Delta States Rural Development Network Program

2023 Grantee Directory

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

Table of Contents

Introduction

The Delta States Rural Development Network Program (Delta Program) provides grant funding to support the planning, development, and implementation of integrated health care networks that collaborate in order to (1) achieve efficiencies; (2) expand access to, coordinate, and improve the quality of basic health care services and associated health outcomes in rural areas within the eight rural Mississippi Delta Region states (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee); and (3) strengthen the rural health care system as a whole.

The goals of the Delta Program are to:

- Expand access to care resources in the designated Mississippi Delta counties and parishes
- Utilize evidence-based, promising practice, or value-based care models known to improve health outcomes, and enhance the delivery of health care services
- Collaborate with network partners in the planning, delivery, and evaluation of health care services to increase access to care and reduce chronic disease
- Implement sustainable health care programs that improve population health, health outcomes, and demonstrate value to the local rural communities

The Delta Program supports and encourages innovative strategies to address delivery of preventative or clinical health services for individuals with, or at risk of developing chronic diseases that disproportionally affect the rural Mississippi Delta communities. This includes populations who have historically experienced poorer health outcomes, health disparities, and other inequities such as racial and ethnic minorities, people experiencing homelessness, pregnant women, disabled individuals, youth, and adolescents, etc.

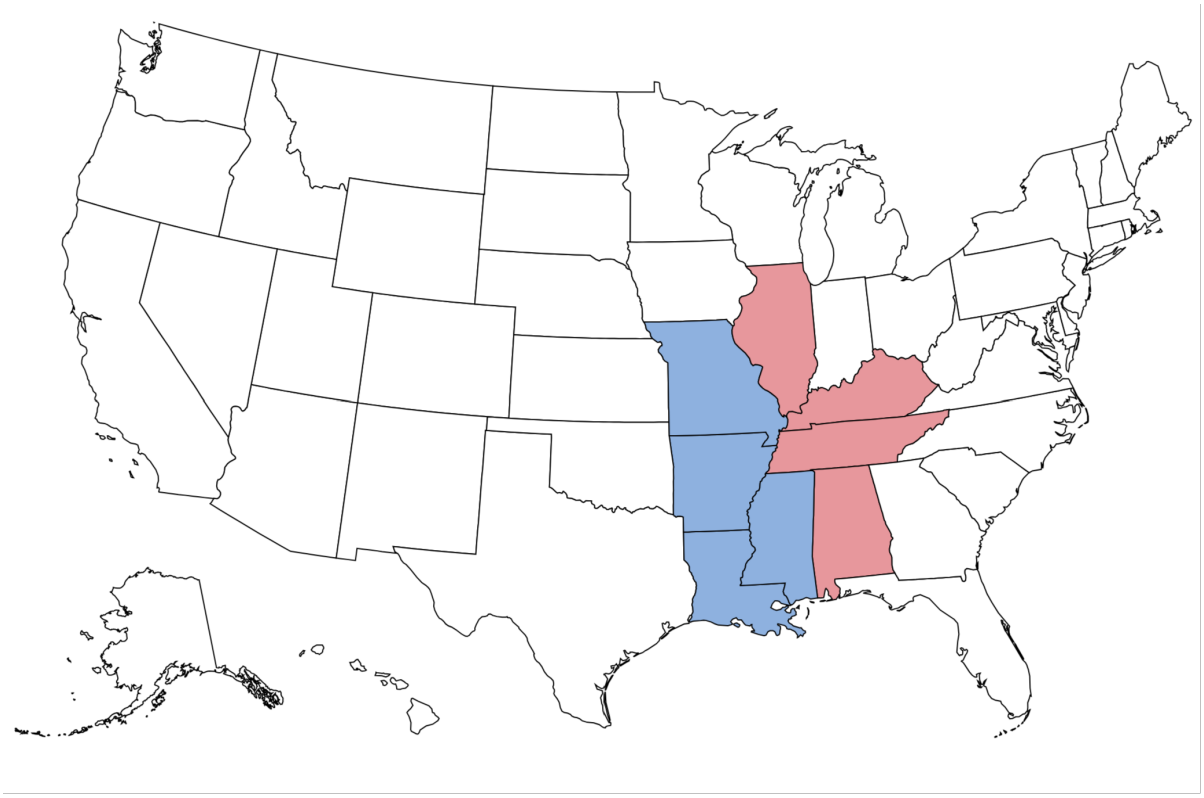
Due to the high disparities in the Mississippi Delta region, applicants are required to propose a project based on no more than two of the following focus areas: 1) diabetes, 2) cardiovascular disease, 3) obesity, 4) acute ischemic stroke, 5) chronic lower respiratory disease, 6) cancer, or 7) unintentional injury/substance use.

The Federal Office of Rural Health Policy selected these focus areas to address the underlying factors that are driving growing rural health disparities related to the five leading causes of avoidable death (heart disease, cancer, unintentional injury/substance use, chronic lower respiratory disease, and stroke).

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 2023-2026 funding cycle.

Cohort Snapshot

Grantee Location Map



Grantee By State

Alabama
Rural Alabama Prevention Center
Arkansas
ARcare
Arkansas Rural Health Partnership
Illinois
Southern Illinois University
Kentucky
Baptist Health Deaconess Madisonville
Lousiana
Health Enrichment Network
Parish of Richland
Mississippi
Delta Health Alliance
Jefferson Comprehensive Health Center
Missouri
Mississippi County Health Department
Missouri Highlands Health Care
Tennessee
Methodist Le Bonheur Community Outreach

Grantee Organization Type

Grantee Organization	County Health Department	Critical Access Hospital	Federally Qualified Health Center	Nonprofit	Other Hospital	University
ARcare			•			
Arkansas Rural Health Partnership				•		
Baptist Health Madisonville					•	
Big Springs Medical Association			•			
Delta Health Alliance				•		
Health Enrichment Network				•		
Jefferson Comprehensive Health Center			•			
Methodist Le Bonheur Community Outreach				•		
Mississippi County Health Department	•					
Parish of Richland		•				
Rural Alabama Prevention Center				•		
Southern Illinois University						•

Grantee by Primary Focus Area

Grantee Organization	Acute Ischemic Stroke	Diabetes	Cardiovascular Disease	Cancer	Chronic Lower Respiratory Disease	Obesity
ARcare			•			
Arkansas Rural Health Partnership		•	•			
Baptist Health Madisonville						•
Big Springs Medical Association		•				•
Delta Health Alliance						•
Health Enrichment Network		•				
Jefferson Comprehensive Health Center			•			•
Methodist Le Bonheur Community Outreach		•				•
Mississippi County Health Department		•	•			
Parish of Richland		•				
Rural Alabama Prevention Center		•	•			
Southern Illinois University			•			•

ARcare

Federally Qualified Health Center

D60RH49280

Primary focus area:
Cardiovascular Disease

Other focus areas:
Access: Primary Care,
Coordination of Care Services,
Heart Disease,
Health Education and Promotion,
Pharmacy Assistance

Grantee Contact Information

Grantee Contact: Dr. Steven Collier
Contact Title: CEO
Organization: ARcare
Address: 117 South 2nd Street, Augusta, AR 72006
Telephone Number: 870-347-3304
Email: steven.collier@arcare.net
Website: www.arcare.net

Project Description

The Arkansas Health Improvement Coalition will collaborate to plan, develop, and implement systematic interventions to improve the health outcomes of adults aged 50-74 diagnosed with cardiovascular disease (CVD) in the 21 eligible counties of Arkansas Service Region B. The coalition will implement the Healing Hearts Initiative that will allow for expansion of services and the addition of new services within the service area.

The coalition will roll existing and new services (described below) into two new processes:

- **Chronic Care Management (CCM)** - a program in which any patient diagnosed with or at-risk for two or more chronic conditions (such as CVD, coronary artery disease, hypertension, diabetes, etc.) will be invited into a proactive, coordinated treatment plan that will serve as a one-stop for patients. A project customer care associate will invite and enroll patients, connect them with any needed monitoring equipment (see remote patient monitoring below), assist with scheduling, and establish monthly communication to assist patients with improved self¬-management. The CCM nurse will work directly with patients to provide CCM services and ensure provider referrals follow the recommended workflow to address all patient needs.
- **Core Team Model** - The coalition will pilot a Core Team Model of care that can enhance the success of CCM or meet the needs of patients who do not qualify for CCM. This pilot will be tested in Augusta (Woodruff County), one of the most underserved Arkansas Service Region B communities, to develop evidence of proof-of-concept and guidance for replicating the model in other communities.

In addition to these new services listed above, the coalition will expand existing services to new eligible locations and providers, as summarized here:

- **Transitional Care Management** - a service in which, after a patient is discharged from hospital, registered nurses contact patients within 48 business hours of discharge to provide a medication review, ensure the patient is scheduled, and attends their follow up visit with their provider to ensure there are no gaps in care left unaddressed for the patient. This evidence-based practice has been shown to reduce hospital readmissions.
- **Medication Therapy Management** - a service in which pharmacists integrated into the primary care setting collaborate with providers to assess patient medications. Their role is to identify any errors, interactions, or adverse effects, consult with the physician when medication changes are needed, and educate patients on their medications. This evidence-based practice has been demonstrated to improve patient health outcomes while lowering total health expenditures.
- **Remote Patient Monitoring** - a program in which a nurse collaborates with the patient to use technology to monitor selected patient indicators beyond the clinical setting, such as in the home. The CDC recognizes this as an evidence-based practice that has improved "medication adherence, outpatient follow-up, and adherence to self-management goals."

The new service below will also be added:

- **Intensive Behavioral Therapy for CVD** - a service in which the patient meets with a registered dietitian to address behavioral and nutritional factors that have been shown to have a positive impact on CVD outcomes, such as reducing salt intake, tobacco cessation, eating healthier foods, and exercise. This is an evidence-based practice.

Each of these services alone has been demonstrated to achieve improved cardiovascular outcomes for patients. Each will continue to be offered as needed, based on patient need and interest. But additional research and other evidence-based practices indicate that organizing services into the cohesive CCM model and using a core team to deliver services in the pilot region will lead to even stronger outcomes. These services will expand the coordination and delivery of care for coalition partners and will allow coalition members to address the holistic needs of patients and not just one illness, ailment, or need at a time.

Expected Outcomes

The Arkansas Health Improvement Coalition expects to achieve the following outcomes through the implementation of the Healing Hearts Initiative for adults aged 50-74 within Arkansas Service Region B:

- Improved clinical measures for cardiovascular disease
- Increase in evidenced-based practices by providers delivering CVD care
- Reduction in hospital readmissions for CVD
- Successful care model that can be shared with other Federally Qualified Health Centers

Evidence-Based or Promising Practice Model Being Used or Adapted

Chronic Care Management (CCM) is recognized by the Centers for Medicare & Medicaid Services as a "critical primary care service that contributes to better patient health and care." Reimbursement for these services continues to change and progress as the evidence basis grows. For this project, any patient diagnosed with at least two chronic conditions, which may include conditions that are at-risk for CVD or one condition is CVD, is eligible to be enrolled into CCM. Adaptations for this project: The proposed chronic care management processes and practices will align with the model's characteristics as promoted by the Rural Health Information Hub and anticipates having to make few adaptations for our service region or population. In CCM, a customer care associate or other project staff invites patients to enroll in the CCM program. If the patient agrees, a customer care associate enrolls them, gathers preliminary intake information, completes paperwork, collects/verifies demographic data, orders appropriate remote monitoring technology as applicable, makes referrals to other providers in the CCM model, and sets up monthly calls to follow up with the patient.

The core team model is the coalition's name for what the Centers for Disease Control and Prevention (CDC) calls "team-based care," recommended by the Community Preventive Services Task Force. The task force recommends "team-based care to improve blood pressure control based on strong evidence of effectiveness in improving the proportion of patients with controlled blood pressure and in reducing systolic and diastolic blood pressure. Findings provide convincing evidence for the effectiveness of team-based care organized mainly with nurses and pharmacists working with primary care providers, patients, and other professionals. Evidence shows meaningful improvements in blood pressure control for Black or African American and Hispanic or Latino patients. When implemented by health care providers to serve patients from racial and ethnic minority groups, interventions are likely to advance health equity. Adaptations for this project: The coalition proposes to create a core team of a registered nurse, registered dietitian, and a clinical pharmacist who are assigned to the same region and clinics to overcome current operational silos and the fact that staff regions rarely overlap. In the CDC's meta-analysis of 54 studies of this model, it was reported that adding pharmacists to the care team led to even higher improvements in blood pressure control than the overall median for all approaches. Because the core team model is personnel-intensive and requires that personnel be integrated into a clinical setting to effect culture change and for providers to learn the habit of referring patients to the team, this grant will pilot-test assigning a core team to one of the most underserved portions of the service region. By the project period's end, the coalition expects to produce patient outcome data to provide proof-of-concept and recommend expanding this evidence-based practice into additional portions of Arkansas Service Region B.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Hispanic/Latinx

Area Served

- Baxter County
- Clay County
- Craighead County
- Cross County
- Fulton County
- Greene County
- Independence County
- Izard County
- Jackson County
- Lawrence County
- Marion County
- Mississippi County
- Poinsett County
- Prairie County
- Searcy County
- Sharp County
- Stone County
- Van Buren County
- White County
- Woodruff County

Consortium Partners

Organization	County	State	Organization Type
1st Choice Healthcare	Clay, Fulton, Greene, Lawrence, Randolph, & Sharp	AR	Federally Qualified Health Center
ARcare	Baxter, Craighead, Cross, Independence, Izard, Jackson, Mississippi, Prairie, White	AR	Federally Qualified Health Center
Boston Mountain Rural Health Center, Inc. Crowle	Baxter, Marion, Searcy, Stone & Van Buren	AR	Federally Qualified Health Center
Crowley's Ridge Development Council, Inc.	Craighead, Cross, Greene, Jackson, Poinsett & Woodruff	AR	Community Action Agency

Arkansas Rural Health Partnership

Nonprofit organization

D6049281

Primary focus area:
Cardiovascular Disease, Diabetes

Other focus areas:
Aging, Community Health Workers, Heart Disease, Pharmacy Assistance

Grantee Contact Information

Grantee Contact: Amber O'Fallon
Contact Title: Senior Project Director
Organization: Arkansas Rural Health Partnership
Address: 101 N. Court St, Lake Village, AR 71635
Telephone Number: 870-461-0276
Email: amberofallon@arruralhealth.org
Website: www.arruralhealth.org

Project Description

In response to the significant increase in the aging population, Arkansas Rural Health Partnership is launching new and expanded efforts to strategically support the health and wellness of seniors across south Arkansas (predominantly the Delta region). The Arkansas Delta Seniors Flourish & Thrive Program is designed to specifically address the following health and wellness barriers for seniors aged 60 and above with diabetes/cardiovascular disease living in the service area: lack of access to locally available health care, barriers caused by prescription medicine costs, lack of health insurance, transportation barriers, food inequality, lack of access to exercise opportunities, and quality diabetes self-management education. Project efforts will improve the health of seniors with diabetes/cardiovascular disease through social determinants of health interventions, new and expanded nutrition and exercise programs, and remote monitoring to improve health outcomes. The program employs multiple evidence-based models: community health worker model, the Diabetes Empowerment Education Program (DEEP), the Drums Alive® Golden Beats program, and tai chi.

Program elements include:

- **Patient assistance services** will be provided by a centralized community health worker team that works with chronic care management staff at partnering hospital-affiliated clinics (80+) to provide targeted interventions (e.g. insurance enrollment, housing assistance, patient navigation, referrals to chronic care management, etc.) for approximately 4,000 seniors (60+) at-risk of and/or diagnosed with diabetes/cardiovascular disease each year.

- **The Diabetes Empowerment Education Program** Evidence-based DEEP classes will be offered to over 1,000 seniors yearly to promote self-management of pre-diabetes and existing diabetes, prevent complications and incapacities, develop self-care skills, and improve patient and health-care provider relationships and overall health.
- **Healthy cooking classes** Targeted patients will benefit from expanded access to healthy cooking classes and cookbooks.
- **Virtual exercise programs** include senior-friendly Drums Alive® Golden Beats and tai chi and can be completed at home or in a group setting (hosted by local churches and other community groups).
- **The Good Food Rx** will provide home-delivered healthy prepared meals to seniors in the program who are experiencing food insecurities.
- **Patient remote monitoring** Chronic care managers will utilize remote patient monitoring devices to support health outcomes and health behaviors (up to 270 seniors throughout three years). The real-time, ongoing health data is integrated into the care visit (within the clinic setting). This rich feedback informs and supports care delivery.

Expected Outcomes

The Delta States initiative is a program designed to improve the health and well-being of seniors (60+) who live within the Arkansas Delta region. The overall mission of this program is to advance health equity in the region by addressing existing barriers to health care within the region.

Patient Outcomes

- Improved health access: Increased access to locally available health care services
- Affordable medication: Reduction in prescription medication cost barriers
- Enhanced health coverage: Increased health insurance coverage for seniors, ensuring the target population can access essential health care services
- Improved and increased mobility: Addressing transportation and distance barriers.
- Nutritional support: Alleviating food insecurity by providing resources and programs to ensure access to healthy foods
- Exercise opportunities: Enhancing access to exercise opportunities to promote physical activity and overall health
- Chronic care management: Providing high-quality chronic disease management and education to seniors, leading to better management of their condition and improved health outcomes

System Changes & Capacity Created

- Enhanced health care infrastructure: Investment in health care infrastructure within the Arkansas Delta region aims to improve health care accessibility
- Collaborative networks: Facilitating collaboration among health care providers, community organizations, and stakeholders to build a network of support and care
- Cost-efficient medication: Implementing a cost-efficient prescription program to reduce the financial burden
- Insurance enrollment: Implementing an insurance enrollment program to assist the target population in obtaining health insurance coverage

- Food insecurity: Establishing and implementing a program to ensure the target population can access nutritious foods

Evidence-Based or Promising Practice Model Being Used or Adapted

The Arkansas Delta Seniors Flourish & Thrive Program employs multiple evidence-based models: the DEEP, Drums Alive Golden Beats and tai chi exercise classes, and the Community Health Worker Model.

- DEEP is a licensed diabetes self-management education curriculum developed by the University of Illinois, Chicago. DEEP was developed to provide communities with tools to manage diabetes better and is based on principles of empowerment and adult education.
- Drums Alive Golden Beats stimulates people, whether young or old, healthy or ill. The rhythmical patterns of the drum increase the synchronization of brain wave activity, providing feelings of euphoria and improved mental awareness and self-acceptance. Golden Beats is specially designed for the senior population.
- Tai chi is a practice that involves a series of slow, gentle movements and physical postures, a meditative state of mind, and controlled breathing. Tai chi originated as an ancient martial art in China. Over the years, it has become more focused on health promotion and rehabilitation.
- Community health worker. The American Public Health Association has adopted the following definition of a community health worker: "A *community health worker* is a frontline public health worker who is a trusted member of and has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve service delivery's quality and cultural competence."

Special Populations Served

- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/Latinx
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American
- Uninsured

Area Served

- Arkansas
- Ashley
- Bradley
- Calhoun
- Chicot
- Cleveland
- Dallas
- Desha
- Drew
- Grant
- Jefferson
- Lee
- Lincoln
- Lonoke
- Monroe
- Ouachita
- Phillips
- St. Francis
- Union

Consortium Partners

Organization	County	State	Organization Type
Ashley County Medical Center	Ashley	AR	Critical Access Hospital
Baptist Health – Stuttgart	Arkansas	AR	PPS Hospital
Bradley County Medical Center	Bradley	AR	Critical Access Hospital
Chicot Memorial Medical Center	Chicot	AR	Critical Access Hospital
Dallas County Medical Center	Dallas	AR	Critical Access Hospital
Delta Memorial Hospital	Desha	AR	Critical Access Hospital
DeWitt Hospital & Nursing Home	Arkansas	AR	Critical Access Hospital
Drew Memorial Health System	Drew	AR	PPS Hospital
Forrest City Medical Center	St. Francis	AR	PPS Hospital
Helena Regional Medical Center	Phillips	AR	PPS Hospital
Jefferson Regional	Jefferson	AR	PPS Hospital
Magnolia Regional Medical Center	Columbia	AR	PPS Hospital
Mainline Health Systems	Drew	AR	Federally Qualified Health Center
McGehee Hospital	Desha	AR	Critical Access Hospital
Mid-Delta Health Systems	Monroe	AR	Federally Qualified Health Center
Ouachita County Medical Center	Ouachita	AR	PPS Hospital
South Arkansas Regional Hospital	Union	AR	PPS Hospital
Sevier County Medical Center	Sevier	AR	PPS Hospital

Baptist Health Deaconess Madisonville

Hospital (non-Critical Access Hospital)

D6049282

Primary focus area:
Obesity

Other focus areas:
Health Education and Promotion, School Health

Grantee Contact Information

Grantee Contact: Kelcey Rutledge
Contact Title: Project Director
Organization: Baptist Health Deaconess Madisonville
Address: 900 Hospital Drive, Madisonville, KY 42431
Telephone Number: 270-825-5100
Email: kelcey.rutledge@baptistdeaconess.com
Website: www.baptisthealthdeaconess.com

Project Description

The Baptist Health Deaconess School Wellness Initiative will be an anti-obesity wellness promotion program offered by the Delta Rural Network Center at Baptist Health Deaconess Madisonville, Inc. in Madisonville, Kentucky. Key activities revolve around serving far western Kentucky's 20 rural Mississippi Delta region counties and include assisting public service area school districts, elementary, middle, and high schools with the following.

- Establishing sustainable school wellness leadership groups to govern, assess, and address health and wellness activity needs, issues, and concerns
- Academic classroom physical activity beyond required physical education
- Wellness policy enhancement
- Professional development training for school staff
- School staff wellness promotion
- Community wellness promotion events

The goal of the initiative is to enhance the culture of wellness in service area schools by involving school administration, school staff, students, parents, and community organizations. Objectives within the goal are to: 1) maintain participation of current schools; 2) expand school wellness leadership group framework to include service area elementary, middle, and high schools; and 3) promote community wellness throughout the

service area. The initiative aims to reach different demographic segments including geographically challenged and low-income residents.

The initiative will provide school wellness policy enhancement assistance centered on solidifying structural guidelines for sustained wellness activity and entrenchment. The initiative will synergize wellness policy efforts with established Kentucky Department of Education guidelines. The initiative will also utilize established school relationships to promote school staff health assessments to encourage increased physical activity. Schools that meet participation requirements will be eligible for incentives to strengthen wellness culture enhancement efforts.

Expected Outcomes

The expected outcomes of the Baptist Health Deaconess School Wellness Initiative relating to schools and communities are:

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

Evidence-Based or Promising Practice Model Being Used or Adapted

The Baptist Health Deaconess School Wellness Initiative school wellness model is patterned after the Alliance for a Healthier Generation's Healthy Schools Program Framework coordinated school health program promising practice model. It is an online wellness group development tool that uses a coordinated approach involving building wellness groups, assessing policies and practices, action planning to address issues, exploring resources needed to address issues, implementation of wellness strengthening activities, and celebrating success to promote wellness enhancement accomplishments. Besides terminology re-wording to describe initiative operations, there are no changes to the Healthy Schools Program model. Such wording includes "team of stakeholders," re-worded "wellness leadership groups" and "school wellness facilitator," re-labeled "school champion." Adaptations will be included, as participating schools will be required: 1) to retain academic classroom and/or before, during, after-school physical activities as an ongoing action plan item; and 2) to review school wellness policy annually. State standards require wellness policy review within a three-year period. Annual policy review will be required so schools maintain current, relevant, and feasible policies while ensuring compliance with required review standards. The Delta Rural Network Center at host agency Baptist Health Deaconess Madisonville, Inc., will administer the initiative. For the initiative, the Delta Rural Network Center will offer and promote the evidence-based GoNoodle program, 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. Initiative efforts will assist middle and high school wellness leadership groups in striving to integrate opportunities for 60 minutes of physical activity within the school day and incorporating age-appropriate academic classroom and/or school-based physical activity beyond required health and physical education, such as such as movement breaks, physical activity clubs, energizers, hop sports, etc.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/Latinx
- Native American/American Indian
- Pacific Islander/Asian American

Area Served

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

Consortium Partners

Organization	County	State	Organization Type
The Alliance for a Healthier Generation	Multnomah	OR	Health Promotion
Baptist Health Deaconess Madisonville, Inc.	Hopkins	KY	Health care
West Area Health Education Center	Hopkins	KY	Health Promotion

Big Springs Medical Association

Federally Qualified Health Center

6 D60RH4928301-01

Primary focus area:
Diabetes,
Obesity

Other focus areas:
Community Health Workers,
Health Education and Promotion

Grantee Contact Information

Grantee Contact: Misty Morrison
Contact Title: Delta Project Director
Organization: Big Springs Medical Association d/b/a Missouri Highlands Health Care
Address: 110 S. 2nd Street, Ellington, MO 63638
Telephone Number: 573-663-2313
Email: mmorrison@mohigh.org
Website: www.mohigh.org

Project Description

The Delta States Project at Missouri Highlands Health Care (MHHC) has a goal of helping uninsured patients manage their chronic health conditions (including diabetes and obesity) and improving overall health by utilizing community health workers. MHHC covers the cost of chronic condition-related appointments at MHHC clinic locations for qualifying patients; in conjunction with this, MHHC assigns each enrolled patient a community health worker (CHW) who helps educate patients on their chronic conditions and ways to manage or improve them. MHHC also offers dietician consultations and behavioral health services to these qualifying patients to provide an all-around health approach, rather than a strictly medical approach.

MHHC CHWs also help patients apply for financial assistance when they are referred to outside medical services and help to set up those appointments for the patients. MHHC also has a medication assistance program which helps qualifying patients pay for prescription medications to treat their chronic conditions.

In collaboration with consortium partners, MHHC sponsors diabetes classes at local public health agencies to educate patients, both diabetic and pre-diabetic, on disease prevention and management. The goal of this program is to produce lower A1C, (blood sugar) levels in the service area.

Community health workers work in the clinics and out in the community to educate and promote resources. These frontline workers assist patients with a variety of needs, including accessing resources to meet social needs, such as housing or energy assistance.

Key Activities:

- Community outreach
- Health education
- CHWs to help patients address the social determinants of health
- Chronic disease management
- Prescription medication assistance
- Advocacy
- Care coordination
- Specialist referrals
- Diabetic classes to lower hemoglobin A1C levels

Expected Outcomes

MHHC and consortium partners hope to achieve improved overall health throughout the service area through chronic disease management and education and by using community health workers to help bridge the gap between patients and providers. CHWs will be used to address the social determinants of health in the service area and to help those struggling with diabetes to lower A1C levels. MHHC consortium partners are doing education on nutrition and physical activity, which is expected to lead to improved physical activity and healthier diet.

Expected outcomes:

- Lowered A1C for diabetes class participants
- Fewer hospital visits/follow-ups due to increased knowledge of disease management
- Improved physical activity and healthier diet
- Lower body mass index

Evidence-Based or Promising Practice Model Being Used or Adapted

The partnership with the public health departments has included the following evidence-based practices.

- The planning and development of an internet-based health literacy strategy among all 12 local public health departments.
- The application of an evidence-based diabetes education strategy delivered at the public health departments with tracking pre and post A1C.
- The evidence-based utilization of the CHWs applying the social determinants of health with uninsured Delta patients seeking health care.

The utilization of a best practice community health development strategy, called the Partnership Approach, to engage with local public health departments and the CHWs in assessing community and regional health needs and interest in identifying strategic opportunities for future collaborative activities.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/Latinx
- Native American/American Indian
- Older adults
- Pacific Islander/Asian American
- Uninsured

Area Served

- Butler
- Carter
- Crawford
- Dent
- Douglas
- Howell
- Iron
- Oregon
- Ozark
- Phelps
- Reynolds
- Ripley
- Shannon
- Texas
- Wayne
- Wright

Consortium Partners

Organization	County	State	Organization Type
Carter County Health Center	Carter	MO	Local Public Health Agencies
Douglas County Health Department	Douglas	MO	Local Public Health Agencies
Missouri Ozarks Community Health	Douglas	MO	Federally Qualified Health Center
Howell County Health Department	Howell	MO	Local Public Health Agencies
Oregon County Health Department	Oregon	MO	Local Public Health Agencies
Ozark County Health Department	Ozark	MO	Local Public Health Agencies
Reynolds County Health Center	Reynolds	MO	Local Public Health Agencies
Ripley County Health Department	Ripley	MO	Local Public Health Agencies
Shannon County Health Center	Shannon	MO	Local Public Health Agencies
South Central Missouri Community Action Agency	Butler, Carter, Dent, Reynolds, Ripley, Shannon, Wayne	MO	Community Action Agency
Four Rivers Community Health Center	Crawford, Dent, Phelps	MO	Federally Qualified Health Center
Texas County Health Department	Texas	MO	Local Public Health Agencies
Wright County Health Department	Wright	MO	Local Public Health Agencies
Whole Health Outreach	Reynolds	MO	Religious – 501c3
Whole Kids Outreach	Reynolds	MO	Religious – 501c3

Delta Health Alliance

Nonprofit Organization

D60RH49284-01-00

Primary focus area:
Obesity

Other focus areas:
Health Education and Promotion

Grantee Contact Information

Grantee Contact: Bria G. Moore
Contact Title: Program Director
Organization: Delta Health Alliance
Address: 435 Stoneville Road, Stoneville, MS 38776
Telephone Number: 662-390-6934
Email: bmoore@deltahealthalliance.org
Website: www.deltahealthalliance.org

Project Description

The NEW YOU (Nutrition, Education, and Wellness for You) collaborative has a primary focus on addressing critically high levels of obesity and a secondary focus on cardiovascular disease in Mississippi Service Area A. Mississippi Delta communities face generational disparities associated with elevated rates of poverty and low educational attainment and are home to a majority Black/African American population who struggle with our nation's highest rates of adult obesity. These factors also impact cardiovascular health, leading to high rates of hypertension, ensuing complications, and premature death. This collaborative seeks to establish a series of coordinated activities to address obesity in a holistic, sustainable, patient-centered, evidence-based manner, incorporating multidisciplinary care teams, nutritionists, fitness experts, direct patient and family engagement, community outreach, and health care partners to improve patient outcomes and overall population health in our rural 21-county region. This collaboration will work with area clinics, fitness centers, and local businesses to carry out its goals.

Key activities include:

- Work with clinics, area programs, faith-based sites, businesses, gyms, and residents to recruit and enroll participants
- Community health workers to receive Obesity Care Model Collaborative (OCMC) training, provide referrals to programs addressing socioeconomic needs of patients, and identify clinic outreach opportunities

- Home visits (minimum of four)
- Grocery store tours and nutrition classes/referrals
- Health education workshops
- Exercise classes
- Monthly or biweekly phone calls depending on the need (minimum of 12)
- Development of patient-specific care management care plans
    - Clinical office visits
    - Patient-centered goals
    - Socioeconomic needs
    - Exercise/nutrition

Expected Outcomes

The NEW YOU collaborative goals include: 1) improving obesity outcomes through the use of a holistic model and teams of community health workers, 2) improving control of hypertension, 3) improving neighborhood health through community outreach, and 4) using data analysis and outcome measurements to create a sustainable plan for obesity and cardiovascular care.

Expected outcomes:

- Achieve a 10% reduction in weight after twelve months or program participation for 70% of enrollees.
- For 70% of program participants diagnosed with hypertension (blood pressure at or above 140/90), achieve three continuous measures over at least a three-week period of systolic blood pressure values of 130mm Hg after six months of program participation.
- Each year, 100% of program enrollees will receive screening for appropriate social support services and fitness needs, with 75% of enrollees participating in one or more external programs to support their overall health, exercise, and wellness goals.

Evidence-Based or Promising Practice Model Being Used or Adapted

The NEW YOU collaborative will use the evidence-based OCMC developed by the American Medical Group Association, which integrates obesity interventions across four care domains - community, health care organization, care team, and patient and family. These interventions focus on making sustainable lifestyle changes rather than a temporary program of diet and exercise. Teams of community health coaches — also known as community health workers — will coordinate activities across all four domains.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Hispanic/Latinx
- Native American/American Indian

Area Served

- Attala
- Benton
- Bolivar
- Carroll
- Coahoma
- Grenada
- Holmes
- Lafayette
- Leflore
- Marshall
- Montgomery
- Panola
- Quitman
- Sunflower
- Tallahatchie
- Tate
- Tippah
- Tunica
- Union
- Washington
- Yalobusha

Consortium Partners

Organization	County	State	Organization Type
Anytime Fitness	Bolivar	MS	Fitness Center
Arcola Health Clinic	Washington	MS	Clinic
Bear's Gym	Coahoma	MS	Fitness Center
Clarksdale Regional Health Clinic	Coahoma	MS	Clinic
Delta Regional Health Clinic	Washington	MS	Clinic
Delta Wellness Center	Washington	MS	Fitness Center
Leland Medical Clinic	Washington	MS	Clinic
MississippiCare Oxford Medical	Lafayette	MS	Clinic

Health Enrichment Network

Nonprofit

D60RH36764-03-02

Primary focus area:
Obesity

Other focus areas:
Children's Health, Health Education and Promotion, Food Insecurity, School Health, Transportation to Health Services

Grantee Contact Information

Grantee Contact: Donna H. Newton
Contact Title: Executive Director
Organization: The Health Enrichment Network
Address: PO Box 566, Oakdale, LA 71463
Telephone Number: 318-335-2112
Email: donna@eatmovegrow.us
Website: www.Eatmovegrow.us

Project Description

The funded Delta States initiative, known as the EatMoveGrow (EMG) program under The Health Enrichment Network, is a comprehensive obesity prevention project in Louisiana's Service Region B. The program is focused on improving the overall well-being of the community, with a particular emphasis on increasing access to healthy food choices and physical activity. Here are the key activities and goals of the EMG program:

- **Expansion of EMG Project**: The primary goal of the EMG program is to expand its reach by implementing evidence-based interventions in 50 elementary schools located within Service Region B. This expansion is informed by the evidence-based Whole School, Whole Community, Whole Child model, which recognizes the importance of addressing health holistically in the school environment.
- **Community-Level Prevention Programs**: EMG seeks to establish new community-level connections with state and national resources in Service Region B. Through expanded collaborations, EMG aims to create a network of support that extends beyond the school environment. This approach recognizes the importance of involving the broader community in promoting healthy behaviors.
- **Integration of Health Resources**: A significant aspect of the EMG program is to bridge the gap between clinical health care services and social determinants of health resources within Service Region B. A program component creating formal linkages between rural health centers and EMG-served elementary schools aims to provide a holistic approach to health by connecting individuals to the necessary resources, services, and support systems that can positively impact their well-being.

In summary, the funded Delta States initiative, EMG, is a multifaceted effort aimed at fostering positive health outcomes in Louisiana's Service Region B. Through project expansion that includes increasing the number of schools served, engaging state and national programs in rural communities, and linking rural health clinic resources to schools, EMG seeks to bring about a cultural shift in the region that promotes healthier lifestyles and overall well-being.

Expected Outcomes

EMG will integrate four new community-level programs into its successful school-based intervention. These programs will address critical health gaps in the community which might not have been addressed otherwise. By focusing on community-level interventions, EMG aims to provide access to resources, social support, cultural relevance, tailored approaches, and sustainability, which are crucial for obesity prevention, especially in rural communities. This expansion aims to replicate previous EMG successes achieved in schools.

Individuals Outcomes:

- Increases in student, staff, and family engagement in health-related activities
- Improvements in the overall health environment within schools
- Changes in student knowledge, attitudes, behaviors, and overall health

System Changes and Capacity Created:

- Increases in physical activity levels among students
- Changes in policy systems related to health and wellness within schools
- Changes in environmental systems that promote healthier lifestyles

EMG Delta States initiative's overarching goal is to create a comprehensive and sustainable approach to improving health outcomes in the community, with a focus on addressing obesity and related health disparities. By targeting both school-based and community-level interventions, EMG aims to create lasting positive changes in the lives of students, families, and the broader community.

Evidence-Based or Promising Practice Model Being Used or Adapted

The Delta States initiative, driven by the EMG program model, is firmly rooted in evidence-based practices and models aimed at addressing obesity prevention and enhancing school wellness in rural Louisiana. Models and practices being employed:

- **Whole School, Whole Community, Whole Child Model**: EMG has evolved into a robust Whole School, Whole Community, Whole Child Model, encompassing comprehensive strategies that address both individual behaviors and the school environment. This model integrates early childhood interventions to instill lifelong healthy habits in students.
- **Evidence-Based School Wellness Committee**: EMG mandates the formation of evidence-based school wellness committees in participating schools. These committees play a crucial role in fostering a health-focused school culture, with EMG offering assistance and funding to support their development.
- **Nutrition Education**: EMG health educators deliver monthly evidence-based nutrition lessons to 20,000 students in 50 schools. Lessons include topics like MyPlate, the U.S. Department of Agriculture's depiction of the five food groups; healthy snacking; and the 5-2-1-0 framework. These lessons focus on healthy eating habits and encourage the consumption of fruits, vegetables, water, while reducing sugary snacks and beverages.

- **Classroom and Playground Activity Promotion**: EMG promotes evidence-based activity breaks within classrooms, utilizing programs such as Walking Classroom and GoNoodle. Additionally, EMG provides technical assistance for creating active recess play areas, incorporating promising practices like painted play spaces.
- **Interactive Health Technologies**: EMG utilizes evidence-based interactive health technologies monitors to assess physical activity interventions and support changes in the school's physical environment.
- **Harvest of the Month**: In collaboration with Lousiana State Univesity (LSU) AgCenter, EMG offers the Harvest of the Month program, designed to encourage the consumption of locally grown produce through an evidence-based curriculum. This includes field visits, taste tests, and educational materials to promote healthier eating habits.
- **School Gardens**: LSU AgCenter provides evidence-based school garden resources, including lesson plans, gardening guides, and technical assistance to EMG schools. These resources support the integration of garden-based learning into the curriculum, enhancing students' understanding of nutrition and sustainability.
- **Community Connections**: EMG partner Louisiana Rural Health Association (LRHA) will pilot Community Connections, an evidence-based health care innovation exchange program. This initiative formalizes connections between rural health clinics and EMG schools, identifying at-risk students and offering interventions, health care services referrals, and health education to promote healthier living.
- **Community Health Worker Program**: EMG and LRHA collaborate with the Louisiana Office of Public Health's evidence-based community health worker program, Community HealthWays. This program focuses on improving health care access, reducing health disparities, and enhancing health outcomes. EMG leverages its network to support Community HealthWays in building relationships and expanding its reach in Service Region B.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/ Latinx
- Native American/American Indian
- Pacific Islander/Asian American
- Uninsured

Area Served

- Allen
- Avoyelles
- Ascension
- Assumption
- Acadia
- Beauregard
- Catahoula
- Concordia
- Evangeline
- Jeff Davis
- Lafourche
- Plaquemines
- Pointe Coupee
- St. Mary
- St. Landry
- St. Martin
- St. James

Consortium Partners

Organization	County	State	Organization Type
Bunkie General Hospital	Avoyelles	LA	Rural Hospital
Health Enrichment Network	Allen	LA	Nonprofit
Louisiana Rural Health Association	Ascension	LA	Nonprofit
Lousiana State University AgCenter	Statewide	LA	State Organization
Pennington Biomedical Center	East Baton Rouge	LA	Nonprofit
Southwest Louisiana (LA) Area Health Education Center (AHEC)	Lafayette	LA	Nonprofit
Southeast LA AHEC	Tangipahoa	LA	Nonprofit

Jefferson Comprehensive Health Center

Federally Qualified Health Center

D60RH49287

Primary focus area:
Cardiovascular Disease, Obesity

Other focus areas:
Community Health Workers, Health Education and Promotion

Grantee Contact Information

Grantee Contact: George Dixon
Contact Title: Project Director
Organization: Jefferson Comprehensive Health Center
Address: 405 Main St., Fayette, MS 39069
Telephone Number: 601-786-3475
Email: gdixon@jeffersonchc.com
Website: www.Mississippishineproject.com

Project Description

The Mississippi (MS) 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 Mississippi. Over the past 16 years, the networks have collaborated to achieve efficiencies; expand access to, coordinate, and improve the quality of basic health care services and associated health outcomes; spread the use of evidence-based practices to improve obesity and diabetes outcomes regionwide; and strengthen the rural health care system in the region. The past focus areas for the MS SHINE project have been obesity and diabetes. In the upcoming project period, project partners have chosen to focus on the new area of cardiovascular disease (replacing diabetes), while continuing to focus on obesity. The project will expand obesity efforts by focusing the scope of services on a new target population of school-age children. This group is becoming more likely to develop type two diabetes due to the rising prevalence of overweight or obesity among this population (Prevent Type 2 Diabetes in Kids, CDC, 12/2022). With its extensive school-based health program, JCHC is well-positioned to lead these efforts.

The primary methodology 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, and through continually active health marketing initiatives, SHINE intends to reach everyone within the target population (those with pressing health concerns within the service region). Mississippi continues to lag behind the rest of the nation with some of the worst statistics in regard 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 positively impact the population's health status. The project addresses these health issues with cost-effective means such as prevention and education services, as opposed to acute care. These goals align with the goals of the Delta Program by expanding access to care resources in the designated Mississippi Delta counties; utilizing promising evidence-based practices known to improve health outcomes and enhance the delivery of health care services; collaborating with network partners in the planning, delivery, and evaluation of health care services to increase access to care and reduce chronic disease; and implementing sustainable health care programs that improve population health, health outcomes, and demonstrate value to the local rural communities.

Expected Outcomes

Goal 1: Maintain and strengthen the existing community-based network of health and social service providers organized to promote health and wellness in southwest Mississippi (Service Region B) by identifying and responding to regional health issues with coordinated, integrated, and sustainable approaches.

- Ensure regular stakeholder input through annual online survey.
- Promote ongoing active participation and communication among project partners.
- Diversify representation in each region's health network by the end of year one.

Goal 2: Reduce the risk for cardiovascular disease (CVD) prevalence and mortality in Mississippi Service Region B through the delivery of health education, preventive screening, and chronic disease management services to the local target population.

- Conduct monthly CVD health screening and education events (blood pressure checks, body mass index (BMI), and blood glucose test), reaching at least 250 adults and adolescents per month per county, Feb. 1, 2024, through July 31, 2026 (reaching 33,000 individuals in year one, 66,000 in year two and year three).
- Conduct the Body & Soul health education program in 22 African American (one in each county) churches by the end of year one, reaching 10,000 individuals annually in year two and year three.
- Enable at least 100 patients with hypertension to track blood pressure at home and report results to their primary care provider by the end of year one, with increases in blood pressure control demonstrated by the end of year two and year three.
- Launch Barbershop Health Initiative in at least 22 Afircan American barbershops (one in each county) by end of year one, measure results in year two and year three.

Goal 3: Reduce obesity and associated health risks in Mississippi Service Region B through the delivery of health education and preventive screening, with a focus on school-age children.

- Launch 5-2-1-0 Healthy Children campaign to improve child nutrition and fitness and reduce screen time and BMI in local schools, reaching at least 26,400 school-age children and their caregivers (22 school districts and approximately 1,200 children each) by the end of year three (eight school districts to be enrolled in year one, 10 school districts to be enrolled in year two, four school districts to be enrolled in year three).

- Conduct Chat & Chew nutritional forums to promote healthy eating in each service area county, reaching at least 2,200 people annually (22 counties x 100 each) by the end of year one (6,600 by the end of the project period).
- Distribute nutritional supplements such as fruits, vegetables, and drinking water to those living in food deserts, reaching at least 1,000 individuals annually (3,000 by the end of the project period).

Evidence-Based or Promising Practice Model Being Used or Adapted

Community Health Workers (Evidence-Based): The unique role of community health workers (CHWs) as culturally competent mediators (health brokers between providers of health services and members of diverse communities) has been extensively documented. Also documented are 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 team 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 (Evidence-Based): 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. The curriculum aims to support churches in implementing church-wide events and environmental changes to support healthier food options. Body and Soul sites aim to use food policy changes to increase the availability of fruits and vegetables. Consenting participants receive two motivational interviews measured at the baseline and a six-month follow-up. MS SHINE CHWs will bring Body and Soul to area churches and support its roll out with congregational leadership.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/Latinx
- Uninsured

Area Served

- Adams
- Amite
- Claiborne
- Copiah
- Covington
- Franklin
- Humphrey
- Issaquena
- Jasper
- Jefferson
- Jefferson Davis
- Lawrence
- Lincoln
- Marion
- Pike
- Sharkey
- Smith
- Walthall
- Warren
- Wilkinson
- Yazoo

Consortium Partners

Organization	County	State	Organization Type
Jefferson Comprehensive Health Center	Jefferson	MS	Federally Qualified Health Center
Sharkey Issaquena Community Hospital	Sharkey	MS	Hospital
Southeast Mississippi Rural Health Initiative, Inc.	Covington	MS	Federally Qualified Health Center
Southwest Mississippi Opportunity	Pike	MS	Community Nonprofit

Methodist Le Bonheur Community Outreach

Hospital-affiliated 501c3 Nonprofit

D60RH49288

Primary focus area:
Diabetes, Obesity

Other focus areas:
Coordination of Care Services, Health Education and Promotion

Grantee Contact Information

Grantee Contact: Chelcie Oseni
Contact Title: Clinical Manager/Interim Project Director
Organization: Methodist Le Bonheur Community Outreach
Address: 600 Jefferson Avenue, Memphis, TN 38105
Telephone Number: 901-287-4700
Email: chelcie.oseni@lebonheur.org
Website: www.methodisthealth.org/healthcare-services/community-outreach/

Project Description

The purpose of the project is to continue and expand region-wide obesity and diabetes services for children, adults, and families using evidence-based care models in an interdisciplinary approach that will improve overall health outcomes in the target region. Key components of the proposed project include continuing and expanding regional services for pediatric, adult, and family-focused health education on obesity/obesity prevention and diabetes/diabetes prevention across multiple settings, providing resources to support and expand health screening, clinical case management, nutritional counseling, pharmacy assistance, and other health services related to obesity and diabetes prevention and treatment, providing patient- and family-centered care coordination to address interrelated medical, social, and behavioral needs of patients with obesity and/or diabetes, promoting capacity building and cross-sector partnerships to better serve residents in rural west Tennessee, and continuing to use data to evaluate, improve and sustain programs and expand program monitoring.

Expected Outcomes

The evaluation will measure outputs [e.g., numbers of persons served, additional partnerships formed), quantitative outcomes measured by body mass index (BMI), A1C, BP, and weight change], as well as qualitative outcomes measured by self-reported surveys, clinical results, and case management notes. Long-term impacts on the region's health will be evaluated annually through analysis of county-level obesity rates for children and

adults and morbidity due to obesity, diabetes, and/or obesity-related diseases. Specific expected outcomes include:

- Decreased emergency department visits and decreased hospital admissions
- Patient report of better managing diabetes and chronic conditions
- A total of $615,000 savings in prescriptions for patients
- Reduction in body mass index (BMI) for adults and BMI percentile for children
- Reduction in hemoglobin A1c
- Reduction in blood pressure
- Increase in fruit and vegetable consumption
- Increase in physical activity
- Reduction in screen time
- Appropriate patient referrals made and followed through to appointment completion
- Improved mental/behavioral health status
- Patient and family satisfaction with services

Evidence-Based or Promising Practice Model Being Used or Adapted

Established and evidence-based programs or promising practices that the network implementing agencies include: Four evidence-based chronic disease management programs (Living Well with Chronic Conditions, Take Charge of Your Diabetes, the National Diabetes Prevention Program, and the Centers for Disease Control and Prevention's Prevent Type 2 Diabetes) will be delivered by Henry County Medical Center, Hardeman County Community Health Center (HCCHC), and University of Tennessee Extension. A pharmacy assistance program will continue to be offered by the Paris Henry County Healthcare Foundation and by HCCHC; School-based health services will continue through Le Bonheur on the Move, a mobile medical unit of Methodist Le Bonheur Community Outreach providing clinical screenings, care coordination, case management, nutritional counseling and referrals for obesity, diabetes, related diseases, and behavioral health in west Tennessee schools. Intensive registered nurse case management for children with obesity, diabetes, or both include care coordination, motivational interviewing, and referrals for behavioral health services. 8-5-2-1-0 Every Day! messaging, an adaptation of the 5-2-1-0 Let's Go! model will continue to be delivered in conjunction with these other pediatric Delta programs.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/Latinx
- Older adults
- Uninsured

Area Served

- Benton
- Carroll
- Chester
- Crockett
- Decatur
- Dyer
- Gibson
- Hardeman
- Hardin
- Haywood
- Henderson
- Henry
- Lake
- Lauderdale
- Madison
- McNairy
- Obion
- Tipton
- Weakley

Consortium Partners

Organization	County	State	Organization Type
Bells City School	Crockett	TN	Public School System
Crockett County Schools	Crockett	TN	Public School System
Decatur County School District	Decatur	TN	Public School System
Dyer County Schools	Dyer	TN	Public School System
Dyersburg City School District	Dyer	TN	Public School System
Gibson County Special School District	Gibson	TN	Public School System
Hardeman County Community Health Center	Hardeman	TN	Federally Qualified Health Center
Haywood County School District	Haywood	TN	Public School System
Humboldt City Schools	Gibson	TN	Public School System
Lauderdale County School District	Lauderdale	TN	Public School System
McNairy County Special School District	McNairy	TN	Public School System
Obion County School District	Obion	TN	Public School System
Paris-Henry County Healthcare Foundation/Henry County Medical Center	Henry	TN	Hospital/Foundation
Tipton County School District	Tipton	TN	Public School System
Trenton Special School District	Gibson	TN	Public School System
University of Tennessee Extension Service	Delta Region	TN	University Extension

Mississippi County Health Department

County Health Department

D60RH49291

Primary focus area:
Diabetes,
Cardiovascular Disease

Other focus areas:
Community Health Workers,
Heart Disease,
Pharmacy Assistance

Grantee Contact Information

Grantee Contact: Dixie Duncan
Contact Title: Project Director
Organization: Mississippi County Health Department
Address: 1200 East Marshall Street, Charleston, MO 63834
Telephone Number: 573-683-2191
Email: dduncan@misscohealth.com
Website: www.misscohealth.com

Project Description

Mississippi County Health Department and the MPower Consortium are 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, tobacco use, and exposure contribute to high mortality rates. Moreover, rural mortality for heart disease is higher than the state and national averages. A five-county area, commonly known as the Bootheel, has historically had some of the highest unmet needs and most hard-to-reach communities in the state and in the nation. Services will be targeted to these five counties that include Dunklin, Mississippi, New Madrid, Pemiscot, and Scott.

The network members utilize evidence-based programs and practices to address cardiovascular disease and diabetes. Activities will be expanded to engage harder-to-reach high-risk populations including Black residents, perinatal women, and those who are homebound and/or food insecure. Each organization participating in the multicounty network contributes to the project and has clearly defined roles and responsibilities. The goals of the project are 1) to develop infrastructure to expand access to preventative and clinical health services to those disproportionately affected by chronic diseases such as Black residents, homebound and disabled residents, food insecure populations, and perinatal women; 2) to improve cardiovascular health through self-management of hypertension and tobacco cessation interventions; 3) to improve health and quality of life of individuals with or at risk for diabetes; 4) to increase access to affordable and necessary prescription

medications for individuals with or at risk of heart disease/diabetes; and to improve maternal and infant health outcomes through prevention, detection, treatment, and self-management of hypertension and smoking cessation in pregnant women and their partners.

Expected Outcomes

The expected outcomes for this project include:

- Expanded reach to rural communities through increased use of telehealth and virtual preventative services
- Increased number of partnerships with local food pantries to reach the food-insecure population in each county
- Increased number of home visiting nurses trained to implement the self-measured blood pressure program to reach homebound and/or disabled populations
- Increased number of lifestyle coaches trained to use a Centers for Disease Control and Prevention-approved curriculum to deliver the Diabetes Prevention Program (DPP)
- Increased number of individuals enroll in DPP
- Increased number of DPP participants achieve an average weight loss of at least 5% of starting body weight over the 12-month intervention period
- Development of a community of practice among MPower-affiliated community health workers
- Increased number of participants enrolled in self-measured blood pressure (SMBP) program
- Increased number of SMBP program participants demonstrate increased knowledge regarding how to take an accurate blood pressure reading
- Increased number of adult patients with a blood pressure that is adequately controlled (<140/90)
- Increased number of participants enroll in the mobile phone text messaging cessation intervention
- Increased number of individuals complete the Walk with Ease physical activity program
- Increased number of patients receive chronic disease related services from a registered dietitian
- Increased number of adult patients with a calculated body mass index (BMI) documented in the medical record and if the BMI is outside parameters, a follow-up plan is documented
- Increased number of adult patients with a diagnosis of diabetes have a hemoglobin A1c value less than 8.0%
- Increased number of patients are screened for clinical depression using a standardized tool
- Increased average number of dollars saved per patient through the Prescription Drug Assistance (PDA) program
- Increased number of community health workers are trained on the PDA program
- Increased number of people enrolled in SMBP and/or DPP receive an optimized medication regimen from a Community Pharmacy Enhanced Service Networks (CPESN) -affiliated pharmacist
- Increased number of county health departments implement a policy to conduct blood pressure screenings among prenatal and postpartum women
- Increased number of postpartum women enroll in the evidence-based Cuff Kits project or SMBP

Evidence-Based or Promising Practice Model Being Used or Adapted

Diabetes Prevention Program: The national DPP is a Centers for Disease Control and Prevention (CDC) -funded program established in 2010 to combat increasing rates of prediabetes and type 2 diabetes. According to the CDC, this national effort created partnerships between both public and private organizations to offer evidence-based and cost-effective interventions aiming to prevent type 2 diabetes across the United States. A 10-year follow-up of diabetes incidence after randomization into the DPP lifestyle program, metformin, or a placebo treatment revealed that in the 10 years since randomization, diabetes incidence was reduced by 34% in the lifestyle group and 18% in the metformin group compared to the placebo. MPower will emphasize enrolling people in the DPP as a lifestyle change program. Focus will be placed on people who are pre-diabetic. In year one, the consortium aims to establish two cohorts of up to 25 people per cohort. To increase efficiency and sustainability, the consortium will utilize the HabitNu platform, the same platform being supported by the Missouri Department of Health and Senior Services. This end-to-end platform can be used for the delivery of DPP through its telehealth portal and integration of a range of connected devices such as Wi-Fi scale, activity tracker, and blood pressure cuffs. The platform enables easy data collection through the HabitNu mobile app allowing the health coaches to track outcomes data and seamless data submission.

Smokefree.gov: Currently, 26.1% of residents in Missouri Region B report they smoke cigarettes, which is significantly greater than the state average (20.8%). Given the strong correlation between smoking and cardiovascular disease, the new initiative will prioritize smoking cessation throughout Missouri Region B. The National Cancer Institute's Smokefree.gov initiative has provided free, evidence-based smoking cessation resources to adults trying to quit smoking for over 40 years and established the Smokefree.gov Initiative in 2003. Today, Smokefree.gov offers multimodal interventions including nine text messaging programs, six mobile-optimized websites, and two mobile applications. Smokefree.gov will be an addition to SMBP screening implemented throughout the county health departments, Federally Qqualified Hhealth Centers, Visiting Nurse Association, and participating pharmacies in Missouri Region B. The screener disseminated to patients will assess the patients' smoking status. If they disclose they are a smoker, they will be provided with information on Smokefree.gov.

Baby & Me Tobacco Free: Smoking during pregnancy is a major risk factor for poor birth outcomes. In 2019, data revealed that 18.07% of women in Missouri Region B (N=375) smoked during their pregnancy. In addition, in 2020, there were 653 women who qualified for Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) who reported smoking (pregnant women/mothers of young children). To assist pregnant women in quitting tobacco use, the current program will incentivize the county health departments to enroll pregnant women and their partners in BMTF when they are enrolling in WIC. Baby & Me Tobacco Free is an evidence-based smoking cessation program proven to reduce the burden of tobacco among pregnant and postpartum populations.

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 can provide direct referrals and warm hand-offs for chronic disease services.

Chronic Disease Self-Management Program: The 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 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.

Self-Measured Blood Pressure 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 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.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Older adults
- Pregnant people
- Uninsured

Area Served

- Dunklin, MO
- Madison, MO
- Mississippi, MO
- New Madrid, MO
- Pemiscot, MO
- Perry, MO
- St. Francois, MO
- Ste. Genevieve, MO
- Scott, MO
- Stoddard, MO
- Washington, MO

Consortium Partners

Organization	County	State	Organization Type
Bootheel Counseling Services	Mississippi, New Madrid, Scott & Stoddard	MO	Mental Health
Community Pharmacy Enhanced Services Network	Missouri Region B	MO	Pharmacy Network
Dunklin County Health Center	Dunklin	MO	Health Department
Dunklin/Stoddard County Caring Council	Dunklin and Stoddard County	MO	Nonprofit Organization
Faith Temple Complex	Pemiscot County	MO	Religious Organization
Great Mines Health Center	St. Francois, Washington, and Madison	MO	Federally Qualified Health Center
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
Regional Arthritis Center	Missouri Region B	MO	Arthritis Program
Regional Healthcare Foundation	Missouri Region B	MO	Private Foundation
Scott County Health Department	Scott	MO	Health Department
Stoddard County Public Health Center	Stoddard	MO	Health Department
Southeast Missouri Food Bank	Missouri Region B	MO	Nonprofit Organization

Organization	County	State	Organization Type
Southeast Missouri Health Network	Dunklin, Mississippi, New Madrid, Pemiscot, Scott & Stoddard	MO	Federally Qualified Health Center
St. Francois County Health Department	St. Francois	MO	Health Department
Ste. Genevieve County Health Department	Ste. Genevieve	MO	Health Department
Visiting Nurse Association	Missouri Region B	MO	Nonprofit Organization
Washington County Health Department	Washington	MO	Health Department

Parish of Richland

Critical Access Hospital

D6049286

Primary focus area:
Diabetes

Other focus areas:
Health Education and Promotion, School Health

Grantee Contact Information

Grantee Contact: Patrick Cowart
Contact Title: Project Director
Organization: Hospital District 1A of the Parish of Richland (Richland Parish Hospital)
Address: 407 Cincinnati Street, Delhi, LA 71232
Telephone Number: 318-878-6346
Email: pcowart@delhihospital.com
Website: www.delhihospital.com

Project Description

The Adolescent Pre-Diabetes Prevention Program is designed to reduce the incidence of type 2 diabetes among adolescents in grades nine through 12 in the twenty-one parish Delta Grant service area designated as Louisiana Region A. The program is offered at 39 rural high schools and provides interventions to students who are either diabetic, pre-diabetic, or at-risk for becoming pre-diabetic. Interventions include health screenings and healthy lifestyle lessons that assist participants in making lasting lifestyle changes that result in improved nutrition and increased physical activity as well as improved diabetes risk factors.

Through a self-selection process, students in ninth grade, with their assent and parental permission, are screened for pre-diabetes.
The screening process includes collecting the following information for each student:

- Height
- Weight
- Blood pressure
- Waist circumference measure
- Family history of diabetes
- Calculated body mass index (BMI) percentage
- Hemoglobin A1c blood glucose levels

Students determined to be diabetic, pre-diabetic, or at-risk of becoming pre-diabetic are admitted to the program. The program provides three screenings during the school year and six healthy lifestyle lessons. The lessons provide simple explanations about making healthier meal and snack choices and introduces easy exercises and ideas for improving physical activity. The entire series of healthy lifestyle lessons is composed of 24 lessons — with six offered during each year of a student's participation in the program. The program also sends an encouraging text message to program participants and parents each Friday afternoon. The messages are designed to bolster self-esteem and offer encouragement for staying on their healthy lifestyle journey.

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 percentage, reduced weight for program participants, and a prevention or a delay in program participants who are pre-diabetic converting to type 2 diabetes. It is expected that the project will be sustained in many schools through community partnerships and through activities of school affiliated school-based health centers.

- Students (ages 14-18) or adult faculty or staff screened and found to be pre-diabetic will be told their status and given health and lifestyle information that includes healthy food choices and the importance of physical activity that can prevent or delay progression into a full diabetes diagnosis. (Knowledge outcome)
- Pre-diabetic students and adults will become more physically active and eat more nutritiously (Attitude/behavior outcome) and will be assessed with increased fitness and health levels by the end of the project. (Fitness/clinical outcome)
- Rural residents, both high school students and parents, who are underserved or uninsured and minorities at higher risk of diabetes will have access to pre-diabetes health screenings and follow-up as needed.

Longer-term (within five years):

- 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.
- There will continue to be a greater awareness of pre-diabetes as a diagnosable illness on the part of the providers and residents in the 21-parish area, and greater use will be made of screening services by both providers and residents.
- School-based health centers, 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.
- 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.
- Additional parishes in Louisiana will become aware of the Pre-Diabetes Prevention Program and its outcomes and become interested in its expansion into their own communities.

Long-term (7-10 years):

- 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.
- The most powerful anticipated change is an improvement in the health status of citizens in the five participating parishes in rural northeast Louisiana, as measured by reduced diabetes morbidity and mortality rates in official Louisiana health statistics.
- There will be a reduction in the degree of disparity in diabetes diagnoses and morbidity and mortality, especially among African Americans, Hispanics, Native Americans, and Asians in the 20-parish area.

Evidence-Based or Promising Practice Model Being Used or Adapted

The Adolescent Pre-Diabetes Prevention Program was born out of the promising practices model program of the Richland Pre-Diabetes Prevention Program in 2013. The Richland Pre-Diabetes Prevention Program was developed based on the evidence-based guidelines of the America Diabetes Association and the American Endocrinology Association which have proven effective in reducing the progression of pre-diabetes to type 2 diabetes. With modifications to the Richland Pre-Diabetes Program, the Adolescent Pre-Diabetes Prevention Program has been able to adapt to the special challenges of offering this intervention to a youth population.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/Latinx
- Pacific Islander/Asian American

Area Served

- Bienville Parish
- Caldwell Parish
- Claiborne Parish
- East Carroll Parish
- Franklin Parish
- Jackson Parish
- La Salle Parish
- Lincoln Parish
- Madison Parish
- Morehouse Parish
- Natchitoches Parish
- Rapides Parish
- Red River Parish
- Richland Parish
- Tangipahoa Parish
- Tensas Parish
- Union Parish
- Washington Parish
- West Carroll Parish
- West Feliciana Parish
- Winn Parish
- Arcadia
- Atlanta
- Bastrop
- Beekman
- Bogalusa
- Calvin
- Campti
- Coushatta
- Delhi
- Dodson
- Epps
- Farmerville
- Forest
- Gibsland

Consortium Partners

Organization	County	State	Organization Type
Richland Parish Hospital	Richland	LA	Critical Access Hospital
West Feliciana Parish Hospital	West Feliciana	LA	Critical Access Hospital
Arcadia High School	Bienville	LA	High School
Bastrop High School	Morehouse	LA	High School
Beekman Charter High School	Morehouse	LA	High School
Ben's Ford Christian School	Washington	LA	High School
Bogalusa High School	Washington	LA	High School
Calvin High School	Winn	LA	High School
D'Arbonne Woods Charter High School	Union	LA	High School
Delhi Charter School	Richland	LA	High School
Delhi High School	Richland	LA	High School
Dodson High School	Winn	LA	High School
Family Community Christian School	Franklin	LA	High School
Forest High School	West Carroll	LA	High School
Franklin Parish High School	Franklin	LA	High School
General Trass High School	East Carroll	LA	High School
Gibsland-Coleman High School	Bienville	LA	High School
Glenmora High School	Rapides	LA	High School
Haynesville High School	Claiborne	LA	High School
Homer High School	Claiborne	LA	High School
Independence High School	Tangipahoa	LA	High School
Jena High School	LaSalle	LA	High School
Jonesboro-Hodge High School	Jackson	LA	High School
Kentwood High School	Tangipahoa	LA	High School
LA School for Math, Science and Arts	Natchitoches	LA	High School
Lakeview High School	Natchitoches	LA	High School
LaSalle Parish High School	LaSalle	LA	High School
Lincoln Preparatory School	Lincoln	LA	High School
Madison Parish High School	Madison	LA	High School

Organization	County	State	Organization Type
Mangham High School	Richland	LA	High School
Natchitoches Central High School	Natchitoches	LA	High School
Oak Grove High School	West Carroll	LA	High School
Quitman High School	Jackson	LA	High School
Rayville High School	Richland	LA	High School
Red River Senior 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
Weston High School	Jackson	LA	High School
Bogalusa High school-based health center (SBHC)	Washington	LA	High School
Delhi Community Health Center SBHC-Delhi Charter School	Richland	LA	School-Based Health Center
Delhi Community Health Center SBHC-Delhi High School	Richland	LA	School-Based Health Center
Glenmora High SBHC	Rapides	LA	School-Based Health Center
Jena High SBHC	LaSalle	LA	School-Based Health Center
Lakeview Jr/Sr High SBHC	Natchitoches	LA	School-Based Health Center
Madison Parish High SBHC	Madison	LA	School-Based Health Center
Natchitoches Central High SBHC	Natchitoches	LA	School-Based Health Center
Richardson Medical Center SBHC-Rayville High School	Richland	LA	School-Based Health Center
Tensas Community Health Center SBHC-Tensas High School	Tensas	LA	School-Based Health Center

Rural Alabama Prevention Center

Community-based Organization

D60RH49289-01-02 962268

Primary focus area:
Diabetes, Cardiovascular Disease

Other focus areas:
Access: Primary Care, Access: Specialty Care, Community Health Workers, Coordination of Care Services, Emergency Medical Services, Heart Disease, Health Education and Promotion, Transportation to Health Services

Grantee Contact Information

Grantee Contact: Loretta W. Wilson
Contact Title: Principal Director
Organization: Rural Alabama Prevention Center
Address: 301 Prairie Avene, Eutaw, AL 35462
Telephone Number: 205-372-3514
Email: Lowwebb9@aol.com
Website: www.Ruralalabamaprevention.org

Project Description

South-West Alabama Health Improvement Initiative (SWAHII) has been awarded to promote and support healthy lifestyles throughout Alabama's Delta counties through the implementation of programs geared toward the prevention and care management of chronic diseases. The overarching goal of the project is to improve the health of people living with or at risk of diabetes and/or cardiovascular disease in Alabama's Delta Region by providing education, self-empowerment support, and clinical care coordination. The target populations include: 1) individuals ages 18-85 with a primary focus on African Americans whose hemoglobin A1c level is at or above 6.5, which puts their type 2 diabetes at risk of becoming chronic; and 2) a patient population with a blood pressure over 140/90 that puts them at risk of developing cardiovascular diseases. The overarching objective is to improve the health of 60% of participants reached through the South-West Alabama Health Improvement Initiative with or at-risk of diabetes and/or cardiovascular disease through health education, self-empowerment support, and clinical care coordination by 2026.

Trained community health workers (CHWs) will be integrated into churches and paired with 15 individuals each year who meet the criteria for participation. CHWs will collect and report participants' results (e.g., blood glucose, weight, food intake, and physical activity) daily (until HBA1c levels are normalized), and provide feedback to the program's nurse. CHWs will also coordinate program activities (e.g., community walks, online exercise programs, and meal plans), weekly, via phone, conference calls, or in-person.

Dr. Anthony Paul, botanist, and Dr. Marlo Paul, internist/board certified in lifestyle medicine, will conduct the 10 educational hybrid classes (in-person and virtual) in all counties. Four additional strategies to support participants with or at-risk of type 2 diabetes are: 1) in-person and one-on-one education 2) incentives for churches that commit to implement the Diabetes Empowerment Education Program (DEEP), 3) incentives for participants to support a three-year commitment to diabetes self-management, and 4) referring system that identify patients out-of-care to a participating rural health clinic medical home.

Nurses (RNs/LPNs) will be used as clinical counselors to review all clinical data weekly and communicate "red flag" results to the program doctors. An initial clinical assessment will be conducted on each participant by the nurse to ensure they are a good program candidate. Approval from the participant's primary care doctor will also be obtained, clearing them to participate in the program.

The use of rural health clinics as partners will strengthen the South-West Health Improvement Initiative efforts to prevent cardiovascular disease by adopting the action steps designated by the Self-Measured Blood Pressure Monitoring (SBPM) initiative established by Million Hearts™, which aimed to increase by 10 million the number of persons in the United States whose blood pressure is under control. Patients of participating rural health clinics ages 18-85 with blood pressures of 140/90 or greater will receive care coordination services to help them achieve and sustain the recommended blood pressure levels.

Funding will be provided to six rural health clinics (two per year) to support staffing to include community health workers, purchase blood pressure machines for home blood pressure monitoring, and 12 months of coordinated care for patients of rural health clinics who meet the criteria for services. Two months will be allotted for planning, training, and evaluation, and ten months for one-on-one care coordination that will consist of 1) regular self-monitored blood pressure by the patient outside the clinical setting, either at home or elsewhere; 2) use of community health workers for regular one-on-one navigation; 3) use of jotform.com for data reporting and collection via cell phone and email to respond to patient-self-reported blood pressure readings; and 4) education provided virtually or in-person that helps patients with pressure-lowering behaviors and lifestyle changes that contribute to improved blood pressure over time. Care coordination is intended to maximize the value of delivering care and ensure that the patient's needs are known and addressed.
Success will be measured by the number of patients who control and maintain their blood pressure over a three-year period as evidenced by improvement in health metrics, knowledge of health condition, and regular communication with their doctor about blood pressure readings. RAPC's clinical director and evaluator will review a monthly report from each participating clinic to determine if the patients receiving care coordination maintain a normal high blood pressure and if their risk of developing cardiovascular disease is lowered. Trigger for further intervention (e.g., a booster training or motivational session) will be reassessed quarterly. The project target is for 60% of 180 patients (108) to achieve and maintain normal blood pressure over a three-year period.

In addition to providing the community access to health education and care coordination, community health workers will take services to the community to eliminate the need for transportation, assist with locating affordable health insurance to eliminate the need to delay health care, assist with vouchers for healthy foods to eliminate the early onset of diabetes and heart disease, and assist with locating safe places for exercising that also prevents diabetes and heart disease. CHWs will also conduct a series of health fairs and health screenings to ensure access to other resources offered by other agencies. Evidence of success will be measured by the number of people linked to health insurance, transportation, medication, medical referrals, and other available resources.

Expected Outcomes

SWAHII will utilize the following baseline measures for the Diabetes Empowerment Education Program (DEEP) curriculum: Height, weight, HbAlc levels, blood pressure, and daily reporting of fasting, midday, and bedtime blood sugar for three months, and longer if normalcy has not been reached. In the DEEP curriculum, the goal is to have participants in churches to achieve an HbAlc level of 5.7 or below and a reduction in weight by 5%.

For the Self-Measured Blood Pressure Monitoring Initiative, SWAHII will utilize the following baseline measures: Height, weight, blood sugar, and weekly reporting of self-monitoring blood pressure — daily if "red flags" appear or as directed by primary care doctor.

Process Measures for evidence-based models:

- % of DEEP participants reporting blood sugar reading daily and weekly
- % of DEEP participants and patients receiving care coordination daily diary data regarding diet, exercise, and well-being
- % of DEEP participants received 10 weeks of education classes
- % of patients receive blood pressure machines and training for home monitoring per right heart catheterization each year
- % of patients diagnosed with high blood pressure completed 10-months of care coordination of three-year period
- % of resident's received resources for unmet health and social determinants of health needs

Outcome Measures for evidence-based models:

- % nurses and CHWs demonstrate increased knowledge of blood sugar control and type 2 diabetes
- % nurses and CHWs demonstrate increased knowledge of high blood pressure and cardiovascular disease prevention
- % nurses and CHWs demonstrate increased knowledge on lowering HbAlc levels utilizing an evidence-based approach to preventing and managing type 2 diabetes
- % nurses and CHWs demonstrate increased knowledge on lowering blood pressure utilizing an evidence-based approach to preventing and managing cardiovascular disease
- % program participants demonstrate increased knowledge of healthy lifestyles as demonstrated by pre- and post-testing, via the knowledge survey and behavioral demonstration of A1c and blood pressure monitoring skills
- % participants attain and maintain hemoglobin HbAlc levels of 5.7 or lower over a three-year period
- % patients attain and maintain blood pressure < 140/90 over a three-year period
- % patients receiving education have improved type 2 diabetes
- % patients receiving care coordination services have improved blood pressure

Baseline data will be taken at the kickoff event for participants in DEEP, during the initial visit for care coordination, and quarterly thereafter. The program seeks to achieve success among 60% of participants.

Evidence-Based or Promising Practice Model Being Used or Adapted

The South-West Health Improvement Initiative evidence-based model for the prevention and management of type 2 diabetes is the Diabetes Empowerment Education Program (DEEP). DEEP is an evidence-based curriculum designed to help people with pre-diabetes or diabetes, as well as their relatives and caregivers, gain a better understanding of diabetes self-care. 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
- Utilizing available resources.

DEEP will include 10 classes implemented over a 10-week period focused on the following learning modules: 1) understanding the human body, 2) understanding the risk factors for diabetes, 3) monitoring your body, 4) physical activity and diabetes, 5) controlling diabetes through nutrition, 6) diabetes and cooking, 7) diabetes complication, identification, and prevention, 8) leaning about medication and medical care, 9) sleep and diabetes, and 10) living free of type 2 diabetes. Dr. Anthony Paul, botanist; and Dr. Marlo Paul, internist/board-certified in lifestyle medicine will conduct the 10 educational classes in person and virtually in all counties. The South-West Health Improvement Initiative's evidence–based model for the prevention and management of cardiovascular disease is the Self-Measured Blood Pressure Monitoring (SBPM) curriculum. The curriculum was an initiative established by Million Hearts™, a U.S. Department of Health and Human Services initiative that is co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services. The goal of Million Hearts™ was to prevent one million heart attacks and strokes by 2017. To help achieve this goal, Million Hearts aimed to increase by 10 million the number of persons in the United States whose blood pressure was under control. The initiative provided action steps for public health practitioners to facilitate the implementation of SMBP plus additional support in five key areas: understanding the environment, working with payers and purchasers, working with health care providers, spreading the word to the public, and monitoring/assessment of SMBP plus additional support implementation.

Rural health clinic providers will utilize the following strategies 1) regular self-monitored blood pressure by the patient outside the clinical setting, either at home or elsewhere; 2) use of community health workers for regular one-on-one navigation; 3) use of JotForm for collecting and reporting data via cell phone an email to respond to patient-self-report blood pressure readings; and 4) education (virtual or in-person) that help patients with pressure-lowering behaviors and lifestyle changes that contribute to improved blood pressure over time if maintained.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Hispanic/Latinx
- Older adults
- Uninsured

Area Served

- Barbour
- Bullock
- Butler
- Choctaw
- Clarke
- Conecuh
- Dallas
- Escambia
- Greene
- Macon
- Marengo
- Monroe
- Perry
- Pickens
- Sumter
- Washington

Consortium Partners

Organization	County	State	Organization Type
Abundant Life Wellness Institute	Hale	AL	Wellness Clinic
Community Health Resource and Education Center	Sumter	AL	Community-based Organization
Hill Hospital of Sumter Physician Clinic	Sumter	AL	Rural Health Clinic
New Generation Community Outreach Center	Greene	AL	Faith-based Organization
University of Alabama College of Arts and Science	Tuscaloosa	AL	Department Communitive Disorder – Hearing Mobile Clinic

Southern Illinois University

University

D60RH49290-01-00

Primary focus area:
Cardiovascular Disease, Obesity

Other focus areas:
Health Education and Promotion, School Health

Grantee Contact Information

Grantee Contact: Ashley Moss
Contact Title: Project Director
Organization: Southern Illinois University
Address: 900 S Normal Avenue, Carbondale, IL 62901
Telephone Number: 618-453-1262
Email: Amoss64@siumed.edu
Website: www.siumed.edu/center-rural-health-and-social-service-development/center-services#catch

Project Description

Those living in the Illinois Delta Region face worsened health outcomes than those residing in counties outside of this region. Similarly, Illinois Delta youth face greater health challenges. Data from the Illinois Youth Survey confirms Illinois Delta Region youth are at risk of modeling the unhealthy living and poor health habits of their parents. Illinois Delta youth have high levels of physical inactivity, obesity, and poor eating habits. Moreover, mental health disparities and high child poverty rates permeate the Illinois Delta counties. In the 2022 Illinois Youth Survey, 43% 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. All of this can play a role on both heart disease and obesity.

The Illinois CATCH onto Health! Consortium (ICHC) plans to enhance and expand current school-based efforts by re-introducing and further promoting the Coordinated Approach to Child Health (CATCH) curriculum as well as integrating social-emotional learning curricula into Illinois Delta Region schools. This expanded focus will incorporate updated CATCH curricula, Character Strong curricula, as well as further reach and equip those within the Whole School, Whole Community, Whole Child models (e.g.- school staff, community partners, parents, and children, respectively) with the tools and resources needed to help improve the health outcomes of Illinois Delta youth.

ICHC is also expanding its reach to include a focus on working with community partners who serve a similar population within a different arena. This allows us to engage with other community partners, providing similar consistent messaging without saturating services. Additionally, ICHC will continue to provide leadership for building increased capacity in Illinois Delta schools to effectively improve 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.

The proposed project aims to make a meaningful and measurable impact in the health outcomes of the Illinois Delta Region. To this end, ICHC will implement program evaluation through the cycle of the grant to regularly engage in formative and practical assessment.

Expected Outcomes

Eight long-term outcome goals guide the proposed project. Aligned with Healthy People 2030, our goal is that these outcomes are achieved by that year (2030) and maintained and sustained for a lifetime.

- Decrease health disparities among children in the Illinois Delta Region.
- Improve the quality of life of children in the Illinois Delta Region.
- Increase knowledge, attitudes, and behaviors pertaining to substance use and misuse.
- Improve health literacy among children in the Illinois Delta Region.
- Increase the overall mental health status of children in the Illinois Delta Region.
- Reduce the prevalence of chronic disease among school-aged children in the Illinois Delta Region.
- Improve student connectedness and academic performance through the creation of a school climate that is engaged, safe, supported, and healthy.
- Improve overall health status of counties in the Illinois Delta Region as determined by the county health rankings.

Intermediate outcome goals also guide the proposed project. These goals are based on four broad areas of creating school environments that are: healthy, safe, engaged, and supported. Our goal is that these outcomes are achieved by the end of this proposed project's grant period (2026) and maintained and sustained by 2030.

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

Evidence-Based or Promising Practice Model Being Used or Adapted

Whole School, Whole Community, Whole Child School Health Model. The overarching model that guides programming decisions is the Association for Supervision and Curriculum Development and the Center for Disease Control and Prevention's Expanded Coordinated School Health (CSH) model: the Whole School, Whole Community, Whole Child model. The model includes ten components: 1) Physical education & activity; 2) Nutrition environment and services; 3) Health education; 4) Social and emotional climate; 5) Physical environment; 6) Health services; 7) Counseling, psychological, and social services; 8) Employee wellness; 9) Family engagement; and 10) Community involvement.

Coordinated Approach to Child Health. The primary program proposed in this model is CATCH, recommended by nationally recognized organizations such as Child Trends, to address components of the CSH model. 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.

Mental Health First Aid. Mental Health First Aid is an international training program originating in Australia in 2000. It is aimed at equipping individuals with the skills and education to assist someone experiencing a mental health or substance use-related crisis.

Signs of Suicide. The Signs of Suicide Prevention Program is a school-based depression awareness and suicide prevention program designed for middle-school and high-school students.

Character Strong. The social-emotional learning program Character Strong strives to build character and equip school staff, faculty, and students with a healthy and supportive school environment.
Additionally, ICHC plans to support and further expand on the following already-existing work-through partnerships.

Making a Difference. Making a Difference! is an evidence-based abstinence-focused sexual health education program. The program's goal is to empower young adolescents and give them the knowledge, skills, and confidence needed to reduce their risk for sexually transmitted diseases (STDs), HIV, and pregnancy.

Be Proud! Be Responsible! Be Proud! Be Responsible! is an evidence-based, six-session curriculum focused on building adolescents' skills, knowledge, and intentions pertained to risky sexual behavior.

Making Proud Choices. Making Proud Choices! is an eight-module evidence-based program with the goal of preventing HIV, STDs, and pregnancy in youth.

Promoting Health Among Teens! Comprehensive. Promoting Health Among Teens! Comprehensive is an evidence-based twelve-session curriculum that serves as a pregnancy prevention intervention and aims to reduce risks for acquiring HIV and STDs.

Project ALERT. Project ALERT is an evidenced-based and age-appropriate substance use prevention curriculum that has been proven effective in decreasing experimentation with drugs among teens and in reducing drug use among teens who experiment.

My Generation Rx. My Generation Rx is a national initiative to educate and promote safe medication practices to help prevent the misuse of prescription medications.

Special Populations Served

- Adults
- Black or African American
- Caucasians or White American
- Children/Adolescents
- Hispanic/Latinx
- Older adults
- Pacific Islander/Asian American
- Uninsured

Area Served

- Alexander County
- Franklin County
- Gallatin County
- Hamilton County
- Hardin County
- Jackson County
- Johnson County
- Massac County
- Perry County
- Pulaski County
- Pope County
- Randolph County
- Saline County
- Union County
- White County

Consortium Partners

Organization	County	State	Organization Type
Egyptian Public and Mental Health Department	Gallatin, Hamilton, Hardin, Pope, Saline, and White	IL	Health Department
Franklin-Williamson Bi-County Health Department	Franklin	IL	Health Department
Jackson County Health Department	Jackson	IL	Health Department
Perry County Health Department	Perry	IL	Health Department
Southern Illinois Healthcare	Franklin, Gallatin, Hardin, Jackson, Johnson, Perry, Pope, Saline, Union, and White	IL	Hospital

Organization	County	State	Organization Type
Southern Illinois University School of Medicine Center for Rural Health and Social Service Development	Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Perry, Pulaski, Pope, Randolph, Saline, Union, and White	IL	University
Southern Seven Health Department	Alexander, Johnson, Massac, Pulaski, and Union	IL	Health Department
University of Illinois Extension	Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Perry, Pulaski, Pope, Randolph, Saline, Union, and White	IL	University


DEPARTMENT OF HEALTH & HUMAN SERVICES • USA