

THE OUTREACH SOURCEBOOK



Volume 12

RURAL HEALTH DEMONSTRATION PROJECTS

2002 to 2005

June 2006

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In 2002, the Office of Rural Health Policy (ORHP) awarded 28 projects in 20 States. These projects, scattered from New York to Oregon, 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 2002 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 28 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 2002 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 2002. 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

AIDS	Acquired Immunodeficiency Syndrome
CDE	Certified Diabetes Educator
CPR	Cardiopulmonary Resuscitation
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
HIV	Human Immunodeficiency Virus
WIC	Women, Infants, and Children

PROJECT 1—AJO DIABETES OUTREACH AND EDUCATION PROGRAM

Community Characteristics

Western Pima County is located in southern Arizona along the U.S.-Mexico border. More than 40 percent of area residents live below 200 percent of the Federal poverty level. The local population had high rates of diabetes as more than 300 persons—more than 7 percent of those who presented at the Ajo Community Health Center (ACHC)—had a diabetes-related diagnosis. In addition, it was estimated that more than half of the American Indian population over age 30 had either diagnosed or undiagnosed diabetes.

Due to the lack of local outreach and education efforts targeting persons with diabetes, ACHC sought to launch a new program targeting the Ajo service area and villages located in the western edge of the Tohono O’odham Reservation. The goal was to improve clinical outcomes and help people learn how to manage their diabetes appropriately. Because of the hereditary nature of diabetes, the program also wanted to direct education and awareness efforts to family members of residents with diabetes because they were at risk for developing diabetes themselves.

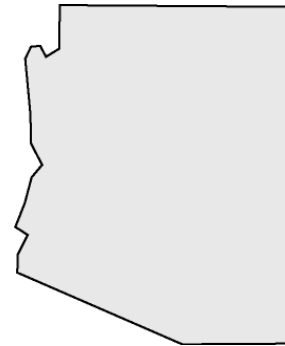
Services Offered

In addition to being the sole provider of local health and dental services, ACHC decided to provide a medical home for people with diabetes who don’t have a medical provider or health insurance. ACHC hired a program coordinator, promotores, and a health educator.

ACHC also joined forces with the Southeast Arizona Area Health Education Center, which provided promotores training and continuing medical education for ACHC employees (including staff and promotores) as well as diabetes education to youth in Ajo schools. The Rural Health Office at the University of Arizona Mel and Enid Zuckerman College of Public Health provided technical assistance in developing the program model and conducted the project evaluation. The Pima County Health Department originally joined the consortium and pledged to recruit and employ a diabetes educator. Unfortunately, the health department was unable to successfully recruit a qualified professional for this position and left the consortium.

The services offered by the Ajo Diabetes Outreach and Education Program included diabetes education, outreach, support,

ARIZONA



**AJO DIABETES OUTREACH AND
EDUCATION PROGRAM
AJO, AZ**

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health education, training for promotores and staff, professional development opportunities, primary care services, social service referrals, and case management services. All area residents—which included large populations of Hispanics, American Indians, and elderly Anglo populations—were eligible to receive services.

Diabetes education classes were available in both English and Spanish throughout the Ajo service area. Classes were offered not only to people with diabetes but also to family members and others in a position to provide patient support. The project also taught patients and loved ones about health-positive nutritional habits and other self-management tools via one-on-one counseling and educational sessions.

Innovative Solutions to Problems

The project used community-based educators and promotores to help medical providers educate patients and to conduct community outreach. Some of the promotores had lived with diabetes for many years; others were newly diagnosed. When the project was unable to recruit a certified diabetes educator (CDE), the project arranged to bring in a CDE experienced in community-based education to train ACHC nurses and promotores as diabetes educators. As the program also was unable to recruit a health educator, the CDE also trained an ACHC nurse to become the project's health educator.

Results

The Ajo Diabetes Outreach and Education Program provided diabetes education and self-management training to 218 persons with diabetes and 33 family members and loved ones. It also provided more than 200 social service referrals and recorded 650 individual case management encounters. In all, the project reported more than 3,000 diabetes-related encounters that included office visits, behavioral health encounters, and group or individual education. The project also trained eight promotores.

One of the key lessons learned as a result of the project evaluation was the importance of ongoing support for program participants and graduates—in relation not only to diabetes but also to any other chronic diseases or health issues they may have. Although the evaluation documented many quantifiable improvements in client outcomes, it also showed that, 6 months to a year later, some graduates began to abandon some of the nutritional

and self-management tools they had acquired as a result of participating in the program.

Potential for Replication

The modified promotores model for diabetes outreach and education is applicable to many rural communities. Given the difficulties many rural programs experience in trying to recruit health care providers, other projects may have trouble recruiting a CDE or health educator to serve in a rural area. It is important to remain flexible, to explore all options, and, if necessary, be creative in solving these types of challenges.

Other rural communities also will want to establish ongoing recruitment procedures to fill staff vacancies created by resignations, promotions, and other unforeseen circumstances. Finally, it is also critical for the agencies involved in the consortium to wholly support the promotores model. This means making resources available when needed and ensuring that providers and clinical staff answer questions from outreach staff, accept referrals for patients with other health problems, and make referrals to education and support classes when appropriate.

After the Grant

The Ajo Diabetes Outreach and Education Program will be sustained, although on a smaller scale. It will offer fewer class sessions per year and will eliminate free lab testing and foot and retinal screenings. Because heart disease is a common complication of diabetes, the project secured mini-grants to support heart health classes. It also hopes to apply for a Healthy Vision 2010 grant to reinstate provision of the retinal screening education component and cover the cost of retinal screenings.

The consortium members are open to collaborating again in the future to expand the diabetes education program and to embark on new projects focusing on other important health topics such as heart health, stroke prevention, and obesity.

PROJECT 2—MENDOCINO COUNTY AIDS VOLUNTEER NETWORK HEALTH OUTREACH AND PREVENTION EDUCATION (HOPE) PROJECT

Community Characteristics

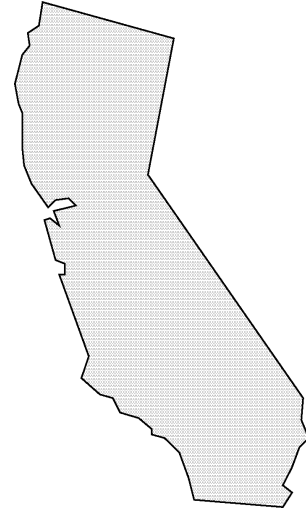
Mendocino County, California, has a population of 89,000 people and a population density of 24.6 people per square mile. Most county residents are white, but the area has seen an increasing number of Latinos and American Indians. Unemployment rates routinely top state averages, and more than 18 percent of residents live below the poverty level. Poverty rates conspired with the county's not-so-flat topography and social isolation to create an ideal setting for marijuana cultivation and methamphetamine production. These and other social factors make Mendocino County a high-risk environment for HIV and hepatitis C infection and transmission.

To acknowledge high rates in the incidence of HIV infection and hepatitis C, the Mendocino County Board of Supervisors declared a state of emergency in April 2000. The AIDS incidence rate in Mendocino County was the second highest of all rural California counties and the 14th highest of all California counties. In addition, since 1995, the county had recorded 305 new cases of hepatitis C. Many of the county's injection drug users and veterans at high risk for HIV and hepatitis C were not using the health services available to them.

Services Offered

The project consortium included the Mendocino County AIDS Volunteer Network (MCAVN), the Mendocino County Department of Public Health's HIV Prevention Education Program, and the Mendocino County Veterans Services Office. The MCAVN Health Outreach and Prevention Education (HOPE) project fielded three outreach teams to distribute prevention messages to injection drug users, homeless individuals, the impoverished, and those alienated from the health care system. The project's goals were to expand outreach services to 3,500 individuals living in 40 communities; to reduce needle-sharing and increase condom use among injection drug users in the county by 25 percent; to test 20 percent of clients for HIV and hepatitis C; to link at least 20 percent of injection drug users contacted by outreach teams to benefits and services; and to emerge as a model for HIV and hepatitis C prevention in other rural communities.

CALIFORNIA



**MENDOCINO COUNTY AIDS
VOLUNTEER NETWORK
HEALTH OUTREACH AND
PREVENTION EDUCATION
(HOPE) PROJECT
UKIAH, CA**

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Innovation Solutions to Problems

HOPE outreach workers went to isolated pocket communities, American Indian rancherias, migrant worker camps, shooting galleries, and needle exchange sites to have face-to-face interactions with county residents at risk for HIV and hepatitis C infection. The teams provided educational and risk-reduction materials, testing, counseling, and referrals to health care and other support services. The project also reached out to the county jail, providing 60 inmates with prevention education, including harm reduction, syringe exchanges, overdose death prevention education, and nontraditional approaches to health care.

HOPE staff also held outreach events, presentations for students at local high schools, and free yoga classes for clients. HOPE outreach workers had real-life street experience, which enabled them to relate to clients and establish trust. Project staff members were required to participate in monthly staff training and more extensive, bimonthly trainings. Training topics ranged from risk reduction, overdose prevention, and sexually transmitted infections to client confidentiality mandated reporting requirements, and the relationship between drug addiction and child sexual assault.

Results

HOPE outreach teams logged 20,672 service contacts, approximately half of which were with injection drug users. Outreach workers also recorded 5,893 referrals to medical care and followed up on 43 percent of these referrals. In the most recent client survey, 95 percent of the 53 respondents indicated they were satisfied with HOPE services, with the most useful services being risk-reduction services and food. Ultimately, the California Department of Health Services lauded the HOPE project as a model outreach program, and the HOPE director was appointed to a statewide stakeholders' advisory group.

Project organizers noted two problems that were not successfully addressed during the grant cycle. First, many clients needed case management services, which the project was unable to provide. Second, the project was not completely successful in connecting clients to medical services. Many clients miss appointments or are less than honest with their providers. In addition, some providers continued to harbor prejudice against this particular clientele. The project found, however, that having

outreach workers accompany clients to medical appointments was effective in improving the quality of care they received.

Potential for Replication

For this type of project to succeed, it must enjoy support from local law enforcement and local government. It also is critical that staff have real-life street experience. Other key factors of success include developing a comprehensive list of community resources as potential referrals, carefully targeting services to those at risk, conducting regular staff training, and providing direct supervision of outreach workers.

HOPE outreach workers also identified potential barriers to successful replication. These include successfully identifying clients at risk who may be dispersed over a large geographic region; establishing trust with clients; assuring rural and American Indian clients of their right to confidentiality; reaching the desired number of clients who are scattered across a large area; and ensuring that each client receives individualized, tailored service.

If other rural communities keep these factors in mind, they have a good chance of replicating this model successfully.

After the Grant

The consortium members will continue to work together to plan and implement services targeting this population. However, services will be sustained at a reduced level through a contract with the Mendocino County Department of Public Health and other resources made available through the local HIV High Risk Initiative, foundation grants, and other funds. The project will continue to provide HIV and hepatitis C testing through a contract with the county health department.

Community Characteristics

The 2000 Community Health Needs Assessment Report for Baker County, Florida, revealed that the county exceeded regional, state, and national rates in 6 of the 12 leading causes of death in the United States—heart disease, stroke, pneumonia/influenza, diabetes, liver disease, and chronic obstructive pulmonary disease (COPD). In addition, the 1999–2000 Five-County Study of Cardiovascular Disease Risk Factors found that, of these five Florida counties—Baker, Bradford, Columbia, Suwannee, and Union, in which the rates of cardiovascular disease exceeded those for the state as a whole—Baker County had the lowest number of people who received regular blood cholesterol screenings, the highest percentage of overweight people, and a significant proportion of residents with chronic drinking problems.

Services Offered

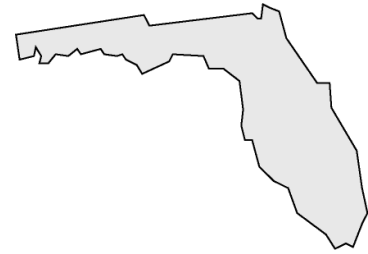
Connecting the Chronically Ill had three goals: (1) to connect chronically ill, medically underserved adults to health care services; (2) to improve quality of life through wellness education and case management services; and (3) to provide health care coverage for low-income, medically underserved, chronically ill adults age 18 and older living in Baker County. Participants were considered chronically ill if they had been diagnosed with obesity, hypertension, diabetes, COPD, or hyperlipidemia.

The consortium members included the following partners:

- The Baker County Health Department provided primary care, case management, prescription drug assistance, and health education services.
- Gateway Community Services, a regional substance abuse treatment provider, offered individual assessments as well as group and individual counseling.
- Northeast Florida State Hospital Community Behavioral Health Services Division, a community-based mental health care provider, offered outpatient mental health counseling, case management, and evaluation services.
- Baker Community Counseling Services, a local substance abuse treatment provider, offered aftercare services.

In addition to providing primary care, case management, prescription assistance, health education, substance abuse, and mental health services, the project also offered diabetes self-management classes, individual wellness planning, referrals for

FLORIDA



CONNECTING THE CHRONICALLY ILL MACCLENNY, FL

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podiatry care and eye exams, laboratory tests, glucometers and test strips, educational materials and health-positive cookbooks, smoking cessation services; referrals to First Place weight loss classes, and transportation services to medical appointments and educational classes.

Innovative Solutions to Problems

At first, few residents expressed an interest in receiving substance abuse services—largely because of the stigma associated with treatment. So the project worked with the Baker County Sheriff’s Office so the project could expand its services to incarcerated individuals who also had qualifying health conditions. Incarcerated clients received intake evaluations, individual counseling, and weekly group counseling. In the third year of the grant, the project further expanded its substance abuse program to include aftercare substance abuse treatment services to inmates upon their return to the community.

Primary care, health education, and prescription drug assistance services were provided at the Baker County Health Department. To help promote the program, the health department also conducted educational classes at local churches. Participants in need also received referrals to diabetes education and weight management classes.

Results

The HOPE project provided services to 272 people during the 3-year grant cycle and expects to serve another 120 people during the no-cost extension period. Some 94 percent of clients served who participated in educational sessions reported that their knowledge of health and wellness increased as a result of the sessions, and 98 percent benefited from a wellness education plan and case management services to help them access needed services. In addition, 97 percent of clients needing mental health services and 98 percent of clients needing substance abuse treatment were scheduled for an appointment within a week of initial referral.

The project succeeded in accessing the resources available for health care coverage by developing and maintaining a manual of free and low-cost health care services for medically underserved and chronically ill patients. Nearly 900 clients received education about Medicaid, Medicare, and Supplemental Security Income (SSI) eligibility. All clients receiving case management services were successfully linked to the health care services for which they

qualified within 6 months of entering the program. In addition, 28 percent of participants were permanently enrolled in Medicaid or Medicare.

Potential for Replication

Many of the HOPE project's initiatives can be easily replicated in other rural communities. In fact, other communities near Baker County already have adapted the prescription drug assistance program because of the model's low startup costs.

Baker County is fortunate in that it is located about 36 miles from the closest urban area, and local health care providers routinely collaborated with metropolitan service providers to fill gaps in local health care services. Many other rural communities are more remote and may not have the local health care resources that are available in Baker County, making it more difficult to replicate such a model.

After the Grant

Many project activities will continue, such as the drug assistance program, primary care services, mental health services, and health education. During the no-cost extension period, the HOPE project is launching a community health improvement initiative to target those at risk for chronic illnesses. As a result of the project's expansion to provide substance abuse treatment for local inmates, the area's judicial system has established a drug court program that diverts those who successfully complete the program from jail. Offenders are required to participate in outpatient substance abuse and mental health services as needed. They also receive referrals to the county health department for primary care services. The drug court program has gained substantial momentum, and many community organizations have joined the consortium, which gives offenders access to an even wider range of services.

PROJECT 4— SMART: DIABETES AND HYPERTENSION EDUCATION OUTREACH PROGRAM

Community Characteristics

Diabetes and hypertension are debilitating, chronic diseases that, left untreated, can lead to death. Each year, diabetes is responsible for 20.2 deaths per 100,000 in Florida—and 28.3 deaths per 100,000 in this project’s target service area. Stroke accounts for 50.2 deaths per 100,000 each year in the state and 67.5 deaths per 100,000 each year in the service area. Both diabetes and hypertension are regarded as “silent killers” because many people are not aware they have these diseases.

The Diabetes and Hypertension Education Outreach Program targeted the rural, minority, and medically underserved communities in Bradford, Dixie, Gilchrist, Hamilton, Levy, Suwannee, and Union counties in Florida. Mostly rural in nature, the region spans approximately 3,900 square miles, with a population density of 38 people per square mile.

Services Offered

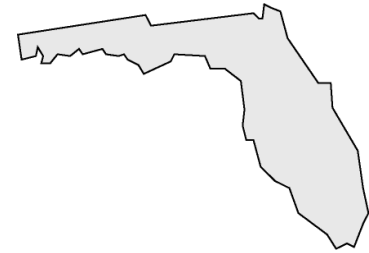
The core project network consisted of three organizations: Lake Butler Hospital in Union County, Shands at Live Oak in Suwannee County, and Trenton Medical Center in Gilchrist County. Lake Butler Hospital and Shands at Live Oak are both critical access hospitals. Trenton Medical Center is a federally funded community health center. Other organizations supported the network by providing referrals, donating educational materials, and contributing funds to help sustain the program.

Each of the three core network members initiated subcontracts with a case manager who traveled to clients’ homes to provide home-based self-management education on effective care for diabetes or hypertension. Specifically, the case managers provided tailored, home-based educational sessions on the causes, risks, and management of diabetes or hypertension; individual counseling; and case management. The project also conducted community health screenings to identify individuals with pre-diabetes and pre-hypertension and provided patient education, newsletters, and follow-up calls to clients discharged from the program.

Innovative Solutions to Problems

Although not an innovative service delivery model, home-based education is an ideal and simple way of delivering care. The program met clients where they were, allowing case managers to get a realistic sense of how each client lived.

FLORIDA



**SMART: DIABETES AND
HYPERTENSION EDUCATION
OUTREACH PROGRAM
LAKE BUTLER, FL**

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Participants learned about this program via physician referrals. Once enrolled, the case managers delivered 12 hours of home-based disease management education over 6 to 12 weeks. Once the education component was complete, case managers made quarterly follow-up calls or visits to track blood sugar and blood pressure levels as well as any hospitalizations or deaths attributable to the client's disease. During the follow-up phase, participants were reminded to receive annual eye, dental, foot, and hemoglobin A1C exams. In addition, the annual community health screenings provided an opportunity to identify individuals at risk for diabetes or hypertension and to determine whether those at risk have a regular source of care. All project services were provided free of charge.

Results

The Diabetes and Hypertension Education Outreach Program screened more than 1,000 area residents for diabetes and hypertension. Nearly 450 participants completed the self-management educational sessions. The project succeeded in reducing hospitalizations among program participants by nearly 70 percent.

An initial barrier in getting the program started was the apprehension of local physicians over a new program in the community. Some physicians even refused to meet with project case managers to discuss the program. However, once residents heard how well the case managers treated their patients and how knowledgeable they were about diabetes and hypertension, potential clients began asking their physicians for referrals.

Potential for Replication

This model would work well in many rural communities as long as they address the potential barriers of transportation, lack of health care coverage, and insufficient numbers of local providers. It is critically important, however, to allocate sufficient resources to support the travel expenses of case managers. Earmarking such resources for travel reimbursement makes a big difference in recruiting case managers who use personal vehicles to travel to clients' homes.

Another step that similar projects could take to generate more community "buy-in" early on in the program would be to recruit case managers knowledgeable of diabetes and hypertension

management from the target community. This approach would help the program to quickly establish a sense of trust with residents.

After the Grant

Due to insufficient funding to sustain the program at its previous level, the project has reduced its staff from three full-time to one full-time and two part-time case managers. Through the support of local providers, foundation dollars, Federal carryover funds, and other agency donations, the program will continue providing outreach and education services at this reduced level for another 2 years.

Community Characteristics

Like many communities, south central Georgia is experiencing a rapidly growing Hispanic population. Latinos in the region tend to be poor, and many are new immigrants. They are employed primarily in the pine straw industry and supplement their income with seasonal farm labor. These jobs generally pay minimum wage and don't offer health insurance. The region's landscape varies as one travels from west to east. The western and northernmost counties are characterized by rolling hills. In the eastern counties, the terrain becomes flatter and sandier.

Services Offered

Language Links for Healthier Families had one overarching goal—to increase access to health care for Latino families in south central Georgia through health education and outreach by eliminating language and cultural barriers to quality care. The Language Links service area included 10 counties that make up the South Central Health District (Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Talfair, Treutlen, Wheeler, and Wilcox counties). Most of these counties are designated health professional shortage areas, and all are rural.

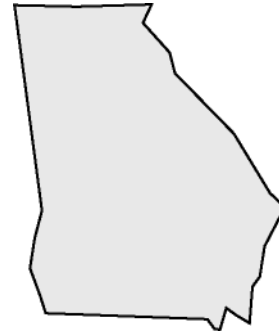
The project consortium comprised four organizations: Laurens County Board of Health/South Central Health District, Georgia Cooperative Health Education Program, Heart of Georgia Technical College, and Fairview Park Hospital. All partners are headquartered in Dublin.

Together, the consortium members provided interpreter training (the only source for such training in south central Georgia), bilingual medical interpretation, cultural competency training for area health professionals, continuing education credits, accreditation application guidance, project registration assistance, and evaluation support. In particular, Spanish-speaking clients were given access to interpretation services at OB/GYN offices and health departments. Interpreters also provided health education at prenatal clinics and assisted clients in securing transportation to and from appointments.

Innovative Solutions to Problems

The project experienced a high turnover rate among interpreters, each of whom received extensive training. Throughout the grant cycle, it was difficult for the project to find interpreters sufficiently proficient in both English and Spanish; however, once

GEORGIA



**LANGUAGE LINKS FOR
HEALTHIER FAMILIES
DUBLIN, GA**

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the project developed a pool of qualified interpreters, it was easier to identify new interpreters.

In the project's second year, program planners recognized that the project may have provided so much medical interpretation training that too few facilities in the region were requesting it, even though training opportunities were provided beyond the 10-county target service area. As a result, the project reduced its interpretation training goals for year 3. However, in its third year, the program was inundated with requests for interpreter training in areas neighboring the towns of Macon and Savannah. News of the availability of training spread via word of mouth and careful marketing. As a result, the project far exceeded its year 3 goals.

Results

During the 3-year project, 1,640 Hispanic clients received 29,918 health services from the district's 10 county health departments. The most commonly needed services were Women with Infant Children and family planning. Other popular services included immunization, child health, and maternal health care.

Language Links provided interpretation services for 133 pregnant Hispanic women. Although many Hispanic women are not eligible for Medicaid, the state's Babies Born Healthy program enabled the project to provide care for low-income women who qualified. The project trained 212 bilingual individuals in the nationally recognized Bridging the Gap medical interpreter training. As a result, southern Georgia now has a cadre of trained medical interpreters available to health departments, hospitals, physicians, and other health care facilities. In addition, more than 600 health professionals received cultural competency training, many of whom were motivated to receive the training in exchange for continuing education credits.

The project evaluation underscores the program's value to the region. In May 2003, only 44 percent of physicians reported a need for interpreter services. By April 2005, that figure had increased to 82 percent.

Potential for Replication

As more and more rural communities face ever-increasing numbers of new immigrants, Language Links for Healthier Families has the potential for replication in other rural settings. Training for interpreters and health professionals is essential, and it's clear that candidates are more likely to access these training

opportunities when they are offered close to home. In short, this project exemplifies a “grow your own” solution to meeting the needs of Spanish-speaking clients.

The main problem other communities might face is obtaining buy-in from the local provider community that their institutions really need trained medical interpreters and that using relatives, friends, or other individuals to interpret is not appropriate and, in fact, may be dangerous, if not illegal.

After the Grant

The Board of Health secured funding to retain two interpreters, but they will not be able to serve the original 10-county service area. One health department hired a bilingual clerk who is available to assist Hispanic women and families eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children, better known as the WIC Program. The project plans to continue providing medical interpreter training and cultural competency training for health professionals—as resources allow as this is the only source for such training in the region.

Community Characteristics

In May 2000, the Toombs County Health Department in southeastern Georgia convened a meeting of community leaders with expertise in health care, education, social services, mental health, and teen-oriented programs. The purpose of the meeting was to discuss ways to combat the area's high rates of teen pregnancy, substance abuse, and school dropout. As a result, organizations throughout the region joined forces to create the Toombs Teen Health Collaborative.

The first order of business for the new collaborative was to conduct a comprehensive community needs assessment and to pursue funding opportunities that would help them reach three key goals: (1) to reduce teen pregnancy rates from 81.1 to 60.0 per 1,000; (2) to reduce repeat births to Toombs County teens by 60 percent by 2005; and (3) to implement a system to improve community-based health care services to teenagers.

Services Offered

On April 1, 2001, the collaborative opened the JusTeens Center within the Toombs County Health Department. The center served teens from Appling, Emanuel, Montgomery, Tattnall, and Toombs counties. This grant enabled the JusTeens Center to expand clinic services and to increase outreach and educational initiatives focusing on reproductive health, teen pregnancy prevention, and health-positive lifestyles. Project services included family planning, health assessments, immunizations, exams and treatment for sexually transmitted infections, perinatal case management, postpartum home visits, and case management services for parenting teens.

The project consortium included Sunshine House, a child advocacy center; Toombs County Family and Children's Services, a state agency that assists children and families in accessing Medicaid coverage and financial benefits; Toombs County Board of Education; Vidalia City School; Robert Toombs Christian Academy; Family Intervention Center, a juvenile justice program that provides counseling services; Southeastern Technical College, which conducted outreach to teen fathers; and Family Connections, a grant-supported collaborative of community service agencies.

GEORGIA



**TOOMBS TEEN HEALTH
COLLABORATIVE
LYONS, GA**

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Innovative Solutions to Problems

Some of the project's more innovative features included the following:

- Providing family planning services under a flexible appointment system after school and during evening hours and still accepting walk-in clients
- Developing a Teen Collaborative Board of teenagers who met to discuss project activities and additional problems in the community that needed to be addressed
- Engaging local media in publicizing community events, such as the annual Teen Health Fair, and airing a series of public service announcements on teen pregnancy prevention
- Establishing an adolescent case management program
- Conducting a health appraisal to identify teens with health risks who needed case management
- Providing educational, recreational, and emotional support programs, such as Teen Health Fairs and parenting classes
- Providing a bilingual interpreter to assist the increasing number of Spanish-speaking clients, and developing bilingual program and educational materials
- Developing a monthly fatherhood program

Results

In spite of state-mandated employee layoffs and other actions that temporarily halted some services, the Toombs Teen Health Collaborative played an important role in reducing Toombs County's teen pregnancy rate by 37 percent (51 per 1,000). The repeat pregnancy rate in the county decreased to 18.2 per 1,000—a 60-percent reduction since 1999.

The expansion of clinic hours and services helped to create a standing, teen-focused resource in the community that provided culturally appropriate health and prevention services as well as health education materials. Nearly 2,000 teenagers and young adults received services, including 1,694 females and 183 males. The project also provided 1,480 units of health education and family planning services, 583 units of perinatal case management, and 76 postpartum home visits. It also conducted 1,044 health assessments and immunizations.

Potential for Replication

The comprehensive community assessment conducted shortly after the collaborative was created in 2001 was a critical factor in this project's success. Other rural communities should consider conducting a similar assessment that outlines clear priorities and goals for such a project. It also is critical to engage area businesses, schools, health care providers, and community groups that have a vested interest in improving teen health.

After the Grant

A staff of two registered nurses and a bilingual outreach worker/interpreter will continue to provide clinic services, parenting teen case management services, and community outreach and health education programs. State-funded public health programs, Medicaid reimbursements, and community contracts will sustain the JusTeen Clinic. The project plans to conduct a biannual meeting of collaborative members. It also hopes to increase participation of teens in the Teen Advisory Collaborative to address future needs and advise project services.

Community Characteristics

Hana, one of the most isolated areas in Hawaii, consists of small, geographically dispersed settlements scattered over 233 square miles. The community is up to 3 hours from the closest urban area, and the only way to get there requires driving on a winding single-lane road through tropical rain forests and along steep sea cliffs. Needs assessments conducted in recent years revealed that Native Hawaiian children and adolescents lacked meaningful, culturally relevant healing, wellness, and health education opportunities.

Although the need for culturally competent behavioral health care in Hana was extensive, such services generally were not available. Children at greatest risk for serious emotional disturbances were those from families with a history of mental or addictive disorders; multigenerational poverty; and caregiver separation, abuse, or neglect—problems that were highly prevalent in the community. Hana is a designated medically underserved area, a primary care health professional shortage area, a dental health professional shortage area, and a mental health professional shortage area.

Services Offered

The project partners consisted of the Hana Community Health Center, Hana High and Elementary School, and Tripler Army Medical Center. The project was designed to provide adolescents with an employment experience at the health center to help build self-esteem, develop healthy decisionmaking capabilities, and prevent the onset of chronic health problems. The medical center provided a range of behavioral health services to students at the two local schools, those participating in the employment program, and young children at home. These services included behavioral health evaluations, diagnostic testing, individual and group therapy, psychoeducational and skills-building groups, psychopharmacological consultation, medication monitoring, and crisis counseling.

Innovative Solutions to Problems

The most innovative feature of the Adolescent Behavioral Health Project was the activities in which employed youth became involved. These culturally relevant health and wellness activities included growing and gathering food, cooking, eating a traditional

HAWAII



**ADOLESCENT BEHAVIORAL
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Hawaiian diet, exercising, and participating in the kupuna (elders) nutrition program.

Results

The Adolescent Behavioral Health Project delivered 1,300 units of behavioral health services to 139 children and adolescents, and 20 children received crisis counseling. The project originally planned to provide these services at the medical center. Instead, these services, especially group therapy programs, were delivered at the school or at students' homes. Some 76 young people participated in the youth employment program for a combined total of nearly 11,000 days. Ten children also participated in the After-School Wellness Program.

The program had hoped to serve a larger number of children and adolescents, but several problems prevented the project from reaching its goals. The project faced some resistance and distrust on the part of teachers, counselors, and care coordinators when the school-based behavioral health component was initiated. This lack of support on the part of Hana school staff made it more difficult to implement the program as originally planned. Other problems included recruiting a qualified project coordinator willing to live in or commute to Hana. It took more than 5 months to fill this position, and then the project coordinator resigned after only 9 months on the job. However, the second project coordinator served in this role until the grant period ended.

Although only three organizations participated in the project, coordinating activities, scheduling meetings, and working around staff travel schedules was a difficult challenge. Logistics were a major problem for consortium members because medical center staff and other behavioral health specialists lived outside the Hana district. In addition, the original school principal was a strong supporter of the partnership; however, she was removed from her position in the middle of the project's second year and replaced by an interim principal during the final months of the project. This affected the project's ability to carry out some of the planned evaluation activities.

Potential for Replication

Schools are convenient settings in which to provide behavioral health services, especially when school-based mental health care programs enjoy the support of school officials and parents. It is important, however, that all partners involved in the consortium are

equally committed to achieving project goals and operating within a predefined project structure unless midcourse adjustments suggest otherwise.

After the Grant

In 2004, the Hawaii State Legislature earmarked \$500,000 so the Hana Community Health Center could continue to provide school-based behavioral health services at Hana High and Elementary School. The legislature found the program to be an excellent model for providing such services for children in geographically isolated communities. State funding was conditional on the state department of education matching the \$250,000 appropriated to the health department. This funding was supposed to be outsourced via a contract with the Hana Community Health Center. Instead, the education department decided to attempt to provide these services on its own. As a result, the health center continues to collaborate with the medical center to meet the mental health needs of children unable to access school-based mental health services.

The youth employment program has been expanded to a full-scale, small farming operation that provides employment opportunities for youth and a pro-recovery setting for adults with substance abuse problems. The farm produces more than half of the produce used in the nutrition center, and outside produce sales are generating income for the farm. The health center has retained seven part-time youth employees on the farm, one youth employee in the nutrition center, and one youth employee in the fitness program. In addition, two youth who participated in the employment program are full-time health center employees. Clearly, this component of the program has had a tremendous impact on the lives of the young people it served.

Community Characteristics

In 2000, Idaho ranked fourth in the nation for residents lacking basic health care and for residents lacking access to dental care; 25 percent of adults and 18 percent of children had no health insurance. That same year, the state ranked 47th nationally in the percentage of physicians accepting Medicare. The five northern counties (Benewah, Bonner, Boundary, Kootenai, and Shoshone) in the Idaho panhandle had 73 general or family practice physicians to provide care for more than 190,000 citizens, and no dentists in the region accepted Medicaid. These counties are rated as health professional shortage areas for dental and primary care providers. This section of the state covers approximately 8,000 square miles and is larger than the states of Delaware and Connecticut combined. The region shares borders with Canada, Montana, and Washington, and contains the Selkirk and Coeur d'Alene ranges of the Rocky Mountains.

Services Offered

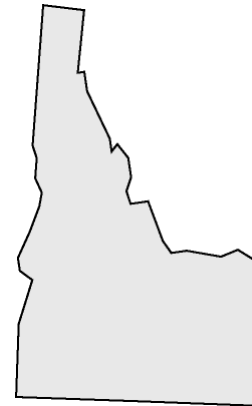
Organizations involved in the North Idaho Partners in Care consortium included Panhandle Health District, which provided financial and administrative oversight; Benewah Medical and Wellness Center, which provided dental professionals; North Idaho Rural Health Consortium, a network of five hospitals that provided physicians and allied health specialists to partner with public health nurses for clinical consultation; and Aging and Adult Services of North Idaho and North Idaho Head Start, which provided clinical sites and advertising of services. Together, the consortium agencies provided primary medical care, dental care, and outreach for low-income, uninsured, and underinsured residents of all ages in the five-county region.

Innovative Solutions to Problems

The project used a mobile clinic to reach remote, underserved rural areas in the region. The vehicle is a self-contained, fixed-body truck with a dental exam room, a medical exam room, an intake area, a bathroom, and storage space.

Designing and constructing the vehicle was the biggest challenge. The project originally budgeted \$180,000 over 3 years for construction and design, but the commercial bids received exceeded the project's budget—in some cases by 100 percent. As a result, the project sought competitive bids for each component of the vehicle—truck cab and chassis, construction of the container to

IDAHO



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fit the frame, up-fit of the interior, and all of the infrastructure equipment. A local bank provided a low-interest loan that enabled the project to use its three yearly allotments of capital investment as a downpayment and two equal yearly balloon payments.

Recruiting providers and volunteers also was a major challenge throughout the life of the project. The state's personnel system prevented the project from offering a competitive salary; and because the clinic's hours of operation were from 9 a.m. to 5 p.m., it was difficult to find volunteers who didn't already have job commitments during those hours. The project overcame this barrier, however, via independent contractor agreements; part-time, grant-funded health district employees; job sharing; collaboration with community health center providers; and finding at least one retired physician volunteer. This enabled the clinic to be fully staffed and operating at full capacity.

Results

The project has emerged as a model of community cooperation and persistence in addressing unmet health care needs in a large, rural, underserved area. The mobile clinic played an important role in education families about the Children's Health Insurance Program, and many parents receive the assistance they need to enroll their children in the program.

More than 2,600 residents found a medical and dental home as a result of the mobile clinic's services—a resource that did not exist before. The clinic also succeeded in helping people access existing education and community-based programs, increasing the percentage of area children who were fully immunized, administering flu shots during the height of flu season, and providing information and counseling about sexually transmitted infections.

In addition, nearly 1,000 underserved residents received either preventative or restorative dental services that weren't available before. The project also provided 204 vision screenings, with 21 residents receiving referrals for more extensive vision evaluation.

Potential for Replication

Other rural communities should be aware that a mobile clinic is a very costly means of providing medical and dental care. Maintenance costs are very high, and low-income or uninsured residents are a difficult market from which to generate revenue.

This model can work, however, if grant-funded, in-kind, or donated resources are available; an established referral network exists for health and dental services; the project is equipped to serve patients with health insurance and has a strong billing infrastructure; the project focuses on a small, targeted service area; and strategies are in place to reduce the number of no-show patients.

After the Grant

Consortium members plan to work with local community health centers to promote the mobile clinic’s services and to provide technical assistance and training in the operation of the vehicle and equipment. In addition, Panhandle Health District will forward patient charts and other medical information as clients give their consent for the release of such information.

Community Characteristics

Local estimates suggest that only 10 percent of the 10,000 people living in Saline County, Kansas, were receiving health care services before the grant period. According to the Kansas Department of Health and Environment, Saline County had more men, women, and children living in poverty and lacking health care coverage than the average for the rest of the state.

Prior to receiving the outreach grant, the Salina Cares Health Clinic was open only two evenings per week and was unable to provide care to all who needed it. The clinic space used at the local health department was not available during the day, and new patients had to wait 4 to 6 weeks for an appointment.

Services Offered

The Salina Area Health Network targeted area residents living below 150 percent of the Federal poverty level. The network consisted of the Salina Regional Health Center, the Salina-Saline County Health Department, the Smoky Hill Family Practice Center, and the Salina Cares Health Clinic. The health department provided space for the Salina Cares Health Clinic from 1991 to early 2003, when the clinic moved to another space that would accommodate daytime appointments, and it continued to provide sliding-scale fees to qualified patients. The Salina Regional Health Center provided pro bono care to patients in need. The Smoky Hill Family Practice Center expanded its administration and clinical staff to support four half-day clinics weekly. In addition to expanding staff at Smoky Hill, the project used grant funds to cover the salaries of a pharmacy technician and a part-time financial director as well as the costs of laboratory, radiology, and surgical services for qualified patients.

Innovative Solutions to Problems

For the first 9 months of the grant, the evening clinics remained housed at the local health department and the daytime clinics were held in unused space at Salina Regional Health Center. The city of Salina then provided funding that allowed the clinics to move to a new location where all services could be provided under one roof. The relocation occurred in early February 2003. After the move, primary care services were provided at one location. Patients needing specialty care received referrals to area specialists.

In an effort to ensure sustainability and ongoing funding, the Smoky Hill Family Practice Center and the Salina Cares Health

KANSAS



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NETWORK
SALINA, KS**

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Clinic agreed to apply for funding under Section 330 of the Public Health Service Act to become a Federally Qualified Community Health Center. All consortium members supported this decision. The two entities formally merged into one entity—the Salina Family Healthcare Center. Throughout this transition and after the transition was completed, the county health department and the Salina Regional Health Center continued to provide the same services to qualified patients as they had in the past.

Results

The project served 1,154 unduplicated patients in 2002, 1,163 in 2003, 1,479 in 2004, and 5,173 from January to April 2005. The merger of two network members and the relocation of most services under one roof clearly had a profound impact on increasing access to care. Hispanic clients had access to a full-time interpreter and Spanish-language medical forms.

The program developed a comprehensive diabetes care program that included education, assistance in helping patients obtain medications and testing supplies, aiding providers in ordering tests and providing interventions in a timely manner, and providing educational opportunities for providers. The clinic also applied for and received a \$10,000 grant from the Kansas Department of Health and Environment to participate in a 1-year state diabetes initiative. The project also assessed each patient for coronary disease. Those at risk were counseled and monitored, and providers received ongoing education on heart disease diagnosis and treatment.

Clients with substance use disorders were referred to the Central Kansas Foundation, the local treatment center. In addition, a counselor from the foundation was available to see patients in the Salina Family Healthcare Center. However, patients needing substance abuse treatment generally were not willing to accept these services.

Potential for Replication

This project succeeded because it enjoyed broad-based support from the medical community. This doesn't always happen in rural communities. The hospital provided pro bono care to qualified patients, and the local laboratory provided pro bono lab testing. In addition, 95 percent of the physicians in Salina participated in the program by donating their services to referred patients. For the first 2½ years of the project, there were no paid staff members: All

workers were volunteers. That type of community commitment is not easy to find.

After the Grant

In September 2003, the Salina Health Education Foundation was designated as a Rural Health Clinic, enabling it to receive enhanced reimbursements for Medicaid and Medicare patients. In October 2004, the Salina Family Healthcare Center became a Rural Health Center/Federally Qualified Health Center, and funding started in December 2004. Since receiving that designation, the health center has had a steady source of income and a higher reimbursement rate for Medicaid and Medicare, which is especially important because 3 percent of the target population have Medicaid coverage. The project now plans to apply for the 340B Drug Pricing Program to cut the cost of prescription drugs. United Way also supports the health center now. In addition, the health center has hired a dentist and is working to establish a dental clinic.

PROJECT 10—APPALACHIAN VIOLENCE OUTREACH NETWORK (AVON)

Community Characteristics

This project operated in four northern counties—Breathitt, Lee, Owsley, and Wolfe counties—of the Kentucky River Area Development District, nestled in Appalachia, about 80 miles from Lexington. The majority of women served by local agencies in these counties had low incomes and low educational attainment, and many lived a long distance from the resources available in the community. Domestic violence and sexual assault appeared to be underreported in the region, even though data suggested a very high rate of interpersonal violence. Women in the community seemed to be unaware of the services available to them, and services that were available were difficult to access. A steering committee of community agencies decided that the public health department was the safest and most likely place for women to learn about, and be connected to, help for interpersonal violence.

Services Offered

Kentucky River Community Care, with 30 years of experience in mental health care and health care administration, coordinated grant activities. The Kentucky River District Health Department provided wellness coordinators to link female patients who had been abused to community resources. The director of the LKLP [Leslie Knott Letcher Perry] Safe House provided training to wellness coordinators. The independent Breathitt County Health Department provided a “home base” for coordinating wellness services during the last 16 months of the project. The University of Kentucky Institute on Women and Substance Abuse designed the screening tool to assess women’s needs and assisted in training the wellness coordinators. The Kentucky State Department of Protection and Permanency, the social service agency that protects area women and children in abusive or neglectful situations, trained and assisted the wellness coordinators.

Innovative Solutions to Problems

The project administered a screening tool with nine questions about stress, depression, eating problems, self-esteem, sexual abuse, and domestic violence to female patients at the health department. Clients who reported any of these problems were referred to a wellness coordinator, who provided information, support, and assistance to meet the client’s needs. Clients were eligible to

KENTUCKY



**APPALACHIAN VIOLENCE
OUTREACH NETWORK (AVON)
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participate in a series of eight workshops focusing on stress, depression, food and mood, relaxation, exercise, safety nets, positive parenting, and how to make health-positive life changes. During the final 9 months of the grant, a HRSA-funded psychologist was hired to provide intensive psychotherapy for those who needed it. Psychotherapy was provided free of charge to clients. The project also established resource centers at each of the health departments that provided information on interpersonal violence.

At first, it was difficult to get women to participate in educational workshops. As a result, the project began offering Wal-Mart gift certificates as an incentive. Clients who attended four or more workshops received a \$20 gift certificate. Those who attended all eight workshops received a \$50 gift certificate. This approach was extremely successful.

One of the project's biggest challenges was establishing relationships between clients and wellness coordinators. Many clients were not willing to confide in someone they did not know or trust. But the project learned that clients were significantly more willing to talk openly about the problems in their lives if the wellness coordinator was someone from the community—someone they knew and trusted.

Results

More than 1,200 women made one-time visits to the health departments, and 319 received follow-up services. More than 60 women received one-time psychotherapy, and 54 received follow-up counseling. More than 150 women participated in at least one wellness workshop, but 53 women attended the entire series of eight workshops. Clients ranged in age from 13 to 84 years old.

The educational workshops were well received by clients, but only after the project provided Wal-Mart gift certificates as incentives to attend. The Foundation for a Healthy Kentucky recognized AVON as one of its 2005 "Models That Work." In addition, Kentucky Educational Television featured the AVON Wellness Workshops in a program aired in October 2005.

The project succeeded in establishing resource centers in each of the four health departments where AVON staff members were located. The screening tool, a tremendous success, has been shared with local health care providers to identify women needing more

intensive or specialized services. The project director, health department staff members, nurses, and social workers were offered trauma training, and those who received it earned continuing education credits.

The project also sponsored conferences on interpersonal violence, attended by clerical staff, social workers, nurses, doctors, attorneys, law enforcement personnel, health department staff, clinicians, psychologists, and the general public. A conference, which provided continuing education credits, was held in 2005 in conjunction with a specialized 2-day training for law enforcement professionals.

Potential for Replication

Interpersonal violence is a huge problem for many rural communities. The screening tool was effective in identifying women who needed assistance. However, some women simply are not willing to admit they live in violent or dangerous situations. Because of this fear, they are sometimes unwilling to access available resources. Other communities must be aware of this reality and prepared to address it if they intend to replicate this model. For those willing to receive help, wellness workshops are a great approach to providing the information and resources they need to build self-esteem and recognize that interpersonal violence is not the norm.

After the Grant

The project offers a manual and a training video on the workshops for communities interested in implementing a similar model. Several programs supported by the grant will continue, including the wellness workshops, the resource centers, local family violence councils, and psychotherapy (although mental health services will no longer be provided free of charge). The consortium members are exploring the possibility of working together on a future grant proposal that would enable them to establish a women's community center.

PROJECT 11—MODIFIED HEALTH RISKS: TREATMENT OF OBSTRUCTIVE SLEEP APNEA

Community Characteristics

Kentucky has high rates of diseases linked to sleep apnea, including diabetes, heart disease, and obesity. The project elected to target five rural counties—Franklin, Laurel, Pulaski, Warren, and Allen—because of the large number of residents who did not have health insurance or who lacked access to health care services because of poverty or insufficient transportation.

Services Offered

Grant funds were used to strengthen a new prevention project to detect and treat obstructive sleep apnea and to modify the health risks of obesity, diabetes, and heart disease associated with untreated sleep apnea. The project was coordinated by the Kentucky Sleep Society, which diagnosed and treated sleep apnea with traditional methods (e.g., continuous positive airway pressure) and monitored the improvement of clients' health status after treatment.

The primary focus of the program was providing health screenings to detect the presence of sleep apnea and the associated health risks of heart disease, diabetes, and obesity. Screenings were provided to adults at local health fairs conducted at health departments, hospitals, exhibits, meetings and conferences, sleep disorder centers, and primary care clinics.

People at risk for sleep apnea and associated health risk factors received referrals to the Kentucky Sleep Society for financial screening and placement in the diagnosis and treatment program. Poor individuals without health insurance were scheduled for a sleep study to diagnose and treat sleep apnea. Following treatment, area doctors provided follow-up care. Many clients also received education on good nutrition and the role of exercise to help manage weight problems, diabetes, and hypertension.

Innovative Solutions to Problems

In addition to educating area residents about sleep apnea and the associated health risks, the project recognized the need to increase awareness of this disorder among local health care providers. To address this need, an aggressive educational program was developed to train local health care workers, state agency educators, caseworkers, health department nurses and administrators, school nutritionists, primary care clinic workers,

KENTUCKY



**MODIFIED HEALTH RISKS:
TREATMENT OF OBSTRUCTIVE
SLEEP APNEA
LEXINGTON, KY**

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specialized day treatment centers, and early childhood teachers. The project also reduced its funding for clerical support in order to develop and print educational materials on sleep apnea to be disseminated by individuals and professionals who received training through the project.

Results

As a result of the health screenings, the project conducted 149 sleep studies to diagnose and treat sleep apnea. The majority of these patients made improvements in managing their diabetes or hypertension, and 91 percent of clients adhered to treatment. Of these, 55 percent reduced their weight, 52 percent decreased their blood pressure, and 75 percent decreased blood sugar levels. In all, the project recorded nearly 37,000 visits. More than two-thirds of the clients were female, including large numbers of pregnant and menopausal women, who are at higher risk for sleep deprivation and sleep apnea.

The project network expanded significantly during the course of the grant cycle so it could provide more varied services to a diverse array of clients. In the end, consortium members included the public school system, Head Start programs, local social service agencies, and Area Health Education Centers. With this expanded network, the project includes school dietitians, teachers, and school nurses to promote preventive messages regarding sleep deprivation, sleep apnea, and associated health risks. Network members continue to request support from the Kentucky Sleep Society, which also laid the groundwork for developing a train-the-trainer model to sustain the project's intent in the years to come.

Potential for Replication

This model works best when a grassroots approach is used to reach potential participants. Churches, family discussions, word of mouth, friends, and casual conversations with health care providers outside the network proved to be the most effective means of educating clients. Although the project's executive director focused on establishing relationships throughout the local health care system, project staff and providers focused on establishing one-on-one relationships with clients.

The biggest challenges associated with this model are reaching beyond the traditional medical setting to gain access to underserved populations; the lack of understanding of the negative effects of sleep deprivation and sleep apnea among professionals, the school

system, and the public; and the financial resources required to implement such a program.

After the Grant

Financial and human resources contributed by the network members will sustain the program. The Kentucky Sleep Society will continue to communicate updates through the network newsletters it publishes. In addition, the sleep disorder centers will continue to see patients they've already treated, and the primary care clinics will continue to screen for potential patients.

PROJECT 12—COMMUNITY-BASED CARE FOR PERSONS LIVING WITH TYPE 2 DIABETES

Community Characteristics

In rural southwestern Mississippi—specifically, Adams, Amite, Jefferson, and Wilkinson counties—63 percent of the population is African American, and 37 percent is white. Roughly two-thirds of area residents age 25 and older are high school graduates. The median household income ranges from \$18,447 to \$26,033 per year. Between 23 and 38 percent of the area’s population live in poverty. Diabetes is the third leading cause of death in Jefferson County, fourth in Amite County, sixth in Wilkinson County, and tenth in Adams County. Diabetes the leading cause of heart disease, and heart disease is the leading cause of death in all four counties.

Services Offered

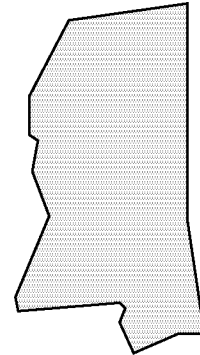
The Community-based Care for Persons Living with Type 2 Diabetes program was designed to prevent complications commonly associated with type 2 diabetes. Specifically, the project hoped to reduce lifestyle risk factors associated with type 2 diabetes that can lead to end-stage renal disease, adult onset of blindness, peripheral neuropathy, amputation of lower and upper limbs, stroke, and cardiovascular disease.

The project consortium was led by Alcorn State University School of Nursing, which sponsored a nurse-managed family clinic that provides primary health care services to people living within 50 miles of the clinic. Field Memorial Community Hospital and the Jefferson Comprehensive Health Center sponsored diabetes clinics for residents of the four-county region. Together, these organizations provided case management, support groups, and continuing education opportunities for health care professionals from a variety of disciplines. All clients served were living with type 2 diabetes.

Innovative Solutions to Problems

The project used certified family nurse practitioners placed at each clinic to provide case management services. The project initially used the prepackaged Life Skills for Diabetes Management model to help clients make health-positive behavior changes. Over time, this model had to be adapted so that it would meet the needs of clients, be more easily administrated by the certified family nurse practitioners, and track incoming clinical data.

MISSISSIPPI



**COMMUNITY-BASED CARE FOR
PERSONS LIVING WITH TYPE 2
DIABETES
NATCHEZ, MS**

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The project sponsored health education sessions in support group settings throughout the four-county region. As a result, some participants stepped forward and expressed a willingness to facilitate group meetings. The nurse practitioners provided these self-appointed group leaders with guidance as needed and arranged for experts to come in to speak about special topics. For example, the chair of family medicine at the University of Mississippi Medical Center delivered a series of three presentations, one at each clinic site, on the American Diabetes Association's 2003 standards of care for diabetes management.

The site provided onsite continuing education presentations on type 2 diabetes. In addition, during Diabetes Education Month (November) for each year of the grant, the project sponsored a Diabetes Education Day at the nursing school to educate people with diabetes, their family members, and area health care professionals about effective self-management.

One of the biggest challenges the project faced was the cost associated with providing hemoglobin (Hgb) A1c laboratory tests. Many patients couldn't afford the test, so the project subcontracted with a local laboratory to perform these tests or used disposable test strips that were purchased in limited amounts. Eventually, the project decided that collecting HgbA1c data from participants on a quarterly basis was cost-prohibitive, so the project adjusted the intervals to suit patients' ability to pay.

Results

The project provided care and case management services to 453 people with type 2 diabetes in the four-county region. Of these, 128 project participants had two or more HgbA1c reports on file. The average first reading was higher than the average second reading, suggesting that clients were making good progress toward controlling their diabetes. The number of clients served increased during each year of the project. Some 414 people participated in support groups, which significantly exceeded the project's original expectations. Support group participants received information on a variety of topics to help them better manage diabetes.

The project also sought to improve cultural competency in the delivery of diabetes-related services in the four-county region. During the 3 years of the project, 63 health professionals participated in continuing education presentations.

Potential for Replication

This model could work well in other rural settings, but other communities can learn from the challenges this project faced. The biggest challenge was establishing trust with community residents, using prepackaged data collection tools such as the Life Skills program, and adapting project goals or activities midcourse to address predetermined strategies that do not work.

After the Grant

All three sites will continue to offer the diabetes clinics, although clients will have to pay for such services or meet eligibility requirements for Medicare or Medicaid reimbursement. The project is now expanding services to an additional local clinic and increasing opportunities for nurses and other health care professionals to learn more about diabetes self-management in rural settings. A new grant will support clinic services.

The project has established partnerships with medical equipment suppliers to provide glucometers and testing supplies to patients at reduced fees. In addition, pharmaceutical companies and local businesses have agreed to provide patients with needed medications. Meanwhile, the support groups continue to meet, and expert presenters continue to share their knowledge with participants on a volunteer basis.

Community Characteristics

In 2000, approximately 18 percent of the 19,309 people living in Morgan County, Missouri, were living below the Federal poverty level. Due to the county's large Mennonite and Ukrainian populations, the number of uninsured individuals was estimated to far exceed the state's rate of 16.7 percent. In this rural county, there was only one physician for every 2,758 people, and the nearest hospital is 45 minutes away.

Lack of transportation and an organized referral system further exacerbated the barriers to accessing health care. Another major barrier was the cultural customs of Mennonite and Ukrainian residents. Welfare and insurance programs are not widely accepted by Mennonites, and although Ukrainian families typically are willing to enroll their children in Medicaid, adults usually are not willing to enroll themselves.

Services Offered

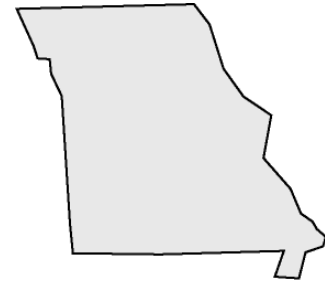
This project targeted uninsured residents of Morgan County with incomes below 179 percent of the Federal poverty level. It also targeted a secondary area that included Moniteau, Miller, Camden, and Cole counties.

The project consortium comprised three organizations:

- The Morgan County Health Center located in Versailles is a local public health agency that had an established relationship with Mennonite and Ukrainian communities.
- Matthew 25 Ministries is a nondenominational group of churches with more than 22 volunteers trained to provide home health, transportation, and other services.
- CeMo CARES, a nonprofit organization focused on improving access to health care for a seven-county region, has operated the volunteer-based Jefferson City Free Medical and Dental Clinic (JC Clinic) since 1995.

Thanks to the grant, the project opened the Dr. Jack Gunn Community Clinic that operated out of the Morgan County Health Center. The clinic provided primary care, mental health services, as well as pharmaceuticals, medical supplies, and referral services at no cost to low-income, uninsured individuals. Clinic staff includes a clinic coordinator and a part-time nurse, along with volunteer physicians, nurses, and clinical staff. The project

MISSOURI



**CENTRAL MISSOURI HEALTH
CARE OUTREACH (CEMO)
VERSAILLES, MO**

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provided a comprehensive referral system that included case management and assistance in accessing services, and helped to create an integrated health care delivery system. The program also purchased two seven-passenger vans to provide transportation from the clinics to local physicians and other services.

Innovative Solutions to Problems

By running sister clinics, the project was able to share administrative staff and medical supplies. This approach significantly reduced costs and helped the Gunn Clinic become fully operational much sooner than most startup clinics.

Although many challenges can be anticipated, others cannot. The clinic's namesake and medical director, Dr. Jack Gunn, died suddenly just a few months before the clinic opened. This was a substantial blow to both the community and the viability of starting a new free clinic. At the same time, the project lost a second physician who retired early to be closer to his children. A few months later, a third physician was dispatched to serve in the war. These losses constituted 50 percent of the community's physician base. Because of the clinic's sister-clinic relationship, Dr. Jeff Sanders of the JC Clinic volunteered his services at the Gunn Clinic—in addition to his other volunteer commitments.

Results

The project had planned to provide free care to 1,500 patients and \$25,000 in prescriptions and medical supplies. Actual visits, however, exceeded 2,000 patients, and the project provided more than \$25,000 in prescriptions. It also provided about 6,000 referrals per year and transportation to approximately 480 health care visits.

Potential for Replication

The lessons learned as a result of the project evaluation are particularly useful to other rural communities seeking to replicate this model:

- Clearly define the roles of the consortium members—in writing.
- Seize opportunities to expand the network and provider involvement whenever possible.
- Plan well, and evaluate activities on a regular basis.
- Maintain strict but balanced governance of the project.
- Make sure the project has several sources of revenue.

- Ensure that the project's structure and network benefits all of the partners.
- Always do what is best for the patients because it is the only way to operate.

After the Grant

Both clinics will continue at the same levels achieved under the grant. The Gunn Clinic has instituted a modest fee schedule for clients able to pay. Seniors now have access to the Prescription Assistance Program at a fee of \$5 per prescription. The JC Clinic is in the process of taking over CeMo CARES, which dissolved in July 2005. JC Clinic staff members now work on a part-time basis, but the clinic also expanded its arsenal of volunteers to support administrative functions. The United Way covers the cost of medications provided via the JC Clinic. Meanwhile, both clinics are actively seeking new sources of grant funding.

PROJECT 14—GREAT BASIN COLLEGE RURAL HEALTH OUTREACH PROGRAM

Community Characteristics

The service area for the Great Basin College Rural Health Outreach Program consisted of nearly 96,000 square miles—86 percent of the state of Nevada. It is home to more than 232,000 people distributed throughout 41 rural and frontier townships and settlements—all of which are far from Nevada’s urban centers. Much of rural Nevada is classified as a Federal health professional shortage area or a medically underserved area.

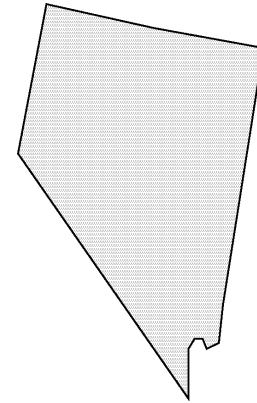
Given the large geographic area of rural Nevada, it is easy to understand the challenges facing emergency medical service (EMS) providers and pre-hospital care providers in the region. Emergency medical services consist of mostly community-based volunteer ambulance services staffed with basic and intermediate emergency medical technicians (EMTs). These volunteer services generally are dispatched from a county-based, multi-community law enforcement dispatch center. Roughly 3,400 licensed EMTs in rural Nevada provide care to nearly 10,000 patients per year. EMS personnel in rural Nevada struggle to recruit new EMTs, retain existing workers, provide training, and improve leadership.

Services Offered

The major focus of this project was fivefold: (1) to recruit new EMTs, (2) to help rural communities retain new recruits, (3) to provide training, (4) to secure training equipment, and (5) to improve pre-hospital response services. Led by Great Basin College, the consortium included the following partners:

- Great Basin College managed the consortium activities, the project budget, and the training academy. Other consortium members included the following:
- The University of Nevada School of Medicine Outreach Center conducted the project needs assessment, provided distance-learning technical assistance and training course coordinators, and offered project advocacy.
- The Nevada State Health Division EMS Section ensured course accreditation, developed the training curriculum, and provided staff support and data.
- The Nevada Emergency Medical Association hosted regional forums, assisted in planning meetings of rural EMS medical directors, supported state EMS conferences, and recruited members to advocate for more rural EMS resources.

NEVADA



**GREAT BASIN COLLEGE
RURAL HEALTH OUTREACH
PROGRAM
ELKO, NV**

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In addition, Great Basin College, Truckee Meadows Community College, Community College of Southern Nevada, and Western Nevada Community College made their EMS education programs available to rural communities throughout the state and increased access to distance learning programs through interactive video connections.

Innovative Solutions to Problems

One of the most innovative features of this project was the interactive video conferencing, which enabled EMTs in isolated rural areas to attend training classes locally and to receive expert instruction from teachers dispersed throughout Nevada. This approach also reduced the required travel time to attend classes and made it significantly easier for EMTs to receive training without taking time off work.

Another innovative feature was the provision of financial aid to all students who attended EMT training classes. The vast majority of students who received training indicated that obtaining financial aid was a major factor in their decision to continue serving as EMTs.

Results

The program provided basic EMT training to 167 people. Another 135 people received intermediate-level EMT training. Between September 1, 2002, and September 1, 2004, 91 EMTs who received basic training became certified by the state of Nevada. Another 67 EMTs who received intermediate-level training also earned state certification. The project trained nearly one-quarter of those certified to serve as ambulance attendants.

The project collaborated with the state EMS office to develop two mobile instructional trailers to provide EMS training in rural areas throughout Nevada, making it possible to reach 75 percent of the state's rural areas. The grant also supported 103 EMTs so they could receive continuing education and attend EMS conferences. Furthermore, the interactive video training successfully reached EMTs in 22 remote rural communities.

Potential for Replication

Many rural communities struggle with the challenges of dwindling numbers of trained EMTs, EMT recruitment, and insufficient compensation to retain existing EMTs. Furthermore, because rural EMTs typically make less money than their urban

counterparts, it is particularly difficult for them to afford training and tuition fees required to maintain their certification.

Consequently, this approach could be useful to other rural communities struggling with these challenges. However, other communities might want to set two or three specific goals for the project to maximize the return on their investment. Once those goals are met, they can expand efforts into new areas.

After the Grant

Great Basin College has hired a full-time EMS instructor and will continue the interactive video academy, while the state EMS office will coordinate the training trailers project. The project hopes to receive new funding from the Nevada State Legislature so that the full range of activities supported under the grant can be sustained.

Community Characteristics

Until January 2002, only two dentists had practices in Ticonderoga, New York, and neither accepted Medicaid or Family/Child Health Plus—both of which provide health insurance coverage for the poor. The nearest full-service dental clinic accepting these health plans was 46 miles away, and there was a 6- to 8-week waiting list for care. The distance, along with the long wait to receive care and transportation barriers, prevented many needing dental care from receiving it.

The Inter-Lakes Dental Clinic was established to provide dental care to nine isolated mountain towns. The area is home to approximately 15,000 year-round residents. In 2003, the average household income was just below \$35,000 per year, with 42 percent of households living below that level. Low-income residents (those who live 200 percent below the poverty level) constitute 40 percent of the area's population, with many communities being even poorer than that. In addition, Essex County has consistently tallied one of the highest unemployment rates of all New York counties.

Services Offered

The Moses-Ludington Hospital started the Inter-Lakes Dental Clinic as part of the Southeastern Adirondack Healthcare System (SAHCS) and the Adirondack Rural Health Network (ARHN). Both organizations are northeastern New York health care networks that comprise a number of provider members such as the Hudson Headwaters Health Network, Essex County Public Health, and Moses-Ludington Hospital. The hospital provided office space and rebuilt it into an airy, efficient dental clinic with six operatories, a lab for X-ray developing, and a waiting room, as well as reception and billing staff. The Hudson Headwaters Health Network, along with the Adirondack Rural Health Network, negotiated favorable pricing for equipment and established the original practice. Essex County Public Health, the Ticonderoga Health Center, and Moriah Family Health Center provided referrals to the clinic.

The clinic offered the full range of dental services, including fillings, sealants, root canals, extractions, crowns, bridges, dentures, cleanings, and checkups. Clients served by the clinic were of all ages and income levels, although the project placed strong emphasis on serving indigent patients covered by Medicaid or Child/Family Health Plus.

NEW YORK



**INTER-LAKES DENTAL CLINIC
TICONDEROGA, NY**

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Innovative Solutions to Problems

The clinic was fortunate to recruit a dentist and his wife, a dental assistant, who were motivated by service rather than the six-figure salaries many dentists expect. Consequently, the clinic did not have to deal with the recruitment challenges that many rural clinics face.

The clinic's biggest problem was no-show clients—clients who did not keep their dental appointments, even though there was a 6-week waiting list to receive care. Two actions, however, corrected this problem. Simply having the receptionist call patients the night before a scheduled appointment reduced no-shows by more than 40 percent. The second step was the establishment and enforcement of a strict policy. Patients who scheduled and missed two appointments were not allowed to schedule a third appointment at the clinic. The project still contacted them in the event of a cancellation or another no-show, and if they failed to keep that appointment, the clinic would not see them. This policy further reduced the problem of no-shows by about 70 percent. Under this policy, patients rarely went without dental care.

Results

The project succeeded in reaching most of its original goals. For example, it succeeded in establishing a full-time dental practice in Ticonderoga and coordinating outreach with the Essex County Sealant Program, which resulted in a large number of referrals and enabled the clinic to hire a dental hygienist. In all, the project provided dental care to 4,337 people of all ages, with only 1,217 of those having private health insurance or paying for care out of pocket.

The project originally planned to train dental residents at two sites; however, a New York law requiring that dental residents train on-campus only prevented this. The project also had planned to establish a satellite clinic, but no space was available for such a clinic in the target service area. In addition, the project elected not to launch a dental van outreach program as intended because it was unsustainable and duplicative of the services provided by the clinic.

Potential for Replication

The Inter-Lakes Dental Clinic is a viable model for many other rural communities. In fact, the project offers to share its grant proposal, business plan, and technical assistance with other organizations interested in replicating the model.

The biggest challenge for other communities will be recruiting dental providers whose salary requirements will fit within a restricted budget. Again, this project was fortunate to find mission-driven professionals committed to community service. Other communities, however, may have to be particularly creative in developing recruiting strategies to attract qualified dental professionals.

After the Grant

The clinic became fully sustainable well within the grant period. Third-party billing covers all clinic operations and expenses. The Inter-Lakes Dental Clinic is in Ticonderoga to stay.

The project hopes to establish a satellite dental clinic in nearby Hamilton County, another rural community with no dental health professionals. The project also is expanding into the field of telemedicine so it is connected to trauma centers and tertiary care facilities across the nation.

Community Characteristics

Data extrapolated from state and county health department data suggest that at least 30 percent of residents living in a 1,200-square-mile region of upstate New York have one or more of the following health risk factors: heart disease, diabetes, obesity, hypertension, hyperlipidemia, osteoporosis, and osteoarthritis.

As a result, a loose coalition of area agencies joined forces to create the Fit for Life program to provide medical supervision so area residents with these and other health conditions could safely participate in an exercise program. Coalition members included Adirondack Medical Center, local fitness and outdoor recreational facilities, a local health food store, the Saranac Lake Adult Center, and the Adirondack Wellness Movement. The target service area included three major population centers—Tupper Lake, Saranac Lake, and Lake Placid—and covered portions of Franklin, Essex, Hamilton, St. Lawrence, and Clinton counties.

Services Offered

Fit for Life accepted referrals of patients who qualified for the program from area health care providers and physicians. At first, a nurse in the medical center's cardiac rehabilitation program conducted a comprehensive intake for each patient; however, because of insurance reimbursement issues, the program switched to having a physical therapist conduct the intake assessment. An exercise specialist worked with each participant to set goals and to develop a tailored, realistic exercise plan.

Innovative Solutions to Problems

To reinforce lifestyle changes, Fit for Life combined the exercise program with education opportunities, including a support group led by a clinical psychologist, lectures delivered by local health providers, shopping trips to a local health food store, cooking workshops, and outdoor activities that helped participants realize exercise can be fun, social, and successfully integrated into their everyday lives. For example, the project partnered with local ski areas, which provided equipment and facility passes at no cost to participants. Similarly, Lake Placid Health and Fitness allowed Fit for Life participants to attend its water aerobics class once a week.

Three different locations throughout a large service area offered Fit for Life in order to make the program accessible. This was critical because patients who desperately need a routine exercise

NEW YORK



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SARANAC LAKE, NY**

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regimen are unlikely to drive 60 miles to participate. The project decided to bring Fit for Life to the people who needed it.

In addition, the project offered a post-Fit for Life program for those in the program for 3 months, which enabled participants to continue exercising at the facility where they were comfortable and had established relationships, while at the same time giving them ongoing access to Fit for Life staff members so they could ask questions. It also helped to link program graduates to new participants so they could share experience and advice, provide support, and reinforce that a health-positive lifestyle can be achieved.

Results

A total of 309 residents participated in the program. Each participant was required to complete a metabolic equivalent level screening, Beck Depression Inventory–II (BDI-II) screening, the Berg Balance Test, the Wellsource heart health questionnaire, and a program survey. After completing Fit for Life, 96 percent of participants had improved their metabolic equivalent level, 83 percent had improved BDI-II depression scores, and 80 percent improved their balance. In addition, 51 percent improved their understanding of their personal risk for heart disease, problems that generate risk, and action that can be taken to reduce chances of developing heart disease.

The program survey showed that the vast majority of participants found the program conveniently located and accessible, reported being comfortable with staff, and felt comfortable in the exercise facility. More than two-thirds went on to purchase a membership at the facility where they exercised.

Insurance coverage for preventive exercise programs is the biggest problem that the project was not able to solve. Medicare does not cover the cost of such services. Some insurance companies are willing to reimburse for exercise programs, but the program could not bill private insurance companies or Medicare. Fit for Life can be reimbursed for the physical therapist's initial evaluation, but not for the exercise specialist and medically supervised exercise time.

Potential for Replication

A tertiary prevention program like Fit for Life would be an asset in most rural communities, especially those with a large aging population. However, the barriers that may keep people from

participating in such programs—namely, transportation and affordability—must be addressed. This program succeeded by finding area organizations willing to share scarce resources. It also is important to determine how to cover startup costs for such a program. This grant made this program possible as the partner organizations most likely would not have been able to come up with sufficient startup capital. It is hoped that more insurance companies will become willing to reimburse such services and provide the revenue necessary to sustain these types of programs.

After the Grant

When grant funding ended, the project promoted the exercise specialist, after extensive training, to the clinical coordinator position. Staff members at each site include an exercise specialist, an athletic trainer, and a physical therapist or physical therapist assistant. All programs developed at the three sites as a result of the grant will continue unchanged.

PROJECT 17—WELLNESS IN THE VALLEY: SUICIDE PREVENTION TASK FORCE

Community Characteristics

In 2000-2001, Barnes County, North Dakota, a rural agricultural community of 11,775 people, experienced nine suicides in a 12-month period. All were healthy, seemingly well-functioning adults ranging in age from 21 to 70, with no common factor linking any victim to another. These suicides had a major impact on this close-knit community. Records at the local hospital emergency department that year showed that one of three suicide attempts was fatal.

Services Offered

Wellness in the Valley was developed to be a community-based program designed to reduce the incidence of suicides and suicide attempts and to address the factors contributing to suicide in the area. The seven-county area served by the project included all of Barnes County and parts of Cass, Griggs, LaMoure, Ransom, Steele, and Stutsman counties.

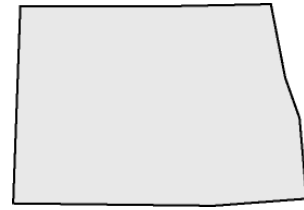
The project's three primary supporting agencies were Mercy Hospital, MeritCare Clinic, and the City-County Health Department. Mercy Hospital managed the project and provided office space for program staff. MeritCare Clinic played a key role in making depression screening a regular part of clinical checkups. The City-County Health Department is planning and conducting the project evaluation as well as providing free depression screening and follow-up services. The project task force originally included 17 supporting agencies but over time expanded to involve 26 agencies in the seven-county area.

The project was modeled after the U.S. Surgeon General's National Strategy for Suicide Prevention. With this foundation in mind, program initiatives included creating a public education campaign on depression and suicide awareness; gatekeeper training on how to identify those at risk for suicide and appropriate intervention; incorporating suicide prevention messages into health and social service outreach efforts; and providing support to those affected by suicides and suicide attempts.

Innovative Solutions to Problems

The most effective and wide-reaching program component was the public education campaign. The project disseminated information on depression, suicide, and mental health to the public

NORTH DAKOTA



**WELLNESS IN THE VALLEY:
SUICIDE PREVENTION TASK
FORCE
VALLEY CITY, ND**

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via radio, billboards, newspapers, newsletters, church bulletins, paycheck inserts, health fairs, door-to-door delivery, speaking engagements, and posters. Despite widespread prejudice, stereotypes, and misconceptions about mental health issues, the project earned the support of community leaders, who recognized that mental health problems are real, painful, and sometimes severe.

Results

By the end of year 3, 2,705 people had received gatekeeper training, education, and information for use in local businesses, volunteer or social groups, schools, and other community settings. This included more than 100 people from the faith community.

The campaign was very successful. Throughout the project, there was a continuous increase in the number of people contacting the program for assistance and referrals, requesting information or training, and openly sharing their stories.

The project coordinated and implemented administration of the Computerized Diagnostic Interview Schedule for Children (C-DISC) in local schools. This computer-driven assessment tool was designed to identify a wide range of mental health problems in children age 9 to 17.

Some 463 area health care professionals received suicide awareness training, education, and information. The local clinic added mental health screening to annual physicals between 2002 and 2004, which resulted in a 32-percent increase in the number of patients diagnosed with depression. The health department also began providing postpartum screenings during baby wellness checks.

Potential for Replication

Provided it has sufficient funding and a strong community coalition, this project could work well in other rural communities. It also is important to have an ample supply of mental health professionals to identify, diagnose, and treat those at risk for suicide or suicide attempts. Most importantly, given the stigma associated with mental health issues and the geographic barriers that inhibit community education throughout rural areas, other communities may want to consider launching a 5-year program that forces residents to continuously see, hear, and speak about mental health issues—particularly that depression is treatable, and suicide is preventable.

After the Grant

Local schools will work with one of the task force members to administer the C-DISC in area schools. Public health departments and the local university intend to continue providing mental health screenings. Meanwhile, the project is looking for other sources of funding to sustain suicide prevention efforts in the region.

Community Characteristics

Scioto County, Ohio, is a rural community with a population of 78,000 people and an unemployment rate of 10 percent, well above the state average of nearly 7 percent. Roughly 17 percent of county residents do not have health insurance. In addition, single women head one in eight households in the county.

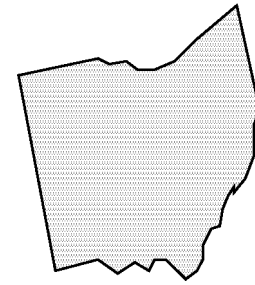
Since 1978, the Community Action Organization (CAO) Health Clinic of Scioto County, a designated rural health clinic, has provided primary and prenatal care to low-income individuals. In 1997, the clinic began offering gynecological health care services at the request of local physicians of obstetrics and gynecology (OB/GYN) who were sponsoring a residency program with Ohio University. At the time, low-income women had no place else to receive such services unless they were seeking contraceptives from a family planning clinic operated by the local health department. However, no funding was available for these services. This grant from HRSA’s Office of Rural Health Policy changed that and helped to enhance the Women’s Intervention Network (WIN) of Scioto County.

Services Offered

WIN offered a variety of services such as gynecological exams and Pap tests, mental health assessments and counseling, advocacy and referrals, referrals and payment for mammograms, transportation, child care during appointments, and women’s health education. CAO provided a weekly GYN clinic and staff to accommodate 30 patient appointments. The project also had four OB/GYNs who provided medical care and supervised residents.

The Referral and Educational Association for Child Health (REACH) provided an outreach worker to make reminder telephone calls and reduce no-show appointments, as well as transportation, child care, and women’s health education via home visits to mothers with newborns. Shawnee Mission Medical Center provided an onsite counselor to conduct mental health assessments, counseling, advocacy, and referrals. The Southern Ohio Women’s Cancer Project provided case management services to women age 40 to 64 to schedule and pay for exams, Pap tests, and mammograms. The Scioto County Department of Job and Family Services provided staff with up-to-the-minute information on Medicaid and other services available to clients. County commissioner Opal Spears provided community outreach services and women’s health education.

OHIO



**WOMEN’S INTERVENTION
NETWORK OF SCIOTO COUNTY
PORTSMOUTH, OH**

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Innovative Solutions to Problems

The project's most innovative aspect was engaging medical residents in the provision of obstetric and gynecological care to low-income women. The residents came from multiple institutions. This approach increased access to OB/GYN services for residents, while providing valuable clinical experience to OB/GYN residents.

Results

The project conducted 149 clinic sessions, averaging about 17 patients per session. In all, 1,295 women received 2,573 units of gynecological services. In addition, 1,113 women received mental health assessments, 354 women received referrals and advocacy assistance, 418 women received mammograms, 600 received women's health education, and 16 women received transportation or child care assistance. The number of women needing transportation or childcare to attend appointments was far lower than originally anticipated.

Potential for Replication

Many other rural communities could benefit from an approach that uses local OB/GYN professionals to serve as mentors for OB/GYN residents. This approach benefits residents seeking training and experience as well as women who live in communities where such services are unavailable or inaccessible. However, it is critical to have the support of local physicians who are willing to assume this role and provide instruction to residents as needed to ensure quality of care.

After the Grant

The CAO Clinic will continue to provide access to gynecological care for low-income and uninsured women. Outreach services will continue as well; however, counseling services will be discontinued, and the project will no longer be able to pay for lab screenings.

PROJECT 19—REPLICATING BEST PRACTICES TO IMPROVE ACCESS TO HEALTH CARE SERVICES AND REDUCE HEALTH DISPARITIES FOR CHILDREN

Community Characteristics

The rural communities of Ashland and Talent are located along the southernmost tip of Jackson County, Oregon, and abut the California border. The formidable Siskiyou Mountains and a federally designated wilderness area known as the Cascade-Siskiyou National Monument, which includes Soda Mountain, separate the two communities.

Ashland and Talent span a geographic area of 830 square miles and has a population base of 25,111 people, including 1,964 children and adolescents who live at or below 200 percent of the Federal poverty level. This includes 153 migrant children of Hispanic origin, 101 homeless children, and 80 children with special health care needs.

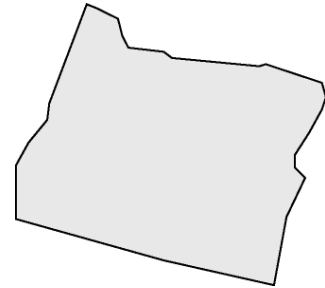
These children suffer from a number of health disparities and access barriers. For example, at the beginning of the grant period (2002), the infant mortality rate for Hispanic infants was 23.0 per 1,000 live births—three times higher than the 3-year averaged national norm (1998-2001). Only 56 percent of 2-year-olds in the community were age-appropriately immunized, and 11 percent of all children had received no immunizations. The area had only one primary care provider for every 3,667 low-income persons in the population, and 49 percent of children eligible for publicly sponsored health insurance were not enrolled.

Services Offered

Local organizations joined forces as a consortium to address these challenges.

- The Community Health Center managed the project and provided a nurse practitioner to increase the ratio of providers to children and adolescents needing care.
- Ashland Community Hospital provided child/adolescent case managers to help children enroll in publicly sponsored health insurance, to connect children with a permanent medical home, and to provide case management for children with special health care needs.

OREGON



**REPLICATING BEST PRACTICES
TO IMPROVE ACCESS TO
HEALTH CARE SERVICES AND
REDUCE HEALTH DISPARITIES
FOR CHILDREN
ASHLAND, OR**

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- Jackson County Department of Health and Human Services provided a full-time adolescent case manager nurse to address a range of issues related to adolescent pregnancy and to improve immunization rates.
- Ashland Community Hospital Foundation advised the project on planning for long-term sustainability.

Innovative Solutions to Problems

The project used mid-level practitioners to provide care in a freestanding clinic model, based on research supported by Johns Hopkins University. The project also used nurse case managers to help reduce specific health disparities and community health outreach workers to increase the number of eligible children enrolled in public-sector insurance programs.

Results

The project surpassed most of its goals, enrolling 796 children in public-sector health insurance programs. It offered case management and system navigation assistance to 492 families, and provided a medical home to 829 children. In addition, the program provided risk-reduction and reproductive health services to 654 adolescents, case management assistance to 81 children with special health care needs, oral health screenings to more than 1,039 children, and oral health education to 699 parents of targeted children. The project also succeeded in reducing the adolescent pregnancy rate for Hispanic females living in Ashland and Talent from 37 to 18 per 1,000.

Potential for Replication

This project was modeled after programs that work. For such models to work effectively in other rural communities, however, the network must include a nonprofit primary health clinic and a local public health department.

After the Grant

The Community Health Center will continue to provide nurse case management through Ashland Community Hospital, thanks to a grant from the Walker Fund at the Oregon Community Foundation. New funding also will make it possible to continue oral health services through a collaborative effort of the Community Health Center, Jackson County Department of Health and Human Services, and La Clinica del Valle.

Consortium members will continue working together to address health care access issues and disparities that arise in the community. The consortium also is working on a new initiative to reduce infant mortality rates among Hispanic women in Ashland and Talent.

PROJECT 20—CHEROKEE HEALTH SYSTEMS RURAL OUTREACH PROJECT

Community Characteristics

As the population of Hispanic migrant workers rapidly increased in eastern Tennessee, the lack of access to adequate health care services became apparent, as with other medically underserved residents of the region. Language barriers, lack of trust in the health care system, and, in many cases, more pressing human needs—such as social services, food, and clothing—compounded access barriers in this predominately rural Appalachian region.

To address these needs, Cherokee Health Systems proposed a collaborative health outreach project built on a network of primary care, behavioral health, postsecondary education, and social service providers. The network was designed to achieve two major goals: to improve access to care, and to improve the use of local health care resources. The target service area included three rural counties—Hamblen, Grainger, and Jefferson—in eastern Tennessee. Individuals came to these communities to get jobs in the agricultural industry. This population was largely invisible to the local health care system; as a result, local health status reports and census counts did not reflect their needs. However, local organizations estimated that up to 20,000 Hispanics lived in the three-county area.

Services Offered

The project consortium comprised five core partners:

- Union-Grainger Primary Care Clinic, an integrated care site, provided primary care, dental, and behavioral health services.
- Appalachian Outreach, a poverty relief ministry, provided food, clothing, furniture, and referrals to other community services.
- Carson-Newman College provided internship opportunities for students in primary care clinic sites as translators and assisting clients with a variety of needs (i.e., food, shelter, clothing, English classes, computer classes, applying for entitlements, completing job applications).

TENNESSEE



**CHEROKEE HEALTH SYSTEMS
RURAL OUTREACH PROJECT
TALBOTT, TN**

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- Hamblen County Central Services provided Hispanic health advocacy, outreach, and networking resources.
- Stepping Out Ministries provided outreach, self-improvement workshops, and English and Spanish classes.

The project also partnered with the University of Tennessee Medical Center to offer prenatal care at the Union-Grainger Primary Care Clinic and doulas to provide support during labor and birth. All organizations involved in the consortium contributed Hispanic outreach staff members and provided translation services.

Innovative Solutions to Problems

To overcome cultural and language barriers to care for area Hispanics, the project recruited and trained bilingual staff to provide translation and outreach services within the organizations involved in the network. By establishing trust with potential clients, project planners hoped that news of the program's services would spread by word of mouth.

The outreach team organized “welcome wagon” gatherings, soccer games, and other community activities. At these events, staff members encouraged Hispanic residents to contact them to receive assistance in accessing health care, food, clothing, and shelter services. When Hispanic residents came to one of the network organizations for help, bilingual staff members were on hand to help them get the services they needed. Once trust was established, Hispanic residents were more than willing to use the resources available to them.

The project also offered training to bilingual staff with some health care experience so they could become certified nursing assistants and placed in primary care offices to assist providers with patient care. The project also hired bilingual registered nurses, translated all forms and educational handouts into Spanish, and staffed the call center for the toll-free telephone lines with bilingual information specialists.

The outreach team developed a map that showed the locations of service organizations equipped to provide culturally appropriate care to Hispanic residents and coordinated weekly transportation to a local dental clinic—staffed by a bilingual dentist. One of the best-received project activities was the production of photo identification badges for undocumented immigrants. Local police, banks, hospitals, the health department, and the department of human services used the ID badges.

Results

During each year of the grant, the number of Hispanic residents accessing services increased substantially. The project succeeded in creating a comprehensive system of care for this population, evidenced by the fact that 76 percent of the health care services provided to residents in the 11 eastern Tennessee counties served by Cherokee Health Systems were delivered within the three-county region targeted by this grant. The project documented more than 15,000 requests to access basic needs for food and clothing.

At the beginning of the grant cycle, the network had one bilingual staff member. By the end of the grant period, the network had 17 bilingual staff members providing behavioral, primary care, dental, outreach, prenatal, and social services to area Hispanics.

Potential for Replication

The collaborative model of care could work well in other rural communities experiencing a rapidly growing Hispanic population. Other communities must recognize, however, that it is very difficult to meet the health care needs of this population without first meeting basic needs such as food, clothing, and shelter. Once those needs are met and trust is established, similar programs will find that Hispanic communities are more willing to access health care and social services.

After the Grant

HRSA's Bureau of Primary Health Care has awarded a new grant to Cherokee Health Systems to establish a migrant health center. It plans to use a promotores model for providing health education services and improving Hispanic health status in the region. Cherokee Health Systems plans to continue collaborating with the consortium members for this grant as they serve as prime locations for sustaining Hispanic outreach activities.

Community Characteristics

Abnormally high premature death rates due to heart disease, cancer, stroke, chronic pulmonary obstructive disease, and suicide in four rural counties in north central Tennessee defined the need of the Four County Health and Wellness Project. The project's goal was to provide increased access to wellness promotion, disease prevention, and rehabilitation services to residents living in the four-county region.

Services Offered

The project consortium included a nonprofit hospital, two local school districts, a regional mental health organization, and a regional university. Together, these organizations worked in tandem to provide a wide range of services at the Wellness and Fitness Center and two school-based health clinics. The project targeted three distinct audiences: school-age children, adults age 18 to 64, and the elderly. All clients had access to women's health education, health screenings, hypertension counseling, smoking cessation counseling and education, mental health counseling, group and individual fitness activities, a cardiopulmonary resuscitation (CPR) certification course, domestic violence education, cooking and nutrition classes, and diabetes education. School-age children received primary medical care services, well child exams, scoliosis screenings, testicular and breast self-exam education, safety and violence education, and parenting classes for teen parents. These services were provided at the school-based health centers. Elderly clients had access to the same services as other adults in addition to medication assistance and driving and home safety classes. Services for adults and the elderly were provided at the Four County Wellness and Fitness Center, the Lafayette Senior Center, well-known local agencies, and community events.

Innovative Solutions to Problems

The project used a new and innovative method of health education and health behavior change called "health coaching." Tested during the original grant period and implemented during the no-cost extension, this method involves a trained health coach who assists clients in understanding their current health status, defining client-specific goals, and developing strategies to overcome personal barriers to achieving those goals. The project provided coaching services over the telephone and through materials mailed

TENNESSEE



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directly to clients. This method allows access to health information, advice, and counseling regardless of geographic location, inclement weather, schedules, and other potential barriers.

Results

The project served more than 1,000 children, approximately 550 adults, and nearly 50 elderly individuals. It recorded more than 5,000 encounters in the fitness program and nearly 1,600 units of mental health services. There were nearly 1,400 cooking/nutrition education encounters and nearly 1,200 smoking cessation counseling/education encounters. The project also delivered more than 1,000 units of safety/violence education, as well as 1,000 units of testicular/breast self-exam education and scoliosis screenings. In addition, the project provided approximately 350 units of women's health education; 250 units of hypertension counseling; 175 units of safety classes for seniors; 175 units of domestic violence prevention education; 130 units of illness screening, treatment, well-child exams, and glucose/hypertension screening; and 70 units of diabetes education.

Potential for Replication

One of the biggest challenges facing rural communities is meeting client needs with such limited community resources. It is difficult to recruit staff members when the community has such a dire shortage of qualified people. It is also difficult to offer competitive salaries.

Other communities may want to consider providing fewer services at fewer facilities with a larger staff. Facilities are expensive to initiate and maintain. Taking services to the population—to the places they already frequent—is more likely to succeed than asking potential clients to come to a new facility they know little about and trust even less.

Project planners believe that, had the health coaching model been implemented earlier, the Four-County Health and Wellness Project would have been able to serve a substantially larger number of clients and would have had a greater impact on promoting meaningful health behavior change. This approach has great potential for replication in other rural communities where extreme geographic separation between clients and services is the norm.

After the Grant

The project was unable to secure new funding to sustain the services provided through the grant. The school-based clinics were turned over to the schools to administer as resources allow. The Wellness and Fitness Center closed. Although the network has disbanded, this project laid the foundation for these organizations to continue working together as new opportunities arise.

Community Characteristics

Briscoe and Hall counties in Texas are both designated health professional shortage areas and medically underserved areas. The most notable barriers to accessing health care are the absence of primary care providers and the lack of affordable health insurance.

Prior to establishing the Briscoe County Community Clinic in Silverton, most county residents traveled in excess of 30 miles to receive primary health care. Language barriers to care intensified access problems for Hispanic residents. The incidence of chronic diseases such as diabetes and hypertension was high. Many expectant mothers were not able to travel long distances to receive prenatal care, which contributed to poor pregnancy outcomes and a rate of low-birth-weight babies that was 39 percent higher than statewide statistics. Cancer, pneumonia, and other illnesses were not being diagnosed early enough, and these illnesses often resulted in hospitalizations that could have been avoided if a local system of care had existed.

Services Offered

The project consortium comprised (1) South Plains Health Provider Organization, Inc., which provided the clinical, financial, managerial, and operational support systems for the clinic; (2) Covenant Hospital–Plainview, which provided inpatient care, radiology services, home health services, physical therapy, speech therapy, occupational therapy, specialty services, and community assessment services; (3) Sidney Ontai, M.D., who supervised the clinic’s mid-level provider and provided telemedicine services; (4) Central Plains Center, which provided mental health services; and (5) Briscoe County Medical Foundation, which provided space and maintenance for the clinic facility.

In addition to providing primary and preventive health care services, the clinic offered health education, screenings, assistance in applying for entitlement programs, discounted fees for services, prenatal care, and class D pharmacy services. Staffed by a mid-level provider, a registered nurse, and a front office clerk, the clinic also provided referrals to laboratory, radiology, individual and group counseling services, Women with Infant Children, and other specialty services.

Innovative Solutions to Problems

To promote its services throughout the community, the clinic was actively involved in a wide range of community organizations

TEXAS



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and programs. Staff members participated in several health fairs each year and served on the Family Consumer Science Committee, which was responsible for steering various community projects. Clinic staff and patients were involved in the Diabetes and Cardiovascular Collaborative and participated in the Walk Across Texas project.

The clinic referred patients to an exercise class held at the Senior Citizens Center three times a week. Silverton Independent School District contracted with the South Plains Health Provider Organization to provide medical services to children of migrant families enrolled in the district. The clinic also partnered with Catholic Family Services to provide abstinence education to students at local schools. The project also provided telemedicine consultations using equipment supplied by Dr. Ontai.

Results

Some 68 residents received diabetes care, and 81 received hypertension care. In addition, 184 children received well-child care, 53 children of migrant or seasonal farmworkers received medical care, 60 people received contraceptive services, and 26 women received pregnancy care. Another 312 people received influenza vaccines. In all, the clinic provided nearly 5,000 units of services to area residents.

Potential for Replication

The project evaluation revealed that population demographics, patterns of out-migration, and provider recruitment and retention issues are major factors in sustaining a clinic. Other communities will need to address these challenges up front in the planning process so they can identify workable solutions to sustain clinic operations after initial funding ceases.

After the Grant

Throughout the course of the project, residents expressed concern for the clinic's long-term sustainability. The project attempted to secure new funding to keep the clinic open, but additional funding was not secured. As a result, on March 28, 2005, the governing board of the South Plains Health Provider Organization decided to close the clinic. Many of those served by the clinic requested that their medical records be transferred to other health care facilities in adjacent communities.

Community Characteristics

With a population of 2,231 people, Van is a rural community located in the eastern region of Van Zandt County, Texas. It is classified as both a medically underserved and a health professional shortage area. The only physician in town had retired, leaving the community with minimal access to health care. Furthermore, the Van Independent School District had been able to employ only two nurses to cover all four campuses within the district.

In 2001, a health needs assessment of high school students, junior high school students, and parents revealed a need to increase access to primary health care services for children and to improve health and well-being of children and youth in the district. Of the 304 parents who responded to the survey, one-third reported they do not seek medical care for their children because they cannot afford it. Mental health also was a major unmet need. Only one licensed psychological counselor practiced in the district.

Services Offered

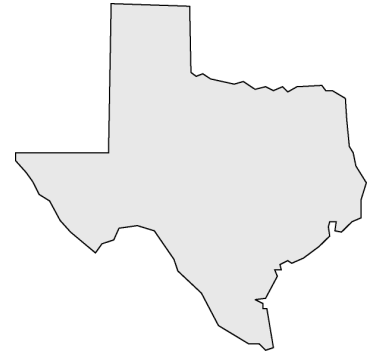
The Van School-Based Health Clinic opened its doors in October 2002. It was designed to provide health promotion, health education, and primary health care services for more than 2,100 students in the Van Independent School District. Specifically, the clinic offered screenings for scoliosis, hearing, vision, and testicular cancer; immunizations; flu clinics; and sports physicals. It also provided access to health care for episodic illnesses, mental health services, and referrals for psychiatric, dental, and ophthalmology services.

The project consortium included the Van Independent School District; the University of Texas at Tyler College of Nursing and Health Sciences, which provided health education services; the University of Texas Health Center at Tyler, which provided a certified nurse practitioner and a physician; and the Lake Country Area Health Education Center, which provided health fairs and field trips to local hospitals for high school students interested in health careers, as well as education on drug and alcohol abuse, drunk driving, proper hand washing, sun safety, tobacco abuse, and gun safety.

Innovative Solutions to Problems

The location of the clinic rotated each year depending on the focus of the student population. The clinic initially opened at the high school for 8 hours a day, 2 days a week. In year 2, the clinic

TEXAS



**VAN SCHOOL-BASED HEALTH
CARE INITIATIVE
VAN, TX**

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moved to the junior high school campus and was open 3 days a week. In year 3, the clinic moved to the intermediate school and was open 3 days a week. Students from all campuses were welcome to receive care, regardless of where the clinic was located at the time.

The clinic had to restrict its days of operation because the project underestimated the demand for counseling services and had to hire an additional counselor. Another challenge was finding sufficient space for the clinic, given the demand for services.

The most significant problem encountered was establishing billing and collecting services for provided care. The billing company hired during the first year of the grant did not fulfill its contractual obligations. Larger billing companies were not interested in contracting with the program because of the small patient volume, and the project was unable to find an experienced billing collections specialist willing to work part-time and commute to this rural community.

Finally, the project consulted with a billing specialist from a Federally Qualified Health Center (FQHC) in Greenville to train clinic staff on billing procedures. FQHC also helped the program obtain its own Medicare and Medicaid provider numbers, allowing the project to receive Medicaid reimbursements; procedures are in development for reimbursement from private insurance companies.

Results

The project served 1,808 students in year 1, 2,144 students in year 2, and 3,057 students in year 3. Clearly defining the roles of each consortium member was critical to the project's success. The Area Health Education Center provided excellent programs, and pre-and post-tests demonstrated that students consistently increased their knowledge of the health topics discussed. In addition, having university nursing students available to the clinic was very helpful due to the large number of participants. For example, on one day, the program immunized 76 students, who promptly returned to their classrooms, causing little disruption to their school schedule.

Potential for Replication

Broad-based community support is critical to the success of this type of program. Other rural communities considering the school-based clinic model will want to plan ahead for securing billing services. The need for mental health services—which are often in as much demand as primary care services—should not be

underestimated. Finally, project planners will want to secure sufficient office space. In fact, some communities may find that a mobile health clinic is more practical than moving a clinic from one location to the next.

After the Grant

The clinic will remain open 3 days a week. The project hopes to merge with the Greenville FQHC or one of the local hospitals so it can be fully sustained. If this is not successful, the project plans to continue offering counseling services and to tap consortium member resources available through other grants.

Community Characteristics

Virginia's Shenandoah Valley is a traditionally Caucasian, rural, and insular community. Like many rural communities, however, this region has witnessed a growing influx of immigrants, especially Spanish-speaking individuals and families, in recent years, and the health care system was ill prepared to meet the health care needs of an increasingly diverse and rapidly changing population.

Services Offered

The service area for the Valley Health Exchange Network included Rockingham, Shenandoah, and Frederick counties in Virginia's central and northern Shenandoah Valley. The region includes two towns—Harrisonburg and Winchester. The project consortium included the Blue Ridge Area Health Education Center, the Central Shenandoah Health District, the Lord Fairfax Health District, Shenandoah Valley Medical System, Rockingham Memorial Hospital, Shenandoah Memorial Hospital, and Valley Health System.

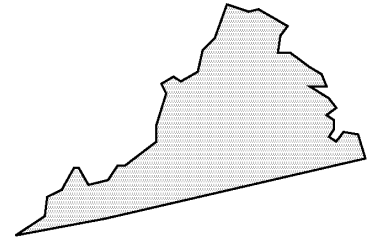
Project services focused on training promotoras and interpreters, mobilizing trained promotoras to conduct community outreach and refer clients to community-based health services, and providing cultural competency training for area health care providers. The end goal was to help create a community-based health care system that was better equipped to meet the health care needs of a more racially, ethnically, culturally, and linguistically diverse population.

Innovative Solutions to Problems

Although many rural communities have used the promotora model to help engage Hispanic communities in health care, this approach was completely foreign to some organizations involved in this consortium. However, the partners quickly recognized that the promotora model held tremendous promise to help link Spanish-speaking residents with area health care resources. The partners also recognized that such an approach, using objective quality assurance measures (e.g., proficiency testing in English and the target language), offered quality assurance and risk management benefits for the organizations involved.

The project's biggest challenge proved to be the management of the consortium. Even though the Valley Health Exchange

VIRGINIA



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Network succeeded in obtaining buy-in from all consortium members, getting key decisionmakers from the partner organizations to attend regular meetings was an insurmountable challenge. Ultimately, the project decided to stop holding formal meetings of the partners and tasked individuals from each partner organization to communicate with each other as needed to coordinate activities. The downside of this solution was the absence of an ongoing, region-wide effort to address project sustainability, new program needs, implementation problems, and project monitoring. In particular, no overarching system was in place to ensure that consortium members followed through with cultural competency training objectives.

Results

The project successfully trained 46 promotoras to conduct outreach to Hispanic residents and encourage them to access the services available in the community. During the 3-year grant cycle, the promotoras recorded 2,496 encounters. The project trained 61 interpreters, who then provided 10,050 units of translation services in community health agencies and partner organizations. Another 33 people received cultural competency training.

The project's greatest success was getting the largest health care system in the northern Shenandoah Valley to recognize the value of using trained medical interpreters. This policy increases communication between health care providers and persons with language barriers. It also increases the quality of the health care encounter for both the patient and the provider. This system now employs trained interpreters in its two hospitals.

The project struggled to identify a sufficient supply of Hispanic individuals to serve as promotoras. Although the project did not reach its goal of training 30 lay health promotoras (each expected to initiate 100 contacts), it made tremendous strides in creating a community resource that did not previously exist.

Potential for Replication

Most rural communities recognize the need to provide translation services in medical settings and the value of using lay health educators to conduct community outreach. This model represents an approach that other communities may explore.

However, in planning a similar project, other communities will want to:

- Address the potential challenge of recruiting a sufficient supply of lay health educators from the community to serve as promotoras
- Lay the groundwork for providing data collection resources that promotoras and interpreters can use to document process and outcome measures to inform project goals and activities
- Educate area agencies and providers in advance about the value of trained interpretation services, how they improve the overall quality of the health care encounter for both patients and providers, and the risks associated with using untrained interpreters in medical settings
- Consider how they will ensure that culturally competency training is delivered as intended, how they will measure its impact, and whether or not Webcasts, DVDs, or telehealth might be more effective means of providing such training

After the Grant

The Blue Ridge Area Health Education Center will continue to train bilingual persons as medical interpreters. Fees and financial support from Rockingham Memorial Hospital offset training costs. It is not clear if the project will be able to sustain the Hispanic lay health educator program. However, project planners are approaching other local primary care organizations to find a new home for this initiative.

PROJECT 25—NORTH CENTRAL WASHINGTON MENTAL HEALTH PROJECT

Community Characteristics

Some 100,000 people live in Chelan and Douglas counties in north central Washington, but only three psychiatrists practiced in the area. One served primarily low-income Medicaid patients. The second was a private psychiatrist who served only adults and refused to accept new patients. The third was the medical director of an inpatient specialty psychiatric program.

The goal of the North Central Washington Mental Health Project was to increase and improve access to appropriate mental health and chemical dependency services, particularly for low-income residents and Hispanics. The project was designed to provide a comprehensive, wraparound system of mental health and substance abuse treatment regardless of a patient's ability to pay for services.

Services Offered

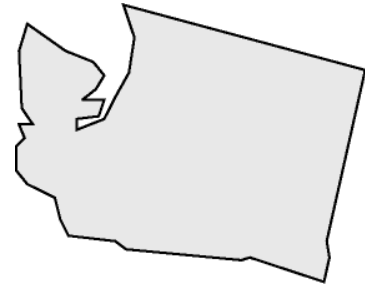
The project provided mental health, substance abuse, education, and training services to those in need, including clients of any age, race, ethnicity, or socioeconomic background. The project also offered educational sessions and trainings to schoolteachers, students, medical professionals, and assisted-living and nursing home personnel as needed.

Innovative Solutions to Problems

The project's biggest challenge was a change of leadership early in the program. The original grant manager was unable to see the project through to the end due to personal problems, which stymied the project's progress during the first year of the grant. This also affected the contributions of the original consortium members. The second grant manager tried to re-create the consortium and regain community trust, but consortium members' involvement was still minimal, and it took significant time to re-establish trust within the community.

Recruiting mental health care providers also was a difficult problem to overcome. The North Central Washington Mental Health Project had planned to recruit and contract with mental health professionals to provide services in the community. Eventually, the project opted to tap existing mental health care providers working for a psychiatric inpatient program so that the project could provide outpatient behavioral health care.

WASHINGTON



**NORTH CENTRAL WASHINGTON
MENTAL HEALTH PROJECT
CHELAN, WA**

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Two outpatient behavioral health clinics were opened in Wenatchee and Chelan to provide mental health services to county residents in need. In addition, one consortium member, Chelan Douglas Behavioral Health, contracted with a psychiatrist at Lake Chelan Community Hospital after budget cuts at the hospital eliminated the availability of hospital-based mental health care. Another consortium member, Columbia Valley Community Health contracted the services of a psychiatrist at its main clinic and a social worker at a satellite clinic to triage patients seeking medical care. In addition, the Manson School District provided educational sessions for schoolteachers and students.

Because some in the community did not perceive a widespread need for mental health and substance abuse services, many people needing services didn't seek them. As a result, the project elected to create its own access points, such as the local domestic violence center, the Children's Home Society, and the Manson School District. These organizations worked in tandem with mental health care providers to identify those in need and to facilitate the delivery of care.

Results

The North Central Washington Mental Health Project recorded nearly 3,700 mental health, substance abuse, educational, and training encounters during the 3-year grant period. More than 500 students, residents, and professionals received education via conferences, educational sessions, trainings, and telehealth programs. More than 2,650 people were reached via community functions—such as the Domestic Violence Pig-Out in the Park, the Women's Show, the Wellness Show, the Cultural Diversity program, and many other community events—where the project sought to increase awareness of mental and addictive disorders.

The project had planned to reach out to the community's Hispanic population via local radio stations, newspapers, and other venues. The hospital also provided a Spanish-speaking provider to help clients communicate their needs. These steps, however, did very little to increase use of mental health and substance abuse services by Hispanic residents.

The project created the Behavioral Health/Addictions Resource and Outreach Program to provide patients and professionals with access to educational and training materials. The project also developed an information library to serve as a resource for those in

the community seeking information about mental and addictive disorders as well as a speakers' bureau to provide onsite training for professionals, teachers, and organizations seeking training and technical assistance about mental health problems, substance use disorders, and co-occurring disorders.

Potential for Replication

This approach could work well in other rural communities, but health care and social services organizations may face similar challenges as those experienced by this project. These may include changes in project leadership, unexpected budget cuts, recruitment and retention problems, and the pervasive stigma associated with mental and addictive disorders. It is important to plan ahead for such challenges and strategize potential solutions—well in advance of project implementation. It also is critical to develop clear and concise memoranda of understanding between the consortium members to clearly define project goals and consortium member roles. It also is critical that consortium members are committed to meeting the needs of the community first and foremost, rather than their own organizational priorities.

After the Grant

The North Central Washington Mental Health Project hopes to sustain this program by continuing to link mental health professionals with local organizations willing to contract for their services. The project continues to offer the services of a Spanish-speaking behavioral health care professional. The key to the project's sustainability will be successful and ongoing billing of mental health professional services.

Columbia Valley Community Health and Chelan Douglas Behavioral Health have merged into a single entity, which will help maximize mental health and substance abuse treatment resources.

Community Characteristics

The Point Roberts Wellness Clinic is located in rural Point Roberts, an isolated community of approximately 5 square miles in northwest Washington state, separated from the U.S. mainland by the Strait of Georgia and the Canadian province of British Columbia. Under good conditions, it used to take an hour, including two international border crossings, to reach the nearest U.S. hospital, in Bellingham, Washington. Since September 11, 2001, long waits at the borders have lengthened the trip to 2 to 4 hours.

Point Roberts has about 1,500 permanent residents, one-quarter of whom are senior citizens. About 5 percent live in households with incomes below 100 percent of the Federal poverty level. The community has been designated a medically underserved area where health care services are usually fragmented and delayed.

Prior to the grant, residents had only three sources for any medical care—the District 5 volunteer EMT response network, Canadian physicians who provided care on a cash-only basis, and traveling 100 miles roundtrip to receive care in Bellingham. Patients needing care typically waited until an illness became acute before calling an ambulance, and such illnesses often required hospitalization.

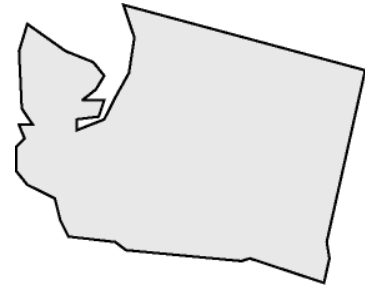
Services Offered

Point Roberts Wellness Clinic, a small facility equipped with state-of-the-art equipment, provides primary care services to people of all ages in the community. Services include treatment for acute and chronic medical conditions, clinical laboratory analysis, health maintenance, infant and child health, immunizations, women's health, adult physical exams, minor medical emergencies, prescription mail services, referral for specialized care, home visits, mental health evaluation and management, patient counseling, and health education. The clinic also sponsored a registered nurse who monitored bimonthly blood pressures as part of the Senior Center Lunch Program. In response to requests from many patients for help with weight control and nutrition education, the clinic also offered a weekly program conducted by the nurse practitioner for education and support in year 2.

Innovative Solutions to Problems

Generally, a nurse practitioner with many years of experience delivered the services; however, a physician was always available

WASHINGTON



**POINT ROBERTS WELLNESS
CLINIC
POINT ROBERTS, WA**

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for backup assistance via telephone. A Bellingham pharmacy maintained a stock supply of medications to ensure availability to patients when they needed them. The pharmacy also mailed prescriptions upon request. The health department provided children's immunizations free of charge. In addition, the project conducted community outreach through community-wide educational forums.

Results

The clinic served more than 650 patients, who tallied more than 2,700 patient visits and 5,000 units of direct medical and laboratory services. This was possible because the project provided ample facilities, built long-term relationships with area providers, eliminated the need for patients to travel elsewhere to receive care, made residents aware of clinic services, and developed long-term funding sources. A key component of the project's success—both during the grant period and beyond—centered on the efforts of three elected commissioners who worked tirelessly to transition the clinic from a grant-funded program to a public entity.

Potential for Replication

The basic structure of this project could be implemented in nearly any rural setting. The most important component is broad-based community support that results in real action by local organizations, consortium members, and community residents.

After the Grant

The elected commissioners for the Public Hospital District will provide governance with financial support from collections for services and the local tax base. The clinic plans to extend part-time hours and perhaps increase the number of days the clinic is open.

Community Characteristics

American Indians in Wisconsin experience twice the number of infant deaths as whites in the state. Discrimination, unemployment, and poverty affect all aspects of family well-being. Tribes are rural in nature, may be isolated, and may be among the poorest communities in the state in spite of the successes of a small number of tribes. Most families have low income, and most have difficulty accessing health care and education services. They also have limited access to health care providers; in fact, many providers in the community do not practice full-time.

Mental health care providers are in short supply, and high-risk mothers must travel more than 100 miles to access specialized care. Furthermore, tribal and non-tribal service organizations did not have formal referral and tracking systems in place.

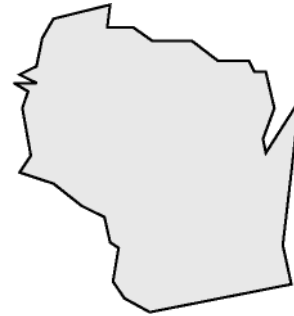
Service Offered

The Great Lakes Inter-Tribal Council's Honoring Our Children Project (HOC) developed a culturally competent, collaborative network of tribal and non-tribal health providers, elders, leaders, and community members to address the complex array of health care problems facing American Indians living near the Lac du Flambeau community. The service area included the Bad River and Lac du Flambeau reservations.

The project consortium included the Great Lakes Inter-Tribal Council, which coordinated the Honoring Our Children Project; two tribal partners—the Bad River Health Center and the Peter Christensen Health Center, each of which offered access to Head Start, Birth to Three, Indian child welfare, domestic abuse, child care, Temporary Assistance to Needy Families, tribal housing, and Women with Infant Children services. The consortium members worked in tandem to foster a close working relationship among area providers and perinatal families and to ensure that families had access to the full range of health care and education services they need to live healthy, productive lives.

HOC had four main goals: (1) to ensure family and community involvement in project design, implementation, and evaluation; (2) to identify pregnant and postpartum women and their children, and sustain their participation in project services; (3) to provide case management services, such as risk assessment, referral, monitoring, facilitation, and follow-up; and (4) to provide health education to project staff, service providers, clients, and community

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**HONORING OUR CHILDREN
PROJECT
LAC DU FLAMBEAU, WI**

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members on positive lifestyle choices, improved nutrition, maternal depression, and proper care between pregnancies.

Innovative Solutions to Problems

HOC was truly innovative in that staff members formed close relationships with the families they served and successfully collaborated with tribal and non-tribal service providers. Although clinics and providers may be available, potential clients won't necessarily access them. Barriers to care include transportation, lack of telephones or family support, denial of pregnancy or serious health conditions, cultural incompatibility with providers or clinical staff, confidentiality concerns, or simple resistance to change. By hiring community members who were familiar with the area's cultural expectations, project staff knew what it would take to meet the community's needs.

The fact that the consortium included both tribal and non-tribal organizations was a major challenge. But this relationship played a major role in informing project activities. The project recognized that case managers needed a referral tracking system (the Secure Public Health Electronic Record Environment data system was ultimately used) and to work together more closely to coordinate care. It also showed that Great Lakes Inter-Tribal Council needed to provide better project and staff supervision and that staff members at one site needed to focus more energy on outreach activities. The depth of collaboration made the program, and its services, better.

Results

The project served 312 pregnant women, 448 postpartum women, and 476 infants, and provided 515 transports to services. HOC provided case management services to 86 percent of women served as well as 80 percent of parenting women and their families. The project also provided health education to HOC staff members, and to individuals and families through 513 service provider contacts and 1,672 youth/community contacts. Approximately 20,000 residents were reached via media outreach.

The project evaluation showed that HOC staff members were trusted, dedicated, and reliable. They provided tailored and confidential assistance, links to community resources, and, when necessary, patient advocacy. Effective outreach methods included mailings; phone calls; making community contacts; newspaper articles; newsletters; monthly event calendars; incentives for

attending activities, receiving immunizations, or breastfeeding infants; and, most important, word of mouth.

Conducting home visits and providing transportation were essential in ensuring families received services and health education. In addition, health education events were successful because they provided useful information for the entire family and were offered to the whole community. HOC staff worked with staffs from many other community programs, which increased the number of participating organizations from 27 in 2000 (prior to the grant) to 57 in 2004.

Potential for Replication

The Honoring Our Children Project succeeded in bringing local providers to the same table as tribal health representatives and consumers to resolve local barriers to care. This approach can be replicated in other rural communities serving American Indian residents, but they will need to address challenges such as the lack of transportation, telephone access, cultural barriers to accessing care, and the lack of an informal referral process. This is especially critical for communities in which there is little or no history of agency collaboration.

After the Grant

The Honoring Our Children Project plans to continue building partnerships with tribal and non-tribal organizations to enhance the community's integrated system of care. In particular, HOC intends to work with urban and rural tribal health systems to link providers for patient referral and tracking to address gaps in the community's continuum of care. Project planners look forward to providing technical assistance to other tribal communities looking to replicate this model.

Community Characteristics

As is the case in many rural communities, Hispanic residents in Portage and Waupaca counties in rural central Wisconsin are typically poor and less educated than the general public. As a result, Hispanics in this community bear a disproportionate burden of illness and disease. Other factors compound this risk. For example, Hispanic residents in the region are the most likely to have no regular source of health care, and many are undocumented. In addition, when they did seek care, language barriers often prevented them from receiving the care they needed because of the lack of meaningful communication between Spanish-speaking patients and area health care providers.

Services Offered

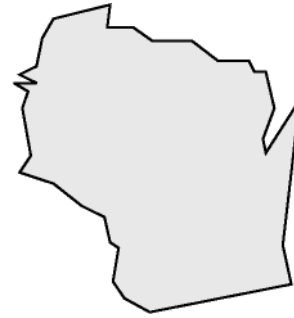
The Hispanic Health Outreach Project provided outreach, education, and case management services to Hispanic residents in Portage and Waupaca counties. Specifically, the project focused on diabetes and maternal and child health services as a means to engage Spanish-speaking residents in the project's health care system.

The project consortium comprised several partners:

- Saint Michael's Hospital, a nonprofit provider, developed the project's diabetes education component and provided staff training in diabetes education.
- CAP Services, Inc., a nonprofit community action agency serving the low-income population of central Wisconsin, led the project implementation under a subcontract with Saint Michael's Hospital.
- Portage County Health and Human Services and Waupaca County Health and Human Services offered venues for health education through their Women, Infant, and Children programs and other initiatives.
- The University of Wisconsin–Stevens Point provided free radio time for health education through the campus radio station.
- The Portage County Literacy Council helped produce a Spanish-language resource manual and provided an outreach venue.

A local publishing firm had planned to support outreach and health education but was unable to do so because of downsizing. Two bilingual health educators provided outreach, education,

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**HISPANIC HEALTH OUTREACH
PROJECT
STEVENS POINT, WI**

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interpretation, cultural sensitivity training for health and human service providers, and case management services. With the exception of cultural competency training, all people served by the program were Hispanics.

Outreach activities focused on diabetes and maternal and child health. Outreach and educational activities included presentations, materials distribution, screenings, and linkages to providers and community resources. Case management became an increasingly important component later in the project as more patients sought care, decreasing the need for outreach. Case management services included appointment scheduling, follow-up on treatment plans, and helping patients to access low-cost care.

Innovative Solutions to Problems

It didn't take long for the project to recognize that the best form of project promotion is word of mouth. Project staff went to worksites and public places such as grocery stores to find people who needed care but weren't receiving it. Contacts also were encouraged to tell their friends and family members about the program and the services it offered. Before long, the project was overwhelmed by requests for services.

Staff members formed a women's exercise group and used it as a venue for health education. In Waupaca County, staff members held office hours at a local food pantry in New London, a town with a large Hispanic population. Because transportation was a major challenge, project staff arranged for diabetes group education sessions, led by a local diabetes educator, to be offered to people with diabetes.

Results

The Hispanic Health Outreach Project provided health care and case management services to nearly 2,000 Hispanic residents, including more than 600 hours of interpretation services and 545 health screenings. The project also conducted 28 cultural competency workshops for area health care professionals.

Potential for Replication

The project evaluation showed that clients and those who received training were highly satisfied with the program and recommended its continuance. The most helpful services, according to clients, were assistance in understanding their medicines and how to take them, in better understanding their

doctor's instructions, in making appointments, and in accessing discounted care. All but two clients indicated that their health status was better because of the program's assistance.

Word of mouth is the best way to market this model to Hispanic populations. The key factors in this program's success were:

- An effective working relationship between public and private health care providers
- Committed staff members who knew how to market the program but also had effective interpersonal communication skills to establish trust in the Hispanic community
- Focusing on personal contact, instead of relying on educational materials, as a means of outreach
- Providing information and education via group or social activities
- Providing a mix of outreach, education, and case management services that included individual follow-up and, in the case of patients with diabetes, effective self-management
- Assistance in filling out forms and accessing discounted care
- Linking clients to a wide range of community resources, such as food pantries, health and human service programs, immigration assistance, thrift stores, and other local charities.

Other rural communities, however, should be aware that providing care to undocumented aliens presents a broad range of challenges and that many rural clients need help with transportation to keep appointments and to access the services available within the community.

After the Grant

CAP Services secured funding from a local source to continue a similar program in Portage County, where a lead interpreter/case manager helps clients to access the services they need. In Waupaca County, a local church sponsors a bilingual health educator to conduct outreach 1 day per week at a local food pantry. Meanwhile, the project is seeking new sources of funding.

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