OUTREACH SOURCEBOOK

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RURAL HEALTH DEMONSTRATION PROJECT

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2008 CONTENTS

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In FY 2005-2008, ORHP awarded 30 Outreach grantees across 20 States.

The Rural Health Care Services Outreach Grant Program encourages the development of new and innovative health care delivery systems in rural communities that lack essential health care services. The program is unique due to the fact that it is based on the specific need within each individual rural community. Outreach grantees deliver a variety of health services. These include primary health care, dental care, mental health services, home health care, emergency care, health promotion and education programs, outpatient day care and other services not requiring in-patient care. Actual services include health fairs, screenings, training and education of providers to name a few.

To be eligible, the grant recipient's organizational headquarters must be a rural public or rural nonprofit private entity and be located in a rural county or in a rural Census Tract within a metropolitan county, exclusively provide services to migrant and seasonal farm workers in rural areas or be a Federally-recognized Tribal Government. Applicants must also form a consortium with 2 other organizations, which may be rural, urban, non-profit or for-profit. www.ruralhealth.hrsa.gov


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GLOSSARY OF FREQUENTLY USED TERMS

ADAPT	Adolescent Drug Abuse Prevention and Treatment
ADRC	Aging and Disability Resource Center
AHC	Alcona Health Centers
AKC	ActiveKids Club
ATOD	Alcohol, Tobacco and Other Drug
BH	Behavioral Health
BHS	Behavioral Health Specialist
BSI	Brief Symptom Inventory
CASII	Child and Adolescent Service Intensity Instrument
CE	Continuing Education
CHAP	Community Health Care Access Program
CHF	Congestive Heart Failure
CHIP	Comprehensive Health Investment Project
CIS	Consumer Industry Services
COPD	Chronic Obstructive Pulmonary Disease
CSQEI	Core Services Quality Evaluation Initiative
DHN	Delaware Health Net
FQHC	Federally Qualified Health Center
HCS	Home Healthcare, Hospice and Community Services
HFAY	Healthy Families Active Youth
HMS	Hidalgo Medical Services
HPSA	Health Professional Shortage Area
HYFP	Ho-Chunk Youth Fitness Program
IELE	The Institute for Educational Leadership & Evaluation
LASRmetrics	Leadership and Solutions Reporting

GLOSSARY OF FREQUENTLY USED TERMS

MAP	Maryland Access Point
MCA	Medical Control Authorities
MDoA	Maryland Department of Aging
MUA	Medically Underserved Area
PMS	Presbyterian Medical Services – Catron County
RHOG	Rural Health Outreach Grant
SDQ	Strengths and Difficulties Questionnaire
SHLRI	The Southern Hills Leadership and Resiliency Initiative
TBCHS	Thunder Bay Community Health Services
TCM	Transitional Case Managers
TCMC	Cheshire Medical Center
TF-CBT	Trauma Focused-Cognitive Behavioral Therapy model
WCHD	Worcester County Health Department
YFL	Young For Life

Community Characteristics

White River Rural Health Center, Inc. has received ADA Education Recognition since 1999. Peggy Barker, RN, CDE is one of the few Certified Diabetic Educators in the State of Arkansas. This year Ms. Barker has started the Silver Sneakers program in Woodruff County, which is a partnership with the Blue Cross Blue Shied and Medicare recipients for preventive exercise. Peggy writes in a local newspaper column monthly. White River has received the State Quality Award – Champion Level, and John Hopkins University has acknowledged the Chronic Disease program from White River as a Model that Works. In July 2007 White River opened its first Wellness Center in Woodruff County.

Services Offered

Funding from this grant application will support the infrastructure of the Care Model element for a comprehensive diabetes self-management education program. A diabetes self-management education center was developed in a clinical site to provide a community location for patient, family and medical staff learning activities. The initial objective of this grant application was to identify and provide effective self-management education to adults with Diabetes, especially the elderly, in the target service area with the establishment of a "Diabetes Center". During the first implementation period, diabetic patients were referred to the "Diabetic Center" for an initial assessment and a personalized self-management education plan. All information will be tracked utilizing the Patient Electronic Care System utilized by the BPHC Health Disparity Collaborative. Reports will be generated and evaluated according to set guidelines.

As the program continued to be implemented, additional curriculum and focus included cardiovascular disease and problems specific to the elderly population. The program no longer had a focus as a "Diabetes Center" but as a "Chronic Care Center". This allowed the services to be customized to reach the needs of a much larger population that currently does not have access to focused specialty services to improve their health outcomes

Innovative Solutions to Problems

The initial problem with implementation at the nursing homes was the training and education of the staff. The nursing home patients have such controlled environment, that they had little to do with their nutrition, exercise, and snacks. The staff had to be trained in remembering that rewards are not popsicles or sugared snacks. Another barrier was the lack of consistency in monitoring of the labs for each patient. The staff did not realize the impact of these tests toward showing improvement or set backs. The Project Director held education classes and worked with the staff to draw specific labs on the chronic disease patients and trained them in reading and showing improvements on each patient. Currently HgbA1c labs are drawn twice a year on each patient to show how the patient has improved on sugar levels. This education has assisted in the plan of care for each patient and assisted in accurate tracking of outcomes.

The program director spent a lot of time training and reworking the staff's thinking on nutrition, exercise, and snacks for the residents.

Results

The program accomplishments of the stated goals and objectives were assessed by the program evaluator, Brenda Kennedy. The following indicators enabled measurement of program success.

1. Percent of D patients with HbA1c < 8. Goal = 50% Outcome = 75%

2. Percent change in HbA1c levels of DM patients. The average percent change in HbA1c level per DM patient was 1 – 2% each patient dropped 1 – 2 points during program.

3. Number of program participants by category (DM, CVD, Obese, Elderly).

   DM = 35 CVD = 29 Obese = 8 Elderly = 131 (65+)

4. Percent of patients with hypertension having blood pressure readings less than 140/90. The average blood pressure reading is 128/70 for program participants

5. Percent of WRRHC patients in target counties diagnosed with CVD or DM who participated in the program. All 247 participants were WRRHC patients, but with this controlled environment of the nursing home settings and families, not all WRRHC patients that have DM, CVD participated. Education classes were given outside the nursing home, but consistency of outcome testing was not accurate.

Potential for Replication

The Program Director trained staff at the nursing home to continue the in-house evaluation, exercise classes, and the self-management education for residents and families. This "train the trainer" concept works well for continuation of the program and staff resources.

The provider visits will continue along with the nutrition services. These services will continue to be billed to the health care provider or directed to the discount program is the patient is uninsured. The support groups and education classes are free.

After the Grant

Yes, the program will be sustainable. Other grant programs assist this mission and the dedication of the partners to continue the education classes and training. The long-range leadership and staffing needs are supported by the fee schedules for the provider assessments performed during the course of the patients care for their chronic disease. Also, through alternative sources of revenue such as third party payors, sliding fee reimbursement and research opportunities revenue will be generated. Currently, White River has other grants that assist this program and the other diabetic care performed outside the nursing home. White River has an aggressive commitment from the CFO and CEO with the financial reserves for our organization. The nursing home also has reserves that they reinvest into the organization. The value to this program has increased over the years through awareness, case models and testimonies of individuals that have gone through the program. Now, with the addition of the dialysis center, the value of this program will increase more due to the need and ease of access to health care.

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Community Characteristics

The project was designed to address adolescent substance abuse by providing youth with knowledge, refusal skills, and opportunities to bring positive change to their communities. The program combined prevention and treatment by teaming a Substance Abuse Therapist with an Intervention Specialist. Both school districts offered alternative classroom experiences for at-risk students and many of these students were a part of the ADAPT project. Services were offered at the following sites:

- In Willits: Willits High School, Sanhedrin High School, Community Day School, Baechtel Grove Middle School
- In Potter Valley: Potter Valley High and Middle Schools, and Community Day School.

ADAPT served primarily white/non-Hispanic students (ages 13 – 18), in keeping with the ethnic profiles of the participating communities. Willits Unified has an enrollment of 2,195 students and Potter Valley has a student population of 295. The enrollment in both school districts is primarily White/non-Hispanic, with 9% American Indian and 17% of Hispanic ancestry. The median household income in Potter Valley was $36,354 and $33,915 in Willits according to the 2000 Census (compared with $35,996 for the county and $47,493 for the state). About 60% of students participate in the Free and Reduced Price Meal Program.

Services Offered

The scope of the ADAPT Project was to reduce substance abuse among youth by providing:

- Substance abuse treatment;
- Prevention education and personal development activities, including project-based learning modules, outdoor adventure, and service learning; and
- Family strengthening services and community education to increase awareness of substance abuse issues.

ADAPT was designed to address adolescent substance abuse by providing youth with knowledge, refusal skills, and opportunities to bring positive change to their communities. The project utilized an innovative design that combined prevention and treatment by teaming a Substance Abuse Therapist with an Intervention Specialist. Project components (described below) were coordinated through local high and middle schools.

- *Substance abuse intervention/treatment groups*. ADAPT used Project SUCCESS for all program components. It is a school-based substance abuse prevention and early intervention program for high-risk, multi-problem adolescents that include individual and small group intervention as well as classroom curricula.
- *Prevention education*. The Project SUCCESS prevention curriculum was delivered to 7th grade students through 10 weekly classroom sessions. At the high school, prevention education was carried out through classroom health presentations delivered by project staff and through coordination with community clinics, non-profit consortium members, and Public Health Branch staff.
- *Out-of-school time activities.* Students participating in ADAPT groups had the opportunity to plan and participate in after school activities, including project-based experiential learning

modules during summer holidays. Out-of-school time activities were also open to youth who were not participating in treatment groups.

- *Family involvement.* Families were encouraged to be involved in the project by participating in their child's initial and exit interviews, meeting individually with project staff, volunteering to assist with out-of-school time activities and events, and attending community education workshops.
- *Community Outreach and Promotion.* ADAPT staff carried out a broad-based outreach campaign to let communities know that youth substance abuse intervention/treatment was available. Outreach strategies relied heavily on word-of-mouth, and also utilized flyers, presentation, and brochures.
- *Professional development.* All ADAPT staff participated in training on the Project SUCCESS model and in annual diversity training to ensure sensitivity to language, age, gender, race/ethnicity, sexual orientation, and other cultural factors, as well as awareness of sexual harassment issues.

Innovative Solutions to Problems

While alcohol and drugs are common elsewhere, the situation in Mendocino County—located in the infamous "emerald triangle" of marijuana cultivation on California's north coast—is especially acute because of geographic isolation, patterns of multigenerational abuse, and a culture of acceptance that considers alcohol and drug use to be normal parts of life. In a 2005 survey of 200 local high school students, nearly half (43%) reported that their parents do not disapprove of their drinking and 20% that their parents knowingly supply them with alcohol. The culture of acceptance is also reflected in the county's growing economic reliance on the wine industry and its rank of 47th highest in retail liquor outlets—at 403.9 outlets/100,000 population, Mendocino County's rate is more than double the statewide rate.[1] Of the state's 58 counties, Mendocino County ranks 54th highest in the state in the rate of school AOD incidents and 53rd highest in the juvenile AOD arrest rate.[2]

The Adolescent Drug Abuse Prevention and Treatment (ADAPT) Project was developed in response to the need for substance abuse prevention and treatment for youth in Mendocino County's underserved rural communities of Willits (pop. 13,500) and Potter Valley (pop. 2,000). Willits is the third largest city in Mendocino County, and Potter Valley is an unincorporated agricultural valley located in the eastern part of the county. Both communities have a Federally Qualified Health Center, and there is also a critical access hospital in Willits. Willits has a small number of physicians and therapists in private practice. However, there are no providers of substance abuse treatment in Potter Valley for youth or adults.

Results

The project contracted with a professional evaluator to assess the overall success of the project, provide formative evaluation input throughout the funding period, and prepare annual summative evaluation reports. Kathleen Hopper of Hopper & Rodin Associates was selected based on professional expertise, prior experience evaluating substance abuse treatment and prevention programs, and a parallel

[1] California Alcoholic Beverage Control, 2004.
[2] Community Indicators of Alcohol and Drug Abuse Risk: Mendocino County (2004).

philosophical approach. The evaluator was also an active participant in the planning process for this project, providing input on evaluation strategies and perspectives. Table Two below details the number of individuals served through each program component, by year.

Table Two. Total number served to date, by component and year

COMPONENT	YEAR 1	YEAR 2	YEAR 3	TOTAL
Unduplicated number served (groups and curriculum)	177	198	192	**567**
Students referred to program	54	72	96	**222**
Completion of initial interview	36	39	96	**171**
Students participating in intervention groups	30	59	102	**191**
Students completing 7th grade curriculum	147	139	90	**376**
Participants in classroom presentations	*Not reported*	590	214	**804**
Out-of-school time participants *(duplicated)*	28	52	115	**195**
Community workshop participants *(duplicated)*	60	56	136	**252**

Throughout the program, the ADAPT Consortium came very close to fully meeting all objectives, building each year on the logistical and collaborative framework established previously. Achievement of objectives is detailed in Table Three below.

Table Three. Achievement of project objectives

OBJECTIVES	PROGRESS	COMMENTS
1A. 60 students participate in substance abuse intervention/ treatment groups each year.	Partially Achieved	The objective was fully achieved in Year Three, but not in Years One and Two: • 30 students participated in intervention groups in Year One. • 59 students participated in intervention groups in Year Two. • 102 students participated in intervention groups in Year Three. The total of 191 participants is a duplicated number, because some students participated for more than one year.
1B. 45 students participate in out-of-school time activities.	Partially Achieved	The objective was fully achieved in Years Two and Three, but not in Year One: • 28 students participated in after school activities in Year One. • 52 students participated in after school activities in Year Two. • 61 students participated in after school activities in Year Three. The total of 141 participants is a duplicated number, because some students participated for more than one year.
1C. 50% of participants complete 90 days of treatment.	Achieved	The objective was fully achieved in all three years: • 3 of the 12 students (25%) participating in treatment groups dropped out prior to the end of the year during Year One (intervention group drop-outs were not tracked). • During Year Two, 10 students (17%) left treatment and intervention groups prematurely. • During Year Three, 27 students (26%) dropped out prior to the end of their program.
1D. 25% of graduates remain involved in program activities.	Achieved	The objective was fully achieved: • Although ADAPT did not include a formal graduation and most students continued throughout the school year regardless of their graduation status, the project distributed 44 "certificates of participation" in Year Two and 77 certificates in Year Three. • No groups were completed prior to the end of the Year One reporting period.

OBJECTIVES	PROGRESS	COMMENTS
1E. 10% decrease in 30-day use of marijuana.	Achieved	The objective was fully achieved in all three years: • During Year One, group participants reported a 25% decrease in past 30-day marijuana use. • For Year Two participants, posttesting showed past 30-day use of marijuana decreasing by 27%. • Year Three posttesting showed a decrease of 13% in past 30-day use of marijuana.
1F. 20% decrease in disciplinary referrals related to drug and alcohol use, from school records.	Achieved	The objective was fully achieved: • AOD-related suspensions at Willits High School dropped from 125 suspensions in the 2004/2005 school year to 70 suspensions in the 2006/2007 school year (the most recent year for which data are available), a decrease of 44%. • Total suspensions at Potter Valley High School dropped from 21 suspensions in the 2004/2005 school year to 13 suspensions in the 2006/2007 school year, a decrease of 38%.
2A. 90% of 7th graders complete prevention curriculum.	Partially Achieved	Objective was achieved in Years One and Two, but not Year Three: • During Year One, 147 seventh graders completed the curriculum, equal to 88% of the 167 students enrolled. • During Year Two, 139 seventh graders participated in the curriculum, equal to 94% of the 148 seventh graders enrolled. • During Year 3, 90 seventh graders participated in the curriculum, equal to 59% of the 153 seventh graders enrolled.
2B. Make 10 prevention education presentations in classrooms each year.	Achieved	The objective was fully achieved in all three years, with staff making a total of 98 presentations: • 57 classroom health presentations in Year One. • 27 presentations in Year Two. • 14 presentations in Year Three.
2C. 20% increase in perception of risk of frequent marijuana and alcohol use.	Partially Achieved	Objective was achieved in Years One and Two, but not Year Three: • Year One posttesting found a 57% increase in student perception of risk of frequent use of marijuana and no change in perception of risk of frequent alcohol use. • Year Two posttesting found a 60% increase in student perception of risk of frequent use of marijuana and a 6% increase in perception of risk of frequent alcohol use. • In Year Three, there was a 24% *decrease* in student perception of risk of frequent use of marijuana and a 6% increase in perception of risk of frequent alcohol use.
2D. 15% increase in prevention knowledge among participating 7th graders.	Achieved	The objective was fully achieved in all three years: • During Year One, students participating in the curriculum showed an overall gain of 17% in prevention knowledge. • In Year Two, the increase in prevention knowledge rose to 54%. • In Year Three, students showed an overall increase in prevention knowledge of 41%.
3A. 50 adults participate in substance abuse education.	Achieved	The objective was fully achieved in all three years: • Year One: 60 adults participated in prevention workshops. • Year Two: 56 adults participated in prevention workshops. • Year Three: 136 adults participated in prevention workshops.
3B. 80% of workshop participants correctly identify AOD signs and symptoms.	Almost Achieved	The objective was almost achieved in Year Three: • During Years One and Two, the project did not ask workshop participants to complete assessments. • During Year Three, 41 of the 56 workshop participants (73%) completed brief surveys at the close of the presentations, and of these, 32 (78%) reported that they had learned from the presentation.

Potential for Replication

AODP believes that the ADAPT model (*e.g.*, utilizing treatment counselors and intervention specialists that work in tandem to provide treatment, intervention, and access to youth development opportunities) to be an effective strategy for engaging youth and gaining the commitment and cooperation of school partners. Project SUCCESS curriculum is flexible enough to accommodate the various needs of different school districts. It delivers a prevention curriculum at the middle school level and prevention, intervention, and treatment services in high schools. When combined with after school and summer activities, it makes a comprehensive multi-faceted program for any school district.

After the Grant

AODP is still seeking funding to continue services in Potter Valley. As with any grant-funded program, the greatest challenge is identifying continuation funding, while the greatest assets are the collaborative relationships that were developed and strengthened through the program and that will continue to support collaborative efforts in the future.

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Community Characteristics

The program's service area was Sussex County, Delaware. Sussex County is generally characterized by its rural nature, having the largest land mass of Delaware's three (3) counties and a population of 180,288. The entire county is federally designated as a Medically Underserved Area (MUA), a low-income Health Professional Shortage Area (HPSA), and a Dental HPSA.

Services Offered

Managed a comprehensive, county-wide prenatal Promotoras program to provide outreach, community health education, and other enabling services targeting pregnant women and women of child-bearing age; Improved perinatal health outcomes and reduced disparities as a result of providing prenatal care and health education for low-income, at-risk women.

Innovative Solutions to Problems

Promotora Program evaluation was been initiated through the use of forms, tools, and defined daily work processes. Communication has been maintained with Ms. Angela Mora, a nationally renowned expert on promotora programs, who provided a feasibility assessment of community readiness for the implementation of the program, as well as on-going technical assistance and training for the promotoras. The Community Health Worker Evaluation Took Kit, developed by the University of Arizona, Border Vision Fronteriza Initiative, was utilized to evaluate program. The Took Kit provides twenty-one basic principles to guide the program, and step-by-step guidance and a selection of tools in conducting evaluation.

Clinical service delivery was held to the standards of care (American College of Obstetrics and Gynecology) and the clinical plan utilized by LRHC as a federally qualified health center. Care delivery was monitored through organizational quality improvement processes to assure that clinical standards of care were being met for prenatal care, diabetes screening and management, and HIV/AIDS screening, diagnosis, education, and referral, and overall women's health. Patient satisfaction surveys were routinely administered to all new LRHC patients. Promotoras had copies of surveys available for patients and routinely elicited conversational feedback. Related to patient satisfaction, LRHC engaged in a patient redesign initiative aimed at increasing clinical efficiency and patient satisfaction.

LRHC, as a member partner of Delaware Health Net (DHN) (a former Bureau of Primary Health Care funded network), implemented a clinical tracking system (DocSite) to monitor clinical outcomes of all LRHC users. Various sort criteria can be utilized for the development of specific reports on prenatal patients. In addition, DHN developed in excess of 200 age and gender appropriate parameters for patient monitoring. Those focused on women of childbearing age were utilized by the SDHWFP as clinical checklists for thorough completion of all required counseling, testing, education, and referral services to be offered. Last year DHN secured a federal HIT grant to implement electronic medical records at its partner member sites. A vendor has been selected and implementation has begun in two phases; the practice management system had a "go-live" date of June 2008 and EMR implementation has been scheduled for February 2009. Once fully implemented, the EMR platform will afford the Center a full array of enhanced clinical tracking and outcome reports.

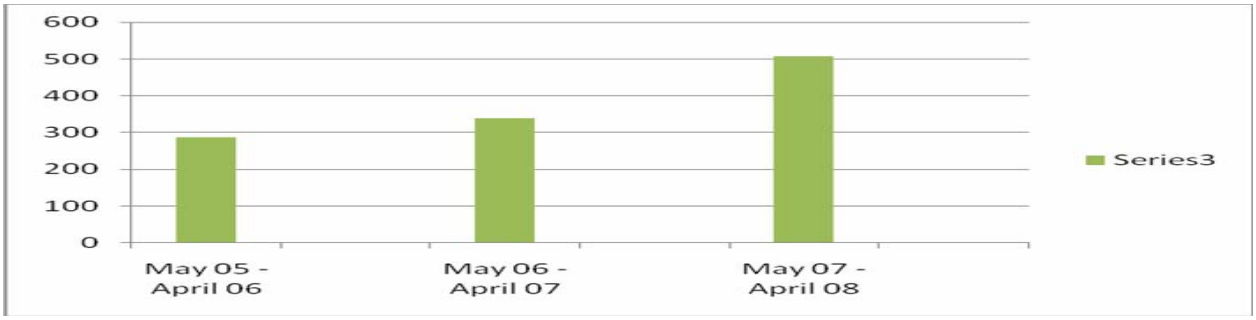
Finally, as part of LRHC's annual UDS and state reporting requirements, a tracking instrument has been developed to secure birth outcome statistics from local hospitals in order to better assess community impact.

Results

The Southern Delaware Healthy Women & Families Project has successfully expanded access to services for low-income women and their families. During the project period there has been an increase of 1,694 or 140% in annual female usership at the Center and an increase of 847 or 523% in children of both genders under the age of 18. Ongoing outreach, education, and transportation services provided by the promotoras have facilitated access to culturally and linguistically appropriate care for these women and their children.

During the three year grant period, the Center provided all or partial prenatal care to 1,134 pregnant women. Over this period, there was an increase of 76% in annual usership of the Center's prenatal services: 288 the first year, 339 the second year, and 507 the third year.

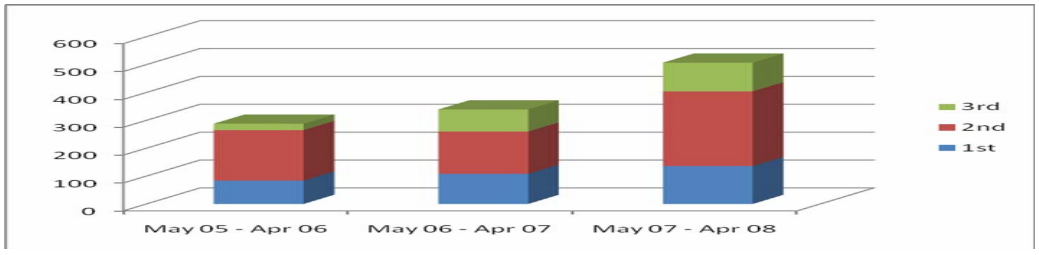
PRENATAL USERS OVER THE GRANT PERIOD



Anecdotally, we have learned that the expansion of LRHC's women's health services have decreased the number of women who present to the local hospital emergency rooms for delivery without any prior prenatal care. This has been a major step in improving the overall birth outcomes and welfare of infants.

Despite our efforts and program successes to date, it remains a challenge to change established consumer behavior(s). Uninsured, low-income women tend to delay entry into prenatal care well into their third trimester. This occurs due to financial, transportation, and sometimes cultural reasons. Changing this behavior is a long-term, ongoing challenge that simply requires time. The following graph illustrates the first entry into prenatal care by trimester and depicts the chronic problem of late entry into care for our targeted population.

FIRST ENTRY INTO PRENATAL CARE BY TRIMESTER



The Consortium will continue to seek and implement innovative strategies to improve early entry into prenatal care.

Another area of potential concern is the continued growth of special populations in southern Delaware (and throughout the state). Not only does the gross population count continue to increase but so too does the proportion of those subpopulations which lack health insurance coverage. This combination of cultural and financial access issues is compounded by a general lack of obstetrical medical resources, particularly those that are culturally competent or affordable.

Since Delaware has one of the highest incidents of low-birth weights and infant mortality in the nation, there has been a great deal of focus on women's health care during this project period. Due to the small size of the state of Delaware, Consortium members are engaged in a number of statewide health care initiatives which converge on many levels. Currently there is movement afoot by the Delaware Health Care Commission to investigate opportunities for merging the Community Health Care Access Program (CHAP) which was a former federal CAP program, and the Delaware Infant Mortality initiatives administered by the Public Health Department. There have also been discussions with the Delaware Health Care Commission to act as a convener of a Sussex County Women's Health Summit to develop and coordinate a countywide women's health delivery system.

Potential for Replication

Promotora programs have been proven to be an effective outreach model for hard-to-reach, at-risk populations who are unfamiliar or distrustful of traditional health delivery systems. Word of mouth is a key factor in impacting improvements in health literacy among such populations. A promotora model strives to focus on wellness, not illness.

It has also been proven that community-driven health promotion programs are more effective than traditional programs. Community "buy-in" promotes ownership and ultimately leads to improvements in health status. Developing a consortium of agencies which can support the activities of the promotoras is an important component of a successful program as it will help to ensure coordination of, and provide training and support for, the promotoras.

The recruitment and training of the promotoras are critical elements in establishing an effective program. The promotoras must be natural leaders who are trusted by the community and skilled at listening and understanding the basic social and medical needs of individuals and their families. The promotoras must have full knowledge of the local programs which can help meet these needs and provide both linkages and follow-up to these services.

After the Grant

The Consortium has worked since onset to establish the program's financial self-sufficiency/sustainability. Case management services that are inherent to the program include aggressive financial screening for public coverage that results in Medicaid enrollments. As clients are enrolled in Medicaid and become established as users at LRHC, program generated income benefits substantially by its ability to bill on LRHC's State negotiated cost-based reimbursement rate. All LRHC providers are enrolled as participating providers in the State's Medicaid program. This too generates referrals of newly enrolled clients directly to LRHC as a facility.

During this grant period, LRHC also was designated as a Federally Qualified Health Center and began receiving federal funding in January 2006. Women's health services are an integral component of both the Center's business and clinical plans under this federal funding program.

There is considerably heightened State awareness on the issue of infant mortality. Health statistics from the Centers from Disease Control place Delaware as the one of the worst states in the nation in terms of infant mortality outcomes. As a result, State funds have been secured and are anticipated as a key source of continued revenue for the program. Additionally, since 2006 LRHC received State of Delaware/Title X Family Planning funds to complement and round out services to women.

AstraZeneca, as part of its *Healthy Delaware Today and Tomorrow* program has funded yet another patient navigator to assist in enrolling low-income individuals into public assistance programs. This has helped to augment enrollment activities conducted the onsite public eligibility worker and to streamline presumptive eligibility for Medicaid eligible women

And finally, Ms. Dora Ward-Kyabu from the Georgia Health Policy Center conducted a technical assistance site visit focused on sustainability in March 2006. Ms. Ward worked with members of the Consortium to identify key sustainability issues for the prenatal program, but also for the combined access to care and services work, that the Consortium fosters. Subsequent to her visit, an LRHC case statement has been developed for use in ongoing fundraising of philanthropic funds to support the current operation and its longterm needs.

The CEO is now being called upon to present outcomes and impacts of the prenatal promotora program to forums throughout the state. LRHC and the Consortium are optimistic that this continued exposure of a best practice will help secure post-grant funding support.

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Community Characteristics

Floyd Medical Center had a history of collaboration with the Floyd County Health Department. This partnership resulted in co-authorizing a health needs assessment, which led to the funding of the new Floyd County Health Department. Floyd Medical Center joined the health Network Partners and partnered with the dental clinic by providing six hours a week of operating room time for young children, who needed extensive dental work. This hospital also offered the professional services of the Floyd Public Relations Department to develop, place, and distribute communications to the public about the clinic. The hospital also provided emergency room data to assist with program evaluation.

Services Offered

A community health assessment in Floyd County indicated a tremendous need for oral health services. Four rural counties; Walker, Gordon, Polk and Haralson also lacked access to oral health services. The need was greatest among low income families in the five targeted counties, Floyd, Haralson, Gordon, Polk and Walker. Only four dentists accepted Medicaid or PeachCare (Georgia's low income child health insurance program) and acceptance of Medicaid patients in private practice was sporadic. Low-income families with dental insurance could not find a provider that would take them as patients. Public Health had a mobile dental clinic that saw approximately 850 children for a school-based sealant program and treated an average of 125 children for emergencies and general dental care while at school. Many of these children had such severe problems that general anesthesia was needed for treatment. The mobile clinic also saw an average of 100 adults per year for oral surgery care. Low-income adults had almost no access to this type service. Services through the mobile clinic were limited and only touched a fraction of the children who needed the oral health care. Clients in need of follow-up care had virtually no options. The Floyd County Health Department Regional Dental Health Clinic was designed to provide access to oral health services in the following areas: Preventive care, restorative care, emergent care, nursing home services, fluoride varnish care, conscious sedation, and services under general anesthesia for five counties in Northwest Georgia.

Innovative Solutions to Problems

Barriers to grant implementation were encountered, and solutions found. One barrier was language differences with Hispanic clients. Often the children spoke better English than the parents who had to give their informed consent. The dentist hired for the Dental Clinic was bi-lingual, speaking both English and Spanish. In addition, a dental assistant was hired who also was bi-lingual. Both of these positions eventually left the clinic. A contract was formalized with an interpreter who was available by appointment to provide interpreter services. The clinic also obtained access to Language Line and reimbursed for this service out of generated fees.

A second problem that occurred was in the delayed construction on the Health Department which contained the dental clinic. Much negotiation was required before the appropriate wiring and plumbing were obtained. The clinic lacked funds to purchase needed equipment and had to borrow $50,000 from the Floyd Board of Health. This debt was repaid in six months through generated fees.

A third problem was in the recruitment and retention of staff due to the traditional public health salaries which are considerably less than salaries offered in the private sector. To resolve this problem, salaries were increased to a more competitive rate.

Results

A contract was negotiated with a private evaluator who completed an evaluation for the first year of operation and is working on the final two years of the evaluation. The outcomes achieved through the grant funds include:

1. Planning and establishment of a regional dental clinic that serves a five county area and offers preventive, restorative, surgical and anesthesia services;
2. Recruiting and maintaining qualified oral health staff; and,
3. Serving as a training center for dental students, dental residents, dental interns, and dental assistants. Student's evaluations from dental residents and dental students have ranked the clinic very highly. As a result, several students have opted to practice in public health clinics in rural areas after graduation. Some have expressed interest in practicing in the Floyd County Health Department Regional Dental Clinic. Thus, the clinic has generated interest in new graduates' desire to serve the underserved populations.
4. The Dental Clinic was instrumental in the developmental of the oral health program in the Rome Free Medical Clinic by providing dental clinic and auxiliary staff. The Floyd Clinic manages difficult and problem patients for the Free Medical Clinic.
5. The Clinic has also provided immediate access to oral health care for children in foster care.
6. The Clinic provides all general dental, surgical, and prosthesis care for the local Ryan White Clinic.
7. The Dental Clinic now accepts clients for surgical services from the local Diversion Center and the Regional Youth Development Center.

The Health Network Partners worked closely with clinic staff and provided ongoing advisory services. Partners also worked with the HRSA consultant in completing a strategic plan and some of the partners worked with a CDC Prevention Specialist on developing a business plan. .

After the Grant

A business plan was developed to provide guidance in how sustainability could be achieved after the grant ended. The revenue generation encompasses diversified funding which includes Medicaid, PeachCare, private insurance, credit card, and cash payments. The clinic has to collect $623,787.15 annually to maintain the current operations. A part-time dentist position was eliminated and funding for a program assistant moved to the district budget. Staff was informed that their salaries were dependant on generated fees. At present, the clinic is operating on current fees generated and has no reserve funding. Donations were requested from Floyd Medical Center; however, these were not received. Actions are also now being taken to get Medical College of Georgia to reimburse the clinic for adjunct faculty services provided by the Dental Director and Clinical Director.

This program is definitely a best practice model for increasing access to low income oral health services for low income populations and for providing comprehensive training services for dental students and dental assistants. [Note: As of July 1, 2008, the clinic had $79,000 in reserve.]

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Community Characteristics

The East Central Georgia Regional Teen Wellness Coalition understands why our heart disease, stroke, diabetes and cancer statistics are so grim. Poverty does not usually exist symbiotically with healthy lifestyles. When an individual is struggling to pay bills and avoid homelessness, he/she does not focus on healthy behaviors such as eating nutritiously, exercising regularly, receiving periodic screening examinations and continuing his/her education. Experts agree that decisions youth make regarding lifestyle and personal behavior in adolescence have tremendous future consequences. These consequences include, but are not limited to: lifelong substance abuse (e.g., tobacco, alcohol and/or other drugs); teen parenthood and subsequent low educational attainment and low socio-economic status; and/or eventual chronic disease (e.g. cardiovascular disease, stroke, diabetes and cancer).

Services Offered

The region displays demographic characteristics similar to many poor rural areas. These characteristics include: high percentage of minority residents, isolation, poverty, negative health indicators, lack of educational attainment and a struggling rural economy.

Due to decades of ignoring prevention activities, by the time many of our county's residents reach middle age, their health status has already begun to deteriorate. With this lack of an emphasis on health promotion, it is not surprising that the region's cancer, heart disease, cerebrovascular and diabetes mortality rates were substantially higher than the state rate.

The East Central Georgia Regional Teen Wellness Coalition understands why our heart disease, stroke, diabetes and cancer statistics are so grim. Poverty does not usually exist symbiotically with healthy lifestyles. When an individual is struggling to pay bills and avoid homelessness, he/she does not focus on healthy behaviors such as eating nutritiously, exercising regularly, receiving periodic screening examinations and continuing his/her education. Experts agree that decisions youth make regarding lifestyle and personal behavior in adolescence have tremendous future consequences. These consequences include, but are not limited to: lifelong substance abuse (e.g., tobacco, alcohol and/or other drugs); teen parenthood and subsequent low educational attainment and low socio-economic status; and/or eventual chronic disease (e.g. cardiovascular disease, stroke, diabetes and cancer).

Innovative Solutions to Problems

The main issues and problems that other communities might face include the complexity of multi-county coordination and youth apathy, acceptance and active participation. We proactively addressed these issues by establishing an active regional coalition with representation from all of the participating counties. We addressed the youth related issues by focusing on the youth. The Initiative increased awareness and access to health promotion services by providing ongoing leadership training regarding healthy lifestyles for local youth; encouraging these youth to take a leadership role in planning, implementing and monitoring local health promotion/education projects; and supporting these youth as they plan and coordinate an ongoing local healthy lifestyles education outreach campaign for the youth in our service area. Furthermore, when assembling/selecting our local Youth Wellness Teams, we ensured that each team was reflective of the community in terms of race, ethnicity, gender, persons with disabilities and socio-economics.

Results

Fortunately, there are no problems or barriers that were not successfully resolved in the implementation of the project.

Potential for Replication

We believe that our approach of empowering local youth to take an informed leading role in facilitating local youth related health promotion efforts can be successful in other rural settings throughout the nation.

After the Grant

We have empowered our local youth. They have taken ownership of this process and do not want to discontinue it. The major issue is securing a relatively small amount of funding in each county so they will have resources to implement their various health promotion projects. The counties will be able to fund these projects through a variety of other grant resources, fund raisers, community donations and adult volunteers.

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Community Characteristics

The Turner County Board of Education applied for and received the Rural Health Outreach Grant on behalf of the South Georgia Regional Dental Health Outreach Coalition. The local community collaboratives with representation from the medical community, including local primary care physicians and local dentists, recognized that lack of access to dental services was a major health barrier and formed the South Georgia Regional Dental Health Outreach Coalition. The coalition is comprised of the Turner County Board of Education; Public Health District 8-1; area volunteer dentists; and five community collaboratives from the five counties served by the project.

Services Offered

The South Georgia Regional Dental health Initiative was designed to provide on-site dental health prevention education in each of the five counties through a full-time Dental Hygienist and dental clinic services one day a week in dental clinic located in Turner County. The coalition named the dental clinic the Rural Smiles Clinic. Subsequently, the community generally referred to the dental health initiative as Rural Smiles. Dental health education and dental clinic services were available to children and adults. Dental Clinic services were limited to uninsured income eligible patients (using State of Georgia guidelines and eligibility standards for free and reduced meals).

At least four days per week, the Dental Hygienist provided dental health education in the school systems (Pre-K – 12), other Pre-Kindergartens programs, Head Start, daycare centers, nursing homes, health departments' diabetes and hypertension clinics, employee health screenings at local businesses, community health fairs and other community-based sites. The dental clinic was scheduled to be open one day per week and staffed by a volunteer dentists, one or two contracted dental assistants, and grant funded Dental Hygienist and Administrative Assistant. The primary focus of the clinic services was to relieve pain. Services included, extractions, restorative and preventative care.

Innovative Solutions to Problems

The first problem encountered in implementation was the delay in setup of the dental clinic. The building space originally planned was no longer available at time of receipt of grant approval in May, 2005; therefore it took several months to locate another site. Finally, two local businessmen agreed to donate a space for life of the grant. Since federal funds could not be used for renovation, additional funding sources, including a private foundation grant, had to be obtained to provide for renovation materials and supplies. In addition, much of the labor was donated by local businessmen and area technical school. All of the dental equipment was donated by area dentists, but since much of the equipment was surplus, a dental supply company donated time to make necessary repairs and install the equipment. As a result of delays in locating building and completing necessary renovations, clinic did not open until March 24, 2006 (11 months into Year 1).

Another problem identified involved long range plan for sustainability. Original plans included charging a small fee for service based on sliding fee schedule and billing for Medicaid. In communication with Georgia Department of Community Health, it was discovered that, according to the Georgia Volunteer Physicians' Act, state liability protection is available to licensed health care professionals as long as they are not compensated and do not charge a fee for services. Therefore, the decision was made that since the Rural Smiles Clinic was using only volunteer dentists, no fees (private or through Medicaid)

could be collected in order for volunteer dentists to be covered by state liability protection. As a result, the Coalition is having to look to other sources for sustainability.

One of the most pressing problems encountered in implementation and which continued throughout the project period was having enough volunteer dentists in the volunteer pool. This is addressed in more detail in Section III.

Results

As planned, the independent evaluator and the coalition members developed the annual evaluation work plan, the regional dental services database, evaluation tools and the format for the quarterly evaluation update reports. The evaluation tools included patient charts and other data collection worksheets which collected the necessary data to monitor progress towards achieving the program goals.

The evaluator subsequently analyzed the data utilizing Excel and Epi Info software and prepared summary evaluation reports which were shared with the coalition. These reports included: the number of targeted individuals actually receiving services; the type of services thy received; the demographic information of individuals served; source of referrals; number of scheduled clinic visits; no-show rate; number of volunteer dentists providing services with number of scheduled appointments; and number of procedures provided with breakdown of types of procedures. These summary reports also included a quarterly summary of dental health prevention education services provided by dental hygienist, a summary of volunteer transportation services and a summary of community outreach and application screening and referral services provided by county family connection coordinators in each of the five counties.

Our general goals of the initiative were to: increase the number of individuals in our five county service area who receive preventive dental screenings by at least 20% by 2008); increase the number of individuals who have access to dental clinic services (from 0 in 2004 to at lease 1,500 in 2008); and increase the community residents' awareness of the importance of dental hygiene and preventive dental care as facilitated by dental hygienist (a minimum of 15,000 individuals per year).

At the end of year 3 (April 30, 2008), a total of 437 individuals had been served by the dental clinic. Of these individuals, 414 were adults and 23 were minors. The average age of those served was 44. Nearly fifty-eight percent (57.9%) of these patients were African American, 39.6% were white, 1.1% were Hispanic and less than 1% were categorized as other. This is compared to our regional demographic profile of 67% white, 32% African American and 1% other. Nearly three-fourths (70.7% were female and 29.1% were male.

These 437 of these patients had a total of 985 scheduled clinic appointments. A total of 2,280 procedures were provided during these appointments. As mentioned in Section I above, a total of 26 volunteer dentists provided services during the scheduled appointments. The dental hygienist provided dental hygiene services during 215 of these appointments. The overall appointment no-show rate was only 8.8%, with 821 keeping their appointment and 69 rescheduling. Only 87 (8.8%) failed to show-up for appointment.

During the project period of 5/1/05 – 4/30/08, the dental hygienist had conducted a total of 413 community dental health education activity sessions, reaching a total of 27,956 individuals through direct contact and 506,742 individuals through other community outreach activities, including news media,

handouts and community health fairs. In addition, the county Family Connection Coordinators in the coalition had reached 147,805 individuals through community outreach. In addition, she provided a total of 767 dental screenings in addition to those during clinic appointments.

The project did not reach the projected outcome for number of individuals served in the dental clinic (see explanation of barriers encountered in Section III, C), but certainly reached the projected outcome of increase in preventive dental screenings and more than surpassed the projected outcome of reaching the project area with the importance of dental hygiene and preventive dental care. As one of the dentists on the consortium stated, the long range success of the project will be determined, not so much through number of individuals served in the clinic, but through the dental health education provided to the service area.

Potential for Replication

My opinion, a project similar to the Rural Smiles dental project could be successful in other rural settings. As stated earlier in this report, in economically deprived areas, dental preventive screenings, dental visits and necessary dental treatment services are viewed by many as expensive non-essential luxuries. Therefore too many adults ignore dental problems both for themselves and their children until these problems result in serious medical problems. I believe the goals and outcomes of this project could be achieved in any rural community as long as you have strong community partners who are committed to improving the results for children and families and are willing to work collaboratively to develop the necessary resources.

After the Grant

The Outreach grant is currently in a 12 month No-Cost Extension. We are still hopeful that the program will be sustainable and are looking for funding to sustain the project when federal grant funding has ended. One of the potential sources for funding includes an application to Georgia Baptist Health Care Ministry Foundation. The deadline for applying for the next funding cycle is September 15, 2008 with anticipated award date of February 16, 2009. Since this award is for only one year, the coalition decided to delay application to this foundation until Outreach grant funding was reaching the end of its funding cycle.

In addition, the Turner County Commissioners have added funds in the county's annual budget for Turner County Connection. These funds are to be dispensed by decision of the Turner County Connection Board of Directors. We are hopeful that this action by the Turner County Commissioners will influence the commissioners in the other four counties to take similar action. The Turner County Connection is also in its second year of an annual fund raising plan. Last year, we reached our goal of $25,000 and hopefully this will be surpassed this year. Funds are included in this budget for dental health education. The other four counties have been asked to devise a fund raising plan for their support of this dental project.

We are still planning to explore insurance and Medicaid billing as well as developing a sliding fee service. Hopefully, these funds could be used to provide he liability insurance that dentists need to support the clinic. We are also hopeful that enough funds could be generated to contract with a dentist to be provide dental clinic services at least one day a week.

The Turner County collaborative is also considering developing a proposal for a full service community schools program which would include mental health services, dental health services and early

childhood services. We will inform the other four counties of our efforts in the event that they would like to develop similar proposals.

We consider our program to be a best practices model.

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Community Characteristics

The Healthy Families Active Youth Rural Health Care Services Outreach Project was created to promote health and fitness at targeted elementary school children in two rural southwest Idaho communities. In 2003, a physician with Terry Reilly Health Services became very interested in gathering data on children's heights and weights after observing children at a farmworker labor camp. The data revealed that 26% of children tested had weights and heights that placed them in the overweight category and another 42% were at risk for overweight. The national average for overweight in children is 11%, with 17% reported for Mexican American children. These results were striking because they were so much higher than national data and there was no data to which to compare it in Idaho.

Being overweight as a child is correlated with adult obesity that increases with age. Overall, 50% of overweight children will remain overweight as adults. The overweight child is at risk of developing Type II diabetes, blood fat irregularities, high blood pressure, pulmonary complications such as asthma and sleep apnea, and endocrine changes, as well as increasing the stress on weight bearing joints. Depression and low self-esteem are added health problems.

Services Offered

At the time the grant was written, there were no specific resources for overweight children in the Canyon or Owyhee County areas. The services and programs proposed in the grant were a welcomed addition to the communities served and provided resources and opportunities that many had never had. The original proposal built on what had been found to work in the communities, specifically health fairs and increased organized physical activities at lunch. The concept was to spread these programs to additional elementary schools, while adding several new and currently missing components – afterschool physical activity program and weight management classes for overweight children and their parents.

Innovative Solutions to Problems

Project activities were managed and coordinated by the Project Coordinator. Decision making on policy issues and major activities related to the grant were made by the consortium during regularly scheduled monthly meetings. Decisions were made by consensus.

At the start of the second grant year, the Project Coordinator and Project Manager felt the need to seek a different representative from Homedale School District to attend partner meetings. During the first year the identified partner was challenging to work with and extremely negative towards the progress of grant activities. Two new school district employees were assigned to our meetings. This was a very positive change and aided the consortium to move forward.

Results

Examination of the fitness scores of non-AKC and AKC participants indicated that the percent change in aerobic capacity and upper body strength among AKC participants was approximately two-times greater than those of non-participants. A statistically significant difference ($p<0.001$) was found in the upper body strength scores among non-AKC and AKC participants, suggesting that AKC participants had more change in upper body strength. This finding may demonstrate the impact of upper body strength training provided to the AKC participants.

Height, weight and fitness data results of post-BMI measures revealed that 34% (171/506) of the third and fourth graders who participated in height and weight measures were "at risk for overweight" or "overweight" based on BMI scores at the end of the school year. Fitness assessments indicated that approximately half (54.3% and 49.7% of third and fourth graders) were physically fit.

Students considered "at risk" based on BMI and/or fitness and those with a specific interest in an after-school program were invited to participate in the ActiveKids Club (AKC) intervention. Recruitment was conducted through the use of mailings to parents, distribution of flyers at schools, and asking AKC members to ask three friends to join.

Among the individuals expressing an interest in joining the club, 126 attended at least one AKC activity during the school year representing a 95% participation rate. Further examination of attendance patterns revealed that 41% (51/126) of AKC members attended more than 80% of the sessions.

Of those AKC participants whose BMI score was greater than the 85th percentile at the beginning of the school year, 61% (25/41) attended more than 80% of the sessions.

A statistically significant ($p<0.001$) increase in BMI scores during the year was found in third and fourth grade ActiveKids Club (AKC) participants. These results were consistent with the BMI change identified among non-AKC participants. Further examination of these differences revealed that the BMI scores of non-participants increased by 2.74% while those of the AKC participants increased by 2.18%. It is interesting to note that while no association between AKC attendance and change in BMI was found; those attending more than 80% of the sessions had BMI increases of only 1.56%.

No statistically significant change in BMI classification (normal, at risk, overweight) was observed among third graders in the AKC or non-AKC participant groups. This is in contrast to a statistically significant shift between BMI classification categories among fourth grade non-AKC participants (<0.001).

These findings indicate that among non-AKC fourth graders whose BMI classification changed, the probability of a child becoming at risk for overweight or overweight was significantly more likely than him/her becoming "normal" weight. There was a significant change in BMI classification among non-AKC fourth grade girls where 12% of them were no longer in the normal weight category at the end of the school year.

No such a trend was observed among AKC fourth grade girls, i.e., they stayed in the same BMI category. These results suggest that involvement in programs such as AKC may serve as a protective measure against increases in BMI especially among fourth graders.

Qualitative information gathered from AKC participants at the end of the school year indicated high levels of satisfaction with program activities, and interactions with staff. The following quote from a fourth grade girl captures the sentiment of most of the participants; ". . . Thank you for AKC. We are having a lot of fun doing the activities. My favorite thing to do was swimming in the YMCA. I learned to go by the rules of respect, responsibility, honesty, and caring."

Approximately half (52% [65/126]) of AKC participants had a parent who attended three or more required education sessions meetings. Many parents attended more than the minimum number required. As in year two, incentives of a swimming suit and/or tennis shoes for the child were offered to parents attending the sessions. Parents of AKC members expressed high levels of satisfaction with the program

as evidenced by good attendance rates at parent meetings and information gathered in the end of the year survey.

Perceptions of the success and sustainability of the Healthy Families Active Youth (HFAY) program were gathered from the community-based partners. The partners, many who had been with the program for at least two years, expressed high levels of satisfaction with the collaboration and expressed interest in participating in similar efforts in the future.

Another component of the HFAY project was the implementation of school-wide lunchtime activities such as organized walking and games. All third and fourth graders regardless of fitness and BMI status were encouraged to participate in these activities. Lunchtime activity leaders at each school logged student lunch time activity.

The weight management component of the program included home visits and YMCA activities and one-on-one counseling sessions. A nutritionist, counselor, and fitness instructor were involved in the intervention. The effect of this effort was assessed though focus groups with participants and interviews with their parents. The phone interviews were conducted with parents approximately two months after the program to determine sustained behavior changes. Participants and parents expressed high levels of satisfaction with the intervention. Participants not only learned about nutrition and healthy eating, but also explored their eating habits and emotional triggers.

The HFAY project demonstrated continued success in year three as evidenced by high participation rates among both students and parents, a possible moderating effect of participation in AKC on BMI scores, positive changes in aerobic and upper body strength among AKC participants, evidence of positive personal development, and the successful implementation of the multi-site AKC and Lunchtime Activity programs.

Potential for Replication

Absolutely!!! With funding from HRSA, a lunchtime leaders' guide, afterschool activities leaders' guide, and evaluation tool kit have been developed for other communities to use and replicate based on their resources and unique community needs. The weight management program can be purchased through Kidshape or Shapedown and replicated in other communities.

After the Grant

The consortium functioned well together and all participated fully in achieving the outcomes of the grant. After removing one individual, the ability to achieve the outcomes was easier and the dynamics of the consortium fostered an environment of creativity.

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Community Characteristics

This Project was designed to address the needs of the at risk populations in north central Louisiana, specifically the parishes of Bienville, Lincoln and Jackson. These parishes have high rates of chronic disease caused in part by obesity and its associated ills such as: diabetes, CVD, HBP, stroke and cancer. Our Project took the approach of attacking this multifaceted problem by looking at disease prevention and health literacy as the driving forces of change. The fuel for this problem has been poverty and health illiteracy. Our approach has attacked and successfully ameliorated in part the gap in knowledge and behavior modification.

More specifically we addressed the issue of obesity and diabetes which are the two driving forces for more chronic diseases that causes mortality in the target population.

Services Offered

This study was carried out to test the effectiveness of "Young For Life" (YFL), a weight loss program designed specifically for urban African-American women, when administered in urban churches by trained lay facilitators.

Innovative Solutions to Problems

The most significant problem in implementing this Project was the fact that our host community was a much closed minded community that was very skeptical of "outsiders" or individuals that they did not see as a part of the clique. This problem I think was unique to the host community and not global in nature. It was a specific quirk of this type of community that was mostly African American and educated with pockets of poverty dispersed within the community. It is a Black college town with a lot of history and misplaced pride.

The only way we overcame this peculiar cultural abnormality was with time, patience, persistence and cultural sensitivity. We did not wholefully overcome the problem but we made a significant dent in it.

Results

In this section we summarize crucial findings from the Healthy Communities of Louisiana-The Obesity Project and provide recommendations for future action. Those recommendations are based upon nearly four years of program implementation experience with obesity and chronic disease prevention screenings and interventions. The implications of these findings are clear –there remain great opportunities to improve this Project.

The need for this service is amply demonstrated, and the evidence is clear that health education, medical screening and health literacy programming can be effective at meeting this need. But the evidence is just as clear that this specific system has some flaws that have simultaneously reduced benefits to a portion of their potential, and takes a lot of dedication and manpower on behalf of the grantee agencies. Sustainability of the program has not been adequately established, and there is danger of losing ground in the effort to meet these screening and health educational care needs if the consortium simply stops screening and educating.

Potential for Replication

I am very competent to say that our model can be very successfully replicated in other rural areas. I think our Project has examined some of the challenges that face rural African American health education and medical screening projects and this knowledge can be successfully replicated in a similar community. The key is very strong moral and fiscal support from the "top" such as; mayor's office, health unit, school board, local medical clinics and local political support.

After the Grant

A weight loss program administered by trained lay volunteers was effective in producing significant and clinically meaningful weight loss among African-American women who often do not benefit from typical weight loss programs.

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Community Characteristics

The purpose of this health outreach project was to access a multidisciplinary community-based intervention to combat obesity and related chronic diseases in Dubach and the neighboring communities through preventive services and health education aimed at lifestyle related behavioral changes.

Services Offered

A total of 639 individuals were screened for obesity, blood sugar, hypertension, and cholesterol, dietary and physical activity habits and were provided with one-on-one counseling based on their screening results at baseline. A total of 474 individuals were provided with follow-up screening every six months for the duration of the project. Participants with at risk values were encouraged to see their doctors. Recommendations for behavior changes to modify the values were discussed. Approximately, 100 of those screened are participating in small group exercise programs. A total of 10 Community Health Mentors were trained to lead the exercise groups.

Innovative Solutions to Problems

The project was well recognized by the local papers and made headlines several times. The project director was recognized by the President of the University for the Successful Implementation of the project in the community and providing service learning opportunities to the students. The project director was awarded the Scholarly Activity Award for the year 2006 as a result of the project implementation and results.

Results

An external project evaluator was contracted to assess the program using both structural and non-structural evaluation instruments. The evaluation instruments were developed to examine the program in the following major areas:

- decrease in overall fat and added sugar consumption,
- increased frequency and duration of physical activity,
- increased intake of fruits, vegetables, and whole grains
- normal cholesterol and blood glucose levels among the participants,
- increase in number of participants taking control of their health by adhering to medical, prescriptions and accessing available services.

Food frequent questionnaires, Physical activity questionnaires and the blood work data were used to collect data before and after training. Intervention goals and objectives were evaluated to assess the knowledge gained and the behavior change or modification made. The following national and international presentations were given using data from the project.

Potential for Replication

Absolutely yes, if rural low income and low literacy population will be reached with health services, this model provides the gateway. Working with the community and addressing their concerns, removes barriers to participation and builds trust. Counseling people on one on one basis at the most teachable moment as they see and understand their results fosters behavior change. Training and equipping recognized and trusted leaders with accurate health information and developing groups in established

organizations in the community provides both multiplication effect and sustains the project impact. Preliminary results of this project indicated that this model is a best practice and it works. Thank you for funding this project. I would be willing to provide workshops to train people in this model or answer any questions. It worked!

After the Grant

Most important aspect of the program will be sustained. For example the exercise groups are still in progress. The mentors have resources to continue teaching about a healthy lifestyle. Most churches included health aspect as part of their activities in church and identified a budget for it.

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Community Characteristics

This project, Worcester County Health Department (WCHD) Aging Initiative [formerly ACCESS] proposed to expand services that promote independent, unrestricted living for Worcester County's aging population. Maryland Access Point (MAP) of Worcester County is a vital part of the Aging Initiative. MAP was developed as a pilot project for an Aging and Disability Resource Center (ADRC) grant received by the Maryland Department of Aging (MDoA). Aging Initiative Project goals include the provision of leadership and direction to the project, increased accessibility to services for the aging in Worcester County, and increased utilization of available services. New and expanded services would address two needs identified by both consumers and providers in the community: in-home care services (including home improvement, chore, and personal care services) and accessible behavioral health (including mental health and addictions services) for the older residents of Worcester County.

Services Offered

This goal was to provide leadership and direction to the MAP project by providing oversight of Maryland Access Point collaborative and operations. This was accomplished by holding monthly MAP team meetings and by conducting Core Leadership meetings at least quarterly. In addition, a MAP web page was created by WCHD. The number of hits to this web page increased over the period of the project, with 1361 hits in year two, and 1846 in year three. This represents an increase of 35.6% hits from year two to year three of the project.

Innovative Solutions to Problems

Worcester County is a designated Mental Health Healthcare Professional Service Area (HPSA). Therefore, recruitment of staff, including psychiatrists continues to be a problem for our rural area in Maryland. We have approached the Maryland Department of Health and Mental Hygiene Mental Health Administration and requested they develop and implement a process to streamline recruitment.

Identification of volunteer services was limited. However, through the Worcester G.O.L.D. Fund, an increase in services is plausible.

Results

There were two components of this goal: 1) Expansion of workforce and volunteer providers for personal care and home improvement, 2) Creation of a MAP Behavioral Health (BH) Team. Initially, we hosted an Asset Based Community Development Training resulting in asset mapping. Throughout the grant period, we continued to foster community support for this project through outreach and education. By the end of year three, the allocation for COA Gap Filling Services (personal chore capacity) increased by 29% during the course of the project. This increase in service capacity resulted in the reduction of the number of people on the waiting list for such services by 18%. Worcester GOLD (Giving Other Lives Dignity), a non-profit organization established a fund specifically for seniors served through the MAP office to finance needed medical equipment, medications, etc. COA established a Supply Closet which offered disposable or consumable items needed to maintain individuals at home.

The BH component included a modification of the IMPACT Model and PACT model. The Behavioral Health Specialist (BHS) linked with primary care providers through Modified IMPACT model. The Mental Health Mobile Treatment Team served clients through the PACT model. Overall the

BHS served 73 clients through both models. The BHS became an integral member of the MAP team and was available to consult and visit patients as identified.

Potential for Replication

This project is replicable in similar settings as it is based on a concept of education, linkage, and accessible service delivery to best serve community members. With behavioral health personnel willing to work in a variety of settings – home, physician's office, and other community settings – and a focus on educating providers of all kinds, this program could be successful in many rural settings.

After the Grant

The sustainability of the Behavioral Health component covered by the grant is facilitated by the Mobile Treatment Team approval from the state allowing the continuation of our modified PACT component through Medicaid reimbursements. This service is limited to reimbursement for Medicaid and Maryland Mental Health Gray Zone patients, thus it generates a small amount of income.

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Community Characteristics

The Economic Disadvantage of Greater Franklin County works to discourage an active lifestyle. Fitness facilities are not readily available with only five such facilities in the 17,000 square miles of the Greater Franklin area, and all are considered unaffordable by many low-income residents. After-school activities and family entertainment are similarly limited and may require substantial transportation time and expense, especially given the escalating cost of fuel. Sidewalks are scarce, community centers and businesses are far-flung, and municipally-sponsored adult activities are rare or unaffordable given the extremely challenged economy of the region.

Services Offered

A multi-dimensional community-wide initiative promoting healthy life choices was implemented in Greater Franklin County. This initiative included a number of diverse and effective activities that addressed physical inactivity, poor nutrition, levels of stress, and fragmented services provided by healthcare providers and HCC.

Innovative Solutions to Problems

Curriculum Development: The design, format, and content development of the 8-week GOAL curriculum was extremely time consuming. Inefficiencies due to time constraints and resource availability between the initiative and the contracted marketing firm contributed to significant delays in completion of the GOAL facilitator and participant guide.

Possible Solution: *Every attempt should be made to identify an existing evidence based curriculum, which reinforces small incremental changes to better health. The curriculum must be flexible to adapt to the limited resources of a rural environment, and promote social support. In addition any materials should be thoroughly reviewed to ensure they meet evidence-based plain language standards.*

GOAL group logistics and facilitation: GOAL group facilitation and coordination was a challenge. Most associations and organizations are receptive to holding a group, but finding facilitators continued to be problematic and limited the number of people reached with this program.

Possible solution: Encourage GOAL group graduates to become GOAL group leaders. Once individuals complete the 8-week program their self-confidence, success in creating and reaching goals, and knowledge of the material make them ideal group leaders. This also helps sustain the program by eliminating the need for training sessions lead by HCC staff.

Provider engagement: Integration of this initiative in physician offices suffered due to varying levels of expertise among the medical community in addressing obesity and overweight issues with patients. Some physicians remain clearly uncomfortable broaching the subject with their patients.

Possible solution: Due to the significant delay in implementing provider-referred GOAL groups, this problem will be addressed during the no-cost extension period, through the establishment of standard scripted protocols.

Results

The evaluation framework includes two components. The first component assesses the process of the initiative including the implementation of activities that collectively and theoretically result in

improvements in health outcomes. The second component determines the initial outcomes or impact of the initiative.

Process Evaluation: Data collection efforts through participant and facilitator satisfaction surveys and group tracking forms are designed to monitor activity implementation. Archival data such as minutes, agenda, and attendance sheets are maintained. Following completion of a GOAL group, a follow-up brief telephone or in-person interviews is conducted by program staff & group leaders to explore and further any process modifications i.e. barriers.

Outcome Evaluation: The implementation of GOAL groups countywide is growing after a slow start up period. The outcome evaluation is assessed through the use of a participant health survey administered pre & post, which includes a 12 item quality of life, KABS & readiness measures, and a self-report ScoreHealth screenings which measures health status, BMI, blood pressure, physical activity, tobacco use, nutrition & stress. A final report will be provided at the end of the no-cost extension.

Potential for Replication

The component of the Healthy Living Initiative most applicable to other rural communities is GOAL. The facilitator and participant guides are so flexible and adaptable in their design and content that this curriculum could easily be delivered using the internet, distance learning technology, and with groups such as churches, Elks and Lions Clubs, seniors groups, and worksites. The internet in particular holds promise as the free and low-cost products of Web 2.0 (i.e., podcasts, blogging, and online social networking) gain popularity among youth, adults, and even seniors and offer a dynamic platform for education and social support.

After the Grant

HCC has begun to weave components of this initiative into the Healthy Maine Partnership program whose goals and evaluation strategies closely align with those implemented over the past three years. In addition, funding awarded from the Office of Women's Health has defined the GOAL program as an effective strategy to further promote and impact work-site wellness. Perhaps, the most significant sustainability measure is HCC long-term commitment to healthy lifestyle initiatives, with ongoing funding from State tobacco settlement funds, a diverse range of private foundations, and an endowment from Franklin Community Health Network. HCC will continue to include new information on obesity and overweight into its existing activities, such as, five school districts, physician offices, health centers, community settings, and on its mobile health outreach program funded by the United Way.

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Community Characteristics

The application proposed to launch behavioral health services at four Federally Qualified Health Center (FQHC) primary care clinic sites. Two of the clinic sites are owned and managed by Alcona Citizens for Health, dba Alcona Health Centers (AHC) (Applicant) and two clinic sites belong to another FQHC, Thunder Bay Community Health Services (TBCHS). The application was awarded in May 2005 and the expansion of the pilot integrated behavioral health services began in the fall of that year.

Services Offered

The proposed services included the placement of Alpena Regional Medical Center psychiatrists (one day/week each) in four, rural FQHC clinics to assist primary care providers in treating patients in need of medication management assistance, initial behavioral health diagnoses and limited psychiatric treatment; the placement of a minimum of two licensed, masters-prepared counselors; and the placement of a neuropsychologist.

Two new, additional behavioral health consultants were in fact hired using subsidies from the grant. They have served the four designated pilot project clinic sites during the three years of this program. Finally, a neuropsychologist was to be contracted with to treat the disproportionate geriatric population suffering from dementia, Alzheimer's and other neurological disorders; he began contracting with AHC and TBCHS in January, 2007.

Innovative Solutions to Problems

It was estimated there were over 12,000 persons in the area served by the clinic/hospital consortium in need of mental health services. The two, state-funded community mental health service agencies operating in the same area cannot provide services to anyone unless they are severely and persistently mentally ill. The 12,000 adults and children in need are faced with multiple obstacles to service, including HPSA, MUA status; low income, education, and cultural barriers; isolation and rurality; stigmas; no facilities or resources; funding disparities; and age discrimination. In FY2004, the two clinics in this project had just 1,561 behavioral health encounters (representing 470 patients). With the HRSA grant, a goal to provide an additional 5,019 new encounters during a three-year project was proposed; it was exceeded by 433%. Barriers were overcome through program design, excellent program promotion, and taking the program into the rural communities where people reside, versus making them travel long distances to reach needed services.

Results

The main goal was to provide 5,019 new encounters through this behavioral health program. The results of the project were:

- All Goals except those involving telemedicine were met. Combined 21,713 new encounters were provided, and 8,157 patients were served.
- Alcona Health Centers provided 13,328 new encounters were provided (9,233 Adults and 4,095 Children age 19 and under), and 5,007 patients were served (3,469 Adults and 1,538 children).
- Thunder Bay Community Health Services provided 8,385 new encounters were provided (5,809 Adults and 2,576 Children age 19 and under), and 5,007 patients were served (2,182 Adults and 968 children).

- Alpena Regional Medical Center Psychiatrists were incorporated in the FQHCs on a part time basis for the period of 2005-2008, and a Neuropsychologist was contracted for a period of fifteen months. Two new therapists were added to the clinic staff.

Potential for Replication

Yes, we do.

After the Grant

Aspects of the program will be sustainable, specifically the masters-prepared counselors and PhD psychologist. The Neuropsychologists and Psychiatrists will be a challenge because of the cost associated and availability.

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Community Characteristics

According to a 2003 survey of 113 active EMTs and paramedics in Huron and Sanilac Counties, 72% percent of Huron County and 56% of Sanilac County respondents stated that they would stay in their EMS related job for 5 or more years. If these percentages carry over to the entire population of Huron and Sanilac County licensed EMS providers, 34 Huron County providers and 55 Sanilac County providers could be expected to retire/resign from EMS service by 2008 compounding the existing shortage of volunteers. This project sought to reverse the declining number of active EMS providers. In order to reverse this trend proactive and innovative strategies were employed. This project was the result of 18 months of assessment and planning by the Huron-Sanilac EMS Task Force. Members of the task force represent the Medical Control Authorities (MCA) in Huron and Sanilac Counties. As a certified training site in the Thumb, the Sanilac Medical Control Authority under its training entity, Sanilac Medical Services, Inc. was the applicant organization. Due to the large portion of the project that targets high school students, the MCAs partnered with the Sanilac and Huron County Intermediate School Districts.

Services Offered

The project goals were to increase EMS volunteers for Huron and Sanilac Counties and increase the number of volunteers with advanced certifications. Four project strategies included 1) increasing access to EMS training, 2) reducing barriers to EMS training and service, 3) increasing awareness of the value and importance of EMS, and 4) increasing value returned for EMS volunteers. Grant funds were used for outreach activities that included utilizing distance learning for a High School EMT Course; establishing a community EMS Tuition Scholarship Program; building relationships with businesses and community organizations; establishing an EMS family support program; increasing community awareness activities; expanding recognition programs; conducting community education programs; and educating federal, state, and local officials regarding the needs of rural EMS.

Innovative Solutions to Problems

- Recruitment of High School Students: Due to advanced planning and timing of the school year, the High School EMT Program was implemented one year before planned. This provided two years to pilot the program. We discovered it was a challenge to attract students who had a goal of pursuing a rural EMS career. This was addressed by revising the grant activities to include CPR programs for youth and adults and MFR programs for fire departments and law enforcement agencies. Young adults who were still interested in rural EMS were able to enroll in evening or summer EMT programs.
- Distance Learning Barriers: Technology and acceptance by students was a major barrier. We discovered that a flawless system was important and that there are special skills needed by an instructor to effectively teach via video-conference and to manage classroom behavior (especially among high school students). In the future, any distance learning projects should provide for special training and instruction in teaching distance learning and several technology tests should be held in advance of beginning the program.
- Political Tension & Buy In from Local EMS Services: As the project was implemented, tensions between Medical Control Authorities & EMS Services surfaced and began to interfere with

successful implementation of programs. The consortium utilized technical assistance from Catherine Liemohn, Georgia Health Policy Center, to assess the problem via surveys and a strategic planning session. Upon her recommendation, every EMS Service Director/ Coordinator was interviewed for feedback on the project and was asked to become involved. Over the next 18 months, the directors became highly engaged and began serving as a grant advisory group for the consortium. Extensive networking between the new Network Director hired in year 3 and each service nurtured this collaborative relationship also reducing the tendency of local EMS Services to act in an isolated manner. Additional activities such as management training, frequent communication, and responsiveness to EMS Director's concerns/needs also helped to reduce the political barriers between EMS services.

- Local Economic Struggles: Economic status for Huron and Sanilac counties has seen a sharp decline over the past five years. Small-scale manufacturing has been hit especially hard with plant closings and lay offs. Tuition for EMT, paramedic, and continuing education (CE) programs is a constant challenge. To reduce this as a barrier, tuition for some CE programs was reduced or eliminated, scholarships were provided to those demonstrating financial need and making a commitment to provide service in the rural area; and course textbooks were purchased with grant funds.
- Changes in Leadership: Over the course of the grant, there were numerous changes in leadership of consortium members. These changes included a new Sanilac County Medical Control Authority Director, new CEOs at four hospitals, and a new Sanilac Medical Services education coordinator. A major strategy which helped to keep the project moving forward amidst this change was an external and consistent project director.
- Clarity on role of staff: The outreach specialist was initially hired as an employee of Sanilac Medical Services, grant fiduciary, and housed in the SMS office. This created a misperception of the role of the outreach specialist and limited the effectiveness of outreach activities. Mid Year 2 of the project, this staff member resigned to take a new position outside the area. This occurred at the same time that the EMS services were becoming actively engaged in the project. Rather than simply hire a new person to fill the existing position, the newly engaged EMS services were involved in revamping the job description and structure of the position so that there was a greater clarity on the person's role. While this took 6 months rather than 6 weeks, the outcome has been shown to be very effective in the continued engagement and commitment of the EMS services. The outreach activities are now directed by the grant advisory group composed of the nine EMS services and implemented by the Network Director as a contract position with a virtual office.
- Programming Delays: All of the above barriers and in particular the changes in leadership and outreach staff created delays in implementing programs. These delays were managed by utilizing the consistent project director and applying for a carry forward at the end of Year 2 and no cost extension at the end of Year 3.

Results

Objective A: Increase access to EMS training opportunities resulting in additional education participants each year of the project as measured by completion statistics in September 2005, 2006, and 2007.			
Outcome	**Measure**	**Target**	**Actual**
Outcome 1: The volunteer pool increases from 246 to 300	Michigan Consumer Industry Services (CIS) licenses.	300	To be obtained in March 2009.
Outcome 2: There is an increase of 10% or more of volunteers that indicate a 4 or 5 rating of satisfaction on training related questions on the volunteer survey.	Comparison of Volunteer Survey data 2004 and 2007.	Access CE- HC (61%); SC (55%) Quality CE- HC (58%); SC (29%)	Survey Scheduled for March 2009
Outcome 3: Survey-Rate of EMS specialized training increases by 5% in the following categories PALS, PHTLS, and ACLS.	Number of Michigan CIS licenses, rates of survey responses from 2004-2008.	PALS- HC (8%); SC (46%) PHTLS- HC (15%); SC (36%) ACLS- HC (21%); SC (61%) Farm: HC (16%); SC (30%)	Survey Scheduled for March 2009
Outcome 4: The pass fail rates on National Registry Exams will increase to at least the state average	State and local pass/fail rates.	State Average	Will be calculated at the end of no-cost extension
Outcome 5: Number of adult EMT/Paramedics completing training will increase from 30 per year to 120 by April 2008.	Class Completion Rates	Year 1: 50 Year 2: 80 Year 3: 90 No Cost: 120	Year 1: 84 Year 2: 77 Year 3: 74 No Cost: 20 to date
Objective B: By April 2008, significantly reduce barriers to EMS training and service as measured by comparison of volunteer survey data.			
Outcome 1: There is a 10% increase in volunteers that plan to stay in the EMS field for 5 or more years.	Comparison of Volunteer Survey data 2004 and 2008	HC- 82% SC- 66%	Survey Scheduled for March 2009
Outcome 2: Number of Adult EMT/Paramedics completing training will increase from 30 per year to 120 by April 2008.	Class Completion Rates	Year 1: 50 Year 2: 80 Year 3: 90 No Cost: 120	Year 1: 84 Year 2: 77 Year 3: 74 No Cost: 20 to date
Outcome 3: Two community sustainability programs are established in each of the counties.	A total of four community sustainability programs are in place.	4 projects	IC Class Instructors; Scholarship Funds; EMS Recognition Event; Michigan Agricultural Accident Rescue System Training

Outcome 4: There is an increase of 10% or more of family members that indicate a 4 or 5 rating of satisfaction the volunteer EMS experience.	Family Survey in 2005 & 2008	Target Available August 2008	Survey Scheduled for March 2009
Objective C: Increase awareness of the value and importance of EMS volunteers as measured by overall support of community sustainability programs and focus groups.			
Outcome 1: Community sustainability programs have the capacity to fund 20 EMS tuition scholarships, support family support programs, recognition programs, and maintain awareness programs.	Account balances and projected budgets.	Scholarships- $6500/year Family Support- $7000/year Recognition- $7000/year Awareness Programs- $60,000/year	Still in development.
Outcome 2: High School EMT courses have an enrollment of 150 students per year by April 30, 2008.	Enrollment for the 2008-2009 school year.	150	Program Discontinued; may consider partnering with college or Voc-Tech programs
Objective D: Increase the incentives for EMS volunteers thereby increasing retention rates of EMS providers.			
Outcome 1: One statewide and 2 community based incentives are in place by April 30, 2008.	Measure: Records of legislation or community programs	State- 1 Community-2	State- Resolution for EMS Week

Potential for Replication

We feel that the project has been a great learning experience and that its current organization and structure is a best practice model.

After the Grant

Some if not all of the project will be sustained following the outreach grant. The outreach activities designed by the original consortium will be undertaken by the Huron-Sanilac EMS Network. This Network is in the process of becoming incorporated and will be developing a business plan for project continuation over the next three months.

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Community Characteristics

Women's health is an identified need for our low-income, primarily rural area. The shortage of practitioners and the access issues our women face, make it imperative that when women seek services they receive comprehensive care. A primary access point for women during reproductive age is for contraceptive care. Our project seeks to improve acceptance of and access to this service; and to make this service more comprehensive for all women.

Services Offered

This project has served primarily females of reproductive age, with an emphasis on women who are low income or uninsured/underinsured. They receive family planning/contraceptive care and assessment/referral for issues relating to women's health; using a community clinic model of service delivery. The project has enhanced the capacity of the staff nurses and midlevel practitioners to serve women in a holistic manner by assessing for risk in the areas of chemical use, mental health, and domestic violence; and providing education to assure that we are not missing opportunities to improve women's health.

Innovative Solutions to Problems

We continue to be challenged with staff turnover of our midlevel practitioners. There were months throughout the grant cycle when one of the clinics was without a midlevel practitioner and recruitment was ongoing. The challenge of sharing practitioners across counties was difficult both due to the large distance to travel as well as medical clinics having full appointment schedules for their existing practitioners. There were also a number of maternity leaves during the project and practitioners could not be replaced for 2-3 months during a leave. Another continuing challenge for practitioners is the cost of liability insurance. If they are contract, the cost of their insurance at times can be higher than what they are paid for the number of hours worked. They need full time employment to make the cost of insurance affordable.

A second challenge is serving the adolescent population in very conservative communities. Outreach to this population is more difficult and requires a more subtle approach. Education and materials have been provided to school nurses and counselors as they are a referral source for the program. Education sessions have been provided at some of the high schools and Alternative Schools on STI prevention. This gives an opportunity to let them know where they can receive services.

Todd County continues to be challenged by their Spanish speaking population. The effort to outreach and provide services to the community takes additional time and resources. A PHN fluent in Spanish has been essential to the outreach effort. She also does home visits before clinic to assist women in completing their health histories and other needed paperwork. The need for Spanish speaking staff at clinic affects the clinic flow. One midwife and one PHN are fluent. If neither is present at clinic that month, Todd County has secured translators for clinic hours. Translations of the outreach and client materials have been completed; in addition this clinic requires a higher staff ratio to assist clients in the process. The consortium has offered to pay for Spanish Immersion classes for a second nurse midwife.

Results

In summary, an outside evaluator was hired for this project. The intent of the evaluation was to measure the project's impact on access to services, identify outcomes that were met and provide recommendations for ongoing programming. The data was collected through patient and community surveys, key informant interviews and patient chart reviews. The intent of the data collection was to monitor client access to and satisfaction with services as well as their perception of these services. Chart audits measured changes in health care providers practice patterns including risk assessments, and established a baseline to continue to measure long term changes. Key informant interviews measured satisfaction with project management and program operations.

Potential for Replication

We believe our project could be easily be disseminated to other rural areas. This project over time can be enhanced in this area by adding additional medical clinics as clinic locations. Other rural counties in partnership with their medical providers could use this model to increase access to family planning for low income women. The risk assessment tool has been disseminated to other family planning programs to enhance the client's visit by including a more comprehensive screening of needs. During the three years of this grant, this project was able to influence the health history questions used on the Title IX forms to include additional questions to screen clients for their additional needs beyond family planning.

After the Grant

Our project has been shown through evaluation to be effective in a large rural area to improve access to family planning services. This public-private partnership has proven to be a best practice model to bring affordable services to low income women needing family planning.

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Community Characteristics

The Mahnomen County Mental Health Network brings together five primary organizations: 1) Mahnomen Heath Center; 2) Mahnomen County Human Services; 3) Indian Health Services; 4) Mahnomen Public School District and 5) Northwestern Mental Health Center. These organizations share a strong history of service to Mahnomen County and a history of collaboration. Together they provided the primary leadership in the development and delivery of the services included in this proposal. The network builds upon the relationships that have emerged with the inception of the Mahnomen County Children's Mental Health Collaborative, and incorporates the members of the Collaborative as extended partners in the initiative. Each organization had either their CEO or an Administrator serve as a member of the Mahnomen County Consortium Steering Committee. These key people represented the core of the Network and shared a strong commitment to the mission and vision of the project. They communicated with staff in their organizations about the services offered which prompted an overall increase in referrals for school-based, in-home and outpatient mental health services.

Services Offered

A primary goal of network building included an interagency process for coordinating early identification, screening, assessment and intervention. The expansion of best practice methods was inherent to all project activities linking both cultural and mental health issues in the design and implementation of project activities. The project was governed by the chief executive officers of the five organizations, with the primary project management provided by the Northwestern Mental Health Center. Each organization was responsible for project related services for which they were best suited, with additional resources used to provide new and expanded services.

Innovative Solutions to Problems

- Recruiting and retaining in-home and school-based services staff
- On-going difficulties with Outpatient services "no show" rate which impacts our sustainability plan and the challenge of continuing services when clients miss appointments

Results

The evaluation of the Mahnomen County Rural Mental Health Outreach project utilized a multi-component approach to gather information about perceived changes in the mental health delivery system, the outcomes of youth and adults receiving services, and the satisfaction level of adults and children being served through these expanded mental health services.

Components of the evaluation plan are described below:

- **Client characteristics**. At intake, participating mental health providers submitted information describing key characteristics of clients, including age, gender, race, and ethnicity.
- **Client outcomes**. Mental health providers administered specific instruments to determine changes in client symptoms and functionality over time. The Strengths and Difficulties Questionnaire (SDQ) and Child and Adolescent Service Intensity Instrument (CASII) were used for youth clients, and the Brief Symptom Inventory (BSI) and Functional Assessment was used for adults. The evaluation plan specified that individuals who received individual services would

complete the tools at intake, after each three month period, and at discharge, while individuals participating in group services would be assessed only at intake and discharge.

- **Systems change**. An online survey was developed to determine how the project activities impacted Mahnomen County's mental health system. The feedback provided by project partners and community informants was intended to examine perceptions of the project's accomplishments, identify barriers, and gather information to guide the project. This online survey was administered once during the first year of the project.
- **Service satisfaction**. At the point of discharge, service satisfaction was also assessed. Surveys were administered to clients over the age of 12, and parents or teachers were asked to complete the survey for younger children.

Potential for Replication

We consider our utilization of Functional Family Therapy, Real Choice Minnesota as a best practices model. We also consider our current use and plans for expanded use of tele-mental health as an emerging best practices model, particularly in a rural/frontier environment.

After the Grant

We have greatly improved our Medical Assistance funding for mental health services. During the third year of this grant, our monthly MA billing average was $2,296 per month, up from the previous year of $1,563 per month. We have also identified areas where we can improve our enrollment in the State Medical Assistance Program and private health insurance and are keeping this enrollment goal active on our agency's agenda.

We are developing methods under our newly awarded school-linked based state grant where we can access state funding for school-based services which includes the Mahnomen School District.

Our agency has taken the tele-mental health lead within six counties to promote and utilize video-conferencing as a tool for clinical appointments and supervision. By the end of 2008, we expect to be handling a percentage of the medication management and psychiatric evaluations via video conference. Agencies have the proper equipment to begin the video conference meetings and after remodeling efforts are completed, we will begin using the video conference units. Capitalizing on this useful tool will not only reduce the travel time and expense for our professionals, but also it will allow for increased flexibility in the scheduling of appointments.

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Community Characteristics

Lafayette County 4 Health is a project that targets the medically underserved and insured residents of Lafayette County, Missouri. The project goal was to improve access to primary health care and social support services in Lafayette County through an integrated network of local providers. A consortium was developed to oversee the project consisting of the applicant agency, District III Area Agency on Aging, as well as Lafayette County Health Department, Lafayette Regional Health Center (the local hospital), Rodgers-Lafayette Dental and Health Center (a local affiliate of the Samuel U. Rodgers federally qualified health center), the Health Care Coalition of Lafayette County, and the Lafayette County 4-Life Project. Pathways Community Behavioral Healthcare, Inc., the local community mental health system, was added as a consortium member during the second year.

The Lafayette County 4 Health Project is a three-year project that incorporates both community education and community outreach efforts to connect the vulnerable populations to an integrated network of local health and social support services. In the first year of the grant, the project was able to complete the 4-Life facility which provides: expanded health and social services to senior citizens, a new preschool which is ran by the local school district, a vocational training center for early childhood education, and a larger community health center (Rodgers-Lafayette. The result was a "one-stop shop" facility that integrates social services, education and health care services.

Throughout the life of the grant, Lafayette County 4 Health has introduced evidence-based programs to improve health outcomes and address disease prevention. These programs include: Missouri On the Move – a program designed to increase physical activity through a community walking program and address obesity, hypertension and type 2 diabetes; Jump Into Action – a program designed for 5th-grade students to increase physical activity, increase awareness of nutritional diets and addresses type 2 diabetes; Enhance Wellness and Enhance Fitness – a wellness program targeted for seniors, but available for anyone, that helps to develop personal wellness plans and provides support groups to achieve success.

The Lafayette County 4 Health Project successfully created a Rural Health Network during the course of the Rural Health Outreach Grant, with support from HRSA in the form of a Network Development Planning Grant, followed by a recently awarded Rural Health Network Development grant.

Services Offered

The service area (scope) of the project was to address the uninsured and underserved residents of Lafayette County, as well as, promote primary care services. Through wellness programs such as EnhanceWellness and Missouri On The Move the consortium has been able to promote healthy living classes and techniques to the community. Funds from the Lafayette County 4-Life Project were also used to bring direct care to mental health providers in order to more adequately address mental health needs in the rural area.

Innovative Solutions to Problems

he most significant problem is the lack of health care professionals in the rural area, and urban professionals willing to go into the rural areas to practice. Rural counties, specifically Lafayette County is constantly struggling with the difficulties of recruiting and retaining health and dental providers. The consortium worked together to address this problem. Rodgers-Lafayette, for example, successfully leveraged some funds allocated for dental health care through the grant to bring two dentists to the clinic,

while Pathways was able to leverage grant dollars to bring a full-time psychiatrist to the county. The availability of grant dollars to provide this leverage was important to the development of the project.

Additionally, one of the newly formed health care network members is now working in conjunction with the consortium to significantly expand scholarships and forgivable loans available to health care providers that will allow us to "grow our own" health care providers from the community who will return to the community to practice when they are trained. This is particularly important in addressing the shortage of physicians and nurses, as well as, finding dentists and psychiatrists willing to work in a rural setting.

Results

The project has consistently been evaluated by the coalition board. We have kept records regarding the units of services provided comparing those to the units of services we anticipated providing. Many of the individual programs have also collected data regarding program outcomes which are detailed above, along with the outcomes that we have achieved. One of the challenges of this project has been the comprehensive nature of the grant, which has led to difficulties in formalizing much of the project evaluation.

Primary outcomes include:

- Significant increases in the provision of primary health care (nurse practitioner); dental health care (two additional dentists); and mental health care (licensed professional counselor and full-time psychiatrist). This includes an expansion of services to the migrant population.
- Development and successful implementation of four- health and wellness programs: Saving Smiles; EnhanceWellness, Missouri on the Move; and Jump Into Action.
- The development of free medical advice and referrals to services through Lafayette On-Call.
- The development of a formal health network, along with a three year strategic plan for that network (including a plan for MIS).

Potential for Replication

This project is already serving as the template for another rural community in the 13-county area served by District III Area Agency on Aging. We believe that the project can serve as an example of what a committed group can accomplish together. The strength of this project has always been local ownership and local commitment to the process. While the specifics of what needs to be done in each community will vary, much of the work we have done on specific aspects of the project can serve as a template for other communities. Most importantly, the ability of divergent organizations to work together over a period of years for the good of the entire community is the most important take away message of this project. We believe strongly that the process of working together not only can be successful, but must occur, in other rural communities in order to increase and expand the services available to rural residents. It is only through this synergistic approach that true progress can occur and be sustained over time.

After the Grant

Yes. Again, because the project will continue after the funding for this grant concludes we would consider our project to be a best practice model. The Health Care Coalition has been asked by a neighboring county to discuss the possibility of a similar consortium and also to assist with the

development of such program. The committee continues to work together to address the primary care of under and uninsured residents of Lafayette County.

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Community Characteristics

The Mercer County Behavioral Health Outreach Project served one of the state's most poor, isolated and distressed areas. Located in north central Missouri along the Iowa-Missouri border, Mercer County suffers from troublesome economic conditions, and suicide incident rates, (Mercer County has the highest per capita rate of suicide in the state and over three times that of the country according to the Missouri Department of Health and Senior Services). These reflect the environmental factors that for years have damaged the mental and behavioral health of its children and youth, families, schools and communities. The project was designed to increase the access of preventive and proactive behavioral health care for these populations by providing outreach, training and interventions through an integrated network of services serving children, families, schools and communities.

Services Offered

The major services/activities provided through this project focused on behavioral health provisions: screenings, assessments, counseling, referrals and prevention messages. The total population who received these services was approximately 900 K-12 grade students attending five school districts and the approximately 120 farm families and senior citizens of Mercer County

Innovative Solutions to Problems

The first significant problem encountered was the difficulty in obtaining the parental permission forms that were needed before the case managers could meet with the students in the various school districts. The forms were sent home to parents but because many did not understand exactly what services were being provided and also because of privacy issues, many parents were reluctant to sign the forms. We used community meetings, presentations at clubs and of course many phone calls to parents to try to explain the importance of this paperwork to the success of our grant. By the second year of the grant, this problem became less of an issue, but was nevertheless a continuing problem.

A second problem of significance was getting community members to attend our meetings that were centered on sharing behavioral health information. Several times we brought in speakers with timely information on child rearing, farm-related health issues, and attitudes and behaviors affecting students, only to be met with very minimal turnouts. Even though we advertised through newspapers, radio, and flyers sent home with students, our attendance was minimal. It seemed that in our small communities, there were often too many other time demands and these informational offerings were not deemed as important as sports and other social gatherings.

Results

The project was evaluated 3 times during the 3-year grant period. At the end of year 1 and year 2, Dr. Michael Rossman, Executive Director and Dr. Jim Meek, Training/Research Coordinator, from AgriWellness Inc. in Harlan, IA, conducted on-site evaluations of the grant. They met with the case managers and the family support specialist and during a full day interview process, monitored the progress of the grant and its effectiveness in meeting the stated goals and objectives. They provided feedback in the form of a written evaluation with areas of program strengths and weaknesses. During year 1, they made suggestions concerning documentation of case files. These suggestions were carried out and during year 2, they found all information and documentation to be complete.

We also underwent a site visit/performance review from the Office of Rural Health Policy in Kansas City, MO in the spring of 2007.

It's difficult to state in a narrative the outcomes achieved with the grant funds. Some of those would include: Training of Instructional Behavioral Health Teams in all 5 school districts; Health screenings at all 5 schools; Development of at-risk student data base; Counseling and family visits for at-risk students; Search Institute *Profiles of Student Life: Attitudes & Behaviors Survey;* Mentoring sessions with families; Search Institute Community Asset Building presentation; Disaster/mental health care for farm families; and Voucher system for participants.

Potential for Replication

Yes, I believe similar projects to this one could be successful in other rural settings. Our grant was patterned after a similar grant in a rural community in Iowa that had experienced success. Most rural communities struggle with the same problems that we face here, and thus would benefit from a rural behavioral healthcare grant.

After the Grant

The main challenge that was faced in developing and implementing a sustainability plan was funding. We live in a very small, isolated rural community. Transportation is a big factor, as the closest large cities are Kansas City, MO and Des Moines IA, both are 2 hours away. Our school districts are finding it difficult to remain afloat with the continued cuts in education spending by federal and state government. Our main success in this grant came through the use of the case managers who pushed into the 5 school districts with classroom presentations, counseling, and referrals. But without the funding to pay the salaries of these individuals, their services can no longer be used. It all boils down to money, or the lack thereof, and that's why we needed the grant to begin with. Although we accomplished a great deal in the 3 years that the grant was in operation, the financial obstacles have not been eliminated, and being able to sustain the program is certainly no more of a possibility now than it was when we indicated that we needed grant funding 3 years ago.

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Community Characteristics

Health care is one of the most critical issues for children of the Mississippi Delta region and especially for those in Claiborne County, Mississippi where over 42 percent of the children under age 18 live below the 100 percent Federal Poverty Level. Chronic health care problems begin with the children of the Delta because of poor diets and nutrition, a lack of exercise, a lack of appropriate health education and a lack of access to proper foods. Preventive health care lacks priority when individuals must focus on basic survival.

Health education must be a priority for Delta residents. Individuals must know how to prevent illnesses and injuries through healthier life-styles and behaviors. The optimal place for health education is the schools. The Claiborne County Rural Health Care Outreach Project was established to provide early health education sessions with children to prevent many of the critical chronic health problems seen in the county. The project provides affordable, accessible, quality primary health care to K-12 school children as well as adults in the surrounding area. The school clinics provide increased access to health care providers regardless of working hours, location, or insurance. Having health care access in the schools is eliminating many of the barriers to health care for a major portion of the population in the county. Health care access in the schools is also providing early detection and monitoring of at-risk behaviors leading to chronic diseases like cancer, diabetes and cardiovascular disease. In addition to regular health checks, children are provided health education through the school nurses and teachers who work with the clinics to provide information throughout the school year.

Services Offered

The health services provided reflect the goals and objectives of Healthy People 2010 for (1) increasing quality and years of healthy life and (2) eliminating health disparities. The program provides primary and preventive health services, reproductive health services, preventive dental services, laboratory services and mental health services. One of the cornerstones of the program is health education and promotion. The key premises utilized in the program include; health is a valuable asset; each individual has primary responsibility for attaining a healthy body and mind; each individual can, in part, ensure a higher quality of life through a healthy lifestyle. Age specific programs will be implemented geared toward educating the students on becoming responsible for their own health and to practice preventive health. These programs will include personal hygiene for the body (all ages), your health as part of your total hygiene makeup (all ages (obesity/weight management classes for identified students, reproductive health/abstinence education, building positive self-esteem and assessment for at risk behavior or at risk psychosocial environment factors.

Innovative Solutions to Problems

Hurricane Katrina hit about three months soon after the project was notified of its funding. The School District did not begin to remodel the first clinic site at the elementary school until the end of June and not much work had been completed when Katrina struck. Because Claiborne County is in south Mississippi and also near Louisiana, many of the evacuees from both the Gulf Coast and Louisiana came to the county. The CCFHC was inundated with new patients for over a month and many of the workers who were doing the renovation on the school went to help with the Gulf Coast recovery. The Outreach project came to a standstill as the county and our state recovered from the devastation of the hurricane.

Katrina delayed the opening of the project by three months due to repairs that had to be made to the building and clean up efforts around the community. There wasn't much the project could do but wait until people could begin working again and things returned to some form of normality. However, personnel were hired before the hurricane hit and they expected to go to work. Unfortunately, no project income or revenue was realized during the hurricane delay making it very difficult to maintain personnel salaries and other expenses during this three-month period. Some personnel left and others had to be hired. Medicaid was extremely slow in getting the project assigned with a Medicaid number and this has also caused problems and adjustments in project revenue. In addition to these problems, the project had to make adjustments in personnel expenses due to the increase in medical personnel salaries necessary to attract quality providers to the area after Katrina.

There was really no way to overcome the difficulties caused by Katrina simply because of the magnitude of the damage and after affects of the storm. However, the project continued even though it was at a much slower pace. Every member of the Consortium was affected by the storm. The school sustained damage that had to be repaired and this slowed down the remodeling efforts for the clinic. The CCFHC buildings sustained some damage that had to be repaired immediately for business to continue. The patient management system used by the clinic was shared with another clinic in Tylertown. Katrina destroyed the telecommunications connections between the two clinics and the PMS was down for over a month. All patient information had to be entered by hand, which slowed down the workflow process immensely, just when there was an influx of new patients from the evacuees. The new influx of patients demanded the clinic's full attention due to the concerns caused by uncompensated care, no information on medical records or pharmacy records, and liabilities for the medical personnel who were treating the patients. However, after about six weeks, the stream of new patients began to slow and clinic workflow slowed to pre-Katrina conditions.

The County Health Department was also faced with the influx of evacuees and experienced many of the same problems as CCFHC. In addition, many of the state health department personnel were called to serve in the medical units that went to the heavily damaged areas of the Mississippi Gulf Coast.

Results

Yes, I believe they could be very successful. Partnerships are much more beneficial to project success than trying to do everything on your own and they also have a much broader impact on the community. Having health care clinics in schools also significantly impacts the overall health of children in the community and increases their quality of life. In rural settings such as Claiborne County, many in the community do not have health insurance and often do not get health care for their children or themselves. Having clinics in the schools increases their access to quality health care and helps get the children enrolled into insurance and other healthcare programs that can help these parents support healthy lifestyles for their children.

This project identified realistic and practical indicators that will provide useful information in improving school health promotion and education in rural communities. While simple and uncomplicated, projects such as this one can provide best practices for building school based clinic networks that make significant impacts on the quality of life and healthcare for rural communities.

Potential for Replication

Yes, I believe they could be very successful. Partnerships are much more beneficial to project success than trying to do everything on your own and they also have a much broader impact on the community. Having health care clinics in schools also significantly impacts the overall health of children in the community and increases their quality of life. In rural settings such as Claiborne County, many in the community do not have health insurance and often do not get health care for their children or themselves. Having clinics in the schools increases their access to quality health care and helps get the children enrolled into insurance and other healthcare programs that can help these parents support healthy lifestyles for their children.

Yes, this project identified realistic and practical indicators that will provide useful information in improving school health promotion and education in rural communities. While simple and uncomplicated, projects such as this one can provide best practices for building school based clinic networks that make significant impacts on the quality of life and healthcare for rural communities.

After the Grant

The biggest challenge was getting the clinic started after Katrina so we could begin using patient revenue for support. Another challenge is the increasing cuts in federal budgets for rural health care. Federal grants will not be the sole source of income for this project and the grant writer is researching private funding from foundations whose focus is supporting rural health care projects.

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MONTANA—BUTTE SILVER BOW PRIMARY HEALTH CARE CLINIC, INC. AKA BUTTE COMMUNITY HEALTH CENTER

Community Characteristics

The Butte Community Health Center formed a consortium with St. James Healthcare, Head Start, Early Head Start and School District #1 and the County Attorney's office to address the issue of child sexual abuse in Butte and Southwest Montana. Sexual abuse of children is a horrifying crime and the incidences of this crime are unusually high in our area. Cases of child abuse and/or neglect reported to the Butte Department of Family Services range around 1,300 a year. The conviction rate of sexual abuse perpetrators was about 20% before a concentrated community effort began to improve this rate, although the prosecution rate is still not as high as the community would like it to be. There are 220 registered sexual and violent offenders in Butte, a large number for a community of 33,000.

Services Offered

Talking About Touching, a personal safety curriculum, is provided to all the Butte Elementary School students (K-3rd grade) and the Head Start and Early Head Start children. This curriculum reaches approximately 1500 children in the community per year. A child abuse prevention training and internet safety has also been offered to any parents of school children and various organizations around Butte and the Butte area through information booths and public trainings. Additionally billboards were used to educate more of the community on the dangers of child abuse. Child Abuse Forensic Interviews and Forensic Medical exams have been offered to children (ages 0-18 and some older developmentally delayed adults) suspected victims of abuse crimes in a six county area. Over the 3 year grant over 200 interviews and exams were provided at the CEC. The grant has also allowed us to offer trauma therapy on-site for the child abuse victim and the non-offending care provider.

Innovative Solutions to Problems

The most significant problems continue to include travel distance for the child: SAP staff has been working with nearby communities to provide information about the Child Evaluation Center in Butte. The hope was to decrease the number of children traveling to Missoula, MT which is an additional 120 miles for evaluation. We have seen an increase in the number of children from the surrounding communities. In 2006, we served 31 of children from surrounding communities compared with 12 in 2005. In the last two years we have received 32 children from surrounding communities. The CEC with support from rural communities is planning to write for the Rural Health Expansion funds to develop satellite clinics in their areas.

Another issue that has arisen during project implementation is evaluating the use of and providing necessary non-reimbursable services. This issue arose in using the Trauma Focused-Cognitive Behavioral Therapy model (TF-CBT), which is considered the best practice model in the treatment of trauma. The model provides for individual therapy with the child and with the non offending caregiver and progresses to conjoint sessions. Due to Montana State Medicaid regulations, we are unable to bill for the non-offending caregiver portion as the patient/child is not present. We have attempted to overcome this reimbursement difficulty by utilizing Crime Victim's Compensation funds whenever possible. Additionally our Behavioral Health Director/SAP director has been in contact with state Medicaid officials and educated them about the model in hopes of instigating change in reimbursement requirements on a state level. Additionally, many of the services necessary for treatment of children who

have been abused are non –reimbursable. These services include: on-site classroom therapy sessions at the Early Head Start, time spent in multidisciplinary team meetings, foster care meetings for children removed from their homes because of the abuse, transitional planning meetings for the children and families. We continue to explore time management strategies and outside financial resources to continue to provide these services.

Additionally throughout the grant years, it was noticed that some children have problems sharing difficult information in a one time interview format due to age, developmental level, lack of trust, etc. To combat this problem it was decided to offer extended forensic evaluations for appropriate children. Two of the five forensic interviews/therapists were trained at the National Child Advocacy Center in the extended forensic evaluation process. The interviewers were selected for this training based on the extended forensic evaluation protocol that requires master's level education.

Results

Each component of the project utilized different evaluation methods to measure outcome. The Talk About Touching program used surveys to teachers and administrators, as well as word of mouth. The success of the prevention program is seen in its continued acceptance and presentation within the schools, as well as in children witnessed using the specific safety skills learned from the curriculum. The CEC utilized a satisfaction survey of users of the center to address problems and potential areas of improvement. The majority of users have reported a positive experience at the center. The multidisciplinary team/task committee meets monthly and a standing agenda item is the delivery of service and access. Therapists use the Achenbach Child Behavior Checklist to monitor and evaluate symptoms, as well as a subjective rating on each sessions progress note. Outcomes of the project showed improvement in all areas: improved access to a "one stop shop", a decrease in the number of people interviewing a child, increased prosecution rates, increases in the number of children and families provided with therapy and case management services.

Potential for Replication

Yes, because the Butte Child Evaluation Center is the first Nationally Accredited Center in the state of Montana, several other sites have come and explored our center, as a model for their community. The Child Advocacy Center in Helena has used us as a resource and they have now applied for National Accreditation. We have been working with other sites throughout the state to form a state CAC chapter aid in developing successful teams and additional centers, as well as providing a training resource in a more local setting. Based on our experiences we hope to guide other communities.

After the Grant

Yes, we followed National Children's Alliance standards to fully develop the center and achieve accreditation, as well as following SAMHSA's best practice therapy model for the treatment of trauma. The prevention program utilized a nationally recognized personal safety curriculum.

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Community Characteristics

In rural areas, long distance between health care facilities presents a large barrier to seeking and receiving health care. In addition, as the population continues to age, the lack of public transportation compounds this problem. Cavalier County Senior Meals and Services provides limited assistance for clients with transportation needs. Satellite clinics in the surrounding areas have decreased this obstacle somewhat by bringing basic health care to the respective communities. Mobile diagnostic services, such as CT scans, bone density scans, mammography, nuclear medicine, and ultrasound are contracted through CCMH to provide an even more comprehensive system of health care support.

In addition, the mind-set and attitudes of rural residents can be a barrier to needed health care services in this area. They generally are stoic, hard-working individuals, often too proud to ask for necessary health care assistance. Depression, due to a declining farm economy, aging, and other stress related issues, are examples of health care needs in the service area that would benefit from the promotion of wellness education.

Services Offered

The grant allowed us to focus on improving overall health in the community. The main way we reached people in the community was through classes. These classes were advertised in the local newspaper, on the local radio as well as in the quarterly wellness newsletter, which was developed under the grant program.

During the life of the grant these classes were held by the wellness programs office which was developed under the grant. Most of these classes/programs are being sustained by the hospital, the city, public health, or NDSU Extension Services. All classes were instructed/supervised by a trained professional.

Innovative Solutions to Problems

The most significant problem we encountered was getting the public interested in our programs. We were able to overcome this problem. We chose programs with topics the public had indicated interest in during a survey. We did away with programs that were not popular and instead focused on the programs that were well received, and offered the popular programs more frequently. This generated word of mouth publicity for many of the classes. This effort has paid off as several of the popular programs now have waiting lists. We also developed a newsletter that was sent out to over 700 households and businesses once a quarter. This newsletter included health living tips as well as information about upcoming classes.

Results

YEAR	MEMBERSHIP REVENUE
2002	$19,609.26
2003	$17,215.17
2004	$18,738.84
2005	$28,847.41
2006	$39,614.12
2007	$41,414.96

We tracked membership revenue at the Langdon Activity Center. When the new cardio and weight equipment was placed in the center many more people joined, and the trend has continued. Please see the chart to the left. Our grant started in August of 2005. In just the four months left of 2005 membership revenues increased by $10,000. Memberships now are double what they were before the grant. The fact that this many more

people are members of a center allowing them access to cardio and weight equipment is an indicator of success. We also looked at the information from the check in system daily. This system allowed us to see how many people come in each day, what times they come in, and in some cases which equipment they use.

Success has also been measured in a more qualitative manner. After each program or class participants were given the opportunity to fill out a survey asking basic questions on what they thought of the class. This information was used when deciding if the class should be offered again and what changes, if any, needed to be made to it.

Potential for Replication

I do feel that our project could be successfully implemented in other areas. Our project was unique as it allowed us to improve community wellness on so many dimensions. I feel the key factor to success is making sure all community organizations that have a vested interested in improving community wide health are invited to participate equally.

After the Grant

I absolutely consider our program is a best practice model. It allowed us to improve the health of so many individuals in so many ways. We were able to reach all ages and a wide variety of fitness levels. The knowledge of the individuals that were involved in the programs was a huge factor in our success. Lives were changed in Cavalier County because of this grant program.

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Community Characteristics

As with the rest of the country, our region has an aging population with increased levels of chronic diseases such as diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). People with chronic diseases use a much higher proportion of healthcare resources than the rest of the population: for example, Medicare beneficiaries with multiple chronic conditions represent 20% of the Medicare population, but require 66% of program spending. On average, these individuals fill 49 prescriptions per year, have 37 physician office visits per year, visit 14 different providers each year, and stay 7 days in the hospital per year.

The gap between best practice and *actual care received* is also a concern when it comes to chronic disease. This problem was reviewed in a study by McGlynn, Asch *et al* published in the 2003 *New England Journal of Medicine*. The study reported that chronically ill people receive recommended care only 50% of the time. It has also been estimated that 50% of chronically ill patients leave a physician's office without knowing how to best care for themselves.

Home Healthcare, Hospice and Community Services (HCS) and its consortium partners recently completed the three-year implementation of a comprehensive system to improve chronically ill patient outcomes and quality of life through:

- Establishment of a **chronic disease management program** for diabetes, CHF, and COPD patients which involved regular "coaching contact" by phone or in person, the distribution of patient self-help resources, and the use of computerized home tele-monitoring devices, when appropriate, for tracking of daily patient measurements. This daily tracking assures timely nurse visits, avoids unnecessary visits, and prevents patient "crises."

Services Offered

The Cheshire Medical Center (TCMC), the physician practice, and the home care agency provided patient self-help materials (educational pamphlet, reminder calendar, healthy recipes, and a symptom log book) to all patients with congestive heart failure and diabetes who were discharged from the hospital, admitted to home care services or seen at their physician's office during the past three years. TCMC also referred all diabetes and congestive heart failure patients to our homecare services when appropriate and recommended at-risk patients for home tele-monitoring.

Innovative Solutions to Problems

It took us longer to roll out the computerized home tele-monitors than we initially expected. Since we were installing them in the homes of our sickest patients, there was a high frequency of "alerts" that required interventions and, at the very least, confirmation that "wayward" patient measurements were accurate.

As we have slowly grown the program from an initial 10 tele-monitors in October of 2005 to 90 today, we realized that effective utilization of this technology and effective response times meant we needed to have more staff monitor results on weekends as well as week days. At the beginning of project year three, in addition to weekend coverage, we added a part time (.27 FTE) nurse specialist to assist with the monitoring of growing numbers of participating patients.

Also, in the initial roll out, we were slowed by the fact that we were converting to electronic medical records at the same time as this program was being implemented. Staff were grappling with both new technologies, and these major adjustments simply took longer than expected. We also ran into some nursing staff resistance. When monitors are initially installed, it is not unusual to discover multiple issues or concerns. As a result of these issues, there might be an increase in nursing visits or need for case manager involvement more than occurred previous to tele-monitoring. Once the clinicians discovered that the tele-health staff was assisting them with managing these issues, and often times following up on the problems in search of resolution, they were more receptive to tele-monitoring.

Skilled nursing visits became more data driven than routine and over time, clinicians were often able to decrease the number of visits they were making (documented below). It is likely this change was due in part to the improvement in the disease management itself, with the frequent guidance, support and contact that the patients had with the tele-health staff. This enhanced clinician buy-in.

Another significant problem at the beginning and one that persists to a much lesser extent today is physician resistance to tele-monitoring. There was some fear at the beginning that by collecting more information about patient condition we would "overload" practitioners and in fact increase liability for physicians if they failed to act in timely fashion. We assured physicians that *we* would track the information and would only contact them when there was good reason to do so. In time, we were successful in securing referrals from a total of 57 physicians.

A final significant problem is patient resistance. We could have monitored and helped more patients if patients themselves weren't frightened or put off by having a computer device in their home. We learned that if we "pushed" the device on them, it rarely was used. Also, there are certain patients who are not motivated to manage their disease. In addition to the fact that some rejected tele-monitoring, there are certain patients who made little or no use of our self-help resources or our coaching, and we had little success changing this hard core group. For example there are diabetics who have been under our care who are determined to eat whatever they want, regardless of the fact that such behavior worsens their condition.

Results

At the inception of the project, Medicare-monitored patient "re-hospitalization within 60 days" rate was 36.9%, a few points above the national average. Our latest re-hospitalization rate as reported on Medicare's web site is 31%, still a few points above the national average, which for unknown reasons happens to be very low at this time. During the course of our implementation, there have been a number of quarterly periods when our Medicare re-hospitalization rate was a point or two below the national average, which was unheard of for our agency and this rural region prior to our disease management program.

Similarly, for the same timeframe, our Medicare homecare patient "emergency room visit within 60 days" rate dropped from 33% to 30%; this ***percentage point*** reduction means 9% fewer patients had to go to the emergency room during the latest 12 months compared with the pre-project 12 months.

The numbers presented in the above two paragraphs represent our entire Medicare patient population (1,300+ each year), which includes many people who did not have diabetes, CHF, or COPD. Also, it is

important to note that a number of people who benefited from the program were under the age of 65 and therefore covered by private health insurance rather than Medicare.

Potential for Replication

We absolutely believe applying this technology to chronic disease management in rural areas is a 'best practice' model for enhancing the patient's involvement in managing their disease process and should be adopted widely.

After the Grant

Our Outreach grant period has ended, effective with the end of our most recent fiscal year (ended 6/30/08), but we have a foundation grant for $35,000 to help us continue the program into our current fiscal year. It is our intention to continue the program, with the knowledge that it will help us provide better, more timely care to many of our most at-risk patients, and that it will help us to reduce visits per episode and maintain the staff efficiencies noted at the end of Section III. A above. The DHK physician practice currently plans to continue its nurse telephone coach position, and all three consortium members plan to continue to distribute our enhanced patient self-help materials.

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Community Characteristics

Hidalgo Medical Services (HMS) is a community health center for the region with offices spread throughout the service area. Included in their services are behavioral health services with some substance abuse treatment services. Dr. Neal Bowen was actively participating in this project, and created shared policies to allow clients to more easily access the various agency's services.

Presbyterian Medical Services – Catron County (PMS), likewise, were regular participants through their Director, Alisa Estrada. This clinic is the most isolated in the state and at the start of the project, had no mental health services available to residents. Currently, their community has a full-time therapist, case manager, and telehealth opportunities as a result of this project

Services Offered

The three main goals of the project were to: 1) increase access to appropriate levels of care for mental health and/or substance abuse services, 2) increase provider capacity to provide services to individuals with mental health, substance abuse and/or co-occurring disorders, and 3) improve access to and management of psychotropic medications. Consortium members will work together to improve linkages among their organizations and with the communities they serve and build capacity within their organizations through training, staffing and the use of technology.

Innovative Solutions to Problems

Recruitment has been the single-most challenging situation throughout the tenure of this project. We have attempted numerous "best practices" to recruit behavioral health care professionals to our rural setting including student loan repayment, professional recruiters, salary adjustments, and national ad campaigns. These efforts resulted in numerous leads, but all but one were unfruitful. Time will tell if these ongoing strategies lead to successful recruitment, but it is extremely difficult to attract professionals to rural areas, with depressed pay, and into a state that creates excessive hurdles for licensure transfer.

Results

Two systems of evaluation were used for this project. First was the ongoing monitoring of program success by the consortium through the matrix presented below. This matrix was reviewed at each meeting, allowing for staff and participants to re-set goals and priorities, and assess the pace of project completion. Second, using in-kind support from a SAMHSA grant, all clients were given the GPRA assessment tool, along with four other behavioral health assessments, all of which provided valuable data related to access to care. These surveys were supervised by Dr. Vern Westerberg, Project Evaluator, and implemented by program staff.

Goal 1: Increase access to appropriate levels of care for mental health and/or substance abuse services.				
Activity	**Status**	**Accomplishments**		**Time Spent %**
Implement/improve identification and referral procedures with key community agencies.	Completed	Ongoing refinement of system by partners. Formalized system established in last reporting period.		3
Standardize clinical practices such as intakes, treatment matching using ASAM criteria, and assessments so that information can be easily transferred among treatment providers and duplication is reduced.	Completed ongoing	As partners' programs evolve, discussions continue to determine one tool to be used by all providers.		3
Establish procedures to coordinate transition/discharge plans, aftercare, and follow-up	Completed ongoing	Ongoing refinement of system by partners. Formalized system established in last reporting period.		3
Establish a comprehensive substance abuse outpatient treatment program.	Completed ongoing	Services in Deming, Silver City & Lordsburg. All programs continuing beyond terms of the grant.		50
Goal 2: Increase regional capacity to provide behavioral health treatment services by increasing the availability of licensed professionals.				
Activity	**Status**	**Accomplishments**		**Time Spent %**
Develop/strengthen collaborative agreements with universities for the placement of residents and interns in rural areas.	Ongoing	Ongoing work conducted by BAMHS HR Director		2
Offer workshops to assist individuals who take the counseling, social work, and LADAC exams.	Completed ongoing	Workshops held through Western New Mexico University. Study supplies purchased through grant and maintained by BAMHS		5
Work to decrease waiting time for licensure from NM Counseling Licensing Board (include establishment of license reciprocity with other states).	Completed ongoing	Numerous meetings with licensing board; contractor conducts submission monitoring for all consortium applicants		10
Provide technical assistance and training that will allow providers within the collaborative to work more effectively with individuals with co-occurring mental health and substance abuse issues.	Completed	Integrated into overall training component; CBI, Suicidal Assessment, White Bison trainings held.		2

Goal 3: Improve access to and management of psychotropic medications				
Activity	**Status**	**Accomplishments**		**Time Spent %**
Teleconferencing consultations between rural health providers within the region and with UNM.	Incomplete	UNM thwarted efforts due to lack of human resource; Consortium exploring other options.		2
Provide local training with continuing education credits to physicians and other professionals regarding behavioral health issues.	Completed	Suicide training, White Bison training; CBI training, Matrix Model training all held with grant funds. Over 450 participants (duplicated) attended the various training.		15
Improve client/family education & medication availability through Pharmacotherapy Initiative, MAP and PAP.	Completed ongoing	Financial access resolved through PAP/MAP programs. Continued shortage of prescribing physicians in the area.		5

Potential for Replication

Not necessarily. We had some successes based on novel strategies for our area, but as a whole the project, while successful, would not be considered a best practice.

After the Grant

The treatment component is sustainable and the planning actions have been absorbed into the Health Council and Continuum of Care Coalition.

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Community Characteristics:

The Northern New Mexico Rural Infant Mental Health Consortium is requesting $200,000 to continue a program that is expanding access to mental health services for high-risk families with young children, ages birth to five. The project serves the residents of Rio Arriba County, a rural, largely mountainous region in Northern New Mexico. Rio Arriba County is an area of extremely high risk and prevalence with respect to infant mental health problems—problems that are directly related to the area's high rates of substance abuse, teen pregnancy, domestic violence, poverty, and child abuse and neglect. Close to one-fourth of the county's families live below poverty level, and 35 – 40% of the county's residents lack of health insurance. Approximately 73% of the county's 41,190 residents are Hispanic, and 14% are Native American. The county qualifies as a Medically Underserved Area and includes 13 divisions designated as Health Professional Shortage Areas.

Research shows that these stressors place infants at high risk for emotional disorders, learning disabilities, developmental delays, and other problems. At the same time, a great deal of recent national research has underscored the critical importance of infant nurturing and support to a person's lifelong mental and emotional health. The Northern New Mexico Rural Infant Mental Health Consortium is a group of organizations that have come together to address the need for expanded infant mental health services in Rio Arriba County. The group includes two rural Federally Qualified Health Centers, a community-based provider of child and family mental health services, a rural child development center, and a university rural psychiatry program.

The project has been using a three-pronged approach: (a) Providing comprehensive, expanded infant mental health services at three sites: Las Cumbres Learning Services in Española (south), Las Clinicas del Pueblo in El Rito/Abiquiu/Ojo Caliente (central), and La Clinica del Pueblo in Tierra Amarilla (north). The program will utilize a successful, evidence-based model that combines home-based, center-based, and community-based services in counseling, case management, parenting skill development, client advocacy, and early intervention. (b) Providing training, consultation and capacity-building to health care and early childhood development programs, enabling them to serve as points of access to services, with full capabilities for identification of risk factors, initial screening and assessment, and referral for services. (c) Increasing access to, and utilization of, infant mental health services, through developing bilingual outreach materials, home visits, Child Find assessments, and strengthening collaborative referral networks. **This HRSA-funded project is serving as a pilot site for a larger, statewide initiative designed to build a comprehensive system of care in infant mental health in New Mexico.**

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Community Characteristics

Older adults are a large, rapidly growing segment of the population, with a high disease burden, high risk for disability, limited financial resources, and difficulty accessing care. Livingston County was designated as a medically underserved population area; over 11% of the population lives below the poverty level. Livingston County's rapid increase in residents age 65 years and older is expected to grow by 4.8% between 2000 and 2015, with an increase of 31.5% in the over 60 years group, and 36% increase in the over 85-years group. This growth rate is consistent with US Census Bureau national data which confirms this age group has greatly exceeded the growth rate of the U.S. population as a whole.

Traditional programs presume access to health and social services, limiting their availability to rural dwelling older adults. Failure to access these programs can result in unnecessary morbidity, institutionalization, and mortality.

Services Offered

The services provided by the project occur at 2 points in the health care continuum. First, EMS providers screen community dwelling older adult patients to identify those with unmet needs. This information is transmitted to Transitional Case Managers (TCM) who go to clients' homes and perform a detailed psychosocial evaluation using established, validated instruments. Based on those results, the TCMs make referrals for the clients to address identified needs.

In addition, an educational service was provided to EMS agencies in Livingston County. All were eligible, and we believe most active agencies took advantage of, the Geriatrics Education for Emergency Medical Services educational program. This program gave EMS providers education regarding the optimal care of the older adult, which was very helpful for them. An evaluation of this program was performed and is going to be published in the Journal of the American Geriatrics Society.

Innovative Solutions to Problems

The funding for this project was, unfortunately, announced after the official grant start date. As a result, pre-preparation activities did not occur. To overcome the problems, immediately upon initiation, a general announcement of award was made via email and letters to participating individuals in the grant. Meetings were organized to begin work and lay the ground work for the funded project.

Data collection. Initially, to maximize the continuity of services and data, the project tried to work with Synergy Corporation to adapt the SAMS program used by the OFA to fit the needs of the project; however, after extensive attempts, it was determined that the SAMS program could not meet these requirements despite initial claims by the vendor. As a result, a Microsoft Access Database was developed to maintain the data in the project.

The database continues to work well for the project. As the project continues to develop on-going additions and improvements are made to maximize efficiency while maintaining a user friendly system. A number of sub-forms are regularly developed to address identified needs. The database continues to evolve and will be key component of a toolkit designed for others who may want to replicate this project.

Communication with Rural EMS Providers. As the project evolved and challenges were identified, we determined that we needed an efficient way to communicate with EMS providers. We decided to leverage the central nature of the EMS agencies and started sending monthly newsletters for the providers in the project. Each month the newsletter discusses a particular geriatrics EMS issue and

includes the EMS screening results for that particular EMS agency. It is proving to be an effective communication tool as it provides feedback to the EMS agencies, educates them in the process, and appears to be improving the screening rates.

Results

Patients' fears leading to the refusal of a home visit continues to be a challenge. Patients worry about nursing home placement, mistrust of strangers in the home, and potential costs (although none exist). In addition, many feel that their existing services are sufficient, not realizing that additional options are available. Through the project advances have been made at addressing these fears and worries, but until this program morphs into a public single point of entry type system and advertising directly addresses patients' concerns, this barrier will continue to exist.

Potential for Replication

Yes this project can be successful in other areas. A group in rural NY and rural Canada are working to replicate the program. A Toolkit is being developed with the Operations Manual and the Access Database, which contains core knowledge of the project for use by others.

After the Grant

A number of methods were developed to continue the program. First, the geriatrics training has created an infrastructure of educators who can teach the course. Now, existing regional and state training dollars can be used to provide the geriatrics training to the EMS community. Second, the EMS screening has been built into the electronic medical record. Therefore, little manual work is needed to have EMS screen or to review the screening results. Third, the transitional case management structure is one that is being integrated into the OFA as the OFA prepares for the NY single point of entry system. Finally, the Synergy Now Harmony software/web tool will be used to integrate the operations of the program into existing infrastructure.

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Community Characteristics

The Southern Black Hills has five communities: Custer, Edgemont, Hill City, Hot Springs and Oelrichs all in the southwest corner of South Dakota. The closest city with primary 24 hour health and mental health services is Rapid City which is 30-80 miles north. Distance and isolation from large metropolitan areas do not shield the southern hills of South Dakota youth from substance use and high risk behavior problems. In fact, it appears, it places them at even higher risk. There is an alarming high rate of alcohol, tobacco and other drug (ATOD) use among the areas youth. A survey of 46 key leaders in the five communities cited ATOD as a major concern for all respondents, with a majority indicating lack of awareness and lack of parent involvement as key issues. The Southern Hills Leadership and Resiliency Initiative (SHLRI) was developed to address these concerns.

The Southern Hills Leadership & Resiliency Initiative's goal is: Reduce alcohol, tobacco, and other drug use among adolescents by providing accurate and consistent information through the use of research based curriculum, and early intervention programs. The prevention and early intervention services in order to accomplish this goal were implemented into Custer, Hill City, Hot Springs, Edgemont and Oelrichs Schools, the five rural schools of the Southern Hills for youth grades 5^{th}- 12^{th}. There is an alarming high rate (higher than national rates) of alcohol, tobacco, and other drug use among our youth of the Southern Black Hills of South Dakota. There is a serious risk of an epidemic in devastating proportions with our Native American youth. The Rural Health Consortium sought assistance to address this most alarming need; prevention and early intervention of alcohol, tobacco and drug addiction.

Services Offered

In order to achieve our goals, objectives and implement the Continuum of Prevention and Intervention Services, several programs were reviewed and selected. Lifeways Prevention specialists were trained in several researched based curriculums which include Life Skills Training, Tobacco Cessation, and Reconnecting Youth. These specialists were placed in the 5 schools participating. Lifeways, Inc. also trained Southern Hills Staff on high school early intervention programs (Promoting Awareness To Health – PATH) developed with the harm reduction model which includes parental involvement. There are also peer-led programs which include; IMPROV Theater Presentations (peer led presentations on ATOD to younger students) and Youth to Youth (peer led support group assisting students to make healthier choices). These specific programs were adapted to each individual school community so they could be implemented across grade levels 4-12^{th}. In order to be culturally appropriate with the Native American population the curriculum and programs were reviewed by Native American staff and suggestions included when working with Native youth.

Eighty seven percent of the students fell into the twelve to seventeen age ranges.

Innovative Solutions to Problems

The need for changes to the equine portion of the early intervention services was a challenge that the Working Group needed to work through in the first year of the grant. The Working Group completed a comprehensive review of all logistical issues, implementation guidelines, technical and safety issues, and number of students served. It was evident during this review that the best use of student and staff time, energy and funding would be to consider using programs that could reach and impact more students with less technical and logistical problems. Upon HRSA's approval we reallocated these funds to provide

another full time prevention specialist in the Hot Springs School District. This was very exciting, as they were reluctant to fully participate in project in the beginning. The change has allowed us to provide an increase in these services to approximately 200 more students and better meet all of our objectives in this school. The integrity of the Leadership and Resiliency programming has not been altered only the number of youth we are serving which increased.

Our evaluation process has been expanded to include an independent evaluator, Dr John Usera from The Institute for Educational Leadership & Evaluation (IELE). The information from this independent evaluation has proven to be very valuable in planning our upcoming program year. The Evaluation Report provided by IELE will be an integral part of the planning for ongoing continuum of prevention and intervention services in all five rural schools

Results

The evaluation team comprised of the SHLRI staff, Black Hills State University College of Education faculty, and the Institute for Educational Leadership and Evaluation staff, designed a questionnaire to be completed by students, grades 7 - 12, in the five Southern Hills communities. The instrument assessed usage of ATOD in the past month or having ever used ATOD, as well as their perception of their friends' attitudes toward these substances. Additionally, the survey assessed an array of internal and external developmental assets. The questionnaire was administered in the spring of 2006, 2007, 2008 will be annually during the life of the project to measure changes in usage and attitudes toward ATOD to ensure the project continues to address the needs. The administration of the questionnaire and collection of data was on-line using the Internet. In order to test the differences among groups, several statistical tests were used. The Chi Square test was performed to test the association between various identified groups and variables at the alpha of 0.05 levels. ANOVA was also used where applicable to test the difference in means between various groups at the alpha of 0.05 levels. Starting with next year's evaluation, a matched pair t-test will be performed at a 95% confidence interval to test for any significant changes in usage and attitudes toward ATOD. Where the data can not be paired to an individual record, an independent t-test will be performed, also at the 95% confidence interval.

Potential for Replication

SHLRI replicated successful and effective programs that already are in existence in the two largest communities in South Dakota, Rapid City and Sioux Falls, using their programming as a template for the Southern Hills Schools. These projects have been successfully ongoing due to support from the state and local government and other resources available in larger communities. The challenges for sustainability in the rural setting are directly correlated to the local school districts and their ability to afford investment in the projects. The acknowledgement of the need and success we have seen by placing prevention specialists in the schools would encourage us to say yes to this question. The challenge is to fund such a project in rural schools where they are already struggling financially to maintain existing programs is an on-going concern.

After the Grant

At this time (July 2008), the program plans are to continue because of a local foundation grant that was written in June 2008. The Consortium and Lifeways has been working to develop a partnership

utilizing the foundation grant and local community and school funds until other grants can be written and state funding continued to be pursued.

Throughout the three years of this grant, the Working Group proceeded to accomplish the sustainability plan with potential funding partners (School Superintendents, State-Department of Human Services-Division of Alcohol & Drug Abuse, County Commissioners, a local Alcohol and Drug Prevention Coalition and other community leaders). Community Town Hall Meetings introduced the program to parents, local business, church, numerous civic organizations, law enforcement, other city government, and chamber of commerce. They were extremely supportive of the program. Many community members attended meetings and this helped create community support which will assist in continuing sustainability.

It was through the hard work of the Working Group, the Project Director and the Prevention Specialists that the communities became willing to be funding partners for the Southern Hills Resiliency and Leadership Initiative (SHRLI).

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Community Characteristics

The *Recycle for Life* program, managed by South Dakota CARES, has recycled previously owned durable medical equipment since the early 1960s. The program involves securing donated durable medical equipment from those who no longer need it, cleaning and refurbishing the equipment, and redistributing the equipment to South Dakota citizens in need. Durable medical equipment includes wheelchairs, walkers, crutches, and bathroom assistive devices such as toilet risers, grab bars, transfer benches, or commodes. Originally, the statewide program was limited to urban areas of South Dakota. The HRSA grant enabled the program to expand and serve the rural populations.

Services Offered

The *Recycle for Life* program provides better mobility, comfort or a sense of well being to people with disabilities in need of assistance obtaining durable medical equipment and assistive devices - giving them an opportunity to have a better life!

An individual in need is defined as someone who has exhausted all other avenues for financial support in their efforts to obtain medical equipment. They have fallen through the cracks of the traditional healthcare system and have no where else to turn. For individuals with disabilities, gaining access to costly medical equipment is difficult and sometimes impossible in the current health care delivery system. A person's ability to stay active is important for their mental and physical wellbeing. When a person cannot obtain much needed durable medical equipment, their life is often jeopardized and independence is severely compromised. The major obstacles facing people who need medical equipment include:

- People between the ages of 18 and 65 do not qualify for Medicare, and many do not qualify for Medicaid. For those that do qualify, Medicare does not cover the cost of bathroom equipment.
- Many of these people have either inadequate or no health insurance, leaving them with limited or no access to medical equipment. Often the insurers do not cover assistive devices such as shower chairs, toilet safety frames, grab bars, crutches, commodes, toilet risers, hand held showers or bathtub transfer benches because they are not deemed "medically necessary".
- Pre-existing condition exclusions in medical insurance policies often place limits on the number of pieces of medical equipment an insurer will provide and few provisions for maintenance, repair or replacement exist.
- The typical lengthy review and prior authorization process by which insurance systems provide equipment is also a barrier for people with little education.

People with disabilities living in rural areas may be able to receive basic health care from a local rural community health clinic, but medical equipment is not available at these health clinics and must be obtained in a larger city. This results in having to travel long distances to purchase the medical equipment which increases their difficulty and the cost to secure assistive devices from health care providers.

Innovative Solutions to Problems

- Labor costs: To process the equipment from the initial equipment donation to distribution to those in need is very labor intensive. Volunteers and teenagers with community service hours were used as much as possible.

- Travel costs: Delivering the equipment to the rural areas was very expensive. Every effort was made to send equipment with individuals or companies who were traveling that direction such as moving companies, furniture companies, state workers, all kinds of truckers.
- Lack of sustainable revenue: The program must rely on donations or grants as the people who need the equipment have already reached their financial limit before they call us. The donations received for using the equipment will never earn enough to sustain the program.

Lack of knowledge: Finding volunteers with basic knowledge concerning medical equipment was difficult. Because of the liability issues, it was a high risk to have equipment distributed by someone who did not understand the basics of geriatrics or physical therapy.

Medicare does not cover the cost of used medical equipment.

Results

The overall objective of the program was to serve as many rural people with disabilities as possible. The evaluation process was an ongoing process with monthly progress meetings held between Recycle For Life staff and the CEO. How to reach people in the rural areas was a constant discussion with various different activities tried until the best was discovered. At the end of each grant period, the final numbers served were compared to the year before the grant was received and the years after the grant was received to determine success.

Potential for Replication

Partnering with rural health clinics in the second grant year was crucial to the success of the program. The staff at the clinics had the knowledge to distribute the equipment, and the equipment was always ready for distribution in a location convenient to the rural population. This greatly reduced the cost and liability risk associated with the program. Two problems with the rural health clinics are that they do not want to accept dirty equipment which hindered the search for equipment to replenish inventory; and they did not want to ask for a donation for the equipment which is the main source of income for the program.

After the Grant

Yes, the program will be sustainable. The program has been downsized and only active in six locations at this time (not including the Rural Health Clinics). Challenges and corresponding changes to the program include:

- The program is labor intensive and expensive. Two main locations have been designated that have South Dakota CARES staff who can fit the program into their current daily work schedules. These locations also have the most potential for people who may need the equipment. In one of these locations, at least one person per day walks into the office for a piece of equipment. The other locations have volunteers distributing equipment approximately 20 times a year.
- The biggest challenge was to serve the rural areas as travel costs are high. Therefore, equipment is no longer delivered. People served must pick up the equipment at one of the 6 distribution centers.

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Community Characteristics

This project was proposed to serve a rural, medically underserved region in Southwest Virginia. In addition to a less than adequate number of doctors, the region also experiences poverty, drop-out, and unemployment levels above the State's averages. The four mountainous counties have no public transportation and the main interstate highway passes through just one of the counties. Other environmental factors such as substandard housing, coal dust, and unpaved roads increase health risks for low-income residents. Just as detrimental to the well-being of these residents is low health literacy, which is predictable among those living in poverty.

This project took on the challenge of improving the health of low-income families in the region through three efforts: to increase enrollment in the Comprehensive Health Investment Project (CHIP), to increase retention of physicians in the area by involving medical residents and nursing students in CHIP home visits, and to assist existing area physicians in gaining knowledge of community-based resources to help their patients.

Program planners also anticipated that not only could families be healthier if they were directed to resources to meet their needs, but physicians would feel more supported and less likely to leave the area due to burn-out.

Services Offered

The project expanded enrollment in an existing home visiting program, the Comprehensive Health Investment Project (CHIP) that serves the counties of Buchanan, Dickenson, Russell, and Washington in rural Southwest Virginia. CHIP seeks to improve health outcomes for children in low-income families by providing education on health and parenting issues to parents participating in the program. Participants receive case management services from a trained health outreach worker and a registered nurse partner. Health care providers in the area were provided information on community-based programs that could also help families improve their health. Additionally, area nursing and medical students were also involved in an effort to increase the number of health care providers in the region.

Innovative Solutions to Problems

For implementation of this project, the most significant problem was staff turn-over. One home visitor position, in the poorest county and the one in the most need, was filled three times during the grant period. There was also lack of continuity in staffing of the Project Coordinator's position. The project started with a Coordinator in place; she resigned. The position was filled and that individual resigned. The current Project Coordinator, Paula Adams, was hired over a year ago and continues to successfully serve in this capacity.

To ensure continued program effectiveness, the Project Director, Linda Midgett, directly addressed the effects of a lack of staffing continuity. The Project Director acted in the capacity of the Coordinator while the position was being filled. She was also able to train the new Coordinator so that this person gained a quick grasp of the project's goals and activities. The CHIP nurse was able to maintain continuity of services for families enrolled in the project in the absence of a home visitor. Enrolled families were also given contact information for the Coordinator and another program home visitor in case they were unable to reach the nurse.

Lack of physician participation was another problem that was evident after the first Rural Health Forum. This was disappointing. Invitations were mailed to all area physicians from Consortium member, Dr. McHaney. In addition, the program's workers visited area doctors that served CHIP families and invited them. Consortium members encouraged their medical acquaintances to attend. Preparation for the event was time consuming and involved arranging for a speaker, applying for the Continuing Medical Education credits for the doctors, inviting human service agencies and ensuring good participating from them, and obtaining the facility. The Consortium decided that the outcomes were not worth the efforts although the goal of linking human service and medical providers was still important. The decision was made to take the information to medical professionals via directly holding four mini forums at local hospitals

An additional problem was encountered in providing resource guides for health care providers. More than half-way through the process of updating information to enter into the on-line resource guides, www.wchelp.org, it was learned that 211, the state-wide information and referral number, was finalizing the Southwest Virginia guide. Not only could area doctors or their staff call this number, they could go to the 211 on-line guide. Rather than duplicate the work done by this project, the 211 information was also provided to health care providers at the mini-forums. Although the issue of an electronic resource guide was resolved, it was not the way we originally planned.

Results

The project's activities have all been incorporated into the existing CHIP program. CHIP has received General Assembly funding for the 2008-2009 program year and three small awards from local United Ways. The relationships that we established within the Consortium will be maintained as much as possible. Dr. McHaney left the area to go to Africa to serve as a medical missionary at the beginning of the summer. Dr. Stanczak is no longer at Edward VIA College of Osteopathic Medicine, but she is still willing to help promote our project's goals. The other members have been asked to serve on CHIP's advisory board. In doing this, the program can continue to involve nursing and/or medical students in home visits and work on strengthening the connections that have been made between health care providers and human service agencies.

Within the past month, the existing program took on a smaller program within People Incorporated that serves first- time pregnant teens. This has allowed us to keep our home visitors at full-time status. Once the babies are delivered, the family will be enrolled in CHIP. It is a good match, since home visitors have training in prenatal health.

Finally, soliciting funding from private and local funders is an important component in sustaining the program. Therefore, an application is being submitted to a local foundation for supplemental funding.

Potential for Replication

Yes. Our Rural Health Project reflects best practices including use of Bright Futures curriculum for children's anticipatory growth and development guidance for parents, following the American Academy of Pediatrics' recommendations for immunizations for children, and use of Ages and Stages for developmental screenings of children. Other best practice models that project activities facilitate include promoting retention of health care providers, assisting in attracting health care providers to the region, and helping improve the health of children in a rural areas.

After the Grant

This project would be extremely successful to implement if a community has the resources to provide a home visiting program involving health outreach workers who focus on improving the health of rural families. Typically, rural communities lack certain resources including the finances to directly address the needs of families that are isolated by geographic location, lack of educational attainment, disabilities, or other barriers that create poorer health outcomes for children. Health outreach workers play an important role in helping communities become healthier because they can provide important health, growth and development instruction to families. They can help families identify and access needed resources that might be available within the community.

Program planners also feel that efforts to connect rural doctors to community-based programs are also beneficial. This part of our project could be implemented by any human service program that was concerned about retention of doctors in their communities or improving health outcomes for residents. Community-based programs such as domestic violence services, supportive services from local health departments, Head Start, school-based initiatives and services, food banks, and emergency assistance programs are a few examples of resources available in many rural areas that can help families meet their needs. Meeting needs, other than medical, will open up time, energy, and sometimes money, which families can use to address health concerns. Doctors benefit from knowing that their patients can be directed to other services; therefore, they can feel less overwhelmed by their patients' non-medical needs.

The collaboration of medical and nursing students and/or resident doctors with a home visiting program could also be successful in rural communities. There would have to be some medical training program within traveling distance of the rural community to make this happen. It is harder to recruit and retain doctors in rural areas. Providing the opportunity for doctors- in-training to get to know local families and see their daily struggles is one way to help these future health care providers connect to the region. It could also be an educational experience for the doctors in the area, if no students are readily available to participate.

For example, Dr. McHaney, a Consortium member, accompanied the CHIP home visitor on a visit in Buchanan County. He felt that he had a better understanding of where some of his patients might be coming from after that. Dr. Ava Stanczak, D.O., a Consortium member who helped students from Edwards VIA College of Osteopathic Medicine attend CHIP home visits provided the following endorsement of this strategy:

"This proved to be one of the best outreach opportunities available for students, and surely one of the most popular "Early Clinical Experience" trips for them…I personally feel that this experience should be part of every medical student's education somewhere in the four years of school. The skills learned in the outstanding program can not be learned in a classroom or from a book."

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Community Characteristics

A 2003 needs assessment completed by the Wisconsin Alzheimer's Association Chapter Network identified an initiative with regard to its rural health service areas to "identify service needs, develop strategies to meet unmet needs and measure the impact of services, and implement strategies in a manner that is community-based and customer-driven." This partnership project was developed to impact dementia service and availability in a sixteen county area in northern Wisconsin. The counties specifically served by this project were: Ashland, Barron, Bayfield, Burnett, Florence, Forest, Iron, Langlade, Lincoln, Oneida, Polk, Price, Rusk, Sawyer, Vilas and Washburn.

Services Offered

Due to the generally rural and undeveloped nature of this service area, the environment poses risk to travel, social and service isolation, and a risk of wandering and death for persons with Alzheimer's disease or related dementias. There is also a higher percentage of persons age 65 and older living alone in this area than in the state as a whole.

Accessibility to medical and support services is hampered by stigma, geography, and availability. As a result, this project was developed to formulate a proactive rather than reactive approach to the identified number one health concern in Wisconsin: Alzheimer's disease.

The consortium had identified the overarching goal of serving persons affected by Alzheimer's disease and related dementias by building not only service capacity, but by also impacting service quality and availability on behalf of those most vulnerable group of Wisconsin's population. As a result, three primary activities of the project included: (1) dementia care network development, (2) rural educational outreach, and (3) diagnostic efficacy, clinic support & development.

Innovative Solutions to Problems

The Northern Area Health Education Center provided advisement and facilitation of technology-based educational, support, and communication services on behalf of the project. This organization also provided assistance and support for outreaching to diverse populations and introductions with the Native American, Hmong, and Hispanic communities on behalf of the project. The Northern Area Health Education Center brought to this project the most current information regarding planning programs for diverse populations. This contribution was extremely helpful during the initial planning and implementation for programs directed to Native American and Hmong groups during this project.

Results

Based on the project's activities and goals, overall success has been measured by seeing greater numbers of persons, including those of diverse populations, served both medically and socially by combined diagnostic clinic and community-based support networks.

Formal and informal evaluation of the project effectiveness occurred at specific intervals throughout the duration of the project. The purpose of this was not only to insure that persons are receiving services in the manner in which they feel best meets their needs and desires, but to also begin to establish program viability pending the conclusion of this grant.

All consortium partners were actively engages in measures aimed at measuring and continuously improving program effectiveness and quality. The Alzheimer's Association is a nationwide outcome-based organization, having developed a "Core Service Quality Evaluation Initiative" and "Leadership and Solutions Reporting" which were used as evaluation tools for this project

The Alzheimer's Association provides support for results qualitative and quantitative measurement and data analysis for all core service activities through the following standardized program evaluation tools.

Leadership and Solutions Reporting (LASRmetrics) is a measurement tool used to collect and report quantitatively the Association's overall capacity, performance and goal attainment. LASRmetrics accomplishes this through the measurement of key indicators of performance from each functional area.

The Core Services Quality Evaluation Initiative (CSQEI) is a systematic process for reviewing, measuring, and improving the Association's core program services. The goal of CSQEI is to quantify the impact of the Association's services on the families and professionals we serve and to determine ways to refine and improve service delivery.

Potential for Replication

This project is innovative and has the true potential to be transformational as it continues to involve the true community support for those affected by Alzheimer's disease and related dementias.

After the Grant

As a result of the positive outcomes of this project, the program will be sustainable to some extent after the grant funding has ended. The Alzheimer's Association has identified the true need to continue these outreach efforts in this project service area. As a result, 75% of the Alzheimer's Association staff allocated to this project will continue to pursing the ongoing work that was intimated via this project.

Community support has increased to a level that makes existing and new programs largely sustainable. Visibility and services have increased and the hope is that dementia care networks, availability of community education and support programs, and diagnostic clinic efficacy will remain an extremely important part of the support to those affected by dementia. As a result of the tremendous increase in visibility, collaboration, and successful outcomes, this project has the potential to be a best practice model. The Dementia Care Network development and maintenance model has really assisted in identifying community dementia-care needs as well as collaborating as a community to attempt to meet those needs.

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Community Characteristics

The organizations involved in the consortium included Ho-Chunk Nation Division of Health, Ho-Chunk Nation Division of Social Services, Ho-Chunk Nation Education Department, Black River Falls School District and Tomah School District. These partners were to provide insight to the vision of helping families/children obtain optimal wellness and fight overweight and obesity problems. The Ho-Chunk Nation Division of Health, Division of Social Services and the Education Department partners provided to this vision but also the necessary insight to the details of the everyday operations of this HYFP. The Division of Health includes clinical and community health services that involve the family unit. Much of those services involve community work – i.e. home visits which lend a helpful direction to the needs of the HYFP objectives. The Division of Social Services and the Education department includes programming and direction such as Youth Services that have objectives linked to grade point average and school associated needs. Their involvement was both direct and indirect by helping the HYFP develop a strong foundation of combining the HYFP health related goals with their education associated goals. We would meet at varied times throughout the year to discuss direction and guidance in obtaining goals. Most of our every other month meetings were between the Ho-Chunk Nation Division of Health and the Ho-Chunk Nation Division of Social Services. One of the main components for the success of our HYFP was the involvement of Youth Services (which is a component of the Ho-Chunk Nation Social Services).

Services Offered

The need for this project was to address the overweight/obesity problem for Native American children ages 6-18 through an after-school based program involving fitness, nutrition and wellness (self-esteem) components. By providing a program to combat against overweight and obesity prevention of diabetes occurs. Diabetes is prevalent in Native Americans. The service area of this project includes children living in the Jackson and Monroe Counties within the state of Wisconsin. Specific areas include the Black River Falls and the Tomah communities.

Innovative Solutions to Problems

In implementing this project we did encounter obstacles. One of the obstacles was the recruitment and the retention of staff Because of the three components of this program – Fitness, Nutrition and Wellness – it was necessary to hire qualified staff for each of these areas. We had in the original application a Pediatric Nutritionist and a Fitness Director as staff funded under this grant. We had a Guidance Counselor also working with this project but this position was funded under another grant. By the 2nd year of the Rural Health Outreach Grant (RHOG) the Guidance Counselor position's funding source, grant, had ended and the approval for funding from our RHOG to include the Guidance Counselor position was obtained. So at that time three positions were funded and directly associated with our RHOG-Ho-Chunk Youth Fitness Program (HYFP). Unfortunately, between the inception of this program and its end we were fully staffed for only one and half years in its duration. In total, we've had three Nutritionists, four Fitness Directors and two Guidance Counselors. During each of the gaps of time that the HYFP was not fully staffed, the Project Director, Linda Lowery- Diabetes/Cardiovascular Risk Reduction Coordinator, had filled in to maintain the project's course and provide the youth with program consistency. All of the Project Director's time associated with this project was identified in the grant as an

in-kind measure. However, lessons and activities provided were not at the same level as if someone hired specific to those positions would have provided.

Results

Total enrollment between 2006 and 2008 was 200 youth. The average class size was 40 per day. Although many participants either moved or grew out of the program results were positive for the youth that participated from the inception of this program through its final phase.

It is important to note that the criteria established for inclusion in this analysis was at minimum **50%** attendance of Ho-Chunk Youth Fitness Program (HYFP) sessions.

By April 30, 2008 75% of the program participants who either are at risk for overweight or are overweight will improve their Body Composition.

Black River Falls Youth Participant results:

- 67% of Black River Falls youth enrolled in HYFP from 2006 to 2008 decreased body fat
- 17% of Black River Falls youth enrolled in HYFP from 2006 to 2008 gained body fat
- 17% of Black River Falls youth enrolled in HYFP from 2006 to 2008 had no change in body fat
- Of the 17% of youth who gained body fat over this period of time, it appears that this gain may haw been attributed to "normal" developmental pubertal changes

Tomah Youth Participant results:

- 67% of Tomah youth enrolled in HYFP from 2006 to 2008 decreased fat percentage
- 33% of Tomah youth enrolled in HYFP from 2006 to 2008 decreased fat percentage
- Of the 33% who gained body fat, the largest amount was 2.6%, which could easily be attributed to developmental pubertal factors

Potential for Replication

I believe that this program can be successful in other rural settings if the community and family have ownership/wants to have a program exist and is willing to provide input and assistance for success. I also believe that this program can be successful in other rural settings if recruitment and retention of staff is fully developed and planned prior to implementation.

After the Grant

Lack of funding is the main reason why the HYFP as it is currently running will not be sustained. However. the implementation of health education (fitness, nutrition and wellness) will become major component in the Youth Services curriculum and goals. This component did not exist prior to HYFP. The Project Coordinator and the Youth Services Director and all of the Ho-Chunk Nation Youth Service staff (6 areas within 15± counties) have been meeting throughout the duration of the program. During the last year these meetings have been happening more often with a definite course for action. Because of this direct conversation of combining the goals of the Youth Services and the Ho-Chunk Youth Fitness Program (Division of Health) ownership of implementing the lessons and activities in the Youth Services curriculum has developed into a strong foundation. The Fitness/Wellness Director and the Pediatric Nutritionist will be providing sample lessons at all of the Youth Centers throughout the Ho-Chunk Nation in August 2008. Along with the sample lesson each center will receive a HYFP binder of lessons and

activities to choose from. The plan is to keep this implementation process as simple as possible so that scheduling is easily completed.

The existing Ho-Chunk Youth Fitness Program (HYFP) has received a No-Cost Extension through April 30, 2009. HYFP will continue its course in maintaining the goals achieved and striving for optimal wellness for all the youth and families in the program.

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