Plain Sight demonstrations in several settings such as teacher institute days, parent education nights, and community events. Also, in line with the WSCC model, ICHC implemented Mental Health First Aid to school administration, teachers, and staff, as well as community partners such as Boys and Girls Club. Overall, within this grant period, ICHC has worked on the goal of reducing the prevalence of chronic disease among school-age children in the Illinois Delta Region.

Outcomes

To date, ICHC provided:

1. One hundred ninety health education lessons (e.g., nutrition, physical education, social-emotional learning, vaping prevention)
2. Twenty-two health education presentations
3. Twenty trainings (e.g., vaping prevention, mental health/social-emotional learning)
4. Four workshops (e.g., nutrition, physical education)
5. Six Hidden in Plain Sight demonstrations
6. Sixty-two outreach events

Sustained Impacts

ICHC is at an advantage to promote and educate various community partners, schools, and early childhood education sites. Training and professional development provided will have a lasting impact on the community and schools served. Through a policy, systems, and environment focus, it encouraged schools to look at wellness as a whole and as a cultural/environmental change to ensure behavior changes are made for a lifetime. Furthermore, the resources provided through the funding period sustain themselves through future use. The COVID-19 pandemic also expanded reach and access with the use of virtual technology. It allowed for work with other agencies, as both a resource and partnership, resulting in diverse relationships. Last, the goals of ICHC have been replicated on a larger community-based scale, taken on by local community coalitions as well as the Healthy Southern Illinois Delta Network as a whole, therefore, positioning the efforts and programming for greater sustainability and impact.

Lessons Learned and Considerations for Program Replication

Despite the program adaptations due to the COVID-19 pandemic, ICHC remained flexible, open-minded, and engaged. This created opportunities outside of traditional programming. Additionally, it highlighted that the Illinois Delta Region stretches far and wide, where every community is unique and different. Through new programming, consistent messaging and curricula were provided, allowing room for flexibility and personalization to best fit school and community needs. This also helps create confidence and buy-in among those implementing CATCH. Also, through this grant period, there was high turnover, both within the consortium as well as in schools. ICHC learned how to operate in a time of high turnover; this was an essential lesson learned. Last, it is imperative to focus on best practices and identify what works for the group and region to streamline transitions and continue work needed in this area.

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The Health Enrichment Network

Nonprofit Organization

D60RH36764

Focus areas:

Behavioral/Mental Health,
Chronic Disease Management,
Health Education/Promotion and
Disease Prevention,
Oral Health,
School-Based Care Coordination

Target Population and Needs Addressed

The EatMoveGrow (EMG) service area was selected based on federal Delta States Rural Development Network guidelines known as Louisiana Service Region B. Though the mileage across the region is vast, the health care concerns across the region are similar. Louisiana ranks 49th in overall health among all states. Health in Louisiana is influenced by where people live. Great health gaps exist, and access to opportunities varies greatly based on where someone lives within the state.

Area Served

Service Region B (SRB) — 17 designated parishes: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Catahoula, Concordia, Evangeline, Jefferson Davis, Lafourche, Plaquemines, Pointe Coupee, St. James, St. Landry, St. Martin, and St. Mary.

Project Goals

The Health Enrichment Network (THEN) EMG project selected four goals supported by a multitude of objectives and activities to support its Whole School Whole Child obesity-prevention project. EMG expanded its program to provide services throughout the newly designated region to a total of 40 elementary schools. The program's successful rural model provided education and tools to integrate health education in every component of school life from recess to classroom core subjects.

Goal 1. Teach students in their formative years how to lead a healthy lifestyle.

Goal 2. Improve school health environments in SRB through policy change.

Goal 3. Create access to social-emotional learning tools in SRB schools.

Goal 4. Increase access to evidence-based oral health in SRB schools.

Network Partners

THEN assembled a strong consortium to support the vast geography and myriad of program activities of the EMG obesity-prevention project selected based on resources they could contribute to rural obesity prevention and possible contributions toward project sustainability, and clinical requirements of oral health promotion. Consortium partners included the Louisiana Rural Hospital Association — rural health coalition, Bunkie General Hospital — Critical Access Hospital, Louisiana State University Dental School — state dental school, Southwest Louisiana Area Health Education Center (AHEC) and Southeast Louisiana AHEC — health education centers, and Louisiana Department of Health — state department.

Evidence-based Model or Promising Practice

EMG was a comprehensive program that follows the Whole School, Whole Community, Whole Child (WSCC) model to promote wellness and prevent obesity in schools. The evidence-based practices incorporated in the program include the use of the School Health Index to assess schools' health and wellness practices, the establishment of a school wellness committee (SWC) to oversee implementation, classroom movement breaks, physical education and recess activity intensifiers, nutrition education programs, social-emotional learning curriculum, and oral health screenings with dental sealants and fluoride varnish. These practices have proven to improve student health and well-being, reduce health care costs, and promote academic achievement. The WSCC model provided a comprehensive approach to student health and academic success and has been proven to effectively support student health and wellness.

Services and Activities

The EMG project implemented a successful rural model in 40 elementary schools that integrated health education into every aspect of school life. The project's school wellness committees developed unique health plans tailored to each school's needs, and a monthly rural-focused healthy lifestyles curriculum was taught in K–3 classrooms. The project also provided evidence-based training and resources to increase student activity levels and access to healthy food choices, resulting in improved body mass index numbers on a large scale. In addition, the project created access to social-emotional learning tools and training, including evidence-based programs in all 40 schools and a teacher training on identifying and assisting individuals experiencing mental health or substance use challenges.

Outcomes

1. Over the last three years, THEN has evolved the EMG obesity-prevention project into a robust WSCC model utilizing several early childhood interventions to help students develop lifelong healthy habits:
2. During this grant cycle, EMG expanded the SWC model to serve 15,000 children in 40 SRB elementary schools.
3. Implemented school wellness committees in 60% of EMG schools.
4. Implemented new social-emotional learning tools and a monthly social-emotional learning capsule lesson for students and Youth Mental Health First Aid for staff. Fifty-five classrooms utilized social-emotional learning capsule lessons at 22 schools, providing new social-emotional learning skills for 1,375 students.
5. EMG health educators taught 3,000 hours of oral health education in 38 schools in 266 classrooms and provided 8,100 toothbrush/toothpaste packs to students.

6. During COVID-19, EMG expanded into providing educational lessons in multiple formats. As a result of these efforts, 3,750 students were reached through lessons taught from the EMG toolboxes. EMG began producing classroom lessons in video format, creating digital newsletters with links to program materials and instructional videos, and creating lesson toolboxes for teachers to use in closed classrooms. These videos have received more than 1,400 views.

Sustained Impacts

The EMG project promoted healthy eating and physical activity to improve the health and well-being of rural elementary school children. Its long-term effects have been substantial, including improved service models, new policies, increased capacity, and changes in knowledge, attitudes, and behaviors. EMG encouraged schools to adopt a WSCC approach, resulting in comprehensive health and wellness programs that will sustain over time. Participating schools developed policies supporting healthy behaviors, such as banning unhealthy food, increasing physical activity time, and incorporating school gardening.

Teachers, administrators, and parents gained knowledge and resources, and students developed positive attitudes and behaviors toward healthy habits. The project raised community awareness, resulting in support and advocacy for similar programs in other schools. These impacts are likely to have long-term health benefits and contribute to the prevention of chronic diseases in adulthood.

Lessons Learned and Considerations for Program Replication

The EMG team learned valuable lessons from implementing the Delta States grant project, which aimed to reduce obesity and promote healthy eating and physical activity in rural communities.

Lesson 1: Understanding the specific needs of each community is essential for designing effective programs.

Lesson 2: Collaboration with local organizations and stakeholders is key to success.

Lesson 3: Sustainability is crucial for long-term impact, and a sustainability plan that builds local capacity and community ownership is necessary.

Lesson 4: Tailored messaging specific to the community's needs and circumstances is more effective.

Lesson 5: Empowering community members to take an active role in the project and promoting healthy habits among their peers is critical for success. The team has created valuable resources at www.eatmovegrow.us for other rural communities interested in implementing similar projects.

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Jefferson Comprehensive Health Center Inc.

Federally Qualified Health Center

D60RH36765

Focus areas:
Diabetes Care Management,
Health Education/Promotion and
Disease Prevention,
Health Screenings,
Pharmacy Assistance,

Target Population and Needs Addressed

The Mississippi (MS) SHINE program is located in the area known as the Mississippi River Delta Region. This region is among the most socioeconomically disadvantaged areas of the United States. According to 2018 U.S. Census population estimates, the total statewide population numbers over 2.9 million, while the total resident population of the targeted region numbers approximately 379,587. The proportion of overweight people has increased substantially during the past 20 years. Morbidity related to being overweight is the second-leading cause of death in the United States and causes approximately 300,000 deaths each year.

Area Served

Adams, Amite, Claiborne, Copiah, Covington, Franklin, Humphreys, Issaquena, Jasper, Jefferson Davis, Jefferson, Lawrence, Lincoln, Marion, Pike, Sharkey, Smith, Walthall, Warren, Wilkinson, and Yazoo counties.

Project Goals

The MS SHINE Project's purpose was to promote health and wellness in Southwest Mississippi by identifying health issues important to the community and developing a program to address those identified health problems. The MS SHINE Project seeks to help people to live their full life expectancy in good health. If the program is to reach its potential, all the people involved in development efforts must work together.

Network Partners

Sharkey Issaquena Community Hospital — Hospital
Southeast Mississippi Rural Health Initiative — FQHC
Southwest Mississippi Opportunity Inc. — Nonprofit Community Action Agency

Evidence-based Model or Promising Practice

Evidence-Based Model — Community Health Workers: The unique role of community health workers (CHWs) as culturally competent mediators (health brokers) between providers of health services and the members of diverse communities has been extensively documented. Also documented are the CHWs' effectiveness in promoting the use of primary and follow-up care for preventing and managing a variety of health care concerns, including asthma, hypertension, diabetes, cancer, immunizations, maternal and child health, nutrition, tuberculosis, and HIV/AIDS. MS SHINE deploys CHWs across the region to conduct health outreach and education activities in partnership with local health and human service agencies and community-based nonprofits.

Services and Activities

1. Provide health education, prevention, and obesity management services to 35,000 individuals annually.
2. Conduct 30,000 health screenings to include blood pressure checks, body mass index (BMI), and glucose test readings annually to adults and adolescents.
3. Provide nutrition and health education and exercise information to combat childhood obesity issues to 20,000 individuals annually.

Outcomes

Progress to Date:

- Residents (65,703) were provided health education, prevention, and obesity management services.
- Health screenings (107,221) were conducted with adults and adolescents, including blood pressure checks, BMI, and glucose test readings.
- Families (27,360) received nutrition and health education and exercise information to combat childhood obesity.

Sustained Impacts

Over the course of the grant period, MS SHINE has worked to ensure that the impacts of the project will endure beyond the grant period. MS SHINE has trained and placed CHWs in four regions of the coverage area. These CHWs are trained individuals who have grown strong local networks focused on addressing pressing health issues in their communities. These networks will continue to work together beyond the grant period, benefiting from the capacity of the CHWs and the collaborative relationships that have been established.

Over the course of the past three years, MS SHINE has provided chronic disease prevention and management education to thousands of residents, helping them to understand their health status, strategies for preventing and better managing chronic disease and assisting them with to access additional health services like prescription medication, primary care services, and chronic disease supports. The impacts of this work will endure among program participants and their family and friends.

Lessons Learned and Considerations for Program Replication

MS SHINE serves communities with high rates of poverty, low rates of health insurance, and a lack of public transportation options. These factors can be barriers to participation in programming for MS SHINE communities. It is anticipated that participation in events and activities will continue to be a challenge. One strategy for ensuring that program activities are relevant and accessible to participants is to partner with local community agencies and meet participants where they work, play, and gather. MS SHINE CHWs organize events and activities in locations that are familiar and comfortable to the target population and are more accessible to people with transportation challenges. For example, some activities were held at local schools, day care facilities, and churches. MS SHINE staff found that word of mouth was a powerful strategy for attracting participants. CHWs encouraged regular participants to bring a friend or neighbor to program events.

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Mississippi County

Health Department

D60RH36766

Focus areas:

Behavioral/Mental Health, Cardiovascular Disease Care Management, Chronic Disease Management, Community-Based Care Coordination, Community Health Worker Services, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Health Screenings, Medication Optimization, Pharmacy Assistance, Population Health, Prescription Drug Assistance, Primary Care Services

Target Population and Needs Addressed

The consortium utilized evidence-based programs and practices to address diabetes, cardiovascular disease, and obesity. A five-county area, known as the Bootheel, has historically had the highest unmet needs and experiences significant racial health disparities. Forty-three percent of adults in the Bootheel and 40.5% in Missouri Region B were obese, compared to 37% in Missouri. Fifteen percent (15.2%) of adults in the Bootheel and 13.7% in Missouri Region B have been diagnosed with diabetes compared to 10.8% of adults in Missouri. Deaths from heart disease occur at an age-adjusted rate (per 100,000) of 182.7 in the Bootheel and 152 in Missouri Region B compared to 104.2 in Missouri.

Area Served

Missouri Service Region B: The counties of Dunklin, Madison, Mississippi, New Madrid, Pemiscot, Perry, Scott, St. Francois, Ste. Genevieve, Stoddard, and Washington are Health Professional Shortage Areas. Dunklin, Madison, Mississippi, New Madrid, Pemiscot, Scott, Stoddard, and Washington are medically underserved areas.

Project Goals

The project activities implemented supported our long-term vision of people in Missouri Region B living long, healthy lives free from the burdens of chronic health conditions. The overall goal was to expand the Delta program's success in improving the occurrence and management of chronic diseases in Missouri's most disproportionately affected rural communities in Missouri Service Region B.

Goal 1: Increase use of self-management programs by recruitment and support via community health workers (CHWs).

Goal 2: To improve management of chronic diseases through delivery of evidence-based chronic disease self-management programs targeting individuals with or at risk of cardiovascular disease and diabetes.

Goal 3: To improve cardiovascular health and quality of life of individuals through prevention, detection, treatment, and self-management of hypertension in rural counties with the highest unmet needs and harder to reach, underserved communities.

Goal 4: To improve health and quality of life of individuals at risk for and diagnosed with diabetes through the achievement and maintenance of healthy body weights in rural counties with the highest unmet needs and harder to reach, underserved communities.

Goal 5: To increase access to affordable and necessary prescription medications for individuals with or at risk of chronic disease.

Network Partners

The MPower Consortium includes broad representation and comprises all 11 county health departments in Missouri Region B, Southeast Missouri Health Network (a Federally Qualified Health Center), Bootheel Counseling Services (a Community Mental Health Center), Regional Healthcare Foundation (a private foundation), Southeast Missouri Regional Arthritis Center, Community Pharmacy Enhanced Services Network affiliate in Missouri (CPESN-MO) and its network of 27 local pharmacies, and other community and faith-based organizations.

Evidence-based Model or Promising Practice

Local pharmacies engaged CHWs in a team-based care model to address cardiovascular disease and diabetes prevention and management. The CHWs were effective in promoting healthy behaviors and improving health outcomes in rural communities and among those who are racial minorities or are underserved. Utilizing pharmacies for providing care in rural communities was a promising practice to improve care and support for patients with poorly controlled chronic conditions.

Implementation of the self-measured blood pressure (SMBP) program model was utilized to improve blood pressure outcomes and medication adherence. The chronic disease self-management program (CDSMP), diabetes self-management program (DSMP), and Walk with Ease physical activity and self-management education program are other evidence-based programs offered by the consortium members.

Services and Activities

Interventions focused on producing changes in knowledge and understanding of chronic disease management, clinical biometrics, and coordination among health and social agencies. The health departments screened adults for chronic disease risk and facilitated linkage to services.

Southeast Missouri Health (SEMO) Network provides primary care, dental, and mental health services through the patient-centered medical home model. Clinical services are also provided through the Mississippi County Health Department's Diabetes Center. A registered dietitian and nurses provided chronic disease and diabetes education.

The MPower Consortium included CPESN-MO and 27 rural pharmacies. At least one CHW has been trained and employed by a pharmacy in each of the 11 counties. The pharmacists and CHWs assessed the social determinants of health and provided self-measured blood pressure monitoring and referrals to chronic disease-related services. The pharmacists also provided medication optimization. The Regional Health

Foundation increased funding for access to prescription medications through patient-assistance programs. These strategies expanded access to essential health care services and strengthened the rural health care system.

Outcomes

The consortium members served over 31,000 individuals during the 2020-2022 project years. The following clinical outcomes were achieved:

- 10,935 of the 13,025 or 84% of patients screened for clinical depression using a standardized tool had a follow-up plan documented.
- 4,912 of the 6,456 or 76% of adult patients with a diagnosis of hypertension had an adequately controlled blood pressure (lower than 140/90).
- 2,145 of 3,035 or 71% of adult patients with diabetes had a hemoglobin A1c less than 8%.
- 11,995 of the 13,714 or 87% of adult patients with a calculated body mass index and if the most recent body mass index was outside parameters had a documented follow-up plan.
- 10,057 of the 10,204 or 99% of adult patients were screened for tobacco use at least once and received cessation counseling if identified as a tobacco user.

Other outcomes included the following:

- Engaged CPESN-MO and a network of 27 local pharmacies as partners and cross-trained CHWs to identify needs based on health factors and the social determinants of health.
- Increased the number of patients receiving an optimized medication regimen from a pharmacist from zero to 300 per year.
- Increased the number enrolled in the SMBP to 665 per year.
- Decreased average blood pressure readings among SMBP participants.
- Increased the number of leaders trained to implement the Walk with Ease program from zero to 16 and increased the number of participants to 140 per year.
- Increased the number of patients that receive services from a registered dietitian from 175 to 228 per year.
- Increased the average number of dollars saved per patient through the prescription drug assistance program from an average of \$7,678 per person per year to \$13,025 per person per year.
- Trained 44 leaders for the evidence-based CDSMP program and 39 leaders for DSMP program.
- Among CDSMP and DSMP participants, 98% reported an increase in self-efficacy to manage the diabetes or chronic condition.

Sustained Impacts

The Delta project has resulted in “new ways of serving” and a shared vision of people living long, healthy lives free from the burdens of chronic health conditions. Training leaders/facilitators and ensuring each organization had the program curricula and other materials to effectively implement the programs allowed the evidence-based chronic disease self-management services to be sustained over the long term. An electronic referral system was developed and is now accessible to any partner or individual who wishes to participate in the evidence-based programs. These factors increased the capacity of the local health system. Development of

new online platforms allowed the participating organizations to upload data electronically and reduced the burden of manual data entry. The improved data collection systems increased capacity for utilization and evaluation of the programs.

A recent network analysis verified the significant impact the project has made on creating a well-connected network of partnerships with extensive multisector collaboration. The Delta project was identified as a significant factor leading to a culture of collaboration across Missouri Region B.

Lessons Learned and Considerations for Program Replication

The MPower Consortium approach to engaging people in chronic disease prevention and management was based on offering multiple access points as well as a coordinated, multipartner program design. This approach was not limited to Southeast Missouri. Intentional community engagement and evidence-based programs that are accessible at various entry points supported replication even in areas with health care provider shortages. The outcome measures allowed for evaluation findings (process, outcome, and impact) to inform quality improvement and program design in other communities with similar needs. For example, health departments and community-based pharmacies were anchors in rural health care systems across the United States. Similar programs were chosen by others that sought to collaboratively improve chronic disease management. With the emphasis being on serving low-income, rural communities where the prevalence of cardiovascular disease and diabetes were high and educational attainment was low.

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Paris-Henry County Health Care Foundation

Hospital (non-Critical Access Hospital)

D60RH36766

Focus areas:

Behavioral/Mental Health, Case Management, Chronic Disease Management, Community-Based Care Coordination, Diabetes Care Management, Health Education/Promotion and Disease Prevention, Health Screenings, Pediatric Care, Pharmacy Assistance, Telehealth/Telemedicine

Target Population and Needs Addressed

The target population of the West Tennessee Delta's Grow Well is low-income and uninsured or underinsured adults and children at risk for obesity and obesity-related chronic diseases and behavior health services.

Area Served

The geographic area of our region includes Benton, Carroll, Chester, Decatur, Dyer, Gibson, Hardeman, Hardin, Haywood, Henry, Lake, Lauderdale, Madison (parts), McNairy, Obion, Tipton, and Weakley counties.

Project Goals

The purpose of the project is to continue to expand regionwide obesity services for children, adults, and families as a primary focus, and to establish and expand behavioral health services for children and adults as a secondary project focus. The project goals were to:

1. Continue and expand regional services for pediatric, adult, and family-focused health education on obesity prevention across multiple settings.
2. Provide resources to support and expand health screenings, clinical case management, nutritional counseling, pharmacy assistance, and other health services that are related to obesity and chronic disease prevention and treatment.
3. Establish behavioral health services for children through school-based clinics and for adults through telehealth services.
4. Establish patient- and family-centered care coordination programs to address interrelated medical, social, developmental, behavioral, emotional, and financial needs.
5. Continue to build new partnerships to better serve residents.
6. Continue and expand program monitoring, using data to evaluate and sustain programs.

Network Partners

Primary project partners include multiple health care and social service agencies comprising the following organizations in Tennessee: Paris Henry County Health Care Foundation (hospital foundation), Henry County Medical Center (hospital), Hardeman County Community Health Center (federally funded health care center), and 10 local education systems (school districts).

Evidence-based Model or Promising Practice

The project has implemented motivational interviewing, cognitive behavior therapy, CATCH (Coordinated Approach to Child Health Curriculum), the Building Stronger Brains TN ACEs mental health curriculum, and the Stanford-developed Living Well with Chronic Conditions and Take Charge of Your Diabetes.

Services and Activities

Paris Henry County Healthcare Foundation provided adult case management, care navigation, pharmacy assistance, and group education focusing on adults with chronic conditions. Hardeman County Community Health Center provided adult case management and pharmacy assistance to adults with chronic conditions and behavioral health services to all ages through telehealth. Methodist Le Bonheur Community Outreach provided access to pediatric services including clinical health care screenings and referral for additional health care services. In addition, Le Bonheur provides individual education to children diagnosed with obesity and case management assistance with follow-up appointments. Le Bonheur's behavioral health program provided assistance to families with mental health needs and counseling for children.

Outcomes

1. Adult Case Management: Henry County Medical Center served 291 individuals, and 52.5% decreased body mass index (BMI), 64.4% reduced blood pressure (lower than 140/80), and 55.9% of patients reduced A1c. Hardeman County Community Health Center served 604 individuals, and 50.3% of patients decreased BMI, 34.8% reduced blood pressure (lower than 140/80), and 55.3% of patients reduced A1c.
2. Pharmacy Assistance: Henry County served 240 patients with a prescription savings of \$604,000. Hardeman County served 151 patients and saved approximately \$508,264 in prescription cost.
3. Behavioral telehealth services served 685 individuals and 13% reported improved behavioral/mental health, 75.5% of patients completed appointments, and 92.3% of patients and families reported being satisfied with the program's services.
4. Mobile health program has provided pediatric care to 1,358 patients. One hundred percent of patients have documented BMI and blood pressure screenings, 96.4% have a development/behavioral assessment completed, and 44.3% of those diagnosed with obesity have been referred to a registered nurse health education program.
5. Registered nurse health education: Le Bonheur has served 158 children, 54% of participants have increased fruit and vegetable consumption, 30.2% increased physical activity, 43.9% reduced screen time, 27.2% have reduced BMI, and 66.5% with elevated blood pressure have reduced their blood pressure reading.
6. Behavioral health (pediatrics): Two hundred six children have participated in navigation services, 53.5% of children have completed follow-up appointments, 18 children have had counseling services, 39% of the children have improved behavior at home and at school, and 91% have completed appointments.

Sustained Impacts

The impacts of all programs combined have reduced unnecessary hospitalizations through improved access to chronic disease management, navigation, and pharmacy assistance. Implementation and expansion of behavioral health counseling and treatment has occurred, as well as improved linkages to primary care providers, specialty providers, community-based resources, and health education.

The project has increased awareness among those served of the importance of a healthy lifestyle through education. Enhanced partnerships have been developed with local health providers and community organizations to work together to enhance patient disease management.

Lessons Learned and Considerations for Program Replication

It is important to be prepared to deliver services in a variety of ways to reach as many individuals as possible when unexpected things happen — in-person, virtually, by phone, by email, or by text. Being open to change as it occurs or even creating change as needs of the population served and programs shift is necessary. When implementing evidenced-based programs, it is important to have buy-in from multiple partners to ensure the program can be delivered as designed and planned. Last, it is ideal to involve partners and key stakeholders in even the small decisions when appropriate — the project could have improved engagement with key partners by helping them understand their importance in the project and the decision-making earlier on.

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Richland Parish

Critical Access Hospital

D60RH36768

Focus areas:

Health Education/Promotion and Disease Prevention
Health Screenings

Target Population and Needs Addressed

The project's target population is adolescent students in grades 9-12 at 28 high schools in Louisiana Region A who are at risk for developing prediabetes, who are prediabetic, or who have diabetes. Also, students determined to be at risk for developing prediabetes, who are diabetic, or who have diabetes receive health screenings three times during the academic year. Additionally, Healthy Lifestyle educational lessons are taught, targeted at helping them to make healthy lifestyle choices, which includes healthier food and beverage choices as well as providing simple exercise activities that can jump-start their implementation of exercise routines.

Area Served

Louisiana Region A: Bienville, Caldwell, Claiborne, East Carroll, Franklin, Jackson, LaSalle, Lincoln, Madison, Morehouse, Natchitoches, Rapides, Red River, Richland, Tangipahoa, Tensas, Union, Washington, West Carroll, West Feliciana, and Winn parishes.

Project Goals

Goal 1: Expand the promising practice model Richland Parish TRAC Pre-Diabetes Prevention Program throughout the 21 parishes designated as Louisiana service Region A by the Delta States Network Program.

Goal 2: Increase the awareness of prediabetes and its importance in predicting future diabetes mellitus type 2 among parents, school staff, the community, and local health care providers.

Goal 3: Decrease the incidence of future diabetes mellitus Type II in Louisiana Delta Region A through aggressive management of those high school students found to have a prediabetic state by applying the Chronic Care Model to diabetes prevention in community and primary care settings.

Goal 4: Increase faculty, staff, and administration awareness of health issues affecting both adults and students by providing health screenings at each of the 28 schools.

Goal 5: Encourage and facilitate healthy lifestyles for adolescents and their families by fostering school-based environments that promote physical activity, healthy eating habits, and social interaction.

Goal 6: To ensure that previous work on the strategic plan for sustainability for the Adolescent Pre-Diabetes Prevention Program initiative becomes a living document that serves as a framework allowing for sustainability by current program partners and adoption by parties interested in implementing the program in the future.

Goal 7: To ensure that project sustainability is ensured in school-based health centers in parishes that are currently deemed rural, but which will not be deemed rural for the 2020-2023 funding cycle.

Network Partners

The network consortium consists of three hospital partners: Richland Parish Hospital, West Feliciana Parish Hospital, and St. Francis Cabrini Hospital School Based Health Centers. There are 28 high school network consortium members and 10 school-based health center network consortium members.

Evidence-based Model or Promising Practice

Richland TRAC Pre-Diabetes Program Adult Model — promising practice model program.

Services and Activities

1. Prediabetes screening for adolescents in grades 9-12.
2. Ninety-day interval A1c blood glucose levels and screening for program participants.
3. Healthy Lifestyle educational lessons for program participants.
4. Weekly “Let’s Stay on this Healthy Lifestyle Journey — Together” messaging to participants, parents, and educators.
5. Faculty, staff, and administration health screenings at participating high schools.

Outcomes

1. Program widely accepted in target parishes.
2. Constituent awareness of prediabetes and the path to delaying or preventing diabetes mellitus type 2 has increased.
3. More than 50% of program participants have either lowered or maintained their baseline markers for weight, blood pressure, waist circumference, body mass index percentage, and A1c blood glucose levels.
4. Faculty, staff, and administration at participating schools have an increased awareness of their personal health status through participation in the faculty, staff, and administration health screenings provided by the program.
5. Program participants, their parents, and faculty are more aware of the necessity for a lifestyle that goes beyond sedentary. Through healthy lifestyle education classes participants have learned easy solutions for making healthier/better food choices, increasing physical activity, and for the need to maintain close monitoring of their health status.
6. The strategic plan for the program connected to the sustainability plan ensured program activities to continue after grant funding has ended.
7. Through consortium participation schools and schools-based health centers have embraced the importance of networking, the concept that student health is a consideration that should be included in the education model, and that through community cooperation “great” achievements can be made.

8. Improved health for faculty, staff, administration, and students has improved the school environment through decreased absenteeism.
9. Awareness of the prediabetes prevention program has been increased through presentations at regional and national conferences.
10. Replication of the program is scheduled to occur in Oklahoma (grantee peer) during the 2023-2024 academic year.

Sustained Impacts

1. Improved service model.
2. New policies.
3. Increased capacity.
4. Changes in knowledge.
5. Changes in attitudes and behaviors.
6. Heightened awareness by schools of the importance of good student health and the student's ability to learn and actively participate in school activities.
7. Confidence by high school and school-based health center staff/administration to reach beyond traditional educational boundaries and to partner with other organizations to meet student needs.
8. Increased awareness by faculty, staff, and administration of their own personal health profiles and wellness.
9. Better quality of life for program participants through empowerment to "take control" of their personal health destiny.
10. Program expansion (sustainability) beyond the borders of participant schools.

Lessons Learned and Considerations for Program Replication

A key lesson learned when working with adolescents is how to reach and engage this population. Including school faculty and staff in wellness screenings aided the buy-in and created a support structure and resulted in increased student engagement. Screening numbers improved, and the number of students admitted to the program increased as well. Student interest in the information contained in the healthy lifestyles lessons was significantly improved when lesson handouts were reworked, and age-appropriate design was provided by a graphic artist.

Another lesson was that changes in school leadership and mandates from the Louisiana Department of Education and local school boards sometimes challenge the effectiveness of the partnerships. Education for new school leadership and work within the consortium are collaborative ways to address mandates that affect the schools' participation level.

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Rural Alabama Prevention Center

Nonprofit Organization

D60RH36769

Focus areas:

Behavioral/Mental Health; Cardiovascular Disease Care Management; Case Management; Chronic Disease Management; Community-Based Care Coordination; COVID Education, Testing, and Vaccinations, Diabetes Care Management; Health Education/Promotion and Disease Prevention; Health Screenings

Target Population and Needs Addressed

The Rural Alabama Prevention Center (RAPC) Southwest Alabama Health Improvement Initiative (SWAHII) program monitored and tracked program participants over time and provided access to preventive and managed care services in a church, a rural health clinic, and communitywide event settings. SWAHII targets individuals aged 15-64 residing in the 17-county service region in Southwest Alabama who have or are at risk of developing heart diseases and diabetes. The project has a secondary focus on the behavioral and health risk factors that make it hard to manage a chronic health condition.

Area Served

RAPC served 17 counties: Barbour, Bullock, Butler, Choctaw, Clarke, Conecuh, Dallas, Escambia, Greene, Macon, Marengo, Monroe, Perry, Pickens, Sumter, Washington, and Wilcox.

Project Goals

SWAHII's Goal:

To promote and support healthy lifestyles throughout Alabama's Delta counties through the implementation of programs geared toward the prevention and care management of chronic diseases.

SWAHII's Objective:

By 2023 reduce the rates of diabetes and heart disease for at-risk individuals and improve the health metrics of individuals with current diabetes or heart disease diagnoses who are enrolled in SWAHII's programs.

Network Partners

- RAPC Community Based Lead Agency, Butler, Clarke, Conecuh, Escambia, Greene, Marengo, Monroe, and Washington counties; Auburn University/ACEs university consortium partner, Dallas and Wilcox counties
- CHEAR, community-based organization; Choctaw, Pickens, and Sumter counties; Sowing Seeds of Hope, community-based organization; Perry County

- Tuskegee Area Health Education, university; Barbour, Bullock, and Macon counties; Hill Hospital Physician Clinic, rural health clinic, Sumter
- Rural Health Medical Center, Federally Qualified Health Center, Clarke, Dallas, Marengo, and Wilcox County

Evidence-based Model or Promising Practice

The Body and Soul Program: A wellness program developed for African American churches. The program encourages church members to eat a diet rich in fruits and vegetables every day for better health.

Diabetes Empowerment Education Program (DEEP): An education curriculum designed to help people with prediabetes, diabetes, their relatives, and their caregivers gain a better understanding of diabetes self-care.

Care Coordination Toolkit: Under the Reducing Fragment Toolkit: A Care Coordination, allied health professionals were trained to serve as care coordinators and partner with rural health clinics.

Mental Health First Aid training: This training is an eight-hour course that teaches participants how to identify, understand, and respond to signs of mental illnesses and substance use disorders.

Services and Activities

The SWAHII program monitored and tracked program participants over time and provided access to preventive and managed care services in churches, rural health clinics, and communitywide events. Services and activities offered through the implementation of the SWAHII program included:

- Seventeen community health workers hired, trained, and certified on Body and Soul, Diabetes Empowerment Education Program, and Mental Health First Aid training. Rural health clinics hired and trained allied health professionals to serve as care coordinators.
- Implementation of Body and Soul in 34 new churches. Implementation of DEEP in 68 churches.
- Implementation of Mental Health First Aid training in 17 churches.
- Implementation of care coordination services for people diagnosed with heart disease and diabetes via rural health clinics, COVID education, testing, and vaccinations in rural Alabama.
- Communitywide health screenings for chronic diseases, vision, and dental services.
- Monthly distribution of educational information on chronic disease prevention, safety, healthy eating. Referred patients to social services (e.g., food, transportation, medication assistance).

Outcomes

Outcomes because of activities implemented during the SWAHII program:

1. Five hundred thirty-two parishioners enrolled in Body and Soul.
2. Four hundred fifty-six parishioners enrolled in DEEP.
3. One hundred fifty patients with chronic heart disease and diabetes received care coordination services provided by a rural health clinic provider.
4. Thirty-five COVID-19 events focused on outreach, education, testing, and vaccination were conducted.
5. Seventeen church coordinators were trained with Mental Health First Aid training and redelivered the information to their congregation with the assistance from SWAHII community health workers.

Sustained Impacts

There are a range of impacts that will sustain beyond the grant period because of the SWAHII program:

- Partnerships at the federal, state, and local levels will endure and organizations will continue to collaborate to improve health outcomes and increase access to health information and services in rural Alabama.
- The curriculum, resources, and capacity created through the Body and Soul, DEEP, and Mental Health First Aid training programs will remain in place in churches in the region.
- Participating churches made policy changes (e.g., healthy food policies, physical activity programming) that will positively impact parishioner health beyond the grant period.
- Community members have increased knowledge of chronic diseases and prevention through communitywide education and health events.
- Improved knowledge of systolic/diastolic blood pressure, physical activity, medication, self-monitoring glucose, oral care, foot care, and eye exams among program participants will positively impact the health of individuals and their families.
- Community gardens established to encourage increased vegetable consumption will serve communities in the long term.

Lessons Learned and Considerations for Program Replication

During and following the COVID pandemic, program staff and partners at the rural churches had to adjust the way that educational programming was delivered, moving from in-person to virtual events. Rural churches and individuals faced challenges with connectivity due to limited access to broadband. Rural churches were not equipped with resources and tools to offer sessions virtually. SWAHII was able to provide tools like cameras and tablets to support church activities and build capacity for those institutions to meet the needs of their parishioners.

Program staff found opportunities to expand the scope of DEEP to include additional modules and strategies that focus on lowering A1c levels among the current DEEP participants.

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