
PROGRAM OVERVIEW	<i>PAGE</i> iii
MAP	v
GLOSSARY	vii

<i>State</i>	<i>Project Number and Title</i>	<i>Page</i>
ALABAMA		
	1. Healthy Schools-Healthy Kids	1
ARKANSAS		
	2. Delta Enterprise Community Rural Health Outreach Program.....	5
FLORIDA		
	3. Panhandle Mobile Dental Program	9
GEORGIA		
	4. Southwest Georgia Multicultural Health Initiative	13
	5. Meadows Regional Medical Center Rural Health Outreach Project.....	17
INDIANA		
	6. Washington County Rural Health Outreach Grant Program.....	19
KENTUCKY		
	7. SKIPA (Southeastern Kentucky Initiative for Pediatric Asthma).....	23
LOUISIANA		
	8. Farmworker Health Initiative	25
MONTANA		
	9. Park County Diabetes Project.....	29
NORTH CAROLINA		
	10. The West Middle School Wolverine Den of Health	31
	11. Rural Health Outreach Program for Southeastern North Carolina.....	35
NEBRASKA		
	12. Diabetes Project.....	39
OREGON		
	13. Samaritan North Lincoln Hospital Community Clinic.....	43
PENNSYLVANIA		
	14. Charlie's Place: Targeting Adolescent and Community Health	47
SOUTH CAROLINA		
	15. Allendale Women's Health Project.....	51
TENNESSEE		
	16. Lauderdale Healthy Hearts	55
WASHINGTON		
	17. Childhood Asthma Project	57

2005 CONTENTS

WEST VIRGINIA

18. Nicholas County Rural Health Outreach Grant.....	61
--	----

INDEX	63
-------------	----

In 2001, the Office of Rural Health Policy (ORHP) awarded 18 projects in 12 States. 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 2001 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 18 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 2001 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 2001. 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.



GLOSSARY OF FREQUENTLY USED TERMS

CPR	Cardiopulmonary Resuscitation
LSU	Louisiana State University
SERPA	South East Rural Physicians Alliance
SKIPA	Southern Kentucky Initiative for Pediatric Asthma
WINGS	Women In Need of God's Shelter

Community Characteristics

Until the mid-1980s, the quality of health care in Pike County, Alabama, was among the worst in the Nation. Preventive health care services were virtually nonexistent, and while substantial progress has been made in improving the quality and availability of health care in the county, the health care needs of many county residents continued to go unmet.

The Healthy Schools—Healthy Kids Project targeted approximately 4,500 young people age 5 to 19 years in rural Pike County. The project was designed to reduce alcohol, tobacco, and drug use; to address unsafe sexual behaviors; and to improve healthy diets and physical activity among children and adolescents. It also was intended to improve awareness among parents about the negative impact of these behaviors on young people, and how these behaviors can continue to impact educational and social problems.

Services Offered

During the course of the project, the consortium increased from 15 members to 24 members. The consortium, which was led by the Charles Henderson Child Health Center, included Troy Regional Medical Center, Asthma Safari and Open Airways for Schools, Pike County Schools, Troy City Schools, the American Cancer Society, Troy Charity League, Troy University, Troy Publications, the City of Troy, the Alabama Cooperative Extension Service, the Alabama Department of Public Health, Tobacco Control and All Kids Insurance, the Troy Police Department, the Hive Creative Group, the City of Brundidge, Troy Group Home, East Central Mental Health, and the Troy Housing Authority. Specifically, the consortium members sponsored:

- Health assessments and scoliosis, hearing, and height/weight screenings
- Wellness appraisals
- Project Alert, an 11-week program focusing on tobacco, marijuana, inhalant, and alcohol education for 6th graders
- Tar Wars, an award-winning tobacco prevention program for 4th graders
- Heart Power/Kidney Kids, which taught elementary students about the importance of taking care of their hearts and kidneys
- Violence prevention, alcohol prevention, dating violence prevention, nutrition education, dental hygiene, physical

ALABAMA



**HEALTHY SCHOOLS—HEALTHY
KIDS
TROY, AL**

CONTACT:

**TERRY WATKINS
PROJECT DIRECTOR
CHARLES HENDERSON MEMORIAL
ASSOCIATION
1300 HIGHWAY 231 SOUTH
TROY, AL 36081
T: (334) 670-5261**

activity education, inhalant abuse prevention, obesity/diabetes prevention, stress management, sexually transmitted infection education, sexual abstinence education, and smoking cessation programs

- Community forums, health fairs, newsletters, and home visits targeting parents and guardians
- School health nursing services.

Innovative Solutions to Problems

The project used several innovative strategies to reach as many young people and parents as possible. For example, the project eased the burden on school nurses in Pike County by providing additional staff, equipment, and other resources. In addition, network members and services providers played an important role in identifying health risk behaviors and augmenting the efforts of school health workers. These strategies gave school nurses more time to conduct physical examinations, provide preventive care, and educate students about health-positive behaviors.

Other innovative strategies included:

- An Asthma Safari for 1st, 2nd, and 3rd graders and their families, during which local physicians, allergy specialists, pharmaceutical representatives, nurses, college students, and community volunteers came together to provide a fun-filled day of educational activities to help students and parents manage asthma appropriately
- An Abstinence in Motion program for 7th through 12th graders that involved classroom instruction, youth events, and a 30-minute teen pregnancy prevention skit
- Operation Save Teens, in which a narcotics officer and a mother who lost a child to a drug overdose gave a powerful, 90-minute presentation to high school students on the dangers and consequences of substance abuse.

Results

In total, the project provided nearly 47,700 units of health care, screening, educational, and transportation services to students and parents throughout the community. Specifically, the project provided services to more than 4,100 children and adolescents, and more than 2,800 parents and caregivers. The project succeeded in decreasing the number of students who carried weapons, were injured in physical fights, felt sad or hopeless, considered suicide,

ever tried smoking, reported alcohol or drug use, reported multiple sex partners or having sexual intercourse in the past 3 months, or used risky weight control measures. However, some health risks persisted. For example, fewer numbers of students reported engaging in physical activity, consuming appropriate servings of vegetables or milk, using protective helmets, and trying to lose weight.

Potential for Replication

Rural communities typically have limited health care budgets and manpower resources. This model demonstrates the success that can be realized when multiple community agencies unite to achieve common goals. Rural communities seeking to address the health care needs and risk behaviors of young people through health promotion and disease prevention can benefit greatly by replicating the Healthy Schools—Healthy Kids model.

After the Grant

Sustaining the comprehensive range of services offered by this project has proven to be a difficult challenge because of the limited financial resources available in the community. Project staff has sought additional funding from private foundations, area businesses, and the Federal Government.

PROJECT 2—DELTA ENTERPRISE COMMUNITY RURAL HEALTH OUTREACH PROGRAM

Community Characteristics

The Delta Enterprise Community Rural Health Outreach Program targeted a six-county region in the Arkansas Delta. Specifically, the primary goal of this program was to expand the availability of existing primary care, mental health, substance abuse treatment, and housing services for uninsured and underinsured individuals living in the region. Of those individuals targeted by the program, 25 percent were ethnic minorities, 20 percent were uninsured, 45 percent were elderly, and 51 percent lived below the Federal poverty level.

Services Offered

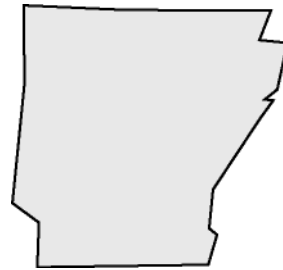
The project consortium consisted of three organizations. The White River Rural Health Center provided medical staff to deliver primary care services, referrals to mental health and substance abuse treatment, and followup care. The North Arkansas Human Services System provided comprehensive outpatient and residential mental health and substance abuse treatment for clients, regardless of their ability to pay for such services. Finally, Arkansas Affordable Housing provided housing for disabled individuals, including those targeted by the outreach program.

The program hired and trained outreach workers to help spread the word that primary health care, mental health, substance abuse, and housing services were available to those who needed them. The program also linked underserved and uninsured clients to health insurance coverage so they could access available services and learn about health-positive behavior changes they could make in their lives.

Innovative Solutions to Problems

The outreach workers served as a single point of contact for low-income persons of all ages to gain access to medical, behavioral, housing, and support services. Once engaged, those in need were encouraged to go to the White River Rural Health Center for initial screening and assessment. Case managers were then responsible for determining each client's unique needs and providing referrals to mental health, substance abuse treatment, and housing services as needed. Clients received care on an ability-to-pay basis, with the most indigent clients receiving the full range of services they needed at no cost.

ARKANSAS



**DELTA ENTERPRISE
COMMUNITY RURAL HEALTH
OUTREACH PROGRAM
AUGUSTA, AR**

CONTACT:

**JOEY MILLER
CHIEF OPERATIONAL OFFICER
WHITE RIVER RURAL HEALTH
CENTER, INC.
623 NORTH 9TH STREET
P.O. BOX 497
AUGUSTA, AR 72006
T: 870-347-2534
E-Mail: JOEY.MILLER@WRRHC-
AR.ORG**

Initially, the outreach workers would visit with potential clients, give them a packet of information describing the program's services, and provide the client with a referral slip to the White River Rural Health Center. At first, some clients did not take advantage of the services available to them. However, once each outreach worker kept a copy of the referral slip, he or she was able to follow up with potential clients to answer any questions, to encourage them to seek the care they needed, and to ensure that those who sought care, but lost their paperwork, were covered by the outreach grant.

Results

The program provided services to 828 adults, 525 elderly persons, and 521 children and adolescents. These clients received 1,193 units of health care services and 498 units of mental health or substance abuse treatment services. Transportation was provided for 100 clients, and 224 clients were enrolled in Medicaid as a result of their participation in the outreach grant.

One of the most important lessons learned as a result of the project was the importance of getting as much information as possible from the client on his or her first visit to the White River Rural Health Center and maintaining contact with clients to keep them engaged in care. Outreach workers were responsible for scheduling client appointments with the eligibility worker to determine if the client qualified for Medicaid or other entitlement programs. They also were responsible for ensuring clients kept their appointments. Unfortunately, clients do not always keep their appointments or bring all of the necessary documentation with them to determine eligibility. This required persistence on the part of outreach workers, as well as a commitment to maintaining frequent and open communication with clients.

Potential for Replication

This project would work well in other rural settings. To create an integrated model of primary care, mental health, substance abuse treatment, and housing services, it is critical that the participating organizations share a commitment to the outreach model, as well as a commitment to working together. It also is important that such programs clearly communicate the project's goals and services throughout the community. Outreach workers must receive training

on each partner organization's mission, the services provided, and practical ways to gain the trust of clients who are reluctant to seek care.

After the Grant

Outreach workers continue to visit local churches, civic groups, community leaders, and businesses to remind them that services are available. The partner organizations continue to provide referrals to one another, based on each client's unique needs, and case managers continue to assist clients in applying for Medicaid or other entitlements. In-kind contributions, other grants, and patient revenues now support activities previously funded by the grant.

Community Characteristics

A significant proportion of low-income children in the Florida Panhandle do not have access to dental services, even though such services are identified as one of the benefits provided by Medicaid. Furthermore, very limited dental services are available to low-income residents. In fact, at the time of the grant award, no dentists routinely treated very young children in any of the five counties included in the project's service area. To make matters even worse, most residents in the region pay out-of-pocket for dental care, and many low-income residents did not access dental care unless they had serious pain or dysfunction.

Services Offered

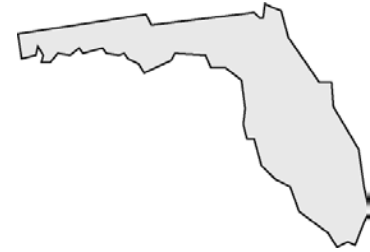
The purpose of this project was to implement a mobile dental service, Smiles on Wheels, that emphasized community-based oral health education targeting low-income preschool children through third-graders as well as pregnant women living in poverty in five rural counties in the Florida Panhandle (Jackson, Calhoun, Liberty, Washington, and Holmes).

The consortium members included the following:

- Jackson County Health Department, the lead agency for the five county health departments participating in the project, supervised the dental staff and site coordinator and processed all third-party billings and payments.
- The health departments in Washington, Holmes, Calhoun, and Liberty counties assisted in scheduling the mobile dental service at schools, childcare centers, and Head Start Programs in their counties.
- The school boards for all five counties sent parental consent forms home to second- and third-graders who qualified for free or reduced-cost lunches.
- Early Childhood Services and Head Start programs in all five counties obtained parental consent forms, encouraged families to complete evaluations, followed through with treatment appointments, and assisted in scheduling of oral hygiene presentations.

Specifically, the services provided by the grant included dental exams, fluoride treatments, sealants, and other treatments to low-income children age 3 through third grade who were eligible for free or reduced-cost lunches. The project also served pregnant women living in poverty.

FLORIDA



**SMILES ON WHEELS MOBILE
DENTAL PROGRAM**
MARIANNA, FL

CONTACT:

LISA LAMAR
EXECUTIVE DIRECTOR
PANHANDLE AREA HEALTH
NETWORK, INC.
2863 GREEN STREET, SUITE 2B
MARIANNA, FL 32448
T: 850.482.9088

Innovative Solutions to Problems

The mobile dental program was unique in that the clinic was able to travel to patients instead of waiting for patients to come to the clinic. Children received oral health care during regular school hours, which enabled the program to reach children who had not been to a dentist's office due to their parents' work schedules or transportation issues.

The project encountered several challenges. It was difficult to identify area dentists who were willing to accept Medicaid clients on referral. Solving this problem often involved pleading with area dentists to accept new referrals. Another challenge was getting pregnant women to show up for their dental appointments. Some 249 pregnant women who qualified for care were scheduled for dental services, but only 124 showed up for their appointments. To address this challenge, the project started calling women to remind them of their scheduled appointments.

At first, many parents did not allow their children to receive dental services—perhaps because they did not know the program dentist or had not met the program staff. Program planners quickly learned that this challenge was about “trust.” Many parents didn't trust the program because they didn't know the people who would be providing care. However, as more and more children benefited from the program, more parents were willing to allow their children to receive care.

Results

Between March 2002 and April 2004, 6,151 children eligible for free or reduced-cost school lunches and 124 pregnant women received preventive and restorative dental services. More than 350 parents completed the customer satisfaction surveys, and 99 percent of respondents noted that the program was a great service or that they mostly liked the service.

The program provided oral health education presentations to every pre-kindergarten through third grade classroom in 23 schools across the five-county service area. In addition, the program delivered oral health presentations at Head Start parent meetings, in classrooms, and to daycare operators in the five-county service area and Walton County.

In-service opportunities were given to nine hygienists and dental assistant students at Gulf Coast Community College and Tallahassee Community College. These students obtained clinical observation hours, and the more advanced students performed actual cleanings on patients. Students were mostly from the five-county service area, and Smiles on Wheels was a convenient way for the students to obtain clinical observation hours without having to travel extensively.

Smiles on Wheels distributed to its clients more than 2,500 applications for Florida KidCare (the State Children's Health Insurance Program) as well as KidCare promotional items such as toothbrushes and medicine spoons advertising the KidCare toll-free help line. Smiles on Wheels staff also distributed KidCare program flyers and training materials to teachers and other school professionals to help promote and increase enrollment in Florida KidCare.

Potential for Replication

The Smiles on Wheels Mobile Dental Program could succeed in other rural settings as long as there is broad-based community support from health departments, schools, and childcare providers, and a strong, focused steering committee that oversees quality assurance. Some of the primary challenges that other communities might face in replicating this model include addressing the lack of awareness about the importance of dental health care for children; combating territoriality among consortium members; recruiting dental professionals to serve in a rural community; accounting for poor road conditions and the toll they can take on a mobile dental unit and its equipment; and prevailing regulations about the provision of dental health care and who can bill Medicaid for such care.

It is important to note that, when this program started in March 2002, the Jackson County Health Department spent \$90,000 to start the program and hire staff. At the end of December 2003, the program had repaid the startup expenses and was operating "in the black." The project was even able to set aside \$200,000 to start up a new land-based clinic, which opened in December 2004.

After the Grant

The Smiles on Wheels Mobile Dental Program has become self-sufficient through the Medicaid billing. The dental bus will continue to serve low-income children and pregnant women.

However, the five health departments involved in the consortium have secured funding for land-based clinics in their counties. The Jackson County Health Department opened a dental clinic in October 2004, and two other counties are scheduled to open dental clinics soon. The dental bus will continue to provide oral health care and serve as a referral site to the land-based clinics for patients requiring extensive treatments.

PROJECT 4—SOUTHWEST GEORGIA MULTICULTURAL HEALTH INITIATIVE

Community Characteristics

During the 1990s, the State of Georgia experienced more than a 300-percent increase in its Hispanic population. However, the health care and social services, especially in impoverished and underserved rural areas like southwest Georgia, were not prepared to meet the health care needs of people with limited English proficiency.

In southwest Georgia, agriculture is the predominant, driving force of the rural economy. Some Spanish-speaking individuals who moved into the region during the 1990s became permanent residents, while others found work as migrant or seasonal farmworkers. But language proved to be a major obstacle that separated many Spanish-speaking individuals from receiving the health care they needed, including basic screenings for blood pressure and glucose levels. As a result, many Spanish-speaking residents received care only at the local hospital's emergency room—when their health had reached a crisis situation.

Services Offered

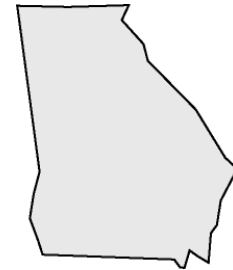
The Southwest Georgia Multicultural Health Initiative was created to achieve three primary goals:

1. to ensure that translation and interpretation assistance was available to individuals with limited English proficiency seeking care at local hospitals and health departments
2. to improve providers' understanding of cultural diversity issues related to the people they serve
3. to ensure that people with limited English proficiency have access to routine health education and screening services.

To achieve these goals, project activities included a telephone interpretation system, document translation, Spanish-language occupational classes for health care providers, and onsite health screening and awareness services for persons with limited English proficiency.

At first, the project's target service area consisted of Brooks, Early, Grady, and Mitchell Counties; however, during the grant cycle, the service expanded to include Thomas County. The original project network was comprised of John D. Archbold Memorial Hospital, Brooks County Hospital, Early Memorial Hospital, Grady General Hospital, Southwest Georgia Technical College, and Public Health Districts 8-1 and 8-2. However, as the

GEORGIA



**SOUTHWEST GEORGIA
MULTICULTURAL HEALTH
INITIATIVE
THOMASVILLE, GA**

CONTACT:

**AMY SCOGGINS
GRANT PROJECT COORDINATOR
JOHN D. ARCHBOLD MEMORIAL
HOSPITAL
P.O. Box 1018
THOMASVILLE, GA 31799-1018
T: 229-228-2822
E-MAIL:
ASCOGGINS@ARCHBOLD.ORG**

project developed, the network became less formal. Other community organizations supported the project's efforts, including the region's Area Health Education Center, local farmworker health clinics, family and community organizations, and two county school systems. While these community partners were not formal members of the network, they made a valuable contribution to developing and implementing project activities. Some of these activities included offering health screenings for migrant summer school students, providing screenings on Saturday evenings at a Catholic church before Spanish mass and in local trailer parks known to have a large Spanish-speaking population, and engaging nursing school students to conduct screenings.

Innovative Solutions to Problems

Project planners recognized that it would not be financially feasible to hire a staff interpreter at each facility participating in the network. Instead, the project created a telephone interpretation system that allows health care providers throughout the service area to contact an interpreter as needed. The system offered interpretation services for up to 150 languages, 24 hours per day. However, it required that each facility use the same telephone equipment, and staff members needed training to know how to use the equipment properly.

Another innovative feature of the project was the occupational Spanish language classes for health care providers. Both the Project Coordinator and the Regional Coordinator were certified as instructors in the Command Spanish, Inc.[®] curricula. This company offers several courses including "Spanish for Nurses," "Spanish for the Physician's Office," and "Spanish for Paramedics and EMTs." These courses teach participants words and phrases directly related to their jobs, so a nurse who must give a patient a shot can ask him to roll up his sleeve and make a fist without learning the entire Spanish language. More than 250 health care providers participated in the classes.

Results

During the grant cycle, approximately 18,000 units of interpretation services were provided at local health departments, and the telephone interpretation system was used for nearly 2,300 service encounters, with each call averaging approximately 8 minutes. More than 1,000 children and adults received health screenings and approximately 5,800 people received health care

services via the annual Emory University South Georgia Farmworker Health Program. In addition, the project has translated approximately 100 documents into Spanish and developed approximately 85 Spanish-language patient education videos.

Potential for Replication

Rural communities experiencing rapid growth in the number of Spanish-speaking residents may find this model to be a promising approach to promoting health and preventing disease among Hispanics. It is crucial, however, that the network members provide support—both financial and in-kind—for such a project. Many companies offer telephone interpretation services, and most charge only for the minutes used. Using such a service generally costs less than hiring a full-time interpreter, so many rural communities may benefit from such a service. In addition, many rural health care providers can benefit from learning how to say common medical terms in Spanish.

After the Grant

The project is seeking new funding to sustain its services. The Decatur County Health Department has expanded its services to three of the five counties in the original target area, and it will be able to continue providing care to farmworkers and their families in case new funding is not secured.

PROJECT 5—MEADOWS REGIONAL MEDICAL CENTER RURAL HEALTH OUTREACH PROJECT

Community Characteristics

Like many rural communities, counties in southeast Georgia have witnessed a significant influx of migrant and Hispanic families in recent years. However, because many of these families lacked access to primary health care, they were forced to seek care at local hospital emergency departments—often after their illnesses had worsened.

Services Offered

Four organizations joined forces to meet the health care needs of migrant and Hispanic families living in the target services area:

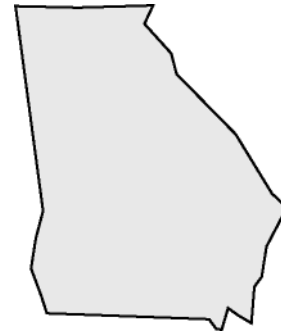
- The Meadows Regional Medical Center served as the lead agency for the project, provided staff and supplies, and purchased a van to bring primary health care services to residents.
- Women In Need of God's Shelter (WINGS), a domestic and sexual assault program, provided training to identify victims of domestic violence and offered counseling and shelter for domestic violence victims.
- The Episcopal Church of the Annunciation provided volunteers and locations for the mobile clinic.
- The Georgia Migrant Health Program provided medications and health services via the mobile clinic.

Together, these organizations provided a wide range of primary health care services, including general health, blood pressure, and blood glucose screenings. The screenings were offered at local churches as well as area farms during peak harvesting periods. The project placed strong emphasis on providing these services to uninsured and underinsured families living in the service area.

Innovative Solutions to Problems

The most innovative feature of the project was the use of a 33-foot recreational vehicle that was converted into a mobile laboratory and clinic. The van offered a portable examination room and administrative and waiting areas. The mobile clinic was intended to overcome the transportation barriers that prevented many residents from receiving routine health care. A translator, health care professionals, and administrative personnel staffed the mobile clinic.

GEORGIA



**MEADOWS REGIONAL MEDICAL
CENTER RURAL HEALTH
OUTREACH PROJECT**
VIDALIA, GA

CONTACT:

CRAIG STUCKLESS
**DIRECTOR OF INDUSTRIAL AND
COMMUNITY PROGRAMS**
**MEADOWS REGIONAL MEDICAL
CENTER**
1703 MEADOWS LANE
P.O. BOX 1048
VIDALIA, GA 30475
T: 912-538-5519
E-MAIL:
**CSTUCKLESS@MEADOWSREGIONAL
.ORG**

The biggest challenge for the project was a Georgia law prohibiting the delivery of medical treatment in a mobile setting. As a result, the project had to change its scope. Instead of providing medical treatment, which many residents desperately needed, the mobile clinic provided screenings only. However, in the second year of the grant, the project contracted with the Georgia State Farm Workers Program, which was exempt from the law, to provide health care services and prescriptions. Unfortunately, the State of Georgia cut funding for the Farm Workers Program, which prevented its participation in the project.

Results

The project provided screenings to nearly 1,500 people during the first year of the grant and to 1,219 people in the second year. The project met its goal of identifying 50 victims of domestic violence. The project's Outreach Pharmacy Assistance Program provided medications to 368 people in the first year of the grant and to 708 people in the second year.

Potential for Replication

This model could work well in other rural communities that do not have the same restrictions regarding delivering medical treatment via mobile clinics. People in rural communities often live far from health care facilities or do not have transportation to care. In addition, many rural elderly residents have difficulty getting their medications when they need them.

After the Grant

Because the project was unable to meet its original goal of providing mobile medical treatment services, grant funding was terminated. However, the Meadows Regional Medical Center continues to support the Outreach Pharmacy Assistance Program by providing prescribed medications to those in need.

PROJECT 6—WASHINGTON COUNTY RURAL HEALTH OUTREACH GRANT PROGRAM

Community Characteristics

Washington County, Indiana, is a rural county situated in south central Indiana that spans 516 square miles of countryside with hilly uplands, steep valleys, and large plains. Approximately 28,000 people live with the county's borders, and the per capita income for Washington County is \$23,119—much lower than other counties in Indiana and across the Nation. Nearly 11 percent of the county's residents live in poverty. The northern half of the county, which is home to the Jackson-Washington State Forest and numerous farms, is the most remote area. People who live in the northern half of the county are about 15 miles from the county's only hospital, making access to health care services a serious challenge.

Services Offered

The Washington County Rural Health Outreach Grant Program was designed to address four key health care issues facing county residents:

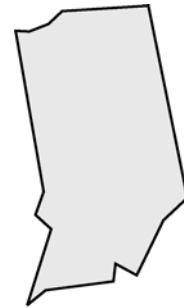
1. the lack of adequate, dependable, and affordable transportation to health care services
2. a need for health education
3. a need for outreach services to outlying areas of the county
4. a shortage of primary health care providers in the outlying regions of the county

The goal of the project was to enable residents to access health care and education services—either by transporting residents to locations where these services were offered or by providing these services closer to where the county's most rural residents live via clinics and outreach events. The project network included Hoosier Uplands, Washington County Memorial Hospital, and the Washington County Health Department. Together, these organizations sought to increase access to primary health care, health education and outreach, and transportation services. The project's target populations included poor, disabled, elderly, and Amish residents, as well as school-aged children.

Innovative Solutions to Problems

Amish families often refuse to receive health care services from facilities managed by “the English.” Recognizing this fact as a challenge, project staff members joined forces with two Amish women and community leaders to establish clinics in the towns of

INDIANA



**WASHINGTON COUNTY RURAL
HEALTH OUTREACH GRANT
PROGRAM
MITCHELL, IN**

CONTACT:

**STEVE ADAMS
DIRECTOR OF STRATEGIC
DEVELOPMENT AND CONSULTING
SERVICES
HOOSIER UPLANDS ECONOMIC
DEVELOPMENT CORPORATION
521 WEST MAIN STREET
MITCHELL, IN 47446
T: 812-849-4457
E-Mail:
SADAMS@HOOSIERUPLANDS.ORG**

New Philadelphia and Rosebud. The clinics were named Martha's Clinic and Marlene's Clinic—after the two Amish women who agreed to open their homes to the public health nurse and health educators. Since health, prevention, and education services were offered in Amish homes and endorsed by key leaders within Amish communities, Amish residents were significantly more willing to receive these services, which was critical because Amish families generally do not have health insurance and typically rely on faith-based health care. This positive relationship between project staff members and people throughout the Amish community laid the groundwork for the project to conduct school physicals at two Amish schools in October 2003. These physical examinations included vision and scoliosis screenings, height and weight checks, blood pressure and temperature checks, and oral health education.

Results

The project provided 13,658 units of unduplicated primary health care services to county residents, and health education and outreach efforts reached 4,360 individuals. In addition, the project provided 1,426 instances of transportation services. Roughly two-thirds of those who received primary health care or transportation services were adult women, while the vast majority of those who received transportation services were elderly women.

The program provided a variety of community outreach and health education programs, including tuberculosis testing, health head lice treatment, nutrition education, community immunization programs, health screenings, food safety education, diabetes education, hypertension education, childhood disease and illness education, and ear checks. These programs were conducted at local senior citizens centers, schools, Head Start facilities, and other forums. Evaluation data suggest that clients who were satisfied with the educational and clinical services would likely use those services in the future.

Potential for Replication

Remote, rural residents commonly have limited access to primary health care and health education services, and can only access such services when transportation is provided. As a result, this model is particularly relevant to other rural communities across the Nation. The degree to which this model would succeed elsewhere, however, depends largely on the strengths and attributes of the project's network. When organizations are able to work

together effectively, the possibilities are endless. This project also underscores the reality that it is possible for mainstream health care programs to provide health care, education, and screenings to Amish families when such programs are endorsed and supported by leaders within the Amish communities.

After the Grant

Washington County Memorial Hospital continues to coordinate transportation services for people living in the outlying areas of Washington County by becoming an approved Medicaid transportation provider. Meanwhile, the project continues to provide primary care clinical services, and staff members at the Washington County Health Department continue to provide outreach and screenings to Amish communities.

Community Characteristics

Before this project, medications to control asthma were under-prescribed in a four-county region in Appalachian Kentucky. Local schools and daycare staff members were not equipped with the knowledge and training they needed to recognize the triggers of asthma, to administer asthma medications properly, to identify asthma episodes, and to limit the severity of asthma attacks. In the Appalachian range of Kentucky, illiteracy is common, and many families lack reliable transportation. Access to medical facilities and specialists also is severely limited.

Services Offered

The Southern Kentucky Initiative for Pediatric Asthma (SKIPA) project conducted home visits to provide caregivers with knowledge, training, and support to decrease emergency department visits, hospitalizations, and school absenteeism related to asthma. The project conducted home visits to limit the transportation and other barriers of rural residents, low-income families, and elderly individuals.

In addition to conducting home visits, SKIPA provided continuing education units and continuing medical education for medical and school personnel in the service area. Project staff also provided training for several daycare centers in each county in the service area. These trainings covered topics such as asthma medications, asthma triggers, how to recognize asthma episodes, and what to do in the case of an emergency.

Innovative Solutions to Problems

SKIPA also partnered with one of the two pediatricians in Harlan, Kentucky, to provide educational training and counseling to parents of children with asthma served by the Daniel Boone Clinic and the Mountain Comprehensive Care Center in Owsley County. The project also participated in numerous community health fairs to increase public awareness of the proper ways to manage and control asthma as well as a local television program—“Issues and Answers”—and a WKEU radio interview. Project staff also helped to develop a Web site that answered basic questions about asthma.

KENTUCKY



SKIPA
HAZARD, KY

CONTACT:

KAREN D. COOPER
DISTRICT DIRECTOR
KENTUCKY RIVER DISTRICT
HEALTH DEPARTMENT
441 GORMAN HOLLOW ROAD
HAZARD, KY 41701

Results

The project conducted approximately 60 to 70 home visits each month during the grant period. Training and educational opportunities were provided at schools four times each month, and parent counseling was provided up to twice a week. The project also provided asthma education at community events about twice each month, reaching approximately 8,000 residents in the service area.

The project succeeded in improving the lives of patients with asthma by educating caregivers about the risks associated with dust mites, carpets, candles, heating and air conditioning, smoking/tobacco use, pets, exercise-induced asthma and school sports, and household chemicals and odors. The project also succeeded in teaching clients and caregivers to have rescue inhalers updated and in their possession at all times.

Potential for Replication

This model is a viable option for other communities experiencing high rates of asthma. Such a project is most likely to succeed if it emphasizes ways to reduce the risk of asthma, effective treatments for asthma, and ways to respond in emergency situations.

After the Grant

The consortium members are committed to continuing the services offered by this project. The grant program has strengthened the asthma knowledge of rural residents living in this Appalachian community and reduced the burden on health care providers and clinics throughout the service area. Most important, the project has succeeded in improving the quality of life for people living with asthma.

Community Characteristics

Farmworkers are the backbone of the agricultural economy. Their labor is needed to produce up to 85 percent of the Nation's fruit, vegetable, and horticultural crops. Typically, farm work requires working from early morning until night, especially during harvest season, which severely limits farmworkers' access to medical services during business hours. In addition, those who work in isolated work environments rarely have access to occupational or preventive services.

Services Offered

The Farmworker Health Initiative was designed to provide health education and screenings to African American, Hispanic, and White men, women, and children working in agriculture-related jobs. The program focused on providing education and screening services to prevent and detect occupational hazards and health problems. The consortium members included the Southeast Area Health Education Center, the Louisiana State University (LSU) Lallie Kemp Medical Center, the Louisiana Office of Public Health, and the LSU Agricultural Center. The consortium members conducted screenings for medical and occupational diseases at health fairs held at migrant housing locations, migrant Head Start programs, agricultural work sites, churches, and area farms.

Innovative Solutions to Problems

The project used several innovative approaches to provide occupational health, education, and primary care services to isolated farmworkers. These approaches included:

- Three FARMEDIC courses that train rescue workers to respond appropriately to farm emergencies
- Spanish-language first aid and cardiopulmonary resuscitation (CPR) training for agricultural workers and their families, and the development of an interactive CD-ROM entitled "First Aid Farm Quest"
- Reduction of uncompensated care by increasing enrollment of eligible adults and children in Medicaid or the Louisiana's Children's Health Insurance Program
- A bilingual community resource manual that provides information about local and national resources.

LOUISIANA



**FARMWORKER HEALTH
INITIATIVE
HAMMOND, LA**

CONTACT:

**EMILY BOND
DIRECTOR
FARMWORKER HEALTH INITIATIVE
SOUTHEASTERN LOUISIANA
UNIVERSITY
SLU 10835
HAMMOND, LA 70402**

PROJECT 8

Originally, the project had planned to dispatch a full-time nurse practitioner to provide primary health care services at locations throughout the community. However, none of the nurse practitioners in the area was bilingual. Instead, the project established an outpatient clinic staffed by a Lallie Kemp Medical Center nurse practitioner, who dedicated part of her time to attending health fairs and outreach events. The project also hired a full-time, bilingual Community Health Outreach Coordinator and purchased a 22'-van equipped with medical equipment, a bathroom, an examination table, a bench, and a desk that served as a mobile clinic at local churches, dairy barns, and migrant neighborhoods.

Results

The project reached nearly 800 farmworkers and their family members. The vast majority of those who received occupational health, education, and primary care services were adults, but the project also served approximately 120 children and adolescents and more than 60 elderly individuals.

The biggest barrier to serving farmworkers and their families proved to be a lack of health insurance. While the Lallie Kemp Medical Center accepts all patients seeking care, the Center is required by law to bill for services not covered by insurance or other sources of funding. This reality discouraged many participants from seeking care. Another challenge was the cost of medications. Even with pharmaceutical assistance, some people are reluctant to receive care because they fear that they cannot afford medications.

Potential for Replication

This model would work well in other rural areas. Since a university managed the grant activities, issues of territoriality were largely avoided. This model enables university students to gain valuable clinical experience in the field, while at the same time improving their understanding of the unique occupational and health issues facing farmworkers. The biggest challenge other communities may face in replicating this model is the pervasive lack of insurance coverage. Farmworkers often do not seek medical care unless they are unable to work; without health insurance, they are even less likely to seek medical care—even when they need it.

After the Grant

The pediatric, hearing, diabetes, and other screening programs made possible through this grant will continue. Children and parents can receive health screenings at the local Head Start facility in the fall of each year. University students, who gain valuable experience and insight as a result of their involvement in the project, conduct the screenings.

Community Characteristics

Diabetes is a complex, multi-system disorder that requires expert professional care and patients who are highly motivated to manage their own care. The nature of this chronic and incurable disease is such that effective self-management of the disease often requires behavioral changes on the part of the patient to control blood sugar and reduce the risk for complications commonly associated with the disease. However, studies suggest that many patients feel ill equipped to manage their own care and tend to rely on busy, medical practices with limited resources to manage their diabetes. At the same time, many health care providers have difficulty keeping up with changing technology, pharmacology, and new advances in diabetes management. These issues are particularly challenging in isolated, rural communities like those in south central Montana.

Services Offered

The Park County Diabetes Project had two goals: (1) to help patients and providers develop the skills they need to manage diabetes successfully; and (2) to reduce the risks for potential complications associated with diabetes by improving key indicators for blood glucose control over long periods of time. Project activities included the following:

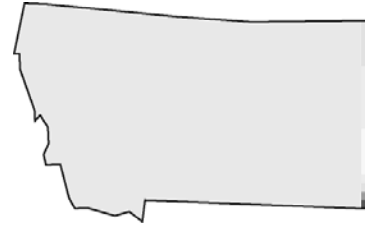
- Advanced diabetes training for health care providers
- Basic diabetes training for ancillary medical staff
- Individual self-management training for patients
- Intensive diabetes education classes for patients
- Foot screenings
- A newsletter on diabetes risk reduction
- Risk assessment surveys
- Placement of diabetes educators at medical offices throughout the service area
- Distributing diabetes self-management tools.

Innovative Solutions to Problems

The project employed several innovative methods for increasing awareness of diabetes and promoting effective self-management throughout Park County. These included:

- Conducting screenings at community health fairs
- Participating in the American Diabetes Association's *Tour de Cure* cycling event, which provided an opportunity to

MONTANA



**PARK COUNTY DIABETES
PROJECT**
LIVINGSTON, MT

CONTACT:

NANCY DETTORI, R.N., CDE
PROJECT DIRECTOR
PARK COUNTY DIABETES PROJECT
LIVINGSTON HEALTH CARE
504 SOUTH 13 STREET
LIVINGSTON, MT 59047
T: 406-222-2587

promote awareness of the disease and effective self-management

- Providing opportunities for nurses and dietitians to complete the national Certification Examination for Diabetes Educators
- Conducting countywide telephone surveys to determine public perceptions about diabetes and self-management practices.

Results

The project provided diabetes-specific training to 25 health care professionals and 80 ancillary medical staff members. Each project year, more than 200 patients received individual diabetes self-management training, and the project successfully delivered 11 intensive patient education classes to 147 participants. In addition, 258 individuals received foot screenings.

The project distributed nearly 1,300 newsletters on diabetes risk reduction, more than 2,000 risk assessment surveys, and more than 750 self-management tools. It also reached nearly 6,200 people at community health fairs.

Potential for Replication

The project was so successful in promoting professional growth and achieving measurable improvements in patient self-management that the Park County Diabetes Project is being promoted as a model of diabetes management throughout Montana, replacing the traditional medical model of diabetes care. In fact, many programs all over the State are implementing similar models to meet the need for diabetes management.

After the Grant

Onsite diabetes educators at clinics throughout Park County continue to provide funding to support the educator's position—but now with expanded hours of service. The county now has five certified diabetes educators in the county. The project also attained national recognition as a Diabetes Education Program of Excellence by the American Diabetes Association. In addition, project data and analyses were published in the *Journal of Rural Health*.

Community Characteristics

Montgomery County, North Carolina, is a rural, medically underserved area. Children are one of the county's most at-risk populations for poor health outcomes. Given that transportation, lack of insurance coverage, and lack of information are barriers that affect children—not just adults—many communities have turned to the school-based health center model to safeguard the health of rural children.

FirstHealth of the Carolinas, Behavioral Health of the Carolinas, Sandhills Center for Mental Health, Montgomery County Schools, and the Montgomery County Resource Team joined forces to establish a school-based health center at West Middle School in Montgomery County. By placing the health center in a middle school, the project specifically focused on the health care needs of 6th, 7th, and 8th graders.

Services Offered

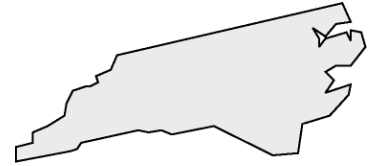
The health center provides comprehensive health care to students and staff members at the school. After the student's third visit to the health center, he or she received a risk assessment. The results of the risk assessment were used to determine if a child needed a referral to onsite mental health, substance abuse, fitness, and nutrition services. In addition, the health center provided referrals to specialty providers and dental services. If necessary, transportation was provided to offsite appointments.

The project placed strong emphasis on prevention. Staff members of the health center often taught classroom lessons on health-related topics. They also provided individual counseling on the potential consequences of tobacco use, gun safety, and helmet use. Staff members also provided educational materials and individual counseling on the importance of physical activity and improved nutrition.

Innovative Solutions to Problems

While many schools have created school-based health centers as a means to promote health and prevent disease, this model was designed to provide a more comprehensive range of services than most school-based health centers. Parents were actively involved in outlining the functions of the health center, completing satisfaction surveys, and serving on the center's advisory board, so they were more inclined to give consent for their children to receive services at school.

NORTH CAROLINA



**WEST MIDDLE SCHOOL
WOLVERINE DEN OF HEALTH**
PINEHURST, NC

CONTACT:

LISA HARTSOCK
ADMINISTRATIVE DIRECTOR
FIRSTHEALTH COMMUNITY HEALTH
SERVICES
P.O. BOX 3000
PINEHURST, NC 28374
T: 910-215-1925
E-MAIL:
LHARTSOCK@FIRSTHEALTH.ORG

Results

By the end of the 2003–2004 school year, nearly 80 percent of students were enrolled in the school-based health center. The average number of visits each year was 2,112. The number of children with health care coverage increased by 8 percent since the beginning of the project. More than one-third of the children enrolled in Medicaid received well-child visits. In addition, health center staff members provided an average of 60 individual, group, and classroom education sessions per month. Based on written survey results, 96 percent of those surveyed reported satisfaction with the health center's services.

One of the most difficult challenges the project faced was changes in the State's credentialing standards for operating school-based health centers; however, the project met all of these standards and was credentialed in early 2004. Yet, some area providers were hesitant to give permission for children under their care to receive services at the health center, so some parents were unnecessarily billed for services from health care providers that could have been delivered in the health center. In many instances, this barrier also presented unnecessary transportation barriers and delays in care. In addition, the project underestimated the need for mental health services among school students. While these services were offered onsite, the need for mental health services far outpaced the school's availability to provide these services.

Potential for Replication

With adequate community and school support, as well as appropriate billing and operational infrastructures, school-based health centers offer an ideal opportunity for rural communities to provide children with a wide range of health care services. By putting a health center on school grounds, transportation barriers are eliminated, and a continuum of care is established by providing care onsite or by referring students to offsite specialty care. Since a majority of the health center's services are provided free of charge, this model reduces the financial burden on children and families. It also reduces the amount of time children spend outside of the classroom to receive care, which is critical to academic performance.

Such a model, however, also is difficult to sustain. Patient revenues never match expenses because of the large number of uninsured children who need care. It also is difficult to develop staff schedules because of the drop in nature of school-based health

services, and to bill families for co-payments after the services already have been provided. It is critical to establish an appropriate billing infrastructure by the time the health center begins operations and to ensure the long-term commitment of network members to sustain the project after initial funding ends. Most importantly, generating parental and community support for the school-based health center model is critical to ensure the center's success.

After the Grant

Since the health center is credentialed, it is eligible to receive reimbursement through Medicaid and the State's Health Choice program. These reimbursements ensure a steady, though still insufficient, funding stream to sustain the delivery of care. The project also has developed a communications plan to promote the health center's activities and has tapped local providers to champion the center's services to local medical professionals, county health and human service agencies, and community members. In addition, the project plans to participate in ongoing community health assessments to ensure that the services offered by the health center are driven by community needs.

PROJECT 11—RURAL HEALTH OUTREACH PROGRAM FOR SOUTHEASTERN NORTH CAROLINA

Community Characteristics

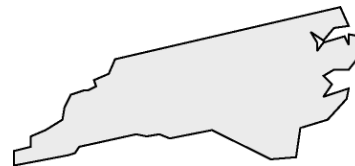
Hispanics are the fastest-growing ethnic group in North Carolina. Between 1999 and 2000, the Hispanic population in the State grew by nearly 400 percent, giving North Carolina the fastest growing Hispanic population in the Nation. Language is a major barrier to meeting the health care and education needs of Latinos who are not proficient in English. There are a limited number of bilingual providers in southeastern North Carolina, and culturally appropriate services for Spanish-speaking individuals and families are scarce. These factors are complicated by the fact that many Spanish-speaking residents are not aware of the services available to them, or the availability of public- or private-sector health coverage. In addition, many Hispanics mistrust the health care and legal systems. Transportation to and from health care appointments is another major barrier, especially for Hispanic women who cannot drive.

Services Offered

Community Partners HealthNet is a network of five nonprofit community health centers that provide primary health care to more than 100,000 consumers in southeast North Carolina. Members include Goshen Medical Center, Green County Health Care, Robeson Health Care Corporation, Stedman-Wade Health Services, and Tri-County Community Health Care. Each network member was required to hire one outreach worker to serve an average of 400 new Hispanic clients each year, to enroll eligible Hispanic children in Medicaid or the State's Children's Health Insurance Program (Health Choice), and to ensure that 90 percent of Hispanic children served were up-to-date on their immunizations within 1 year of enrollment.

The network covers 14 counties with 30 sites that provide primary care, dental, and behavioral health care to low-income, medically underserved individuals and families. For this project, the network targeted exclusively Hispanic families living in the region, especially children age 6 years and younger. The majority of this population in southeastern North Carolina is underserved, uninsured, and below the poverty level.

NORTH CAROLINA



**RURAL HEALTH OUTREACH
PROGRAM FOR
SOUTHEASTERN NORTH
CAROLINA
SNOW HILL, NC**

CONTACT:

**DOUG SMITH
CHIEF EXECUTIVE OFFICER
COMMUNITY PARTNERS
HEALTHNET, INC.
P.O. Box 658
SNOW HILL, NC 28580
T: 252-747-8162, EXT. 205**

Innovative Solutions to Problems

Outreach workers and mid-level health care providers were the centerpiece of the project's strategy to meet the health care needs of Hispanic residents. Providers conducted assessments, made prescriptions, or referred clients to the relevant clinic, when necessary. Outreach workers routinely visited Hispanic residents in their homes or at farmworker camps. They provided information about the clinics, health education materials, and asked residents about the health issues that concerned them most. They also conducted health education classes on a variety of topics—including reproductive health, HIV/AIDS, sexually transmitted infections, pesticides, back pain, and other topics—and encouraged parents to keep their children's vaccinations up-to-date. Whenever necessary, the project provided transportation and interpretation services for the clients.

Results

The goals of the project were to expand access to care, restrain costs, and improve the quality of services delivered to Hispanic individuals and families living in the service area. The project achieved all of these goals. It reached nearly 7,800 adults, more than 3,400 children and adolescents, and nearly 200 elderly persons. Project planners attribute much the project's success to involving community members, including Hispanic residents, during the planning phase of the project. Before the project was implemented, planners conducted surveys involving the Hispanic community, as well as community-based organizations, health departments, and social service agencies serving the Hispanic community. As a result of these surveys, the project determined which services were needed most, which existing services should be improved, and the best outreach practices for reaching Hispanic families and their children.

Potential for Replication

Rural communities across the Nation are experiencing an influx of Spanish-speaking families, but few communities are adequately prepared to meet the health care needs of this population. This model can succeed in other rural communities as long as the network members are committed to the project and to hiring staff members who are equally committed to serving Hispanic populations. It is critical, however, that other communities address the major barriers that can jeopardize the health of Hispanic

families, including transportation, the cultural competence of staff members, and translation services.

After the Grant

Project activities have continued beyond the grant period, thanks to new State funding. The network members also continue to provide transportation, interpretation, and health education services, and to use mid-level practitioners for the delivery of primary care services.

Community Characteristics

In 2000, the incidence of diabetes in the State of Nebraska was 5 percent. In the rural southeast Nebraska counties of Fillmore, Jefferson, Johnson, and York, the percentage of individuals with diabetes soared to 11 percent—with approximately another 11 percent living with undiagnosed diabetes. Some 33,487 people lived in these four counties, which span 2,101 square miles, and residents live anywhere from 45 to 100 miles from the State capital of Lincoln.

Services Offered

Based on the high incidence of diabetes in these counties, the South East Rural Physicians Alliance (SERPA) created a consortium of agencies to:

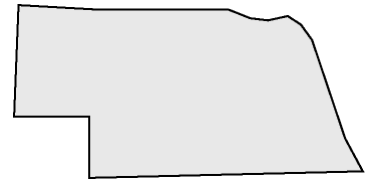
1. increase the knowledge of local physicians regarding appropriate management of diabetes
2. increase patient awareness of the need for treatment and how to manage diabetes properly
3. increase public awareness of diabetes, the risk factors for the disease, and where to go for testing.

In addition to SERPA, the consortium members included Family Health Services, a nonprofit public health organization, the State of Nebraska Diabetes Control and Prevention Program, and the Sunderbruch Corporation of Nebraska (a peer review organization and quality improvement organization that was responsible for collecting and analyzing data). During the course of the grant cycle, however, the Sunderbruch Corporation was dissolved, and the project was unable to involve the organization that took over that role at the State level.

To achieve project goals, this initiative supported the following activities:

- Lectures at seven educational events for physicians and other health care providers, and dissemination of diabetes-specific information to care providers
- Patient education programs that were coordinated by a local diabetes educator
- A Fasting Plasma Blood Glucose Program, which was designed to help get individuals at risk for diabetes into regular medical care

NEBRASKA



THE DIABETES PROJECT
CRETE, NE

CONTACT:

JOLEEN TENHULZEN HUNEKE
SOUTH EAST RURAL PHYSICIAN
ALLIANCE
995 EAST HIGHWAY 33, SUITE 2
CRETE, NE 68333
T: 402-826-3737
F: 402-826-3746
E-MAIL: JTHSERPA@NEB.RR.COM

- Eleven mini-grants to SERPA-member clinics to develop and expand their own diabetes programs, sponsor education classes, develop educational materials, and purchase pedometers
- Educational displays at community events to disseminate information, increase awareness of diabetes, and encourage testing for high-risk individuals
- Presentations on diabetes at Lion's Clubs, rotary clubs, schools, and other groups.

Innovative Solutions to Problems

In terms of increasing public awareness of diabetes, the risk factors for the disease, and the need for those at high-risk for diabetes to be tested, the project developed a creative way to encourage people to complete a risk assessment. The assessments were offered at community events such as health fairs, civic group meetings, and other gatherings, and those who completed the risk assessment were given a chance to register in various contests. In some cases, the prize was a gift certificate to a discount store or a restaurant. At large events, the project offered prizes that both men and women would enjoy, such as University of Nebraska Cornhusker team wear. In fact, at one event, a University Regent donated free tickets to a University of Nebraska/Penn State football game, and when word spread that tickets, which are almost impossible to get in advance, would be given away, the event drew an enormous crowd. These inexpensive prizes made it worth people's time to complete the assessment. Those who were deemed in need of testing were given a voucher for a free fasting plasma glucose test at a local physician's office.

Results

At the beginning of the project, there were two certified diabetes educators. By the end of the project, there were four certified diabetes educators located in the four counties. The project succeeded in getting 49 health care providers from 9 different communities to participate in 1 of the 7 diabetes education sessions.

Approximately 5,000 residents completed the risk assessment for diabetes, and all of them received general information about diabetes. More than 1,000 people with diabetes were identified, and half of them received the 6 hours of diabetes-specific education from the certified diabetes educators. Approximately 300 school students were educated about diabetes and ways to reduce the risk,

and 2,000 area employees received information about diabetes along with their paychecks. In all, the project reached approximately 18,000 residents in the target outreach area with general information about diabetes—which represents 54 percent of the total population in the 4-county area.

Potential for Replication

This project was successful in large part due to the commitment of the consortium members. Each member brought different expertise to the project, and that proved to be a major factor in the project's success. This model is relevant to other communities—both urban and rural—that have high rates of diabetes or are concerned that a large number of people have the disease and don't know it, or are at high-risk for developing diabetes.

After the Grant

SERPA and Family Health Services are joining forces again to seek funding for obesity education, which is a major risk factor for diabetes. Meanwhile, project planners are considering re-initiating a similar community education effort focusing on diabetes in approximately 5 years, but funding for such an effort has not yet been obtained.

PROJECT 13—SAMARITAN NORTH LINCOLN HOSPITAL COMMUNITY CLINIC

Community Characteristics

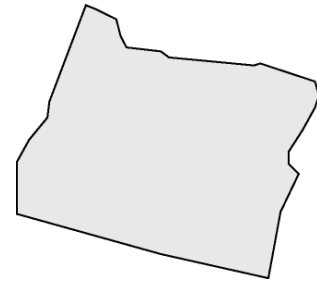
In 1996, Samaritan North Lincoln Hospital—located in north Lincoln County, Oregon—conducted a telephone survey of 416 county residents. More than 70 percent of those surveyed reported a need for an alternative clinic for low-income and uninsured residents, and a similar percentage of respondents supported the idea of a hospital-based clinic. At the time, 29 percent of respondents had household incomes below the Federal poverty level, and 16 percent were uninsured.

A second survey conducted by a local Hispanic advocacy agency found that 35 percent of Hispanic residents had no health insurance, and many respondents indicated there were significant barriers to obtaining health care. More than one-third specifically identified language as a serious barrier to care.

Services Offered

The Samaritan North Lincoln Hospital Community Clinic was established to provide primary medical and preventive services for low-income and uninsured residents. The clinic also was intended to offer a range of public health services including family planning, mental health services, prenatal case management services, and diabetes education. The project consortium included North Link Hospital, which employed clinic staff and provided free outpatient services to the uninsured; North Lincoln Hospital Foundation, which provided vouchers for emergency prescriptions for the uninsured and covered the cost of bringing a dental van to the clinic to serve uninsured patients; Oregon Pacific Area Health Education Center, which conducted outreach to Hispanic communities and coordinated patient and network surveys; Samaritan North Lincoln Hospital, which provided medical staff to serve uninsured patients referred by the clinic, 20 different lab tests, and an obstetrician to provide care to low-income and uninsured pregnant women; Oregon Health and Science University, which placed two physician assistants at the clinic; and Lincoln County Health and Human Services, which provided low-income patients with mental health and substance abuse services, screenings for sexually transmitted infections, immunizations, family planning services, prenatal case management services, and a diabetes nutrition education program.

OREGON



**SAMARITAN NORTH LINCOLN
HOSPITAL COMMUNITY CLINIC**
LINCOLN CITY, OR

CONTACT:

JACK FLAIG
CHIEF EXECUTIVE OFFICER, GRANT
DIRECTOR
SAMARITAN NORTH LINCOLN
HOSPITAL
3043 NE 28TH STREET
LINCOLN CITY, OR 97367
T: 541-996-7100

Innovative Solutions to Problems

The biggest obstacle to implementing the project was locating suitable space for a medical office. Rural communities typically have few buildings that would make a good environment for the delivery of medical care. To address this concern, the project planners decided to lease a modular medical office building for approximately \$1,500 per month. This approach proved to work quite well.

The project also struggled with the criteria that would be used to determine who would receive free care at the clinic. The project worked with a local indigent care center to design an easy screening form and to establish income guidelines. This approach enabled clinic staff members to more easily identify individuals and families that qualified for free care. Others who did not meet those criteria were asked to pay a small co-payment for the services they received.

Another challenge was the demand for care. For example, even after the consortium agencies joined forces, the area still suffered from a paucity of mental health, dental, and case management services. This led to a long-term community health planning process, which ultimately underscored the need for a federally qualified health center in the area. To this end, Lincoln County Health and Human Services prepared a grant application that was submitted to the Health Resources and Services Administration in June 2004.

Results

The project both met and exceeded its goals. The clinic was able to expand its hours of operation to 7 days per week. A physician and two physician assistants staffed the clinic, and clients had access to laboratory, radiology, respiratory, physical therapy, and dietary services. The clinic provided primary care services to 993 patients per year, and another 258 patients per year received referral for specialty services not available at the clinic. Some 496 individuals received interpretation services each year, and another 639 patients received free outpatient services each year. The project provided Women with Infant Children services to 430 people per year, family planning services to 570 people per year, mental health services to 288 people each year, and STD and HIV screenings to 180 patients per year. It also provided immunizations to 407 children per year and oral health services to 75 patients each year. Another 200 patients received free

prescriptions. The project also found time to provide cultural competency training to 22 health care professionals.

Potential for Replication

The clinic model could be easily replicated in other communities. The key ingredient to success, however, is collaboration. This project included a diverse array of partners, each of which offered something uniquely beneficial to the project. The partners must be committed to the project's success and remain flexible as new challenges arise.

After the Grant

Even at the time that the network submitted its grant application to the Office of Rural Health Policy, it understood the importance of attracting patients who had health insurance to generate revenue for the clinic. Initially, the clinic worked to attract Medicaid beneficiaries; however, due to State budget cuts and reductions in the number of Medicaid enrollees, this approach no longer seemed viable. In a bold move in June 2004, Samaritan North Lincoln Hospital opened an Urgent Care Center and combined it with the clinic patients. In June 2004, the clinic saw more than 700 patients. Two-thirds had health insurance or were Medicare beneficiaries. Another 23 percent were uninsured, and 11 percent were Medicaid beneficiaries. Uninsured patients are charged a \$20 co-payment for services and are encouraged to apply for hospital charity care to cover the remaining charges. Meanwhile, Lincoln County Health and Human Services hopes to receive funding for a federally qualified health center, which would make it possible to operate an adult clinic, a dental clinic, a school-based health center, as well as expand the mental health services in the area.

PROJECT 14—CHARLIE’S PLACE: TARGETING ADOLESCENT AND COMMUNITY HEALTH

Community Characteristics

Westfield, Pennsylvania is nestled in the northern part of Tioga County. It has been designated a health professional shortage area and a medically underserved area for physical, mental, and dental services. Based on low market values for real estate and the local personal income ratio, the Northern Tioga School District is the 15th poorest of 502 school districts in the Commonwealth of Pennsylvania.

According to the 2003 Tioga County Youth Survey Report, 61 percent of 8th graders in the county reported drinking alcohol, and 38 percent smoked cigarettes. The prevalence of alcohol and substance abuse increases substantially by 12th grade, with 81 percent of students having used alcohol, 61 percent having smoked cigarettes, and 42 percent having used marijuana. In addition, according to data generated by the local school district and the Pennsylvania Department of Health, roughly 1 in 4 Tioga County students are seriously overweight. These staggering statistics underscored the dire need for long-term improvement in the health status and behaviors of the county’s future adults.

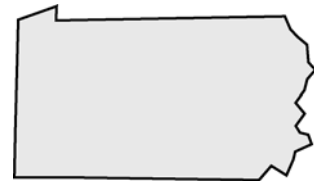
Services Offered

Charlie’s Place was established to promote healthier lifestyles among the county’s adolescents. It targeted low-income youth age 10 to 15 years living in one of the poorest and most remote regions of the county. Specifically, the project was designed to improve physical activity; promote healthy eating habits; reduce alcohol, tobacco, and other drug use; increase self-esteem; and cultivate a spirit of community connectedness. In addition to providing physical fitness, health education, safety, and prevention programs, the project also offered tutoring, access to computers to do homework and conduct research, and healthy snacks and lunches for students throughout the year.

During the grant cycle, the original project consortium expanded to include more than a dozen groups:

- The Tioga County Partnership for Community Health provided staff for the day-to-day operation of Charlie’s Place.
- The Northern Tioga School District provided space for education and physical activities, and helped to identify eligible students.

PENNSYLVANIA



**CHARLIE’S PLACE: TARGETING
ADOLESCENT AND COMMUNITY
HEALTH**
WELLSBORO, PA

CONTACT:

**ANNE LOUDENSLAGER
EXECUTIVE DIRECTOR
TIOGA COUNTY PARTNERSHIP FOR
COMMUNITY HEALTH
P.O. Box 812
WELLSBORO, PA 16901
T: 570-723-0520
E-MAIL: TCP29@EPIX.NET**

- Laurel Health System provided volunteers to help assess the physical health of young people in the target age group. It also provided healthy lunches and snacks as part of the Summer Lunch Program.
- Fit for Life coordinated physical activities, health-oriented education programs, and healthy meals during the school year.
- Mansfield University provided an intern who designed and directed the health assessment program.
- The local Area Health Education Center offered information and programs focused on health education and health occupations.
- The Tioga County Human Services Agency provided physical activity programs and substance abuse prevention programs.
- Harbor Counseling conducted staff development sessions. It also helped create a student volunteer program and the project's substance abuse policy, and delivered mental health services.
- The Girl Scouts, Pennsylvania State Police, and Tioga County Extension Service supported programs focusing on interpersonal relationships and safety issues.
- The Foster Grandparent Program provided volunteers to help support day-to-day project operations.
- Harry Jones, an expert in substance prevention, assisted in coordinating drug and alcohol prevention programs.

The Tioga County Partnership's Executive Director served on the project's Advisory Board along with key community leaders and officials from the Northern Tioga School District. The Advisory Board was responsible for determining project policies, setting goals, and recruiting volunteers.

Innovative Solutions to Problems

The project's primary innovation was that all of the activities were conducted at a single site rather than multiple locations. Another innovation involved a point system that required that students accumulate points by reading books appropriate for their age and grade level, get passing grades on tests and quizzes, do homework, and accomplish other achievements. They were then able to redeem their points for specific activities in which they

wanted to participate, such as billiards, computer or video games, and other fun activities.

Improving the academic performance of students was a serious challenge. Many students were not at the expected grade level for their age, and many of their parents were not high school graduates. In this community, education is not highly valued in many families. To break this cycle, the project joined forces with a local pizza shop that gave a free small pizza to students after they finished reading five books. The project also held competitions at the end of each grading period to reward academic achievement.

Results

The project succeeded in engaging 164 children and adolescents in the activities offered by the program. More than 2,300 meals were provided during the school year, and nearly 2,100 meals were provided as part of the Summer Lunch Program. The most recent Tioga County Youth Survey Report shows slight reductions in tobacco use among students; however, alcohol use remains above national norms, in part because alcohol is commonly viewed as a rite of passage for youth, and alcohol use is a major problem among adults in the community. The project succeeded in making physical activity and healthy eating a part of many students' daily routine, and Charlie's Place continues to be involved in a countywide initiative to reduce obesity.

Students who came to Charlie's Place found a safe and nonjudgmental place to hang out. The rules are strict, but they also are consistent and fair. School principals have recognized fewer discipline problems since the program opened, and students, parents, and other members of the community have given the program high satisfaction marks.

Potential for Replication

The consortium members were committed to creating an atmosphere of success at Charlie's Place. Students were rewarded and recognized for their achievements—no matter how big or how small. Other communities that are considering a model like Charlie's Place should place strong emphasis on cultivating an atmosphere in which success is rewarded. It also is important to provide adequate supervision of young people while they are at the project location.

Transportation remains a difficult challenge. While the Northern Tioga School District agreed to transport young people

from school to Charlie's Place, getting the kids home afterwards proved to be a very difficult task. Other communities will want to address this challenge up front in the planning phase. In addition, it is important to keep in mind that many rural families move into a community and then move away shortly thereafter, leaving a small window of opportunity to impact the behaviors and lifestyle choices of youth.

After the Grant

The project currently is seeking new funding sources. If new funding is obtained, the project may need to shift its priorities to accommodate fewer resources. If no new funding is available, Charlie's Place probably will be forced to close.

Community Characteristics

Allendale County, South Carolina, is located in the southwestern part of the State, and is approximately 65 miles south of Augusta, Georgia and 70 north of Savannah, Georgia. The closest cities in South Carolina are Charleston (90 miles east) and Columbia (100 miles north). The county spans approximately 408 square miles, and the county is home to approximately 11,700 residents. Of these, roughly two-third are African American, and 60 percent have incomes below 200 percent of the Federal poverty level.

In the 3 years prior to a grant from the Federal Office of Rural Health Policy, Allendale County’s infant mortality rate was 13.8 percent per 1,000 live births. The county’s teen pregnancy rate was among the highest in the Nation, and 51.7 percent of pregnant women in the county received inadequate prenatal care. Some 14.4 percent of births in the county were considered low-birthweight babies.

Services Offered

The goals of the Allendale Women’s Health Project were to:

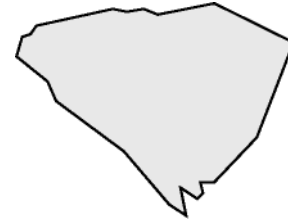
1. increase the availability and accessibility of primary health care services to women
2. improve birth outcomes and reduce infant mortality in Allendale County
3. improve the over all health status of women living in the county.

To accomplish these goals, the project expanded the hours of operation for the Low Country Health Care System, which is a federally qualified health center. It also sought to make transportation to and from health appointments available to everyone without restrictions and provided two pregnancy intervention specialists and a health educator to educate women about the importance of prenatal care, how to prevent an unintended pregnancy, and ways to reduce their risk for cancer, heart disease, and a range of acute and chronic illnesses. Area medical practitioners routinely provided their patients with referrals so that women in their care could benefit from counseling and education services.

Innovative Solutions to Problems

One of the most innovative aspects of the program was the consortium itself. Low Country Health System joined forces with

SOUTH CAROLINA



**ALLENDALE WOMEN’S HEALTH
PROJECT
FAIRFAX, SC**

CONTACT:

**DAVID C. HAYDEN
EXECUTIVE DIRECTOR
LOW COUNTRY HEALTH CARE
SYSTEM
P.O. Box 990
FAIRFAX, SC 29827
T: 803-632-2533**

Low Country Healthy Start and the Allendale County Health Department to identify women in need of care and to deliver primary health care and prenatal care services. The fourth member of the consortium was the Allendale Council on Aging, which provided a van to transport the women to and from appointments. The van operated 40 hours per week and was accessible to all women needing transportation to health care or health education services. The transportation program was so successful that a coalition of local organizations decided to spearhead a countywide transportation system now known as the Low Country Regional Transportation Dispatch system. This new system ensures that the lack of transportation will no longer be a barrier to accessing medical care for county residents.

Results

The project provided services to nearly 7,000 women, the majority of whom were African American. More than 4,800 were adolescents, nearly 1,400 were adult women, and nearly 700 were elderly. The project also provided nearly 2,500 transports between October 2001 and December 2003, and nearly 3,000 women participated in 177 health education classes sponsored by the program. The pregnancy intervention specialists served an average of 18 women per month. Some patients received referrals for mental health or substance abuse treatment, but this was a small number of patients due to the lack of behavioral health treatment services in the community and recent State budget cuts for these services. In addition, 326 women participated in individual family planning classes, and numerous women benefited from educational classes on breast self-examination.

During the first year of the grant cycle, the project expanded clinic hours to one evening per week. This approach was intended to make services more accessible to women at more convenient times. However, an average of only five women took advantage of the services available during hours. The project tried to advertise the extended hours via local newspapers and radio stations, but these efforts did not attract additional clients during evening hours. Ultimately, the project decided to cease offering expanded clinic hours.

Potential for Replication

This model will work well in other rural communities as long as local providers are willing to work together to share and

coordinate services and discuss patient progress. Other communities, however, should be prepared for the challenges of finding sufficient funding sources to cover the cost of salaries and identifying adequately trained, culturally competent personnel.

After the Grant

Low Country Health System continues to provide women's health services and transportation for clients in need. It also provides a nurse midwife to consult with clients at Low Country Healthy Start, which has retained a pregnancy intervention specialist to sustain the availability of counseling and education services for teenage girls in Allendale County, as well as the health educator who now provides health education services in a four-county region.

Community Characteristics

Lauderdale County is located in northwestern Tennessee—approximately 80 miles north of Memphis. Of the nearly 25,000 people who live in the county, roughly one-third are ethnic minorities. The county is characterized by rampant poverty and unemployment. Residents of Lauderdale County historically have suffered from disproportionately high rates of morbidity and mortality due to poor cardiovascular health. These poor outcomes are directly related to high rates of poverty and a shortage of health care providers.

Services Offered

Lauderdale Healthy Hearts had five main goals: (1) to increase awareness of cardiovascular risk factors; (2) to improve early detection of hypertension and access to treatment; (3) to increase access to physical fitness and wellness programs; (4) to increase patient adherence to treatment regimens via community-based support groups for behavioral change; and (5) to enhance patient tracking and referrals.

Several community agencies came together to support the project. Lauderdale County government coordinated the project. Baptist Memorial Hospital donated staff members to conduct screenings. The school system granted access to elementary school students so they could receive healthy heart education, using the American Heart Association’s *Heart Power* curriculum. Community groups provided sites for wellness programs. The local extension service offered heart-healthy cooking classes. Local businesses opened their doors to the project so their employees could benefit from screening and wellness programs. Area physicians provided referrals for behavioral change support groups. In addition, smoking cessation classes were offered throughout the county.

Innovative Solutions to Problems

The project emphasized a “stages of change” continuum as a means to improve cardiovascular health. The “stages of change” model is based on the premise that change results from completing a series of steps. Each step in the continuum prepares the individual for the next stage and reinforces the messages of the previous stages. This model provides individuals with the information and support they need to make fundamental changes in their lives to improve their cardiovascular health. Furthermore,

TENNESSEE



**LAUDERDALE HEALTHY
HEARTS**
RIPLEY, TN

CONTACT:

KEVIN MORRIS
TENNESSEE DEPARTMENT OF
HEALTH
295 SUMMAR DRIVE
JACKSON, TN 38301
T: 731-421-6778

each stage is linked with the other stages to form a support network for patients.

Results

Project planners believe that the program played a role in reducing countywide mortality rates related to heart disease and stroke. The project provided approximately 2,100 health screenings as well as 4,600 units of cardiovascular health education for children in elementary school. Another 375 people participated in the “stages of change” program.

Reducing obesity among county residents, however, proved to be a more difficult challenge, so the project is exploring approaches that focus on childhood obesity.

Potential for Replication

This project was adapted from a model previously implemented in a similar community in rural Arkansas. This model should work well in other communities with limited resources in which partner organizations are willing to work together to improve cardiovascular health.

After the Grant

Most of the activities developed as a result of grant funding will be sustained, although on a smaller scale. The hospital will continue to provide cardiovascular health screenings but with a limited focus on local businesses. This population is more likely to have insurance and a primary care physician. Also, the consortium members will continue to provide behavioral change support groups as well as classes in exercise and wellness, nutrition and healthy cooking, diabetes management, and smoking cessation.

Community Characteristics

Like other rural communities across the Nation, the Yakima Valley community in Washington State has experienced a large influx of Hispanic individuals and families moving into the community in recent years. For many of these families, English is not their first language, and many speak no English at all. The inability to communicate effectively with health care providers can have a negative impact on their health and their understanding of preventable and treatable illnesses.

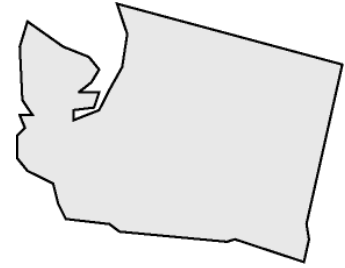
Also in recent years, the community has recognized an increase in the number of children diagnosed and treated for asthma. Particularly alarming is the fact that children are disproportionately represented within the larger population of people with asthma who live in the community. Several socioeconomic factors are associated with asthma, including poverty, limited access to health care, and ethnicity.

Services Offered

The Yakima Valley Farm Workers Clinic established the Childhood Asthma Project to serve families of children with asthma. Based on a similar project implemented in the Atlanta area, the project targeted rural, low-income, Hispanic children living in two counties in eastern Washington. The goals of the program were to improve access to health care services for families of children with asthma and to improve the environmental health of the community. These goals were achieved by visiting families' homes and by providing training to childcare providers. Both of these activities were designed to reduce indoor and outdoor environmental triggers for asthma, to help families better manage medications for their children, and to help them control the disease more effectively. Multicultural staff members provided services in both Spanish and English.

The Yakima Valley Farm Workers Clinic coordinated the project and provided an asthma home educator to conduct home visits. Other consortium members included the American Lung Association, local school district nurses, the local education service district, the Indian Health Service, the local hospital emergency department, CareOregon Insurance, the Community Health Plan of Washington, a medical equipment supplier, local public health nurses, the Yakima Area Asthma Coalition, and parents of enrolled clients.

WASHINGTON



CHILDHOOD ASTHMA PROJECT
TOPPENISH, WA

CONTACT:

LISA CAMPBELL-JOHN
PROGRAM DIRECTOR
COMMUNITY HEALTH SERVICES
YAKIMA VALLEY FARM WORKERS
CLINIC
518 WEST FIRST AVENUE
P.O. Box 190
TOPPENISH, WA 98949
T: 509-457-7540

Innovative Solutions to Problems

The project included the following innovative features:

- Use of bilingual and multicultural paraprofessionals from the community who provided home assessments and education
- Development and implementation of asthma care plans for use in medical clinics, schools, homes, and childcare sites
- Development and implementation of an asthma care plan for children under age 6
- Creation of a one-page, color coded environmental checklist (based on the Mater Home Environmentalist Program) that was used to ensure consistency across all home visits
- Development of a bilingual, illustrated brochure to share with schools, hospitals, clinical staff members, and potential clients
- Intervention with home childcare providers to reduce environmental triggers for asthma
- Modification and translation of the American Lung Association of Washington curriculum, *Little Lungs Breathing*©, for use among Spanish-speaking populations.

Results

By the end of the grant cycle, the Childhood Asthma Project had succeeded in reducing the number of asthma-related outpatient visits, emergency department visits, and hospitalizations. It also increased the number of families able to identify and minimize environmental threats, as well as the number of families accessing primary health care services and participating in home visits. In addition, the project succeeded in educating childcare providers in the knowledge they need to identify and reduce environmental threats in childcare environments. More than 600 childcare providers received training via the *Little Lungs Breathing* curriculum.

Potential for Replication

This model has demonstrated its effectiveness in motivating families to better manage the home environment. If other communities are interested in replicating this model specifically to address high rates of asthma, it is important to consider population density (whether or not there are enough patients to keep the program operational) and geography (whether or not it is

financially feasible to conduct home visits across a large geographical area). It also is important to ensure strong support from primary care providers. In addition to providing referrals, these individuals can help to reinforce the information that is communicated to families during home visits. This project was fortunate in that the Yakima Valley Farm Workers Clinic already had established strong collaborative relationships with area primary care providers. Other communities may need to cultivate these relationships before such a model is implemented.

After the Grant

The Yakima Valley Farm Workers Clinic is seeking new funding sources to sustain the Childhood Asthma Project. Until then, the clinic and the Washington Health Foundation will allocate whatever resources possible to keep the project up and running.

PROJECT 18—NICHOLAS COUNTY RURAL HEALTH OUTREACH PROGRAM

Community Characteristics

Nicholas County, West Virginia, is a rural, mountainous medically underserved county that covers 649 square miles. Approximately 26,000 people live in the county, and more than half of them live below 200 percent of the Federal poverty level. A large number of residents do not have health insurance, and county residents are disproportionately affected by a wide range of health-related problems, including diabetes, obesity, sedentary lifestyle habits, and heart and lung diseases—all of which can be prevented via education and behavior change.

Services Offered

The services delivered through this program included:

1. primary medical services for people who lacked access to health care services
2. health education and prevention programs
3. ongoing assessment, screening, and followup care.

The target population for this project included the working poor and senior citizens; however, health education and prevention programs had the capacity to reach a broader range of county residents.

The project consortium consisted of an extensive network of local government agencies, schools (including a school-based health center), the local hospital, a rural health clinic, a free clinic, and nonprofit organizations. The network collaborated with a wide range of community organizations and local media to support public education activities.

Innovative Solutions to Problems

The biggest challenge the project faced was laying the groundwork to sustain project activities. Billing and fundraising alone was not enough to cover operating expenses. However, project planners managed to secure funding for the project's school-based health center as a federally qualified community health center beginning in the 2004–2005 school year. Project planners also began to explore the possibility of converting the free clinic to a satellite federally qualified health center. This would enable the free clinic and the school-based health center to increase their hours of operation and offer a sliding-scale fee system for patients. It also would allow those accessing services at the free clinic to continue receiving care at reduced or no cost since they are

WEST VIRGINIA



**NICHOLAS COUNTY RURAL
HEALTH OUTREACH PROGRAM**
SUMMERSVILLE, WEST VIRGINIA

CONTACT:

DORA A. DOUGLAS
CHIEF FINANCIAL OFFICER
SUMMERSVILLE MEMORIAL
HOSPITAL
400 FAIRVIEW HEIGHTS ROAD
SUMMERSVILLE, WV 26651
T: 304-872-2891
WEB SITE:

WWW.SUMMERSVILLEMEMORIAL.ORG

below the Federal poverty level, and to continue receiving medications through the 340b-government drug program.

Results

Since opening its doors in September 2000, the Summersville Wellness Center has served 15,000 patients. The State School-based Health Assembly deemed this project as the most successful new program in the State. Major accomplishments include a viable and busy school-based health center, a new office complex, an expansion of provider hours to 32 hours per week, and securing funding to sustain the project.

The Community Clinic of Nicholas County is fully operational and meeting community demand for medical and prescription services. Volunteers, including volunteer physicians, provide primary medical care and medication assistance for elderly individuals who cannot afford their medications. The clinic also sponsors a breast and cervical cancer screening program.

The project offered a wide array of health education programs for local residents. These include a blood pressure clinic for senior citizens, diabetes clinics, education on good nutrition, a program to promote physical activity and fitness, cooking schools, a youth drug prevention program, and numerous other health education projects.

Potential for Replication

Two of the programs supported by this project were modeled after other programs. The Wellness Center was designed to replicate the Richwood High School Wellness Center in Richwood, West Virginia. The free clinic was modeled after different features of other clinics in West Virginia and other States. This model could be replicated in other rural communities seeking to promote health and prevent disease.

After the Grant

Project activities will be sustained due to new funding obtained through the Federally Qualified Health Center program.

2005 INDEX (BY PROJECT NUMBER)

EDUCATION

PROJECT NUMBER

Continuing education for health professionals.....	7, 12
Patient/public health education	4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18
School health education	1, 3, 4, 6, 7, 10, 12, 14, 16, 17, 18

HEALTH PROMOTION/DISEASE PREVENTION

PROJECT NUMBER

Abstinence/sexual disease prevention.....	1, 11, 13
Asthma	1, 7, 17
Behavioral health	2, 10, 15, 16
CPR/first aid	8
Diabetes	1, 6, 8, 9, 12, 13, 16, 18
Domestic violence/sexual assault	1, 5
Heart/cardiopulmonary disease.....	8, 15, 16, 18
HIV/AIDS.....	11, 13
Mental health	2, 10, 13, 14, 15
Nutrition.....	1, 6, 10, 13, 16, 18
Self-esteem.....	14
Substance abuse	1, 2, 10, 13, 14, 15
Tobacco prevention/smoking cessation	1, 7, 10, 14, 16

POPULATION GROUP

PROJECT NUMBER

Adolescents.....	1, 2, 8, 11, 14, 15
African Americans.....	8, 15
Amish residents	6
Children	1, 2, 3, 4, 6, 7, 8, 10, 11, 13, 14, 16, 17
Elderly.....	2, 6, 7, 8, 11, 15, 18
Hispanics.....	4, 5, 8, 11, 13, 17
Infants	13, 15

2005 INDEX (BY PROJECT NUMBER)

POPULATION GROUP (CONTINUED)

PROJECT NUMBER

Low-income residents	2, 3, 6, 7, 11, 13, 14, 15, 16, 17, 18
Migrant farmworkers	4
Pregnant women	3, 13, 15
Teenagers	1, 15
Women.....	3, 5, 6, 8, 12, 13, 15

SERVICES

PROJECT NUMBER

Case management	2, 13
Counseling	5, 7, 10, 15
Dental/oral health	1, 3, 10, 11, 13, 14
Emergency medical.....	4, 7, 17
Health fairs.....	1, 7, 8, 9, 12
Home visits	1, 7, 17
Immunizations	6, 11, 13
Interpretation/translation.....	4, 11, 13, 17
Materials	1, 3, 9, 10, 11, 12
Medicaid/Medicare	2, 3, 6, 8, 10, 11, 13
Mental health services.....	2, 10, 13, 14
Outreach.....	2, 5, 6, 8, 11, 12, 13
Pediatric care.....	7, 8
Pharmaceutical services	5, 8
Prenatal care.....	13, 15
Preventive care.....	1, 3, 6, 8, 10, 12, 13, 14, 15, 18
Primary care	2, 5, 6, 8, 11, 13, 15, 17, 18
Public health	4, 6, 8, 11, 12, 13, 17
Referrals.....	2, 3, 10, 11, 13, 15, 16, 17
Rural health outreach.....	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18
Screenings (general).....	1, 2, 4, 5, 6, 8, 9, 16, 18

2005 INDEX (BY PROJECT NUMBER)

<i>SERVICES (CONTINUED)</i>	<i>PROJECT NUMBER</i>
Screenings (specific)	
Blood pressure	4, 5, 6
Breast cancer/mammogram	18
Cancer (general)	15
Cardiovascular	16
Cervical cancer	18
Diabetes/blood glucose	4, 5, 8, 9
Hearing/vision.....	1, 6, 8
HIV	13
Occupational health	8
Oral health	6
Scoliosis.....	6
Sexually transmitted diseases	13
Social services.....	4, 11
Support groups.....	16
Transportation.....	1, 2, 6, 10, 11, 14, 15