

THE OUTREACH SOURCEBOOK



Volume 10

RURAL HEALTH DEMONSTRATION PROJECTS

2000 to 2003

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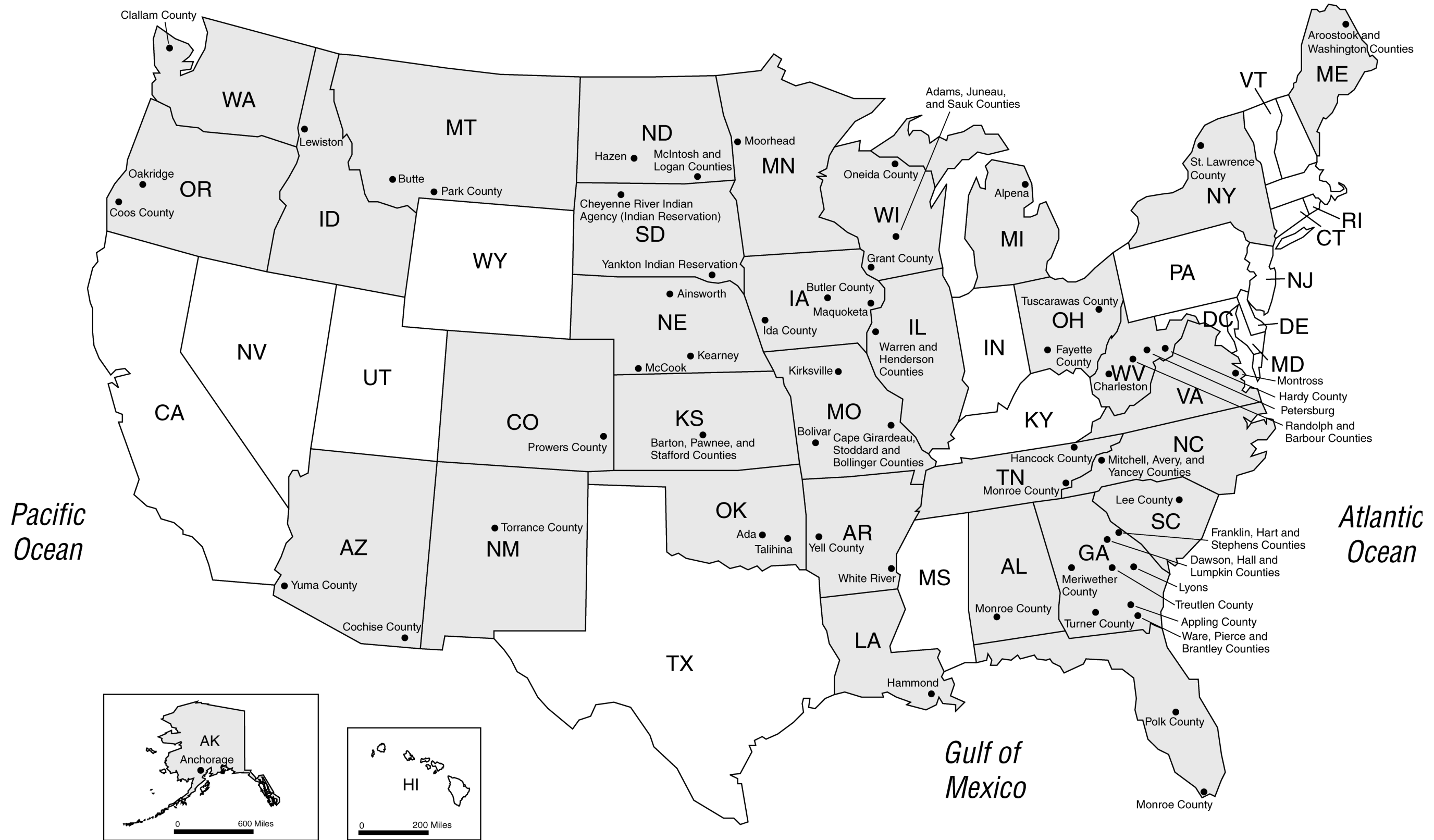
In 2000, the Office of Rural Health Policy (ORHP) awarded 79 projects in 33 States including Hawaii and Alaska. These projects, scattered from Maine to California, were designed to test and demonstrate innovative models for the delivery of primary medical care, prevention services, treatment, and health professions training and services. Each project funded in 2000 was required to develop a consortium of local and State agencies and organizations to ensure that the fullest range of health care resources would be brought to the communities where the programs were established and implemented.

Every year, the health care system in the United States faces new and emerging challenges. Budget cuts, a decline in the number of health care providers, and in recent years, the focus on homeland security and defense have all meant a reduction in the availability of health resources and the means by which to deliver them. Some of these challenges such as geographic isolation from existing services and a shortage of rural health care providers have existed in rural communities for many years. Others, including influx of immigrants with little or no language skills and support systems, tested a region's ability to adapt and respond to its own changing landscape and culture. Regardless of its specific challenges, each of the 35 projects described in this sourcebook was able to fashion creative and workable solutions to the unique health care needs of its communities.

Whether responding to economic need, population growth, an aging population, cultural diversity, or geographic expanse, all of the consortia created as a result of ORHP's 1999 Rural Health Outreach Grant cycle succeeded in their efforts. More importantly, utilizing resources at-hand, these consortia increased access to health care, reduced or eliminated barriers to care, and improved the lives of rural residents through humane and sensitive outreach. As a result, thousands of rural residents whose health care needs had largely gone unmet are healthier and more productive today than they were prior to 1999. And their prospects for good health in the years to come are significantly improved.

The diversity of the following programs, in terms of populations served and program models implemented, belies that they are united in one common goal: to improve the lives of their residents.

- The Farmworker Case Management Across Borders in Putnam County, Florida, provided free primary and preventive health care to a population of 1,500 migrant and seasonal farm workers using a mobile clinic.
- The Kokua Program of Maui Hawaii, using culturally-sensitive methods to overcome language and cultural barriers, provided breast and cervical cancer education and health screenings to Native Hawaiian, Filipino, and Pacific Islander women in remote areas on the island of Maui.
- The Expansion of Rural Dental Health Care Services in Macoupin and Montgomery County, Illinois Program provided dental services to 5,000 children in rural Illinois who had no dental care.



GLOSSARY OF FREQUENTLY USED TERMS

AHEC	Area Health Education Center
AHEC	Area Health Education Center
BASICS	Behavioral Access Study Integrating Continuum Services
BCMSA	Belington Community Medical Services Association
BMI	Body Mass Index
BOE	Board of Education
CCHCI	Chiricahua Community Health Centers, Inc.
CHED	Community Health Education and Development
CHIP	Children’s Health Insurance Program
CMC	Community Medical Center
CTMC	Cross Trails Medical Center
CVD	Cardiovascular Disease
DFCS	Department of Family and Children Services
EAHHC	E.A. Hawse Health Center, Inc.
EMS	Emergency Medical Service
EMT	Emergency Medical Technician
ESU	Educational Service Unit
FAN	Family Advocacy Network
FQHC	Federally Qualified Health Center
FQHC	Federally Qualified Health Center
FYI	Frontier Youth Initiative
GAP	Graduating Achieving Parents
GMA	Group Medical Appointment
GMH	Grant Memorial Hospital
HCFSS	Health Connection for School Success
HHH	Horn Memorial Home Health

GLOSSARY OF FREQUENTLY USED TERMS

HMH	Horn Memorial Hospital
IDEA	Individuals with Disabilities Education Act
LCSC	Lewis-Clark State College
LCSW	Licensed Clinical Social Worker
LSU	Louisiana State University
MAYland	<u>M</u> itchell, <u>A</u> very, and <u>Y</u> ancey Counties
MCSD	Maquoketa Community School District
NCCCP	North Central Community Care Partnership
NGCSU	North Georgia College and State University
PAH	Partners in Agricultural Health
PAL	Proactive Living
PHG	Potomac Highlands Mental Health Guild
PPC	Primary Prevention Coalition
SCHIP	State Children’s Health Insurance Program
SEHU	Southeast Health Unit
SGCP	Southeast Georgia Communities Project
SLCHI	St. Lawrence County Health Initiative
SMC	Sakakawea Medical Center
SUNY	State University of New York
TATU	Teams Against Tobacco Use
TLC	Timely Life Care
UAB	University of Alabama-Birmingham
WCHC	Wishek Community Hospital and Clinics
WIC	Women, Infants, and Children

Community Characteristics

Good oral health habits can be developed at an early age. However, many children and adolescents living in rural areas do not have sufficient access to affordable dental health services. This is especially true in the area surrounding Monroeville, Alabama, where children and adolescents covered by Medicaid experienced numerous barriers to receiving oral health education and treatment services.

Services Offered

To help meet the oral health needs of Medicaid-covered children and adolescents in the region, the Monroe Health Foundation joined forces with local and State organizations to establish a consortium in which each organization had a vested interest in safeguarding the oral health of area youth. The consortium members included the University of Alabama-Birmingham (UAB) School of Dentistry, the county Department of Human Resources, the State and county Departments of Public Health, Monroe County Hospital, and the local Maternal and Child Health Rural Health Clinic. UAB provided a dentist, and the Department of Human Resources referred patients to dental services. The State and county Departments of Public Health provided educational information and resources, while Monroe County Hospital provided space and billing staff for the dental clinic. Monroe Health Foundation served as the fiscal agent for the project, overseeing all grant activities and coordinating resources as necessary.

Innovative Solutions to Problems

The centerpiece of the project was the establishment of a dental clinic at Monroe County Hospital for children younger than 18 years of age. The main purpose of the clinic was to provide a wide range of oral health services and to educate children about the proper ways to prevent oral health problems in the future. Dental services were available to Medicaid-eligible children in Monroe County and the surrounding counties.

ALABAMA



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MONROEVILLE, AL**

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Results

The project recorded 2,693 patient visits during the 3-year grant period. More than two-thirds of the children and adolescents served by the project were African American, and nearly one-third were Caucasian. In addition, nearly two-thirds of the young people who received oral health care were adolescents aged 12 to 18 years. In the third year of the project, the clinic provided dental health care to 1,210 children, including 703 children aged 2 to 12 years.

Potential for Replication

It is not uncommon for children in rural areas to have limited access to oral health services; therefore, this model is particularly relevant to other rural communities in which Medicaid-eligible children have little or no access to dental services. By bringing together a wide range of organizations, such a project can create and maintain an infrastructure for educating children about good oral health habits, provide referrals to dental services, and house the physical clinic itself. One of the most difficult challenges, however, is recruiting and retaining qualified dentists to provide oral health treatment. Involving a school of dentistry from an academic institution can help meet this challenge and provide a valuable training opportunity for aspiring dentists; however, it is important to ensure that the institution is committed to participating in the project over the long haul.

After the Grant

Late in the project, UAB was no longer able to provide a dentist to participate in the project. The project attempted to recruit another dentist but to no avail. As a result, the project was forced to stop offering the dental clinic. Fortunately, a husband and wife, both of whom are dentists, recently set up a dental practice in the area and are providing dental care to children covered by Medicaid.

Community Characteristics

It is not uncommon for rural communities in Alaska to be designated as health professional shortage areas. The shortage of health professionals in these communities limits opportunities to educate rural residents, including youth, about healthy behaviors that can reduce morbidity and mortality later in life.

The Alaska Youth Media Project was designed to deliver health promotion and disease prevention messages via television to Alaskan youth aged 12 to 18 years throughout the State. Specifically, the project sought to train youth to produce a television show targeted toward their peers. In addition to learning media production skills, young people had the opportunity to develop and produce broadcast stories on health and substance abuse issues. Students were required to research their stories and conduct interviews, and local health care professionals served as resource consultants for the young people developing the news stories. While one of the main goals of the project was to teach young producers new job skills and media literacy skills, the project also sought to help young people throughout the State to make better, more-informed choices about their health.

Services Offered

The Alaska Youth Media Project originally targeted a group of high schools in Matanuska Susitna Valley, which is located in south-central Alaska. The project consortium included the Health TV Channel, Inc.; Spirit of Youth; KRASH—Sitka; the Alaska Native Health Board and its 21 statewide native organizations; KNBA's Native Summer Youth Media Project; the Anchorage Borough School District (Burchell High School and the Extended Learning Program); and the local Department of Health (Anchorage region). Each organization had the opportunity to refer students to the project or to provide resource consultants for the project.

In the first year, the student participants attended after-school training at a local high school. In the second year, the project offered both an in-school class and an after-school class, which provided an opportunity to earn both high school and college credit (from the University of Alaska). In the third

ALASKA

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year, the project transitioned to a Web-based, satellite-delivered distance learning course that expanded the project's reach to additional schools in remote regions of Alaska (Wrangell, Angoon, Craig, Kwigillingok, and Pelican).

Innovative Solutions to Problems

Students were required to create a 3-minute story on the health topic of their choice. They had to do their own research, often via the Internet, and conduct their own interviews. Resource consultants were available to help ensure their stories were accurate and to identify local sources for interviews. Students accumulated their facts, created a storyboard, wrote the story, conducted interviews, and produced the segment.

In the third year, the project identified additional rural schools and provided them with WEBEX technology. A Ph.D.-level instructor led the distance learning class. The WEBEX technology made it possible to present live training at the remote sites and to offer an online course in video production. The Web site also provided a collaborative forum for teachers, resource consultants, and students to interact.

One of the biggest challenges the project experienced was competing effectively with students' other priorities. For example, in the first year, the project lost some of its students because of other commitments such as cheerleading, football, and hockey. As a result, the project stepped up its efforts to recruit students who would be able to commit to participating in the project over the long haul by developing radio public service announcements, distributing flyers, and sponsoring lunchtime meetings. Another challenge was the technological skill level of the teachers at remote sites. In retrospect, providing technical training to teachers before classes began would have increased their proficiency with distance learning technology.

Results

The project succeeded in achieving its goals. With each group of students who participated, the project yielded greater success, which set the stage for expanding it into other rural communities during the third year of the grant.

Potential for Replication

Similar projects would work well in other rural settings. It is critical, however, to have competent and trained staff. The materials and course forms developed throughout the course of the project are available to other communities that want to launch a similar effort. Once the project is launched, it is also important to sustain the enthusiasm of the participating students.

After the Grant

The project currently is seeking new funding sources and hopes to expand nationwide in the years to come.

PROJECT 3—DELTA ENTERPRISE COMMUNITY RURAL HEALTH OUTREACH PROGRAM

Community Characteristics

Although some health care services were available in a six-county region of Arkansas (Cross, Lee, Jackson, Monroe, St. Francis, and Woodruff Counties), before receiving the ORHP grant, many low-income people were unable to access the services available in these communities. Furthermore, the health care, mental health, substance abuse, and housing services available in these counties were severely limited.

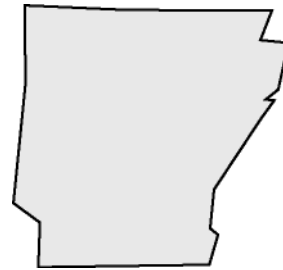
Services Offered

To address these needs, the White River Rural Health Center, a community health center located in the region, formed a consortium of organizations to create an outreach-based approach to increasing access to these services for low-income individuals and families in the target service area. White River Rural Health Center provided medical staff for clients referred to the program. The center also provided referrals for mental health and substance abuse services, followup care, and other necessary services. The North Arkansas Human Services System provided comprehensive outpatient and residential substance abuse treatment to patients regardless of their ability to pay for care. Arkansas Affordable Housing provided housing services. A 15-member Project Coordinating Council guided the consortium. The project activities focused on training and deployment of community outreach workers throughout the six-county region, health promotion and disease prevention programs, and linkages to health insurance coverage resources and human service agencies.

Innovative Solutions to Problems

The project established a single point of contact for clients to the services available throughout the six-county region. The single point of contact was the outreach workers employed by the program. Community outreach workers received extensive training in health, mental health, and housing issues. Armed with this knowledge, they targeted individuals and families who were likely to need care, including low-income children, youth, and elderly. Once contact was initiated, the outreach

ARKANSAS



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workers encouraged families to access an interlocking system of care that offered services and supports. White River Rural Health Center conducted the initial screening and assessment of new clients and then linked clients to a case manager who worked with physicians and mental health professionals to facilitate additional assessments. Providers developed medical and mental health treatment plans and provided referrals to consortium and community resources.

Outreach workers attended meetings at area churches, civic groups, and workplaces. At these meetings, they explained the program's services, distributed a packet of information about the program to new clients, and asked new clients to complete a referral slip that included contact information for the client. Sometimes, however, clients did not attend initial appointments, which meant that outreach workers had to attempt additional contacts to engage clients in care. Clients also were given a toll-free telephone number they could call to access services.

Results

The project provided 1,193 units of primary health care and 498 units of mental health services. When necessary, the project assisted clients by providing transportation services and assessing their eligibility for Medicaid coverage. During the grant period, Medicaid enrollment in the six-county region increased by 59 percent.

Potential for Replication

Many rural communities could benefit from an outreach-based model that links clients to primary care, mental health care, and housing services. However, it is important to establish clear lines of responsibility among the participating agencies and to educate the community about the availability of services. Outreach workers must be fully trained and well informed about each agency's services and missions. In addition, transportation is a serious barrier in rural communities and must be addressed to ensure clients can attend scheduled appointments.

After the Grant

The transportation program is fully operational, and all newly identified clients are evaluated for eligibility for Medicaid. Five outreach workers are stationed in various clinics throughout the six-county region to identify new clients. The project also continues to employ two case managers.

Outreach workers continue to visit local churches, civic groups, and employers to educate members of the community about the services available to them. The partner organizations also continue to provide and accept referrals for care. Case managers are actively involved in helping clients access community resources and, when eligible, to enroll in Medicaid. Project activities are funded by in-kind contributions, other grant sources, and patient revenues.

Community Characteristics

Arkansas residents consistently rank as the least healthy of residents in all 50 States. Arkansas ranks first in the Nation in deaths attributed to cerebrovascular diseases, and its death rate from heart disease is 21 percent higher than the national average.

Located in west-central Arkansas, with approximately 18,000 residents, Yell County is the fifth largest county in the State in terms of land mass and is bordered by the Ozark Mountains to the north and the Ouachita Mountains to the south. Danville, Arkansas, which is located in Yell County, has approximately 2,300 residents. The county's Hispanic population has grown dramatically. In 1995, enrollment of Hispanic children in the Danville School District was 7 percent. In 1999, Hispanic children accounted for 32 percent of the district's students. Danville's Hispanic population grew from 1 percent in 1990 to 43.5 percent in 2000.

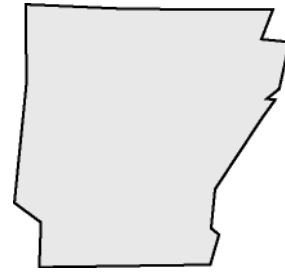
Services Offered

The goal of the Yell County Rural Health Consortium was to increase access to basic health care and to improve the cardiovascular health of the residents of Danville and the surrounding areas. The project was designed to achieve this goal primarily through health education and the delivery of primary preventive services.

Chambers Memorial Hospital, a 41-bed rural hospital serving some 38,000 residents in the 3-county area, led the project consortium. The hospital was responsible for providing project direction, coordinating and implementing community outreach programs, and hiring a bilingual physician. The Arkansas Tech University's Department of Nursing, which enrolls 50 to 60 nursing students each year, implemented the school-based program and supported community screenings and educational programs. The head of the department also served as the project evaluator. The Danville School District, which had more than 700 students in schools covering an area of 141 square miles, provided facilities for and coordinated the implementation of the school-based program.

Clients who received services ranged from elementary schoolchildren to older adults. Modeled after a nationally tested program, a school-based cardiovascular disease (CVD) prevention program was implemented in two rural elementary schools, with

ARKANSAS



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participation by third, fourth, and fifth grade students. The fifth-graders also participated in a tobacco prevention class. The project provided community health screenings at local civic organizations, churches, businesses, community groups, and poultry processing plants. Screenings included blood pressure, cholesterol, HDL cholesterol, and blood sugar checks. In addition, the project offered community education classes. To improve access to primary health care services, Chamber Memorial Hospital added a bilingual family practice physician to its staff.

Innovative Solutions to Problems

The school-based CVD prevention program focused on developing healthy eating habits, smoking prevention, and physical activity. The classes were incorporated into the physical education program and taught by third- or fourth-year nursing students. All teaching materials, which had been used in other successful multicultural outreach programs, were presented in both English and Spanish. Hiring professional personnel proved to be the most difficult challenge the project faced. A bilingual physician was not hired until the project's second year, and by the end of the second year, the registered nurse coordinator had resigned. Although it is always difficult to recruit and retain professional staff to serve in rural areas, hiring a bilingual physician was significantly more difficult than the project anticipated. The physician was eventually located with the help of one of the hospital's staff physicians.

Results

Over the 3-year grant cycle, 697 elementary school students participated in the CVD prevention program. A sample of students was tested pre- and postintervention with a 10-question true/false quiz. Some 379 students took the pretest, and 400 students took the posttest. Data suggested that the intervention had a significant effect on the students' understanding of cardiovascular health and health-positive behaviors.

One of the project's goals had been to increase to at least 40 percent the number of Danville residents who accessed primary health care services, health education programs, and screening services. This goal was met in the project's first year. By the end of the grant cycle, the project recorded more than 14,000 service encounters.

The school-based smoking prevention program was offered in three of the five proposed schools. At one school's request, the program was expanded to include not only fifth graders but seventh and eighth graders as well.

Evaluation of the Yell County Rural Health Consortium project revealed a significant increase in the number of patients accessing care. In fact, the number of unduplicated visits by Hispanic patients increased each year to a high of 1,227 patients by the end of the third year.

Potential for Replication

Other communities with a local hospital, school of nursing, and elementary schools would be able to create a consortium similar to the one established for this project and carry out many of the same activities. The project's community education programs were modeled after successful national community programs, which also could be replicated or adapted for local use. In addition, educational materials are readily accessible at a reasonable cost.

One potential challenge for other communities may be recruiting bilingual medical personnel. Rural areas frequently have difficulty recruiting and retaining qualified staff. Bridging the cultural and linguistic gaps also may be a challenge for communities seeking to replicate this model as a means to improve the health status of some ethnic minority populations. In addition, it is important to engage community leaders from target populations to be actively involved in planning and promoting project services for the target population.

After the Grant

Health screening and community education programs continue to be offered by Chambers Memorial Hospital. The hospital also continues to provide primary health care services to the target population and covers the salary of the bilingual physician. The Arkansas Tech Department of Nursing will continue to use the facility as a clinical site, and nursing students will participate in community outreach programs as part of their clinical rotations. Arkansas Tech also is evaluating its future curriculum needs and hopes to continue the school-based educational program, if feasible.

Community Characteristics

In 1996, the Arizona Department of Health Services, the Office of Rural Health, and the University of Arizona convened a group of medical providers practicing along the U.S.-Mexico border. The purpose of the meeting was to better understand the prevalence of diabetes and its associated risk factors and complications in the Douglas and Elfrida communities in Arizona. The study, which was completed in December 1998, found that the prevalence of diabetes in the Douglas and Elfrida communities, using a glucose level of 140 or higher, could be conservatively estimated at 18 percent, compared with the national average of 10 percent. Many local residents who knew they had diabetes did not have their blood sugar levels under control. In fact, of the 915 people interviewed in the study, only 19 percent had their glucose levels under control. The average height of study participants was 5 feet 3 inches, and the average weight was 167 pounds. The average body mass index (BMI) of participants was 29 compared with a healthy BMI of 19 to 25. A total of 38 percent of the participants were overweight, and 36 percent were obese.

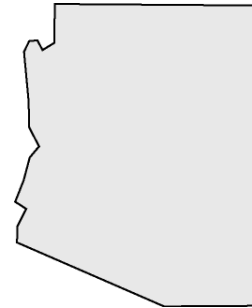
Services Offered

The service area for the Diabetes Outreach and Education program was the central and southern portions of Sulphur Springs Valley, located in the southeast corner of Cochise County. The region's borders include the U.S.-Mexico border to the south and New Mexico to the east. The area, where the mining industry once thrived, was characterized by rampant poverty. The Diabetes Outreach and Education program was based on a successful model used in neighboring Santa Cruz County.

The project consortium included the following organizations:

- Chiricahua Community Health Centers, Inc. (CCHCI) provided oversight of the grant and employed the program director, two *promotoras*, and a data entry clerk. CCHCI also provided a medical home for persons with diabetes who had no medical providers or health insurance.
- Cochise County Health and Social Services hired the diabetes educator.
- Compañeros provided a *promotora* coordinator and two *promotoras* to support outreach activities.

ARIZONA



**DIABETES OUTREACH AND
EDUCATION
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- The Southwest Border Rural Health Research Center provided technical assistance for the project and evaluated its success in the second and third years.
- Southeast Arizona Medical Center provided continuing medical education opportunities for providers in the third year of the project.

Innovative Solutions to Problems

The project's most innovative feature was the use of *promotoras* to conduct outreach to residents in the service area. *Promotoras* are lay health workers who live in the service area and have an in-depth, personal understanding of the community and of residents' cultural expectations regarding health care. They conducted home visits and provided grassroots outreach services. The project also offered a 6-week course on diabetes, available in both Spanish and English, to residents in Douglas and Elfrida Counties.

The project's biggest challenges stemmed from the consortium itself. From the beginning of the project, Southeast Arizona Medical Center was on the verge of bankruptcy and was not able to participate until the third year of the project. Personal and family illness at Cochise County Health and Social Services interfered with the agency's ability to provide a diabetes educator. Management changes at *Compañeros* resulted in frequent turnover in personnel. CCHCI also experienced high turnover among the *promotoras*. These constant changes required the ongoing training and retraining of new *promotoras* and diabetes educators on the program curriculum and data collection tools. The changes also required more frequent meetings between network personnel, beginning during the third year of the project, to increase the network's focus on the project's activities.

Results

The Douglas Diabetes Consortium recruited 360 individuals with diabetes to participate in the diabetes classes. Of these, 156 (43 percent) attended all 5 classes. Two-thirds of the participants were female, and more than half (55 percent) were between the ages of 50 and 70 years. The majority of participants were Hispanic (80 percent), although the project also served

Caucasian and American Indian clients. A whopping 80 percent of the participants also had family members with diabetes. Among these participants, random blood glucose levels dropped from 177 to 164. Many participants also reduced their weight as well as their systolic and diastolic blood pressure levels.

The individuals who participated in the diabetes classes had numerous other health problems. Some 52 percent of participants reported experiencing depression, 58 percent reported high blood pressure, 64 percent reported vision problems, and 53 percent reported numbness in their hands and feet.

Six-month followup interviews with 56 participants demonstrated the following results:

- The percentage of respondents who reported that they monitored their blood glucose increased from 66 to 82 percent.
- The percentage who regularly checked their feet increased from 75 to 89 percent.
- The percentage who reported exercising regularly increased from 73 to 80 percent.

The percentage who reported having a family member participate in exercise increased from 27 to 38 percent, and the percentage who reported having a family member help with their diet increased from 39 to 77 percent.

Indepth interviews conducted with 26 randomly selected participants at the end of the second year indicated several factors that improved diabetes self-management. These factors included interaction with the *promotoras* to receive basic information on necessary lifestyle changes, improved relationships with medical providers, and reduced isolation. In particular, the *promotoras* were critical to offering support and encouragement to attend diabetes classes, monitor glucose levels, eat right, and exercise regularly. *Promotoras* also provided linkages to medical appointments and screenings, glucometers and strips, and medications.

Potential for Replication

Program planners thinking about replicating this program should keep a few factors in mind. First, it is important to establish procedures and systems for monitoring the quality of the activities

managed by the consortium members. Second, recruiting a certified diabetes educator is critical to the project, but it can be difficult to attract providers to rural areas. Third, it is important for the organizations involved in the consortium to identify clear expectations for the *promotoras*.

After the Grant

CCHCI is working with the Bureau of Primary Health Care's Health Disparities Collaborative for Diabetes and the Health Services Advisory Group in the Arizona Diabetes Initiative. Two of CCHCI's nurses are being trained to become certified diabetes educators. Project activities are being sustained through patient revenues and other funding sources. Meanwhile, CCHCI is replicating a successful model of care from a Pennsylvania program that monitors chronically ill patients on an ongoing basis, emphasizing the development of patient self-management skills.

PROJECT 6—RURAL HEALTH OUTREACH DIABETES EDUCATION PROGRAM

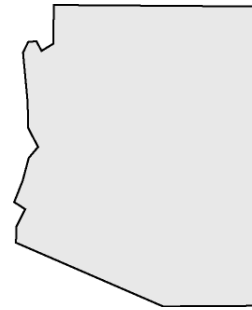
Community Characteristics

The diabetes rate in Yuma County, Arizona, is an astounding 10 to 12 percent. As a border community, 75 to 80 percent of the county's residents are of Hispanic descent—a population that typically experiences a prevalence rate of diabetes that is 2 to 3 times higher than the rate in non-Hispanic whites. Insufficient control of diabetes among Mexican Americans has been related to inadequate access to health care and education services. It also has been associated with inadequate skills and support to integrate and sustain self-care management strategies in everyday life. Conditions such as diabetes require careful and consistent monitoring and, in many cases, regular treatment. Migrant farmworkers with diabetes, however, often are unable to receive the treatment they need because they move frequently and work up to 7 days a week at the height of the agricultural season. Language is another formidable barrier. For example, 95 percent of Yuma County's border population prefers to read and speak Spanish.

Services Offered

The Yuma Diabetes Consortium elected to target the migrant, Spanish-speaking population living in the border communities of Somerton and San Luis. These communities had been designated as medically underserved areas, and about 75 percent of their residents live at or near the federally designated poverty level. The consortium members included Sunset Community Health Center, which provided a comprehensive array of primary health care and dental, obstetric/gynecologic, and pharmacy services; *Puentes de Amistad*, a grassroots, community-based agency that employed *promotoras* to provide linguistically and culturally appropriate health education services to Spanish-speaking residents; the Yuma Regional Medical Center, which is the only hospital located in the county; and the University of Arizona College of Public Health, which was responsible for providing technical assistance and evaluation expertise. Specific services provided by the grant included a series of four diabetes education classes, foot and eye clinics,

ARIZONA



**RURAL HEALTH OUTREACH
DIABETES EDUCATION
PROGRAM
SOMERTON, AZ**

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promotora outreach and support, and assistance in accessing health care services and needed medications.

Innovative Solutions to Problems

Each series of diabetes education classes was conducted in an environment intended to be comfortable and convenient for participants. One-third of the classes were held at the San Luis Community Center, and the remaining two-thirds of the classes were held at the youth center or a local church in Somerton. The project deliberately arranged to offer these classes someplace other than in a health care facility, and this approach seemed to have a positive effect on the participants' willingness to interact with the facilitators and to communicate with one another. The classes helped the participants to realize that diabetes is a controllable disease and that they could learn to manage their diabetes on their own.

Another project innovation was the use of *promotoras*, who played an important role in engaging new clients. *Promotoras* conducted home visits and field presentations, provided patient referrals, and participated in local health fairs—all of which presented opportunities to disseminate linguistically appropriate information about diabetes and to recruit clients needing education or care.

Results

The rural health outreach project made nearly 2,500 potential patient contacts, and, as a result of this outreach, 476 people became enrolled in the diabetes education program. Project data revealed the following results:

- The percentage of participants reporting that they monitored their blood glucose levels increased from 53 percent to 95 percent.
- The percentage who conducted regular foot checks increased from 85 percent to 99 percent.
- The percentage who reported exercising regularly increased from 70 percent to 83 percent.
- The percentage reporting that they had received an eye exam increased from 63 percent to 88 percent.

- The percentage who knew what a hemoglobin A1c test was increased from 23 percent to 62 percent.
- The percentage who knew whether they had received a hemoglobin A1c test increased from 48 percent to 91 percent.

Potential for Replication

This project is relevant to any rural community that possesses the health care resources to train *promotoras* and is committed to addressing the education and health care needs associated with diabetes and poor self-management. The *promotora* component requires identifying a few local residents who are familiar with their community and the needs of its residents and who are willing to be trained to conduct outreach. However, effective outreach will achieve little good if culturally appropriate strategies are not used to get potential patients to actually attend classes or receive care. In many cases, patients are willing to seek help but do not have transportation to and from classes or appointments, so it is often necessary to provide transportation services to clients in need.

After the Grant

This project is now part of the activities administered by the Sunset Community Health Center. The center employs a *promotora* who provides onsite information about diabetes and coordinates enrollment in diabetes classes. The project also is examining opportunities to expand the *promotora* model to other communities and to address additional public health issues.

Community Characteristics

Besides family get-togethers, elderly individuals and young people rarely have an opportunity to interact and learn from each other. Senior citizens have a great deal of life experience to share with young people who have their whole lives in front of them. Likewise, young people often have had the opportunity to develop technical skills (e.g., computer expertise) to which many rural elderly individuals have not been exposed. In rural communities, however, it is common for there to be a substantial “gap” between the young and the old, even though there are many ways in which these two age groups can benefit from interaction with each other.

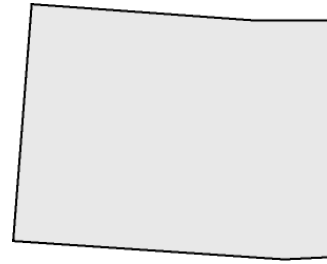
Services Offered

The primary goal of the Caring Country Community project was to promote interaction between the community’s elderly and young residents. More fundamentally, the project was designed to provide a level of mutually beneficial interaction that would promote personal enrichment, increase knowledge, and improve the health status of the participants.

The network members for the project provided the means to offer a wide range of health and related services to seniors:

- The Prowers County Nursing Service provided flu shots.
- A local attorney provided legal clinics for senior citizens.
- Sunshine Body Works provided foot clinics.
- Weisbrod Memorial Hospital conducted blood sugar screenings and blood pressure testing.
- Meals on Wheels provided weekday meal service to seniors.
- Prowers Medical Center sponsored health fairs that covered a variety of health topics.
- The Lamar Public Library provided books with large print for seniors.
- The Wiley School District sponsored youth/senior computer programs.

COLORADO



**A CARING COUNTRY
COMMUNITY
WILEY, COLORADO**

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TOWN CLERK
TOWN OF WILEY
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- Wiley Summer Recreation sponsored youth reading and computer programs.
- Local service clubs sponsored programs in which youth cooked and served meals for seniors.

Innovative Solutions to Problems

The interaction component of the Caring Country Community project was its main innovation. For example, senior citizens volunteered their time to read to elementary school children and to encourage these young students to read as part of their summer reading program. Likewise, junior high and high school students helped senior citizens improve their computer skills and prepared and served meals for senior citizens.

Results

During the course of the 3-year project, 138 seniors and 145 children and adolescents participated in grant activities. In addition, 125 adults aged 18 to 64 years were involved in the project. Most of the elderly individuals who participated were living on a fixed income that would have prohibited them from receiving the services provided by the project. Seniors also benefited from home health care, legal counseling, and transportation services provided by the project. The majority of individuals involved in the project were Caucasian (80 percent), and the remaining 20 percent were people of Hispanic origin.

Potential for Replication

This project demonstrated that young people and elderly individuals can interact successfully, teach each other new skills, and benefit from one another in many different ways. Consequently, this model could be easily adapted to other rural communities. One of the key ingredients for success is to engage a diverse array of organizations—from senior citizens groups to local school districts to faith-based organizations—in planning and implementing such a project.

After the Grant

The project will continue to provide many of the activities supported by the grant, including foot clinics, flu shots, and free legal consultation. The community also will continue to seek out opportunities for young people and elderly individuals to interact, to learn from one another, and to participate in mutually enriching activities.

PROJECT 8—WESTERN YUMA COUNTY RURAL HEALTH OUTREACH PROJECT

Community Characteristics

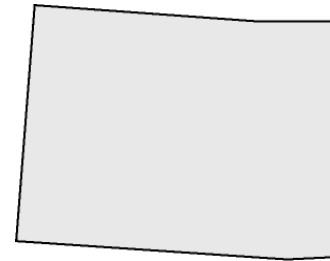
The 1990 census indicated that Yuma County, Colorado, was 99 percent Anglo. However, in the years to follow, the rapid evolution in agricultural practices, such as the emergence of housed commercial swine feeding operations, resulted in the rapid influx of minorities in the region. At the time of the grant award, ethnic minorities accounted for about 20 percent of the county's population. Immigrants from Mexico, eager for work, had moved to the county and were quickly hired by employers seeking workers. The broader community, however, was ill prepared for the infusion of the minority population. Local schools and health and human service providers were overwhelmed with individuals who did not speak English but nonetheless needed education and health care services. Culturally and linguistically appropriate services were not available to this population, as became painfully clear when Yuma County Social Services investigated a number of medical neglect cases involving Hispanic families. The investigation showed that the immigrant population did not understand the health care environment in Yuma County, how to access services, and how to overcome the language barriers they experienced when attempting to receive care.

The service area encompassed western Yuma County, a rural, agricultural area spanning 1,200 square miles and home to approximately 5,000 individuals. However, because of the lack of culturally relevant services within a 60-mile radius of the target area, the project anticipated the opportunity to serve Hispanic families living throughout the county as well as some living in Washington County. The county's population density—3.9 persons per square mile—underscored that Yuma County would be more accurately classified as a frontier county rather than a rural county.

Services Offered

The Western Yuma County Rural Health Outreach Project was designed to increase access to health care services for the growing Hispanic population in Yuma County. The majority of grant funds were allocated for conducting outreach to the county's Hispanic families to engage them in prenatal, obstetric, postnatal, mental health, and family enrichment services. The project network included the Yuma District Hospital and Clinic, the Northeast Colorado Health Department, Baby Bear Hugs (the regional home

COLORADO



**WESTERN YUMA COUNTY
RURAL HEALTH OUTREACH
PROJECT
YUMA, COLORADO**

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visitation program), Centennial Mental Health Care, Yuma County Social Services, and the University of Colorado Health Sciences Department. In the final year of the project, another organization, the Rural Communities Resource Center, which had a long history of community advocacy, joined the network.

Innovative Solutions to Problems

One of the first tasks for the project was to post signage throughout network facilities in both English and Spanish. Another critical task was the recruitment of bilingual and multicultural staff members among the network members. At the beginning of the project, only three bilingual individuals were employed by the network partners. Yuma District Hospital and Clinic procured four bilingual and multicultural staff members, both in the primary care clinic and in the front office. Baby Bear Hugs added a bilingual/multicultural paraprofessional who conducted home visits to pregnant Hispanic women and those with children younger than 5 years of age. The health department provided a staff member to write a Spanish-language newsletter that was distributed widely in the community. All county health materials were translated into Spanish, and the needs of Spanish-speaking audiences began to be considered in various health department projects focusing on tobacco prevention, AIDS prevention, tuberculosis screenings, and other health issues. Centennial Mental Health Care provided both mental health services and cultural competency training, and Yuma County Social Services provided financial assistance, entitlements, cash assistance, and enrollment in Medicaid.

All forms used by the network members were available in Spanish. By the middle of the second year, the network partners employed 15 bilingual and/or multicultural staff members. The project had hoped to recruit a bilingual physician, but the remoteness of the community hampered recruitment efforts. A female physician from Mexico who could be credentialed as a physician assistant in the United States was hired, but she left after 6 months because many in the Hispanic community refused to receive care from her. In general, however, once the Spanish-speaking population became aware that efforts were under way to provide them with culturally and linguistically appropriate care, they were eager to access services and, most importantly, to seek help before their medical problem warranted a visit to the

emergency room. The most effective means of marketing the project turned out to be word of mouth among Hispanic individuals who either heard about the project or had been pleased with the care they received.

Results

The project succeeded in expanding access to health care for Hispanic families in Yuma County and the surrounding area. Hispanic visits to the Yuma District Clinic increased by 253 percent, and visits to the hospital increased by 131 percent. The presence of culturally competent individuals and staff helped clients feel that their participation was welcomed and encouraged. Most importantly, once this project was created, Yuma County Social Services did not receive a single complaint of medical neglect from the Hispanic community.

One of the project's most notable accomplishments was the development of the Latino Council, a group that focused on empowering Hispanic individuals and families. Dr. Art Reyes, director of Centennial Mental Health Care, played a key advocacy role in bringing the Latino Council into existence and promoting cultural competency training opportunities throughout the area.

Potential for Replication

This model can be applied to other rural settings, but program planners must be aware of the kinds of challenges and resistance that might arise. For example, when the project posted signs in Spanish throughout the Yuma District Hospital and Clinic, there was some community discussion about "making everyone learn English" and not "catering to an immigrant culture." Overcoming these kinds of barriers requires strong leadership. Communities also must be prepared for the challenge of recruiting qualified bilingual health care professionals.

After the Grant

The network partners continue to promote the value of high-quality health care and social services for everyone who lives in the community. The project's interagency council, Linking Yuma County, continues to meet once a month to assess community needs, to develop new programs, and to respond to the changing needs of Hispanic residents.

Community Characteristics

Farming and ranching are the major economic forces on the plains of northeastern Colorado. Yuma County has a population of approximately 9,800 people, with less than half of the county residents living in the more heavily populated towns of Wray and Yuma.

Services Offered

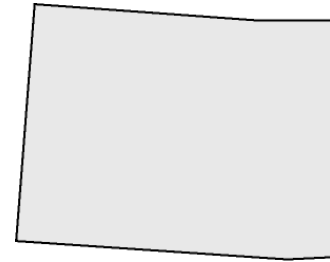
Before the implementation of the Wray Health Initiative Project, very little had been done to promote physical activity and healthier lifestyles to the area's residents. To fill this gap, a group of community organizations—composed of the Wray Hospital and Clinic, Wray City Government, Community Recreation Center, and local schools—joined forces to create a health promotion and disease prevention initiative designed to provide enjoyable activities that encouraged physical activity and healthier living. Some of the sponsored activities were group-based, whereas others provided an opportunity for one-on-one health education.

In addition to offering enjoyable activities to promote physical activity and healthier lifestyles, the project provided individual health assessments so that people were more aware of their current health status and the steps they could take to improve their health. The project's health coordinator, who also happened to be a registered nurse, conducted the health assessments and helped establish realistic health improvement goals for clients (e.g., reducing weight, reducing body mass index, etc.).

Innovative Solutions to Problems

The Wray Health Initiative Project took aggressive steps to promote physical activity and healthier lifestyles among the residents of Yuma County. For example, the project sponsored a program to educate residents about healthier food choices and how to identify healthy foods while shopping in local grocery stores. Staff members participated in health promotion programs at local schools and conducted health seminars throughout the community. The project also erected a new playground for children, set up basketball hoops to encourage physical activity among teens, and offered

COLORADO



**WRAY HEALTH INITIATIVE
PROJECT
WRAY, COLORADO**

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WRAY, CO 80758**

activities at a local swimming pool that were available to people of all ages.

Results

The activities sponsored by the Wray Health Initiative Project succeeded in encouraging local residents to be more physically active and to improve their overall fitness. Some 570 people participated in the “Wray Walks the World” project, and 236 people participated in the Yuma County Health Challenge. Another 154 people took part in the Holidays Marathon 5-K Race, and 100 people participated in the “Yuma County Walks” activity. In addition, 200 residents received individual fitness assessments, which in many instances resulted in the provision of personal training for residents.

Potential for Replication

Given the recent public attention focused on rapidly increasing rates of obesity among people of all ages in the United States, many other rural and urban communities could benefit from a health promotion/disease prevention model that emphasizes physical activity and healthier lifestyles. It is important to bring together a consortium of organizations that includes health care practitioners, service providers, educators, senior citizens groups, community-based organizations, recreational departments, community leaders, and other groups so that the consortium has access to the equipment, supplies, and planning expertise necessary to carry out such a project.

After the Grant

The organizations involved in the consortium are dedicated to keeping physical activity at the forefront of the county’s health agenda. The members are discussing the possibility of building a walking trail that would be available to area residents. They also plan to continue working together to address other community health needs in the years to come.

Community Characteristics

La Esperanza (Spanish for “hope”) is a community health center located in Georgetown, Delaware. The center was founded to provide social justice for the large number of Latino immigrants moving into southern Delaware. At the time of the grant award, the influx of Latino families, predominantly from Guatemala and Mexico, was growing exponentially, but few culturally and linguistically appropriate services were available to meet this population’s health needs. La Esperanza was established to provide high-quality, affordable health care services to the area’s Latino population and to other vulnerable populations in Sussex County, the southernmost—and most rural—county in the State.

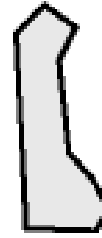
Sussex County is the largest of Delaware’s three counties and has a population of 156,638. The entire county is federally designated as a medically underserved area, a low-income health professional shortage area, and a dental health professional shortage area. The dearth of health care providers represents an enormous barrier to health care for residents who are uninsured, underinsured, or living in poverty. These challenges are further exacerbated by the lack of public transportation. There is only one taxicab service in the area, and it has a limited fleet of vehicles. The only bus service in the area caters to the tourist industry on the eastern seaboard of the county instead of to rural residents living in the central and western sections of the county.

Services Offered

La Esperanza sought to establish a community-based health center to improve access to care for Latinos, African Americans, families living in poverty, and other rural residents with health care needs. La Red’s network included five partners—La Esperanza Community Center; Nanticoke Health Services, a local community hospital; a network of 20 bilingual rural private practice physicians; the Division of Public Health; and the Episcopal Diocese of Delaware. Each network organization provided financial and in-kind resources to support the project.

La Red Health Center officially opened its doors to patients on February 21, 2001, as the only ambulatory primary care site in the community that offered a sliding fee scale for medical services to uninsured individuals. La Red also participated in Medicare and Medicaid and most insurance plans offered by local employers.

DELAWARE



**LA RED HEALTH CENTER
GEORGETOWN, DELAWARE**

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The center was modeled after the Public Health Service's Community Health Center Program (Section 330). It offered fully bilingual staff members, including a receptionist, a case manager, an outreach worker, a part-time family nurse practitioner who donated her time toward the completion of her degree, and two part-time, contracted primary care physicians. Funding from other sources enabled the project to contract with a part-time bilingual psychiatrist, hire an outreach worker to address HIV prevention and childhood immunizations targeting the Latino community, hire an additional caseworker, and hire a part-time pediatrician.

Innovative Solutions to Problems

The project was implemented in two phases. The first phase involved establishing a bilingual health service referral hotline. The hotline received approximately 350 calls per month, which proved that the second phase—development of a comprehensive, community-based health center—was desperately needed in the region. The project obtained broad-based community input through a needs assessment and focus group discussions with representatives of target populations. The data gathered during the assessment phase played an important role in informing the scope of services to be offered through La Red Health Center. La Red received donated clinical space to provide bilingual primary care services, health screenings, medical referrals, case management, and outreach services, including transportation.

Results

Although the project experienced a slow startup period (53 patient encounters between February and April 2001), it recorded 1,557 patient visits between May 2001 and April 2002. Between May 2002 and April 2003, the project recorded 2,574 patient encounters. The project did very little marketing of its services; the increase in patient encounters can be attributed largely to word-of-mouth referrals. The rapid increase in the number of patients seeking care is expected to continue, and project leaders are in the process of developing a strategic plan to increase clinical capacity.

In addition to providing a full-life continuum of pediatric, adolescent, and adult primary care services, La Red now offers community outreach and education programs focusing on childhood immunizations, diabetes, and HIV prevention. La Red is

the only community health center in Delaware that offers bilingual mental health and substance abuse counseling services. The women's health initiatives of the center have expanded dramatically in response to the growing number of uninsured pregnant women seeking care. The project also offers diagnostic breast and cervical cancer screening to qualifying women as part of Delaware's Screening for Life program.

Potential for Replication

A model such as this is most likely to be successfully replicated when a full range of linkages with local hospitals, service providers, community organizations, and State agencies is established. La Red's infrastructure grew out of La Esperanza's existing infrastructure, which proved to be a significant factor in the project's success. Adequate administrative and clinical resources must be in place at the time a new health center is established. For example, the project originally planned to hire a part-time administrator and part-time clinical staff members. However, the demand for services quickly pointed to the need for a full-time administrator and full-time staff.

After the Grant

La Red is considering the possibility of opening satellite centers throughout the county to make it easier for target populations to access care. Project leaders are in the process of developing the collaborative arrangements necessary to make this vision a reality. The project hopes to expand to include family planning services and increased HIV surveillance and prevention services. It also is stepping up its marketing activities to attract a larger number of insured patients.

Community Characteristics

Florida's Monroe County is the southernmost county in the continental United States. The inhabited portion of the county is characterized by a chain of small, narrow islands (43 islands connected by 42 bridges) that stretch for nearly 150 miles—from the southernmost end of the Florida peninsula to the Gulf of Mexico. The county encompasses a land area of 997 square miles and a water area of 2,740 square miles. According to 2000 census data, approximately 79,600 people live in the county.

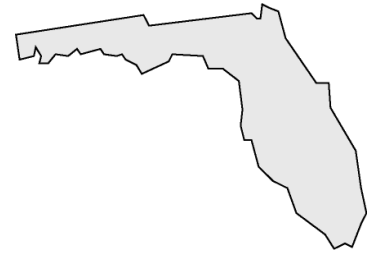
In the late 1990s, Monroe County faced a severe reduction in the availability of primary care services for the county's uninsured. The traditional provider of last resort for such services was the local health department. When the health department refocused its mission from primary care and public health to only public health services, the community was left without a source for indigent care.

Services Offered

To address this need, the Rural Health Network of Monroe County sought to develop and sustain a countywide infrastructure for providing primary health care services to the county's uninsured inhabitants. The ORHP grant enabled the network to begin establishing a primary care service infrastructure for the uninsured, the working poor, and the homeless through the use of a medically equipped van and two part-time, mid-level practitioner service teams.

The network consisted of more than 30 local organizations. Key members of the network included the Rural Health Network of Monroe County, the Florida Keys Area Health Education Center, the Monroe County Health Department, Mariner's Hospital, Fisherman's Hospital, the Lower Florida Keys Hospital District, and the Southernmost Homeless Assistance League. Other network members included area chambers of commerce, consumer representatives from the region, faith community representatives, the county emergency medical services team, a mental health and substance abuse treatment clinic, representatives of county government, AIDS Help, long-term care providers, State government representatives, and several other organizations that were uniquely positioned to enhance the project's scope of services.

FLORIDA



**LIFELINES
KEY WEST, FLORIDA**

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Innovative Solutions to Problems

The medically equipped mobile van was placed at strategic locations throughout the community so that no resident had to travel more than 15 miles to access the services available at the van's location. Although recruiting competent, part-time staff members for the service teams proved difficult, Lifelines successfully recruited stable and competent advanced registered nurse practitioners, registered nurses, and support staff. This feat was accomplished by marketing the project's staffing needs through the network's board of directors, local television and radio, and, in some cases, word of mouth. Another challenge was establishing the credibility of the program and communicating its purpose to area residents. The retreat of health underwriters left the community with few insurance companies and limited affordable health care options. Many in the community viewed this project as a "fly by night" effort that would in all likelihood disappear in time. Again, the network used its board of directors—which included the county mayor, other local politicians, civic and community health care leaders, and faith communities—to promote the program as a serious and coordinated response to the community's health care needs.

Even while Lifelines was in the planning phase, project planners were concerned about the feasibility of sustaining project services once grant funding expired. To help ensure the project's sustainability, the network was able to advocate for line-item funding, albeit insufficient to meet the community's needs, through the county's annual budget.

Results

Lifelines provided a variety of health care services to more than 11,000 area residents. More than half of those served were adults aged 20 to 64 years; in addition, the project provided primary care services to more than 4,200 children and adolescents and nearly 1,000 senior citizens. Most of the patients were Caucasian, but the project also served a large number of African Americans and Hispanics. During the grant cycle, the project provided 13,878 examinations, 831 immunizations, 708 cases of first aid, 1,950 women's health exams, 2,685 laboratory tests, 4,482 units of health education, and 8,109 instances of pharmacy assistance. The project also reported 34,956 units of "other health services," which

included cancer screenings, cardiac care, diabetes checks or diagnoses, endocrine exams, treatment for fever, hypertension screenings and treatment, eye infection treatment, mental health services, respiratory exams, vision/hearing screenings, orthopedic exams, treatment for other health problems, and followup care.

Some of the key lessons learned for the project include the following:

- Communication is critical to sustaining a healthy and vibrant network.
- Clients are most likely to express satisfaction with the services they receive if they feel that they were respected during the treatment process and if staff members value clients' opinions about their own treatment.
- Communication to and throughout the community is essential to ensure that such a project is viewed as a viable and dependable source for primary care services.
- Having influential community representatives on a board of directors can play a powerful role in promoting project visibility and safeguarding project sustainability.

Potential for Replication

The Florida Department of Health's Office of Rural Health has referred to Lifelines as a "best practices model" for improving access to health care. Similarly, in the Rural Healthy People 2010 Plan, the Texas A&M University School of Rural Public Health touted this model as one that merits replication in other communities. Project planners note that, although using medically equipped mobile vans is not a new concept in health care delivery, they learned a great deal from the experiences of other communities that have employed this model as a means to provide health care to the uninsured and underserved.

There are several factors that other communities should keep in mind when replicating this project. Using a medical van as a main source of service delivery is costly. It may require an initial investment of \$150,000 to \$300,000 to purchase the van, obtain insurance, maintain the van, buy gas, pay the driver, and cover other expenses. Communities also should plan ahead (e.g., establish a depreciation fund) so the van can be replaced when the time comes, and they should develop contingency plans in case the van

breaks down unexpectedly. Also, rural areas typically have difficulty recruiting competent, mid-level practitioners. Many potential staff members may be hesitant to travel long distances to the worksite, which can change on a daily basis, and nonprofit operations often cannot offer the same salaries and benefits as hospitals and private practice facilities.

After the Grant

The network currently operates six primary care sites throughout the county, which are available to residents in different regions on certain days of the week. The Lifelines project receives funding from local municipalities and the county government, as well as third-party reimbursements and client co-payments. The network is launching a countywide dental care program targeting the uninsured, which will involve opening dental clinics in Key West, the Middle Keys, and the Upper Keys.

Community Characteristics

Before the grant award, residents living on the ridge of Polk County had severely limited access to primary, preventive, and specialty health care services. Although the region's Indigent Healthcare Plan was designed to increase access to affordable health care services for the county's poorest residents, the services available through the plan generally were concentrated in the county's urban areas. Many residents did not have transportation to these services and, as a result, were forced either to travel long distances to receive care—or to receive no care at all.

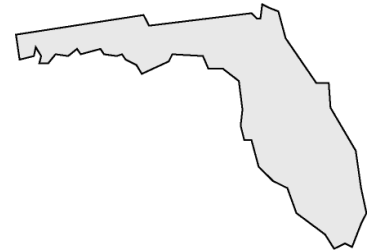
Services Offered

The Ridge Health Partners Program was established to meet the primary care and preventive health needs of six target communities—Dundee, Davenport, Haines City, Lake Hamilton, Loughman, and Waverly. Before receiving the grant, Central Florida Health Care, Inc., rented a small space in Dundee where it provided part-time primary care services 3 days a week for half a day. Grant funds made it possible to purchase a new location that could provide medical care 5 full days a week (Monday through Friday).

With the days and hours of services expanded, the Ridge Health Partners Program launched an aggressive and ambitious marketing initiative to increase awareness of its services. The project developed a wide range of marketing materials in both English and Spanish and collaborated with the network members (see Innovative Solutions to Problems) to disseminate these materials at 52 community events and health fairs. On many occasions, these materials were distributed as part of National Infant Immunization Week, National Blood Pressure Month, National Teen Pregnancy Prevention Month, National HIV Testing Day, and numerous other national health observances. The project also conducted direct mailings to area residents, coordinated live radio interviews to market the project's services, arranged for feature stories to be published in local newspapers, and distributed flyers to local businesses and schools.

The project recognized, however, that its marketing efforts would achieve little good if residents did not have transportation to and from appointments. As a result, the project hired transportation staff and collaborated with the Polk County transit system to

FLORIDA



**RIDGE HEALTH PARTNERS
PROGRAM
AVON PARK, FLORIDA**

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expand the system's routes and create additional pickup points near the ridge.

Innovative Solutions to Problems

The most innovative feature of this project was the consortium of organizations involved in conducting outreach and marketing the project's services to potential clients. For example, the outreach partners included 77 faith organizations of various denominations; 21 childcare, daycare, preschool, and religious school organizations; 28 elementary, middle, and high schools and 1 college; and 27 mobile home parks. These groups were responsible for disseminating English- and Spanish-language marketing materials to individuals and families who might qualify to receive care through the Ridge Health Partners Program.

Another innovative feature of the project was the diversity of the Ridge Health Partners Advisory Board. The 29-member board included representatives of health and social service providers, area schools, faith organizations, advocacy groups, mental health organizations, and local government. Together, these individuals played an important role in planning and implementing activities, coordinating resources, and identifying workable solutions to new challenges affecting the community's indigent residents.

Results

The project network reached 442 families that met the criteria for enrollment in the program. In addition, the project provided care to another 3,487 individuals from the 6 targeted communities and 2,412 individuals living in neighboring communities in Polk County. In total, the project provided care to 8,516 individuals during the 3-year grant period. Although recruiting private health care providers was difficult at first, largely because many providers were hesitant to join the network owing to low reimbursement rates, the project ultimately succeeded in recruiting 10 health care facilities that provided primary and specialty care services to clients.

Potential for Replication

The Ridge Health Partners Program succeeded in increasing access to health care for indigent individuals and families living in Polk County. One of the biggest reasons for the project's success was the extensive networking and collaboration that occurred

among the project partners. Other communities considering replicating this model will want to invest significant time and staff resources in establishing relationships with potential partner organizations and sustaining open lines of communication between the partners.

After the Grant

Central Florida Health Care, Inc., in coordination with the Polk County Board of Commissioners and the Polk County Indigent Healthcare Plan, will continue to provide services to indigent clients living on the ridge of Polk County. The program is seeking additional funding to support these services in the six targeted communities.

Community Characteristics

Turner County, Georgia, is home to approximately 9,500 residents who live in a geographic area that spans 286 miles. According to 2000 U.S. census data, the area includes 2,538 families and 3,435 households. The county comprises 3 municipalities, yet more than 4,000 residents live in unincorporated areas. Like many rural areas, Turner County has a higher percentage of residents aged 25 years and younger than the statewide average. More than one of every three children younger than age 18 lives below the poverty level, and most of these children were born to adolescents. In addition, about 45 percent of all adults aged 25 years and older did not complete high school.

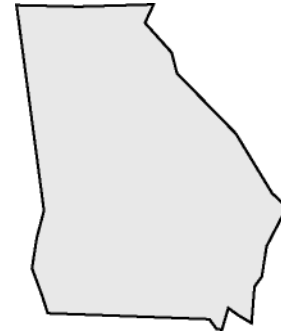
Turner County is widely considered a “lagging” rural county. Jobs are limited, and the county’s unemployment rate is more than double the State and Federal rates. There is no hospital in the county, so residents must travel 30 to 45 minutes (one way) to obtain emergency, outpatient, and inpatient services. Only two full-time physicians practice in the county.

Services Offered

Because children are hard hit by poverty, the Focus on Wellness project was designed to create a healthier community through a coordinated and comprehensive school health initiative targeting the county’s 2,012 students (prekindergarten through 12th grade). Specifically, the project sought to strengthen existing health education programs, to provide school nurses with the necessary supplies and equipment, and to deliver mental health counseling, substance abuse prevention education, case management, and parent support services.

The Turner County School System provided space and facilities for school clinics, staff resources for the Focus on Wellness project, and funding to hire additional staff and purchase equipment and supplies. Its partners included the county health department, Turner County Connection (a local community collaborative), and the Department of Family and Children Services (DFCS). The health department and DFCS delivered staff training as needed, participated in community health fairs, and provided representatives to serve on the collaborative board and health network committee. Turner County Connection supervised the activities of the resource director and administered the governing board.

GEORGIA



**FOCUS ON WELLNESS
TURNER COUNTY, GEORGIA**

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To maximize staff resources, the Turner County Board of Education provided funding for the assistant superintendent to serve as project director. It also provided the elementary school nurse, school health educators, and school counselors. The Focus on Wellness project provided funding for a coordinator, one full-time and one part-time mental health counselor, and 64 percent of the middle/high school nurse's salary. (The remaining portion of her salary was funded through tobacco settlement resources.) The school nurses, school and mental health counselors, and health educators were responsible for making health-related services, both physical and emotional, available to all students in the Turner County School System. The school nurses also provided a range of health screenings, including blood pressure, diabetes, and cholesterol screenings, for school staff, area businesses, and others throughout the community. However, because school nurses were available only a small portion of the school day, a retired nurse manager from the health department assisted in providing health screenings in area businesses and other locations in the community.

Innovative Solutions to Problems

Many organizations have a difficult time recruiting qualified staff members to serve in rural areas. The same was true for this project. After two rounds of advertising and interviewing a full-time coordinator, the project ultimately hired a retired DFCS director in October 2000 to serve as a part-time coordinator. The project also had trouble recruiting a qualified, licensed mental health counselor who was willing to relocate to a rural area; instead, the project hired a retired school counselor trained in peer mediation as a part-time counselor and a full-time unlicensed mental health counselor who also had extensive experience. Although the project was unable to follow its original hiring plan, these three staff members brought a wealth of experience to the activities.

All network members shared responsibility for ensuring the success of the Focus on Wellness project, and before the grant, each organization already was a member of Turner County Connection, a community collaborative that served as the governing board for the project. Under the Turner County Connection umbrella, a Focus on Wellness Prevention Education Planning Committee was established. This committee was actively involved in planning and

participating in community health fairs, school staff health fairs, and other activities. In addition, the Focus on Wellness Executive Committee, now known as the Turner County Health Network Committee, was expanded to include all local area health providers in addition to the network members. With broader representation from the medical community, the committee has proven to be more effective in identifying community resources and in eliminating barriers to care for Turner County residents.

Results

The overall goals of this project were to decrease the percentage of students who were absent from school 10 days or more each year, to increase the percentage of high school students who graduated on time, and to decrease pregnancy rates among female students aged 15 to 17 years.

During the 2000–2001, 2001–2002, and the first 7 months of the 2002–2003 school years, school nurses recorded 38,169 student visits, and the regular school counselors logged 11,716 student sessions. The part-time and full-time mental health counselors conducted 2,587 individual, group (including peer mediation and conflict resolution), and crisis intervention sessions. In addition, the health educators provided a comprehensive school health education and prevention curriculum. During the 2000–2001 school year, an average of 1,105 students per quarter received the comprehensive school health education curriculum, and an average of 1,132 students per quarter received abstinence and substance abuse education. Also, an average of 1,736 students per quarter received character education on courtesy and fairness, self-responsibility, respect, and helping others. In the 2001–2002 school year, 834 students in kindergarten through 5th grade and an average of 200 students per quarter in grades 6 through 12 received comprehensive school health education; 267 5th grade students received abstinence and substance abuse education; 1,803 kindergarten through 11th grade students received character education; 835 kindergarten through 5th grade students and an average of 230 students per quarter in grades 6 through 12 received drug and tobacco prevention services; 19 alternative school students received violence prevention services; an average of 28 alternative school students per quarter received criminal and traffic law education; an average of 22 alternative school students per quarter

received basic living skills training; and 83 kindergarten through 12th grade students were referred for the peer mediation program. In the first 7 months of the 2002–2003 school year, an average of 716 students per quarter received the comprehensive school health education curriculum; an average of 824 students per quarter received substance abuse education; an average of 1,791 students per quarter received character education; 670 kindergarten through 5th grade students and an average of 18 alternative school students per quarter received violence prevention education; an average of 22 alternative school students per quarter received basic living skills training; and 149 students were referred for peer mediation.

Although it will be many years before the project will know whether students avoid premature pregnancy or graduate from high school on time, program staff are confident that the seeds planted through this grant, beginning in kindergarten and extending through 12th grade, will make a difference in the lives and health status of the participants.

The most important lesson learned from the project evaluation was the need to refine the evaluation plan as the project developed to ensure detailed and complete data for all service components supported by the project. For example, in the second year of the project, more detailed data were collected on the delivery of the comprehensive health curriculum than during the first year. This additional information was used to modify and expand various aspects of the curriculum, such as adding the violence prevention component and expanding abstinence education in middle schools. Evaluation data also revealed the lack of an adequate disease prevention curriculum in high schools. Evaluation findings such as these can be used to ensure that the project is responsive to the needs of students.

Potential for Replication

Given that other rural areas face problems similar to those present in Turner County—poverty, health provider shortages, transportation barriers, illiteracy, and isolation—the Focus on Wellness model could be readily replicated in other communities. This project benefited from the fact that the network partners already had a history of working together successfully. If a high level of collaboration does not already exist, then it is necessary to develop and cultivate those collaborative relationships and to

involve other key community partners before launching such an endeavor.

After the Grant

The school board now provides funding for the middle school/high school nurse. The seed money provided by this grant, along with the project evaluation data collected during the grant cycle, has resulted in additional grants to expand the health education curriculum, including a Special Projects of Regional and National Significance grant to provide abstinence education and an Early Learning grant to provide parenting skills training. The Turner County Connection and Health Network Committee continue to seek additional funding to sustain the availability of mental health counseling services in the school system.

PROJECT 14—IMPROVING ACCESS, OUTCOMES, AND COST FOR WOMEN’S AND CHILDREN’S HEALTH SERVICES

Community Characteristics

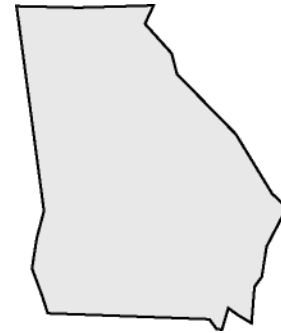
In the early 1970s, a group of concerned service providers, citizens, and community leaders formed the Meriwether County (Georgia) Interagency Council. The purpose of the council was to address the health care and social service needs of the county’s children and families. The council grew in scope, and in 1995, it received a Family Connection Strategic Planning Grant from the State of Georgia to conduct a comprehensive community assessment of needs and resources. As part of this project, the council surveyed social service providers and conducted town hall meetings in four locations to obtain input from the broader community. It also conducted a series of focus groups to further discuss service needs and resource concerns raised during the survey and town hall meetings. After several months of work, the council published *Meriwether County: A Look at Ourselves*, which summarized the major findings of the assessment process. This report resulted in the creation of the Meriwether County Interagency Council/Family Connection, Inc., which then developed a 5-year strategic plan that focused on three of the community’s most pressing needs—teen pregnancy, juvenile delinquency, and healthy births. Eventually, the organization’s scope was broadened to reflect the need for comprehensive primary care services for all women and children living in the county. Another community assessment revealed that the county had alarmingly high rates of infant mortality, a dire shortage of physicians, rampant poverty, and low educational status.

Services Offered

After securing funding to create a pediatric practice at Baptist Memorial Hospital, the project provided transportation services for pregnant women and women with young children to health and social appointments. It also provided expectant mothers with transportation to the delivery room. The ORHP grant was designed to provide obstetric and gynecologic services at a women’s clinic in Warm Springs, Georgia, which was near Baptist Memorial Hospital. The consortium for this project included the following organizations:

- The Meriwether County Health Department provided child immunizations; Women, Infants, and Children entitlements; screenings; a baby van (for perinatal

GEORGIA



**IMPROVING ACCESS,
OUTCOMES, AND COST FOR
WOMEN’S AND CHILDREN’S
HEALTH SERVICES
GREENVILLE, GEORGIA**

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transportation); and early intervention perinatal case management.

- Baptist Meriwether Rural Health Clinic provided comprehensive primary medical care and education services, well-baby checks, and consultation with nurses in area elementary and middle schools.
- Baptist Memorial Hospital and Nursing Home employed the obstetrician/gynecologist and provided office space.
- Meriwether County Department of Family and Children Services promoted the project's services to its clients and provided case management services.

Innovative Solutions to Problems

The project's primary innovation was that it fostered a strong link between traditional clinic-based services and those offered by the public health department and school nurses. In fact, the project observed a "marrying" of sorts between the services offered in these settings. Residents were informed that services targeting women and children were available, and all of the partners worked in tandem to educate patients on how to access these services. The project also succeeded in engaging area physicians and earning their trust, which has been crucial to the project's success. Local physicians began making referrals for obstetric and gynecologic services at the Women's Clinic, which was a critical component in the project's efforts to firmly establish a continuum of care for the county's women.

Results

The project succeeded in establishing labor and delivery services at Baptist Memorial Hospital. The first baby delivered at the hospital was to a teenage mother who had received no prenatal care. The project estimated that, by the end of 2004, approximately one-half of all babies born to Meriwether County citizens would be born within the county.

In all, 45 women received 501 units of obstetrical services, and 820 women received 859 units of gynecological services. Some 45 babies were born at the county's hospital during the project period, and a total of 6,000 individuals were reached as a result of 32 health education and service promotion events.

One of the most important lessons learned as a result of this project was the need to have a large and diverse array of partners

who are wholeheartedly committed to the consortium's goals. Since the project was interrupted by critical personnel changes at two of the five consortium member agencies, the other agencies were able to help pick up the slack until new personnel could be hired.

Potential for Replication

This model could work well in other rural areas. Bringing obstetric and gynecologic services to rural communities is essential to establishing a continuum of care that strengthens existing service systems. Again, having a strong and vibrant collaborative that can meet the diverse needs of women and children is critical to ensuring that the envisioned continuum of care becomes a reality.

After the Grant

The Women's Clinic and other services started as a result of this project will continue after grant funding expires. In fact, project personnel are confident that they will be able to continue expanding the range of services available to women and children in Meriwether County.

PROJECT 15—NINTH DISTRICT OPPORTUNITY RURAL HEALTH OUTREACH PROGRAM

Community Characteristics

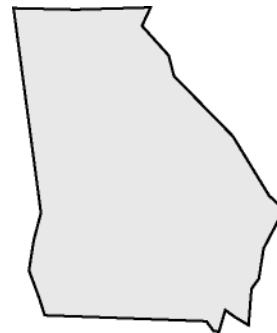
Hall County, Georgia, is often referred to as the “Poultry Capital of the World” because of its important role in supporting the Nation’s poultry industry. Located in the foothills of the Appalachian Mountains, Hall, Franklin, Hart, and Stephens Counties are surrounded by scenic mountains and beautiful lakes that attract tourists and summer residents. However, the region is characterized by an unequal distribution of wealth, because many area residents make their living through low-income, service-oriented jobs. In addition, land values vary and there are numerous poverty-stricken neighborhoods. The three counties span a 52-mile range where female heads of households, low per capita income, insufficient transportation, and limited access to medical services jeopardize the health and well-being of many residents. Specific public health challenges in the three-county region include socioeconomic disparities, poverty, inadequate access to health care, low educational attainment, teenage motherhood, substance abuse, family violence, and child abuse and neglect. The fact that 28, 550 Hispanics live in Hall County also has resulted in language being a significant barrier in accessing health care services.

Services Offered

Ninth District Opportunity, Inc., joined forces with several organizations in the area to promote safe and healthy home environments, to connect children to health care services, to reduce infant mortality, and to reduce the risk of a second teen pregnancy among area youth. The project network included the following organizations:

- Ninth District Opportunity, Inc., provided fiscal and administrative management of the project, as well as program oversight.
- El Puente (The Bridge), a project of the Georgia Campaign for Adolescent Pregnancy Prevention, developed and reviewed project materials to ensure cultural appropriateness and provided cultural sensitivity training to project staff.

GEORGIA



**NINTH DISTRICT OPPORTUNITY
RURAL HEALTH OUTREACH
PROGRAM
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- Two Family Connection sites assisted in information dissemination, referrals, public relations, and the planning and coordination of project activities.
- The Children First Program served as the primary referral source for families needing indepth intervention and counseling, provided assessment and case management training to project counselors, supported outreach activities, and contributed health assessment tools.

To achieve its goals, the project offered a variety of services, including

- In-home visits to conduct safety and environmental assessments
- Referrals to community resources, including health and social service agencies
- Information and counseling on topics such as dental hygiene, vision care, and vitamin supplements; how to select child care services; how to recognize instances of abuse and who to call for help; how to address child health problems such as ear infections, diarrhea, and respiratory allergies; car seat safety; safe interaction with animals; why babies cry; how to locate free or affordable medications; and the devastating results of shaking a baby
- Child and family assessments
- Service coordination and transportation and child care assistance
- Followup care

The target populations for these services were people of Hispanic heritage who experienced language barriers and/or low-income families that lived in rural communities and had limited access to health care services. The Children First Program served as the initial gateway to the services offered by the network. The program identified children who were at risk for health and social problems stemming from socioeconomic status, poverty, language barriers, inadequate access to health care, or low educational attainment. Children deemed at risk—such as those born to a teen mother, those who had a history of child abuse and neglect or family violence, and those belonging to families experiencing

substance abuse problems—were immediately assigned a family resource coordinator.

Innovative Solutions to Problems

The Ninth District Opportunity Rural Health Outreach Program supported a project titled “Graduating Achieving Parents” (GAP), which was offered in the Stephens County school system for pregnant and mothering teens. The purpose of this effort was to help teen mothers overcome the obstacles that can jeopardize their future and the health of their baby by helping them improve their parenting and coping skills, graduate from high school on time, prevent repeat pregnancies, and enroll in job training and posteducational studies. The participants met once a week at the school. Community volunteers provided workshops on the prevention of birth defects, infant/child CPR, enrollment in the Women, Infants, and Children and Medicaid programs, career opportunities, and positive parenting. Project staff members also conducted monthly home visits to ensure that children were healthy and living in a safe environment and that the family had access to the resources they needed to thrive and succeed.

Results

The project served 750 children during the grant period. Of the 942 household members receiving services at the end of the project, 26 percent had not finished high school and 88 percent lived at or below 100 percent of the Federal poverty level. Many of these clients participated in parent support groups, literacy programs, and other educational opportunities.

By the end of the project, 132 participants had modified their personal behaviors to improve their parenting skills, and 273 parents took steps to provide a safer and healthier home environment for their child. In addition, 341 families reported that they increased their knowledge and use of existing community resources, such as public transportation services, English-language classes, adult literacy classes, and places where they could get their child fully immunized by the age of 2.

Potential for Replication

Many rural communities could benefit from this type of project. However, project planners must be careful not to take certain things for granted. For example, not all teenagers know how to read, and not all parents know about healthy baby formulas, how to reduce the risk of sudden infant death syndrome, or when and for which diseases a child should be immunized. Projects designed to reach similar target audiences should consider these factors in determining the scope of services and the types of educational opportunities available to clients.

The project experienced several difficult challenges that were never completely resolved. First, initial contacts with families were difficult because many of them either had no phone or lived in unstable housing conditions—a problem that also hampered followup efforts. Second, the project network suffered from persistent “turf guarding” and nonparticipation by area human service providers, which limited referral opportunities for clients in need. Third, there continues to be prejudice on the part of service providers against these populations, as well as a pervasive sense of apathy regarding the populations’ needs. Communities should take these challenges into account when collaborating with other agencies and engaging area providers to strengthen a network’s services.

After the Grant

Ninth District Opportunity, Inc., is seeking funding from private-sector sources and the North Georgia Community Foundation. Many of the special programs developed as part of this project will continue to be offered through other networks established previously by the project staff.

Community Characteristics

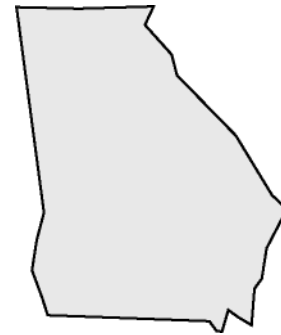
The purpose of the Partnership for Rural Elderly was to provide direct rehabilitation, consultation, and educational services to a population of rural and low-income elderly citizens in northern Georgia who did not otherwise have access to such care. Recent changes in health care delivery in the region had a profound effect on the area's elderly citizens. The elderly population in Georgia grew substantially between 1995 and 1997, at a rate of 5.8 percent. However, during the same period, three contiguous counties (Dawson, Hall, and Lumpkin) experienced a growth rate in their elderly population of 14 percent—3 times the statewide rate. This rural region was designated an underserved area, which is underscored by the fact that Dawson County is the only county in the State without any health care facility.

Services Offered

The Partnership for Rural Elderly used graduate students in the nurse practitioner and physical therapy programs at North Georgia College and State University (NGCSU) to provide a broad network of support and services for elderly residents in Georgia's Dawson, Hall, and Lumpkin Counties. The project used 150 nursing and physical therapy graduate students and 8 faculty members. The students enrolled, assessed, served, and followed up with rural elderly clients and facilitated the delivery of additional services with area providers. The Partnership for Rural Elderly offered a wide range of rehabilitation, consultation, and education services, including home safety evaluations, home safety maintenance, construction of wheelchair ramps and handrails inside or outside of clients' homes, transportation, aquatic therapy, client advocacy, a walking program, a creative movement program, an exercise program, client/student education opportunities, rehabilitation evaluation services, network referrals, medication assistance, caretaker training, wellness activities, and numerous other programs.

The consortium for this project included the NGCSU Physical Therapy and Nursing Departments, Programs Assisting Community Elderly, Inc., the Gainesville Aid Project, and the State Area Agency on Aging (also known as Legacy Link). However, as the project matured, the original network found itself involved with

GEORGIA



**THE PARTNERSHIP FOR RURAL
ELDERLY
DAHLONEGA, GEORGIA**

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more than a dozen other agencies in the region, expanding the depth and breadth of services available to the region's elderly citizens.

Innovative Solutions to Problems

The use of graduate students in the fields of nursing and physical therapy was the project's most innovative feature. In fact, student participation in the program was required as part of the university's curriculum, which meant that caring for the region's elderly was a prerequisite for degree completion.

One of the biggest challenges faced by the program was that a large number of elderly clients requested services that were far beyond the scope of the project. For example, some clients asked students to modify their trailer homes, to give them money for transportation, to pay family members who were primary caregivers, to supply respite care, and to provide financial assistance for prescription drugs and medical bills. The inability to meet all client needs frustrated both the clients and the students. The project worked closely with county governments, local medical administrators, physicians, and leaders of area civic organizations to make them more aware of the kinds of challenges experienced by the region's elderly citizens in day-to-day life and to develop solutions to help meet those needs.

Results

The project was an overwhelming success. Data collected from focus groups, client satisfaction surveys, student exit interviews, and agency evaluations were based on a Likert scale of 1 to 4 on eight different variables. Over the 3 years of the project, the mean score for the project was 3.56 on a 4.00 scale. Client complaints were virtually nonexistent, and the project received several unsolicited commendations.

The Partnership for Rural Elderly yielded several important lessons learned:

- Students benefit from seeing firsthand how the reality of aging and poor health can affect quality of life.
- Medical and rehabilitation literature does not adequately address the unique characteristics of rural life.
- "Providing assistance" can be well received in rural communities, whereas "receiving charity" is contrary to the pride of many rural residents.

- Many elderly clients are “too wealthy” for public assistance, yet “too poor” to afford the services they need.
- Many family members are forced to quit their jobs to care for elderly family members—and have limited or no affordable resources for respite or long-term care for their loved ones.

Potential for Replication

This model could work well in other rural communities in which a local university offers health professions training. However, universities and licensed health care professionals must be aware of the liability issues associated with providing care to clients.

After the Grant

NGCSU has committed space, staffing, and resources to sustain key elements of the project. Nursing and physical therapy students will continue to provide care to area clients. The network participants continue to pool their resources to meet the needs of elderly clients in the region. The project is seeking additional funding from other sources and the State government to sustain project services.

Community Characteristics

Diabetes is a global epidemic. The disease can lead to long-term health complications that, in turn, can result in premature death. Even more alarming, research has shown that diabetes damages the body for an average of 6 years before the symptoms of the disease become apparent.

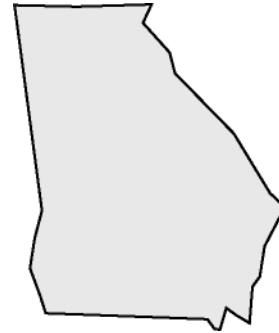
At the time of the grant award, diabetes was a serious public health problem in Appling County, Georgia, which is nestled in the heart of slash pine country. In 2000, the number of physicians in the county was 1 per 1,000 residents, compared with the State average of 1.9 per 1,000. The limited number of physicians and other health care providers—coupled with the lack of concerted community education efforts to teach residents about the risk factors for diabetes and its proper management—meant that many residents living with diabetes were not armed with the knowledge they needed to manage the disease effectively. Likewise, many rural health care facilities lacked the resources needed to carry out widespread community education efforts.

Services Offered

The Rural Health Education Program sponsored an array of programs designed to increase awareness of diabetes, to reduce the risk factors for the disease, and to teach people with diabetes how to manage the illness properly. For example, the project sponsored health fairs throughout the community, which provided an opportunity for local residents to receive diabetes screenings as well as other health screenings (e.g., for hypertension). It also developed educational materials about diabetes that were widely distributed to area residents at community events and through the project's resource center.

To support this project, Appling Health Care System developed a consortium of organizations and individuals to create a comprehensive infrastructure for diabetes education. For example, area physicians involved in the Appling Medical Group and the South Georgia Medical Association were recruited to participate in the consortium to identify patients with diabetes and refer them to educational opportunities. These classes were hosted by other consortium members, including area health care facilities and the Altamaha Technical College. The consortium also involved a local

GEORGIA



**RURAL HEALTH EDUCATION
PROGRAM
BAXLEY, GEORGIA**

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pharmacy, which offered the expertise of a certified diabetes educator.

Innovative Solutions to Problems

The project used classroom and group meeting formats to educate residents about diabetes and to help them reduce their risk for diabetes. For example, it offered a Diabetes Self-Management Education Program, which consisted of two 5-hour sessions available to area residents with diabetes. The project also offered Overeaters Anonymous meetings and Weight Watchers meetings so that residents could gain support from others struggling with unhealthy eating habits or obesity.

Results

During the grant period, the project provided diabetes education to 328 individuals. The majority of those who participated in the project were adults aged 18 to 64 years; the project also served 114 elderly individuals aged 64 years and older and a small number of adolescents. About three-fourths of those reached were Caucasian, 20 percent were African American, and 5 percent were Hispanic.

Potential for Replication

Projects similar to the Diabetes Self-Management Education Program could work well in other rural settings. In fact, several hospitals from surrounding communities are considering the idea of replicating this program. It is critical, however, that such projects enjoy broad-based support throughout the community. One of the reasons for the success of the Diabetes Self-Management Education Program was that a local pharmacist and certified diabetes educator recognized the need for educating residents about diabetes and how to manage the disease effectively and were willing to dedicate time from their busy schedules to participate in the project. In addition, strong organizational backing is important. In this case, Appling Health Care System's authority board, medical staff, and chief executive officer wholeheartedly supported diabetes education throughout the community and were willing to dedicate resources to support this effort.

After the Grant

Since it is now certified by the American Diabetes Association, the project is able to receive reimbursements from the Centers for Medicare & Medicaid Services and some private insurers for diabetes-related education and health care services. These revenues will be used to support staff salaries, materials, and supplies. Those individuals who would benefit from diabetes education but are not covered by Medicare or private insurance can still attend educational classes, with the costs being covered by Applying Health Care System.

Community Characteristics

As in many other communities, senior citizens in Ware, Pierce, and Brantley Counties in Georgia struggled with the challenge of covering the cost of their prescriptions before receiving the ORHP grant. While pharmaceutical prices continued to increase at a steady pace, the region's poorer senior citizens lacked the resources to pay for needed prescriptions. This situation was especially true for senior citizens living at or below the poverty level—many of whom were forced to choose between buying medications or paying utility bills.

To address this need, the McKinney Community Health Center developed a consortium of organizations to provide senior citizens living at or below the poverty level with discount-rate medications for hypertension, diabetes, and hypercholesterolemia. The consortium members included the Satilla Regional Medical Center and the Ware County Health Department. The McKinney Community Health Center coordinated the project and provided staff, transportation, and office space for overseeing project operations. The Satilla Regional Medical Center provided the pharmaceuticals, and the Ware County Health Department provided patient education on managing diabetes and hypertension.

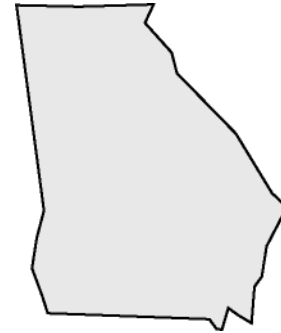
Services Offered

All area providers were invited to participate in the Senior Discount Drug Program by referring eligible senior citizens to the McKinney Community Health Center, which was responsible for obtaining an initial medical history and conducting an inventory of the patient's prescribed medications. Once this preliminary information was obtained, the prescriptions were taken to the pharmacy at the Satilla Regional Medical Center. The filled prescriptions were then returned to the McKinney Community Health Center, where clients could pick up their medications.

Innovative Solutions to Problems

Many area providers were reluctant at first to participate in the program because nothing like it had ever been offered in the area. To address this problem, a registered nurse and certified nursing assistant affiliated with the project visited area providers and explained how the program worked. The registered nurse also visited civic organizations in the area, such as AARP, Kiwanis, and the Chamber of Commerce, to promote the program to their

GEORGIA



**SENIOR DISCOUNT DRUG
PROGRAM
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constituents. The project also developed flyers and brochures about the program and distributed these materials throughout the service area. In addition, the certified nursing assistant appeared on a local television show to help viewers throughout the region to better understand how the program worked and how it could benefit them and/or their loved ones.

Purchasing medications also proved to be a challenging undertaking for the project. Since McKinney Community Health Center did not have an onsite pharmacy, it contracted with the Satilla Institutional Pharmacy to order medications, to maintain an inventory of pharmaceuticals, and to fill prescriptions. In addition, the Office of Pharmacy Affairs was consulted to ensure that all relevant regulations were followed. To obtain the lowest possible price, the project purchased all medications through the 340B Drug Pricing Program.

Results

In spite of the initial barriers, the project was a resounding success. In fact, the Senior Discount Drug Program had to limit the availability of prescriptions to 500 participants in order to stay within the project's budget. Others who needed medications were put on a waiting list to be admitted to the program when participants dropped out.

Because participants were able to get their medications at a cheaper cost, they were better able to adhere to their medical regimens. As a result, their overall health status improved greatly because they were able to control their hypertension and diabetes. Through a partnership with Med Xpress, participants were provided glucometers and diabetes testing supplies. Many patients also were fitted for diabetic shoes. Patients with hypertension were counseled on healthy eating habits, exercise, and other ways to control their disease.

Potential for Replication

This project would work well in any area with a large number of senior citizens. Many elderly individuals in communities across the Nation have trouble paying for the medications they need. The Senior Discount Drug Program provides a model that can be easily replicated in other communities. It is important, however, for project planners to consider how local resources can be best used to meet the needs of clients—and to utilize those resources fully. If a

pharmacy is not available, then it may be necessary to contract with one, which may require extensive negotiations.

Transportation also may be a challenge. Many seniors are unable to drive and need transportation to and from the location where they are supposed to pick up their medications. In addition, local health departments can be valuable resources in providing patient education services either through one-on-one teaching, group meetings, or distributing educational materials.

After the Grant

Six months before the end of the grant cycle, patients were notified that the project would no longer be funded so that they could locate other resources for receiving medications. Many participants were referred to a local program that offers antihypertensive medications.

Seniors older than age 60 were referred to the Georgia Care program, which is operated by the McKinney Community Health Center. Participants were given applications for patient assistance programs offered by various pharmaceutical companies; if necessary, project staff helped them complete their portion of the application. Participants younger than age 60 who were patients of the McKinney Community Health Center were referred to the center to determine whether they were eligible to receive medications through the center's programs. After an interview, eligible patients are able to have their medications mailed from pharmaceutical companies to the center for pickup.

PROJECT 19—SOUTHEAST GEORGIA COMMUNITIES HEALTH LINKS PROJECT

Community Characteristics

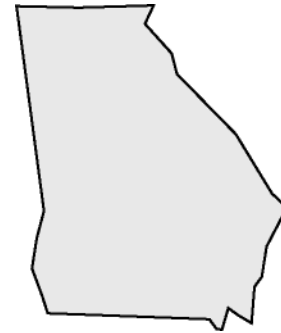
Southeast Georgia is Vidalia onion territory. The vast majority of the 9,000 Latinos in a four-county area in southeast Georgia are migrant and seasonal farmworkers who harvest onions, tobacco, blueberries, and vegetable crops. On average, farmworkers earn about \$8,000 per year, placing most families below the poverty level and putting them among the lowest paid workers in the United States.

According to the U.S. Department of Labor, farmwork is tied with mining as one of the most hazardous occupations in the United States. Exposure to machinery, dangerous working conditions, and pesticides puts farmworkers at high risk for injury and/or illness. Unfortunately, the vast majority of farmworkers do not have medical insurance, and many do not qualify for public benefits such as Medicaid. In Georgia, growers are not required to have worker's compensation insurance, so when a farmworker is injured on the job, he or she receives no compensation and becomes dependent on the health care system for treatment. Farmworkers average a sixth grade education, and many lack basic English conversational skills. Together, language barriers, cultural barriers, the lack of transportation, and insufficient or no health care coverage means that farmworkers typically face formidable barriers to health care.

Services Offered

The primary purpose of the Health Links project was to address linguistic and cultural barriers to health care experienced by migrant and seasonal farmworkers in a four-county region in southeast Georgia by providing interpretation services, health education, case management, and improved access to primary health care services. The Southeast Georgia Communities Project (SGCP) served as the lead agency in a consortium that also included the Southeast Health Unit (SEHU) and the Magnolia Coastlands Area Health Education Center (AHEC). SGCP employed bilingual staff and developed a health education and outreach component to support the project's goals. The SEHU's Farmworker Health Program provided primary care and case management services to farmworkers. The AHEC helped link clients with physicians and health facilities in the area, developed educational materials, and supported the annual Farmworker Health Festival.

GEORGIA



**SOUTHEAST GEORGIA
COMMUNITIES HEALTH LINKS
PROJECT
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Innovative Solutions to Problems

Because so many clients did not have telephones or transportation, project staff members delivered many services at clients' homes. Delivering health education in the home is more time intensive because it usually means working with a small group of people; however, this approach was necessary because, without it, these individuals and families would never have received health education. Home-delivered health education created a more comfortable atmosphere in which clients could ask questions and discuss health-related issues. In some cases, health education services were provided at farm worksites during lunch or dinner breaks. SGCP had an excellent working relationship with growers in the area, which made it possible for outreach and education to occur at farm worksites.

One of the most significant challenges encountered during the project period was the lack of interpretation resources in the target area. At the project's inception, few health providers or hospitals had access to interpreters. Most relied on the client's family members or friends to serve as interpreters. Other public-sector resources, such as Family and Children Services and Medicaid offices also did not offer interpreters for those seeking services. Although Health Links had planned to help fill this gap, project planners did not anticipate that the demand for such services would be so overwhelming. Fortunately, during the course of the project, some health providers, such as an area hospital and the local health departments, hired bilingual staff to help meet this need.

Another major barrier for the project was the shortage of health care resources for the area's underserved families. The Farmworker Health Program had limited resources to meet these needs, and those resources were targeted for a very specific population. When clients were not eligible for the Farmworker Health Program or did not have Medicaid, they had difficulty finding the care they needed. During the first year of the project, staff members began working with the region's community health center, located approximately 30 miles from project headquarters. Previously, the health center had seen few Hispanic patients. Over time, the health center emerged as the best site for referring uninsured clients. The health center was eager to serve clients and genuinely interested in providing quality care in a user-friendly, culturally sensitive environment. The health center has since received expansion funds

to open a satellite facility in Tattnall County, which also has a large Hispanic population.

Results

The Health Links Project had five primary goals:

- To provide linguistically and culturally appropriate health care services for current and past Latino farmworkers
- To increase the community's capacity to provide linguistically appropriate services to Latinos
- To provide health education services to Latinos
- To provide physicians and other health care providers with high-quality, Spanish-language health education and medical materials for Spanish-speaking clients
- To improve access to primary health care services for Latino farmworkers

Health Links succeeded in providing linguistically and culturally appropriate health care and health education services to Latino farmworkers and their families. The project hired bilingual staff members and provided medical interpretation training to ensure that interpretation services were of a high caliber. Throughout the project, staff members received continuing education on topics relevant to the target population, including pesticide safety, domestic violence, HIV/AIDS prevention and counseling, CPR, diabetes, health-positive living, and breast and cervical cancer. Ongoing staff training was critical to the success of the project's health education component.

During the course of the project, Health Links provided 4,009 units of case management and interpretation services, including 2,380 units of interpretation services. Some 2,067 individuals received health education in group settings, not counting the more than 2,000 individuals who attended the annual Farmworker Health Festivals and those who received one-on-one education. In addition, 1,203 clients received primary health care services, and transportation assistance was provided for 83 long-distance physician and hospital visits for patients who needed specialty care. The project also delivered Spanish-language health education materials to area health care providers.

Potential for Replication

The Health Links model is applicable to other rural areas with a large Spanish-speaking population. The biggest challenge is recruiting bilingual staff. They must be screened for linguistic proficiency, receive training in medical interpretation, have access to continuing education opportunities, and be evaluated from time to time to ensure the quality of their interpretation skills. All SGCP staff members are bilingual, so the program has systems and procedures in place for locating, interviewing, and recruiting desirable and qualified bilingual staff members. Other communities interested in providing bilingual health care services should develop a plan up front, before project start up, to identify processes for screening, training, and evaluating bilingual staff members.

After the Grant

Many of the services that were made possible because of the ORHP grant—including medical interpretation, health education, outreach, and transportation—continue to be available to clients in the four-county region. Health Links has retained two outreach workers and the bilingual project coordinator. The project had hoped to sustain the full range of activities by billing health care providers for medical interpretation services, but many providers remain unwilling to pay for interpretation services even though they are now more aware of the value of such services in the clinical setting. However, the project has generated some revenue by charging providers for interpretation services hopes to increase such revenues in the years to come.

Community Characteristics

At the time of the grant award, preventive health services were nonexistent in Treutlen County, Georgia. There were no hospitals in the county and no physicians, and the county health department was by and large a forgotten entity. What was needed was an onsite, comprehensive school health program for students and staff members. The program would be designed to decrease absenteeism, increase the number of students who graduated on time, and decrease the teen pregnancy rate among school-age girls.

The service area for the project included the entire Treutlen County School System, which comprised more than 1,200 students from kindergarten through 12th grade. Of these students, 41 percent were African American, 58 percent were Caucasian, and less than 1 percent was Hispanic. The project also was designed to serve school faculty and staff members.

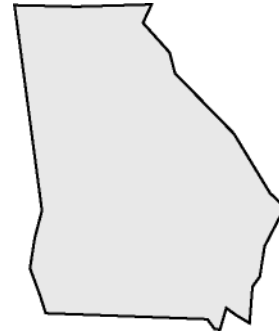
Services Offered

The project consortium included the following organizations:

- The Treutlen County Board of Education, which provided equipment, space, and facilities for the school nurses, family services, and additional staff
- The Treutlen County Board of Health, which offered its district health director to serve as the project's medical director, provided additional staff, and accepted referrals from school clinic staff
- Mental Health Services of Middle Georgia, which accepted referrals from project staff and consulted with them on student mental health problems
- The Treutlen County Department of Family and Children Services, which provided training on child abuse awareness and accepted referrals from project staff

Together, the consortium members launched an onsite school clinic; conducted onsite assessments and screenings for vision, hearing, blood pressure, and mental health; provided onsite case management services; offered referrals to other community programs; sponsored health education classes and taught occupational health classes; provided mental health counseling services; coordinated the school's drug awareness program; and offered numerous other programs and services. These programs and services were available to all Treutlen County students and staff.

GEORGIA



**TREUTLEN COUNTY SCHOOL
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Innovative Solutions to Problems

The model's primary innovation was to join forces to provide or coordinate the full range of services that students needed. School nurses were able to monitor students taking prescribed medications, and students with significant medical problems had a file on record in the clinic, with a copy provided to the student's teacher. Under this system, for example, if a student had an asthma attack or a drop in blood sugar, the teacher would know what immediate actions to take. This approach reduced the number of doctor and hospital visits by students. School nurses also identified students who needed medications, glasses, or more intensive hearing tests.

School social work and family services coordinators built strong relationships with families whose children had chronic absenteeism. Being able to work with these families on a one-to-one basis through home visits and supplying monthly attendance updates increased student attendance at school. Students with perfect attendance were awarded with free admission to a school sports event, a candy bar, a soda, a movie pass, a certificate, or having their pictures posted on the bulletin board.

The project also experienced its share of challenges. Teen pregnancy, absenteeism, and failure to graduate were serious, systemic problems that were difficult to overcome. The project found that making services more convenient for families was an effective strategy in addressing these problems, and the project observed a tremendous change in the attitudes of parents toward the school health problem. Over time, parents became more willing to seek help from the school clinic when their child had a problem.

Results

School nurses recorded 52,023 student contacts. Of those contacts, 23,056 were attributed to illness and injury, and only 14.7 percent of students who came to the clinic were sent home.

One of the project's main goals was to decrease the rate of pregnancy among school-aged females aged 10 to 19 years from 50 per 1,000 to 40 per 1,000. Although final evaluation data will not be available until 2006, local health department and clinic data indicate that 19 per 1,000 females in this age group were pregnant during the 2002–2003 school year.

Another goal of the project was to decrease the percentage of students absent 10 or more days each school year. In the 1998-1999 school year, 37 percent of students were absent from school 10 or more days. In the 2002–2003 school year, 24 percent of students were absent 10 or more days.

The third project goal was to increase the graduation rate among students in the area. In the 1998–1999 school year, 78 percent of students graduated on time. Unfortunately, the project did not succeed in this area. In Georgia, a student can drop out of school at age 16. Additional efforts are needed to reinforce the importance of education, beginning at a young age. It is difficult to help students understand the importance of completing high school when dropping out is so common.

Potential for Replication

Many schools and communities are struggling with the issues of absenteeism, teen pregnancy, and failure to complete high school; therefore, this model may be relevant to communities across the Nation. Undertaking such a project entails understanding the unique dynamics of rural communities; trust must be established with individuals and parents. It also is important to clearly delineate the roles and responsibilities of participating agencies and to respect their individual contributions, perspectives, and guidelines.

After the Grant

School nurses will continue to be funded through State tobacco settlement funds. They will provide health services to students and staff, including medication disbursement; hearing, vision, dental, and scoliosis screenings; illness and injury monitoring; and student and staff health education. The project is seeking additional funding to sustain school clinic services.

Community Characteristics

Region 2 of Idaho, which covers more than 11,000 square miles, is known for its scenic rivers, mountains, and canyons. Tourists enjoy the beautiful drive through these rugged areas. From 2001 to 2007, during the Lewis and Clark bicentennial celebration, some 750,000 people are expected to travel through the area, expanding the need for additional emergency services. Unfortunately, emergency care providers in this region struggle with the challenge of remaining viable and strong amid increased demand for emergency care. Area residents typically are Caucasian, but a small number of American Indians and Hispanics also live in the region. The area has a large number of elderly residents, and the region's unemployment rate remains unacceptably high. Sources of income for area residents include logging, lumber mills, farming, forestry, fisheries, mining, and retail trades. The region includes two State prison facilities, a psychiatric hospital, and three medical hospitals.

Services Offered

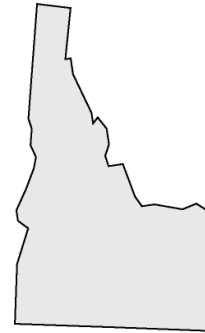
The main purpose of the Protecting the Golden Hour project was to develop and implement an adaptable, ongoing system of training, coordination, and accountability among 18 rural emergency medical service (EMS) units in Region 2. Specifically, the project funded an online basic emergency medical technician (EMT) course, a 24-hour refresher course, and a first-responder course. This training provided a standardized level of education to potential basic EMTs. Basic EMT instructors received additional training to upgrade and improve their skills, using classes with standardized skills training scenarios. In addition, three mass-casualty trailers were strategically placed throughout the region for use by the rural EMS units.

The project consortium members included Lewis-Clark State College (LCSC), which oversaw project activities; the Idaho State Region 2 Emergency Medical Bureau; St. Mary's Hospital and Clinics; Syringa General Hospital; Clearwater Valley Hospital and Clinics; Clearwater National Forest; and EMS units throughout the region.

Innovative Solutions to Problems

The online training component for providing basic EMT training was the project's most innovative feature. This approach

IDAHO



**PROTECTING THE GOLDEN
HOUR
LEWISTON, IDAHO**

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eliminated the need for individuals to travel a long distance to receive training and laid the foundation to decrease the burden on the 18 EMS units in the region by expanding their workforce. The project also developed a Web page, which provided the focal point for communicating with EMS personnel throughout the region.

Internet connectivity, however, proved to be a barrier for the project. Many rural areas were limited to 28.8Kbps lines, which made it difficult to transmit videos electronically. Project staff members discussed the possibility of distributing the videos by CD or cassette to EMS personnel; however, the companies that own the videos wanted to charge unreasonably high fees to allow the project to edit clips from existing videos into a new video for distribution. In addition, many communities were not technologically equipped to handle streaming video. Nevertheless, the project's online training component was successful despite the problems with Internet connectivity.

Results

The 3 mass-casualty trailers were purchased, equipped, and strategically placed so that the 18 EMS units have access to them, if needed. All EMS units in the area have computers and Internet access, although some units opted to disconnect because of the associated costs. The Web site continues to serve as a major source for project communications and for distributing information about new educational opportunities. The online curriculum is accessible in both rural and urban areas, and supplemental teaching videos and CDs have been provided to the LCSC library. The training has been pilot-tested to determine its success in instructing basic EMTs. The course will continue to be evaluated to improve the quality of the training program. The project learned that the distance-learning format is most effective, at least initially, when a field coordinator delivers clinical instruction. Other instructors will be trained to teach the online portion of the course after the training program is improved. It should be noted, however, that some community instructors were reluctant to change their teaching techniques to accommodate a distance-learning format.

Potential for Replication

The project could work well in other rural areas, but it is likely that other communities will experience similar challenges, especially those targeting EMS units based in rural areas. Online

instructional formats are more widely accepted now than at the beginning of this grant, and many communities are beginning to upgrade Internet connectivity speeds, which may make it easier for them to replicate this model.

After the Grant

The online courses will continue to be available to the public. The online EMT instructor will continue to work with local EMS units to assist clinical instructors in teaching the online class. The project also offers annual prehospital workshops that focus on different topics of relevance to basic and advanced EMTs. The most recent workshop focused on geriatric prehospital care.

PROJECT 22—OSTEOPOROSIS AND BREAST CANCER SCREENING AND PREVENTION PROGRAM

Community Characteristics

Osteoporosis and breast cancer are two of the leading causes of morbidity and mortality among women. Although the medical technology exists to measure a woman's bone density and to detect the early stages of breast cancer, women in rural areas often do not have ready access to such screening services. Furthermore, many rural health care facilities do not have the financial resources to purchase such screening equipment, forcing the women they serve to travel long distances for these screenings—or to risk their health and well-being by not receiving screenings at all.

Services Offered

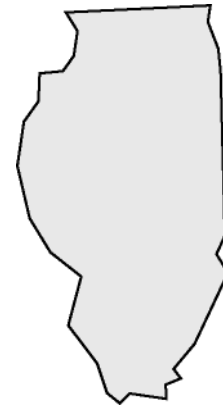
The Community Medical Center (CMC) of Western Illinois served as the lead agency in implementing an osteoporosis and breast cancer prevention and screening program for women living in Illinois' Warren and Henderson Counties. Grant funds made it possible for the hospital to upgrade its mammography services by purchasing a new transducer. The project also purchased a bone density scanner to help determine a patient's risk for osteoporosis and provided training to professional staff so they could learn how to use this new equipment.

The network for this project included Strom Senior Center, Jamieson Community Center, Alternatives for the Older Adult, the Warren County YMCA, Henderson County Rural Health Center, Henderson County Health Department, and the Susan B. Komen Breast Center. The network organizations worked in tandem to provide health education on osteoporosis and breast cancer prevention to women aged 55 years and older living in the two-county region. Special emphasis was placed on reaching women of Hispanic descent. The network members also played an important role in disseminating information about the project's services through their newsletters, health fairs, and group meetings.

Innovative Solutions to Problems

As part of the grant activities, the project established the CMC Speakers Bureau, which played a critical role in educating area women and their loved ones about osteoporosis and breast cancer. To support this health education component, the project identified qualified speakers who were knowledgeable about these topics and well respected throughout the community. These individuals

ILLINOIS



**OSTEOPOROSIS AND BREAST
CANCER SCREENING AND
PREVENTION PROGRAM
MONMOUTH, ILLINOIS**

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participated in group meetings and other community events attended by area women. The CMC Speakers Bureau played a critically important role in educating women about osteoporosis and breast cancer, explaining how screenings work, and motivating women to access these services locally.

Results

The project provided more than 1,600 osteoporosis and breast cancer screenings during the grant period. About three-quarters of those who received screenings were women aged 64 years and older, and the remaining one-quarter were women aged 18 to 64 years. Approximately 1,000 of the patients served during the grant period were low-income women. Although the vast majority of participants were Caucasian (96.5 percent), the project also provided screenings to a small number of Hispanic women (2 percent) and African American women (1.5 percent).

Potential for Replication

A similar project could work well in other rural settings. It is important to offer health education to women who might not otherwise have access to information. It also is important to provide critically important services, such as mammograms and bone density screenings, to women who would otherwise go without these screenings or would have to travel long distances to receive such screenings. CMC is a testament to the fact that women are more than willing to participate in these screenings if the services are convenient and affordable.

After the Grant

Because the project purchased the equipment necessary to provide bone density and breast cancer screenings, these services will continue to be available to area women. Providing these services is a self-sustaining endeavor because the cost is covered through Medicare, Medicaid, private insurance, and self-payment.

CMC now participates in the Illinois Breast and Cervical Cancer Program, which provides free mammograms to women who qualify. The project will continue to offer health education services to women throughout the community.

Community Characteristics

Butler County, located in northeast Iowa, has a population of 15,000 people, with 20 percent of county residents aged 65 years or older. Like many rural areas, agriculture is the leading industry, but income levels are slightly less than State averages. This quiet, rural community, which does not even have a stoplight within its borders, is a designated health professional shortage area, and there are no hospitals in the county.

Because of the large elderly population and the high incidence of heart disease and cancer among county residents, public health nurses in Butler County realized that they had cared for many patients whose suffering could be prevented with early detection and treatment. Like the nurses, residents of Butler County recognized the need for prevention and early detection services. A survey conducted by the local health department revealed that residents had a variety of health concerns. It also showed that residents were willing to participate in prevention and early detection programs if such activities were available.

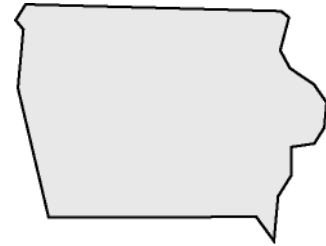
Although many of the initiatives of the Butler County Parish Nurse Project were designed to address heart disease and cancer among the elderly, the project also recognized that health-positive behaviors begin early in life; therefore, additional initiatives focusing on a variety of topics were developed for various age groups

Services Offered

The Butler County Parish Nurse Project was developed to create a delivery system that focuses on the prevention and early detection of several illnesses, including heart disease and cancer. The project was designed to make health promotion and disease prevention services readily available and easily accessible, affording citizens the opportunity to improve the quality and length of their lives by addressing the health needs of the “whole” person.

The Butler County Public Health Department coordinated the project, oversaw its management, and served as its home base. To support the project, the health department joined forces with the Allen College of Nursing, which provided the parish nurse training course (through the Iowa Communication Network) for nursing staff, and Circle of Friends, a local volunteer organization. In addition, 14 churches became involved in the network by

IOWA



**BUTLER COUNTY PARISH
NURSE PROJECT
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promoting project services, donating facilities in which prevention and early detection services could be delivered, and providing members to engage in community outreach.

The Parish Nurse Project sought to promote the “whole” health of clients by educating them about the relationship between lifestyle, attitudes, faith, and well-being; by counseling clients about health issues, prevention, and coping with chronic disease; and by referring clients to appropriate community resources. This process came to be described as the “journey to wholeness.” County residents also had access to the following group programs sponsored by the project:

- The “Stomp Out Stroke” program, attended by more than 400 people, consisted of a stroke screening and education on reducing the risk for stroke and the importance of early detection. Stroke awareness information also was disseminated through local newspapers, billboards, and public service announcements.
- The “Friend to Friend” program targeted women and focused on providing breast cancer education in area homes. More than 85 women participated in this popular, nonthreatening approach to education.
- The “Fit for Life” program promoted enjoyable and friendly competitive activities to encourage physical activity. In addition, 500 participants received cholesterol and colicare screenings.
- “Live Well, Body and Soul” was an educational event attended by 200 women. The event consisted of a keynote address, music, and 10 different health- and wellness-related breakout sessions.
- “Sun Safety,” an interactive skit targeting elementary school-age children, emphasized prevention and early detection of skin cancer.

In addition, the Butler County Parish Nurse Project offered several other health promotion and disease prevention activities, including “Kick Your Stress God’s Way” classes; a one-session presentation on osteoporosis; an interactive, one-session Teams Against Tobacco Use (TATU) class targeting upper elementary and junior high students; a Heart Healthy Dinners program; an

abstinence and sexual purity program; a “Take Control” cancer risk-reduction program; and several other health-positive initiatives.

Innovative Solutions to Problems

One of the most important lessons learned as a result of the project was the need to “go where the people are.” If a local church was sponsoring a soup supper, then the Parish Nurse Project was there to present the “Take Control” program. At senior citizen breakfasts at the local AMVETS, a parish nurse was on hand to check blood pressure levels and answer health-related questions. Project staff participated in seven parades using a “Sun Safety” float, which enabled staff members to distribute brochures and sunscreen samples. The project also rented a tent in the city park to offer cholesterol screenings during a community barbeque.

The biggest challenge in carrying out the project was educating the community about the program’s intent and what a parish nurse is. Staff members recognized the need to be patient, to remain dedicated, and to establish trust throughout the community.

Results

The main goal of the Butler County Parish Nurse Project was to create a system for providing health promotion and disease prevention services. Parish nurses provided personal health counseling, education, and referral services as part of more than 1,800 individual visits and contacts. During these contacts, the nurses talked about nutrition, home safety, medication instructions, spiritual and emotional concerns, end-of-life situations, grief, and numerous other topics. These services were especially beneficial to the county’s elderly residents.

Monthly blood pressure clinics detected abnormal readings in 149 people. Each client was referred to his or her physician and received blood pressure education and followup visits by the parish nurse. Two of these clients went on to have open-heart surgery, which prevented full-blown heart attacks. Both are now doing well and frequently express their gratitude to the parish nurse for helping them receive care sooner rather than later.

In all, nearly 20 different health promotion and disease prevention programs have been offered to area residents, ranging from serving 700 heart-healthy meals during Heart Health Month, to teaching abstinence education to teens, to snowmobile safety and first aid classes. The project’s success lies in the fact that the people

it served never before had the opportunity to participate in a wellness-oriented program.

Another important lesson learned by the project was the importance of collaboration. The most successful programs provided by the project involved collaboration with other community groups.

Potential for Replication

The Butler County Parish Nurse Project could be successfully adapted to other rural settings. However, two primary challenges are likely to occur. First, parish nursing is still a relatively new concept for many people; therefore, financial support during the startup phase is critical. Over time, as residents become more familiar with a parish nurse and experience the benefits of the approach, they begin to recognize and trust the project as a valuable resource. Second, the network partners must work to develop and maintain a true spirit of cooperation. Public and private-sector organizations must be willing to work with faith communities and remain flexible in making programming decisions. At the same time, faith communities must be willing to open their doors to “outsiders” and to work in tandem with people who may have different religious perspectives.

After the Grant

Twelve of the 14 partner churches have continued the Parish Nurse Project in some form. Some churches use an unpaid volunteer; others have been able to hire a parish nurse and provide compensation as part of the church’s staff. In Greene, Iowa, a task force has been established to devise a way for the community’s four churches to pool their resources to hire a full-time parish nurse to serve their community.

PROJECT 24—MAQUOKETA COMMUNITY SCHOOL DISTRICT (MCSD) RURAL HEALTH OUTREACH PROGRAM

Community Characteristics

Jackson County is located in east-central Iowa. Some 19,950 people call Jackson County home, and of these, some 6,130 live in Maquoketa, the county seat. Ten to 20 percent of youth living in Maquoketa have no health insurance or access to health care services. At the time of the grant award, approximately 1,700 children were enrolled in the Maquoketa Community School District (MCSD). The median annual household income in Jackson County is \$28,890, whereas the State median household income is \$33,436.

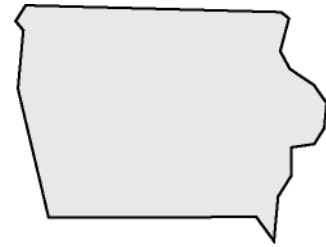
In addition to lacking health insurance and ready access to basic health care services, many MCSD students did not have adequate dental or vision care, and many did not have access to social services. Many local dentists had stopped accepting new Medicaid patients, which meant that Medicaid enrollees who needed dental care had to travel 30 to 100 miles to see a dentist. Health care agencies in Maquoketa did not have a system in place for improving the coordination of health care and social services, and many such agencies had policy and procedural barriers that limited access to health care services. In addition, many families did not have reliable transportation to services, and many MCSD students were not making healthy decisions about alcohol, drugs, or sexual relationships. In short, very little attention was focused on preventing poor health; instead, most area residents viewed health care as a crisis issue that required attention only when a condition became serious.

Services Offered

The MCSD Rural Health Outreach Program provided a wide range of health promotion and disease prevention activities. These initiatives included nursing offices in every school, annual health screenings for all students, dental care, mental health services, community education, annual scoliosis screenings for sixth through eighth grade students, and annual vision, height, weight, and blood pressure screenings.

The school-based nursing offices were the vital link between students needing services and area health care providers. In many respects, the nursing offices functioned as the only available medical home for many students. An outreach coordinator managed services. The project was built on a consortium of three

IOWA



**MAQUOKETA COMMUNITY
SCHOOL DISTRICT (MCSD)
RURAL HEALTH OUTREACH
PROGRAM
MAQUOKETA, IOWA**

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organizations—MCSD, the Gannon Center for Community Mental Health, and the Maquoketa Rural Health Advisory Council, which consisted of more than 20 area health care providers who agreed to participate in the project.

Innovative Solutions to Problems

The project's most innovative feature was the way in which it was designed—to take the services to students. In addition, the outreach coordinator worked closely with parents to collect student health data at least once a year, which enabled the outreach coordinator to analyze each student's unique needs, to make appropriate referrals, and to plan effective school-based programs.

It should be noted that many people in the community resisted the idea of school-based health services. Many believe that schools should be responsible only for educating students, not for meeting their health needs. The project found, however, that this resistance was grounded largely in the fact that many people knew very little about the benefits of school-based health services or the strong relationship between a child's health and his or her readiness to learn. Once the project educated residents about these realities, the community became significantly more supportive.

Another barrier that the project experienced was the widely held belief that schools should not have access to detailed health information about students. However, once community members realized that student health information was strictly confidential and that such information was necessary to provide care and to coordinate referrals, parents were more at ease providing health information about their children. Of course, in spite of the project's success in changing attitudes about the collection of basic health information, some families refused to provide this information—and the project respected their right to do so.

Results

The project served approximately 1,700 children and adolescents. Some 150 of these students received special education services and were from low-income families. Among these students, the project recorded nearly 7,000 service contacts, which included direct services, collaboration with other service providers, and/or prevention education. The vast majority of students were Caucasian; however, the project also served a small number of African American, Pacific Islander, and Hispanic students.

In addition, the project offered a wide range of educational opportunities for students, parents, and community members. Educational topics included well-child clinics, how to apply for public-sector health insurance programs, West Nile virus, methamphetamine use, child and adult abuse training, domestic violence prevention education, bullying prevention, dental health education, traumatic injury prevention strategies, automatic external defibrillator information, and HIV/AIDS prevention.

The most important lessons learned as a result of the project were to

- Involve area health care providers, students, family members, and community members in all aspects of the project, including decisionmaking
- Involve students in designing educational programs that would engage and benefit students
- Use contacts throughout the community to help create and support the service network
- Remain flexible as consortium members experience financial difficulties and/or staffing changes
- Continue to search for new funding activities to sustain project activities

Potential for Replication

The MCSD model could be implemented in any school setting that has access to computer technology, nurses, and school counselors. Implementation challenges might include being viewed as competition or a threat to existing health care providers, understanding that not every student or family wants services, obtaining necessary consents from parents, dealing with resistance from parents who believe that schools should not teach children about certain topics, and facing a lack of understanding about the importance of health promotion and disease prevention.

After the Grant

The project will continue to provide a variety of services to students. District nurses will continue to provide school-based health services, thanks to district funding. The project has applied for grant funding to sustain project services.

Community Characteristics

Iowa has the largest population of individuals aged 85 years and older in the Nation. The Timely Life Care (TLC) project was designed to provide a wide range of services for chronically ill patients and their caregivers. One-third of people with a chronic disease report having physical limitations that make it difficult for them to manage basic, day-to-day activities. At Horn Memorial Hospital (HMH), located in Ida County, Iowa, 66 percent of all admissions are Medicare-age individuals—53 percent of whom have chronic illnesses. Nearly 60 percent of HMH patients are aged 65 years or older and have one or more chronic illnesses. At Horn Memorial Home Health (HHH), about 95 percent of the patients are older than 65 years of age.

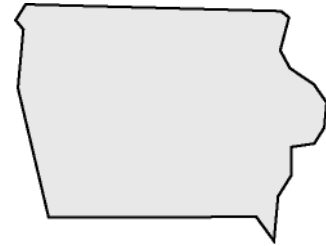
The TLC project served an area in west-central Iowa that spans a 35-mile radius, including portions of 5 counties and 19 small rural communities. These communities within the service area range in population from 272 to 2,357 residents, with the majority having a population of less than 1,000 individuals. Ida County has a total population of 7,936 residents and is a designated health professional shortage area.

Services Offered

The TLC network included Odebolt Nursing Home and Rehabilitation Center, Willow Dale Care Center, Morningside Rehabilitation and Care Center, and Holstein Good Samaritan Center. All of these facilities are nursing homes within a 15-mile radius of Ida Grove. Each facility had a palliative care nurse integrator on staff, who was trained in palliative care concepts, pain management, symptom/disease management, drug regimen therapy, end-of-life planning, and other issues related to geriatric and chronic disease care. As part of the grant, facilities identified registered nurses to receive additional training through a 3-day pain management course and continuing education units. The grant also provided respite care services—including room, board, and nursing care—for caregivers and family members.

Area nursing homes admitted TLC clients for up to 7 days—at no cost to the patient, family members, or caregivers. The nursing homes also screened patients upon discharge to assess their ongoing care needs. The TLC social worker and chaplain were responsible for addressing psychological, social, and spiritual problems among

IOWA



**TIMELY LIFE CARE PROJECT
IDA GROVE, IOWA**

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the clients. Area doctors, nursing homes, hospitals, and clergy provided referrals to the TLC project.

Innovative Solutions to Problems

Telemonitoring is a technology that connects health professionals and patients in separate locations via a telephone line. Telemonitoring units can be placed in patients' homes, with a base station located at the health care professional's office. The central station receives a clear, close-up picture of the patient and is able to assess blood pressure levels, oxygen saturation levels, blood sugar readings, and weight. Detailed and timed readings are gathered and automatically stored in the patient's telehealth monitor. The base station also stores clinical notes, physician orders, and medication schedules. Medical information can then be printed out in a chart or graph format. It is important to note, however, that some patient homes were equipped with older telephone lines that could not accommodate telemonitoring systems.

Results

A total of 50 area nurses participated in the pain management course—at no cost to the nurses. During the 3-year grant cycle, 54 patients received care through the program, many of whom were able to maintain independent living in their own homes. Others, however, were transferred to hospice care, assisted living, or nursing home facilities—or passed away. In total, the project funded 4,320 patient visits, and there was increased understanding among many in the area's health care system of the value of palliative care in reducing acute care recidivism, the length of hospital stays, and emergency room and doctor's office visits. In addition, the project evaluation revealed that 48 study subjects who participated in the telemonitoring program generally achieved better health status than 20 control subjects who did not participate in the program.

Potential for Replication

Telemedicine offers a potentially useful model for rural, medically underserved communities. Patients can manage chronic illnesses better if their condition is monitored more frequently and if they are educated about disease progression. However, telemedicine is a relatively new technology that requires costly equipment. Many rural facilities simply do not have adequate

funding to purchase such equipment or to train staff members on how to use it properly. These challenges are further complicated by the fact that Medicare reimbursements generally are not sufficient to cover the costs associated with monitoring a patient's condition via telemedicine.

After the Grant

Due to inadequate funding and reimbursements, only portions of the TLC project will continue to be available to area patients. Telemedicine will be offered only to patients who can afford to pay the fee for the service. However, telemedicine technology will continue to be used to provide monitoring services and patient education to patients in the home health and hospice departments at Horn Home Health and Hospice.

Community Characteristics

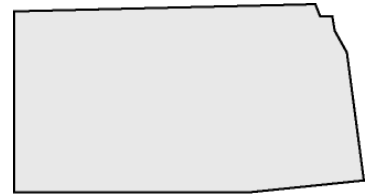
The Central Kansas Rural Health Outreach Project sought to address the chronic health issues of diabetes, hypertension, and high cholesterol among residents living in a three-county region in central Kansas. Although the project placed no restrictions on who could receive services (e.g., age, gender, income level, insurance status, disability, or country of origin), it emphasized reaching out to Hispanic residents in the service area who experience disproportionately high rates of diabetes, hypertension, and high cholesterol.

Services Offered

The Central Kansas Rural Health Outreach Project was designed to increase access to affordable, culturally competent, and linguistically appropriate health care services for low-income Hispanic residents living in Barton, Pawnee, and Stafford Counties. The We Care Project, Inc., provided overall guidance for the project, with the project's executive director overseeing its day-to-day functioning. Other members of the consortium included the Barton County Health Department, the Pawnee County Health Department, and the Stafford County Health Department. (The Stafford County Health Department pulled out of the consortium during the last year of the project.) We Care provided comprehensive primary health care services at affordable prices, trained medical interpreters, a trained health promoter, and a case manager. Each of the county health departments provided space for satellite clinics, immunizations, family planning services, and women, infants, and children services.

The project provided a wide range of primary health care services, including laboratory and x-ray testing, assistance with prescription medications, and transportation services. Staff interpreters received training in accurately interpreting the spoken word and correctly translating the written word. Clinic staff members worked with patients diagnosed with diabetes or hypertension in developing an individualized control and prevention plan. A certified diabetes educator worked with clients with diabetes to teach them about healthy eating, exercise, sexuality, and other aspects of their lives. A trained bilingual *promotora de salud* (health educator) supported clients by conducting home visits and providing one-on-one and family health

KANSAS



**CENTRAL KANSAS RURAL
HEALTH OUTREACH PROJECT
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education. In addition, a case manager facilitated a support group, which met once a month, for Spanish speakers with diabetes, hypertension, or high cholesterol.

Innovative Solutions to Problems

Before establishing a satellite clinic in Stafford County, primary health care services were very limited, inaccessible, or not affordable for some clients. Because of the severe lack of access to care in Stafford County, the project established the satellite clinic a year before it was scheduled in the original timeline. However, as the clinic became busier, the physician in that county—who also happened to be the medical director for the Stafford County Health Department—complained that the clinic was taking away his patients and threatening his practice. As a result, the Stafford County Health Department left the consortium. Stafford County residents can still receive services at the Great Bend clinic. For clients who do not have their own source of transportation, the Retired Senior Volunteer Program provides transportation to and from client appointments.

Results

Thanks to the funding received as part of the grant, We Care successfully transitioned from a referral agency to a free-standing clinic. Early in the grant cycle, the clinic added a nurse practitioner to its staff to provide onsite primary care. The clinic continued to grow, adding a second full-time nurse practitioner in June 2001. A registered nurse/clinic supervisor was added in late summer 2001, along with other clinic and administrative support personnel. The medical director was hired in August 2002, with a second physician added in May 2003. A bilingual case manager was added to staff in 2002, and an outstationed eligibility worker from the local Social and Rehabilitation Services office was added to the We Care staff near the end of the grant cycle.

The project succeeded in achieving all of the activities and action steps described in the original grant proposal, including the following:

- Reducing health disparities among the region's Hispanic community
- Providing training for staff interpreters and translators, as well as a 40-hour certification program

- Developing Spanish-language signage, health education, and marketing materials
- Creating more flexible clinic hours

In total, the project recorded 3,011 service units for children aged 0 to 11 years; 1,021 service units for adolescents aged 12 to 19 years; 11,208 service units for adults aged 20 to 64 years; and 842 service units for elderly individuals aged 65 years or older.

Potential for Replication

Projects such as the Central Kansas Rural Health Outreach Project could work well in many other rural areas. However, other communities may experience similar challenges, such as “turf issues” or the fear of losing clients. Although many providers do not want to serve low-income or uninsured individuals, they also do not want others to serve them. For such a program to succeed, it is critical to have a strong and committed network of partners that share common goals and are able to work together effectively.

After the Grant

All the activities initiated as a result of the grant funding will be continued—and many services and programs will be expanded. This is possible because We Care now receives Federal community health center funding, which was initially awarded in September 2001. Because of this new funding, there are no geographic restrictions regarding who can receive care. All potential clients also are now able to receive care regardless of their ability to pay. In addition, We Care is collaborating with the Barton and Pawnee health departments to provide prenatal care services for uninsured and low-income women in central Kansas.

Community Characteristics

Farmworkers are the backbone of the agricultural economy. Their labor is needed to produce 85 percent of the crops grown in the United States and to care for and manage livestock operations. Expected to work from the early morning hours until late in the evening, especially during the harvest season, the typical farmworker has a limited amount of time to access health care services. Furthermore, tracking data indicate that farmworkers are at high risk for occupational and medical problems. Many farmworkers experience back pain, but they do not report their symptoms for fear that they will lose their jobs. Farmworkers also are at risk for high cholesterol, hypertension, and high glucose levels, and they rarely benefit from occupational health or prevention services because they work in an isolated environment.

The Farmworker Health Initiative was designed as an educational and screening outreach program targeting African American, Hispanic, and non-Hispanic men, women, and teenagers who worked in agriculture-related jobs. The program focused on preventing and treating occupational and medical health problems.

Services Offered

The project consortium included Southeastern Louisiana University, the Southeast Area Health Education Center (AHEC), the Louisiana State University (LSU) Lallie Kemp Medical Center, the Louisiana Office of Public Health, and the LSU Agriculture Center. Together, these organizations sponsored health fairs at migrant housing facilities, migrant Head Start programs, worksites, churches, and farms. The health fairs provided an opportunity for a nurse practitioner to screen farmworkers for medical and occupational diseases and, if necessary, to refer farmworkers for treatment. The same nurse practitioner ran the Farmworker Health Clinic on Friday afternoons at the LSU Medical Center.

The Southeast AHEC coordinated three FARMEDIC courses. FARMEDIC is a national farm emergency training program that has developed a system to train rescue workers on how to respond properly to rural emergencies. All training participants are required to pass a certification exam at the end of the 2-day course. The project also taught first aid and CPR to agricultural workers and their families. In addition, the AHEC helped to enroll eligible farmworkers and their families in Medicaid and the State

LOUISIANA



**FARMWORKER HEALTH
INITIATIVE
HAMMOND, LOUISIANA**

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Children's Health Insurance Program. A bilingual enroller was available to attend community health fairs and to travel to farmworkers' homes.

Innovative Solutions to Problems

The project had originally planned on hiring a full-time nurse practitioner to drive a van throughout the community to provide primary health care services. However, none of the nurse practitioners in the area were bilingual. Therefore, the project established an outpatient clinic at the LSU Medical Center staffed by a nurse practitioner who also attended health fairs and outreach events. This step enabled the project to hire a bilingual, multicultural community health outreach coordinator to link farmworkers to health care and social service agencies in the community. The coordinator also played an important role in training students on farmworker health issues and following up with farmworkers who had abnormal screening results or needed referrals.

In addition, the project purchased a 22-foot van that stores health fair materials and medical equipment. The van contains a restroom, an examination table, and a desk. It serves as a single examination room and has been used for individual counseling sessions.

Results

The project succeeded in achieving all but one of its objectives (to provide tetanus vaccines to farmworkers, which proved not to be administratively feasible because of the limited availability of tetanus booster vaccines). The biggest barrier that the project encountered involved providing health care services to farmworkers who were uninsured or underinsured. Even though the hospital accepted all patients who walked through its doors, the law requires hospitals to bill for services not covered by other sources of funding. As a result, many patients elected not to receive care. In addition, many patients were reluctant to seek care because of their inability to pay for needed medications.

The students involved in the program benefited from the opportunity to see examples of the cultural differences in agricultural life. They came to understand the degree to which language can be a barrier to health care and to appreciate the fact that farming is physically demanding work. In addition, many

farmworkers who normally would not have agreed to be screened for various illnesses acquiesced because they saw it as an opportunity to help students learn.

The project also developed a bilingual community resource manual to provide agencies and individuals with information on local and national resources. The manual is available online at the Florida Parishes Social Sciences Research Center Web site.

Potential for Replication

This model can be duplicated in any rural setting. When the university is responsible for managing grant activities, most of the “territorial” issues common in health care systems can be averted. Students studying nursing, communication disorders, athletic training, and kinesiology received a unique educational experience, while farmworkers and their families benefited from the screening and educational opportunities provided by the students. However, other communities may need to identify specific strategies for addressing the lack of health insurance coverage that is common among farmworkers.

After the Grant

Outreach screening services will continue, and health professions students will provide additional screening services for farmworkers and their families in the region. The project also offers hearing screenings, Spanish nutrition classes, diabetes screening, nursing care, pediatric services, and referrals. A Spanish-language CD-ROM version of First Aid Farm Quest is being developed under the grant’s no-cost extension.

Community Characteristics

Major depression is believed to affect 20 to 30 percent of elderly home care patients. However, major depression is not always diagnosed, especially among the elderly, because of high poverty rates, inadequate insurance coverage, transportation barriers, the stigma associated with mental illness, the limited supply of mental health care providers, and the attitudes of primary care providers toward geriatric depression. Prior studies have shown that telehealth technologies provide the means to deliver mental health services to home health clients.

This project was designed to expand home care services for patients with anxiety and depression in the easternmost counties of the United States—Aroostook County, which covers 6,672 square miles and has a population of 73,140 people (14.3 percent of whom live below the poverty level), and Washington County, which spans 2,568 square miles and has a population of 33,573 people (19.0 percent of whom live below the poverty level).

Services Offered

Two home care agencies—the Sunrise County Healthcare Services division of the Regional Medical Center at Lubec and the Visiting Nurses of Aroostook—collaborated with Horizons Health Systems, a specialty practice network in Aroostook County, to address barriers to the delivery of mental health services for home care patients living in these geographically isolated and economically distressed counties. The home health agencies provided certified psychiatric nurses, a psychiatric occupational therapist, and licensed clinical social workers. Horizons Health Systems provided a geriatric specialist to serve as the project's medical director.

Innovative Solutions to Problems

A significant focus of the project was the use of a novel application of inexpensive, interactive video systems to enhance conventional, in-person home visits for clients with depression. The goal of this approach was to improve their health status and reduce the need for institutionalization. In addition to providing direct, in-home mental health services, the project used small, telephone-line-based home telemedicine units and ISDN-based Polycom units for meetings and consults.

MAINE



**OUTREACH RURAL HEALTH
FOR RURAL MAINE
LUBEC, MAINE**

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Another innovative feature for delivering home-based mental health services was the use of psychiatric occupational therapists for assessments, therapeutic interventions, and participation in monthly case review sessions with the clinical committee. The occupational therapist's assessments included visual and memory checks and sensory integration.

Results

The project provided immediate access to psychiatric services in an area in which clients frequently waited for 2 to 3 months for followup after acute care. Monthly case review sessions during videoconferenced meetings of the clinical committee allowed a means to provide quick, responsive service to remote clients, to remain current on changing home situations, and to plan for therapeutic responses to anticipated crises.

The project recorded 38 assessments by the occupational therapist, 207 visits by social workers, 2 telemedicine assessments by the psychiatrist, and 526 sessions with a psychiatric nurse. The age of patients ranged from 40 to 95 years, and more than a third of patients were female. Nearly 96 percent of patients served were Caucasian, some of whom lived up to 45 miles from their nearest home care facility.

The project resulted in several important lessons:

- Home-based mental health screening and treatment is an important supplement to home health programs. The high proportion of chronic disease among these patients increases the likelihood that symptoms of depression and anxiety will go undetected and untreated.
 - A psychiatric occupational therapist is a critical component of a balanced treatment team.
 - Supplementing in-person visits by home mental health care staff with telehealth sessions is readily accepted by most home health patients and yields a high rate of patient satisfaction.
 - Videoconferencing technologies are a cost-effective approach for conducting program management meetings involving staff members at different agencies.
- Videoconferencing also provides an effective means for

conducting case reviews and promoting collaboration among program staff and specialists.

- It is critical to develop clinical protocols when a new service is added to a home health agency's range of services. These protocols help to ensure that all staff members fully understand and comply with clinical procedures.

Potential for Replication

The home-based telehealth model for mental health service delivery would be a valuable asset to many rural communities. However, the following steps can help improve the likelihood of program success:

- Involve staff members who will be performing the service and collecting the data in the project's planning to avoid gaps between the planning and execution phases of the project.
- Establish clear lines of authority and responsibility for all managers, staff members, and patients.
- Hire qualified staff members, which can be a formidable challenge in rural areas.
- Provide staff members with information-processing resources and sufficient training to use those resources. This step includes providing adequate computer software and hardware to support the collection, processing, and delivery of data.
- Provide a full-time director to ensure effective management of the project.

After the Grant

The project will continue to use the clinical protocol for assessment, referral, and enrollment for telemedicine and psychiatric followup. The project also hopes to share its results with policymakers who can influence reimbursement reforms related to home-based mental health care through telehealth technologies. Meanwhile, the project continues to seek new funding opportunities while providing telehealth-based case management and psychiatric consultation services through a fee-for-service arrangement.

Community Characteristics

According to 1997 data from the Michigan Department of Community Health, the death rate for heart disease and stroke in a 5-county region in northeast Michigan was 419 deaths per 100,000—substantially higher than the State average of 285 deaths per 100,000 and the national average of 271 deaths per 100,000. These data revealed that the region desperately needed an innovative, regional program to reduce major risk factors for heart disease, including high cholesterol, overweight and obesity, high blood pressure, and sedentary lifestyles. Implementing such a program, however, was no easy task. The target service area consists of nearly 5,000 square miles—an area larger than the States of Delaware and Rhode Island combined. With the exception of Alpena, with about 15,000 residents, the region is largely a rural area in which poverty is rampant and household incomes low. Most residents in the region are Caucasian; however, a small number of Asian Americans and Pacific Islanders, Alaska Natives, American Indians, and African Americans also live in the region.

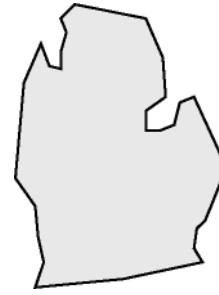
To implement a regional program, Alpena General Hospital developed a coalition of organizations to support a wide range of health education activities throughout the five-county region. In addition to Alpena General Hospital, which coordinated the project, the consortium members included District Health Department No. 4, Alcona Health Center, and Thunder Bay Community Health Center. Each member of the coalition agreed to contribute staff resources to support the project, which in some cases involved allocating organizational resources as a “match” to grant resources.

Services Offered

The HeartNet project had several specific and measurable goals in mind when it first started:

- Decrease the percentage of residents reporting that they do not exercise from 45 percent to less than 25 percent
- Decrease the percentage of residents who are overweight from 45 percent to less than 40 percent
- Decrease the incidence of high blood pressure from 13 percent to 10 percent
- Decrease the incidence of high-risk cholesterol from 50 percent to less than 40 percent

MICHIGAN



HEARTNET
ALPENA, MICHIGAN

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To achieve these goals, the project focused its efforts on providing health education and health screenings to area residents. Community outreach workers and volunteers played an important role in encouraging residents to attend health education activities and to receive heart-health screenings. Health promotion and disease prevention activities were offered at more than 30 community sites throughout the region where prevention, education, and resources had not been previously available. These locations included worksites, community organizations, and churches. HeartNet sites offered comprehensive heart-health screenings, personal wellness and lifestyle assessments based on self-report questionnaires, and tailored prevention activities to meet the needs of participants. Some of these activities included structured classes taught by area health professionals on exercise, weight management, nutrition, blood pressure management, and cholesterol management.

Innovative Solutions to Problems

The HeartNet program was a grassroots effort that mobilized volunteers willing to serve on health teams and to become involved in health promotion efforts throughout the region. Each team was headed by a coordinator whose primary responsibility was to function as the team's "cheerleader." Team members were actively involved in tailoring services and activities for the needs of those they served and for reducing the barriers to participation. For example, those working with church groups conducted health promotion, disease prevention, and assessment activities before or after church services. Likewise, teams at worksites conducted activities during lunch breaks or shift changes. By playing an important role in designing their activities, team members felt a profound sense of ownership for their programs, as well as responsibility for ensuring their success.

The project also allocated funds for contracting with physicians, physical therapists, and registered dieticians to provide interesting and innovative programs. These activities included strength-training classes, exercise classes, cooking demonstrations, and physician-led community presentations.

The most difficult challenge for the program was sustaining the motivation and enthusiasm of each volunteer team. At the beginning, team members were excited by the prospect of

conducting projects simultaneously or offering programs throughout the year. This excitement, however, sometimes resulted in high levels of stress among team members—and in some cases, burnout. To address this challenge, each team was given the freedom to set its own goals and objectives based on the needs of its own group.

Results

HeartNet served about 6,000 individuals during the 3-year grant program, including 3,900 individuals aged 65 years and older and 2,100 adults aged 20 to 64 years. Approximately 4,200 participants were female, and 1,800 were male. The vast majority (97 percent) of participants were Caucasian. However, the program also served a small number of Asian Americans and Pacific Islanders, American Indians, and African Americans.

The first year of the project provided an opportunity to collect baseline data on population health behaviors as they related to the four project goals identified above. Baseline data revealed that area residents exhibited higher rates of high blood pressure, at-risk cholesterol levels, and overweight and obesity than were originally projected in the regional comparison averages. Nonetheless, over the course of the 3-year project, the HeartNet program yielded improvements in three of the four areas, including increasing physical activity, decreasing blood pressure measurements, and reducing cholesterol levels.

The most important lesson learned from the program evaluation process was that evaluation components must be clearly defined in the project planning phase—before the program is implemented. Having clear-cut evaluation components built into the project from day one is critical to ensuring that the project collects the most important information in the most scientifically reliable manner. It also distinguishes between essential and nonessential evaluation components.

Potential for Replication

The HeartNet model could work well in other rural settings. Evidence shows that worksite wellness and parish nurse programs can be effective in promoting healthy behaviors and reducing health care costs for employers. Simpler, volunteer-based, grassroots efforts also can be effective in increasing awareness, strengthening health education opportunities, and maintaining health-positive

behavior change. The primary challenge that similar programs might encounter involves developing and sustaining health teams. As time passes, volunteers may lose their enthusiasm or become frustrated by the lack of available resources to support their efforts. It is essential that such teams have a capable and qualified individual to whom they can turn for support, direction, and leadership. In addition, it is important to provide the teams with as many resources as possible to support their work.

After the Grant

Several sites have continued to offer regular blood pressure screenings at their churches, and others have committed to providing a regular exercise class taught by a member of the congregation. To help sustain such activities, each health team received a “Coordinator’s Tool Kit,” which is essentially a wellness kit in a binder. The binders contain the resources and tools necessary to implement health education programs in a community group environment. In addition, each health team was encouraged to select a realistic number of programs from the tool kit to implement over the course of a year.

The program will continue to provide ongoing support to the teams through Alpena General Hospital’s Community Health and Education Department, including community-based site coordinators, educational opportunities for team members, and informational resources from the Health Resource Center Library to be used in community education efforts.

PROJECT 30—DIABETES LAY EDUCATOR PROGRAM: ENHANCING HEALTH CARE FOR HISPANIC MIGRANT FARMWORKERS

Community Characteristics

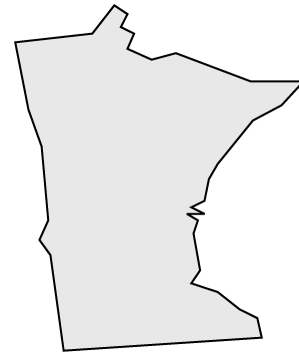
Recent studies indicate that the prevalence of type 2 diabetes among the U.S. Hispanic population is 3 to 5 times higher than in the general population. Poor housing, limited sanitation facilities, inadequate diet, and substandard health care put migrant Hispanic farmworkers and their families at greater risk for chronic health problems than the general U.S. population. Although migrant Hispanic farmworkers are essential to the agriculture industry, they rank among the most disadvantaged, medically underserved populations in the country.

The Diabetes Lay Educator Program was designed to reduce the high mortality rate and medical costs associated with diabetes in the area's Hispanic population and to increase access to high-quality, culturally competent health care services geared toward helping clients effectively manage diabetes. The project targeted Hispanic farmworkers in northwestern Minnesota and eastern North Dakota between the months of April and September, and those working in southern Texas between the months of October and February.

Services Offered

Health care and education services targeting the Hispanic population were based on American Diabetes Association standards of care. Continuing education services were offered to health care providers to increase cultural sensitivity and to integrate new research findings related to diabetes care. The project network included Migrant Health Services, Inc., which provided fiscal and administrative management of the grant and 10 nurse-managed diabetes clinics in Minnesota and North Dakota; Altru Diabetes Center, based in Grand Forks, North Dakota; the Migrant Clinicians' Network in Austin, Texas; and the Moorhead Division of Continuing Education of Minnesota State University. Together, these organizations identified potential clients, provided personnel to conduct large-group educational sessions for clients, screened clients for diabetes and complications associated with diabetes, and used diabetes lay educators and medical professionals to meet the educational and health care needs of clients.

MINNESOTA



**DIABETES LAY EDUCATOR
PROGRAM: ENHANCING
HEALTH CARE FOR HISPANIC
MIGRANT FARMWORKERS
MOORHEAD, MINNESOTA**

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Innovative Solutions to Problems

The project was based on several innovations, which resulted in its being named the outstanding rural health program by the National Rural Health Association in 2003. The innovations included the following features:

- The project provided diabetes screenings, services, and followup care using a nurse-managed model of service delivery involving more than 300 health care providers in Minnesota and North Dakota. These services were provided by four seasonal satellite health centers, two seasonal mobile units (available 2 to 5 months during the year), and four centers providing year-round care to residents living throughout a 447-mile region spanning southern Minnesota and northeastern North Dakota.
- The model was largely access driven—it brought health care and education services to migrant farmworkers where and when they could access such services—after Mass on Sundays, in the evenings, at the camps where they lived near the fields, into their homes, and into the States where they traveled for work.
- The project provided a single, yet comprehensive, source of care by offering screening and monitoring services, treatment, and referral services, as well as education, psychosocial support, and self-management education in the areas of nutrition, exercise, weight control, dental hygiene, foot care, and eye health.
- The diabetes lay educators provided culturally and linguistically appropriate care for the client population, including providing transportation services and consulting with health care providers. The project also provided continuing multicultural education for health care providers through professional conferences.
- The project provided care in a collaborative manner by coordinating the schedules of nurses, an ophthalmologist, a nutritionist, a dental hygienist, foot-care specialists, a diabetes educator, and other service providers so that they could provide care in client-convenient settings.

Results

The project served a total of 6,765 individuals, with adults between the ages of 18 and 64 and children between the ages of 0 and 12 being the largest age groups served by the project. Some 700 individuals received diabetes screenings through the course of the project. Another 180 individuals participated in diabetes complications clinics. The diabetes lay educators provided 526 educational encounters and 420 case management encounters, with 66 individuals receiving both education and case management services. As of February 2003, 1,168 patient entries were recorded in the project database, and outcome data were generated for 475 patients. The project succeeded in achieving its goals, which were to (1) provide preventive diabetes screening and education to migrant and seasonal farmworkers, (2) identify clients with diabetes and obtain baseline assessment data, (3) provide diabetic clients with preventive health care and education services through diabetes lay educators and professional health care staff, (4) improve quality of care and continuity of services for clients, and (5) evaluate the development and implementation of all project activities. The project could not have been successful without the collaboration and cooperation of the network members.

One of the lessons learned through the Diabetes Lay Educator Program was that health care and education services often must be delivered in less than ideal settings. Another lesson learned was that providing culturally sensitive care requires listening to the input of representatives from the target audience—in this case, diabetes lay educators and clients served by the project.

Potential for Replication

The health care service and education components of this project could be applied in other rural settings and could be adapted to other populations (e.g., American Indians). Meeting the needs of the Hispanic population with diabetes requires effective, two-way communication between Spanish-speaking clients, service providers, and the loved ones of clients. In addition, this model works best when information is provided to clients in both English and Spanish. As with many service delivery programs, implementing this model involves guarding against “turf” issues and “superiority complexes” among providers and agencies involved in the network.

After the Grant

Migrant Health Services, Inc., has provided the financial support necessary to extend the project's services for a fourth year. The network partners and evaluators are working in tandem to prepare an application for funding from the National Institutes of Health for a longitudinal study of the effectiveness of a self-management model for diabetes, cardiovascular disease, and depression targeting migrant and seasonal farmworkers.

Community Characteristics

ElderLynk was established to reduce the stigma associated with mental illness and to build awareness of the mental health needs facing rural senior citizens in a 10-county region in northeast Missouri. Before the establishment of the ElderLynk program, mental health services in the region were severely fragmented. Mental health and primary care programs in the service area did not coordinate their services, and mental health care providers were not adequately distributed in the area. The region had limited resources for conducting outreach to engage individuals needing mental health care. All 10 counties in the region were designated as mental health shortage areas, geographic/low-income health professional shortage areas, and medically underserved areas.

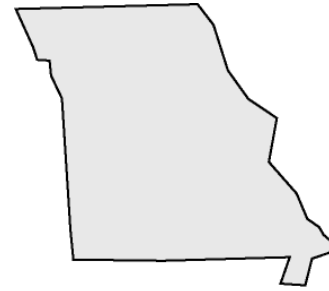
Services Offered

The ElderLynk consortium included six health education and service providers:

- Kirksville College of Osteopathic Medicine, a rural medical school
- Northeast Regional Medical Center, a 109-bed regional hospital and health system
- Northeast Missouri Health Council, a federally qualified health center (FQHC)
- Mark Twain Area Counseling Center, an outpatient mental health care provider
- Preferred Family Healthcare, an outpatient and residential substance abuse and behavioral health care provider
- Hospice 2000, a comprehensive end-of-life care provider

The primary goals of the project were to implement a locally accessible and seamless mental health delivery system that was coordinated and integrated with area primary health care services and targeted to elderly patients; to provide community education to reduce the stigma associated with mental illness; and to provide professional education to strengthen health care workforce capacity to serve elderly residents.

MISSOURI



ELDERLYNK
KIRKSVILLE, MISSOURI

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Innovative Solutions to Problems

ElderLynk used a case-management model of care that included an interdisciplinary team of professionals who provided treatment planning and ongoing geriatric education. Led by a case manager, the team included a psychiatrist, psychologist, and two counselors. The range of services offered in each community throughout the region varied, depending on each community's unique mental health service needs. The project director and case manager visited the communities on a regular basis to establish personal relationships with area physicians and to offer continuing medical education opportunities.

Results

ElderLynk provided a seamless continuum of locally accessible mental health care to 285 elderly residents in the service area. It was the catalyst for promoting collaboration among area providers and bridging the gaps in existing mental health and primary services. In the end, the project gave elderly residents access to high-quality, community-based mental health services. It also created an infrastructure for providing mental health services to the elderly residents of northeastern Missouri.

Collaboration between partner organizations and area providers occurred on several levels. Primary care providers and FQHCs established contracts with mental health professionals to provide mental health care for their elderly patients. The project developed an interagency joint training program for community health care workers on how to access area mental health treatment resources. The project also played an important role in establishing the Northeast Missouri Psychology Association and in promoting the availability of behavioral health care services at the Northeast Regional Medical Center.

Perhaps the best evidence of the project's success was its ability to begin establishing a core, dedicated team of professionals working for ElderLynk. The project was able to establish two postdoctoral training slots for psychologists, which began in September 2003. It also recruited two social

workers to provide billable services for the ElderLynk program.

Potential for Replication

The project's experience has shed new light on the key ingredients for success in implementing such a model. These ingredients include tapping the expertise of experienced and knowledgeable consultants; convening at least one initial and one followup retreat to bring the partners together to establish a shared vision for the project and to encourage communication and relationship-building; remaining flexible in working with local health care providers; clarifying how participation benefits providers themselves; and having strong project leaders who are wholeheartedly committed to the project's mission. An important challenge that requires careful planning is making such a project financially sustainable in an environment in which resources for health and social service programs are on the decline.

After the Grant

In September 2002, ElderLynk received additional funding from the Substance Abuse and Mental Health Services Administration's Targeted Capacity Program. The additional funding allowed the project to expand its services to two other counties to begin screening patients in primary care settings using the patient health questionnaire. This expansion allowed the project to begin receiving reimbursements for mental health services provided by postdoctoral trainees. The project is pursuing other funding opportunities to sustain and expand project services.

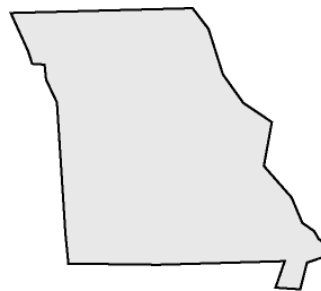
Community Characteristics

Barton, Cedar, Dade, Dallas, Hickory, Polk, and Vernon Counties, located in southwest Missouri, span 4,700 square miles and have a population of 103,170 residents. Before the Miles for Smiles project was developed, a comprehensive community resource appraisal revealed that many children living in this seven-county region were not receiving adequate dental care. The children who were most at risk for not receiving dental services were children covered by Medicaid and those who had no health insurance at all. In fact, at the time of the grant award, no dentists in the seven-county region were accepting nonpaying or Medicaid patients, even if those patients were children.

Services Offered

The mission of the Miles for Smiles project was to create a mobile dental unit to provide quality, onsite dental care to low-income children in the seven-county area. The project was built on the collaboration of a 40-member task force that included representatives of local human service agencies, health care organizations, businesses, the education system, local media, governments, and private citizens. Through this collaboration, the organizations worked in tandem to ensure that all children in the region had access to a comprehensive array of dental services, including dental screenings, oral examinations, x-rays, cleanings, sealants, fillings, extractions, oral health education, and other dental services (e.g., scaling, root canals, space maintainers, and stainless steel crowns). The project was originally designed to serve kindergarten through eighth-grade children who did not have adequate health insurance or were covered by MC+, a State-sponsored insurance program for low-income families. However, because of a large demand for dental services for children aged 3 to 5 years, the project expanded its scope so that these children also would have access to dental services.

MISSOURI



**MILES FOR SMILES
BOLIVAR, MISSOURI**

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Innovative Solutions to Problems

The two-operatory, fully equipped mobile dental clinic was staffed by a full-time dentist, two full-time dental assistants, a truck driver, and a project coordinator. The clinic provided dental services at 28 school districts during the school year and at 7 county health departments during the summer months. School nurses were responsible for notifying parents about dates the clinic would be at their child's school and for mailing consent forms to parents. Once the consent forms were returned to school nurses, they were responsible for scheduling appointments.

Results

Since the project had difficulty recruiting a full-time dentist to staff the mobile clinic, Miles for Smiles did not provide dental care to as many children as it had hoped during the first year of the project. However, once the dentist was hired, the project served 350 children during the first year, 1,798 children during the second year, and 2,192 children during the third year—for a total of 4,340 patients. In all, the project provided 1,544 cleanings and fluoride treatments, 5,600 fillings, 4,069 sealants, 672 extractions, and 234 pulpotomies.

Potential for Replication

Rural children often lack access to dental care, so the Miles for Smiles model could be useful in many rural communities. In fact, staff members involved in this project have worked with other local communities, as well as programs in other States, to provide assistance in planning and implementing similar projects. Local health departments and State welfare agencies are in an excellent position to publicize such a program to Medicaid-eligible and low-income families. However, other communities should be aware that recruiting a full-time dentist to participate in such a project can be a difficult task. In this case, the project was able to engage a volunteer dentist until a retired dentist ultimately agreed to work in the mobile clinic.

After the Grant

The Miles for Smiles project has received two new grants from the Missouri Foundation for Health. The first grant of \$150,000 has been used to purchase a new, self-contained mobile unit and to expand project services to five additional counties. The second grant of \$1.3 million will cover the project's operational expenses for the next 3 years and will allow the project to hire new staff, including a dental hygienist to implement a new oral health prevention and education program.

Community Characteristics

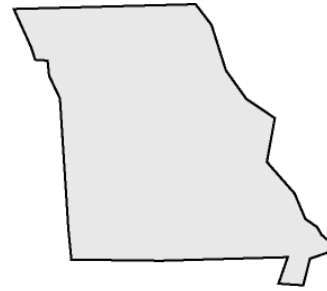
The demand for primary health care services in a three-county region in southeast Missouri was so great that area Medicare and Medicaid beneficiaries, uninsured individuals, and those living below 200 percent of the Federal poverty level had virtually no access to health care. Working families found it difficult to access care because area clinics typically closed at 5 p.m., forcing them to seek after-hours care at emergency rooms. In addition, the area's poorest residents often exhibited unhealthy lifestyle behaviors, underscoring the need for community-based prevention education. The three-county service area also had a large number of elderly residents who experienced numerous barriers to health care. As a result, it is no surprise that two of the counties targeted for this project—Stoddard and Bollinger Counties—were medically underserved areas, and the third county, Cape Girardeau County, was designated as a medically underserved population.

Services Offered

The Cross Trails Medical Center (CTMC), a federally funded community health center that serves all three counties, used grant funds for expanded evening hours in the towns of Marble Hill and Advance. Grant funds also were used to increase access to care for the target population. These services included collaborating with Southeast Missouri Hospital to provide a range of podiatric services, such as wound care, diabetic foot assessments, and orthotic fittings. A nurse educator was hired to provide patient education on a variety of topics, including diabetes education, smoking cessation, heart disease, podiatry, and nutrition. CTMC providers referred patients to the nurse educator, who was available to meet with them on an individual basis to discuss their unique health care needs.

Some patients served by CTMC have Medicare, Medicaid, or private insurance coverage, while others qualify for the center's sliding fee scale. However, the majority of CTMC patients are uninsured, underinsured, working poor, or indigent.

MISSOURI



**RURAL HEALTH OUTREACH
CAPE GIRARDEAU, MISSOURI**

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The organizations involved in the project consortium included CTMC, Southeast Missouri Hospital, Sainte Francis Medical Center, and Southeast Missouri State University. CTMC managed grant activities, while Southeast Missouri Hospital provided foot care professionals and health educators. Southeast Missouri State University provided graduate students to offer patient education, and Sainte Francis Medical Center offered onsite bone mineral density screenings.

Innovative Solutions to Problems

Expanding clinic hours enabled working patients to access services at a time that was more convenient for them. Another innovative feature was the project's health education component. The nurse educator and professionals from Southeast Missouri Hospital met with patients and provided one-on-one counseling that was responsive to the individuals' unique health care needs. They worked with patients to educate them on their medications and the importance of good nutrition—at no cost to the patient.

The onsite bone mineral density screening service was not in high demand among area residents; as a result, the project elected to cover the cost of the screenings for patients referred to Sainte Francis Medical Center.

Results

Expanding clinic hours required rescheduling and hiring additional staff members, but, in the end, clinic services were more accessible for area residents. The nurse educator completed requirements to become a certified diabetes educator and is qualified to provide one-on-one counseling on diabetes, nutrition, heart disease, stroke, and weight management. Through CTMC's collaboration with Southeast Missouri State University, the project observed improvements in patients' weight loss and in their blood sugar and lipid levels. Patients also learned the skills they needed to manage their own health more effectively.

One of the most important lessons learned as a result of the Rural Health Outreach project was that if patients want to improve their health, they must be willing to make lifestyle changes and to adhere to the prescribed plan of care. The best

approach is to make patients aware of the services available to them and to allow them to access those services once they are “ready” to receive care. The project also recognized that patients are more receptive to one-on-one education than to education offered in a group setting. In addition, the project revealed the importance of flexibility in handling the education needs of elderly patients, children, and those with low literacy skills.

Potential for Replication

The strategies implemented by CTMC could be easily duplicated in other rural settings. Expanding clinic hours requires progressive thinking on the part of program planners and staff members. However, once the project was implemented, the clinics were self-sufficient, and patients had access to the services they needed at a time that was convenient for them.

The health education component of the Rural Health Outreach project was a resounding success. Staff members were pleased to be able to refer patients to the nurse educator, and patients benefited from having someone to talk to about their health needs on a one-on-one basis.

After the Grant

All grant activities will be continued as planned. Medicare and Medicaid reimbursements, insurance coverage, and patient payments will support project services.

Community Characteristics

Butte is a poor, blue-collar community with a population of 33,000 people. Historically, Butte is a mining community. Many residents have become caught up in the unhealthy life patterns of violence, alcohol and other drug use, and tobacco use. Health care services are extremely limited, especially for low-income residents who exhibit high rates of these destructive behaviors.

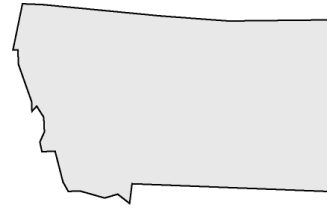
The Butte Community Health Center is a nonprofit federally qualified health center that has served the Butte community for more than 17 years. Mental illness has been the third most frequent diagnosis at the center; mental health and addiction problems remained a glaring, unmet need in the community.

Services Offered

The service area for this project was the community of Butte, the only community in Silver Bow County. The main goals of the project were to (1) change destructive life patterns and improve the physical and mental health status of residents by providing intensive mental health services, parent education and support, case management, and substance abuse counseling, (2) promote collaboration among key health and social service agencies in providing comprehensive services and reducing duplication of effort, and (3) educate community members about how, when, and where to get help when they need it. To meet these goals, the project focused its efforts on increasing community awareness, supporting training opportunities throughout the community, and using a care team approach that often consisted of a case manager, a licensed mental health therapist, an addiction counselor, a parenting coach, and other service providers. Together, the team serving each family developed a proactive living plan (PAL) that outlined the family's service needs and specific goals to achieve each month.

Ten organizations joined forces to support the project—the local hospital, the county health department, the public school district, the public housing authority, child protective services, the juvenile probation department, a battered persons

MONTANA



**BUTTE SILVER-BOW
PRIMARY CARE CLINIC
BUTTE, MONTANA**

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shelter, the local college, Head Start, and the local mental health center.

Innovative Solutions to Problems

Since the primary care clinic was a demonstration project, evaluators monitored the project's success in improving the health behaviors of patients. Innovative approaches to increasing the project's success included the following:

- Using treatment/service teams from various community agencies and involving those providers in monthly family/team meetings
- Providing a \$50 food or clothing voucher to families that succeeded in making the desired behavior changes
- Holding monthly steering committee meetings to update provider agencies on program operations and client progress
- Providing annual training opportunities for community agencies to help them collaborate more effectively and to cultivate a community-based system of care

Some of the major challenges encountered by the project were the scarcity of reimbursement sources for behavioral health services; the intensity of the model and the resources necessary to make it work; dealing with the long-lasting effects of addiction on families; recognizing that not all people are ready to change their lives at the time services are offered to them; and facing the fact that financial incentives for families are not necessarily enough to result in behavior change. Another major challenge was the intensity of case management services needed by families and the expense associated with having enough case managers on staff to coordinate services for families. Unfortunately, the project was forced to eliminate case management positions at the end of the grant period.

Results

Over the 3-year grant period, the project served 1,467 clients. During the first 2 years of the project, more than 200 families received some level of service, including

monthly team meetings with providers. In the third year, the project altered the model to focus more on individual client services and less on services for the whole family, which proved to be more effective in yielding positive changes in the lives of individual family members. In the first year of the grant, 37 percent of clients made moderate to significant improvements compared with 47 percent in the second year and 68 percent in the third year. Approximately two-thirds of the clients served were uninsured and had no other resources for care, and 84 percent were low-income individuals.

The project evaluation, which was conducted by a local college, revealed that the most important factor in generating behavioral change was the contact clients had with clinic staff members—not the monthly team meetings. This finding was a major reason why the project disbanded the monthly team meetings approach and moved toward an integrated behavioral health model, using licensed mental health therapists who attended the client’s primary care appointments with the medical provider.

Potential for Replication

Other communities considering replicating this model should be aware of the labor-intensive aspect of treatment for mental illness and addiction. A program must have an ample supply of qualified providers, support staff, volunteers, and funding. It also must identify strategies for covering treatment costs, because such services are not always reimbursable in rural areas.

After the Grant

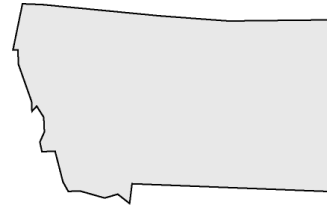
During the third year of the project, the clinic was awarded a grant from the Bureau of Primary Health Care to expand the clinic’s mental health services. However, because the funding was \$50,000 less per year than the project grant, the project was forced to reduce its case management resources by two positions. However, the Butte Silver-Bow Primary Care Clinic continues to provide integrated mental health and addiction services to individuals and families, and community agencies continue to collaborate to meet each family’s unique needs.

Community Characteristics

Nestled in the eastern slopes of the Rocky Mountains, Park County, Montana, is a designated frontier region that lies north of the entrance to Wyoming's Yellowstone National Park. The county's population of 15,694 people is scattered across 2,656 square miles—similar to the size of Rhode Island. Residents often live far away from the health care services available in the county seat of Livingston and must endure dangerous driving conditions to access medical care. At the time of the grant award, Mammoth Hot Springs in Yellowstone National Park housed a small clinic, with about 70 percent of its patient base living in Park County's southern region. Patients requiring more advanced medical care were often referred to health care facilities in Livingston. In addition to the Mammoth clinic, a federally qualified rural health clinic and a critical access hospital, both of which are located in Livingston, served as the primary source for health care involved in the Park County Diabetes Project. The core provider base in the region included six family practice physicians, two internal medicine physicians, and several nurse practitioners and physician assistants who were available to participate in the project.

The vast majority (99 percent) of Park County's population is Caucasian, and a significant portion of these residents are Medicare-age individuals. More than one-third of the county's residents live at 200 percent of the Federal poverty level. The county ranks near the bottom in national wage scales and relies on a service-based economy, which forces many families to maintain several incomes in order to survive the high cost of living in a tourist region. In addition, the incidence rate of diabetes in Park County in May 2000 was similar to the national rate of 6 percent, yet diabetes was the seventh leading cause of death in the State of Montana. The nearest endocrinologist was more than 100 miles from Livingston, and a single diabetes educator provided minimal services at the local hospital, serving approximately 20 to 25 patients per year. At the time of the grant award, limited information about diabetes and its associated complications was available to the public.

MONTANA



**PARK COUNTY DIABETES
PROJECT
LIVINGSTON, MONTANA**

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Services Offered

The Park County Diabetes Project was developed to instigate a formal process for identifying and tracking patients with diabetes, to coordinate health care services for residents with diabetes, to increase the knowledge of area health care and ancillary providers regarding diabetes management, and to provide diabetes education to patients and families. The project consortium, which targeted Park County and nearby Mammoth Hot Springs in Wyoming, included the Mammoth Clinic, the Park Clinic and its affiliate Livingston Memorial Hospital, the Community Health Partners Clinic, and the Montana Diabetes Project (a special program sponsored by the Montana Department of Health and Human Services). Each clinic offered diabetes education, provided by a diabetes educator, and resources for educating patients and families. Area providers involved in the project adopted the National Standards of Practice Guidelines for diabetes management and took advantage of professional educational opportunities made available to them. For example, six diabetes educators received extensive training in diabetes education. In addition, physicians, nurse practitioners, and physician assistants attended out-of-town advance training classes that focused on managing the complications of diabetes, as well as onsite education provided by traveling endocrinologists and diabetes specialists. Except for the A1c analyzer and the diabetes educator at the Mammoth Clinic, all of these services were made possible by the ORHP grant.

Innovative Solutions to Problems

The main feature of the project was the development of an electronic database designed to track key indicators related to diabetes control among patients with diabetes. The Montana Diabetes Project provided the database software and technical assistance on how to use the software. The project also provided advanced data analyses, developed training and patient education materials, and reported disease management progress compared with State and national levels. The database tracked patient outcomes over time, which enabled providers to access trended reports at each patient visit. A1c analyzers were located in Mammoth and Livingston and were

able to provide results within 8 minutes of testing. The database also offered the capacity to generate patient reminders for lab and office visits.

One of the biggest challenges for the Park County Diabetes Project was a dramatic increase in referrals for onsite diabetes education. Before this program, a single diabetes educator served 20 to 25 patients each year. Once area providers recognized the benefits of onsite diabetes education, referrals increased dramatically. Four months after the project began offering onsite diabetes education, referrals rose to 151 clients, which required more than 600 hours of one-on-one education with clients. To address this need, the project stepped up its timeline for producing a diabetes education curriculum and developing a format for group education. The project invested a great deal of effort in a short period of time toward finalizing the curriculum, identifying effective presentation methods and documentation tools, and establishing data collection and analysis procedures. The project's curriculum was recognized by the American Diabetes Association in November 2002.

Results

By the end of the no-cost-extension period, the project estimates that approximately 500 patients will be tracked through the electronic database. More than 6,500 people will have received diabetes screenings at local health fairs, and nearly 260 people will have received community foot screenings. Approximately 200 patients received individual diabetes education during each year of the project, and about 180 people will have participated in group-oriented diabetes education. Diabetes prevention materials were distributed to approximately 140 teenagers, and about 150 area health professionals will have received some form of diabetes training. In addition to achieving reductions in many patients' blood glucose levels, many patients experienced decreases in their blood pressure levels and increased their use of aspirin to reduce their risk for heart attacks and strokes.

Potential for Replication

Project outcomes suggest that the Park County Diabetes Project can be a best practice model for diabetes management in rural areas. It also could serve as a model for managing any chronic disease, provided that sufficient funding is available to organize, implement, and evaluate such projects. If a community plans to use this model for the purpose of diabetes education, then it would be wise to be recognized by the American Diabetes Association so that the program can be reimbursed by third-party payors. However, case management services are not yet reimbursable, so other communities will need to take that fact into account and have additional funding sources specifically for the purpose of case management.

After the Grant

Although the no-cost extension makes it possible to extend services beyond the original grant period, the reduction in annual funding will require more in-kind support from the consortium members and a reduction in services. The Community Health Partners Clinic has hired the diabetes educator assigned to the clinic and increased her hours to meet the increasing demand for education services. Two of the consortium members are seeking new funding opportunities so that services can be expanded. The Montana Diabetes Project will continue to upgrade the database software and provide technical support when necessary. The supportive relationship between the three clinics will continue, though at a decreased level of involvement.

Community Characteristics

Violence can take many forms. Data from the Nebraska Health and Human Services System show that, in an average month in 1997, 3,500 Nebraska children (7.9 per 1,000) were in out-of-home care. An average of 9.2 of every 1,000 children aged 18 years and younger were victims in substantiated cases of child abuse or neglect in 1997. In addition, there were 73,851 crisis calls to domestic violence agencies and 7,017 new contacts reported by these agencies in 1996.

To address these issues, the Family Advocacy Network (FAN) elected to tackle the difficult challenge of domestic violence and sexual abuse, which can happen to anyone at anytime regardless of age, gender, race, or socioeconomic status.

Services Offered

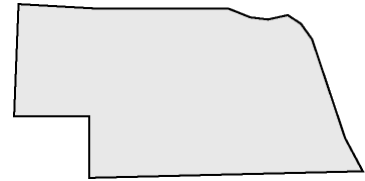
The service area for the FAN project included a 32-county area in west-central Nebraska and northern Kansas, a region that spans 28,613 square miles and has a population of 195,088. Organizations involved in the FAN network included Good Samaritan Health Systems, the Kearney Police Department, Nebraska Department of Health and Human Services, Buffalo County Domestic Violence, Buffalo County Sheriff's Office, University of Nebraska Medical Center College of Nursing (Kearney Division), SAFE Center, Area Agency on Aging, Multicultural Human Development, Nebraska State Patrol, county attorney offices, and other law enforcement agencies in Buffalo, Custer, Dawson, Phelps, Franklin, Harlan, Kearney, Red Willow, and Hitchcock Counties.

FAN was established to achieve two primary goals: (1) to raise community awareness and educate providers about child abuse and domestic/sexual violence and (2) to establish the FAN center as a coordinated response agency for victims and their families. FAN's response focused on obtaining the client's psychosocial history, interviewing the client, conducting medical examinations, and coordinating care for the client. The ultimate goal of the project was to prevent revictimization of the client by providing the full range of services and supports the client needed.

Innovative Solutions to Problems

Before this project, agencies and organizations involved in health, domestic/sexual violence, and child abuse in central Nebraska had rarely collaborated to meet the needs of victims of

NEBRASKA



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violence. FAN addressed and overcame this barrier by engaging a diverse array of area organizations in sharing ideas, expertise, and resources that could help victims of violence. Another major barrier was the distance victims of violence had to travel to receive help. Using telemedicine technology, FAN conducted 43 interviews with victims of violence.

Results

Nearly 350 children and teenagers received services through FAN. In addition, 19 adults received care. FAN also convened two 1-day conferences and several miniconferences that involved area law enforcement personnel, health and human service providers, schools, and other agencies. In addition, network members provided training to rural counties, and FAN provided scholarships to dozens of professionals to attend training opportunities. In all, 2,000 individuals in rural Nebraska received training in domestic violence and sexual abuse.

Potential for Replication

FAN would not have been successful had it not been for key critical features of the project. Telemedicine technologies, which were made available to the project by the Mid-Nebraska Telemedicine Network, made a significant difference in the project's success. FAN used the network to facilitate nearly 50 forensic interviews in the project's service area. In addition, telemedicine enabled FAN to link with other sites in metropolitan areas (Atlanta, St. Paul, Portland, and Sioux City) for education and technical support.

Other communities that want to replicate this model should consider linking with an established regional program that is recognized and accepted throughout the target service area. In this case, much of FAN's success could be attributed to Good Samaritan Hospital's outstanding reputation throughout the service area. It also is important to have a clearly defined strategic plan for reaching victims living in remote rural areas. Again, telemedicine technologies offer the capacity to address this need.

To help ensure the project's success, network members should agree to commit financial resources to the implementation and continuation of the project. Without their initial and continued financial support, the project may not be sustainable.

After the Grant

FAN will continue to provide professional education opportunities, forensic interviews, and medical exams to clients. The project's activities will be sustained by several local, State, and national sources.

Community Characteristics

The Frontier Youth Initiative (FYI) originally was conceived as a response to the loss of funding for school nurses in a nine-county region of north-central Nebraska (Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties). These counties span more than 14,000 square miles of frontier terrain and are home to more than 13,000 school-age children in over 100 school districts. There are 55 communities with 11 hospitals and about 25 physicians.

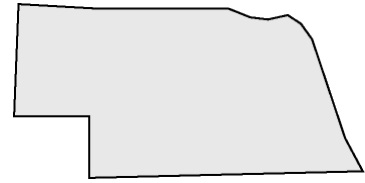
Lack of funding amplified the shortage of health services available to school-age children in this medically underserved area. Health indicators showed that students in the region had deficiencies in completion of regular wellness examinations, as well as the health promotion and disease prevention education available as part of their school curricula. In addition, students experienced high rates of unintentional injury and death, exhibited high rates of tobacco and alcohol use, and had insufficient insurance coverage for wellness services.

Services Offered

The FYI partners included Educational Service Unit (ESU) #17, ESU #8, two community action agencies (Central Nebraska Community Services and Goldenrod Hills Community Action), and the North Central Community Care Partnership (NCCCP). FYI offered wellness exams, health checks, and immunizations to school-age children. Local nurse practitioners, physician assistants, school nurses, and community action agencies delivered these services. A portion of the grant funding was set aside so that school nurses could attend workshops and conferences on a variety of topics ranging from bioterrorism and legal issues to diabetes and asthma. In addition, school personnel and community members were offered workshops on wellness exams, health communities, tobacco cessation, and other public health topics.

The project sponsored the FYI Youth Summit, which provided an opportunity for area students to create action plans for promoting healthier lifestyles for students and their larger communities. The project also developed a series of brochures on a range of topics, including nutrition, stress, tobacco use, alcohol and other drugs, sexually transmitted infections, and sexual harassment.

NEBRASKA



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Innovative Solutions to Problems

School-based health clinics were not the norm in north-central Nebraska, so this model was an innovative approach to promoting wellness and preventing disease. Many school administrators were leery of the concept of providing these services in their schools. School locker rooms, nurses' offices, and kindergarten rooms served as the sites for wellness exams. Monies generated from these fee-for-service health checks were returned to the participating schools to help support school nursing and other health programs.

FYI originally had planned to use a sliding fee scale for children from low-income families, based on income and third-party reimbursements from Medicaid and/or the State Children's Health Insurance Program (CHIP). However, the project was unable to implement the sliding scale because it did not receive Title V funds. Instead, the project was required to charge the full amount for health checks, or it would not be eligible to receive full reimbursement from Medicaid or CHIP. The cost of the health checks was too high for families not enrolled in either Medicaid or CHIP, and without private insurance, these families were unable to participate in the program.

Results

The resistance on the part of school administrators to participating in the project proved to be a formidable barrier; therefore, the FYI board decided to discontinue the health check clinics in September 2002. The project evaluation confirmed that more students and schools were needed to participate in the project for the effort to be successful and self-sustaining. Instead, the board decided to encourage schools to promote wellness programs, nutrition education, and increased physical activity among school students and staff members. Many schools began offering walking programs, and students and staff members at several schools joined forces to advocate for the introduction of milk and juice machines in their schools.

Key project accomplishments included the following:

- Sponsoring the FYI Youth Summit
- Offering a workshop on tobacco education and awareness, which was presented to school nurses, counselors, janitors, parents, public health workers, and a principal

- Contracting with the Buffalo Beach Company to launch an assessment of health risk behaviors across the nine-county area as part of the Youth Risk Behavior Survey
- Developing an FYI Web site, which provided health education materials, articles, and links to other health-positive sites

Potential for Replication

If communities can address the challenge of third-party reimbursements for wellness checks, this model could be successful in other rural areas. Eligibility for Title V funding is essential to receive full reimbursement from Medicaid or to offer a sliding fee scale for such services. It also is critical to obtain the full support of area schools early in the planning process.

After the Grant

Due to the success of the FYI Youth Summit, the NCCCP, the ESUs, and the newly formed North Central District Health Department will work together to plan another Youth Summit. NCCCP has volunteered to provide space to store tobacco cessation workshop materials and will offer additional training to area school personnel. In addition, the FYI Web site will continue to be available, thanks to a volunteer who will maintain and update the Web site on a regular basis.

Community Characteristics

Numerous national studies have indicated that older people have high rates of depression, and southwest Nebraska has a large aging population. Southwest Nebraska also has a dire shortage of primary medical and mental health services, underscoring the need for outpatient mental health services targeting the region's elderly population.

Census data from 1996 indicate that approximately 19,200 people live in a 4-county region of Frontier, Hayes, Hitchcock, and Red Willow Counties in southwest Nebraska. The target service area for the Rural BASICS (Behavioral Access Study Integrating Continuum Services) project also included Furnas County in Nebraska, northwestern counties in Kansas, and northeastern counties in Colorado, bringing the total population within the target service area to approximately 40,000 residents.

Services Offered

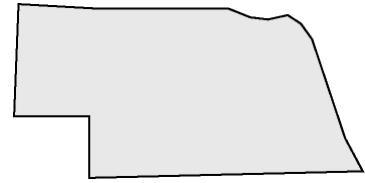
Mary Lanning Memorial Hospital provided clinical management for the project and shared financial oversight responsibilities with McCook County Hospital, which provided physical space for the clinic. In addition, Hillcrest Nursing Home provided consultation regarding the scope and effectiveness of the program.

Specific services offered by the project included outpatient psychiatric assessments, diagnosis, and treatment for mental disorders. The project also provided medication management for clients and ongoing psychotherapy for those in need. To locate potential clients, project staff members conducted outreach to various nursing homes throughout the area. However, mental health services offered by the project were available to people of all ages.

Innovative Solutions to Problems

Project staff members included a full-time master's level counselor, a full-time master's level social worker, and psychiatrists from Mary Lanning Memorial Hospital. However, the primary innovation of the project consisted of recruiting a full-time nurse practitioner who lived in the community. A local nurse practitioner who arranged for psychiatric assessments and provided medication management would be able to provide these services in a cost-effective manner. Unfortunately, recruiting a nurse practitioner and

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a social worker proved to be a difficult challenge in spite of wide-ranging recruitment efforts.

Results

Rural BASICS succeeded in developing and implementing a continuum of care that served individuals of all age groups and ethnicities. Its success can be attributed largely to the collaborative and cooperative efforts of the local medical community, Mary Lanning Memorial Behavioral Services, area nursing homes, schools, and community leaders. It is widely believed by those affiliated with the project that Rural BASICS succeeded in reducing the use of emergency medical services related to an underlying mental health problem. The project used media outreach—as well as meetings with local health care providers, nursing home administrators, schools, and health officials—to increase awareness throughout the community of the importance of mental health to an individual's physical well-being. The project also made an important contribution to increasing the availability of mental health services throughout the target service area.

Potential for Replication

A project such as this requires substantial, broad-based planning and networking that include the input of health care facilities and organizations in the community, as well as the input of established mental health care providers. Many rural communities experience a shortage of mental health services, so this model could help meet an important, yet unmet, need in communities across the Nation.

Communities that are considering replicating this model, however, should be aware of how difficult it can be to recruit qualified professionals to provide mental health services. For Rural BASICS, it took nearly 3 years to fully staff the project. Fortunately, the project was granted an extension through April 2004 so it could continue its work.

After the Grant

The activities that were started during the project period will be enhanced after the grant cycle. The McCook clinic is now fully staffed and plans to support the continued delivery of mental health care through patient copayments, Medicare, Medicaid, and insurance reimbursements.

Community Characteristics

Torrance County, New Mexico, which covers a larger geographic area than the State of Connecticut, is a designated health professional shortage area. In spite of its proximity to Albuquerque, the county retains a rural character, with much of the population living in unincorporated areas and land grant villages. Because the county has so few residents—many of whom are poor and undereducated with limited employment opportunities—it is difficult to recruit health care providers to set up practice there.

According to 2000 census data, 43 percent of county residents are ethnic minorities. People who live in Torrance County face a myriad of barriers to health care services, including geographic distance from health care services, inadequate infrastructure such as public transportation, a lack of health care providers, and cultural alienation. In addition, many residents do not know how to apply for public assistance, and even if they did, many would not qualify for public health care services such as Medicaid.

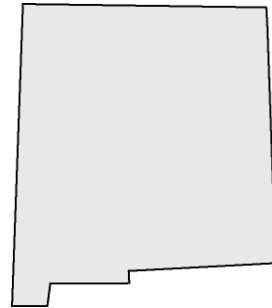
Services Offered

The Torrance County Rural Outreach Initiative targeted the county's two most vulnerable populations—children covered by Medicaid and the uninsured. The project emphasized four primary components: (1) education and support for families covered by Medicaid or without any health insurance, (2) a sliding fee for primary care services for those living in the northern portion of the county, (3) a sliding fee for behavior health services for residents in the northern section of the county, and (4) transportation to and from health and social services.

The project was guided by the Rural Healthcare Task Force, which was appointed by the Torrance Health Council, a grassroots, community-based group intended to address health care issues facing the residents of Torrance County. The Task Force's primary goals were to guide and oversee a restructuring of the county's health care system, to improve access to care, and to reduce the financial burden on clients, providers, and communities throughout the county.

The project consortium included the Torrance County Board of County Commissioners, which acted as the fiscal agent for the project; Presbyterian Medical Services, which was responsible for program oversight, staff supervision, and quality review for the

NEW MEXICO



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primary care and behavioral health components; the Torrance Health Council, which provided personnel for program oversight and review of the project's administrative and management plans; the Public Health Department in Moriarty, which provided referrals and assisted in designing the project's education and support components; Mary Ma, M.D., an area pediatrician who assisted in designing the program and implementing the primary care and behavioral health components; and Health Systems Development, which provided management, administrative support, and staffing for the program.

Innovative Solutions to Problems

One of the program's most innovative features was the education and support component, which targeted families covered by Medicaid and those with children covered by the State Children's Health Insurance Program (SCHIP). Many of these families were confused about how to access care; the confusion resulted from the statewide transition from a fee-for-service health care program to a managed care system. As part of the education and support component, the project also developed an easy-to-use guide, written at a sixth grade reading level, that provided helpful hints to parents enrolling their children in SCHIP on how to practice preventive care and how to access the full range of benefits available to them under the State's managed care system. In addition, the guide offered redeemable coupons to families who practiced preventive care. The project also developed an educational tool on how to navigate the State's managed care systems successfully—a tool that was embraced and used by the three managed care organizations providing care to Medicaid and SCHIP populations.

The project's sliding fee scale for primary care and behavioral health care services was a much-needed innovation in the northern region of the county, where no sliding scale systems were in place before the grant. The average cost per encounter for these services was \$35.71, which made accessing services significantly more affordable for many residents.

Another unique feature of the program was the Group Medical Appointment (GMA) model. As the project unfolded, it became clear that a large number of residents had chronic illnesses such as diabetes, hypertension, and high cholesterol. The GMA model

offered a way for patients to spend more time with providers in an education, group-oriented format, while still being able to receive individual assessment services. This approach also helped reduce provider burnout from repeating the same information for clients with similar health concerns. The model currently is being pilot-tested for providing prenatal care.

The project's transportation component was designed to address the biggest barrier to accessing health care for Torrance County residents. Through the project's consortium members, residents now have access to eight transportation providers, all of whom participate in a referral network to assist clients seeking care or assistance from multiple points in the health care system.

Results

The education and support component of the project was a resounding success. Nearly three-fourths of program participants complied with their immunization schedules, compared with a 61-percent compliance rate throughout the State. Ninety-five percent of clients were not reported for child abuse, and over the 3 years of the project, only five high-risk clients made emergency room visits.

The transportation program had a tremendous impact on decreasing the number of individuals using ambulance services as a form of transportation. The average cost to transport a client of this program was \$70 compared with \$150 for Medicaid and \$900 for ambulance services.

The primary care program filled a critical need for county residents and resulted in a federally qualified health center (FQHC) being funded and built in the area to serve county residents in the years to come.

The behavioral health component, however, was a challenging endeavor that was not successfully resolved. The project struggled to get the behavioral health specialist to think along the lines of treatment planning and reaching specific and achievable client goals. Instead, in many respects, services were provided with no end in mind. Some clients had more than 30 behavioral health visits.

Potential for Replication

This model could work well in many rural areas, especially those that have a strong community health council in place and those that are committed to a collaborative approach to addressing health and social service delivery problems. The GMA model also is directly relevant to providers and systems that serve a large number of individuals with chronic illnesses such as diabetes, hypertension, and high cholesterol. It is economically feasible and an easier approach for both providers and clients, and, at the same time, it ensures that all patients receive individualized assessments and care. Some of the challenges that might occur when replicating this model include unexpected licensing issues, the failure on the part of some providers to honor contractual obligations, successfully spreading the word about the project throughout the community, and sustaining the program beyond the initial funding period.

After the Grant

Primary care and behavioral health care services will be provided by the new FQHC, and the project is awaiting grant funding to sustain the education and support programs. If grant funding is not awarded, area managed care organizations have expressed an interest in contracting with the project to provide education and support services.

Community Characteristics

St. Lawrence County, New York, is home to 111,000 residents scattered over more than 2,700 square miles. The county's population density is 41 people per square mile. St. Lawrence County is primarily a rural and agricultural community, with population clusters in four villages—Canton, Potsdam, Messena, and Gouverneur—and the city of Ogdensburg. According to the *New York State Statistical Yearbook*, the per capita income in St. Lawrence County in 1997 was just over \$11,000 per year (about 60 percent of the statewide per capita income) and the second lowest income among the State's 44 rural counties. According to the St. Lawrence County Public Health Department, 43 percent of the county's population lived at or below 200 percent of the Federal poverty level. The region is a health professional shortage area and a New York State Department of Health-designated medically underserved area.

In 1998, a comprehensive community health needs assessment, a local survey, and planning retreats and focus groups with area residents and providers showed that many St. Lawrence County residents had undetected health problems, were without health insurance, and did not understand the importance of preventive health screenings or how to access such services.

Services Offered

The St. Lawrence County Health Initiative (SLCHI) served all of St. Lawrence County. The initiative involved a network of organizations that included the St. Lawrence County Public Health Department, Department of Social Services, Office for the Aging, North County Prenatal/Perinatal Council, Canton Housing Authority, State University of New York (SUNY) at Canton Nursing Program, American Cancer Society, Warner Cancer Treatment Center, Canton-Potsdam Hospital, and E. J. Noble Hospital. Supplemental network partners included Claxton-Hepburn Medical Center, St. Lawrence Psychiatric Center, SUNY Potsdam, United Helpers, Kinney Drugs, St. Lawrence County Community Services, and the Medical Society of St. Lawrence County.

SLCHI activities included an intensive education and outreach campaign to increase awareness of the need for and availability of preventive health screenings, a concerted effort to access points to

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network services for uninsured and underinsured residents, and the provision of followup and diagnostic testing for uninsured and underinsured clients with problematic screening results.

Innovative Solutions to Problems

The St. Lawrence Access to Care Program used several innovative methods to help achieve its goals. For example, SLCHI launched a targeted media campaign to educate the community about the importance and availability of preventive health screenings. The project worked with an area radio station to create a radio program called “You Can Feel Like a Million Bucks,” which was presented in a game show format. The program also used posters that featured the same tag line and television ads that featured local residents receiving preventive screenings.

Another innovative feature of the initiative was to offer 12 preventive health screenings each year at non-health-focused locations where the target population could be reached. These locations included church socials, neighborhood centers, hunting and sports events, and farm expositions. Volunteers from the public health department and hospitals, nurses, physicians, and physician assistants conducted the screenings. In addition, 26 screenings took place each year at area worksites. These screenings were available not only to employees but also to their spouses, family members, and other community residents. The worksites where screenings were offered included hardware stores, small manufacturing plants, and grocery stores. Individuals with positive screening results were offered followup care by participating physicians. In addition, the network’s hospitals provided more advanced diagnostic testing.

The project also used trained health advocates from the community who had regular contact with people who might need preventive screenings. Some of the project’s health advocates included beauticians, firefighters, business owners, and clergy. In addition, the project conducted a community telephone survey in fall 2001 and a series of focus groups in February 2003 to help inform project activities. The findings of these evaluation efforts assisted the project in assessing community and network satisfaction with the initiative’s services.

Results

During the grant period, 2,755 residents received free screenings at community gatherings and worksites. Of those screened, 125 uninsured individuals had positive screening findings and were referred for free diagnostic testing and followup care. Another 88 individuals who had health care coverage had positive screening results and were referred to their primary care practitioners for followup care. Health advocates made more than 300 documented referrals for health information and services. The project provided free followup care to more than 300 uninsured residents whose screenings pointed to a serious health care problem such as diabetes and high cholesterol. Likewise, the project provided free followup diagnostic testing, such as colonoscopies and biopsies, for people who needed additional care.

Potential for Replication

For this model to be successful in other communities, it is vital to have a diverse cadre of health care providers who vigorously support the project and are wholeheartedly committed to its goals. Broad-based community support also is necessary. Medical providers and hospitals must be actively engaged in the project to provide followup care and diagnostic testing; their commitment often requires providing such services at or below the Medicaid rate.

This model also relies heavily on volunteers and hospital staff to conduct preventive screenings in kind. The grant paid \$5 for each person screened for blood pressure, glucose, cholesterol, and body fat. This fee covered the cost of the test, but volunteers and generous health care professionals conducted the screenings at no cost. In addition, agreements with medical and specialty providers are needed to conduct in-kind Pap testing and prostate and colorectal cancer screenings.

After the Grant

The preventive screening services provided by this project will continue to be available to area residents, even though funding limitations may require some staffing changes. During the grant period, SLCHI was able to secure additional grant funding and to hire staff members to sustain the project's services. The SLCHI Worksite Wellness Program will continue to support community

PROJECT 40

and worksite screenings. However, the project is seeking new funding so that it can continue to provide followup care for uninsured residents who have positive screening results.

Community Characteristics

Children of low socioeconomic status living in the rural, mountainous regions of North Carolina have been found to have the most severe, untreated dental decay in the State. Children living in the MAYland (Mitchell, Avery, and Yancey Counties) region of western North Carolina are no exception. According to 1998–1999 North Carolina calibrated dental screening data, 30 percent of Mitchell County children entering kindergarten had untreated dental decay. The problem gets even worse in Avery and Yancey counties where dental decay rates are 41 percent and 37 percent, respectively. All three counties were well above the North Carolina State average of 23 percent. These data underscore the harsh reality that the MAYland region is plagued by limited access to dental health care resources.

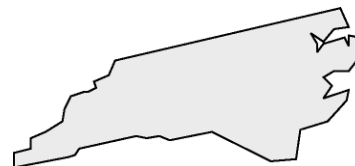
The MAYland region is part of the southern Appalachian Mountains. Like much of Appalachia, the area has experienced numerous economic challenges that have created lower incomes, higher unemployment rates, and higher rates of poverty than the State average. Nearly one-quarter of all children in the region live in poverty.

Services Offered

The Child Dental Health Initiative was designed to develop and implement a comprehensive, innovative approach to the delivery of dental services to low-income children living in the MAYland region. At the core of this initiative was the creation of the Toe River Children’s Dental Clinic, which made dental care available to children aged 0 to 18 years in the MAYland region who were covered by Medicaid or Health Choice, as well as children from low-income families without health insurance.

The initiative was supported by a strong consortium of agencies, including Spruce Pine Community Hospital, which agreed to manage and operate the clinic; Bakersville Community Medical Center, which leased a building for the project; the Mitchell-Yancey Partnership for Children, which provided startup and gap funding; and Toe River Health District, which agreed to retain knowledgeable and experienced staff for the project. The project also used grant funding to develop an outreach and education component to address the main causes of poor dental health among children.

NORTH CAROLINA



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Innovative Solutions to Problems

As a collaborative effort, the clinic was designed to integrate existing community resources in a more efficient and effective manner. This level of integration made it possible to provide more comprehensive dental health services, including treatment, education, prevention, and case management.

The clinic also used an unusual and innovative management structure. Although Spruce Pine Community Hospital was the administrative “home” to the project, the hospital administrator emphasized the importance of collaboration and community outreach. In addition to promoting community involvement and outreach to maintain the project’s visibility and to increase access to both inpatient and outpatient services, Spruce Pine Community Hospital allowed the dentist and office manager to determine the practice guidelines to be used in the clinic. The hospital also afforded the dentist and office manager the autonomy necessary to develop a successful, self-sustaining dental practice.

One of the biggest challenges the project faced was the number of “no shows” for dental appointments. In spite of the dire need for dental care among the area’s children, a large number of children failed to show up for their appointments. Grant funding made it possible to implement a case management component to assist families in overcoming barriers to accessing services (e.g., transportation). Addressing this challenge required the constant vigilance of project staff members.

Results

The Toe River Children’s Dental Clinic has had a powerful impact on improving the dental health of MAYland’s children. From August 20, 2001, to April 29, 2003, a total of 2,126 children became established patients at the clinic. Medicaid, Health Choice, or a sliding-fee-scale option for low-income, uninsured families covered the cost of care.

Another major project accomplishment was the way in which it addressed the need for extensive restorative care, which is done in an operating room setting with general anesthesia. The project obtained additional funding for this task, and Spruce Pine Community Hospital provided an operating room for such procedures. Graham Children’s Dental Program in Asheville entered into a contract with the hospital to provide extensive

restorative treatment at the hospital 1 day per month. Area children are now able to receive care at their local hospital rather than having to travel 75 miles for treatment. Unfortunately, the need for extensive restorative care is so great that the project must refer many patients to Asheville for treatment, and there is often a waiting period before a child can receive treatment.

By working with public health dental projects in the area and the MAYland Smart Smiles Project, the Child Dental Health Initiative was able to reach children and families with positive dental health messages and to provide the tools necessary to begin a lifelong habit of good oral care. North Carolina calibrated dental screening data show that the percentage of children with untreated dental decay declined in all three counties within the service area, whereas the percentage of children statewide with untreated dental decay increased slightly.

Potential for Replication

The key to successfully replicating this model in other communities would be to involve grassroots organizations in designing the project and to establish a strong partnership of organizations that possess the resources to implement such a model. It is important to be open and inclusive and to address the community's concerns early on in the development process. It also is important to involve representatives of the dental community in the project planning phase so that their experience can inform the selection of the most appropriate practice models.

Because of current dental reimbursement rates through Medicaid and the State's Health Choice program, obtaining additional grant funding through the Kate B. Reynolds Charitable Trust was vital to the project's success. This grant made it possible to purchase necessary equipment and to support building renovations.

After the Grant

Project planners believed that the Child Dental Health Initiative could be a self-sustaining endeavor if at least 80 percent of children served were covered by Medicaid or Health Choice and if the project met its expectations for productivity. This belief proved to be accurate. By the end of the funding cycle, project revenues offset operating expenses. However, additional fundraising, grants, and donations may be necessary to supplement project activities in the years to come.

Community Characteristics

At the time of the grant award, a 34-county region in west-central North Dakota had experienced both a declining population base due to outmigration and an increasing population of elderly individuals. Many residents lived too far away to access the few health care and counseling services available in the region. Only six counties in the State of North Dakota are not designated as medically underserved areas for behavioral health services.

Services Offered

The primary focus of the grant was to expand the number of behavioral health encounters by increasing the number of, and access to, behavioral health care providers. This goal was accomplished by training psychiatric clinical nurse specialists (an approach that has been used in other communities with demonstrated success) and by offering behavioral health services in primary care settings and nursing homes. Additional services included providing counseling services in a drought-stricken area and offering education sessions on behavioral health for staff members at rural health care facilities.

Sakakawea Medical Center (SMC), which is a 32-bed critical access hospital with an attached assisted living center, led the project consortium. SMC, the only hospital within a 70-mile radius, managed the grant and served as the fiscal agent for the project. The Rural Mental Health Consortium, a nonprofit organization started in 1992, provides behavioral health services to rural areas in North Dakota. St. Alexius Medical Center, a tertiary center located in Bismarck, offers an extensive telemedicine system with more than 25 video consoles strategically located in rural communities throughout the region. This system enabled the Behavioral Health Services Model Project to expand its reach to underserved rural residents and to provide access to a full range of medical providers.

Innovative Solutions to Problems

The project experienced several challenges during the implementation phase:

- The lack of people willing to pursue graduate education, especially since these educational opportunities were available only out of State

NORTH DAKOTA



**BEHAVIORAL HEALTH
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- The shortage of nurses in rural communities, which made it difficult for area facilities to accept the loss of a staff nurse during the 2-year graduate program
- The resistance of area psychiatrists to the prospect of collaborating in the network, supporting mid-level practice in rural communities, and driving to rural communities to provide services

Project staff members took several steps to address these barriers. The most effective response was to cultivate an ongoing dialogue with all partner organizations and members of the Northland Healthcare Alliance to increase awareness of behavioral health care needs in the region and to devise workable solutions to implementation challenges. Eventually, the University of North Dakota added a graduate program in behavioral health for nursing students, which may help to increase the number of nurses in western North Dakota with the requisite training to provide behavioral health services.

Many psychiatrists practicing in the area never completely embraced the idea of using mid-level professionals to provide behavioral health services, largely because mid-level providers generally were viewed as an economic threat to area psychiatrists. In addition, some of the tertiary care centers in the State opted to use family nurse practitioners instead of appropriately trained psychiatric mid-level professionals to provide mental health services.

Results

The project had five key goals:

- Increase the number of mental health encounters and consults in the 34-county region
- Decrease barriers and improve access to mental health care services for rural residents
- Provide coordinated behavioral health education and improve quality of life for rural residents
- Improve outcomes for major chronic behavioral disorders affecting rural residents by increasing access to qualified providers via telemedicine
- Improve the database of outcomes and research available about mental illness and behavioral disorders among rural

North Dakota residents so that providers can enhance quality of care

Because the program started late, project outcome data have not yet been completely collected and analyzed. The project has succeeded in educating providers and communities about the need for behavioral health care services among rural residents and the potential to integrate such services into primary care and nursing home settings. The certified advance-practice nurses who received training as part of the grant will be valuable assets in expanding behavioral health care services throughout the 34-county region.

The most important lesson learned as a result of the project was the need for establishing formal agreements among participating partners and providers. Such agreements should clearly define the expectations for each partner organization and participating provider to avoid confusion during the implementation phase.

Potential for Replication

With appropriate support and planning, this model could work well in other areas. Mid-level providers can be valuable assets in meeting the needs of rural residents as long as they receive the necessary training to provide behavioral health services. However, program planners must develop specific strategies for engaging psychiatrists in similar networks and generating support among psychiatrists for the concept of infusing mid-level providers into the service delivery system in a way that does not threaten their practice. Another challenge is the behavioral health reimbursement structure and the difficulty associated with generating the necessary volume of patients to create a viable behavioral health care practice.

After the Grant

SMC applied for and received a 12-month, no-cost extension that will allow a second individual to attend graduate school—this time via the Internet—at the University of Missouri. The no-cost extension also will enable the Behavioral Health Services Model Project to continue at an area nursing home. The student who completed her graduate program in behavioral health will soon begin practice as a reimbursable provider, which will increase access to behavioral health services for residents in the region.

Community Characteristics

Wishek Community Hospital and Clinics (WCHC) is located in a federally designated medically underserved area and health professional shortage area. WCHC consists of a 24-bed critical access hospital, 3 rural health clinics, 5 part-time outreach clinics, and a home health agency. Established in 1954, at the time of the grant award, WCHC was the largest employer in McIntosh County, with 133 employees. The active medical staff included three general practitioners, three physician assistants, and several visiting specialists. These and other providers served WCHC's four-county area. In addition to the WCHC, rural health clinics are located in Napoleon (28 miles from Wishek) and Kulm (32 miles from Kishek).

The service area for this project covered four counties in rural North Dakota (McIntosh, Logan, and portions of Emmons and LaMoure Counties), which are home to about 6,500 residents. At the time of the grant award, agriculture accounted for 55 percent of the region's economic base. Many family farms were failing each year, and the farms that were managing to stay afloat generally had to rely on income from off-farm jobs to supplement limited farm earnings. Census 2000 data revealed that McIntosh County had the highest proportion of people aged 85 years and older among the Nation's 3,142 counties. North Dakota also had the highest proportion of elderly residents in the Nation.

Services Offered

WCHC joined forces with MedCenter One Health Systems, McIntosh District Health Unit, Wishek Drug, and Napoleon Drug to expand access to essential health care services, to improve the coordination of those services, and to reduce health care costs. The project was designed to promote preventive care, early detection, chronic disease services, and support services as a means to improve the health and well-being of residents throughout the service area. Specifically, the project's four goals were to

- Provide preventive care for the community by focusing on promoting health and preventing disease through a range of immunization and wellness programs
- Provide screening services for heart disease, diabetes, cancer, and osteoporosis

NORTH DAKOTA



CARING FOR OUR COMMUNITY
WISHEK, NORTH DAKOTA

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- Offer chronic disease management programs using a computerized patient tracking system
- Set up support systems (e.g., legal, medication assistance, transportation) that would help clients participate in prevention, screening, and chronic disease management programs offered by the project

With those goals in mind, the project sponsored the following services:

- Influenza and pneumonia immunizations
- Community education programs
- Wellness programs and health screenings
- Chronic disease management
- Financial and insurance counseling
- Legal assistance
- Medication assistance for indigent individuals
- Support groups and individual counseling
- Transportation for physically disabled clients
- A large-scale marketing campaign that used radio marketing, newspaper ads, fliers, promotional booths at fairs and festivals, and presentations at professional conferences

Innovative Solutions to Problems

The patient tracking database played a critical role in encouraging residents in the service area to use the program's services. The database was used to send letters to individuals 2 weeks before their annual vaccinations, mammograms, colonoscopies, and other services. This approach had a dramatic impact on getting clients to attend scheduled appointments. The database also enabled the project to log service encounters rather than to keep such records manually.

Results

The Caring for Our Community program provided more than 5,000 units of direct care services, which represents a gross savings of more than \$5 million in future health care costs. A total of 1,491 screens and vaccinations were logged in the patient tracking database, which included 106 colonoscopies, 508 influenza vaccines, 546 mammograms, 282 prostate-specific antigen tests, and 49 pneumonia vaccinations. Archival records indicate that the

nurse educator provided care for 3,131 individuals, and these clients received a total of 3,659 health screenings. Data from the four counties in the WCHC service area show that three of the four counties experienced diabetes growth rates below the statewide average.

The outreach social worker provided services to approximately 1,750 clients through support groups, health insurance counseling, wellness activities, and an indigent medication program. In total, the medication program provided approximately \$900,000 in medications at no cost to clients.

Potential for Replication

The project can be replicated in many types of communities—both rural and urban. The project evaluation revealed several lessons learned that are relevant to other communities considering replicating this model:

- Rural residents are more likely to attend health promotion and disease prevention events, health screenings, and other program activities when they are held in conjunction with established, seasonal community events (such as the Annual Farm/Ag Day show held in the Napoleon community).
- Education and service events must be planned around the work schedules of residents, especially farmers or ranchers.
- Residents are more likely to attend such events in the summer rather than in the winter.
- The most effective way to engage residents in care is to offer free health screenings, in which community members are willing to participate. The screenings provide an opportunity for one-on-one education and referral by a health care professional.
- Promotional materials should be written at an eighth grade reading level and should avoid providing too much information, which can overload or confuse the readers.
- It is difficult to persuade people to accept health screenings or modify lifestyles unless a chronic disease already has affected their lives.

After the Grant

WCHC will continue to actively seek funding to help defray the cost of providing services that are not reimbursable through traditional insurance plans.

Community Characteristics

Before receiving funding from ORHP, Fayette County, Ohio, had only two dentists who accepted Medicaid patients, and even then, Medicaid patients were accepted only on a limited basis. In addition, there were no dentists in the area who provided dental care using a sliding fee scale or an extended payment program.

Services Offered

The Fayette County Dental Clinic was created to meet the oral health needs of Medicaid recipients and low-income families in Fayette County. The clinic provided x-rays, prophylaxis, extractions, fillings, sealants, crowns, dentures, and partials to eligible patients. It was established as close as possible to a private general dental practice. The goal of the program was to provide oral health services to the underserved population and to educate patients about good oral health practices. Several patients presented at the clinic with life-threatening oral infections. The clinic also served a large number of pregnant women referred by obstetricians, as well as patients from local nursing homes and children from the local Head Start program.

The project's consortium consisted of the Community Action Commission of Fayette County, a local hygienist, the local health department, and Job and Family Services. The health department provided referrals to the clinic and offered some funding to cover the costs of dental care for patients with no income. Grant funds were used to purchase equipment and supplies and to cover staff salaries to help the clinic get started.

Since the project's inception, local dental practitioners have become involved in providing dental care, and some local small businesses have begun to help cover the cost of dental care for low-income patients. The clinic also worked closely with other dental clinics in the region to provide oral health services to Medicaid recipients and low-income individuals.

Innovative Solutions to Problems

The project offered a sliding fee scale that enabled many patients to contribute to the cost of their oral health care. This

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approach enabled people to receive the care they needed while still taking pride in the fact that they paid for the services they received, an issue that is critically important to many rural residents. Patients also had the option of setting up payment plans to help ease the financial burden associated with their care. In addition, no patients needing emergency treatment were turned away because of their inability to pay for care.

The most significant problems experienced by the project involved the large number of “no shows” and cancellations. Many patients were content to go without dental care for a long period of time; others were afraid and embarrassed to go to a dentist. The project took several steps to address this challenge without refusing to serve no-show clients or charging individuals for missed appointments. Instead, the clinic instituted a policy that patients who missed two appointments would be scheduled to come to the clinic on a certain day, and those clients would be served on a first-come-first-served basis. The clinic also began double-booking patients who missed appointments so that the clinical staff did not lose time because of no-show patients. If both patients actually showed up for care, then the clinic limited the level of treatment, for example, by doing one filling on each patient instead of two or more.

Results

By the end of the grant period, the Fayette County Dental Clinic had about 2,100 patients on record, which is similar to the volume managed by a private dental practice. More than half of those on record were adults, but the clinic also served a large number of children and adolescents and a small number of elderly patients. In addition, the clinic provided more than 150 sets of dentures. The vast majority of clients were Caucasian, but the project also served a small number of African American, Hispanic, and American Indian clients.

The clinic is now staffed by a full-time dentist and a part-time dentist. It is planning to expand its hours of operation. It also is working with other counties in the region that are launching similar projects. In addition, the clinic now receives funding from local organizations, businesses, and dental clinics. In spite of this progress, the project recognizes that the

oral health needs of county residents are far more substantial than the clinic itself is able to address. For example, the clinic is not able to serve young children who require sedation to receive dental treatment.

Potential for Replication

Medicaid recipients and low-income individuals living in rural areas need dental health care, just like everyone else, and this model can be readily replicated in other rural settings. In fact, other counties have sought consultation from the clinic; therefore, similar clinics could be established in those counties. The biggest challenge to establishing such a clinic is securing sufficient funding. The second biggest challenge might be recruiting a dentist to serve in a rural area and provide care to low-income individuals.

After the Grant

The Fayette County Dental Clinic operates 5 days a week. It continues to seek funding from other sources, but Medicaid and private insurance reimbursements have become its primary sources of income. The clinic also continues to enjoy broad-based support from local businesses and residents.

Community Characteristics

Beautiful and historic Tuscarawas County is nestled in the east-central region of Ohio. The county was home to Schoenbrunn, the first Protestant settlement in Ohio. Astronaut and former U.S. Senator John Glenn took his first flying lessons at Harry Clever Field in New Philadelphia. Newcomerstown was the childhood home to baseball great Cy Young, and Ohio State football legend Woody Hayes started his head coaching career with the New Philadelphia Quakers.

Although local schools have always sought to ensure that area students learned about the county's rich and accomplished history, the health care needs of many children and adolescents far too often have gone unmet. In particular, before the grant award, many children did not have ready access to physical and speech therapies, and others were not receiving essential developmental screenings or basic health care services. In addition, many parents and others throughout the community were not aware of how these therapies and screenings could benefit the health and well-being of the county's young people.

Services Offered

The Pediatric Wellness Program was designed to be a comprehensive education and health intervention program targeting children and adolescents aged 0 to 18 years living in Tuscarawas County. Specifically, the project provided physical, speech, and occupational therapy; educational opportunities for parents and health care providers; and free monthly developmental screenings for children aged 0 to 18 years. During the third year of the grant, project planners recognized the need to expand the services of the Pediatric Wellness Program to include scoliosis screenings and dysphagia studies to area youth. To meet this need, the program began providing scoliosis screenings at local schools. It also began conducting dysphagia studies to identify children and adolescents who were good candidates for speech therapy.

The project network included Children's Hospital of Akron, Tuscarawas County Health Department, Tuscarawas

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County Job and Family Services, the Tuscarawas County Extension Office, the American Red Cross, and the National Safety Council. The network also included local charities, educational programs, and a pediatrician practicing in the area. Over the course of the project, the network expanded to include a local school nurse, another pediatrician, and the county Department of Mental Retardation and Developmental Disabilities. All network members were actively involved in planning project activities, providing services, disseminating information about the Pediatric Wellness Program, attending network meetings, and evaluating project activities.

Innovative Solutions to Problems

Project planners had not anticipated that the demand for the therapies and screenings would be so high. For example, during the second year of the grant, the demand for speech and occupational therapies more than doubled. In addition, many more students needed school-based treatment for acute conditions than what local schools could provide. Therefore, the project added a school nurse to the network to help meet the need for acute treatments. It also added a second pediatrician to address the increased demand for therapies and screenings.

Results

During the 3-year grant cycle, the project delivered more than 2,200 units of physical therapy and nearly 2,900 units of speech therapy. In addition, the project provided nearly 3,500 units of occupational therapy and nearly 2,600 units of school-based treatment. During the third year of the grant, the project delivered 208 scoliosis screenings and 12 dysphagia studies. In all, the project served more than 8,700 students and adults.

Potential for Replication

The Pediatric Wellness Program is applicable to both rural and urban settings. Many rural and urban children do not have access to the therapies and screenings that are so critical to healthy development. Naturally, such a model requires a broad-based and diverse consortium of community organizations, as well as a high degree of collaboration and

cooperation between the project network, school officials, health care providers, and parents.

After the Grant

The project network will continue to collaborate in planning and implementing health promotion and disease prevention programs throughout the county. Meanwhile, the therapies and screenings provided by this project will continue to be provided at no cost to clients thanks to public and private-sector reimbursement sources, grants, and private donations.

PROJECT 46—CHICKASAW NATION RURAL HEALTH OUTREACH PROGRAM

Community Characteristics

The Chickasaw Nation, a federally recognized Indian tribe, is responsible for providing health care to all Native Americans living within a 13-county area in south-central Oklahoma. The region has been hit hard by poverty and a dire shortage of health care professionals. In fact, the area has been designated a health professional shortage area by the Health Resources and Services Administration. At the time of the grant award, many areas in the region had no access to geriatric health care, jeopardizing the health and well-being of the region's oldest citizens.

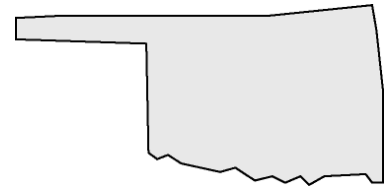
The Chickasaw Nation Rural Health Outreach Program was designed to provide a range of primary health care services to Native American elders living in the most rural and remote areas of the region. Specifically, the program was designed to expand services to areas where geriatric care was not available. The program also placed strong emphasis on serving Native American elders who were homebound, frail, or lacked transportation to visit area health clinics on a regular basis.

To support this project, the Chickasaw Nation Carl Albert Indian Health Facility (also known as the Chickasaw Nation Health System) in Ada established a consortium of organizations. The consortium included the Ardmore Indian Health Clinic in Ardmore, the Tishomingo Indian Health Clinic in Tishomingo, and the Durant Indian Health Clinic in Durant. The three clinics provided general and specialized health care, as well as dental and limited optical health care.

Services Offered

Grant funds were used to establish a "portable clinic" within the Carl Albert Indian Health Facility. The clinic consisted of routine primary care visits designed to promote health, prevent disease, and treat illness. The Rural Health Outreach Team consisted of a geriatrician, a nurse practitioner, and a licensed practical nurse. The team traveled to outlying Chickasaw Nation clinics and the homes of elderly patients who were not able to travel to a clinic for care. The geriatrician, whose salary was funded by the grant, made rounds to local nursing homes at least two mornings each

OKLAHOMA



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week. One day a week, the Rural Health Outreach Team traveled to the three outlying clinics in Ardmore, Tishomingo, and Durant. Also, a nurse and nurse practitioner spent 2 days a week visiting homebound patients who were unable to travel to the nearest clinic. Seeing patients in their homes can take many hours because of the cultural and educational barriers that may arise when serving elderly Native Americans. Establishing trust between the provider and the patient is a critical step that must occur before quality health care and health education can be provided.

In addition, the Rural Health Outreach Team traveled to area senior citizen sites to check blood pressure levels, monitor blood sugar, administer flu vaccines, and distribute information about aging and illness. Team members also were available for telephone consultations with health care providers in the Chickasaw Nation Health System and other providers in the Indian health system throughout Oklahoma.

Innovative Solutions to Problems

At first, the team members traveled to clinic sites and homes using a four-door vehicle. Later, the trips were made in a van that provided adequate space for portable equipment such as an EKG monitor, Holter monitors, blood pressure machines, dopplers, nebulizers, an oxygen saturation monitor, bandages, supplies, exercise equipment, stools, a TV/VCR combination unit for patient education, brochures, and handout materials.

Results

The program hoped to achieve four major goals:

- To provide efficient and effective health care services to Native American elders
- To obtain and maintain professional staff members who were qualified to provide care
- To develop a centralized health care center specifically designed to provide health care to Native American elders
- To sustain program operations once grant funding expired

For the most part, all of these goals were achieved. The first goal was achieved by expanding the program's services to include senior citizen sites, nursing homes, outlying clinics, and home visits. The second goal proved to be the most challenging because of short periods of staff vacancies in the first 2 years of the project. It was not until the third year of the project that all vacancies were filled and the team was fully functional. The third goal was achieved by establishing the Carl Albert Indian Health Facility as the central office for coordinating project activities. In addition, the outlying clinics in Ardmore, Tishomingo, and Durant provided office space for team members during their visits. The fourth goal was achieved by using third-party billing as a means to obtain reimbursements for services rendered. Eighty percent of the patients seen during the project had third-party health care resources such as Medicare, Medicaid, and private insurance.

The most important lesson learned was related to coping with key staff vacancies. Although staff vacancies cannot always be foreseen or avoided, programs such as this one must identify strategies for ensuring the smooth conduct of the program—even when key positions are not currently filled.

Potential for Replication

The mobile clinic model is applicable to many other rural areas in which there are large elderly populations and significant transportation or geographic barriers to accessing health care services.

After the Grant

The Chickasaw Nation Health System has assumed responsibility for what is now called the Elder Care Program. Program services are funded via third-party reimbursements and tribal funding. The program continues to offer the mobile clinic, and team members still travel to the outlying clinics, nursing homes, and homes of elderly homebound patients to provide care. However, due to an expansion of the Chickasaw Nation Health System, the project's home base is moving to a more accommodating clinical setting with the system's hospital.

PROJECT 47—CHOCTAW NATION SPECIALTY SERVICES PROGRAM

Community Characteristics

The service area of the Choctaw Nation Health Services Authority spans 10½ counties in southeast Oklahoma covering 15,000 square miles (roughly the size of Vermont). The area is remote, mountainous, rugged, and sparsely populated. Each of the counties is larger than the State of Rhode Island. At the time of the grant award, seven of the counties were health professional shortage areas, and nine were medically underserved areas.

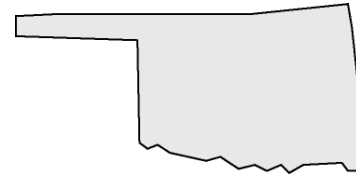
Tertiary health care services are available in Tulsa and Oklahoma City—more than 3 hours away. Only the counties in the southwest, northwest, and northeast extremities of the service area have or are close to secondary services. The vast areas in the middle of the service area are up to 2 hours away from secondary medical services and more than 3 hours away from tertiary services.

Native Americans experience high rates of poverty. There are no public transportation systems in the service area, and many people are reluctant to travel outside the area to seek medical services. Residents in the service area generally do not receive specialty medical care until their illnesses are in an advanced stage, and in today's litigious environment, primary care practitioners will not treat chronic conditions.

Services Offered

The project consortium, led by the Choctaw Nation Health Services Authority, comprised a diverse array of organizations, including universities, medical centers, the State Office of Rural Health, an area health education center, the State Medicaid program, and advocacy groups, as well as several specialist health care professionals. Services available to clients included specialties such as ophthalmology, cardiology, orthopedics, pediatric dental care, pediatric endocrinology, Alzheimer's care, psychiatry, neurology, and otorhinolaryngology. These services were provided either by private practice specialists or specialists on staff at participating universities and medical centers.

OKLAHOMA



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Innovative Solutions to Problems

The innovation in the Choctaw Nation Specialty Services Program was to have medical specialists conduct specialty clinics throughout the service area. This task was not easy. In one case, it involved flying the pediatric endocrinologist into the area via private aircraft because of his time constraints. The project also agreed to participate in the research projects of specialists and academic institutions in exchange for their donating time to conduct local specialty clinics.

Results

The project succeeded in giving rural residents access to the specialty medical services that previously were unavailable to them. Although residents may not be willing to travel long distances for care, they are willing to receive those services if the services are brought to them.

The specialty clinics served more than 3,000 people in 6,600 visits over the 3-year period. Project revenues increased as the grant cycle progressed, and the project cultivated a steady and reliable list of participating specialists. The Choctaw Nation Specialty Services Program also was able to expand the scope of specialty services available to clients beyond what was originally anticipated.

The biggest challenge for the project was the high cost of providing specialty medical care and providing that care in close proximity to patients' homes. Conducting specialty clinics in remote locations requires substantial investments in capital equipment. Planning specialty clinics also requires a great deal of time and effort. Another major challenge was creating a stable group of specialty practitioners willing to provide care for little or no compensation. The project found that practitioners working in academic institutions were more willing to provide low-cost or free care than private practice providers.

Potential for Replication

This model would work in many other rural communities, especially if the project is overseen by a large organization that is willing to absorb some of the project costs and contribute some of the initial capital. In addition, such a model relies heavily on the generosity of providers who are

willing to donate their time and expertise with little or no financial return. If those providers were to cease their participation, the project would not be sustainable.

After the Grant

All of the activities started under the grant have been sustained, and since grant funding expired, the project has been able to expand the specialty medical services available to clients. The Choctaw Nation Health Services Authority continues to provide substantial financial resources to support the delivery of specialty care to residents throughout the service area.

PROJECT 48—SERVING THE WORKING POOR, RETAINING HEALTH CARE PROVIDERS, AND PLANNING FOR BEST MANAGEMENT PRACTICES: THE CHALLENGES FACED BY A NETWORK OF RURAL HEALTH CARE PROVIDERS

Community Characteristics

The community of Oakridge, Oregon, is one of the poorest in the State. Nearly 60 percent of the population consists of Medicaid recipients or is classified as working poor with no insurance.

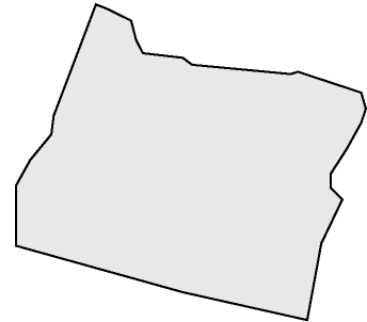
Another 25 percent of the population is covered by Medicare. At the time of the grant award, three clinics in the Oakridge community generally assumed responsibility for providing care for the community's uninsured and underinsured residents, but low reimbursement rates for health care services and providing free health care to needy patients made it difficult for health care facilities serving these populations to remain economically viable.

The Oakridge area spans a mountainous region of 924 square miles amid the rugged Cascade Mountain Range. It is situated approximately 4,000 to 5,000 feet above sea level and is 30 miles from a thriving ski area that is accessible by one major highway—Highway 58. The highway is one of the deadliest in the State because of wet, snowy, and icy conditions coupled with a narrow, curvy route along a roaring but scenic river. This highway is not suitable for elderly, sick, or distracted persons to traverse. Oakridge's high poverty rate is attributed to the fact that it is a former timber town. Good paying jobs began leaving the area in 1985, and no new jobs have been created. Highway 58, which runs through the nucleus of Oakridge, is lined with boarded up buildings and empty lots. However, the region is well known for its scenery and attracts outdoor enthusiasts, the elderly, and those seeking inexpensive housing.

Services Offered

The purpose of this project was to stabilize and sustain the practices of three area providers who were vital to safeguarding the health of residents. The three clinicians were operating independent practices in a competitive manner. They did not communicate with one another or share weekend calls, and they offered many of the same services. This competitive atmosphere made it difficult to sustain three health care providers in this small community and constantly put the community at risk for losing one of its few providers.

OREGON



**SERVING THE WORKING POOR,
RETAINING HEALTH CARE
PROVIDERS, AND PLANNING
FOR BEST MANAGEMENT
PRACTICES: THE CHALLENGES
FACED BY A NETWORK OF
RURAL HEALTH CARE
PROVIDERS
OAKRIDGE, OREGON**

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The project network consisted of the three area health care providers, the City of Oakridge, a community representative, and the Area Health Education Center of Southwest Oregon. Two of the clinics were owned by the clinicians who operated them as proprietary businesses. The third clinic was owned by a large hospital located in Eugene. However, midway through the grant cycle, the hospital divested itself of the clinic, and the nurse practitioner moved to Eugene. The consortium and the community at large then recruited another provider, and the clinic became an independently owned, proprietary business. It also applied to renew the rural health clinic status held by the previous owner. Consortium members met each month to participate in network planning, to access training and educational opportunities provided by the grant, and to remain committed to building good communications and trust among the three providers. The training opportunities provided by the grant enabled the area providers to incorporate better business practices into their clinical operations, including coding and billing, computer/software efficiencies, shared services, and information about the State and Federal programs that were available to support their clinics.

Innovative Solutions to Problems

Financing project services was one of the project's most innovative features. Uninsured and underinsured patients were responsible for paying for 30 percent of the cost of their care. In turn, the providers donated 30 percent of their cost for treating uninsured and underinsured patients, while grant funds paid providers 30 percent of the cost of care. This approach ensured that people who needed care were able to access it, and, in the end, this formula made it possible for about 700 patients each year to receive the care they needed. This approach also generated an additional \$26,000 per year for the area providers, which prevented bankruptcy or closure of their clinics.

At first, the three providers did not attend monthly consortium meetings on a regular basis. To encourage participation and collaboration, the project instituted contracts with each of the providers. The contracts stated that they would not receive payments for the care they provided to uninsured and underinsured patients unless they attended monthly consortium meetings. The

providers began attending regularly, and, over time, they came to rely on one another for shared resources and support.

Results

The project succeeded in cultivating a provider compensation pool, which proved to be an important factor in successfully recruiting a new health care provider to set up practice in the community. The three clinics also benefited greatly from incorporating more cost-efficient business practices into clinical operations.

The project had significant difficulty developing a shared vision for the future of health care in the community. One of the three providers was only a few years from retirement, so his highest priority was to maintain a sound business that he could sell. As a result, he was reluctant to embrace the idea of housing all three clinics in a shared space. The other two clinics were anxious to forge ahead in securing Community Development Block Grant monies so they could construct a community health care center. Since each clinic was an independent, proprietary business, the owners were reluctant to give up that status to create a one-stop-shopping clinic.

The project learned several important lessons:

- It is vital to have the evaluation process clearly outlined at the beginning of the project and to achieve consensus about measurable outcomes for evaluating success.
- Agreed-upon, measurable outcomes must be discussed on a regular basis to ensure that the network remains focused on the project's main goals.
- When the network membership involves individuals who operate proprietary businesses, clinics owned by large hospitals, and clinics classified as rural health clinics, it is difficult to achieve a shared vision that serves the interests of the individuals involved.
- Community needs were not always valued, even though individual owners were struggling to keep the clinics open and financially viable.

Potential for Replication

Many rural communities have independent health care practices that do not collaborate to meet the health care needs of uninsured and underinsured families. The provider compensation pool model is an inexpensive approach to creating a safety net for residents and safeguarding the economic viability of limited health care resources. As this project learned when it set out to recruit a new provider to replace the one who moved away, the provider compensation pool was a major factor in attracting a new provider to serve in this economically depressed, rural area. It is important, however, to have unbiased, strong leadership in such a project to effectively balance the community's needs with the priorities of clinic owners. It also is critical to involve providers and community members in the design and implementation of the model.

After the Grant

The project has resulted in a private, nonprofit organization that is seeking other grants to sustain the project. The consortium members have pledged to continue to meet on a regular basis to expand services and share resources. A local foundation has expressed an interest in maintaining the consortium's work.

Community Characteristics

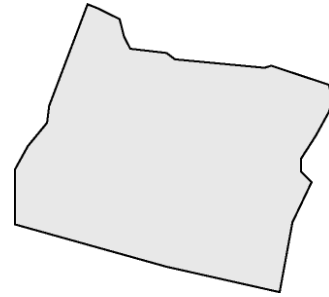
Coos County, Oregon, is surrounded by mountains to the north, east, and south and the Pacific Ocean to the west. The county is about 385 miles north of San Francisco and 335 miles south of Portland. Located in the southwest region of Oregon, Coos County and its residents prospered for many years from the economic mainstays of tourism, timber, fishing, and agriculture. However, the past decade saw such a drastic decline in the prosperity of these industries that the primary sources of household support became low-paying jobs in the retail sales and service industries—with no opportunities for economic development in sight. In 1999, the largest employers were the hospital and the public school district, and the school district itself was experiencing severe budget difficulties. Many area schools were closing, and those remaining open were cutting faculty, staff, and programs.

In 1998–1999, 23,756 of the 49,700 people living in western Coos County were classified as “working poor,” living between 101 and 185 percent of the Federal poverty index. These individuals also were without employer-sponsored health insurance and were not covered by the Oregon Health Plan (the State’s Medicaid program). At that time, 9,400 residents were eligible for the Oregon Health Plan. Another 16,544 individuals had either private insurance or Medicare coverage.

Services Offered

The service area for the Waterfall Clinic was the western portion of Coos County, which comprises the principal communities of Coos Bay, North Bend, and Bandon. The project consortium included Bay Area Hospital, which served as the fiscal agent for the project and donated more than \$18,000 to the clinic’s operations; DOCS, an independent physicians association, which accepted specialty medical referrals from the clinic and discounted the cost of received services by 50 percent; the associate degree nursing program from Southwestern Oregon Community College, which developed a practicum program for nursing students, placed senior nursing students at the clinic, and provided student supervision; and the Coos County Public Health Department,

OREGON



**WATERFALL CLINIC
COOS BAY, OREGON**

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which provided intensive maternity case management to pregnant women served by the Waterfall Clinic.

Innovative Solutions to Problems

The clinic offered extended office hours so that clients could access services after normal working hours. Having the clinic open during evening hours enabled entire families to receive care when the primary wage earner returned home from work, a reality that was particularly common among the area's Hispanic families. The project also offered a sliding fee scale for primary health care services received by uninsured and working poor families.

Although the project experienced very few challenges, it did have some trouble recruiting and retaining nursing personnel. With the ongoing nursing shortage, it was difficult to staff the clinic with highly educated case management nurses. In addition, the family nurse practitioner relocated to the Midwest during the third year of the project, but a recently graduated, highly skilled family nurse practitioner was eventually found. These staffing shortages, however, limited the number of patients the clinic could serve at certain times simply because the clinic was not sufficiently staffed to operate at maximum capacity.

Another challenge involved funding. The clinic relied heavily on an already financially strapped community for funding. However, through public speeches, advertising, and networking, the project succeeded in educating members of the public about the importance of health to the community's overall well-being. The project also had difficulty accessing medications. Many patients could not afford the cost of prescriptions; therefore, project staff members had to become experts in helping individuals locate financial assistance to help pay for needed medications.

Results

During the project period, the clinic recorded approximately 6,900 service encounters involving more than 3,200 patients. Project data reveal that the vast majority of patients were adults aged 20 to 64 years, but the project also served a large number of children and adolescents. Elderly patients accounted for only 2 percent of those served by the

clinic. Without the clinic, many of these patients might never have received the primary care or specialty services they needed. The area's medical and business communities actively supported the clinic, and from time to time they provided volunteers to work at the clinic. In spite of this progress, the clinic recognized that it was meeting the health care needs of only a small portion of those who needed care, and it hopes to expand access to care to other individuals and families in need.

Because of their work together on creating and implementing the Waterfall Clinic, some of the consortium partners are now collaborating on other projects. For example, Bay Area Hospital is working with the County Mental Health Department, Waterfall Clinic, and DOCS to form a Community Care Access Program. This partnership is examining innovative methods of providing assistance to those in need—from developing a communitywide program to help patients access assistance programs from pharmaceutical companies, to the development of a prescription discount card.

The most important lesson learned by the project was the importance of reflection. The project evaluation process provides an opportunity to think seriously about what has worked well and what could have been done differently. Another important lesson is what can happen when individuals and organizations truly work together. The Waterfall Clinic is a prime example of the power of collaboration and the success that can be achieved when issues of territoriality and personal gain are set aside.

Potential for Replication

This project can be replicated easily in other communities. However, community buy-in is critical; such a project will not likely succeed if the community does not support the endeavor. Other communities may encounter challenges similar to those experienced during this project—recruiting and retaining personnel, generating financial support from already strapped communities, and making medications affordable for patients without health coverage.

After the Grant

The Waterfall Clinic is applying for federally qualified health care status, and the region is now a designated medically underserved area. The clinic is working with local schools to establish a school-based health center, an effort that has since received \$100,000 in funding from the Ford Family Foundation. The project is planning a series of community fundraising opportunities, and several local organizations have pledged to support the clinic by providing funding and volunteers.

Community Characteristics

Lee County, a rural community 50 miles northeast of Columbia, South Carolina, is one of the most disadvantaged counties in the State. Many families lack transportation and live in poverty. At the same time, many parents lack basic knowledge about the relationship between a child's health and his or her performance in school. Of the county's 20,199 residents, 26 percent of the children live in poverty, and 42 percent live in single-parent homes. Some 63 percent of the county's population is African American, and 74 percent is aged 0 to 17 years.

Services Offered

Health Connection for School Success (HCFSS) was established to address the fact that children's health not only is an important measure of community well-being but also is strongly associated with how well children perform in school. The project had three core goals:

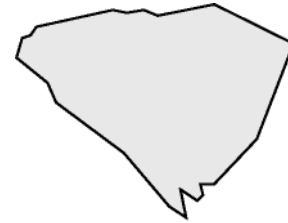
- To provide transportation to and from health services to at-risk children and their families so they can access preventive health, dental, and/or specialty care
- To offer comprehensive health education services to families on parenting, dental health, HIV awareness, blood pressure training, and volunteerism
- To maintain the viability of and linkages within the Lee County Primary Prevention Coalition (PPC)

The primary partners of the PPC, a 90-member consortium, included the Lee County School District, the Lee County Health Department, the Lee County Department of Social Services, the Health Reach Program of the Toumey Regional Medical Department, Care South Carolina, the Lee County Disabilities and Special Needs Board, and the Lee County Mental Health Clinic. The consortium also included a wide variety of health and social service agencies and organizations, as well as faith community organizations.

Innovative Solutions to Problems

The HCFSS outreach driver visited families at their homes. This approach was necessary because as much as 16 percent of the target population was without a vehicle, and 19 percent did not have a telephone. The outreach driver initiated contact with families

SOUTH CAROLINA



**HEALTH CONNECTION FOR
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who needed services and assisted them by scheduling appointments, driving clients to and from appointments, and providing information on health and community service programs that were available to meet the families' needs. During the school year, HCFSS transported children from school to their appointments, which helped limit the amount of time they were away from school.

The project's community health coordinator was primarily responsible for distributing a health book titled "What To Do When Your Child Gets Sick," which was written at a fourth grade reading level. The health book was designed to assist parents and children in addressing basic health needs. To receive a copy, people were required to attend a short workshop that provided basic instruction on how to use the book effectively. Initially, it was difficult to identify channels for disseminating the book. In the project's final year, however, HCFSS worked with the Department of Social Services and the local Women, Infants, and Children program to get more parents to participate in the workshop.

Given the dire need for dental health care in the county, the community health coordinator worked with the Health Reach Program to launch an oral health initiative. In addition, the faith community coordinator was responsible for training a health volunteer advocacy group, including representatives from area churches, to help address community health needs through parenting workshops, healthy lifestyle workshops, HIV education, blood pressure training, and teen pregnancy prevention. However, since Lee County communities continue to be largely divided along racial and ethnic lines, the faith community coordinator, who was African American, was not generally well received or accepted by white churches. As a result, 90 percent of the health workshops were conducted in African American churches.

Results

In the third year of the grant cycle, 934 medical appointments were scheduled for children living in the county, and 678 of those appointments were successfully completed. HCFSS provided transportation to and from 609 medical appointments. The project distributed more than 650 Healthwise handbooks, including 14 Spanish-language copies for Hispanic families. In addition, the project developed a directory that identified health and social

resources throughout Lee County. Some 229 copies of the resource directory were purchased, including 212 that were distributed to various agencies throughout the county.

Potential for Replication

This primarily transportation-based model could be easily replicated in other communities where transportation to and from health appointments is severely limited. The model can benefit both adults and children.

After the Grant

The transportation component of the project will continue, and the outreach driver and administrative assistant positions will continue to be funded by HCFSS so that medical appointments can be scheduled and children can be transported to them. However, due to a lack of funding resources, the health education and health promotion components cannot be sustained.

Community Characteristics

In July 1997, the area surrounding the Yankton Indian Reservation in southeastern South Dakota was designated as a health professional shortage area. In June 1998, the same region was designated as a mental health professional shortage area, and in January 1999, as a medically underserved area. The reservation is mostly farmland, with some small areas of timber. The remainder is rolling hills and prairie suitable for grazing. The Missouri River is the southern border of the reservation. Fort Randall Dam on the Missouri River creates Lake Francis Case, which is in the southwestern part of the reservation. The land around the lake area is high rolling hills, with wooded coulees providing drainage into the lake. The reservation experiences seasonal extremes of hot and cold temperatures ranging from 110 degrees in the summer to 20° below zero in the winter. The annual average rainfall is approximately 23 inches.

Services Offered

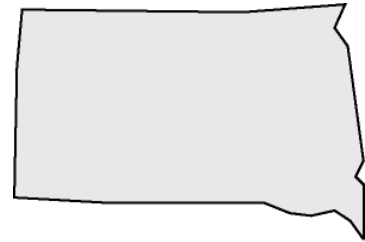
Before the grant award, mental health and substance abuse services were severely limited to those individuals living on the reservation. The Continuum of Care project was created to increase access to culturally appropriate mental health and substance abuse services for those in need. The project specifically targeted low-income tribal members and their families.

Innovative Solutions to Problems

Because the Continuum of Care project focused on substance abuse and mental health issues among American Indians, the services offered by the program required a unique approach that emphasized cultural appropriateness. For example, the project sponsored a sweat lodge, which is modeled after a traditional American Indian ceremony. The participants use rocks from the river, build a fire, and cover themselves with blankets in order to purify their minds and bodies through sweating. In essence, the sweat lodge functions much like a sauna. During the ceremony, the participants sing and pray to aid in the purification process.

The project also sponsored an annual sobriety walk to honor members of the tribe who have remained sober. The participants walk throughout the town to testify to the fact that they are, and want to remain, sober. After the walk, the participants receive a

SOUTH DAKOTA



**CONTINUUM OF CARE
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t-shirt and then return to the powwow grounds where they partake in a traditional tribal meal.

Meeting the mental health needs of tribal members requires a carefully tailored approach that is consistent with the cultural values and expectations of the tribe. Many clients had to receive intensive pretreatment (e.g., to prevent them from doing harm to themselves) before they were ready to receive the mental health services available through the project's network.

Results

More than 100 tribal members have participated in the sweat lodges, and more than 600 people participated in last year's sobriety walk. Many of the individuals who received substance abuse treatment services through the project also received mental health services. In addition, the project launched a new work-study program designed to recruit and train tribal members to serve as substance abuse and mental health peer counselors.

Potential for Replication

Activities such as the sweat lodge and the sobriety walk could be easily replicated as part of other tribal substance abuse and mental health treatment programs. These activities are deeply rooted in American Indian culture and could be readily adapted for use in other tribal settings.

After the Grant

The Continuum of Care project continues to provide sweat lodges, which are now offered more than once a week. The project also plans to continue sponsoring the annual sobriety walk in the years to come.

PROJECT 52—RURAL HEALTH OUTREACH TO THE CHEYENNE RIVER RESERVATION: CREATING AN EARLY HEALTH CARE COMMUNITY

Community Characteristics

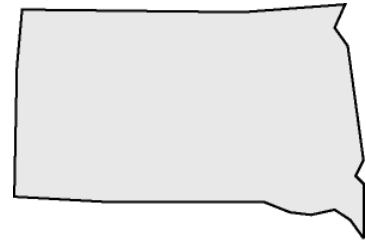
The Cheyenne River Reservation is located in a remote area in north-central South Dakota. It is a medically underserved area and health professional shortage area. Before the grant award, the lack of trained pediatric specialists required families with young children to travel hundreds of miles off the reservation to receive pediatric services. Both environmental and biological issues jeopardized the health and development of children living on the Cheyenne River Reservation. Early intervention services were not available in the education system, and the lack of trained pediatric specialists in the area meant that many children aged 0 to 5 years who needed early intervention services went unidentified and untreated.

Services Offered

This project focused on increasing public awareness of early intervention services; providing prescreening, screening, and tracking services; referring children in need for further evaluation; providing evaluation and diagnostic services; and linking children to area resources. The primary means of providing and coordinating these services was monthly clinics in which a broad range of health practitioners provided an equally broad range of screenings and referrals to followup care. Several organizations were involved in this project:

- The Cheyenne River Sioux Tribe linked children to tribal programs, provided transportation services, and offered developmental screenings for children associated with the Women, Infants, and Children program.
- The Eagle Butte Indian Health Service Unit linked children to health services available through Indian Health Service programs in the area.
- The Prairie Community Health Clinic, Inc., provided health exams and followup services, as well as health care services to area schools.
- The Northwest Area Schools provided screening services, developmental screening training, referrals to services, and followup care.
- The Center for Disabilities at the University of South Dakota School of Medicine directed the project, provided fiscal management, developed project materials and a Web

SOUTH DAKOTA



**RURAL HEALTH OUTREACH TO
THE CHEYENNE RIVER
RESERVATION: CREATING AN
EARLY HEALTH CARE
COMMUNITY
VERMILLION, SOUTH DAKOTA**

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site, and coordinated a team of trained pediatric specialists and staff training activities.

- The Bureau of Indian Affairs provided clinic and office space, support for a clinical coordinator, and early intervention services referred from the monthly clinic.

The project created a reservationwide system for delivering developmental screenings to children aged 0 to 5 years. A team of pediatric specialists was brought in to provide health and education services at monthly clinics. The project also established linkages to early intervention and other appropriate services, as well as referring children for followup care.

Innovative Solutions to Problems

Using a small aircraft, the clinic team members traveled from southeast South Dakota to the Cheyenne River Reservation to provide monthly clinics for area children. The clinical team included pediatric specialists; speech and language professionals; two teams of evaluators who conducted cognition, communication, motor, and psychosocial skill assessments; a registered dietitian, who provided anthropometric and nutritional assessments; and allied health professions students, who participated in the clinics as part of their fieldwork requirements. Because poor weather can hamper air travel, the project often was forced to cancel monthly clinics. However, the project also specified a backup date each month for holding each clinic.

Results

The project succeeded in creating a comprehensive system of developmental services for children aged 0 to 5 years living on the Cheyenne River Reservation. In all, 936 children were served by the project, with 230 children receiving developmental, hearing, and vision screenings as part of the pediatric clinic evaluations, and another 706 children receiving developmental screenings. Sixty-six of these children were connected to additional services as part of their followup care. The majority of children served were American Indians of Sioux heritage from low-income families. In addition, 12 members of the clinical team received cultural sensitivity training, and 20 allied health students participated in the program as part of their clinical training experience.

Potential for Replication

This project was based on a similar model developed by the University of South Dakota Center for Disabilities. Minor adjustments were made to adapt the model based on local needs, and the model emphasized best practice standards for developing a comprehensive system of services for infants, toddlers, and young children with developmental concerns. As a result, this project would work well in other rural settings. However, other communities considering replicating this model should ensure that the partners are equally committed to the project and willing to cooperate in meeting the needs of at-risk children. It also is critical to have the support of a charter flight service that is willing to transport the clinical team to remote rural areas to conduct screenings.

After the Grant

All activities supported by the grant will continue. The Cheyenne River Sioux Tribe will support the monthly clinics, using funds from the Individuals with Disabilities Education Act (IDEA). These services will continue through a contract between the Sioux Tribe and the University of South Dakota Center for Disabilities.

Community Characteristics

Hancock County is very rural, sparsely populated, and isolated. There are no major roads in the area, and the region's mountainous ridges are connected by twisting country roads—a situation that increases the isolation experienced by many of the county's residents.

At the time of the grant award, Hancock County was designated as a health professional shortage area. The county's 6,000 residents could receive primary medical care at 2 clinics located in the county, and a public health dentist provided dental services to the county's children 1 day per week.

People living in Hancock County experienced several formidable barriers to accessing the health care services available to them. More than 80 percent of the county's children were living in poverty, 12 percent of high school students in the county reported that they had used the powerful narcotic Oxycontin, and obesity and adolescent pregnancy were common problems for area youth. In addition, many residents did not have health insurance, and those who did often could not afford the high copayments required to receive medical care.

Services Offered

Grant funds were used to establish a comprehensive school-based health center in one of the county's high schools. In the second year of the project, the clinic was moved to a new location so that it could serve both middle school and high school students. The project also supported an additional clinic based in an elementary school; this clinic provided comprehensive, onsite primary care services to some of the State's poorest children. Children and parents were able to use the clinics' services at no charge, which dramatically increased their access to health care services. The services offered by the clinics included immunizations, health assessments, family planning, episodic care, chronic disease care (e.g., for asthma or diabetes), mental health treatment, substance abuse treatment, first aid, anger management sessions, and health education. The middle school and high school-based clinic employed a full-time mental health professional who provided individual and group counseling.

TENNESSEE



**HANCOCK COUNTY SCHOOL-
BASED HEALTH CENTER
SNEEDVILLE, TENNESSEE**

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A wide range of organizations participated in the project consortium:

- The county public health department provided immunizations, pregnancy care, infectious disease care, and dental services.
- The local rural health care consortium accepted clinic referrals when students needed to see a physician.
- The county recreation program provided after-school mental health services and first aid and triage care during the summer months.
- Jubilee Youth Ministries offered a range of programs for troubled youth.
- The county court received referrals for alcohol and drug abuse treatment.
- The county extension agent provided nutrition and diabetes education programs.
- The local school system provided space for the clinic and covered the cost of utilities.
- The Hancock County Health Council worked to better coordinate health services and reduce duplication of services.
- Local pharmacies provided free or low-cost medications.

Innovative Solutions to Problems

The Hancock County School-Based Health Center project offered several innovative education and support programs. The “Walk Across Tennessee” program was available to sixth through eighth grade students. The 6-week program encouraged students to walk during their free time and to keep track of the number of miles they walked during the 6-week period. Most of the students who participated in the program accumulated miles that equaled what it would take to walk across the State of Tennessee. Several high school students also participated in the program. Clinic staff walked with the students, which provided an opportunity for students to talk about their problems and concerns in a more relaxed atmosphere.

Other innovative programs offered by the project included

- A mock rape trial, presided over by one of the county’s judges, in which students role-played the trial participants, including the defendant, the district attorney, the attorney

for the defense, the victim, the jury members, and the witnesses

- A “Baby, Think it Over” program, in which students were given a doll with a computer chip that recorded feeding, changing, holding, cleaning, and attention and indicated which babies were being neglected
- A drug abuse prevention program sponsored by the National Guard
- A life skills program for 6th through 12th graders

Results

Some 97 percent of students were enrolled in the primary care clinic program, and 100 percent were enrolled in the triage, first aid, health screenings, and health education programs. Children with chronic health problems, such as diabetes, obesity, and asthma, were provided case management services to coordinate their care across multiple organizations and service agencies. One of the project’s surprising findings was the high demand for mental health services. In fact, the most frequent reason that students came to the clinic was to receive mental health services.

Tennessee’s health care crisis proved to be one of the project’s most challenging realities. During the course of the project, many students lost their health insurance because of increasingly stringent requirements for qualifying for TennCare, the State’s Medicaid program. Many working parents withdrew from employer-sponsored health insurance programs because they could not afford the premiums. In such cases, students who are eligible for insurance coverage through their parents’ employers are not eligible for TennCare coverage.

Potential for Replication

The school-based health care clinic model could be useful to many rural communities. Many of these communities are skeptical of health care services provided by “outsider” organizations, but this challenge can be overcome by making the community aware of how such services can improve the health, well-being, and educational attainment of children. In addition, although this project did not encounter any resistance to providing family planning services, treating sexually transmitted infections, and serving pregnant teens, other communities should be prepared to address such opposition by educating the community about the need for

such services and how these services can prevent future health and social problems.

After the Grant

The project is seeking additional funding sources to support staff positions and clinic services. In the meantime, the project is exploring the possibility of asking local health service organizations to support staff positions so that the services provided by the program can be sustained.

Community Characteristics

At the time that the Tellico Plains Full-Service, School-Based Clinic was established, Monroe County, Tennessee, already was medically underserved. Within the county, the Tellico Plains area had the greatest need for medical services. This part of the county had only one clinic, which employed a full-time nurse practitioner supervised by a medical director who was onsite a half-day per week. The only other medical service provided to area residents came from a family practitioner and a pediatrician who served patients on Thursdays in a space provided by the town. No mental health services were available in Tellico Plains, despite a tremendous need for such services in the area.

Services Offered

The school-based clinic was designed to address several health problems in the community by improving the physical health status of school-age children in Tellico Plains and surrounding communities and by identifying and treating health problems and ensuring followup care. The clinic also provided a counselor and a case manager to promote healthy psychological development through group and individual counseling. The primary goal of the clinic was to offer physical and mental health services in the school setting. The project’s original service area included five schools in the Tellico Plains area, with a combined enrollment of about 1,600 students, with plans to expand services into other schools in the county.

Several organizations were involved in the project consortium. The Monroe County Department of Education provided in-kind contributions, space, and the clinic’s utility expenses. The Department of Education provided maintenance, technology, janitorial, and financial management services. Family Practice Associates contracted with the clinic to provide two nurse practitioners to work in the clinic 5 half-days per week. The Peninsula Outpatient Center provided a case manager, training, supervision, and a representative on the clinic’s management team. The East Tennessee Community Services Agency provided partial funding for the administrator’s position and a representative on the clinic’s management team. The University of Tennessee at Knoxville assisted in evaluating the project’s services. Finally, the Monroe County Health Department provided materials and

TENNESSEE



**TELLICO PLAINS FULL-SERVICE, SCHOOL-BASED CLINIC
MADISONVILLE, TENNESSEE**

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MADISONVILLE, TN 37354**

immunizations and a sliding fee scale model to help finance clinic services.

Clinic services included early periodic screening, diagnosis, and treatment; a school bus driver; and new-employee physical exams. The nurse practitioner saw patients with acute illnesses, such as strep throat, sinusitis, and ear infections. Tuberculosis skin testing and tetanus shots were available to school faculty and staff members. The clinic nurse also managed daily medications for some students. Another service offered by the clinic was participation in Tennessee's Vaccines for Children Program. All of these services were available to students, faculty, and staff members of the Monroe County Department of Education. Behavioral services also were available, at the parent's request, to students in kindergarten through eighth grade.

Innovative Solutions to Problems

In rural areas, innovative methods of service delivery are essential. To make the clinic as accessible as possible to the largest number of students, it was established in a school building with another school across the parking lot. The students at these two schools had access to a full-time school nurse and a part-time nurse practitioner who was onsite 3 half-days per week. The outreach nurse traveled 4 days a week to the other three schools in the area and to students' homes as necessary. Nurse practitioner services were offered a half-day at two other schools. Parents could give their written consent for nurses to provide over-the-counter medications to students. If parents chose to use the nurse practitioner service for their children, they filled out a complete medical history for the first visit. Future office visits did not require the presence of a parent; however, parents could call the clinic to schedule an appointment, and the clinic would call the child out of class.

Counseling services were provided in very much the same manner. Parents came to the office for the initial intake, which normally was performed by a case manager with a master's degree in counseling, after which the child was able to see a counselor. The case manager also conducted home visits to collect intake information and traveled to two other schools in the area to provide counseling services.

The project's first year was stressful for the staff members because they had not anticipated the high demand for services. The clinic simply did not have the staff resources to accommodate the demand. In addition, many people in the community did not understand the purpose of the clinic, so project staff members used Parent Teacher Organization meetings as an opportunity to educate parents about the clinic's services. Perhaps the biggest challenge was dealing with third-party reimbursements. It took more than 2 years to obtain a provider number with State Medicaid managed care organizations; even then, many managed care organizations did not recognize the value of school-based health care services.

Results

More than 82 percent of the county's student body was successfully enrolled to receive clinic services. The clinic logged more than 19,000 encounters with the school nurse and nearly 2,400 nurse practitioner visits. More than 600 students received case management services, and more than 2,300 students and families participated in group and family sessions. Although the vast majority of clients were children and adolescents, the project also served 200 adults. Every student with health needs became enrolled in a health plan, and nursing staff provided followup care to children and adolescents with special health care needs.

Project case managers averaged 21 home visits per month. In addition, the licensed clinical social worker and the licensed professional counselor averaged approximately 50 individual sessions each month.

Potential for Replication

This model could work well in other rural areas. It may be necessary to contract for services that are not readily available within the network. It also is necessary to have a dedicated, full-time administrator and to negotiate with State managed care organizations to obtain a provider number.

The fact that the school system was a cooperative partner in this effort played a major role in the project's success. However, other communities should be cautious because many school systems are not as open to change as the school system in Monroe County. Many agencies may be reluctant to contract with school systems to provide services. In addition, other communities should not

underestimate the amount of time, effort, and patience necessary to obtain a provider number for third-party reimbursements.

After the Grant

Since the project saved \$120,000 of its funds during the grant cycle, the project will be able to extend its services for an additional year. The clinic now has the necessary infrastructure to bill third-party payers for provided services. Meanwhile, the project continues to seek new funding sources to extend clinic services into the years to come.

PROJECT 55—COMMUNITY HEALTH EDUCATION AND DEVELOPMENT PROGRAM

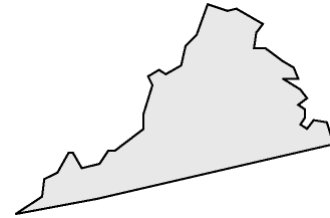
Community Characteristics

The Community Health Education and Development (CHED) program was established to increase health care access in the Northern Neck and Middle Peninsula of Virginia. Before this program was created, there was no structured coalition in place to educate residents about the services available to them or to develop a strategic plan for expanding community-based health care services. The service area spanned a nine-county region in northeastern Virginia (Westmoreland, Caroline, Essex, Richmond, Northumberland, Lancaster, King and Queen, King William, and Middlesex Counties). The major public health problem identified in the area was the high rate of diabetes within the African American community. At the time of the grant award, about 40 percent of residents in the service area were African Americans who typically experienced poorer access to health care services compared with their Caucasian counterparts. Statewide data indicated that African Americans died from complications associated with diabetes at twice the rate of Caucasians.

Services Offered

The lead agency for the CHED program was the Rappahannock Area Health Education Center, a State and federally funded program designed to increase access to care in health professional shortage areas. Representatives of State and local government service organizations provided training and materials for use in community health partner certification classes. Other partners included the Three Rivers Health District, Rappahannock Area Health District, Mary Washington Hospital, and Riverside Tappahannock Hospital in Essex County. The target population for the project included area residents of socially, economically, culturally, geographically, and ethnically disadvantaged backgrounds, as well as the elderly, individuals with poor health status, and others who experienced difficulty accessing health promotion, disease prevention, and treatment services. In particular, the project focused on the prevention, screening, detection, and treatment of diabetes and hypertension.

VIRGINIA



**COMMUNITY HEALTH
EDUCATION AND
DEVELOPMENT PROGRAM
MONTROSS, VIRGINIA**

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Innovative Solutions to Problems

Over the course of the grant cycle, the CHED program has evolved into the Neighbors Helping Neighbors program. The primary goal of this project was to use lay educators to provide health education services at faith community organizations. More than 100 lay educators were trained to perform outreach health screenings for hypertension and hyperglycemia. The project also developed the Northern Neck Community Resource Directory, which was distributed to area businesses and organizations; at community events, such as health fairs, church services, and agricultural festivals; and at tourist venues and migrant labor camps.

Results

More than 5,000 individuals were screened for blood pressure and hypoglycemia at 250 events sponsored by CHED or its partner organizations.

Potential for Replication

There are four components to developing a successful grassroots coalition:

- Long-term funding
- Enhancing service capacity and collaboration at a grassroots level
- Supervising lay educators
- Making critical changes to project operations in terms of the program's goals, implementation, delivery of services, and project evaluation

After the Grant

Sustaining the project's services and activities will depend on funding from philanthropic foundations and social service organizations.

PROJECT 56—OLYMPIC PENINSULA MATERNAL CHILD HOME VISITING: STRENGTHENING SERVICES THROUGH COLLABORATION

Community Characteristics

Clallam County, Washington, is a rural, rugged, geographically isolated peninsula that is home to a diverse population, including four Indian tribes and two Hispanic communities. The county terrain includes miles of coastline and vast sections of wilderness. The local economy has been driven historically by the timber and fishing industries, but in recent years, a large influx of retirees and transplants from other cities have changed the county's population dynamics.

The county's youngest residents experience disproportionately higher rates of several health risk factors than young people in other parts of the State do. These include poverty, births to single and adolescent mothers, and smoking by pregnant mothers. It has been well documented that conducting home visits to new mothers is an early intervention strategy that can improve long-term outcomes for young families. However, planners for this project identified several gaps in the area's home visiting services:

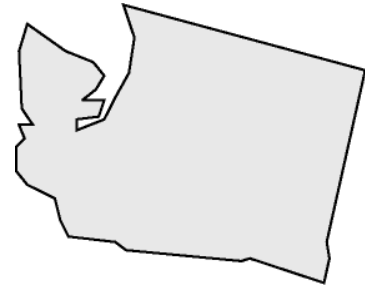
- Clients did not receive all of the home visiting services for which they were eligible, and those who were considered low risk did not receive any home visits.
- Area providers lacked knowledge regarding who in the community was eligible to receive home visits and how to receive full reimbursement from private insurance companies or Medicaid for home visits.
- About 95 percent of postpartum women did not receive a home visit from any health agency within the first few days after discharge.

The service area for the project included most of Clallam County, which had a population of 66,000 people. Although a majority of residents lived in the Port Angeles area, a nurse based in Forks, Washington, often spent up to 4 hours travel time to conduct one home visit. The target population for this project was all women with children aged 0 to 3 years, with special emphasis on reaching new postpartum women within the first 3 days after delivery.

Services Offered

The project consortium included New Family Services at Olympic Medical Center, which provided maternal and child health

WASHINGTON



**OLYMPIC PENINSULA
MATERNAL CHILD HOME
VISITING: STRENGTHENING
SERVICES THROUGH
COLLABORATION
PORT ANGELES, WASHINGTON**

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services and worked closely with the inpatient obstetrical unit; Fork Hospital, which provided comprehensive obstetrical services and served a large number of Hispanics and American Indians; and First Step Family Support, which provided home visiting services to families throughout the county, many of which were high-risk families, and was well-respected throughout the community.

The goals of the project were to improve the quality of maternal and child home visits through training, support, and enhanced local resources; to improve the home visiting program by increasing revenues through private insurance and Medicaid; and to expand the number of home visits by increasing outreach to postpartum women living in outlying areas.

Innovative Solutions to Problems

What made this project unique was its focus on visiting postpartum mothers while they were still patients at the hospital. Project staff members met mothers soon after their deliveries, established trust, and explained how the home visiting program worked. Mothers responded positively to the program, and the home visiting program was an immediate success.

To generate revenue through reimbursements, the project worked with local representatives of insurance companies, the billing offices at Forks Hospital and Olympic Medical Center, and the local social services office in Port Angeles. It also met with local employers to present the idea of adding a maternal and child home visiting component to their insurance plans as a way to emphasize prevention and reduce premiums.

Reimbursement issues, however, were the most significant challenge that the project faced. Many insurance companies did not understand the home visiting components of their policies. The hospital billing office did not know how to bill for the home visitation service, and Medicaid reduced its funding for home visitation. Addressing these challenges was a time-consuming process, but, in the end, the project succeeded in making substantial headway in generating project revenues.

Results

The project established postpartum home visiting programs at Forks Hospital and Olympic Medical Center, using policies and procedures for billing and reimbursement approved by the Joint Commission of Hospital Accreditation, assessment forms, and

computer interfaces. In addition, the project succeeded in using home visits as a means to increase rates of breastfeeding, decrease neonatal jaundice, and facilitate referrals to health and social services agencies. By 2002, nurses at New Family Services and Olympic Medical Center made universal home visits to more than 85 percent of new mothers within 72 hours after their deliveries. (Universal home visiting does not carry the stigma of being a high-risk patient.) More than 1,000 home visits were conducted in both 2001 and 2002.

Two of the network members became instructor certified in nursing child assessment satellite training through the University of Washington School of Nursing. These individuals are qualified to provide up-to-date training to health care workers throughout the peninsula. The project also conducted a 34-hour lactation certification course for 20 area health care providers; 2 workshops on how to reach out to the Latino community; Spanish-interpreter certification training for 20 participants; workshops on how to work with American Indian families; and ongoing trainings in third-party reimbursement issues targeting health care workers, insurance agencies, peninsula employees, and Clallam County commissioners. The project also partially funded the translation of the *First Teacher Newsletter* into Spanish for distribution to Spanish-speaking residents.

Potential for Replication

Assuming that reimbursement for maternal and child home visits remains stable, this model could work well in other settings. However, it requires initial investments to set the project up properly. Travel time for staff members is not reimbursable, so project planners must address this issue to ensure that the project remains self-sufficient. In addition, the changing third-party payor environment is uncertain and may affect project sustainability.

After the Grant

The program is largely self-sustaining, but revenues barely cover program costs. The project now generates approximately \$130,000 in annual revenues.

Community Characteristics

Southern Barbour and Randolph Counties are located in the Allegheny Highlands of West Virginia. Randolph County is well known as the largest county east of the Mississippi River, and both counties are among the five largest counties in the State; however, the primarily rural area has a sparse population density. This region of West Virginia is characterized by severe economic depression and rampant poverty. Before the grant award, mental health services were extremely limited, and many residents needing mental health care did not have reliable transportation to access the few services that were available.

Services Offered

The main goal of the Community Connection project was to provide integrated mental health and primary preventive services to adolescents and elderly individuals living in the Beverly, Daily, Mill Creek, and Mingo districts of Randolph County and the Belington district of southern Barbour County. Rather than adding new services, the project was designed to reduce the use of expensive inpatient mental health services by reducing the barriers to the less expensive outpatient mental health services available in the community. In addition, the project provided extensive case coordination with other service agencies on behalf of clients and their family members.

The project's network included Valley Health Care, Inc., a nonprofit rural primary care clinic; Youth Health Services, Inc., a nonprofit health and social services agency targeting children and adolescents; Elkins Family Counseling Center, a for-profit outpatient community mental health agency; and the Belington Community Medical Services Association (BCMSA), a nonprofit rural health care agency. This model was built on the success of a previous model, Health Connections, which provided comprehensive and integrated primary, mental health, and behavioral health care services within a primary care setting. Valley Health Care was involved in Health Connections and already had the model in place at its clinic site. BCMSA had adapted the Health Connections model for use at its site as well.

Innovative Solutions to Problems

The consortium sought to provide comprehensive health services, including outpatient mental health and behavioral health

WEST VIRGINIA



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services, to youth, adolescents, and elderly individuals in these rural communities. Elderly people needing mental health services received care through Elkins Family Counseling Center, whereas young people needing services were put in touch with Youth Health Services. After purchasing a 15-passenger van, the project was able to provide transportation to and from appointments for those in need. The project also implemented a marketing campaign to inform residents that mental health services were available and accessible, disseminated age-appropriate brochures about mental health, and erected information displays on mental health at local senior citizens centers and schools.

Results

During the grant period, Community Connection conducted more than 750 risk assessments involving adolescents and elderly individuals, and more than 650 clients received referrals to mental health care. Of these clients, 322 were children aged 0 to 9 years, 252 clients were adolescents aged 10 to 17 years, and 66 clients were elderly persons. The project provided transportation for clients who had no other means to attend their appointments.

Potential for Replication

The Community Connection model serves as a good example of how rural areas can make more effective use of their mental health resources and enhance the integration of mental health and primary care services. Mental health problems affect people of all ages—young and old alike—and rural residents are not immune to these issues. Many rural communities could benefit from a model that is specifically geared toward the unique mental health needs of adolescents and elderly adults. However, it is important to note that the stigma associated with mental health problems continues to impede many individuals from seeking help. Other communities will need to develop culturally appropriate, age-specific strategies for combating the stigma associated with mental health problems so that people needing help are willing to access the services available to them.

After the Grant

The Community Connection project will continue to provide integrated mental health and primary care services to the residents of southern Barbour and Randolph Counties. The network members have agreed to continue working together to sustain this program in the years to come. In addition, each facility is seeking new funding sources so that mental health services can be expanded to additional age groups needing mental health care.

PROJECT 58—EASTERN PANHANDLE INTEGRATED DELIVERY SYSTEM RURAL HEALTH OUTREACH PROJECT

Community Characteristics

At the time of the grant award, people aged 55 years and older living in the eastern panhandle of West Virginia experienced high rates of preventable, lifestyle-related health conditions that put them at serious risk for disease. These conditions included obesity, heart disease, sedentary lifestyles, and tobacco use. Elderly individuals, particularly those in rural, impoverished areas, often took multiple medications for multiple medical conditions. They also were at increased risk for depression and other mental illnesses.

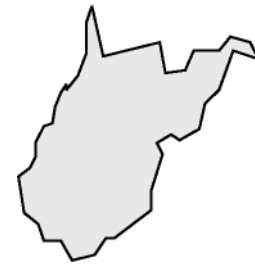
The project was designed to promote health, prevent disease, and increase access to health care services for older individuals by providing outreach and education about existing health care and social services. The project focused on individuals aged 55 years and older living in the six most medically underserved counties in the mountainous, eastern portion of West Virginia. This population ranks among the highest in West Virginia for the number of elderly persons living below 100 percent of the Federal poverty level. The counties in the service area were Grant, Hampshire, Hardy, Morgan, Pendleton, and Tucker Counties.

Services Offered

Under the leadership of the Grant County Health Department, the Potomac Highlands Health Departments, which consisted of five county public health departments, assumed responsibility for coordinating a breast and cervical cancer screening program and a cholesterol and blood pressure screening program, as well as for developing a new prostate screening program. The Potomac Highland Mental Health Guild and East Ridge Mental Health Services, both of which are nonprofit mental health centers, coordinated a new mental health program in partnership with the six county Commissions on Aging and the Upper Potomac Area Agency on Aging. An exercise psychologist at the Hardy County Health and Wellness Center created exercise and prevention programs to be offered at the Wellness Center, Grant Memorial Hospital, the six Commissions on Aging, and numerous worksites in the region.

The lead agency for the project, Grant Memorial Hospital (GMH), developed diabetes and osteoporosis screening programs and supported the expansion of its breast and cervical cancer

WEST VIRGINIA



**EASTERN PANHANDLE
INTEGRATED DELIVERY
SYSTEM RURAL HEALTH
OUTREACH PROJECT
PETERSBURG, WEST VIRGINIA**

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programs. It also used grant funds to augment its cholesterol and blood screening programs. In addition, GMH created an encounter database to track participation and a regional health care resources directory, and managed the cardiac, diabetes, multiple sclerosis, fibromyalgia, and cancer support groups. The consortium members agreed that all of the programs, screenings, and services offered by the program had to be self-sustaining.

Innovative Solutions to Problems

The project used several innovations to promote health and prevent disease. “Lunch and Learn” educational programs were offered at worksites and Commissions on Aging throughout the six counties. Typically conducted during the noon hour, the “Lunch and Learn” programs provided an opportunity to educate elderly residents about exercise, nutrition, diet, diabetes, mental health, and substance abuse. Another project innovation involved the adaptation of the diabetes and osteoporosis screening programs so they could be delivered at health fairs throughout the six-county region. The project purchased an osteoporosis screening machine, and two staff members from each of the participating health departments receiving training in how to use the machine. GMH’s radiology department agreed to read the screening results, identify individuals with borderline problems, and refer those patients to care. Registration forms were designed so that screening results could be recorded in triplicate—a copy for the patient, a copy for the screeners, and a copy for the health care provider. The design of these forms also helped to identify elderly individuals without primary care providers or health insurance coverage.

Results

Before this project, no prostate, osteoporosis, or diabetes screening services were available in the region. If patients receiving prostate screenings had insurance, their insurance company was billed \$16.80 for lab fees. If the patient had no insurance and was unable to pay, the lab fees were billed to the grant. In 2002, 381 men received prostate screenings, with 35 referred for followup care. Twelve providers conducted the 2002 and 2003 prostate screenings, and they were compensated by the grant for providing their expertise. Many area health care providers are now referring patients to the program to receive affordable prostate screenings.

All six health departments offered osteoporosis screenings in 2002, with 700 people receiving free screenings. More than 200 individuals received referrals for further evaluation. Osteoporosis screenings are now held in conjunction with the monthly breast and cervical cancer screenings offered at the hospital and at the Grant and Pendleton County Health Departments.

Diabetes education and screening days were held at GMH as part of the “Passport to Health” program. Free screenings also were provided at local health fairs. More than 600 people received diabetes screenings, and 50 people were referred for additional care. The project also has received an increased number of referrals to the diabetes screening program from area providers.

Meeting the mental health and substance abuse needs of area residents proved to be a substantial challenge. Many area residents simply were not able to overcome the stigma associated with these disorders, and, as a result, only a limited number of elderly individuals sought care for these disorders.

The most important lesson learned was the importance of using a tracking database to monitor patient outcomes. Such a database should be launched at the beginning of the project rather than trying to implement the database midstream.

Potential for Replication

This model would work well in other rural areas. One lesson learned involves the importance of being willing to adjust the grant goals and to modify the grant budget to achieve the project goals. Challenges that other communities may experience in replicating this model include a lack of participation by area health care providers and a limited understanding among health care providers and the community about the mental health and substance abuse needs of elderly residents. Like this project at the outset, other communities may not have a comprehensive database in place to document the health care needs of older individuals and the services they receive. As stated above, such a database is critical to document encounters and track patient outcomes.

After the Grant

Most of the project's services are now self-sustaining. The consortium members agreed to meet two times a year for the next 2 years to continue coordinating their health promotion and disease prevention efforts.

Community Characteristics

Hardy County is located in the rural eastern panhandle region of West Virginia—known as the Potomac Highlands. About 12,000 people live in the county, with a population density of 19.3 people per square mile, which is significantly lower than the State average of 75.0 people per square mile. The county is geographically divided into east and west by a large mountain range, which also separates area school sites.

The majority of people living in Hardy County are low-income families. Many of these families are uninsured or underinsured and must rely on public-sector programs, such as Medicaid and Medicare, for health care coverage. Farming, including poultry production and processing, is the major industry in the area. There is no reliable public transportation, and although there are several highways, most are two-lane roads. The majority of children ride a bus to school, with travel time taking up to 1½ hours each morning and afternoon.

School-age children in Hardy County experience high rates of poverty, and because of the rural, mountainous terrain, they have poor access to health care services. As a federally designated health professional shortage area and medically underserved area, the county has only a limited number of health care providers.

Services Offered

The Hardy County School-Based Health Project was a collaborative effort involving the E.A. Hawse Health Center, Inc. (EAHHC), the Potomac Highlands Mental Health Guild (PHG), and the Hardy County Board of Education (BOE). The BOE provided space and assistance in conducting the program, as well as staff members to support the project. EAHHC, a nonprofit federally qualified health center, provided two physician assistants, who delivered primary care services on a daily basis to preschool through 12th grade students. PHG, a nonprofit outpatient mental health care provider serving the region, is staffed by a licensed clinical social worker (LCSW), a licensed professional counselor, and two bachelor's level social workers. The primary goal of the project was to improve access to health services for children in the Hardy County schools and to enhance their physical and emotional well-being by providing them with comprehensive health care services. Specifically, the project was designed to

WEST VIRGINIA



**HARDY COUNTY SCHOOL-
BASED HEALTH PROJECT
BAKER, WEST VIRGINIA**

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- Decrease disruptive behavioral episodes, suspensions, and expulsions
- Help provide a nurturing and safe environment for children
- Increase understanding and cooperation among the education, health, and mental health systems
- Improve each student's ability to reach his or her full academic potential without interference from physical or mental health issues
- Support families in their efforts to nurture their children and raise competent adults

Innovative Solutions to Problems

Primary care services were made available onsite at the three school complexes in the county—an elementary and high school, a middle school, and a preschool through eighth grade with another high school across the road. Services were available to students every schoolday, and services also were available after hours through a 24-hour telephone number for primary care and a toll-free telephone number for crisis mental health services. At first, recruiting qualified, competent staff members for the health centers was a difficult challenge, but eventually the project was able to hire capable primary care staff members. Another challenge was recruiting staff members who met the necessary qualifications for billing. Many well-qualified professionals cannot bill for services because billing is restricted to LCSWs and clinical psychologists. As a result, some staff positions were covered by grant funds.

Results

The project served nearly 2,000 individuals—the vast majority of whom were students. Some 1,086 were children aged 0 to 11 years, and 698 were adolescents aged 12 to 19 years. Service utilization increased dramatically during each year of the grant cycle, with 1,244 individuals receiving 3,129 units of primary care in year one and 1,993 individuals receiving 5,952 units of primary care in year three. Similarly, 206 clients received 834 units of mental health care in year 1, and 560 received 997 units of mental health services in year three.

The project yielded several additional accomplishments. For example, staff members organized a prevention program that was offered at East Hardy High School and at special events at two middle schools. The program promoted tobacco and substance

abuse prevention and provided health-positive alternatives for children and adolescents. Ultimately, the project was selected to develop statewide public service announcements on substance abuse prevention. In addition, articles about children's mental health appeared regularly in the Hawse Health Center newsletter, increasing awareness of children's mental health issues among the target audience.

Potential for Replication

This model could be replicated successfully in other rural areas. In fact, the project team already has provided technical assistance to other West Virginia communities planning to replicate the Hardy County model, and the mental health project has gained local, State, and national recognition.

It is important to note that school-based health care services require increasing community awareness of the project's goals and services and generating broad-based community support. The project also requires securing the firm support of the local BOE during the planning phase—before the project is implemented.

After the Grant

The Hardy County School-Based Health Project plans to continue providing school-based primary care and mental health services at the East Hardy site. Only primary care services will be offered at the Moorefield sites until additional funding is secured to support mental health services at that location. Due to budget constraints, PHG decided to stop participating in the school-based project and terminated the mental health team's services in June 2003. As a result, EAHHC submitted an application to the West Virginia Health Care Authority to become a mental health care provider site. The request was granted, and the project hired an LCSW and a social worker to strengthen the project's mental health services. The project continues to seek additional funding from local, State, and private foundation sources to help sustain project activities.

Community Characteristics

People with HIV/AIDS often lack access to the services they need. People with HIV/AIDS who live in rural areas face even greater challenges than their urban peers because of the culture and environment in which they live. Add to that circumstance the fact that poor adherence to medications results in frequent hospitalizations and increased medical expenses—both for the client and the community. On the other hand, complete adherence to drug therapies and health care regimens enhances quality of life, reduces disease progression, and inhibits the spread of HIV.

West Virginia is one of the most rural States in the Nation. Meeting the health care needs of West Virginians with HIV/AIDS is complicated by physical disconnection from services, supports, and health care; social isolation and community stigma; high illiteracy, substance use, and poverty rates; mistrust of health care providers; and impatience with complex medical combinations, rigid dosage schedules, and harsh reactions to medications.

The target service area for the Rural Health Outreach program encompassed all 55 West Virginia counties, the majority of which are rural.

Services Offered

This program, the only one of its kind in West Virginia, was designed to overcome some of the key rural health care access issues experienced by people with HIV/AIDS. The program used mobile registered outreach nurses and case managers who sought to establish understanding and trust between patients and providers and to improve medication compliance through followup. The primary goal of the Rural Health Outreach program was to provide education and support as a means to improve adherence, stabilize the clients' health status, and reduce individual and community costs.

The partners for this program included the West Virginia Coalition for People With HIV/AIDS (The Coalition) and West Virginia Health Right. The Coalition comprises three AIDS service organizations—Covenant House, located in Charleston; Caritas House, located in Morgantown; and Community Networks, located in Martinsburg. Each coalition member provides housing and support services to low-income West Virginians with HIV/AIDS. West Virginia Health Right is a clinic located in Charleston that

WEST VIRGINIA



**RURAL HEALTH OUTREACH
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provides health care services to low-income and uninsured West Virginians in four southern counties.

As the lead agency for this grant, Caritas House was responsible for managing grant activities and providing a nurse to cover a 25-county region. Covenant House partnered with West Virginia Health Right, since both organizations are located in Charleston, and West Virginia Health Right provided a nurse to serve a 22-county region. Community Networks' nurse covered an eight-county region. The sites identified new clients either by professional referral or word-of-mouth. Most referrals came from surrounding hospitals, clinics, and physicians' offices.

Innovative Solutions to Problems

Each of the three sites employed a case manager who worked directly with the outreach nurse to meet each client's specific needs. On many occasions, the nurse and case manager conducted joint home visits. Health Right provided clinical support and oversight of the nurses' activities, while social service administrators in the three service areas ensured that systems ran smoothly in each service area.

The biggest challenge faced by the three sites was retaining qualified nurses. Although wages and benefits were consistent with the current marketplace for such skills, medical personnel are in great demand throughout the State, often leaving health professional shortages in the areas of greatest need. Another challenge was the mountainous terrain and long travel times for the nurses and case managers. Funding was not available to increase the number of nurses on staff.

Results

The Rural Health Outreach program's goals were to increase the number of clients receiving care and to improve medication adherence. In total, the program served 417 clients. The majority of clients were male, 105 were female, and 14 were children aged 11 years or younger.

The one-on-one, in-home service delivery model used by the nurses and case managers was effective in allowing clients to have their needs met in a timely, noninvasive manner. Having nurses travel to clients' homes to answer their medical questions and help them sort out their medical needs proved to be an effective approach.

Although first-year data regarding adherence are not available, data analysis demonstrates that the medication adherence rate was approximately 90 percent, based on client self-report and information gleaned from a monthly data collection sheet. In the majority of cases, clients' lab results pointed to good adherence with their medical regimens.

Potential for Replication

A program focused on increasing access to care and improving medication adherence is applicable to many rural areas. The success of such health promotion programs, however, depends on three key factors. First, the program must have a close relationship with physicians, clinics, and social service agencies in the service areas. This relationship is vital to generating referrals and helping clients successfully navigate the local health care system. Second, the program must contact clients either by phone or in person to collect medication adherence information. Third, an open and trusting relationship must be cultivated between the client and the program to ensure truthful self-reporting regarding medication adherence.

After the Grant

The Coalition intends to use another 3-year grant to continue services and is seeking funding from various foundations. The Coalition also hopes to expand learning opportunities for nursing students by allowing fourth-year nursing students to "shadow" the outreach nurse. This opportunity would enhance their knowledge and skills regarding how to meet the needs of people with HIV/AIDS and their understanding of how to work effectively with social service agencies to meet those needs.

The Coalition continues to work together as the only statewide AIDS housing group.

Community Characteristics

Before receiving the ORHP grant, children and families in Grant County, Wisconsin, faced many barriers in accessing family and health-related services. The most difficult barriers to these services were geographic, social, and economic in nature. Grant County is a rural area, and farming and agribusiness are entrenched in the county's social fabric. Geographically, it is the eighth largest county in Wisconsin, with 49,600 residents. More than 10 percent of county residents live below the Federal poverty level, compared with 8 percent statewide.

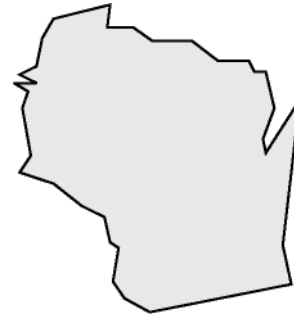
There is no public transportation system in Grant County, and some families have no vehicle to drive to health and social service appointments. Many parents have more than one job, often at minimum wage, which prevents them from using primary care and preventive health services because of time and health insurance constraints. At the same time, area service agencies offered many duplicative programs, such as parenting education, nutrition education, and child development services, even though such services were severely fragmented because of personnel limitations.

Services Offered

Connect for Healthy Kids targeted all families with children—from unborn children to children 8 years of age—in Grant County. The project was supported by a diverse network of organizations, including the Southwestern Wisconsin Community Action Program, Inc., the Southwest Health Center, the Grant County Health Department, Head Start, the Family Center, Child Care Resource and Referrals, the Even Start Family Literacy Program, Grant County Extension, and the University of Wisconsin-Plattville Early Childhood Department.

The project centrally coordinated and co-located health education, health promotion, and disease prevention services targeted to families with young children. The partners joined forces to provide health and developmental screenings; followup care; the Women, Infants, and Children (WIC) supplemental nutrition program; prenatal/childhood health and nutrition education programs; parenting education and family support programs; adult basic education services; training and resources for child care providers; lending libraries for toys, books, and equipment; child passenger safety checks and information; and activities sponsored

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through the Parent and Child Together program. Services were provided either at center-based sites or through home visits.

Innovative Solutions to Problems

One of the project's main innovations was identifying parents of newborns in the obstetrics departments of the county's three hospitals. After an initial contact, parents were given the opportunity to receive home visits, to join the programs of their choice, and to receive services offered by the network. In addition, through collaboration with area schools, Even Start, Healthy Start, and the Family Center were co-located at the Prekindergarten and Kindergarten Early Learning Center. To support this effort, early childhood students at the University of Wisconsin-Platteville served as volunteers at this facility to receive practicum experience. The students worked with families and planning agencies to provide and coordinate services. Families also participated in playgroups, field trips, child passenger safety checks, and workshops that were planned and offered collaboratively by the network partners.

As is common in many rural areas, families feel a responsibility to provide for their children, so they are reluctant to ask for assistance or resources. In such cases, home visits were a beneficial approach to reduce the "threat" of outside influences on the families. Other effective methods of engaging these families included distributing newsletters and providing a toll-free information line and Web site.

Finally, co-locating project services helped increase collaboration among the network partners, promote joint planning of activities, and make the most efficient use of limited staff time and resources. Ultimately, this approach increased both the service capacity of the network and the quality of services provided to clients.

Results

The project's prenatal/childhood health and nutrition education programs reached 1,875 families in the region, and the parenting education and family support programs reached 1,960 families. Some 2,620 children received health and developmental screenings and followup care. Approximately 2,100 families were served through the WIC supplemental nutrition program, and 610 families benefited from the child passenger safety checks programs. In addition, 820 childcare providers received training and information

about local resources. In total, Connect for Healthy Kids reached 5,525 children, 185 adolescents, 4,535 adults, and 40 elderly individuals.

Potential for Replication

The project's structure was adapted from the Healthy Families America model, which emphasizes a holistic approach to health education and service delivery. With the national model in mind, other communities could apply the Connect for Healthy Kids model in their area. In doing so, it is best to begin the replication process by conducting a comprehensive assessment of community needs, forming a diverse and strong collaborative, and developing a strategic plan for achieving the desired change in the community's service infrastructure. It also is important to identify and understand the barriers that families face in accessing services and to sustain active involvement in the collaborative. If those preliminary steps are taken, the one-stop-shopping model of service coordination and delivery can maximize limited resources, enhance the capacity and quality of services, decrease costs, and reduce duplication of effort.

After the Grant

Connect for Healthy Kids played an important role in establishing and strengthening relationships among the network partners. Many of the project's services will continue to be provided jointly by the network members, but because of resource constraints, it may be necessary to offer these services on a smaller scale than was possible when grant funding was available.

Community Characteristics

The love and attention that parents provide children in the first years of life provide a critical foundation that lasts a lifetime. However, a wide range of stressors can jeopardize the healthy development of children. Today, many families struggle to maintain their strength, pay their bills, and provide a safe and secure environment for their children. Children who are victims of abuse can experience delayed development, as well as poor psychological and physical health.

Families in Oneida County, Wisconsin, face additional hardships. Like many other communities, the local economy in this northern Wisconsin county is suffering. Due to the abundance of forest land, lakes, rivers, and heavy snow—and only two major, year-round population centers—a substantial amount of time can be required to travel from one region of the county to another. These realities can lead to social isolation and limited access to services.

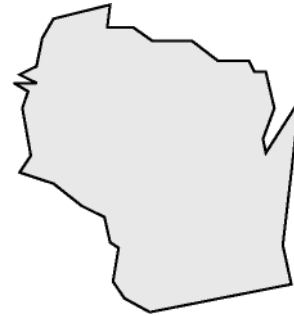
Services Offered

The Oneida County Department of Social Services, along with Howard Young Health Care and Sacred Heart-Saint Mary's Hospitals, launched the Family Net program to provide a more coordinated, better functioning system of care for at-risk families. Services offered by the program included parenting education and support services. The centerpiece of Family Net was a home visitation program designed to promote positive parent-child interaction and healthy childhood growth and development.

The Family Net home visitation program was offered to any Oneida County family with a child younger than 1 year of age at the time of entry to the program. Weekly home visits emphasized a strength-based, family-centered approach that promoted nurturing, empathetic parent-child relationships, and healthy childhood growth and development. Families involved in the program were afforded access to information and activities designed to help parents achieve eight key outcomes:

- Families access formal and informal support services geared toward specific needs.
- Parents respond effectively to their child's needs for care, comfort, and stimulation.
- Parents interact with their child in ways that enhance the child's learning and development.

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- Parents use positive parenting techniques.
- Parents demonstrate appropriate behavior management skills.
- Parents have realistic expectations when interacting with their children.
- Families implement changes to promote child safety.
- Parents establish a medical home for their child.

Innovative Solutions to Problems

One of the most innovative aspects of the program was how families became involved. Some eligible families were referred to the program. Many entered through the Kid's Net program, which consisted of a Kid's Net coordinator visiting all new mothers before they left the hospital. Regardless of the point of entry, the initial interaction with eligible families provided an opportunity to tell families about the supports and resources available to them in the community, and to immediately link those who wanted to participate with the services they needed. This method of outreach worked extremely well.

The program emphasized a "wraparound" approach to services coordination and delivery. When families had complex needs, current providers and other needed service providers were brought together during the engagement and assessment period. Staff members were committed to facilitating all of the services and supports each family needed and, when necessary, to creating an extended "family" that could provide ongoing support.

The program experienced three major challenges. First, since two small programs in the county had provided parenting education and support through home visits, confusion resulted when the programs were brought together and expanded. To remedy this situation, the project fine-tuned its marketing and outreach efforts and promoted its toll-free number. Second, it took longer than expected for the consortium members to learn how to work together. At first, a clear understanding of each member's roll in the program was lacking, which created a great deal of tension. To fix this problem, an independent evaluator was brought in to interview the members of the project's steering committee, to evaluate the collaborative process, and to prepare a report that was distributed to the steering committee members. Third, since Howard Young Health Care and Sacred Heart-Saint Mary's Hospitals had

previously operated home visitation programs, but in different fashions, the Family Net program had to develop an infrastructure for integrating the two programs into a unified and expanded program. This challenge involved creating new policies and procedures and developing a “Growing Great Kids” curriculum, which ensured that the same information was shared with each family. At first, some home visitation staff members resisted the more structured approach. However, the program listened to their concerns, developed a series of expected outcomes that all visitation staff members could support, and created more user-friendly forms for documenting service information.

Results

The program successfully developed a service delivery infrastructure by creating a unified and committed leadership foundation, by soliciting input from organizations throughout the service delivery system, and by cultivating a philosophy and model for service delivery that emphasized shared approaches, a shared system of quality control, and a shared evaluation protocol.

Throughout the project period, the number of families participating in Family Net increased steadily to an average of 65 actively involved families at any given time. Family Net visited a total of 123 families. The project also made substantial gains in increasing parents’ awareness and basic knowledge of the psychological, social, and physical needs of children.

Another important outcome of the program was increased knowledge and skills on the part of home visitation staff members. The program sponsored a 3-day workshop early in the grant period to train staff on how to use the “Growing Great Kids” curriculum. Home visitation staff members also met once a month with a child psychologist to better understand how to advise parents to deal with a child’s problem behaviors. In addition, staff members were able to participate in other training and education opportunities as time and resources allowed.

One of the most important lessons learned as a result of the project was the need to ensure that all project staff members clearly understood specific information to be collected for evaluation purposes and the frequency of data collection. Although documentation increased the workload on staff members, they grew to understand the importance of collecting this information in an

accurate and timely manner. It also was helpful to develop a customized data collection and storage system to be used and shared by everyone involved in the program.

Potential for Replication

The Family Net model would work well in communities with fragmented or duplicative programs or services for families. By forming partnerships with other agencies, including those that may be viewed as “competitors,” resources can be pooled, and the range of services available to families can be significantly expanded.

Many communities offer services to families when a baby is born but do not offer followup services after the first few weeks. Prevention-oriented programs such as Family Net can be more successful than intervention-oriented programs that are accessed only after a problem has occurred. They also can teach positive parenting practices—before negative parenting patterns are established.

After the Grant

Various funding sources are being investigated to sustain the home visitation program. The program is considering a range of options to help sustain it if funding is not located. These options include limiting the frequency of visits, narrowing the target population, or decreasing the length of time families can participate.

Community Characteristics

Farming is one of the most dangerous occupations. Farmers and agricultural laborers face many barriers in accessing occupational health services that can educate them on how to prevent injuries and poor health. The rising cost of health insurance forces many people living in farm households to forego doctor visits or preventive health education—a problem that has been magnified in recent years because of low market prices for milk, livestock, and crops.

In rural Wisconsin, many health care professionals lack the experience, training, and expertise to meet the unique needs of farmers and farmworkers or to recognize farming-related diseases. The Partners in Agricultural Health (PAH) program was created to address the education and service needs of both health care professionals and farmworkers in Adams, Juneau, and Sauk Counties. While the farm industry in these counties depends largely on dairy farming, many area farmers raise crops, vegetables, fruits, hogs, and poultry.

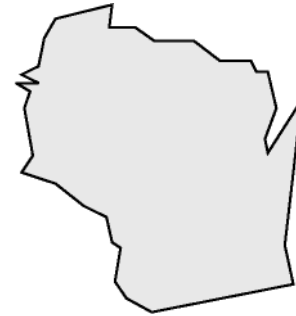
Services Offered

PAH was designed to strengthen existing occupational health services within three county health departments and five participating hospitals by providing educational programs and preventive screenings for farmers and their family members, creating an educational program for health professionals to enhance their understanding of the unique education and health care needs of farmers and agricultural workers, and developing an interactive Web site to market the project and disseminate educational information (www.farmershealth.com). Specific services offered by the grant included health promotion and disease prevention screenings; counseling, referrals, and case management services; and health and safety education for farmers.

The PAH consortium included the following organizations:

- Five area hospitals, which contributed staff resources, in-kind hours for educational services, equipment, supplies, and the in-kind participation of their chief executive officers on the project Steering Committee

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- Three county health departments, which supplied staff members to provide direct services and referrals at health fairs and agricultural events, outreach services, in-kind educational services, equipment, and supplies
- The Rural Wisconsin Health Cooperative, which provided fiscal management and oversight
- The Wisconsin Office of Rural Health, which conducted ongoing evaluations of grant activities
- The Southwest Area Health Education Center, which conducted educational seminars and trainings for area health care professionals

Educational programs also were offered at church council meetings, agribusiness workshops, women's health conferences, and tractor safety classes. The project sponsored weekly public service announcements, which were aired on local radio stations, focusing on agriculture-related injuries. In addition, project coordinators were interviewed on several regional radio talk shows and staffed educational booths at local agricultural events, county fairs, expositions, and workshops.

Innovative Solutions to Problems

The project offered its services at times and locations that were convenient for the farmers rather than the consortium members. Health screenings and educational sessions were held at dairy breakfasts, agricultural meetings, county fairs, and churches. Health screenings—including blood sugar, cholesterol, skin cancer, back, pulmonary function, and audiology screenings—were provided to farmers and farmworkers at the participating hospitals on a quarterly basis. Parish nurses participated in the project's educational component by setting up health education bulletin boards at area churches and updating the bulletin boards each month.

Another innovative feature was the project's Farm Health and Safety Curriculum, which was available in hardcopy as well as on the PAH Web site. The curriculum included chapters written by farm health experts, handouts for lectures at community events, and 11 self-study modules that could be downloaded in a PowerPoint format.

Results

More than 1,200 health screenings were provided to area farmers and farmworkers. Some 62 clients were referred for followup care, and 13 clients received case management services. About three-quarters of those served were males, but the project also served a large number of women and adolescents. In addition, a total of 2,100 hours of provider education were offered during the grant cycle, which is about half of the hours offered during the project's third year.

The project yielded several key lessons about providing education and screening services to farmers and farmworkers:

- Providers should listen to the needs of farmworkers and incorporate their suggestions into project activities. This approach helps to ensure that services are responsive to their needs and cultural expectations.
- It is important to be sensitive to the unpredictability of the weather and the unforeseen tasks that can arise on a particular farm on a given day. These factors can prevent farmers and farmworkers from attending a scheduled screening appointment.
- Having screening personnel dressed in street clothes increases the likelihood that farmers will approach them and be more willing to receive screenings or educational materials.
- A wide variety of channels should be used to reach the farming community, including radio, newspapers, local merchants, parish nurses, Web sites, and local events.

Potential for Replication

This model relied heavily on in-kind support provided by the consortium members; therefore, replicating such a model requires either additional funding sources or a firm commitment on the part of the network partners to provide in-kind resources.

After the Grant

The network partners have incorporated the health screening and farmer education activities into their own programs so that these services can be sustained. The Rural Wisconsin Health Cooperative will manage the PAH Web site, and the Wisconsin Office of Rural Health will update the Farm Health and Safety Curriculum on a regular basis. In addition, the University of Wisconsin Department of Distance Learning will continue to provide continuing education units in farm health and safety for physicians and nurses.

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