Delta States Rural Development Network Program

GRANTEE DIRECTORY

2020

FEBRUARY 2021

HEALTH RESOURCES AND SERVICES ADMINISTRATION
THE FEDERAL OFFICE OF RURAL HEALTH POLICY

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Introduction

The purpose of the Delta States Rural Development Network Grant Program (Delta) is to fund organizations located in the eight Delta States (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee) which address unmet local health care needs and prevalent health disparities through the development of new and innovative projects.

The Delta grant program fosters 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 multi-county/multi-parish 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. BMI, 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 area(s), grantees may devote a percentage of grant funds toward another issue which may be of need in the service area. This other issue area may or may not be clinical 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, or women's health etc.

This directory provides contact information and a brief overview of the twelve initiatives program funded under the Delta States Rural Development Network Grant Program in the 2020-2023 funding cycle.

Grantees by State

State	Grant Organization
Alabama	Rural Alabama Prevention Center
Arkansas	ARcare
	Arkansas Rural Health Partnership
Illinois	Egyptian Public & Mental Health Department
Kentucky	Baptist Health Madisonville, Inc.
Louisiana	Health Enrichment Network, The
	Richland, Parish of
Mississippi	Delta Health Alliance, Inc.
	Jefferson Comprehensive Health Center, Inc.
Missouri	Big Springs Medical Association, Inc.
	Mississippi County Health Department
Tennessee	Paris-Henry County Health Care Foundation, Inc.

Grantees by Grant Organization Type

Grant Organization Type	Grant Organization Name
County Health Department	Egyptian Public & Mental Health Department
	Mississippi County Health Department
Critical Access Hospital (CAH)	Richland, Parish of
Federally Qualified Health Center (FQHC)	ARcare
	Big Springs Medical Association, Inc.
	Jefferson Comprehensive Health Center, Inc.
Network	Arkansas Rural Health Partnership
	Health Enrichment Network, The
Other Hospital (Non-CAH)	Baptist Health Madisonville, Inc.

Others:

Grant Organization Type	Grant Organization Name
501c3 Non-profit	Paris-Henry County Health Care Foundation, Inc.
Community-Based Organization	Rural Alabama Prevention Center
Non- Profit	Health Enrichment Network, The
Rural 501c3 organization	Delta Health Alliance, Inc.

Grantee Profiles

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Arkansas, Service Region B

ARcare

Grant Number:	D60RH36758					
Organization Type:	Federally Qualified Health Center (FQHC)					
Grantee Organization Information:	Name:	ARcare				
	Address:	117 S Second Street				
	City:	Augusta	State:	Arkansas	Zip code:	72006
	Tel #:	870-347-2534				
	Website:	www.arcare.net				
Primary Contact Information:	Name:	Rebekah Youngman				
	Title:	Delta States Project Director				
	Tel #:	870-347-3390				
	Email:	Rebekah.youngman@arcare.net				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Sep 2020 to Aug 2021	$1,132,080
	Sep 2021 to Aug 2022	$1,132,080
	Sep 2022 to Aug 2023	$1,132,080
	Total Funding	**$3,396,240**

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	ARcare	Cross, Independence, Izard, Jackson, Mississippi, Poinsett, Prairie, White, Woodruff	AR	FQHC
	Boston Mountain Rural Health Center	Baxter, Izard, Marion, Searcy, Stone, Van Buren	AR	FQHC
	1st Choice Healthcare	Clay, Fulton, Lawrence, Randolph, Sharp	AR	FQHC
	Crowley's Ridge Development Council, Inc.	Cross, Greene, Jackson, Poinsett, Woodruff	AR	Community Action Agency
	Unity Health	White	AR	Hospital
	White River Medical Center	Independence	AR	Hospital

Counties the project serves:	Baxter, Clay, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Marion, Mississippi, Poinsett, Prairie, Randolph, Searcy, Sharp, Stone, Van Buren, White, Woodruff

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☐	Pacific Islanders	☒
	African Americans	☒	Pre-school children	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☒	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐

	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other: Adults 50-74	☒
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Education and Promotion	☒
	Access: Specialty Care	☒	Health Information Technology	☒
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☒
	Behavioral/Mental Health	☒	Maternal/Women's Health	☐
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☒	Oral Health	☐
	Chronic Disease: Diabetes	☐	Pharmacy Assistance	☒
	Chronic Disease: Asthma/COPD	☒	Physical Fitness and Nutrition	☒
	Community Health Workers /Promotoras	☐	School Health	☐
	Coordination of Care Services	☒	Substance Abuse	☒
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

The Arkansas Health Improvement Coalition consists of ARcare (lead applicant/ FQHC), Boston Mountain Rural Health Center (BMRHC/FQHC), 1st Choice Healthcare (FQHC), Crowley's Ridge Development Council (community action agency), Unity Health (hospital), and White River Medical Center (hospital. Coalition members are committed to the rural communities we serve and providing access to programs that will improve the quality of life for the residents in those communities. Selected evidence-based models for the project include:

1. Transitional Care Management;
2. Medication Therapy Management,
3. Remote Patient Monitoring
4. PRAPARE Social Risk Assessment Tool.

Patients presenting at one of the 35 Coalition member clinic sites in Arkansas Service Region B or the 2 hospital locations will be given top priority for these services. Patients can be assured they will receive the most appropriate treatment while ensuring that health care services are not duplicated. Registered nurses will implement Remote Patient Monitoring (technology to enable monitoring of patients outside of conventional clinic settings such as in the home) for patients who present with a diagnosis of cardiovascular disease or obesity at one of the Coalition's primary care clinics or through hospital discharge/referral to care. A hospital liaison will serve as the point person between the hospital and the primary care clinic for Transition of Care Management services, which is a 30-day program after hospital discharge to ensure there are no gaps in care for the patient.

Clinical Pharmacist will be available to provide Medication Therapy Management services to assess and review patient medications and look for any possible medication errors or anything that would cause an adverse event, provide counseling on the medication to the patient or consult with a medical provider regarding patient medications.

Enhancing and expanding scheduling of annual wellness visits and preventive visits for our high-risk patients in the 20-county service area. By the end of Year 3 of the project, the Coalition anticipates developing and presenting this level of patient wellness care as a Population health and Value Based Care Best Practice model.

The Behavioral Health component will allow for coordination of training events/sessions for Coalition member organizations on behavioral health care coordination workflows and protocols, assess gaps in behavioral health care and resources for the 20-county service area, collaborate with existing mental/behavioral health agencies/professionals on

service delivery opportunities, and continue to work with the Arkansas Office of Rural Health and the Arkansas Foundation for Medical Care on initiatives to address the opioid and substance use epidemic in the Coalition's service area. Implementing and integrating PRAPARE (social determinants of health tool) into electronic medical record system.

This will allow the primary care clinic sites to collect data on the patient's social determinant needs and measure patient complexity on non-clinical risks to demonstrate the value of the Coalition's FQHCs in effectively meeting the needs of the complex patients.

Expected Outcomes:

The expected outcomes for the project include, but are not limited to: improved health outcomes and quality of life for program participants, reduction in 30-day readmissions and/or ER visits among program participants, increased capacity to address cardiovascular disease and/or obesity and overlapping mental health issues among the targeted age group in Arkansas Service Region B, increase in health care providers that can assess for social determinants of health of these complex patients and find appropriate resources for them, and residents are better aware of programs & resources available in the Coalition's service area. With the blended use of TCM and the RPM equipment, participants can be directly connected to a clinical team and/or provider for signs or conditions which require immediate attention but may not be urgent enough to require an emergency room visit or hospital stay. Monitoring from home will also be able to give the participant a sense of security as they are able to check in on their health and vital signs on their own.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Arkansas Health Improvement Coalition has selected the following evidence-base models to address the primary focus of cardiovascular disease and/or obesity for residents age 50-74 in the Arkansas Service Region B. Remote Patient Monitoring (RPM) is 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 healthcare professionals. Electronic devices are sent home with patients to monitor their glucose, BP, weight & oxygen levels. Patients will keep these devices anywhere from 8-12 weeks depending on the patient's results. The Clinical Care Coordinator (RN) will conduct continuous monitoring of these levels and will note any changes as well as discuss changes/ issues with the provider. Depending on needs of the patient, clinics can conduct the following labs/tests for patients diagnosed with CAD – EKG, Cholesterol level, TC, LDL; for patients with Congestive Heart Failure – BNP and EF. ARcare (lead applicant) is currently using this practice in three of its clinic locations in Arkansas. Due to patient engagement and success (improved health outcomes) with participants, the Coalition determined to implement this practice throughout the Delta States territory primary care clinic sites. Transitional Care Management (TCM) includes the partnership between the hospitals and the FQHC partners for hospital patients with a cardiovascular disease diagnosis (including Congestive Heart Failure).

Transitional Care Coordinators will serve as the liaison between the hospital and the Coalition member organization. This staff member will be responsible for contacting the hospital to request any discharge lists and/or paperwork on recently discharged patients (related to cardiovascular disease) if needed. This staff member will then attempt to contact the patient within the 48-hour timeframe of discharge from the hospital. If contact is successful, a visit with the patient's provider of choice will be scheduled within the 7-day timeframe. A second follow-up will be scheduled with the provider with the 30-day discharge period. If the patient is able to stay out of the hospital within the 30-day timeframe, then the FQHC can bill patient insurance for TCM services. The Coalition has agreed to use a Care Coordinator model due to the improved patient experience, improved health outcomes, and reduced cost of care for the patients.

Medication Therapy Management (MTM) is a range of services provided to individual patients to optimize therapeutic outcomes (help patients get the most benefit from their medications) and detect and prevent costly medication problems. Services will be provided on a referral basis from the patient's provider. The Clinical Pharmacist will meet with the patients (in person or virtual) to discuss medications, how to take the medications and follow the treatment plan, any adverse effects the patient has had, and will review the patient's medication list. The Clinical Pharmacist will consult with the provider on any changes that need to be made to the medications or treatment plan and work the family on medication adherence and compliance.

PRAPARE is a social determinant assessment tool that can be integrated into the electronic medical record system of each FQHC and possibly the hospital partners in the Coalition. These assessments along with care coordination of the

patient will allow the Coalition to address the whole person, not just the health issue at hand. The medical partners in the Coalition will work with the community action agencies within their area to refer patients for these social determinants needs and track those who receive the services. CRDC, a Coalition member, will work with the partners and other agencies throughout Arkansas Service Region B to develop and implement a tracking system for this level of care

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Brandy Holloman				
	Tel #:	404-413-0314				
	Email:	bholloman@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Arkansas, Service Region A

Arkansas Rural Health Partnership

Grant Number:	D60RH36759					
Organization Type:	Network					
Grantee Organization Information:	**Name:**	Arkansas Rural Health Partnership				
	Address:	1969 Lakehall Rd.				
	City:	Lake Village	**State:**	Arkansas	**Zip code:**	71653
	Tel #:	870-632-7299				
	Website:	www.arruralhealth.org				
Primary Contact Information:	**Name:**	Amber O'Fallon				
	Title:	Project Director / Clinical Director				
	Tel #:	870-461-0276				
	Email:	amberofallon@arruralhealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Aug 2020 to Jul 2021	$1,018,872
	Aug 2021 to Jul 2022	$1,018,872
	Aug 2022 to Jul 2023	$1,018,872
	Total Funding	**$3,056,616**

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	DeWitt Hospital and Nursing Home	Arkansas	AR	CAH
	Baptist Health Medical Center	Arkansas	AR	Acute Care Hospital
	Ashley County Medical Center	Ashley	AR	CAH
	Bradley County Medical Center	Bradley	AR	CAH
	Chicot Memorial Medical Center	Chicot	AR	CAH
	Dallas County Medical Center	Dallas	AR	CAH
	Delta Memorial Hospital	Desha	AR	CAH
	McGehee Hospital	Desha	AR	CAH
	Drew Memorial Health System	Drew	AR	Acute Care Hospital
	Jefferson Regional Medical Center	Jefferson	AR	Acute Care Hospital
	Helena Regional Medical Center	Monroe	AR	Acute Care Hospital
	Ouachita County Medical Center	Ouachita	AR	Acute Care Hospital
	Medical Center of South Arkansas	Union	AR	CAH

Counties the project serves:	Arkansas, Ashley, Bradley, Calhoun, Chicot, Dallas, Grant, Jefferson, Lee, Lincoln, Lonoke, Monroe, Ouachita, Phillips, St. Francis, Union

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☒	Pacific Islanders	☒
	African Americans	☒	Pre-school children	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☒	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☒	Other:	☐
	Focus Area:	**Yes**	**Focus Area:**	**Yes**

Focus areas of grant program:	Access: Primary Care	☒	Health Education and Promotion	☒
	Access: Specialty Care	☐	Health Information Technology	☒
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☐	Maternal/Women's Health	☐
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☐	Oral Health	☐
	Chronic Disease: Diabetes	☐	Pharmacy Assistance	☒
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☐
	Community Health Workers /Promotoras	☒	School Health	☐
	Coordination of Care Services	☒	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☒
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

AHRP's project is designed to:

1. Strengthen the organizational and infrastructural capacity of hospital and primary care clinic partners to improve quality of care (with a specific focus on individuals with chronic disease) throughout the rural south Arkansas Delta Region by 2023.
2. Increase the number of qualified staff in the region dedicated to strengthening and supporting the health workforce and health care service delivery.
3. Provide health workforce training to support the delivery of high quality, best practices in the primary care setting.
4. Improve the delivery of preventive and clinical health services to address social determinants of health and opportunities for telehealth resources (specifically for those individuals with chronic disease) by 2023.
5. Enhance efforts to decrease barriers to care for individuals diagnosed with chronic illnesses.
6. Increase access to available healthcare and social service resources, including social determinants of health, for the target population through the expansion of effective communication strategies.
7. Promote and optimize the use of telehealth services and remote patient monitoring resources for local healthcare partners through training and exposure to available resources.

Expected Outcomes:

ARHP's expected outcomes are:

1. Continual engagement of consortium members throughout grant increases leveraging of resources and sustainability of project; project activities have a regional impact on quality and delivery of health care services as evidence-based models are implemented and sustained.
2. Formalized processes and program services are imbedded into organizational infrastructure of consortia members; dissemination methods (print, web, social media, and presentations) share project impact on a local, regional, state, and national level.
3. Inform and educate public of need for evidence-based clinical efforts, program impact, and sustainability efforts.
4. Additional funding secured for sustaining the project.
5. Increase in skilled health workforce in region; increase in ability for clinic partners to achieve chronic disease improvements; successful project activities and related staff are sustained beyond grant funding.
6. Grant deliverables are consistently tracked, measured, and collected; documented evidence of effective plans enable replication in other rural settings.
7. Increased number of staff available to care for patient needs that contribute to health outcomes; decrease in barriers to care experienced by patients engaged in population health services; increase in medication and treatment adherence in patients engaged in population health services.
8. Decreased barriers to accessing quality health workforce education in local, rural setting; increased learning opportunities for health workforce in the Arkansas Delta and improved quality of care in the Arkansas Delta

9. Increased understanding and correct usage of communication methods by senior leadership, staff, board members, and contractors; increased access to and utilization of healthcare and support services among the target population
10. Increased understanding throughout service area of newly available training, education, and services offered through program; increased utilization of new training, services, and resources by community members and providers.
11. Increased access to needed healthcare and support services among community members.
12. Increased communication improves knowledge, collaborative efforts, and savings among consortia members.
13. Improved understanding of current telehealth capabilities as well as learning what telehealth and remote patient monitoring services are needed/desired by partner clinics.
14. Increased knowledge of available telehealth resources within the state.
15. Increased knowledge of available remote patient care monitoring equipment and resources within the state.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Community Organizer and Capacity Builder Model - the skills and roles of a Community Health Worker include the ability to: provide support to individuals and communities for identifying and prioritizing needs and using available resources to meet those needs, offer information and support for people, provide advocacy services, collaborate with community partner, and build or participate in rural networks and coalitions.

Simulation-Based Healthcare Education (Simulation-Based Mastery Learning) - Simulation is increasingly being used in healthcare education to teach cognitive, psychomotor, and affective skills to individuals and teams. Simulation-based mastery learning, or SBML, significantly improves skills for all participants, and leads to skill retention.

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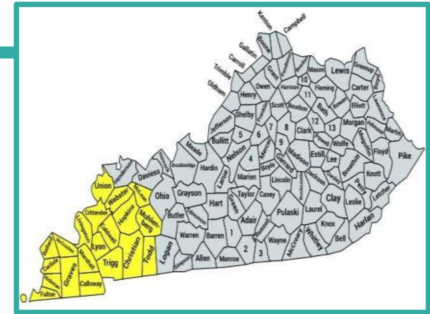
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Brandy Barnett Holloman				
	Tel #:	404-413-0314				
	Email:	bholloman@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Kentucky, Service Region A

Baptist Health Madisonville, Inc.

Grant Number:	D60RH36760
Organization Type:	Hospital (Non-CAH)

Grantee Organization Information:						
	Name:	Baptist Health Madisonville, Inc.				
	Address:	900 Hospital Drive				
	City:	Madisonville	**State:**	Kentucky	**Zip code:**	42431
	Tel #:	270-825-5100				
	Website:	https://www.baptisthealth.com/madisonville/				

Primary Contact Information:		
	Name:	Kelcey Rutledge
	Title:	Director
	Tel #:	270-824-3736
	Email:	kelcey.rutledge@bhsi.com

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Aug 2020 to Jul 2021	$1,132,080
	Aug 2021 to Jul 2022	$1,132,080
	Aug 2022 to Jul 2023	$1,132,080
	Total Funding	**$3,396,240**

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	The Alliance for a Healthier Generation	Multnomah	OR	Health Promotion
	West Area Health Education Center	Hopkins	KY	Health Education

Counties the project serves:	Ballard, Caldwell, Calloway, Carlisle, Christian, Crittenden, Fulton, Graves, Hickman, Hopkins, Livingston, Lyon, Marshall, McCracken, McLean, Muhlenberg, Todd, Trigg, Union, Webster

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☒	Pacific Islanders	☒
	African Americans	☒	Pre-school children	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☐	School-age children (elementary)	☒
	Infants	☐	School-age children (teens)	☒
	Latinos	☒	Uninsured	☐
	Native Americans	☒	Other:	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Education and Promotion	☒
	Access: Specialty Care	☐	Health Information Technology	☐
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☐	Maternal/Women's Health	☐
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☐	Oral Health	☐
	Chronic Disease: Diabetes	☐	Pharmacy Assistance	☐
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☐

	Community Health Workers /Promotoras	☐	School Health	☐
	Coordination of Care Services	☐	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

The Baptist Health School Wellness Initiative will be an anti-obesity wellness promotion program offered by the Delta Rural Network Center at Baptist Health Madisonville, Inc. in Madisonville, KY. The initiative will serve far Western Kentucky's twenty rural Mississippi Delta region counties and offers assistance to public service area school districts, elementary, middle, and high schools with:

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

Expected Outcomes:

The expected outcomes of the proposed Initiative relating to schools and communities are:

- Retained school participation;
- Sustainable wellness leadership group structure;
- Retention of school and/or classroom-based physical activity beyond required school health and physical education including GoNoodle ® and/or similar programming i.e. Adventure to Fitness, Brain Breaks, TAKE 10! ®, walking clubs, running clubs, etc.;
- School wellness action planning preparedness;
- School commitment to continued wellness activity integration into school culture; and
- Community education on anti-obesity, self-care, and overall wellness as it relates to healthy living, healthy eating, exercise and physical activity.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Baptist Health School Wellness Initiative (BHSWI or the Initiative) school wellness leadership group framework development is patterned after the Alliance for a Healthier Generation's "Healthy Schools Program Framework coordinated school health program promising practice model." Besides terminology re-wording to describe Baptist Health School Wellness Initiative operations, there are no changes to the Healthy Schools Program model. Such wording includes team of stakeholders, listed as wellness leadership group, or wellness group, or wellness committee; and school wellness facilitator, labeled school champion. BHSWI will also offer and promote the evidence-based GoNoodle ® 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. BHSWI will assist middle and high school wellness leadership groups in working with principals and staff to ensure students receive the opportunity for sixty daily physical activity minutes within the school day, and incorporate age-appropriate school and/or classroom physical activity programming such as such as classroom movement breaks and physical activity clubs.

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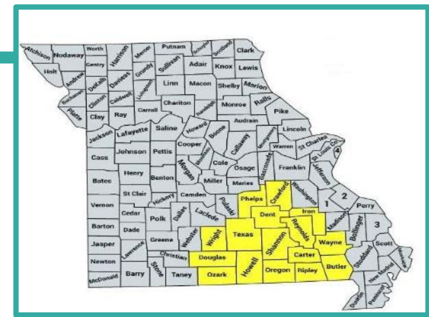
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Rachel Campos				
	Tel #:	404-413-0314				
	Email:	rcampos1@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Missouri, Service Region B

Big Springs Medical Association, Inc.

Grant Number:	D60RH36761					
Organization Type:	Federally Qualified Health Center (FQHC)					
Grantee Organization Information:	**Name:**	Big Springs Medical Association, Inc.				
	Address:	PO BOX 157				
	City:	Ellington	**State:**	Missouri	**Zip code:**	63638
	Tel #:	573-663-2313				
	Website:	www.mohigh.org				
Primary Contact Information:	**Name:**	Amie Brooks				
	Title:	Program Director				
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Aug 2020 to Jul 2021	$905,664
	Aug 2021 to Jul 2022	$905,664
	Aug 2022 to Jul 2023	$905,664
	Total Funding	**$2,716,992**

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Carter County Health Center	Carter	MO	Health Center
	Crawford County Health Department	Crawford	MO	Health Department
	Dent County Health Department	Dent	MO	Health Department
	Douglas County Health Department	Douglas	MO	Health Department
	Howell County Health Department	Howell	MO	Health Department
	Oregon County Health Department	Oregon	MO	Health Department
	Ozark County Health Department	Ozark	MO	Health Department
	Parkland Health Mart Pharmacy	Iron	MO	Pharmacy
	Phelps/Maries County Health Department	Phelps	MO	Health Department
	Reynolds County Health Center	Reynolds	MO	Heath Center
	Ripley County Health Center	Ripley	MO	Health Center
	Shannon County Health Center	Shannon	MO	Health Center
	Texas County Health Department	Texas	MO	Health Department
	Whole Health Outreach	Reynolds	MO	Faith Based Org
	Whole Kids Outreach	Reynolds	MO	Faith Based Org
	Wright County Health Department	Wright	MO	Health Department
	Your Community Health Center	Phelps	MO	Community Health Center

Counties the project serves:	Oregon, Iron, Douglas, Shannon, Dent/Reynolds, Texas, Reynolds, Crawford, Iron, Ripley, Reynolds, Carter, Shannon, Ripley, Ozark, Carter, Wayne, Wright, Texas, Iron, Wayne, Reynolds, Wayne, Wright, Ripley, Butler, Wayne, Wayne, Iron, Butler, Phelps, Crawford, Carter, Iron, Howell, Wayne

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☐	Pacific Islanders	☐

	African Americans	☐	Pre-school children	☐
	Caucasians	☐	Pregnant Women	☒
	Elderly (65 and older)	☐	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐
	Latinos	☐	Uninsured	☒
	Native Americans	☐	Other:	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Education and Promotion	☐
	Access: Specialty Care	☐	Health Information Technology	☐
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☐	Maternal/Women's Health	☒
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☐	Oral Health	☐
	Chronic Disease: Diabetes	☒	Pharmacy Assistance	☐
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☐
	Community Health Workers /Promotoras	☒	School Health	☐
	Coordination of Care Services	☒	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☒
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

Big Springs Medical Association, Inc., completing business as Missouri Highlands Health Care (MHHC), is a non-profit health care provider and a Federally Qualified Health Center (FQHC). In partnership with Your Community Health Center, another FQHC, area health departments, two-faith based organizations, and a pharmacy, MHHC will seek to: improve access to care, provide care coordination services, and improve health outcomes for Missouri Delta Region A residents. Many residents of Missouri Delta Region A face generational poverty and culture whereby health care is addressed only in an acute stage, when pain is extreme. The lack of available health care providers compounds access challenges, and a lack of specialists willing to serve the rural area impedes health outcomes for many.

The Delta Project consists of the following program models: the community health worker model, diabetes self-management model, women's health care model, and utilization of Telehealth services model. The community health worker model functions to provide care coordination to low-income individuals in Missouri Delta Region A who are uninsured or under-insured. The community health workers utilize the PRAPARE tool to identify needed community services and resources and then assist the patient with obtaining the needed resources and services.

The diabetes self-management model is a coordinated effort between the health departments and community members to educate the public on diabetes self-management. The health departments utilize the T2 Curriculum to provide diabetic prevention and management strategies to the patient. In addition, a patient with an uncontrolled A1C level can choose to participate in the High Risk Diabetes Clinic in which the Diabetic Educator provides regular follow up as to diabetic health related information and guidance in an effort to lower the patient's A1C level. The women's health care services model increases access to women's health care services (i.e. birth control and gynecological services) in rural Missouri Delta Region A. This increase in access to care is provided by the addition of The Missouri Highlands Women's Clinic.

The Telehealth services model provides patients with the ability to meet with their primary provider, dietitian, and a licensed clinical social worker via a communication platform (i.e. Zoom) or by phone call. The ability for patients to be able to utilize Telehealth services has increased access to care in the rural Missouri Delta Region A territory.

Expected Outcomes:

In partnership, consortium members seek the following outcomes related to the project:

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

- Number of residents receiving diabetes education using Prevent T2 Curriculum to address healthy eating, being physically active, and reducing risk
- Number receiving diabetes self-management education and support
- Number of patients who receive nutrition counseling
- Number of adults who are referred for A1c diagnostic testing services
- Number of adults who complete A1c diagnostic testing services.

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

- Number of patients served and patient visits provided
- Number of relationships created to enhance access to prenatal care and women's health services
- Percentage of women who access prenatal care in the first trimester (target above Missouri UDS average of 69.29%)
- Percent of low birth weight babies (target below state average of 9.7%)
- Number of women who are referred for women's health and annual wellness exams
- Percentage who complete age-appropriate screening services (target increasing from 54.9% to 60.0% for cervical cancer screening).

Goal 3: Improve network collaboration, communication, action planning, and sustainability.
Outcome measures for Goal 3 include:

- Strengthen partnership and shared vision (target increasing Assessment for Advancing Community Transformation or AACT tool from 7 to 9)
- Strengthen internal and external communication (target increasing AACT tool from 6 to 8)
- Identify community needs and assets, establish goals, and design strategies for change (target increasing AACT tool from 6 to 8)
- Diversity of resources, plan for sustainability, implement policy and system change (target increasing AACT tool from 7 to 9).

Evidence Based/ Promising Practice Model Being Used or Adapted:

Chronic Disease Self-Management: High-risk patients diagnosed with diabetes, whose A1c has historically been greater than 9.0, will be invited to enroll in the Delta Cares Diabetic Clinic, which will include a provider team to address chronic disease management, incorporating one-on-one patient educations, behavioral change, medication adherence and titration of insulin, as well as nutritional counseling. In addition, area health departments will address healthy eating, being physically active, and reducing risk as part of the CDC's PreventT2 curriculum.

Community Health Workers: Delta Cares Community Health Workers will provide outreach and assistance to clients in need, connecting them with resources to improve their overall health and well-being, as well as providing peer support and holding clients accountable for their daily health-related decisions. Community Health Workers (5.0 FTE) will be deployed throughout the region and provide supportive services to improve health outcomes.

Telehealth and Show-Me ECHO: Missouri Highlands Health Care's clinic locations are equipped to provide telehealth, and the organization maintains 26 Zoom licenses. Telehealth will be utilized to connect patients with transportation barriers to providers as well as connect specialists to aid in patient care via the University of Missouri Show-Me ECHO program. Via Show-Me ECHO, MHHC providers will have access to endocrinologist and obstetric/gynecological specialists to help give their patients the right care, in the right place, at the right time.

PRAPARE (Protocol for Responding to and Assessing patients' Assets, Risks, and Experiences) Tool: This tool, developed by the National Association of Community Health Centers, aids provider teams in assessing and

understanding their patients' social determinants of health and the impact on their wellbeing. The tool is part of a national effort and has been shown to aid in integrated and supportive services to meet the needs of patients by connecting them with the resources they need.

Prevent T2 Curriculum: The Centers for Disease Control and Prevention (CDC) have engaged in a national effort to offer evidence-based cost-effective interventions to help prevent type 2 diabetes in communities. Health Department network partners will utilize this evidence-based curriculum to educate and engage residents in lifestyle modifications to reduce their diabetes risk.

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Coleman Tanner				
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	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Prev TOC Next

Mississippi, Service Region A

Delta Health Alliance, Inc.

Grant Number:	D60RH36762					
Organization Type:	Rural 501c3 organization					
Grantee Organization Information:	**Name:**	Delta Health Alliance, Inc., a rural 501c3 organization				
	Address:	435 Stoneville Road, P.O. Box 277				
	City:	Stoneville	**State:**	Mississippi	**Zip code:**	38776
	Tel #:	662-686-7004				
	Website:	www.deltahealthalliance.org				
Primary Contact Information:	**Name:**	Bria Beal				
	Title:	Program Director				
	Tel #:	662-394-6934				
	Email:	bbeal@deltahealthalliance.org				
Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**				
	Aug 2020 to Jul 2021	$1,018,872				
	Aug 2021 to Jul 2022	$1,018,872				
	Aug 2022 to Jul 2023	$1,018,872				
	Total Funding	**$3,056,616**				
Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**		
	*Baptist Memorial Hospital-North MS	Lafayette	MS	Hospital		
	Bolivar Medical Center	Bolivar	MS	Hospital		
	Delta Regional Medical Center	Washington	MS	Hospital		
	North Sunflower Medical Center	Sunflower	MS	Hospital		
	South Sunflower Medical Center	Sunflower	MS	Hospital		
Counties the project serves:	Attala, Bolivar, Carroll, Coahoma, Grenada, Holmes, Lafayette, Montgomery, Panola, Quitman, Sunflower, Tallahatchie, Tippah, Tunica, Union, Washington, Yalobusha					
Target population served:	**Population**	**Yes**	**Population**	**Yes**		
	Adults (18 – 64)	☒	Pacific Islanders	☒		
	African Americans	☒	Pre-school children	☐		
	Caucasians	☒	Pregnant Women	☐		
	Elderly (65 and older)	☒	School-age children (elementary)	☐		
	Infants	☐	School-age children (teens)	☐		
	Latinos	☒	Uninsured	☐		
	Native Americans	☒	Other:	☐		
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**		
	Access: Primary Care	☐	Health Education and Promotion	☒		
	Access: Specialty Care	☐	Health Information Technology	☐		
	Acute Ischemic Stroke	☒	Health Professions Recruitment and Retention/Workforce Development	☐		
	Aging	☐	Integrated Systems of Care	☐		

	Behavioral/Mental Health	☐	Maternal/Women's Health	☐
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☐	Oral Health	☐
	Chronic Disease: Diabetes	☐	Pharmacy Assistance	☐
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☐
	Community Health Workers /Promotoras	☒	School Health	☐
	Coordination of Care Services	☐	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

The Delta Stroke Initiative was developed as a three-year project that serves 18 Mississippi rural counties. This program is designed to educate low-income, minority residents of rural communities about preventing stroke and its' recurrence. The first set of activities involves working with hospital administration to target and work directly with those patients that need additional care and assistance post-discharge after a stroke diagnosis. The second set of activities involves health education, and local outreach by a network of trained Community Health Workers, and certified nurse assistants that provide the extra layer of care the patients need upon discharge from the hospital.

Expected Outcomes:

The Delta Stroke Initiative has as its targeted outcomes the following:

- Reduced 30-day unplanned readmission to the hospital after a stroke
- Enhanced chronic disease management
- Increase in the number of patients with stroke diagnosis receiving nutrition counseling and education
- Decreased stroke rate through education
- Increased awareness of the early warning signs for stroke
- Increased awareness of stroke as well as its signs and symptoms

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Delta Stroke Initiative utilizes three evidence-based models to achieve its goals, including

- The Value-Driven Healthcare System model supported by the U.S. Department of Health and Human Services for improved interoperability of Health Information Technology systems
- The Community Health Worker model promoted by the Office of Rural Health Policy
- Dr. Eric Coleman's Care Transitions model for improved care coordination. Under the value-driven health care model, interoperable health information technology underpins health care reform.

Through value-driven model, patients spend less for better outcomes, patient satisfaction increases, and it is efficient for healthcare providers. This is especially important for providers as there are decreased reimbursements resulting from readmissions.

Measuring quality of care requires standardization of performance measures. The Community Health Worker model and the Coleman's Care Transitions model are incorporated into the program as they are the basis in which the community health workers and certified nurse assistants will ensure the patients' needs are met during the transition from hospital to home.

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	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant	**Name:**	Amanda Martinez				
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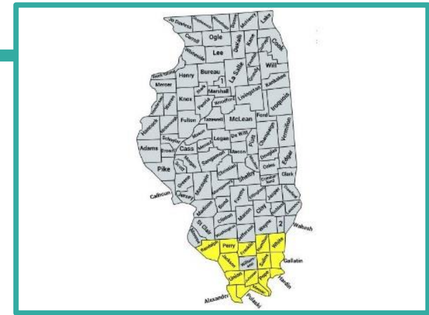
	Email:	aphillipsmartinez@gsu.edu				

Contact Information:	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303



Illinois, Service Region A

Egyptian Public & Mental Health Department

Grant Number:	D60RH36763					
Organization Type:	County Health Department					
Grantee Organization Information:	**Name:**	Egyptian Public and Mental Health Department				
	Address:	1412 US Highway 45N				
	City:	Eldorado	**State:**	Illinois	**Zip code:**	62930
	Tel #:	618-294-8322				
	Website:	https://egyptian.org/				
Primary Contact Information:	**Name:**	Angie Hampton				
	Title:	CEO				
	Tel #:	618-279-3326				
	Email:	ahampton@egyptian.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Aug 2020 to Jul 2021	$849,060
	Aug 2021 to Jul 2022	$849,060
	Aug 2022 to Jul 2023	$849,060
	Total Funding	**$2,547,180**

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	American Cancer Society	Illinois Delta Counties	IL	Non-profit Organization
	Centerstone	Illinois Delta Counties	IL	Behavioral Health
	Franklin/Williamson Bi-County Health Department	Franklin/Williamson Counties	IL	Public Health Department
	Jackson County Health Department	Jackson County	IL	Public Health Department
	Perry County Health Department	Perry County	IL	Public Health Department
	Southern Illinois Healthcare (SIH)	Illinois Delta Counties	IL	Hospital System
	Southern Illinois School of Medicine Center for Rural Health and Social Service Development	Illinois Delta Counties	IL	University
	Southern Seven Health Department	Alexander,	IL	Public Health Department
	University of Illinois Extension	Illinois Delta Counties	IL	University

Counties the project serves:	Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Perry, Pope, Pulaski, Randolph, Saline, Union, White

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☐	Pacific Islanders	☐

	African Americans	☐	Pre-school children	☒
	Caucasians	☐	Pregnant Women	☐
	Elderly (65 and older)	☐	School-age children (elementary)	☒
	Infants	☐	School-age children (teens)	☒
	Latinos	☐	Uninsured	☐
	Native Americans	☐	Other:	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Education and Promotion	☐
	Access: Specialty Care	☐	Health Information Technology	☐
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☒	Maternal/Women's Health	☐
	Children's Health	☒	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☒	Oral Health	☐
	Chronic Disease: Diabetes	☒	Pharmacy Assistance	☐
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☐
	Community Health Workers /Promotoras	☐	School Health	☐
	Coordination of Care Services	☐	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

Mental health disparities and high child poverty rates permeate the Illinois Delta counties. In the 2018 Illinois Youth Survey (IYS), 38.1% of youth in Delta schools who participated reported that, during the past 12 months they felt so sad or hopeless every day for two weeks or more in a row that they stopped doing some of their usual activities. This statistic has increased from 25.3% in 2014, showing there is still more work to be done.

The Illinois CATCH onto Health Consortium (ICHC), of which the Egyptian Public and Mental Health Department (EHD) and SIU Medicine's Center for Rural Health and Social Service Development are founding members, plans to enhance and expand the successful, current school-based efforts by expanding the strong emotional and mental health component.

This expanded focus will incorporate the Signs of Suicide (SOS) curriculum, provide bullying and character education, train community and school personnel in Mental Health First Aid (MHFA), and strengthen the region's mental health workforce serving school-aged children. Additional work with regional partners and initiatives will strive to connect available resources to ensure Delta youth are able to access and utilize the necessary services.

The ICHC is expanding its reach to include a focus on HIV/AIDs in the Illinois Delta region. This work will be supported through the region's Ryan White Part B HIV Care Connect agency, the Jackson County Health Department. Further, HIV/AIDs curricula will be introduced into the school setting throughout the region.

The introduction of this new curriculum, in addition to expanding the current initiatives, reflects a continued commitment to the implementation of the expanded Whole School, Whole Community, Whole Child (WSCC) model to improve overall health of youth in the Illinois Delta Region. The ICHC will provide leadership for building increased capacity for Illinois Delta schools to continue effectively improving school health through policy, systems, and environmental change, thus promoting sustainability and a strong fundamental attitude= regarding the importance of general wellness, both in schools and in the community.

Expected Outcomes:

The ICHC is working to increase health equity, health literacy, and remove barriers that allow for making the healthy choice the easy choice throughout the Delta region. The ICHC wants to positively impact the close relationship between health and education, as well as, foster health and well-being within the school environment, and surrounding community, for all students and their families.

To accomplish this task the ICHC expanded its thinking and programmatic efforts to look at all of the social determinants of health. The range of personal, social, economic, and environmental factors that influence health and often fall outside the hospital or clinic walls, yet their inter-relationship affects individual and community health.

These factors disproportionately affect vulnerable and underrepresented populations and adversely affect quality of life and health for all of us. Because of this, the ICHC strives to implement interventions that are community-based and target multiple determinants of health. The ICHC does this by engaging allies from outside the traditional boundaries of health care facilities and the public health sector such as education and social work. Health and education must work together whenever possible. Schools are the perfect setting for the culmination of these collaborations, and it is our belief, that these collaborations can achieve great outcomes. The ICHC suggests that the development of a positive social and emotional school climate will increase academic achievement, reduce stress, improve health behaviors, and improve positive attitudes toward self and others.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Whole School, Whole Community, Whole Child School Health Model: The overarching model that guided programming decisions was the Association for Supervision and Curriculum Development's (ASCD) and the Center for Disease Control and Prevention's (CDC) Expanded Coordinated School Health (CSH) model the Whole School, Whole Community, Whole Child (WSCC) model. The expansion model focuses additional attention on the effect of the Social and Emotional Climate and the Physical Environment of schools on children's overall health.

Coordinated Approach to Child Health: The primary program proposed within this model is the nationally recognized Coordinated Approach to Child Health (CATCH) school health program. CATCH is designed to include classroom teachers, physical education teachers, school nutritional service staff, and children's families and guardians in the planning and implementation of the program. The coordination among these components designates CATCH as a coordinated school health program. This program has been shown to be effective to improve physical activity among, improve the school nutritional environment for, and decrease overweight among, elementary school students.
Mental Health First Aid. Mental Health First Aid (MHFA) is an international training program originating in Australia in 2000 aimed at equipping individuals with the skills and education to assist someone experiencing a mental health or substance use-related crisis. MHFA is listed in the Substance Abuse and Mental Health Services Administration's (SAMSHA) National Registry of Evidence-based Programs and Practices (NREPP).

Signs of Suicide. The SOS Signs of Suicide Prevention Program (SOS) is a school-based depression awareness and suicide prevention program designed for middle-school and/or high-school students. Signs of Suicide is included in SAMHSA's NREPP as an intervention program with evidence of effectiveness.

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	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Rachel Campos				
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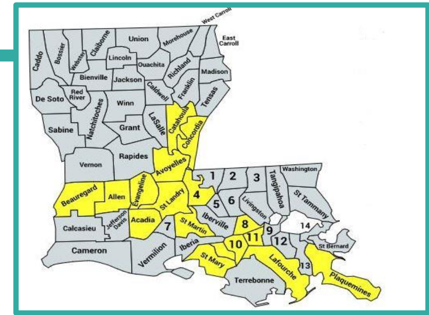
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Louisiana, Service Region B



Health Enrichment Network, The

Grant Number:	D60RH36764					
Organization Type:	Network, Non- Profit					
Grantee Organization Information:	**Name:**	The Health Enrichment Network				
	Address:	713 E. 7th Avenue				
	City:	Oakdale	**State:**	Louisiana	**Zip code:**	70820
	Tel #:	225-335-2112				
	Website:	www.Eatmovegrow.us				
Primary Contact Information:	**Name:**	Donna Newton				
	Title:	Program Manager				
	Tel #:	318-335-2112				
	Email:	donna@eatmovegrow.us				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	Aug 2020 to Jul 2021	$962,268
	Aug 2021 to Jul 2022	$962,268
	Aug 2022 to Jul 2023	$962,268
	Total Funding	**$2,886,804**

Consortium Partners:	Partner Organization	County	State	Organization Type
	The Health Enrichment Network	Allen	LA	Network
	Louisiana State University Dental School	Orleans	LA	Medical School
	Louisiana State University School of Public Health	Orleans	LA	University
	Southwest LA Area Health Education Center	Lafayette	LA	AHEC
	Southwest LA Area Health Education Center	Tangipahoa	LA	AHEC
	LA Department of Health – WellAhead	EBRP	LA	Health Dept.
	Bunkie General Hospital	Avoyelles	LA	Rural Hospital
	LA Rural Health Association	Assumption	LA	Health Assoc.

Counties the project serves:	Acadia, Allen, Ascension, Assumption, Ayoyelles, Beauregard, Catahoula, Concordia, Evangeline, Jefferson Davis, Lafourche, Plaquemines, Pointe Coupee, St. James, S. Landry, St. Martin, St. Mary

Target population served:	Population	Yes	Population	Yes
	Adults (18 – 64)	☐	Pacific Islanders	☐
	African Americans	☒	Pre-school children	☒
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☐	School-age children (elementary)	☒
	Infants	☐	School-age children (teens)	☐
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Education and Promotion	☒

	Access: Specialty Care	☐	Health Information Technology	☐
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☒	Maternal/Women's Health	☐
	Children's Health	☒	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☐	Oral Health	☒
	Chronic Disease: Diabetes	☐	Pharmacy Assistance	☐
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☒
	Community Health Workers /Promotoras	☐	School Health	☒
	Coordination of Care Services	☐	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

The Health Enrichment Network, Inc. (THEN) is a nonprofit organization that has been dedicated to health education, access to care issues and preventive services in rural Louisiana for twenty years. Under this grant THEN has organized a tight-knit consortium of eight health care organizations and health related governmental agencies to execute EatMoveGrow (EMG), a childhood obesity prevention project to reduce the incidence and prevalence of childhood obesity in 17 rural Louisiana parishes.

EMG is an evidence-based Whole School, Whole Community, Whole Child (WSCC) program providing health educators to support health improvement efforts in 40 rural elementary school. EMG's high touch, technical assistance model is designed to create self-sustaining cultures of health in each EMG school and an ongoing network of support by linking previously isolated rural school together in a supportive peer community. Oral health efforts will promote in-school screening and prevention clinics and provide a Medicaid case management pilot to assist students identified in EMG clinics as having urgent oral health needs. Two evidence-based social emotional learning interventions, Mental Health First Aid and Everyday Speech SEL Curriculum will address the increased adverse childhood experiences faced by children in rural areas.

EatMoveGrow program includes technical assistance and support for the implementation of a myriad of evidence-based practices which in sum compose a CDC recommended Whole School, Whole Community, Whole Child (WSCC) model. The success of the obesity prevention project will be measured by evaluation and outcome measures connected to each EatMoveGrow goal and objective. EatMoveGrow is highly replicable in other rural communities facing similar barriers (geographic isolation, low-income, lack of cultural sensitivity).

Expected Outcomes:

The expected project impact of the expanded WSCC model EatMoveGrow project is a decreased incidence and prevalence of childhood obesity and its associated chronic health issues. The EatMoveGrow program has successfully reduced childhood obesity rates in rural Louisiana. To date, 43% of current EMG participants demonstrated improved BMI measures.

The EMG team has designed and implemented an evaluation plan to measure all expected outcomes:

- Increases in student, staff, and family engagement in health-related activities
- Improvements in school health environment
- Changes in student knowledge, attitude, behavior and total health
- Increases in physical activity
- Changes in policy system and environmental systems

Evidence Based/ Promising Practice Model Being Used or Adapted:

Every EatMoveGrow site will participate in core evidence-based interventions including:

CDC Whole School, Whole Community, Whole Child (WSCC): The EMG project will transition to a full WSCC model with the addition of two SEL components and the expansion of current EMG activities that support each of the ten WSCC components.

CDC School Health Index: The index will be used as the assessment tool in elementary schools to highlight areas of opportunity unique to each school

School Wellness Committees (SWC): Informed by the findings of School Health Index assessments, SWCs will evaluate the school health environment supporting improved programs and policies that impact the health of students, families and staff

Growing Up Fit Together: Staff will provide obesity prevention lessons including nutrition, physical activity, healthy lifestyle, screen time and 5-2-1-0 to students at all 70 partner sites. Developed specifically for the target audience and designed to meet Louisiana Department of Education standards and benchmarks, this curriculum has been selected for both early care programs and elementary schools.

As directed by the WSCC model, the primary evidence-based approaches selected will be supported with a roster of more than twenty additional nutrition and activity evidence-based interventions uniquely bundled to meet each school's needs/goals as identified by their School Wellness Committees. The high touch, localized technical assistance was developed to meet the needs of isolated rural schools and will support all interventions. The EMG methodology and the roster of evidence-based interventions have been extensively evaluated and found to yield replicable improvements in every process measured.

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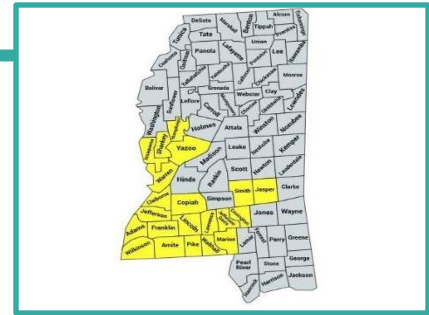
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Rachel Campos				
	Tel #:	404-413-0314				
	Email:	rcampos1@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Mississippi, Service Region B

Jefferson Comprehensive Health Center, Inc.

Grant Number:	D60RH36765					
Organization Type:	Federally Qualified Health Center (FQHC)					
Grantee Organization Information:	**Name:**	Jefferson Comprehensive Health Center				
	Address:	405 Main St.				
	City:	Fayette	**State:**	Mississippi	**Zip code:**	39069
	Tel #:	601-786-3475				
	Website:	www.mississippishineproject.com				
Primary Contact Information:	**Name:**	George Dixon				
	Title:	Project Director				
	Tel #:	601-786-3475 ext. 1035				
	Email:	georgedixon@jchchealth.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Aug 2020 to Jul 2021	$1,188,684
	Aug 2021 to Jul 2022	$1,188,684
	Aug 2022 to Jul 2023	$1,188,684
	Total Funding	**$3,566,052**

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Southeast Mississippi Rural Health Initiative, Inc.	Covington	MS	FQHC
	Jefferson Comprehensive Health Center	Jefferson	MS	FQHC
	Southwest Mississippi Opportunity	Pike	MS	Community Non-Profit
	Sharkey Issaquena Community Hospital	Sharkey	MS	Hospital

Counties the project serves:	Adams, Amite, Claiborne, Copiah, Covington, Franklin, Humphreys, Issaquena, Jasper, Jefferson, Jefferson Davis, Lawrence, Lincoln, Marion, Pike, Sharkey, Smith, Walthall, Warren, Wilkinson, Yazoo

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☒	Pacific Islanders	☐
	African Americans	☒	Pre-school children	☒
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☒	School-age children (elementary)	☒
	Infants	☐	School-age children (teens)	☒
	Latinos	☐	Uninsured	☒
	Native Americans	☐	Other:	☐

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Information Technology	☐
	Access: Specialty Care	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Acute Ischemic Stroke	☐	Integrated Systems of Care	☐
	Aging	☐	Maternal/Women's Health	☐

	Behavioral/Mental Health	☐	Migrant/Farm Worker Health	☐
	Children's Health	☐	Oral Health	☐
	Chronic Disease: Cardiovascular	☐	Pharmacy Assistance	☒
	Chronic Disease: Diabetes	☒	Physical Fitness and Nutrition	☐
	Chronic Disease: Asthma/COPD	☐	School Health	☐
	Community Health Workers /Promotoras	☒	Substance Abuse	☐
	Coordination of Care Services	☐	Telehealth	☐
	Emergency Medical Services	☐	Transportation to health services	☐
	HIV/AIDS	☐	Other: Obesity	☒
	Health Education and Promotion	☒	Other:	☐

Project Description:

The Mississippi SHINE Project is a community-based health networking effort governed by a five-member Consortium that engages a wide variety of health and social service agencies to provide health outreach and services to over 30,000 individuals annually. Additional health marketing and promotion efforts produce a total aggregate impact of over 750,000 encounters. The Network Lead is Jefferson Comprehensive Health Center (JCHC), a Federally Qualified Health Center in Fayette, Jefferson County, Mississippi that has functioned as the federal lead agency for this project since 2007. The service area consists of twenty rural Delta counties in the southwest corner of the state of Mississippi. The primary health issue to be addressed by this grant is obesity.

The primary methodology employed involves collaboration among and between multiple organizations cooperating with a local health network arrangement to provide a variety of health programs and services to individuals within the region. Through the direct provision of health-related services and programs, as well as through very active health marketing initiatives, SHINE intends to reach virtually every individual within the target population to educate on pressing health concerns within the service region and target population. Mississippi continues to lag behind the rest of the nation with some of the worst statistics in regards to chronic disease morbidity and mortality. Key chronic disease risk factors such as obesity and lack of physical activity include strong lifestyle and behavioral components. This provides the Mississippi SHINE Project with great potential to achieve positive impact on the health status of the population. The project addresses these health issues with cost-effective means such as prevention and education services, as opposed to acute care.

Expected Outcomes:

By the end of the grant period, the MS SHINE Network will achieve the following outcomes:

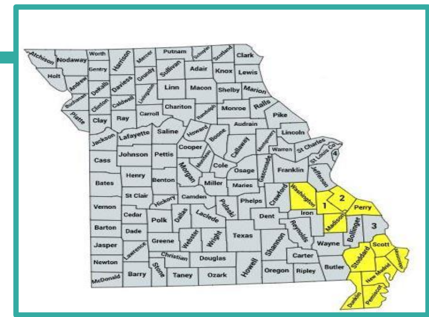
- Provide health education and services to medically indigent residents of all 21 counties and ensure that at least 50% of the JCHC adult patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months had a follow-up plan documented, if they were overweight or obese.
- Conduct 30,000 health screenings to include blood pressure checks, BMI and glucose test readings annually to adults and adolescence and provide blood pressure monitors within the 21 county networks.
- Through collaborations with school districts and fitness centers, provide nutrition and health education and exercise information to combat childhood obesity issues to 20,000 individuals annually.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Community Health Workers Evidenced-Based Workers: The unique role of CHWs as culturally competent mediators (health brokers) between providers of health services and the members of diverse communities have 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, HIV and AIDS. Integrating CHWs into multidisciplinary health teams has emerged as an effective strategy for improving the control of hypertension among high-risk populations. MS SHINE CHWs are responsible for leading partnerships, outreach and education activities and implementing work plans in the counties covered by their Networks.

Body and Soul: Body and Soul is an evidence-based model that is designed for use among faith-based groups, with a focus on increasing fruit and vegetable consumption. He curriculum aims to support churches in implementing church-wide events and environmental changes to support healthier food option. Body and Soul sites are aimed at the entire congregation and include inviting guest speakers, sponsoring food demonstrations, watching a video, and implementing food policy changes to increase the availability of fruits and vegetables. Consenting participants receive two motivational interviewing calls from lay counselors, a cookbook, and several educational pamphlets. Fruit and vegetable intake are measured at baseline and 6-month follow-up. MS SHINE Community Health Workers will bring Body and Soul to area churches and support its roll out with congregational leadership.

Project Officer (PO) Contact Information:	**Name:**	Patricia Burbano				
	Tel #:	301-443-7238				
	Email:	DeltaStatesGrantPrgm@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Amanda Phillips Martinez				
	Tel #:	404-413-0314				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Missouri, Service Region B

Mississippi County Health Department

Grant Number:	D60RH36766					
Organization Type:	County Health Department					
Grantee Organization Information:	**Name:**	Mississippi County Health Department				
	Address:	1200 East Marshall Street				
	City:	Charleston	**State:**	Missouri	**Zip code:**	63834
	Tel #:	573-683-2191				
	Website:	https://www.misscohealth.com/				
Primary Contact Information:	**Name:**	Jody Diebold				
	Title:	Program Director/Registered Dietitian				
	Tel #:	573-683-2191				
	Email:	jdiebold@misscohealth.com				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	Aug 2020 to Jul 2021	$622,644
	Aug 2021 to Jul 2022	$622,644
	Aug 2022 to Jul 2023	$622,644
	Total Funding	**$1,867,932**

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Dunklin County Health Center	Dunklin	MO	Health Department
	Madison County Health Department	Madison	MO	Health Department
	New Madrid County Health Department	New Madrid	MO	Health Department
	Pemiscot County Health Center	Pemiscot	MO	Health Department
	Perry County Health Department	Perry	MO	Health Department
	St. Francois County Health Department	St. Francois	MO	Health Department
	Ste. Genevieve County Health Department	Ste. Genevieve	MO	Health Department
	Scott County Health Department	Scott	MO	Health Department
	Stoddard County Public Health Center	Stoddard	MO	Health Department
	Washington County Health Department	Washington	MO	Health Department
	Community Pharmacy Enhanced Services Network (CPESN-MO)	Missouri Region B	MO	Pharmacy Network
	Southeast Regional Arthritis Center	Missouri Region B		Arthritis Program
	Southeast Missouri Health Network	Dunklin, Mississippi, New Madrid, Pemiscot, Scott & Stoddard	MO	FQHC
	Bootheel Counseling Services	Mississippi, New Madrid, Scott & Stoddard	MO	Mental Health
	Regional Healthcare Foundation	Missouri Region B	MO	Private Foundation

	University of Missouri Extension	Missouri Region B	MO	University Extension
	Missouri Arthritis and Osteoporosis Program	Missouri Region B	MO	Arthritis Program
Counties the project serves:	Dunklin, Madison, Mississippi, New Madrid, Pemiscot, Perry, St. Francois, Ste. Genevieve, Scott, Stoddard, Washington			
Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☒	Pacific Islanders	☐
	African Americans	☒	Pre-school children	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☒	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☐
	Latinos	☐	Uninsured	☒
	Native Americans	☐	Other:	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Education and Promotion	☒
	Access: Specialty Care	☐	Health Information Technology	☐
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☒	Maternal/Women's Health	☐
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☒	Oral Health	☐
	Chronic Disease: Diabetes	☒	Pharmacy Assistance	☒
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☒
	Community Health Workers /Promotoras	☒	School Health	☐
	Coordination of Care Services	☒	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

Mississippi County Health Department and a rural health network is jointly addressing delivery of services for individuals with, or at risk of developing, chronic diseases, which disproportionately affect rural communities in Missouri Service Region B. Underlying risk factors such as physical inactivity, poor nutrition, and tobacco use and exposure contribute to high mortality rates. Moreover, rural mortality for heart disease is higher than the state and national averages. Dunklin, Mississippi, New Madrid, Pemiscot, and Scott Counties have historically had the highest unmet needs and most hard to reach communities. These counties are specifically targeted.

The network members utilize evidence-based programs and practices to address cardiovascular disease and diabetes. Each organization participating in the multi-county network contributes to the project and has clearly defined roles and responsibilities. Interventions focus on producing changes in knowledge and understanding of chronic disease and the importance of good health behaviors, clinical biometrics (BMI, weight, A1C, blood pressure), evidence-based self-management programs, strategies to increase access to prescription medications, and coordination among health and social agencies.

A team of registered dietitians and nurses employed through the project ensure access to chronic disease services. The health departments utilize influenza clinics as a means to conduct Chronic Disease Risk Assessments and facilitate

linkages to services. CPESN-MO, the Community Pharmacy Enhanced Services Network affiliate in Missouri, provides critical support through the pharmacy-based Community Health Workers (CHW).

Implementation of the CHW services in community-based pharmacies enhances the number of clinical touchpoints for individuals with, or at risk of developing, chronic diseases. The Regional Healthcare Foundation provides assistance to help uninsured and underinsured individuals obtain prescription medications through patient assistance programs, most commonly those provided by pharmaceutical manufacturers. SEMO Health Network utilizes the Patient Centered Medical Home model to coordinate delivery of clinical health services. Bootheel Counseling Service provides mental health services for individuals who live with chronic diseases and comorbidities such as depression and other mental health conditions.

Expected Outcomes:

The MPower Program will result in improved health outcomes and quality of life among patients with chronic disease, through a coordinated and efficient system of service delivery.

The expected outcomes for this project include:

- Increased use of self-management programs by recruitment and support via Community Health Workers (CHW)
- Improved 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
- Improved 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
- Improved 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
- Increased access for individuals with or at risk of chronic disease to affordable and necessary prescription medications.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Cardiovascular Disease: Pharmacy-based Medication Adherence Interventions
Utilizing pharmacies as locations for providing care and increasing provider touchpoints in rural communities is currently accepted as a Promising Practice in improving care and support for patients with poorly controlled chronic conditions. The Community Preventive Services Task Force recommended tailored pharmacy-based adherence interventions for cardiovascular disease in July 2019. Patient interviews or assessments tools are used to identify adherence barriers. Pharmacists use results to develop and deliver guidance and services intended to reduce patients' barriers.

Community Health Workers
The Community Preventive Services Task Force recommends interventions that engage community health workers (CHWs) to prevent cardiovascular disease. There is strong evidence of effectiveness for interventions that engage community health workers in a team-based care model to improve blood pressure and cholesterol in patients at increased risk for cardiovascular disease. By utilizing the CPESN model of pharmacy-based care and integrating CHWs into pharmacy settings, pharmacies will be able to provide direct referrals and warm hand-offs for chronic disease services.

Chronic Disease Self-Management Program: The Centers for Disease Control and Prevention (CDC) recognizes the Chronic Disease Self-Management Program (CDSMP) as an effective self-management education workshop for people with chronic health problems. This program includes techniques to deal with problems associated with chronic disease, appropriate exercise, appropriate use of medications, effective communication, and nutrition.

The Tool Kit for Active Living with Chronic Conditions: The Tool Kit for Active Living with Chronic Conditions is based on the CDSMP. The program is recognized as evidence based. The tool kit is mailed to the participant's house. The MPower collaborative partners present the tool kit programs through six weekly conference calls for four to six people. Each session is approximately one hour.

Diabetes Self-Management Program: This evidence-based program was developed by the Stanford University and is recommended by the CDC. The Diabetes Self-Management (DSMP) is a six-week group program for people with type 2 diabetes.

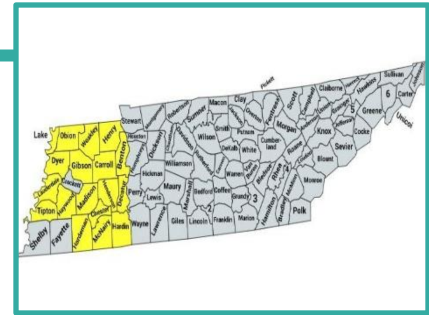
The Tool Kit for Active Living with Diabetes: The evidence-based Tool Kit for Active Living with Diabetes is based on the DSMP. The program is recognized as evidence based. The tool kit is mailed to the participant's house. The MPower collaborative partners present the tool kit programs through six weekly conference calls for four to six people. Each session is approximately one hour.

Target: BP Improvement Program: Developed by the American Heart Association and the American Medical Association, Target BP is an evidence-based quality improvement program. Adoption of the Target: BP and self-measured blood pressure (SMBP) programs will 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. The research literature has shown that, when combined with additional clinical support, SMBP is effective in reducing hypertension, improving patient knowledge, improving the health system process, and enhancing medication adherence.

Walk with Ease – Group: The community-based walking program is a CDC recognized program. The group sessions meet three times per week for six weeks. Trained leaders begin each session with a pre-walk discussion. The walk includes a warm-up and a cool-down period.

Walk with Ease – Self-Directed: The CDC recognizes the Walk With Ease –Self-Directed program as a promising physical activity program. The six-week program helps people learn to walk safely and develop the habit of walking regularly.

Project Officer (PO) Contact Information:	**Name:**	Patricia Burbano				
	Tel #:	301-443-7238				
	Email:	DeltaStatesGrantPrgm@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Brandy B. Holloman				
	Tel #:	404-413-0314				
	Email:	bholloman@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Tennessee, Service Region A

Paris-Henry County Health Care Foundation, Inc.

Grant Number:	D60RH36767					
Organization Type:	501c3 Non-profit					
Grantee Organization Information:	**Name:**	Paris & Henry County Healthcare Foundation, Inc.				
	Address:	301 Tyson Avenue				
	City:	Paris	**State:**	Tennessee	**Zip code:**	38242
	Tel #:	731-644-8266				
	Website:	www.growwelltn.org				
Primary Contact Information:	**Name:**	Lori Stambaugh				
	Title:	Community Educator/ Project Director				
	Tel #:	731-644-8269				
	Email:	lstambaugh@hcmc-tn.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	Aug 2020 to Jul 2021	$1,018,872
	Aug 2021 to Jul 2022	$1,018,872
	Aug 2022 to Jul 2023	$1,018,872
	Total Funding	**$3,056,616**

Consortium Partners:	Partner Organization	County	State	Organization Type
	Methodist Le Bonheur Community Outreach	Delta Region	TN	Hospital
	Henry County Medical Center	Henry	TN	Hospital
	Hardeman County Community Health Center	Hardeman, Chester, Haywood	TN	FQHC
	Dyersburg City Schools	Dyer	TN	Public School System
	Dyer County Schools	Dyer	TN	Public School System
	Haywood County Schools	Haywood	TN	Public School System
	Humboldt City Schools	Gibson	TN	Public School System
	Lauderdale County Schools	Lauderdale	TN	Public School System
	Obion County Schools	Obion	TN	Public School System
	Tipton County Schools	Tipton	TN	Public School System
	Trenton Special School District	Gibson	TN	Public School System
	Decatur County Schools	Decatur	TN	Public School System
	Gibson Special School District	Gibson	TN	Public School System

Counties the project serves:	Benton, Carroll, Chester, Decatur, Dyer, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Tipton, Weakley			
Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☒	Pacific Islanders	☐
	African Americans	☒	Pre-school children	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☒	School-age children (elementary)	☒
	Infants	☐	School-age children (teens)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☒	Health Education and Promotion	☒
	Access: Specialty Care	☒	Health Information Technology	☐
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☒	Maternal/Women's Health	☐
	Children's Health	☒	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☒	Oral Health	☐
	Chronic Disease: Diabetes	☒	Pharmacy Assistance	☒
	Chronic Disease: Asthma/COPD	☒	Physical Fitness and Nutrition	☒
	Community Health Workers /Promotoras	☒	School Health	☒
	Coordination of Care Services	☒	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☒
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

This project includes a consortium of members listed above who are working together while utilizing community partnerships and resources to target two main goals. These goals are to reduce obesity and obesity-related chronic disease and to provide increased access to behavioral health services. The consortium will be using evidence-based chronic disease self-management programs, RN Care Coordination, pharmacy assistance, school-based mobile health services, motivational interviewing, behavioral health navigation and counseling, behavioral tele-health services and group and individual health education to achieve these goals in the 18 target counties in West Tennessee.

Expected Outcomes:

The expected outcomes include reduced unnecessary hospitalizations, improved access and linkages to primary care providers, specialty providers, community-based resources, and health education. Expected long-term impacts include reduced morbidity and mortality from obesity and chronic conditions and improved health and mental status.

Evidence Based/ Promising Practice Model Being Used or Adapted:

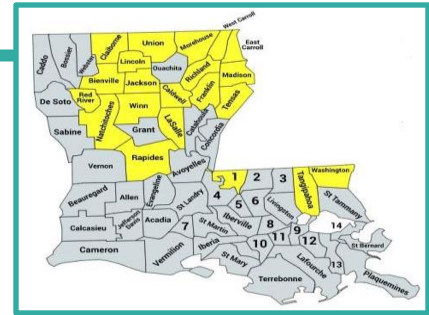
This project will be using the Care-Coordination evidence-based model as demonstrated by the Rural Care Coordination Toolkit. The care coordinator model will be followed which uses health educators and navigators to help monitor at-risk patients. The project also uses the evidence-based standards in the American Academy of Pediatric Guidelines. Additional evidence-based models include motivational interviewing, cognitive behavioral therapy, patient navigation delivery model, and CATCH Kid's Club curriculum. An adaptation of the promising practice 5-2-1-0 Let's Go! Model is also used in this grant program: 8-5-2-1-0 Every Day!

This project will be using four evidence-based chronic disease self-management programs. They are:

- Living Well With Chronic Conditions
- Taking Charge of Your Diabetes

- Prevent Type 2 Diabetes
- ALA Smoking Cessation Classes

Project Officer (PO) Contact Information:	**Name:**	Patricia Burbano				
	Tel #:	301-443-7238				
	Email:	DeltaStatesGrantPrgm@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance (TA) Consultant Contact Information:	**Name:**	Coleman Tanner				
	Tel #:	404-413-0314				
	Email:	Ctanner18@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303



Louisiana, Service Region A

Richland, Parish of

Grant Number:	D60RH36768				
Organization Type:	Critical Access Hospital (CAH)				
Grantee Organization Information:	**Name:**	Richland, Parish of / Hospital Service District No. 1-A of the Parish of Richland / Richland Parish Hospital			
	Address:	407 Cincinnati Street			
	City:	Delhi	**State:** Louisiana	**Zip code:**	71232
	Tel #:	318-878-6346			
	Website:	www.delhihospital.com			
Primary Contact Information:	**Name:**	Patrick Cowart			
	Title:	Project Director			
	Tel #:	318-878-6346			
	Email:	pcowart@delhihospital.com			

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	Aug 2020 to Jul 2021	$1,188,684
	Aug 2021 to Jul 2022	$1,188,684
	Aug 2022 to Jul 2023	$1,188,684
	Total Funding	**$3,566,052**

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organization Type**
	Richland Parish Hospital	Richland	LA	Critical Access Hospital
	West Feliciana Parish Hospital	West Feliciana	LA	Critical Access Hospital
	Christus St. Francis Cabrini Hospital	Rapides	LA	Tertiary Hospital
	Bienville Family Clinic	Bienville	LA	Rural Health Clinic
	Arcadia High School	Arcadia	LA	High School
	Atlanta High School	Winn	LA	High School
	Beekman Charter School	Morehouse	LA	High School
	Bogalusa High School	Washington	LA	High School
	Caldwell Parish High School	Caldwell	LA	High School
	Calvin High School	Winn	LA	High School
	Delhi High School	Richland	LA	High School
	Epps High School	West Carroll	LA	High School
	Family Community Christian School	Franklin	LA	High School
	Franklin Parish High School	Franklin	LA	High School
	General Trass High School	East Carroll	LA	High School
	Glenmora High School	Rapides	LA	High School
	Haynesville Jr/Sr High School	Claiborne	LA	High School
	Homer High School	Claiborne	LA	High School
	Independence Magnet High School	Tangipahoa	LA	High School
	Jena High School	LaSalle	LA	High School
	Jonesboro-Hodge High School	Jackson	LA	High School

	Lakeview High School	Natchitoches	LA	High School
	LaSalle High School	LaSalle	LA	High School
	Lincoln Preparatory Academy	Lincoln	LA	High School
	Madison Parish High School	Madison	LA	High School
	Natchitoches Central High School	Natchitoches	LA	High School
	Oak Grove High School	West Carroll	LA	High School
	Rayville High School	Richland	LA	High School
	Red River High School	Red River	LA	High School
	Ringgold High School	Bienville	LA	High School
	Summerfield High School	Claiborne	LA	High School
	Tensas Parish High School	Tensas	LA	High School
	Union Parish High School	Union	LA	High School
	West Feliciana Parish High School	West Feliciana	LA	High School
	Bogalusa High School SBHC	Washington	LA	School Based Health Center
	Delhi Community Health Center SBHC	Richland	LA	School Based Health Center
	Family Services Center SBHC West Feliciana	West Feliciana	LA	School Based Health Center
	Glenmora High School SBHC	Rapides	LA	School Based Health Center
	Jena High School SBHC	LaSalle	LA	School Based Health Center
	Lakeview Jr/Sr High School SBHC	Natchitoches	LA	School Based Health Center
	Madison Parish High School SBHC	Madison	LA	School Based Health Center
	Natchitoches Central High School SBHC	Natchitoches	LA	School Based Health Center
	Richardson Medical Center Rayville High SBHC	Richland	LA	School Based Health Center
	Tensas Community Health Center SBHC	Tensas	LA	School Based Health Center

Counties the project serves:	Rapides, Bienville, Winn, Morehouse, Washington, Winn, Natchitoches, Caldwell, Red River, Richland, West Carroll, Union, Rapides, Lincoln, Claiborne, Jackson, Claiborne, Tangipahoa, LaSalle, Jackson, East Carroll, Natchitoches, West Carroll, LaSalle, Richland, Bienville, West Feliciana, Tensas, Claiborne, Madison, Franklin

Target population served:	**Population**	**Yes**	**Population**	**Yes**
	Adults (18 – 64)	☐	Pacific Islanders	☐
	African Americans	☐	Pre-school children	☐
	Caucasians	☐	Pregnant Women	☐
	Elderly (65 and older)	☐	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☒
	Latinos	☐	Uninsured	☐
	Native Americans	☐	Other: Adult Faculty and Staff at Participating Schools	☒

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	☐	Health Education and Promotion	☒
	Access: Specialty Care	☐	Health Information Technology	☐

	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐
	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☐	Maternal/Women's Health	☐
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☐	Oral Health	☐
	Chronic Disease: Diabetes	☒	Pharmacy Assistance	☐
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☐
	Community Health Workers /Promotoras	☐	School Health	☒
	Coordination of Care Services	☐	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

The overarching purpose of the proposed North Louisiana Regional Pre-Diabetes Prevention Collaborative Adolescent Initiative is to reduce the incidence of Type II Diabetes in communities in Rural Northeast Louisiana by increasing access to preventive health care services and promoting community awareness of the need to make lasting lifestyle changes that improve nutrition and increase physical activity.

Expected Outcomes:

Expected outcomes include an increased self-awareness of the risks that prediabetes plays in the healthy well-being of program participants; improved health indicators including reduced A1c Blood Glucose levels, decreased BMI%, and reduced weight for program participants and ultimately, a prevention or a delay in program participants who are pre-diabetes converting to Type II Diabetes. Additionally, it is expected that the project will be sustained in many of the schools through community partnerships and through activities of school affiliated School Based Health Centers. A viable Pre-Diabetes Screening & Prevention Program targeted to students ages 14-18 in their formative years, and involving support of parents, teachers, and health providers, will be established in high schools in each of 21 Region A Delta parishes, in rural areas where diabetes prevalence is higher than state or national levels.

Specifically:

1. Students ages 14-18 and Adult Faculty/Staff screened and found to have diabetes will become aware of their Pre-Diabetes status, given health & lifestyle information, & offered the opportunity to participate in physical activity & consumption of healthy foods in order to prevent or delay progression into a full Diabetes diagnosis. (Knowledge Outcome)
2. Pre-diabetic students and adults will become more physically active and eat more nutritiously (Attitude/Behavior Outcome) and will be assessed with increased fitness & health levels by the end of the project. (Fitness/Clinical Outcome)
3. Rural residents both high school student and parents who are underserved, uninsured, and minorities at higher risk of Diabetes will have access to Pre-Diabetes health screenings & follow-up as needed.

Longer-term (within 5 years):

1. A greater recognition of the potential to prevent pre-diabetes and diabetes through increased physical activity and better nutrition will empower students in their formative years of identity and independence to make better choices in their health habits.
2. There will continue to be a greater awareness of Pre-Diabetes as a diagnosable illness on the part of the providers & residents in the 21-parish area, & greater use will be made of screening services by both providers & residents.
3. SBHCs, school nurses, and other health care providers in health facilities in the 21-parish region will make more standardized use of Pre-Diabetes screening for patients.
4. Through the school-based diabetes screening of students with identified risk factors (BMI, family history, ethnicity) more of the population of low income, uninsured, and minorities-at-risk will have increased access to screening, and the opportunity to learn preventive strategies to overcome their risks for diabetes.

5. Additional parishes in Louisiana will become aware of the Pre-Diabetes Prevention Program & its outcomes & become interested in its expansion into their own communities.

Long-term (7-10 years):

1. There will be a cohort of young adults in each parish who participated in community-oriented pre-diabetes and pre-diabetes prevention activities in their formative years. This will result in a "critical mass" of residents in positions of influence to promote physical and nutritional environments conducive to healthier living.
2. The most powerful anticipated change is an improvement in the health status of citizens in the 5 participating parishes in rural Northeast Louisiana, as measured by reduced Diabetes morbidity & mortality rates in official Louisiana Health Statistics.
3. There will be a reduction in the degree of disparity in Diabetes diagnoses, morbidity & mortality especially among African Americans, Hispanics, Native Americans, and Asians in the 20-parish area.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project is based on the Richland Pre-Diabetes Prevention Program that was developed based on the evidenced-based guidelines of the American Diabetes Association and the American Endocrinology Association which has proven effective in reducing the progression of Pre-Diabetes to Type II Diabetes through rigorous evaluation.

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Technical Assistance (TA) Consultant Contact Information:	**Name:**	Coleman Tanner				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Alabama, Service Region A

Rural Alabama Prevention Center

Grant Number:	D60RH36769					
Organization Type:	Community-Based Organization					
Grantee Organization Information:	Name:	Rural Alabama Prevention Center				
	Address:	301 Prairie Avenue				
	City:	Eutaw	State:	Alabama	Zip code:	35462
	Tel #:	205-372-3514				
	Website:	www.Ruralalabamprevention.org				
Primary Contact Information:	Name:	Loretta W. Wilson				
	Title:	Principal Director				
	Tel #:	205-496-0562				
	Email:	Lowwebb9@aol.com				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	Month 2020 to Month 2021	$962,268
	Month 2021 to Month 2022	$962,268
	Month 2022 to Month 2023	$962,268
	Total Funding	**$2,886,804**

Consortium Partners:	Partner Organization	County	State	Organization Type
	Alabama Cooperative Extension Systems	Dallas	AL	University
	Community Health Education and Resource Center	Sumter	AL	Community-Based
	Tuskegee Area Health Education Center	Macon	AL	AHEC
	Sowing Seeds of Hope	Perry	AL	Community-Based
	Hill Hospital Physician Clinic	Sumter	AL	Hospital-based
	Rural Health Medical Center	Marengo	AL	FQHC

Counties the project serves:	Barbour, Bullock, Butler, Choctaw, Clarke, Conecuh, Dallas, Escambia, Greene, Macon, Marengo, Monroe, Perry, Pickens, Sumter, Washington, Wilcox

Target population served:	Population	Yes	Population	Yes
	Adults (18 – 64)	☒	Pacific Islanders	☐
	African Americans	☒	Pre-school children	☐
	Caucasians	☒	Pregnant Women	☐
	Elderly (65 and older)	☐	School-age children (elementary)	☐
	Infants	☐	School-age children (teens)	☒
	Latinos	☒	Uninsured	☒
	Native Americans	☐	Other:	☐

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	☐	Health Education and Promotion	☐
	Access: Specialty Care	☐	Health Information Technology	☐
	Acute Ischemic Stroke	☐	Health Professions Recruitment and Retention/Workforce Development	☐

	Aging	☐	Integrated Systems of Care	☐
	Behavioral/Mental Health	☐	Maternal/Women's Health	☐
	Children's Health	☐	Migrant/Farm Worker Health	☐
	Chronic Disease: Cardiovascular	☒	Oral Health	☐
	Chronic Disease: Diabetes	☒	Pharmacy Assistance	☐
	Chronic Disease: Asthma/COPD	☐	Physical Fitness and Nutrition	☐
	Community Health Workers /Promotoras	☐	School Health	☐
	Coordination of Care Services	☐	Substance Abuse	☐
	Emergency Medical Services	☐	Telehealth	☐
	HIV/AIDS	☐	Transportation to health services	☐

Project Description:

South West Alabama Health Improvement Initiative (SWAHII) promotes and supports healthy lifestyles throughout Alabama's Delta counties through the implementation of programs geared toward the prevention and care management of chronic diseases. The program focuses primarily on the prevention and management of diabetes and heart disease with an intense focus on related risk factors such as poor diet, inactivity, smoking, and mental illness in 17 of Alabama's Delta Counties. The overarching objective is to reduce the rates of diabetes and heart disease for at-risk individuals and improve the health metrics of individuals with current diabetes and/or heart disease diagnoses who are enrolled in SWAHII's programs.

Community Health Workers will be integrated into churches in 17 counties to support churchgoers in making healthy lifestyle choices to prevent or reduce the onset of the chronic disease focus areas. Consortium partners and the lead agency will be responsible for ensuring that each county has a CHW to carry out the strategies of Body and Soul, Diabetes Education Empowerment Program (DEEP), and Mental Health First Aid Training. Allied health professionals in the participating rural health clinics will be trained to implement a Care Coordination component utilizing the "Reducing Care Fragmentation Model: A Toolkit for Coordinating Care. The Clinical Director of SWAHII will conduct each training session. Care coordination is intended to maximize the value of care being delivered and ensure that the patient's need, and preferences are known and addressed. The goal is to provide safer and more effective care by sharing pertinent information among all providers involved with the patient to reduce fragmentation of care, help patients access timely, appropriate care, and help patients fully engage in their care. SWAHII strategies encourages full participation and cooperation between the patients, providers, and care systems.

Expected Outcomes:

The program activities target a range of outcomes related to provider capacity, policy changes, health behaviors and health outcomes

The expected outcomes of the SWAHII activities include:

- CHWs demonstrate increased knowledge of heart disease, diabetes, mental health
- CHWs have improved training skills
- Allied health professionals demonstrate increased knowledge of heart disease, diabetes
- Body and Soul participants have improved health metrics, such as height, weight, blood pressure, and blood sugar over a 12-month period (measured at quarterly intervals)
- Body and Soul participants demonstrate increased knowledge of healthy lifestyle as demonstrated by pre- and post-testing of how to lead a healthy lifestyle.
- Body and Soul participants demonstrate healthier lifestyles as demonstrated by increased consumption of fruits and vegetables and increased physical activity
- Changes in church policies that promote healthy lifestyles.
- DEEP participants demonstrate improvement in systolic blood pressure; increased knowledge about preventing and managing diabetes knowledge; increased physical activity and healthy eating plan; increase in glucose self-monitoring; improved medication adherence; and perceived confidence in self-care.

- Those that receive MHFA training demonstrate increased knowledge of how to identify mental illness and substance use problems in a church setting
- Patients receiving care coordination services have improved health metrics.
- Patients receiving care coordination services are screened and receive referrals for needed health and other services
- Patients receiving care coordination services have reductions in non-emergency room visits and repeat hospitalizations

Evidence Based/ Promising Practice Model Being Used or Adapted:

Model for Chronic Disease Prevention: Body and Soul Wellness Program for Churches
Researchers at the University of North Carolina at Chapel Hill and Emory University worked together to develop, test, and distribute Body & Soul, a program that encourages proper nutrition among Black church members. The program incorporates healthy lifestyle education, church events, and peer counseling and has been proven to promote healthy food choices among participants. It was based on the success of two projects that promoted healthy nutrition among Black church members. Body & Soul encourages pastoral involvement and support; peer counseling for participants; church-wide activities to promote healthy food choices such as health fair, kick-off event, educational sessions with cooking classes, and a church environment that promotes healthy food choices such as fresh fruits and vegetables at general church events and sponsoring a farmer's market at the church.

Model for Care Management: Reducing Care Fragmentation: A Toolkit for Coordinating Care
Reducing Care Fragmentation: A Toolkit for Coordinating Care is for clinics, practices, and health systems that want to improve care coordination by transforming the way they manage patient referrals and transitions. Providing coordinated care is an essential feature of any patient-centered medical home (PCMH)—but one that can be challenging to implement. The toolkit was designed to make it easier. Unlike other aspects of medical care, there has been relatively little rigorous research to direct efforts to improve care coordination. It considers the major external providers and organizations with which a PCMH must interact—medical specialists, community service agencies, and hospital and emergency facilities—and summarizes the elements that appear to contribute to successful referrals and transitions. Those elements include: 1) Assuming accountability; 2) Providing patient support; 3) Building relationships and agreements among providers (including community agencies) that lead to shared expectations for communication and care; and 5)Developing connectivity via electronic or other information pathways that encourage timely and effective information flow between providers (including community agencies)

Model for Diabetes Prevention - Diabetes Empowerment Education Program (DEEP)
The Diabetes Empowerment Education Program, also known as DEEP™, is an education curriculum designed to help people with pre-diabetes, diabetes, relatives and caregivers gain a better understanding of diabetes self-care. Classes last a total of six weeks, providing participants with eight unique learning modules. Program Goals of the DEEP curriculum include: Improving and maintaining the quality of life of persons with pre-diabetes and existing diabetes; Preventing complications and incapacities; Improving eating habits and maintaining adequate nutrition; Increasing physical activity; Developing self-care skills; Improving the relationship between patients and health care providers; and utilizing available resources.

Mental Health First Aid Training (MHFAT)
Mental Health First Aid will be utilized to help with identifying and understanding signs of mental illness and substance use disorders. Mental Health First Aid was created in 2001 by Betty Kitchener, a nurse specializing in health education, and Anthony Jorm, a mental health literacy professor. Mental Health First Aid is an 8-hour course that uses role playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect people to the appropriate professional, peer, social and self-help care. The program also teaches common risk factors and warning signs of specific illnesses like anxiety, depression, substance use, bipolar disorder, eating disorders and schizophrenia. MHFA teaches participants a five-step action plan to support someone developing signs and symptoms of a mental illness or experiencing an emotional crisis. Like CPR, Mental Health First Aid prepares participants to interact with a person in crisis and connect the person with help. The program offers concrete tools and answers key questions like, "What do I do?" and, "Where can someone find help?" All trainees receive a program manual to complement the course material.

<table>
<tr><td colspan="7">Participants will receive a 3-year certification upon completion. Mental health first aid will be offered to church members from participating churches.</td></tr>
<tr><td rowspan="5">Project Officer (PO) Contact Information:</td><td>Name:</td><td colspan="5">Patricia Burbano</td></tr>
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