

THE OUTREACH SOURCEBOOK



OFFICE OF RURAL HEALTH POLICY

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RURAL HEALTH DEMONSTRATION PROJECTS

1999 to 2002

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In 1999, the Office of Rural Health Policy (ORHP) awarded 38 projects in 25 States and the Republic of Palau. These projects, scattered from Maine to California, across Hawaii and to the western Pacific, were designed to test and demonstrate innovative models for the delivery of primary medical care, prevention services, treatment, and health professions training and services. Each project funded in 1999 was required to develop a consortium of local and State agencies and organizations to ensure that the fullest range of health care resources would be brought to the communities where the programs were established and implemented.

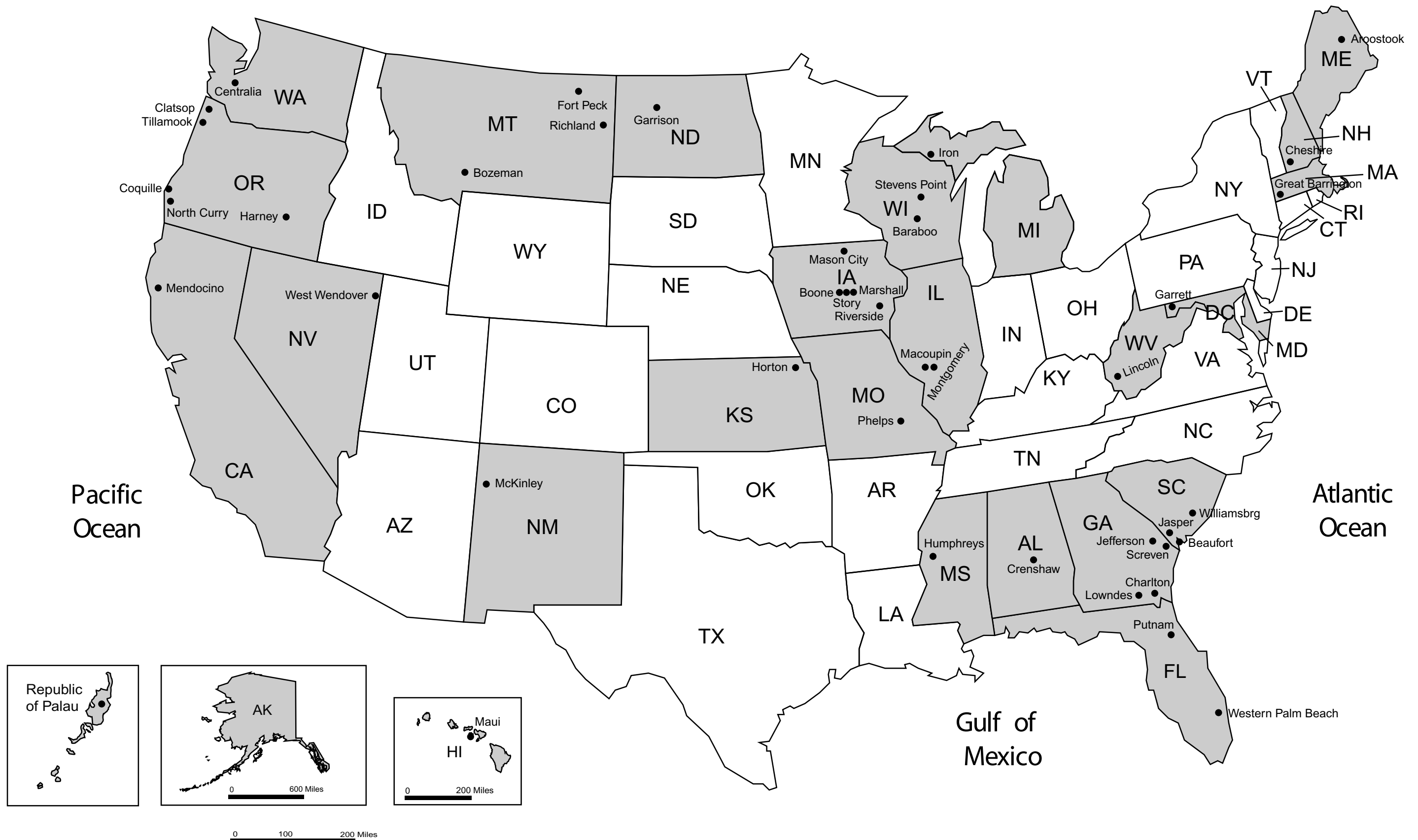
Every year, the health care system in the United States faces new and emerging challenges. Budget cuts, a decline in the number of health care providers, and in recent years, the focus on homeland security and defense have all meant a reduction in the availability of health resources and the means by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

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

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

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

Outreach Grants Awarded



MAP NOT TO SCALE

GLOSSARY OF FREQUENTLY USED TERMS

AIDS	Acquired Immunodeficiency Syndrome
AMSEA	Alaska Marine Safety Education Association
CPR	Cardiopulmonary Resuscitation
CVD	Cardiovascular Disease
HCI	Healthy Connections, Inc.
HDL	High-Density Lipoprotein
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
KRCC	Kentucky River Community Care
ORHP	Office of Rural Health Policy
RHOP	Rural Health Outreach Program
RMEP	Rural Medical Education Program
SCHIP	State Children's Health Insurance Program
STD	Sexually Transmitted Disease
SWAT	Student with Advocacy Training
UKCRH	University of Kentucky Center for Rural Health
YMCA	Young Men's Christian Association

Target Service Area

Crenshaw is a small, rural, Alabaman county with a large number of families and individuals living at or below the poverty level. Many parents are uneducated and uninsured and the overall status of the community is poor. Health care in Crenshaw County is not readily accessible to all residents, and many children do not receive adequate health and dental care.

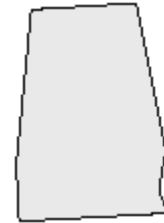
Network Objectives

The For Our Children project is a collaborative effort among Crenshaw Baptist Hospital, Baptist Health, Crenshaw County Board of Education, Crenshaw County Mental Health Center, and Crenshaw County Health Department to provide unmet health care needs to approximately 2,500 students attending Crenshaw County public schools. Before the grant, there was only one school nurse to provide services to the entire student body in all three local public schools.

Network Innovations and Results

Through the ORHP grant, each of the county's three public schools now has a full-time Registered Nurse and one dedicated social worker who divides her time among the schools. Nurses provide the students with health assessments, preventive care, medication administration, emergency care, vision/hearing/scoliosis screenings, head lice checks, monitoring for appropriate immunizations, health-related education, transportation, and appropriate referrals as needed. The social worker serves as a student advocate and mentor and works with school counselors and teachers to identify student needs and make appropriate referrals. The Crenshaw County Health and Mental Health Departments provide treatment, screenings, vaccines, and education through Federal and State programs to referred clients. They also keep network members abreast of new and existing programs, and actively participate in special school health events. Students also receive mental health screenings, and support group therapy is made available to children and parents.

ALABAMA



**FOR OUR CHILDREN
CRENSHAW COUNTY, AL**

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Thanks to the donation of a nebulizer from a local durable medical equipment company, the school can supply on-site breathing treatments to prevent acute asthma attacks and to reduce absenteeism due to asthma or asthma-related illnesses.

The project objective to provide improved health care services to 2,500 K–12 students met with 85 percent success. Increasing student access to social and mental health services achieved an 80 percent success rate. Improving parent health knowledge and participation in responding to their children’s needs received a 65 percent rate. Some delays in service provision were due to unforeseen and unavoidable project personnel and management changes. Overall, the project was very successful.

Lessons Learned

Sudden senior-level personnel turnover in consortium partner members can cause an unpredictable slow down in project implementation. Shortly after receiving the grant, hiring of For Our Children grant staff was put on hold while two consortium members were without top-level leaders. Once hired, the project nurses experienced tremendous utilization meaning that having one nurse double as the program coordinator proved manageable but challenging. When needed, the project had to hire a temporary nurse to fill in at one of the school campuses while the project coordinator was needed for other grant obligations.

Potential for Replication

Many rural school systems do not receive adequate State funding to provide sufficient nurses and social workers in their schools. Consequently, rural school students do not receive the medical attention they need. Often the only medical screenings rural school students do receive are from nurses and social workers. As such, the For Our Children project model would benefit many rural communities. Because sufficient staffing is needed to adequately provide screenings, nurse and social worker visits, health promotions and education, as well grant duties, the project coordinator duties should not be combined with school nurse duties.

After the Grant

The For Our Children project is currently in a 12-month extension period ending in August 2003. The project coordinator is actively completing State and foundation applications for more funding. Local government officials are assisting the project coordinator to identify other potential sources for continued funding.

PROJECT 2—PROJECT FOR RURAL ACCESS TO SUBSTANCE ABUSE TREATMENT

Target Service Area

Substance abuse is a serious challenge in the rural communities of Mendocino County, California. Relative to the State as a whole, Mendocino County residents experience higher levels of unemployment and family poverty—factors that are intertwined with substance abuse. The rugged rural nature of the region, which for decades has provided a natural cover for the clandestine growth and harvest of marijuana and the manufacture of methamphetamines, contributes to the magnitude of the substance abuse problems in Mendocino County. The resultant localized “cottage industry” of drug production has led to a culture of acceptance of drug use.

The target service area covered several locations throughout the county including Fort Bragg, the second largest city in the county; Laytonville, a community 60 miles northeast of Fort Bragg that includes the smaller communities of Leggett and Branscomb; Point Arena; and the south coast area of the county 20 miles south of Point Arena.

Network Objectives

The Mendocino County Department of Public Health’s Division of Alcohol and Other Drug Programs (AODP), in collaboration with two health clinics and several community-based organizations, developed the Program for Rural Access to Substance Abuse Treatment (PRASAT) to provide substance abuse treatment, primary medical care, childcare, and transportation assistance to residents in rural areas of the county. PRASAT had three goals: (1) to prevent and reduce substance abuse by providing treatment in selected rural areas to people who cannot afford to pay; (2) to improve client health by addressing medical problems associated with substance abuse among those unable to pay for their medical treatment; and (3) to improve clients’ economic standing by providing referrals to vocational preparation and job placement assistance.

Services provided through PRASAT included substance abuse treatment, medical care, family education groups, childcare, transportation vouchers, and healthy start services. Clients also attended groups on domestic violence, sexual abuse, anger management and education, and women’s empowerment.

CALIFORNIA



**PROJECT FOR RURAL ACCESS
TO SUBSTANCE ABUSE
TREATMENT
MENDOCINO COUNTY, CA**

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Network Innovations and Results

Clients were referred to alcohol and other drug (AOD) treatment by clinic physicians, emergency rooms, family members, public health nurses, social workers, probation and the courts, and through community outreach and self-referrals. Treatment began with a medical, chemical, psychological, and social assessment. Using the Development Treatment Model, counselors developed a comprehensive treatment plan that included goals and action steps geared toward the client's life and cultural issues and addiction. The provision of the medical examination and treatment at no cost to the client was one of the most innovative features of the program and was an effective incentive for clients to seek and begin substance abuse treatment. Each patient received an initial health assessment that addressed routine primary health care needs followed by treatment progress monitoring through chemical testing for substance abuse. Clients also received assistance in accessing medical benefits including the State-funded California Medical Service or Medi-Cal.

Past experience has illustrated that approximately 25 percent of clients in AOD treatment need childcare services and that the lack of childcare poses a significant barrier to a substance abuser's participation in treatment. PRASAT provided childcare through vouchers for licensed childcare facilities or through agreements with Healthy Start sites. Additionally, over 50 percent of clients in rural areas either cannot access or cannot afford transportation. The program budget included funds to provide 1,560 trips over the 3-year funding period to ameliorate the lack of transportation as a barrier to treatment.

Significant challenges to the program went unsolved. Despite efforts by consortium members to recruit a bilingual, Spanish-speaking substance abuse counselor at one site, no qualified applicant was found for the position. Data collection also posed a challenge. Because each site served a unique clientele in a unique community, it was difficult to standardize collection of program data. A revised monthly reporting format was scheduled to begin in July 2000; however, counselors were still not using it uniformly. During the no-cost extension year of the grant, PRASAT will work to solve these issues.

Lessons Learned

As PRASAT moves into its no-cost extension year, it has provided services to 369 individuals. If treatment continues at the current rate, approximately 450 individuals will have participated in substance abuse treatment during the project period—60 percent of the original objective. This level of service was reached despite the fact that one clinic site was only with the program for 1 year and treatment was not provided at two planned sites because of the lack of a qualified bilingual substance abuse counselor. PRASAT took a practical approach to balancing clients' needs with local resources. As a result, subcontractors were brought into the project to provide family education groups and other support, and a growing number of clients are participating in various groups. PRASAT also has been flexible in building and restructuring as staff and partners have joined or left the program leading to a greater understanding of clients' needs. These changes have resulted in a more cohesive partnership and a firm foundation for continuation of the project.

In 2000, California implemented a new law that mandates treatment rather than incarceration for first- and second-time drug and alcohol offenses. This significantly increased the number of people requiring treatment and many of them qualify for PRASAT due to low-income or lack of insurance coverage for AOD treatment. Therefore, since the program's inception, the project has experienced a shift in the source of client referrals. Currently, 70 percent of PRASAT's clients are mandated individuals referred through the County Probation Department. This has changed the tone of both group meetings and individual client management. Consequently, counselors have adapted treatment as necessary to meet the needs of the changing client.

Potential for Replication

PRASAT meets a need for substance abuse and medical treatment in isolated rural communities where treatment is not available, and could be replicated in other rural areas in the United States. An important component of replicating this program is the ability to network with community health centers so that health services can be offered along with substance abuse treatment. Engaging clients and helping them to better understand their addiction and how it affects their physical health is more effectively

achieved when the program partners and providers in the network understand the program model. Therefore, it is essential that the consortium establish protocols for the medical component of the program at the outset and that all partners are uniformly informed. Clinics that are new to providing substance abuse treatment services will need a standardized system to measure and report clients' treatment progress.

After the Grant

PRASAT will continue with a no-cost extension for 1 more year, ending in June 2003. During the final year, the consortium will work to develop strategies for continuing the program beyond the grant. Consortium partners will look for grant money and for methods to create a billing mechanism to serve the low-income substance abuse population who have no health insurance. Federally Qualified Health Centers (FQHC) can hire a licensed clinical social worker or clinical psychologist and bill for counseling services. Through the State Department of Alcohol and Drug Programs, a certified Drug Medi-Cal site can bill for assessment and outpatient treatment services. The consortium will evaluate the enrollment process and determine the value of having clinics in the network become certified for one or both of these options.

Target Service Area

Northeast Florida is a major producer of potatoes and cabbage and is the principal source of ornamental ferns used worldwide in the floral industry. An estimated 8,500 of the region's more than 15,000 migrant and season farm workers live or work in rural Putnam County (population 71,038) or on its immediate borders.

Network Objectives

Since 1997, the Putnam County Health Department and St. Vincent's hospital of Jacksonville have partnered to provide free primary and preventive health care to a population of 1,500 migrant and seasonal farm workers using St. Vincent's Mobile Health Unit (MHU) and hospital and health department staff.

While the Health Department/St. Vincent's outreach partnership was meeting the most immediate health care needs of the target population, many workers still needed specialized treatment and enhanced services not available on the MHU and a mechanism for managing individual health care was lacking. ORHP funding allowed the project to expand and create the Farmworker Case Management Across Borders (CAB) program to supplement the project's other services. New partners were brought in and the Rural Health Farmworker Coalition was formed by the original partners and the Family Medical and Dental Centers, the local Community Health Care Center, Medical Specialists of Hastings and St. Augustine, St. John's Eye Care, and the Alchemist Touch Dental Clinic.

The CAB project's overall objective for the migrant and seasonal worker populations was to increase their access to health services and specifically: (1) to increase management of their chronic diseases; (2) to increase completion of their treatment for communicable diseases; (3) to reduce their need for emergency dental care; and to increase their access to vision care. Transportation to and from care providers and health education on diabetes and nutrition were also provided.

Network Innovations and Results

The MHU set up in Crescent City 2 days per week with locations varying from fernery to fernery. In the Hastings area, where the patients are predominantly African American, Medical

FLORIDA



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Specialists of Hastings set up a Monday night late clinic and provided their physician and medical supplies. Outreach workers provided transportation to the night clinic and to specialty appointments as arranged by the providers. During the peak cabbage and potato season, MHU set up a second night clinic in the Hastings area to cover seasonal increase in patient health care needs. The night clinics often stayed open until midnight to accommodate all necessary service. Vision and dental services were also provided using ORHP funding and a second van was purchased to in order to address increased transportation needs due to the increase in the provision of services.

The program has been a tremendous success. The following numbers illustrate this success and represent the number of patient encounters by service provided: 553 dental encounters; 297 vision encounters; 373 chronic disease encounters; 585 communicable disease encounters; 1,702 family planning encounters; 28,069 adult health encounters; and 814 child health encounters. In March 2000, the Department of Health's Quality Improvement Review Committee deemed the CAB project a Model Program for Primary Care in the underserved populations. Although the initial goals were to increase vision and dental services and the availability of transportation, the use of comprehensive adult health care services exploded.

Lessons Learned

The nurses and outreach workers found that the demand for and the impact of family planning services in the Crescent City area was much greater than initially anticipated. As one nurse noted, the women served "finally have a feeling of empowerment."

The greatest challenge to the project was the provision of diabetes and nutrition education. Various formats were used, including group classes. The final solution was to train the outreach workers as lay health advisors so that they were able to provide basic education and to encourage simple lifestyle changes in ways that clients could relate to.

Potential for Replication

Most rural communities have similar problems with access to health care services for indigent populations. Because of its broad applicability, a model of this type is an ideal solution. It combines

the resources of multiple agencies that are committed to reducing the disparity in the underserved populations—the best way to solve any problem. The biggest advantage of this particular CAB project was its outreach workers. They were able to establish a level of trust among the farm worker population that broke down many barriers to service.

After the Grant

The Putnam County Health Department submitted two separate proposals to various foundations in an attempt to keep the program going in its current format. Unfortunately, these attempts were not successful. However, due to the success and strength of the consortium, the program will be sustained at a reduced level. The Coalition will continue to work together to meet the unique needs of this particular population and to search for funding sources to further expand the scope of services provided.

Target Service Area

The Glades area of Western Palm Beach, Florida, experiences a pervasive cycle of poverty among its mostly Haitian and African American migrant farm worker population. This cycle contributes to domestic problems including violence, child abuse and neglect, childhood depression, unhealthy living conditions, inadequate health care, low levels of parental involvement in child education, and a lack of positive relationship skills. These problems can lead to poor concentration in school and increased high school dropout rates among the youth, distracting students from obtaining an adequate education and thereby causing them to miss out on their one opportunity to escape this cycle of poverty.

Network Objectives

Healthy Connections West was designed to address this pervasive poverty cycle through the Healthy Connections West Consortium led by the Western Palm Beach County Mental Health Clinic (WPBCMHC) in collaboration with the Gladeview Elementary School, Palm Glades Rural Health, Big Brothers/Big Sisters (BB/BS), and the FAU Community Wellness Program. The project sought to provide mental health intervention services to targeted children and their families in order to achieve improved academic and social performance.

Network Innovations and Results

Therapists from WPBCMHC taught social skills to students, addressed behavior concerns of teachers, and designed interventions to help parents become more effective in their parenting. WPBCMHC also provided stress reduction workshops for teachers and administrators at Gladeview Elementary. Family advocates worked with parents to help them open and maintain communication with their children's teachers and school administrators. BB/BS mentors from the high school were recruited to work with students at the elementary school.

The Healthy Connections West project was able to reach over 130 families in the Glades area during the 3-year grant period. In 10 percent of the cases, a child who completed the program was referred again if the presenting problem reappeared or new problems developed. Ten percent of the participants moved away from the area or chose to terminate their program

FLORIDA



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participation before completion. In total, the project worked with 161 children (15 of whom were repeat clients) and 131 guardians—short of the targeted goal of 240 children.

Lessons Learned

The project's biggest challenge was replacing the pervasive attitude among the majority of parents that education is unimportant in their children's futures with the recognition that education is a means to escape the cycle of poverty. Parents' fear of losing their children also slowed implementation of the program, as did the prejudice among families regarding mental health services. Many families were so devoid of hope that they did not believe that poverty could be broken through education, or they believed that becoming a professional athlete was the solution simply because it had worked for a couple of local boys in the last 20 years. Parents tended to ignore the accomplishments of a large number of local citizens who had grown up in the Glades area and become successful professionals due to their pursuit of education. As a result, the program had to dedicate more time to getting parents to buy into the educational solution than originally planned, leaving more limited time to actually work with the children on improving their education.

Potential for Replication

In order for this project model to work well in other areas, it is essential to understand how much importance the target population gives to the problem and proposed solution rather than assume that they will simply adopt an objective outsider's point-of-view. If these views differ greatly, as in the case of this project, then more time will be needed to modify the proposed solutions or to modify the views of the target population.

After the Grant

During the 3-year grant period, several agencies and funding sources recognized the severity of the problems of poverty and their resultant impact on future generations in the Glades area and began taking steps to address them. Employees of WPBCMHC are working with some of these agencies to continue to provide solutions. The foundation laid during the grant period will allow the program to build upon its experience and to cooperate with

other area agencies that are more and more dedicated to ending the cycle of poverty that afflicts so many of the area's families.

Target Service Area

Lowndes County is located in extreme south central Georgia, 14 miles from the Florida State line. According to the 2000 census, the county population is 92,115. Approximately 62 percent of the residents are White, 34 percent are Black, and 2.7 percent are Hispanic.

Consistently over the last 10 years, cardiovascular disease, including heart disease and stroke, has accounted for almost half the deaths in Lowndes County. In 1996, African Americans in Lowndes County comprised 35 percent of the deaths from cardiovascular disease. And one in seven Lowndes County citizens who died from cardiovascular disease that year was under age 65.

Network Objectives

The Health for a Lifetime project was designed to combat cardiovascular disease in Lowndes County by addressing the modifiable risk factors, as described by the American Heart Association, in three populations: hourly wage workers, the African American faith community, and middle school children. The consortium partner members included representatives from eight local and national health care service providers, businesses, churches, schools, and universities.

Network Innovations and Results

The project adopted two implementation models as the framework for delivering wellness programs to the business and church communities. Both models are based on James Prochaska's behavior change model that states that behavior is changed in stages and these stages are quantifiable. The two models used were the Well Workplace model developed by the Wellness Councils of America, and the Health Promotion model developed by the Cooper Clinic of Aerobics Research.

Services provided to achieve project objectives included:

- Comprehensive wellness programs that targeted cardiovascular disease through health screening and education, motivation, and intervention programs conducted in 16 local businesses

GEORGIA



**HEALTH FOR A LIFETIME
LOWNDES COUNTY, GA**

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- Permanent church-based clinics that focused on cardiovascular disease prevention in 10 African American churches
- A school nurse clinic in a local middle school that served 700 students and provided education programs promoting healthy lifestyles

Although the original proposal strove to achieve a number or percentage of participants who would actually change their behavior to lower the risk of cardiovascular disease, this early estimation did not consider the amount of time needed to effect these changes. Therefore, outcome goals were modified during the project to reflect movement through the change process. At least 85 percent of the participants surveyed stated that participation in the wellness programs had influenced at least some positive behavior change or had positively affected their attitude toward adopting a healthy lifestyle. Additionally, the project met most of the process objectives dealing with providing health education programs at businesses, churches, and schools.

Lessons Learned

Initially, the most significant challenge to the project was gaining access to employees and overall company support of the program. By providing these services for free, the project was able to gain entry but, without senior level participation, little headway was made in shaping behavior change. The Well Workplace model provided the answer to this issue and the project had little problem implementing its programs after use of this model commenced.

The project's original goal was to quickly reduce the number of people with modifiable risk factors for cardiovascular disease. However, research shows that although comprehensive wellness programs can produce risk reduction in as little as 1 year, quantifiable behavior change takes 3 to 5 years. The project overcame this obstacle by obtaining additional funding sources to support the program and by contractually requiring participating companies and churches to take over operation of the program once the wellness program is established and the trained volunteer leaders are in place.

Potential for Replication

The Health for a Lifetime model is ideally suited for rural communities. In fact, larger communities may have greater

difficulties unifying community stakeholders around disease prevention strategies. To achieve successful outcomes, a community must be able to bring together community stakeholders; adequate funds to effect change must be present in the community; proper models must be thoroughly researched and utilized; and competent trained staff must have the proper background and understanding of behavior change and health promotion to facilitate the programs.

After the Grant

An additional \$820,000 in funding was secured to continue and expand the project from cardiovascular disease prevention to chronic disease prevention in local businesses and churches. Both the wellness program and a developing disease management program will soon be marketed to local businesses as a fee-for-service program. Additional grants and fee-for-service programs will continue to fund the initiative for the near future. Consortium partners are also seeking funding to expand the school initiative.

PROJECT 6—SCREVEN COUNTY HOSPITAL RURAL HEALTH OUTREACH PROGRAM

Target Service Area

Screven County is located in southeast Georgia, approximately 65 miles from Savannah. The county's population of 15,000 is split almost equally between Caucasians and African Americans. Sylvania, the county's largest municipality, has a population of 4,000. This rural area lags behind the rest of Georgia in key economic indicators. Low per capita income, high unemployment rates, and low education standards all contribute to poor health status.

Network Objectives

Screven County Hospital's SEARCH (Screven County Expanded Access for Rural Cardiovascular Help) project was developed to bring health care to rural communities in Screven County through the use of outreach health screenings. The screenings were designed to identify people at risk for cardiac, cerebral vascular, and diabetic health problems. Emergency room use indicated that many of the patients seen for these three health problems were first seen at an acute crisis stage of their disease. This project strove to identify these individuals at an earlier stage of disease, provide them with access to treatment, and to educate them on staying healthy.

The SEARCH project partner members include Screven County Hospital, the Screven County Health Department, Memorial Health University Medical Center, and three primary care physicians in Screven County.

Network Innovations and Results

Through its bright orange mobile van, the SEARCH program is able to offer 15 health screenings to the community per year. Screenings can provide free blood sugar testing for diabetes, cholesterol and lipid panels for cardiac problems, and blood pressure testing for cerebral vascular disease. Educational programs for the three focus diseases are sponsored three to four times per year. The program also offers financial assistance to indigent clients for medical expenses incurred in identifying and treating their cardiac, cerebral vascular, or diabetic disease.

GEORGIA



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Final results of the program's primary goal to reduce emergency room visits of patients being seen for the first time by 30 percent have not yet been calculated. In the program's first and second years, there was a 4 percent decrease in emergency room visits. The program surpassed its goal of screening 200 patients per year. The total number of clients registered in the program during the three years was 1,666. The goal of achieving a 50 percent African American patient participation rate was not met; 42 percent of the patients were African American. Of these, however, 82 percent were over age 30, fulfilling another goal of the program.

Lessons Learned

The most significant lesson learned was the difficulty of attracting the county's indigent and uninsured population to the screenings. Most participants were insured either through Medicare, Medicaid, or private insurance. The second lesson learned was that a prescription component must be in place to truly help decrease emergency room visits. Without the means to obtain necessary medications, screened patients will still go to the emergency room in a crisis situation.

Potential for Replication

In October 2000, the SEARCH program was used as a model by the Georgia Coastal Rural Health Cooperative (CRHC) to form a similar screening health assessment project. Based on the project's model, CRHC was awarded a \$227,920 grant from the State of Georgia to fund health screenings in the Cooperative's seven southeast rural counties. The success of CRHC indicates that the Screven County program can be replicated in other rural settings.

Screven County was fortunate enough to have the use of a mobile health van. However, having such a van should not be considered critical to the successful replication of this program model. As long as suitable locations such as churches, community halls, and other locations are available, the program can be easily replicated.

After the Grant

The outreach program will continue its operation of health screenings in the community after the end of the Rural Health funding period. Because Screven County is part of the above-mentioned CRHC, funds will be available from that source to conduct and promote the screenings. Additional funding from the State of Georgia Indigent Care Trust Fund grant to Screven County will help pay salaries for the project's case manager and staff.

Target Service Area

Charlton County is the southernmost county in Georgia. Nearly half of its land area is surrounded on three sides by Florida. The Okefenokee Swamp on the west and the St. Marys River on the south and east create a geographic, economic, and political isolation that adversely affects the delivery of health care and social services. Charlton County is medically underserved and ranks below the national and State averages in income, public services, education, and general well-being. Approximately 25 percent of the county population is on some form of public assistance.

Network Objectives

In response to the recognized health care need and a survey of citizens indicating that 76 percent would use a health clinic if available, the county built a small building to provide health and social services to one-third of county residents living in the southern region. A collaboration of agencies including the Health Department, the Department of Family and Children's Services, and the County Commissioners, joined forces to secure funding and guide the policy and management functions of the future clinic. Once the funds were secured, other health service agencies joined the consortium and commenced offering health care and social services at the clinic twice monthly. Subsequently, staff were hired and trained and eventually the St. George Clinic began full operation in March 2003.

Network Innovations and Results

The innovation of the St. George Clinic was that where there was nothing, now there is a clinic. The need for such a facility became apparent, a coalition formed to find funding, and finally the St. George Clinic was operational. It took 2 years to establish the full clinic from the time the building was built. Another strength was the unusually good cooperation among the coalition which has grown from three partners to seven, plus a slew of churches, public-minded citizens, doctors, and patients all working together so that the goal of providing quality, affordable, accessible health and social services to the St. George area was met.

The two private physicians who share office space and exam rooms in the clinic worked well together. Although the number of staff serving at the clinic hit a plateau after the first year, client

GEORGIA



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satisfaction remained high. Better prenatal care, reduced school absences, better blood pressure and diabetes management, and more public awareness of good health practices were all successes of the St. George Clinic. The Patient Assistance Program, which has 70 clients, saves patients an average of \$250 a month on prescription drugs.

Lessons Learned

It is not enough to build the building; there must be resources to establish a clinic. Despite the 2 years it took to evolve the combination of people, agencies, and money to set up the clinic, operation has gone smoothly. The minor physical problems of efficiently utilizing a general purpose building as a clinic, sharing office space among different agencies, using water that is high in iron and sulfur, and surviving a forest fire that burned the backyard were challenges that the clinic staff soon learned were all part of everyday life.

Potential for Replication

The St. George Clinic model could easily be adapted to other rural areas and underserved communities that can buy in to the need/solution paradigm. The most important ingredient is the people. Both political and administrative leaders who plan, promote, and implement the program, as well as the onsite personnel who provide the day-to-day services are critical to success. Gaining the trust of the client target group and orienting outside providers who come into the community are also essential since nothing works until the clients walk in the door.

After the Grant

All the current clinic activities will continue after the initial 3-year grant period. Due to full operational start-up almost 6 months after the grant period began, efficient operations, and cost controls, the clinic has enough money to continue operations for another year. After that, new grants will have to be obtained. State-funded agencies are currently under severe budget pressure and the county is unable to increase support monies. Particular provisions of future grants will likely affect specific clinic programs, but the major objectives of providing health care and social services to an underserved community will continue to be met.

Target Service Area

Jefferson County is a large rural region encompassing 527.7 square miles in the eastern part of central Georgia. None of the county's three major municipalities—Louisville, Wadley, and Wrens—has more than 2,506 residents. The majority of the county's estimated 17,680 residents live scattered in unincorporated areas or townships of less than 400 people.

Teen pregnancy is one of the most serious and devastating issues facing Jefferson County. Although Georgia's teen pregnancy rates are some of the highest in the Nation, Jefferson County continues to maintain rates higher than the State average. Jefferson County also has the dubious distinction of being in the bottom 25 counties in the State regarding serious social and economic factors: 27.8 percent of the population live below poverty, 50.3 percent do not finish high school, and 82 percent of the students in P-12 qualify for free or reduced lunches. In 1996, Jefferson County's 10-19 year old residents had 83 pregnancies. Almost one third were repeat pregnancies. Furthermore, although African Americans comprise approximately 66 percent of the adolescent population, they represent 79.5 percent of all teen pregnancies.

Network Objectives

Teen pregnancy plays a major role in creating Jefferson County's economic and social problems. According to the 1997 Georgia Kids Count supplement, children of teen mothers are 50 percent more likely to have low birth weight; require 20 percent more medical care; are two to three times more likely to run away; are two to three times more likely to be abused and neglected; and approximately 5 percent of them end up in foster care each year. Furthermore, daughters of teen mothers are 83 percent more likely to become teen mothers themselves and are twice as likely to drop out of school.

To address this serious issue and to establish an effective mechanism for proactive pregnancy prevention and health promotion outreach for the county's rural adolescents, a network of key local organizations combined forces to design and implement the Warrior Wellness Center. To reach the targeted population, the network placed a nurse and other outreach service providers in Jefferson County High School where they could consistently

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provide and facilitate access to necessary health promotion and prevention services for adolescents.

Consortium partner members included the Jefferson County Board of Education, Jefferson County Board of Health, Hospital Authority of Jefferson County, Ogeechee Behavioral Health Services, Jefferson County Hospital, and the Jefferson County Family Connection.

Network Innovations and Results

Placing the Warrior Wellness Center in the high school afforded close contact with the student population. During the 3-year grant period, there were 22,260 visits to the clinic. The school dropout rate went from 7 to 4.6 percent during the grant period and the school completion rate went from 73.6 to 77.9 percent. These results are attributed to the program's monitoring of school attendance and the nurses ensuring that many students stayed at school.

The consortium is now awaiting official word on approval of a Safe School, Healthy Students Federal grant proposal for over \$1 million per year to establish a strong support system within the school and community to fight drug and substance abuse.

Lessons Learned

The most significant lesson learned was how profoundly the Warrior Wellness Center positively impacted the school dropout and attendance rates. The Center became an integral component of checks and balances on student performance.

The Wellness Center had to address a host of misconceptions and myths that particularly influence the adolescent mind set: it won't happen to me, ignoring the problem will make it go away, adolescents are almost always healthy. The Center staff found that even minimal encouragement and guidance could help adolescents overcome the barriers that keep them from obtaining education, support services, and preventive health care for themselves and their children.

Potential for Replication

The Warrior Wellness Center model can be very valuable to other rural areas. Perhaps the most important feature for replication was the collaborative setup and coordination by the local health

department. As in most rural school systems, the Wellness Center project director wore many hats and did not have the time or expertise to establish medical protocols and procedures for the clinic. The health department hired the nurses, developed the protocols, monitored the clinic programs, and contracted with the school system for the nurses' services, creating a win-win situation for both the school system and the health department.

After the Grant

The Warrior Wellness Center services will continue through the use of State nursing funds (tobacco money settlement that was not available when the project began) and grant funds through a Safe Schools, Healthy Students Initiative proposal. The entire school system and the community have come to expect these clinics in the schools. The Warrior Wellness Center and its contracting system with the health department have become models in the State of Georgia as other systems begin developing their clinics using "tobacco money."

Target Service Area

The remoteness that helps maintain Maui’s lush intrinsic beauty is also the primary barrier to health care access for many of its residents. Several remote areas of Maui lack sufficient health service providers. These include the communities of Han, Ke’anae, and Kahakuloa Village, which are also predominantly Native Hawaiian and consequently at increased risk of having poor socioeconomic status in comparison to other ethnic communities and groups in Hawaii. The geographic remoteness of these communities also means that health service providers are a 1- to 2-hour commute away. Although there is a primary health care center in Hana, a designated Health Professional Shortage Area, the facility experiences its own difficulties in delivering medical services due to physician and nurse recruitment and retention issues.

Native Hawaiians, who represent the majority population of the area, primarily share Maui with Pacific Islanders and Filipinos. Ethnicity and culture affect lifestyle choices and health-seeking behaviors of these ethnic groups, particularly among women. Additionally, a revival of Native Hawaiian indigenous culture has encouraged Hawaiians to seek traditional methods of spiritual cleansing, physical healing, eating, and exercising. Unfortunately, traditional Hawaiian healing practices are still perceived as incompatible with the Western system of medicine. Studies of population-based approaches to health particularly in native and ethnic populations, show that the burden of disease is shouldered more heavily by the poor and racial minorities who are more likely to be at the lower end of the income and social hierarchy, and more likely to have lower educational levels, higher unemployment rates, poor diets, high-risk lifestyles, and inadequate social support networks. The convergence of these factors puts the population of Maui at increased risk for chronic disease morbidity and mortality.

Network Objectives

Hui No Ke Ola Pono (Hui) was the lead agency in a consortium of six area health service providers, agencies, and universities that created and implemented the Kokua Program. The program got its name from the Hawaiian value “kokua” which means to help each other. The project’s primary objectives were to reach and educate local women on breast and cervical cancer, and provide health

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screenings using culturally appropriate methods that reduce fear and anxiety. The project's primary goals were to provide the local uninsured female population with breast and cervical education, clinical breast exams, pelvic exams, Pap tests, mammogram screening, appropriate followup for abnormal results, case management, and transportation to clients.

Due to increased health risks associated with particular ethnic groups, glucose, cholesterol, and blood pressure screenings also were provided along with clinical assessments in order to address diabetes, heart disease, and hypertension.

Network Innovations and Results

Networking with community leaders to identify and establish gatekeepers who could help overcome language and cultural barriers was essential to reaching minority populations, particularly among Filipino women. These gatekeeper escorts helped schedule breast and cervical presentations in clients' homes or churches, aided in scheduling health-screening appointments, and provided translation services that bridged cultural and linguistic gaps and replaced anxiety with comfort. Another technique employed by the project to bridge cultural differences was providing health education in a "talk-story" manner that demystified Western clinical practices. In Hawaii, "talk-story" is an important social convention for sharing information informally, finding common ground, and getting to know each other. Using this method, the project staff were able to develop close relationships with the Native Hawaiian target group and gain their trust.

Outreach workers helped clients complete registration forms for screenings, eliminating the need for clients to stand in registration lines at screening facilities. The project established a Resource Center to provide health educational materials including pamphlets, brochures, and videos on breast and cervical cancer. Project staff also provided transportation and helped with child care while clients attended health screening appointments.

The project was able to buy a van and remove geographic barriers by providing a client transportation system. Other results include diagnosing three women in the service area with cervical cancer and ensuring that they received proper treatment; diagnosing another three clients—through glucose screening—with

diabetes and placing them on medication; and, through blood pressure screening, referring three women to physicians for further care and diagnosing two women with hypertension and placing them on medication. A client satisfaction survey indicated that clients felt the program was valuable and they wished to continue using the services.

Lessons Learned

The biggest problems associated with the Kokua Program were the late cancellations and no-shows for screening appointments, particularly when they involved transportation for the 2-hour ride to Hana. As a solution, staff implemented a reminder system where women were called and reminded of their appointments. They also established a protocol that defined the number of no-shows, cancellations, and outreach attempts before a final letter was sent identifying a response date. If the client still did not respond, she was dropped from the program.

Potential for Replication

Because the Kokua Program uses as its basis the Hawaiian value of helping each other, the project model is applicable to any other rural community with or without cultural barriers. However, in culturally diverse settings, using the project model component of scheduling a group of four or five family members or friends for health screenings eliminates fear and embarrassment and helps create a natural support group for clients. Also in areas with language barrier issues, it is recommended that the project pay interpreters or hire outreach workers with language skills instead of relying on the availability of volunteer translators in order to increase client time scheduling possibilities.

After the Grant

The Kokua Program served as a basis for the Breast and Cervical Control Program for Maui County grant application. The network members will continue to provide project activities and two new partners will be added to expand the clinical breast exam, pelvic exam, and Pap test screening appointments. The program has already received several grants that will ensure that uninsured and underinsured women in the target area will continue to receive the full spectrum of breast and cervical health services as well as

PROJECT 9

monitoring of risks related to glucose, cholesterol, and blood pressure levels.

PROJECT 10—EXPANSION OF RURAL DENTAL HEALTH CARE SERVICES IN MACOUPIN AND MONTGOMERY COUNTIES, ILLINOIS

Target Service Area

In 1998, Macoupin and Montgomery Counties in west central Illinois were designated as Dental Health Professional Shortage Areas. That same year, the Macoupin County Public Health Department (MCPHD) in cooperation with the Montgomery County Health Department, the Montgomery County Housing Authority, the Illinois Dental Society, and the Southern Illinois University School of Dental Medicine formed a coalition to establish the Macoupin and Montgomery County (M&M) Dental Clinic. Illinois Medicaid data showed that there were an estimated 11,000 to 13,000 Medicaid participants within a 35-mile radius of the M&M Dental Clinic located in Litchfield, Illinois. At the time, none of the area's 26 dentists actively participated in the Medicaid program.

Network Objectives

When it first opened, the M&M Dental Clinic was only able to operate 7 hours a day, 1 day per week and the waiting period for preventative and restorative dental services was 2 months. The ORHP grant allowed the coalition to step up development of the clinic's comprehensive oral health services and to implement the project's four primary objectives: (1) to buy equipment and expand the clinic to full-time hours of operation, (2) to develop the clinic as a satellite teaching site for the Southern Illinois University (SIU) School of Dental Medicine, (3) to establish a Kidcare out-station program providing assistance to families newly eligible for Medicaid services under the new Title XIX Federal Program, and (4) to offer oral health education to children in primary grades at all local schools.

Network Innovations and Results

The project has been an enormous success in meeting or surpassing all four of its primary goals. Additionally, the clinic strove to serve 1,500 M&M Dental Clinic patients annually, but by the third year, 2,384 participants received 5,490 procedures. Beyond expanding all services to achieve its baseline objectives, the clinic's oral health education program for children reached 4,821 students in 14 school districts and expanded to include a community-wide Baby Bottle Tooth Decay Program. The clinic also implemented a home visit program to families served by

ILLINOIS



EXPANSION OF RURAL DENTAL HEALTH CARE SERVICES IN MACOUPIN AND MONTGOMERY COUNTIES, ILLINOIS MACOUPIN AND MONTGOMERY COUNTIES, IL

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private wells in order to monitor fluoridation status and provide fluoride use counseling.

Lessons Learned

Due to the success of the clinic and its ability to develop full-time comprehensive services—including full dentures, root canals, and oral surgery—there was substantially greater expenditure in contractual dentist costs, dental supplies, and office supplies than anticipated. The coalition learned that dental care is an issue that many community leaders were willing to support.

Potential for Replication

Local community willingness to provide dental care services in rural areas is an untapped resource that is often overlooked. With the right leadership, perseverance, and motivation, the M&M Dental Health Clinic model can be undertaken in any community in the country.

After the Grant

The clinic plans to continue providing all its primary services and to expand its relationship with the SIU Dental School to include a Dental Senior Student Externship contract with supervision from the M&M Dental Clinic staff as ad-hoc Professor Supervisors. Due to an increase in consumer demand, the clinic also will expand its Kidcare application processing. Beyond that, the partner members will continue to grow the M&M Dental Clinic's operations in order to reach the new goal of serving 2,500 patients per year.

Target Service Area

The Healthy Kids Clinic (HKC) project provided a school-based health clinic in 13 rural schools in three Iowa school districts—Highland, Washington, and Mid-Prairie. Area statistics from 2000 reported that there were 821 children living below poverty level; all were under age 19. In an attempt to identify these children, a Health Survey was sent home from every school in the target area. School personnel also helped identify families in need of health services.

Network Objectives

A consortium of three local school districts, two local health departments, one nonprofit health agency, and all local area physicians and dental providers participated in implementing the Healthy Kids Clinics in schools throughout the target area. The goal was to provide health and dental services to students in the schools regardless of income or insurance status. However, children living in poverty, without dental or medical insurance, and who were not obtaining regular routine dental or medical care were especially targeted.

Network Innovations and Results

Using the project team of one nurse practitioner, a social worker, and a dental hygienist, onsite school clinics provided physical exams, dental screenings, vision and hearing screenings when appropriate, immunizations when indicated, nutritional education, health and safety education, and a screening to determine the need for additional resources that may include financial assistance for further medical and dental care; food, shelter, and clothing needs; mental health or family counseling needs; weight reduction instruction; and assistance in filling out insurance applications. The nurse practitioner interfaced with local health care providers, the dental hygienist worked with local dental providers, and the social worker provided the majority of outreach services and coordinated referrals.

The overall project goal was to ensure that every child living in poverty in the target service area had access to health and dental services. Of the area's 821 children under the age of 19 living in poverty, 584 (71 percent) of them received one or more services in the project's clinics. This represents a stellar project outcome.

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The Healthy Kids Clinics served a total of 584 children. From March 2000 to March 2002, there were 300 immunizations, 421 children referred for additional dental services, and 25 emergent referrals for dental care.

Lessons Learned

Communication with school staff was one challenge that presented itself. The school staff who were most involved with identifying and referring children for project services were not brought into the conversations prior to the program's implementation. Buy-in from school administrative staff does not guarantee that the "line staff," or those implementing the program will be equally supportive. Future project efforts may include a line staff representative in program design since forming a consortium and hoping that the people will participate after funding receipt is no guarantee of success.

One other school issue that was not completely resolved was space. In the Washington School District, space was limited due to large enrollments and lack of building space. The project had to move several clinics from schools to the Public Health Office to resolve issues over space. School staff and the local mini-bus provided creative transportation solutions to help students access these off-site clinics.

Potential for Replication

Similar projects could work very well in other rural settings as long as collaboration exists prior to the receipt of funding. Schools are the best connection to all youth and the easiest place to ensure that health care needs of all students are met.

Project model areas that may pose challenges include:

- (1) community collaboration—turf issues may intimidate some providers who fear that they will lose clients to the program;
- (2) on-site space in schools and cooperation with school staff need to be established in advance of project implementation;
- (3) transportation for clients to appointments must be considered in project design;
- (4) knowledge of funding assistance for medical and dental treatments, and of the health care system, payment options, regulations, and insurance coverage are essential to project success.

After the Grant

The Healthy Kids Clinic model will continue on a more limited basis in the school districts based on the project's final outcome evaluation. Current conversations between HKC, the local hospital, and outlying clinics indicate that collaboration with these existing providers may be implemented. Preliminary discussions are currently underway to determine the feasibility of a satellite clinic site using the HKC model in an area south of Washington County. Other grant funds and aggressive billing of Title XIX will also aid in the sustainability of the Healthy Kids Clinics in Washington County.

PROJECT 12—MAXIMIZING INDEPENDENCE OF RURAL ELDERLY THROUGH USE OF ASSISTIVE TECHNOLOGY AND ACCESS TO HEALTH CARE SERVICES

Target Service Area

Iowa's population is both highly rural and disproportionately elderly compared with the country as a whole. In Iowa, 39 percent of the population reside in rural areas compared with the national average of 27 percent. According to the 2000 Census, the State of Iowa ranks second in the percentage of residents over age 85 and fourth in those over 65. Access and transportation to health care and accidental injury prevention are major health care needs among the rural elderly. The disproportionate number of elderly rural Iowans requires a new approach to providing health care and to maintaining these residents in their homes for as long as possible.

Network Objectives

Five organizations—Mercy Medical Center—North Iowa (MMC-NI), Easter Seals of Iowa, Rockwell Community Nursing Home, Pony Express Riders of Iowa, and the Iowa Program for Assistive Living Technology—joined forces to address the health care needs of the aging rural Iowa population and formed the Maximizing Independence of Rural Elderly through Use of Assistive Technology and Access to Health Care Services project. The project uses a three-prong approach to assist the elderly across 14 counties in north central Iowa:

- (1) Provide assistive technologies and home modifications to help disabled, low-income, elderly residents remain in their homes—rural elderly with no health care coverage receive free equipment and installation, those with defective equipment receive in-home repairs and refurbishing through a mobile van/shop.
- (2) Increase access to primary health care and rehabilitative therapies—the project developed a multiprovider, multiservice clinic in Rockwell to ensure local access to a physician, and a physical, occupational, and speech therapist.

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**MAXIMIZING INDEPENDENCE OF
RURAL ELDERLY THROUGH
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- (3) Educate rural elderly and health care workers—elderly receive information about assistive technology and help identifying potential hazards in their homes; health care workers are taught to perform assistive technology assessment and to refer persons needing this equipment.

Network Innovations and Results

The partnership itself is probably the project's most innovative component. Through this consortium, each partner has been able to connect with new client populations and provide valuable, new health care services that they would not have been able to do alone. Through health fairs, direct mailings, presentations, and media coverage, MMC-NI conducts an extensive community education program about assistive technologies for the elderly including information about low-cost equipment available in local stores. Easter Seals developed several types of new, low-cost equipment for the project including walker bags and recyclable steel ramps. Engineers in their Ingenuity Network refurbished old bus lifts into porch lifts for areas where ramps cannot provide the appropriate slope. The Rockwell Clinic provides unusual services for a rural health clinic including rehabilitative services.

Lessons Learned

Traditional emphasis on self-reliance and independence in rural culture has made many rural elderly reluctant to seek assistive technologies. Consequently, project staff have had to devote far more time to ongoing publicity and marketing of these technologies than originally planned. The staff learned that direct mailings of project brochures produced far fewer referrals compared with health presentations and media articles. Despite the “make-do or make-do-without” mentality of the depression era generation, the project—short of reaching its targeted 680 home modifications—has provided 535 services to 193 families. These include 10 ramp and 60 handrails/grab-bar installations, 68 medical equipment loans, 81 assistive technologies, 142 assessments, 154 followup visits, and 20 other miscellaneous services.

Despite its limited hours of operation and the necessity of sharing staff with other Mercy clinics, the Rockwell Clinic has provided health care services to 2,064 patients visits including 1,369 physician/mid-level provider visits, 500 ancillary visits, and 195 physical therapy visits. The average number of patient visits per month is 98, significantly more than the original monthly goal.

The education program goal of reaching 300 health professionals and community members at 20 sites was greatly exceeded. Using a variety of methods, over 2,000 health professionals and 45 community sites received health education. Despite the project's success in reaching so many rural citizens and professionals, consortium members agree that not enough community members or local health care and human service providers are aware of the project's services. As a result, project staff are considering moving the clearinghouse from the small Rockwell Clinic to a more visible and central location within MMC-NI.

Potential for Replication

Similar collaborative assistive technology projects could succeed in other rural settings with high elderly populations. However, until there is public or private reimbursement for providing in-home assistive technologies to the elderly, it will be difficult to support these services without outside funding. Based on the difficulties the project experienced in creating community awareness and reaching elderly residents in need of services, prospective consortiums should plan and budget for extensive community outreach, education, and marketing activities. Also, if local planners are considering offering rehabilitation services in a new clinic, they should closely review locations of existing services. If such specialty therapies are available less than 30 miles away, there may be only limited use of the new site.

After the Grant

Although the Rockwell Clinic will continue to receive a small amount of Federal support through the extended funding period, it is expected to be financially solvent without outside contributions after the grant period has ended. The future of the assistive

technology/home modification program is less certain. Consortium members are working with local health and human services agencies and foundations to explore alternative resources to maintain some level of assistive technology support. Regardless of their success in raising additional funds for the project, consortium partners have agreed to maintain their relationships and to direct regional requests for assistive technologies to an MMC-NI clearinghouse, which will forward appropriate responses to Easter Seals. When possible, Easter Seals will respond to these requests through their partnerships with the Iowa Program for Assistive Technology and the Pony Express. Easter Seals is also committed to sustaining part of the project by teaching north Iowa home care professionals simple strategies using low-cost technologies that will help their patients to remain living in their homes.

Target Service Area

Boone, Marshall, and Story Counties are located in a rural region of central Iowa. Specific demographic groups within this geographical area with a high level of need for support include pregnant teens and teen mothers, Hispanic immigrants with limited English and family/social support, women with mental health or substance abuse issues, and students at Iowa State University. The target population was all pregnant or postpartum women residing in the tri-county area.

Network Objectives

The Tri-County Health Connections project was a community-based initiative to enhance prevention and early intervention services for pregnant and postpartum women, their infants, and families living in rural central Iowa. The Tri-County Health Connections project had 18 partner members including hospitals, home health, social service extension, education, and clinical services agencies. Through the joint efforts of all network partners, the project sought to fill in significant gaps in health care services particularly in regard to early interventions for at-risk families and pregnant women receiving late prenatal care. At the beginning of the project, infant mortality rates and the percentage of birth to teens in two of the three project counties were higher than State and national averages.

The direct service component of the program model featured adding provider staff time to established programs in order to: (1) promote access to prenatal care; (2) offer risk assessment to pregnant women at all initial prenatal care visits; (3) provide prenatal and postpartum home visiting services delivered by nurses, family development specialists, nutrition educators, and other specialists to a greater percentage of high-risk families; and (4) to increase access to services for the Hispanic population who have limited English skills by offering interpretation services from a pool of trained bilingual/bicultural community members. The program sought to reduce the disparity between Hispanic and non-Hispanic women in their rates of initiating prenatal care during the first trimester of pregnancy. The number of Hispanic births in the region has tripled in the last 5 years and now accounts for nearly 20 percent of all births in one county in the project area.

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Methamphetamine use also has increased within the target population. The project sought to update service providers' knowledge and awareness of this growing epidemic and its potential effect on future populations.

Network Innovations and Results

As in many rural areas, health care resources and providers in the tri-county region are in short supply. The best way to maximize benefits to clients was to build on the infrastructure that was already in place. The project's innovative multi-sector approach involved nearly every single prenatal care provider in the tri-county area in offering the projects' risk screening assessment to pregnant women during the initial prenatal care visit. Another innovation of this approach was sharing resources not only between several agencies, but also among three counties. Budgets and expenditures also were reviewed on a regular basis. On several occasions, agencies agreed to transfer some of their unspent funds to another agency to meet a need. Other innovative aspects of the project were the ability and flexibility to use project funds for emergency client needs and the freedom to serve any family in need without having to hassle them with eligibility criteria, income verification, and other barriers to service.

The project sought to reach at least 70 percent of women giving birth each year to offer either prenatal or postpartum risk screening and other health services. At the start of the project, approximately 50 percent of women were reached in two of the three counties and there was no systematic prenatal screening offered in the third county. By the third year of the project, across all three counties, approximately 73 percent of pregnant women were offered a screening and health services.

Lessons Learned

Geographic distance posed a challenge to communication and collaborative planning that fairly represented the tri-county network members. Progress meetings were held in Story County, the most centrally located county in the region. Consequently, agencies from that county were always well represented at meetings and issues from that county—often not directly related to project business—tended to dominate meetings. As a solution, project partners opted to have their own separate quarterly meetings for local project subcontractors and to vary the location of meetings in order to share the travel burden.

The project strove to achieve consistency, timeliness, and completeness in reporting. However, establishing a data collection system that would work and fit into pre-existing data gathering systems and capacities was time consuming and difficult. As a result, the project simplified the data-collection process in order to place fewer administrative demands on service providers. Also, the project had 10 official objectives that were consistent with the overall mission of the participant agencies and the broader goal of the program—to improve perinatal health. However, tracking 10 objectives became cumbersome. In the future, it would be better to keep objectives simple, easy to measure, and few in number.

Potential for Replication

The model used in the Tri-County Health Connections Project can be very successful in rural communities. It is important to have an established infrastructure in place with protocols related to home visitations, as a home visit service is neither simple nor inexpensive to start up. The many upfront and ongoing costs associated with home visits include training for home visitors, transportation and mileage, and staff time. Home visits tend to last longer than the usual 10-minute office visit. Along with travel time, staff time needed to complete home visits can be significant. However, given the high level of client satisfaction and positive outcomes associated with home visiting, this approach is particularly successful. Another challenge to this model is working with so many agencies. An open, participatory management style and consistent communication are needed to ensure positive collaboration. All partners need to feel invested in the project and must be able to see a clear benefit to their agency in order to commit staff time and resources to a collaborative initiative.

After the Grant

Activities supported after the grant will be limited. Empowerment funds will be applied to continue home visitation programs in all three counties. Marshall County is applying for a Rural Health Outreach grant to expand service to include immunizations, well child programs, and to lead hazard awareness and prevention programs. Consortium members will continue to seek out appropriate grants that will enable all project activities to continue.

Target Service Area

Northeast rural Kansas has a high percentage of elderly residents, a high percentage of mobility issues among its residents, and for rural Kansas, a high proportion of minorities. The area has some of the State's poorest health status indicators and is economically depressed.

Network Objectives

The Northeast Kansas Center for Health & Wellness (NEKCHW), working with local communities and their steering committees, designed the Rural Health Outreach project to develop and operate a network of Health and Wellness Centers located strategically in communities that are served by NEKCHW in order to provide comprehensive primary care, prevention, health education, and transportation services to locally owned clinic sites. By combining traditional methods of patient treatment and education (person-to-person) and virtual methods (Internet and Intranet), NEKCHW hoped to bring treatment and education resources closer to residents in isolated rural communities.

Network Innovations and Results

Implementing the Rural Health Outreach project included hiring an Outreach Program Director and appointing a committee to oversee the program. Outreach clinics in two communities, Everest and Wetmore, were equipped and staffed. A community education department was established, a computer with Internet access was donated to the Horton Public Library, a relationship with KU Medical Center was established for community and health care provider educational programs, and a transportation program was initiated.

The project goal to promote access to health, wellness, and social services in five northeastern Kansas counties met with overall success. However, there were struggles. The Wetmore Clinic was ultimately closed because the community wanted a clinic in its town but only for emergency services. NEKCHW was unable to see the benefit of spending limited funds on a clinic that was rarely used and transferred the funds to the Everest Clinic.

The community education program has been extremely successful. Since the beginning, 78 events have been sponsored with approximately 2,290 participants. NEKCHW also

KANSAS



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sponsors an annual Health Fair, monthly “breakfast chats,” quarterly support groups, and monthly seminars on a variety of health topics.

A 15-passenger van was purchased to initiate the transportation program. However, some clients had difficulty getting in and out of the van. NEKCHW subsequently purchased a minivan to replace the larger one. The smaller van increased client satisfaction resulting in increased use. The transportation program has served approximately 650 customers.

The project’s goal to harness new technologies in appropriate and cost-effective ways in order to complement Health and Wellness Center services resulted in the installation of a computer network (30 terminals) at NEKCHW. The computer network increased health education materials available to patients and staff, improved clinic network interfacing, and increased public awareness of online health resources. NEKCHW is working closely with the KU Medical Center to establish links with their medical library and health care personnel, which ultimately will provide NEKCHW staff with quicker access to information and aid in staff decision-making.

NEKCHW has increased health knowledge and information available to catchment area residents through individual, small group, and public education programs. It also has improved the health status of residents in these areas through support groups, improving the levels of immunization in children, increasing the number of women receiving prenatal care during their first trimester of pregnancy, and increasing the number of people who recognize symptoms and receive screening and early detection of treatable illnesses and pathologies.

To reduce professional isolation burnout and enhance medical knowledge of health care professionals in catchment areas, NEKCHW provides a series of programs and resources for continuing education opportunities to health care professionals. NEKCHW also established a relationship with KU Medical Center to provide interdisciplinary clinical training in northeast Kansas and to offer continuing education courses.

Lessons Learned

Limits on project staff time meant that project implementation met with some challenges. To address this, one full-time position was created to implement the outreach program. Staffing and collaboration problems delayed initiation of the transportation program by 1 year. It took longer than anticipated to find a staff member who could coordinate the transportation schedule. Moreover, the committee had to work with other active transportation plans so that services were not unduly duplicated.

The misunderstanding of project goals and expectations led to the closing of one of the network health clinics. In the future, all parties involved must reach consensus and understanding before spending project funds in a manner incompatible with project goals.

Potential for Replication

The Rural Health Outreach project model can benefit rural communities. However, it is difficult to initiate without complete support of the community and the possibility of outside resources. Local and visiting providers saw benefits of the outreach services and volunteered time to educational programs. Furthermore, the relationship NEKCHW was able to establish with KU Medical Center led to an interactive television outreach program and a patient education series that is open to the public. Without complete buy-in and support from community resources such as these, the success of a similar outreach program would be difficult to ensure.

After the Grant

The NEKCHW Rural Health Outreach project will continue to serve the community; it has been permanently incorporated into the organization's mission. NEKCHW will support current and future outreach services through reimbursement and fundraising efforts. In summer 2002, NEKCHW raised over \$11,000 through its golf benefit. Next year's benefit proceeds will go to supporting community education and the transportation program. Additional fundraising efforts are being explored through the Hospital Auxiliary and other community events. Free Will donations will continue to be collected at NEKCHW community education programs.

Target Service Area

Aroostook County is the northern most and largest county in Maine, covering 6,543 square miles with a population of 86,936, or 13 people per square mile. Significant portions of Aroostook County have been designated as both Medically Underserved Areas and Health Professional Shortage Areas. Residents with chronic conditions living in rural areas of Maine often cope with debilitating illnesses in an environment of limited access, inadequate transportation, and health care cost containment efforts. As a result, existing resources are often manipulated to meet health care needs such as using ambulance service for non-emergent transport and emergency rooms when primary care providers are not available. In addition, current reimbursement strategies do not provide for post-discharge health care services necessary for optimal recovery. This pattern of resource utilization escalates the cost of personal health care.

Network Objectives

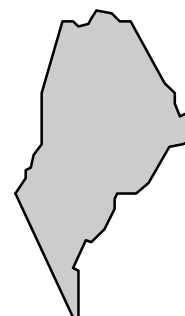
The Rural Health Outreach project was established by three hospitals and one Preferred Provider Organization to: (1) coordinate and manage health care services for patients with chronic health conditions, (2) achieve better outcomes with services provided, (3) reduce utilization of emergency department and inpatient services, and (4) improve patient satisfaction and compliance. The project created an outpatient care management program for rural consumers, especially the elderly, people with disabilities, minorities, and children who have chronic health problems including chronic obstructive pulmonary disorder (COPD), diabetes, asthma, and heart disease.

Network Innovations and Results

The care management services provided by this project facilitated a cooperative effort among health care providers, patients, and community support services. This joint effort facilitated patient education and compliance by encouraging patients to take more control and responsibility for their personal health care.

Because of this sense of participation, patients felt more secure knowing that they had a hospital contact to call when they needed resources or answers. Consequently, patients felt that the hospital sincerely cared about them and how they were doing.

MAINE



**RURAL HEALTH OUTREACH
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The development of rural care management software and a Web site allowed care managers to systematically monitor high-risk/high-utilization patients on a prescribed basis using uniform care management processes. The software provided the capacity to tailor protocols to the needs of specific patients, physicians, or medical staff. Diagnosis-specific protocols developed as part of the software are being used as a foundation for replication efforts with broader populations.

Nurses and social workers worked as a coordinated team to cover both the medical and social aspects of care management. For very difficult or complicated cases, care managers were available to attend medical appointments to assist the patient in understanding and complying with physician's orders. In some cases care managers also served as interpreters for patients with limited English skills.

The system-wide outpatient care management proved to be effective in maximizing preventive care, controlling utilization of emergency and inpatient services, and effectively coordinating the utilization of care for a chronic disease population with complex medical and social needs. The successful implementation of this project demonstrated the need to establish and expand care management services to a broad rural population. Specific results of care management services impacting on hospital readmissions, length of stay, and emergency department visits for the target population were met or surpassed:

- A 30 percent reduction in admissions for the same condition was targeted; a 52 percent reduction was achieved
- A 30 percent reduction in the number of hospital days was targeted; a 53 percent reduction was achieved
- A 25 percent reduction in emergency department visits was targeted; a 22 percent reduction was achieved

Lessons Learned

The data component needs to be computerized. Collection of baseline data was difficult due to a wide variety of data collection approaches between the hospital participants. Partners reached agreement on uniform data collection methods while developing the content for the care management software.

The need for a physician champion/advocate became apparent when the project compared provider participation in care management services between facilities with strong physician advocates to those without such individuals. This issue was addressed through ongoing physician contact and education efforts and as the project demonstrated its value through patient successes. Strong physician participation support is also critical to continuing the care management project after the grant-funded period.

Limited support resources in rural northern Maine were a serious problem in the first year of the project. A shortage of nursing home beds and home care providers was critical. This issue was addressed through group and individual meetings to inform area providers of the program and its services. Relationships formed through these efforts resulted in more proactive and mutually beneficial collaboration such as nursing homes contacting care managers in regard to open beds.

In rural areas without access to dedicated cable lines, Internet connectivity is a problem. To alleviate this problem, the Maine Health Alliance (one of the project partner members) secured local foundation funding that assisted rural member hospitals to significantly improve Internet connectivity by the end of 2002.

Potential for Replication

The care management software and Web site model of this project makes it especially appropriate to rural settings. But a commitment to such a project's success by hospital physicians and administrators is critical. Diminished reimbursement for home care-related services is one crucial consideration for the replication of this project in other rural communities. In recent years, third-party reimbursements have shifted from reducing hospital stays to reducing home health care costs, making it difficult for small rural hospitals to finance care manager positions.

After the Grant

All three hospital partner members have committed to continuing their care management staff and services to the targeted patient populations. Reimbursement for these services will be provided through the State Maine Cares program for Medicare patients. In addition, one of the largest insurance providers in the State, Cigna HealthCare of Maine, has committed to buying

PROJECT 15

care management services from all 11 Maine Health alliance hospitals, which includes the three grant participants.

PROJECT 16—SOMETHING TO SMILE ABOUT: PREVENTIVE DENTAL CARE PROJECT FOR GARRETT COUNTY

Target Service Area

Garrett County is located in westernmost Maryland, 163 miles from Baltimore and 94 miles southeast of Pittsburgh. It is a rural, mountainous resort area with a year-round population of 28,000. The city of Oakland serves as the county seat. Due to a cold climate and lack of any large city, Garrett County remains rural and sparsely populated. Tourism has made a dramatic rebound in the county with logging and farming making up the greatest part of the economic base. The State of Maryland is the largest landowner in the County, maintaining several large State parks. Old Order Amish still live in the north and south ends of the county. Garrett County is a Health Professional Shortage Area for primary and dental care, and a large number of the county's resident do not receive dental care.

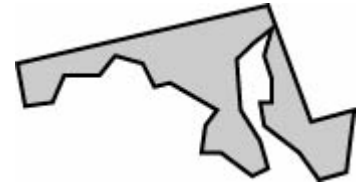
Network Objectives

The Something to Smile About: Preventive Dental Care Project for Garrett County was established by the Garrett County Health Department, Garrett County Memorial Hospital, Garrett County Dental Society, and the Garrett County Community Action Committee to:

- Provide dental health care to underserved individuals by utilizing existing private providers and providing additional dental care service through a community dental health center
- Develop a sustainable dental network by coordinating community efforts to negotiate with managed care organizations (MCOs) and to recruit needed health providers to the area
- Develop and conduct a comprehensive education campaign promoting preventive dental health care

Specifically, the project strove to provide dental care services to pregnant women and children participating in the Maryland Children's Health Program (MCHP) who do not receive dental care due to inadequate reimbursement for services and the amount of paperwork required of providers to receive reimbursement.

MARYLAND



**SOMETHING TO SMILE ABOUT:
PREVENTIVE DENTAL CARE
PROJECT FOR GARRETT
COUNTY
GARRETT COUNTY, MD**

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Network Innovations and Results

The Garrett County Health Department (GCHD) formed a network of community dentists to provide dental care in their offices or in the GCHD dental clinic. The network negotiated for higher reimbursement rates from MCOs. This, combined with GCHD guaranteeing payment and acting as “middle man” between MCOs and dentists, resulted in the number of dentists seeing MCHP and medical assistance (MA) patients increase from three to six in the County. A dental surgery center was established in the local hospital where a general dentist can perform dental surgery while the patient is under general anesthesia, thus eliminating 6-month waits for this service in a hospital that is over 50 miles away. The network also advocated for fluoridation of community water supplies. Three municipalities subsequently voted to fluoridate their water.

Dental education was also increased in the public school using a dental hygienist, community outreach workers, and an AmeriCorps member.

Other results of the program include:

- Providing coordinated dental care to 2,365 patients (the goal was 1,500)
- Providing community education directly to 11,996 individuals
- Providing Continuing Medical Education (CME) to 30 health professionals
- Successfully recruiting a dentist to provide full-time services in the public health dental clinic

Lessons Learned

The most significant problem was the recruitment and retention of dentists in this rural area. The solution was to contract with dentists to work in the clinic. Using loan prepayment programs and adequate reimbursement as incentives has allowed the program to recruit dentists to work full- or part-time in the clinic.

One frustrating lesson learned is the amount of lag time needed between when services are provided and when data is available. For instance, calendar year 2001 data was not available from Medicaid until the end of 2002. Since most of the components of the project started in fall 2000, the project still has no aggregate data to show progress or to compare itself to other jurisdictions.

Another lesson learned was that it is important to have data systems in place at the beginning of the project in order to easily access local data.

Potential for Replication

This project could be replicated in other rural settings with several factors considered beforehand. Recruitment of dentists to a rural area is difficult. Some local dentists who rely heavily on MA patients in their practice may feel threatened by this type of program. Prior agreement is essential. Encouragement and direction from the State Office of Oral Health can greatly facilitate program efforts.

After the Grant

Once the no-cost extension of the grant is completed, most of the project's components will continue. MCHP reimbursement rates are sufficient to continue the dental clinic; the network of community dentists should sustain itself; the dental hygienist will continue outreach in the public schools, offsetting nonreimbursable health education responsibilities by providing hygiene services in the dental clinic; the municipalities that installed water fluoridation equipment will pay for fluoride supplies through income generated from water bills; and the dental surgery center will be paid for through the medical and dental sides of Medicaid, benefiting the hospital since this keeps one of its operating rooms productive 1 day per week.

Target Service Area

Community-based outreach workers in Massachusetts noticed that even after people were successfully enrolled in the State Medicaid program, many were not getting care. Without an understanding of how to utilize Medicaid services, many people did not develop the crucial relationship with a primary care provider necessary for effective use of services. Because Massachusetts Medicaid eligibility standards require a household income under 200 percent of the Federal Poverty Guideline, virtually all households in the Medicaid system are below poverty level. Three rural regions of Massachusetts—Lower/Outer Cape Cod, the North Quabbin, and the South Berkshires—compose the target area and include 30 communities with a total population of 104,931 individuals.

Network Objectives

The Moving Beyond Enrollment (MBE) program was established by three direct service agencies, the coordinating agency, two community coalitions, and three statewide agencies to support experienced community-based outreach workers in providing the followup necessary to educate Medicaid clients, help them solve problems, and utilize the health care system most effectively in order to receive health care. The three direct services agencies—Children’s Health Program, Athol Memorial Hospital, and Outer Cape Health services—employed and supervised outreach workers. Steps included verifying eligibility, helping members choose an appropriate plan and provider, educating members on how to use the system and the importance of preventive care, following up to ensure that visits to providers were scheduled and completed, and helping members with the annual review process.

Network Innovations and Results

One innovation of the MBE program was the model of using experienced community-based outreach workers to do systematic, proactive post-enrollment followup. These workers already have detailed knowledge of State programs and local resources, have the trust of their clients, and are very effective in helping clients negotiate the system particularly in rural areas where the only alternative may be an 800 customer service number.

MASSACHUSETTS



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A second innovation of the MBE program was the inclusion of medical providers in the dialogue on post-enrollment issues. Because outreach workers and provider staffs work with many of the same clients on the same issues, sharing perspectives was useful in cementing their relationships.

The Moving Beyond Enrollment project fulfilled and exceeded expectations. Between September 1999 and June 2000, three regional sites served 4,485 individuals. Of the 2,477 individuals who received followup, 83 percent succeeded in making an appointment or confirming their relationship with a primary care provider during the course of the grant period. More will follow.

The effectiveness of the MBE program as a model for connecting Medicaid enrollees to care inspired the Massachusetts Division of Medical Assistance to offer mini-grants statewide to organizations wishing to include post-enrollment services in their health access programs. Unfortunately, the mini-grants program was suspended in 2002 due to budget cuts.

The MBE program also developed a Welcome Kit for new Medicaid members and a checklist for outreach workers to use with their clients. The checklist has been distributed statewide.

Lessons Learned

An initial obstacle to program implementation was the difficulty in reaching some clients to complete the scheduled followup. Some were impossible to reach by phone during business hours and would not return phone calls. To address this problem, the program evaluator conducted a small number of participant interviews, which indicated that most clients would welcome further followup by the outreach workers if they knew about it in advance. As a result, outreach workers began explaining the MBE program to clients at the beginning of their relationship, inviting them to participate in followup activities. The response was excellent.

Potential for Replication

The MBE model is well suited for replication in other rural settings. Using community-based outreach staff is particularly important in rural areas that do not have central sources of information. Outreach workers already in the communities bring knowledge of available programs, the local community, and its resources. The relationships of trust that they have with their clients

enable them to be effective in overcoming barriers to accessing care. In an environment of financial cutbacks and limited funding, when the emphasis is on utilizing existing resources, the MBE model is especially appropriate.

After the Grant

The MBE followup activities that have been supported by the Outreach Grant will continue for 6 more months on an \$88,000 grant received from the State Medicaid agency and \$33,333 received from the Blue Cross Blue Shield of Massachusetts Foundation. Also, MBE received \$20,000 from the Center for Health Care Strategies to help support further development and dissemination of “lessons learned” materials and followup tools created through the MBE program.

PROJECT 18—THE GREATER IRON COUNTY ADVANCED LIFE SUPPORT PROJECT

Target Service Area

Iron County, Michigan, is located in the southwestern portion of Michigan's Upper Peninsula. The geographic service area is 1,200 square miles with a 1990 census population of 13,121. The communities of Iron County are served by a sole community hospital located in Iron River, Michigan. The newly formed Greater Iron County EMS provides emergency medical services to the entire county. There are no additional EMS resources in the area. Iron County's low population density and expansive geographic area result in long response and transport times for the emergency medical service system.

Network Objectives

The Greater Iron County Advanced Life Support Project was established to create a full-time hospital-based paramedic transportation system to address the dwindling personnel resources, outdated transportation equipment, high cost of paramedic equipment, and the lack of access to a community-based paramedic-training program for the residents of Iron County, Michigan. The project's primary goal was to improve and upgrade the prehospital healthcare delivery system in the county.

Network Innovations and Results

Consortium members created a nonprofit corporation, the Greater Iron County EMS, Inc., to implement the goals of the project. These members included the Marquette General Health System, Iron County Community Hospitals, and the Iron County Board of Commissioners. Marquette General Health System assumed two-thirds ownership of Greater Iron County EMS, Inc., and Iron County Community Hospital assumed one-third ownership. Consortium members also created a seven-member governing board representing a cross-section of hospital administration, community physicians, nursing administration, and emergency department supervision.

The project achieved the overall goal of improving and upgrading the prehospital healthcare delivery system for residents of Iron County. Specific results included: the purchase of two Type III ambulances; the purchase of State-required paramedic equipment including ECG monitors/defibrillators, laryngoscopes, pulse oximetry, automated blood pressure machines, and volumetric intravenous pumps; salaries and wages for paramedic,

MICHIGAN



**THE GREATER IRON COUNTY
ADVANCED LIFE SUPPORT
PROJECT
IRON COUNTY, MI**

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EMT, and management services; professional malpractice and workman's compensation insurance coverage; commercial insurance coverage for equipment and facilities; and a community-based paramedic education program.

Lessons Learned

The most significant lesson learned was that consortium development and commitment are essential to the success of a community-wide project. Maintaining cohesiveness and resolve among partners is a constant challenge but essential to achieving desired outcomes. Also, geopolitical barriers to acceptance of change should not be underestimated as a potential challenge to project implementation. Equipment, training, and education are mere components of system development. The dedication and commitment of the employees are the most valuable assets.

Potential for Replication

The continuation of volunteer EMS systems is under threat. Despite the unique characteristics of each rural community in the United States, the lessons learned by the implementation of the Greater Iron County Advanced Life Support Project potentially apply to all rural communities, as the EMS system requirements of Iron County are probably very similar to those of other rural communities. Each rural area should evaluate the ability of health delivery organizations to coordinate and collaborate to provide the most efficient and effective prehospital medical transportation system possible.

The Greater Iron County Advanced Life Support project secured funding to meet specific needs and expanded the original network to include more health care organizations and representatives of law enforcement and the courts. The task forces also played a major role in ensuring appropriate and effective utilization of health care resources.

After the Grant

A high priority for project partners in the post-grant period is to create a functional Medical Control Authority in order to address the ongoing challenge of ensuring hospital recognition and fulfillment of Medical Control responsibilities.

PROJECT 19—HUMPHREYS COUNTY MEMORIAL HOSPITAL RURAL HEALTH OUTREACH PROGRAM

Target Service Area

Humphreys County, a rural agrarian area located in the heart of the Mississippi Delta, is one of the most impoverished and underserved regions in the country. The county is characterized by high rates of poverty and unemployment and low rates of educational attainment. Over two-thirds of the population are African American, two-thirds of the county's children are born to single mothers each year, and one-third of infants are born to teen mothers. The majority of children live in single-parent households below the poverty level.

Health data indicate poor health outcomes for county residents including higher than national averages for low birth weight babies, infant mortality, and child death rates, as well as heart disease death rates, cancer death rates, and sexually transmitted disease (STD) infection rates that are also higher than national averages. More than one-third of county residents are overweight, two-thirds of adults report sedentary lifestyles, and almost half the county residents report non-use of safety belts.

Network Objectives

In response to the county's poor health indicators, Humphreys County Memorial Hospital (HCMH), Humphreys County School District, and Humphreys Academy formed the Humphreys County Health Network (HCHN) to implement the Humphreys County Memorial Hospital Rural Health Outreach Program to improve the county's health outcomes. Specifically, the project sought to increase the use of primary and specialty health care services and to increase health promotion, health education, and disease prevention knowledge in the county's K–12 student population.

The project's main goals were to increase the numbers of K–12 students who are covered by health insurance, who use the health care services provided, and who follow up on recommended health care; to increase transportation to primary and specialty health providers; and to decrease the number of families of K–12 students who are noncompliant in regard to their children's health needs.

MISSISSIPPI



**HUMPHREYS COUNTY
MEMORIAL HOSPITAL RURAL
HEALTH OUTREACH PROGRAM
HUMPHREYS COUNTY, MS**

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Network Innovations and Results

Using Peer Health Advisors in the junior and senior high schools was one program innovation that facilitated dissemination of accurate health information to students who are at the stage in life where they will make many decisions that will affect their future health and opportunities. This group of advisors also can serve as a pool of potential local health care professionals who can be groomed for success and one day return to serve the community.

The project's sixth-grade Hepatitis B Vaccination Program was one of its most successful components. This program involved the cooperation of parent, schools, local health care providers, and the health department. Volunteer nurses gave free shots to students at school, and the health department provided the vaccines. Although infants now receive the hepatitis B vaccine, most adolescents are not protected. The 2003–04 school year will be the last year before the incoming sixth-grade class will already have been inoculated. This catch-up vaccination program has inoculated 1,080 students over the 3-year grant period. Of these, 85 percent of the participants were Black and 15 percent were White.

Grant funds allowed HCMH to lease/purchase a van to transport county residents to area health care facilities and pharmacies. During the 3-year grant period, the van logged over 130,000 miles and transported approximately five to seven people daily.

Project staff directed extensive effort at the Children's Health Insurance Program (CHIP) enrollment outreach including distributing information, assisting parents in completing applications, mailing letters to every family of a student-aged child, and providing all daycare centers and clinics with information and applications. The coordinated effort to enroll children in the Mississippi Health Benefits Program paid off. There was a 65 percent increase in the number of Humphreys County children enrolled in Medicaid or CHIP.

The only two project objectives that did not achieve the positive impact as planned were the low results from trying to increase the proportion of K–12 students who followed up on recommended health care and the inability to decrease the proportion of families who were noncompliant in regard to their children's health needs. The project encountered difficulties in

locating case management protocols to help provide solutions in these two areas.

Lessons Learned

Changes in Federal and State health care regulations have a major impact on the survival of health care services in poor rural communities. Mississippi's adoption of CHIP has had a very positive effect. However, there were devastating impacts from the effects of the Balanced Budget Act, which put tremendous strain on rural providers who are dependent on Medicare and Medicaid. Changes in reimbursement policies to rural health clinics meant that clinic services had to be consolidated. Local health care providers and the communities they serve need to be aware of the effects of Federal and State regulations on the health care system and be prepared to act quickly to find alternative sources of coverage.

Potential of Replication

HCHN is the major force behind the success of this project. Forming an ongoing local health network of health care providers, schools, and social services agencies that meet on a regular basis is necessary for continuing projects that initially have outside funding. All of the activities of the Humphreys County Memorial Hospital Rural Health Outreach Program could easily be applied to other rural communities that have established local health networks. Exceptionally poor communities with limited resources to address enormous problems need extensive and organized networking to locate and utilize existing resources.

After the Grant

Due to the success of HCHN in mobilizing so many community health care service providers, including the training of volunteers and the supply of free health education materials and vaccines, all of the project activities will continue after the grant. Many of the project's components have been adopted by local agencies and incorporated into their own programs. Consortium members will continue to raise funds for project activities such as student incentives that are not provided through the in-kind participation of community agencies.

Target Service Area

In 1995, a coalition of community members conducted a community health needs assessment in Phelps County, Missouri. The data and survey results indicated that a number of health care delivery and health education issues put the population of Phelps County at risk. The coalition identified four of those issues as needing immediate attention: (1) access to health care, (2) family planning/unwanted pregnancy, (3) child abuse and neglect, and (4) substance abuse. In 1997, community members reached a consensus that a reduced cost clinic was necessary for the county's uninsured population and those who had no access to basic health services.

Network Objectives

In August 1997, four network members—the Phelps County Health Department, the Phelps County Regional Medical Center, the Rolla Family Practice, and the Mid-Missouri Area Health Education Center—funded and established the Community Care Clinic in Rolla, Missouri. The clinic linked existing health care providers and social services agencies to address and provide for the medical, emotional, and health education needs of individuals and families. Because Rolla is the regional hub for medical services, the clinic reached beyond Phelps County into six surrounding counties that were designated Health Professional Shortage Areas, to serve the needs of residents who faced similar economic and health issues.

Network Innovations and Results

The proposed project innovation of using health care students to help staff the clinic was not completely realized due to academic inflexibility. Despite its efforts, the Mid-Missouri Health Education Center was unable to establish the clinic as a clinical elective site. However, the students did volunteer at the clinic without receiving academic credit. Because they were taught to approach the practice of medicine as a coordinated effort between health professionals and support, educational, and community-based services, the students brought special skills to the clinic.

Another project innovation was the creation of a free dental clinic for children. The coalition developed a dental hygienist program at the local technical college and, by securing a grant, was

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able to purchase equipment in exchange for use of the student lab after hours. Dentists were recruited to volunteer in the clinic and eight continue to volunteer after 2 years of service.

During the 3-year grant period, the clinic provided primary care visits and dental care procedures during 4,131 patient encounters. This number represents 69 percent of the 6,000-patient targeted goal. Health education encounters providing printed materials and counseling on disease management, medication usage and side effects, and lifestyle modification to promote health numbered 1,219. This reflects 41 percent of the targeted 3,000 encounters. Although 1,482 mental health patient encounters were scheduled, only 891 appointments were kept. This represents 19 percent of the targeted 5,000 mental health patient encounters.

Lessons Learned

A continuing problem was the failure to keep appointment rate, especially among the mental health patients. Transient living arrangements of this population prevented calling the patients before the appointment. In response, clinic staff aided walk-in mental health patients by assessing their response to medications screened for side effects and by obtaining psychiatrist approval to continue medications until the next available appointment.

Project goals for the health education program were unrealistic. Individuals and families challenged by poverty, mental illness, and lack of transportation are unwilling to commit time or energy to health education classes. Diabetic education programs were the only sessions that were well utilized. Although volunteer medical students were not able to provide the staffing hours to the clinic as originally planned, they were able to provide limited, individualized health education sessions during new clinic visits.

Project evaluation revealed many patients with chronic diseases had improved outcomes. Diabetic patients had lower blood sugar and blood pressure levels and clinical depression rates decreased. Most of these improvements were attributed to patients' newfound access to low cost clinic visits and medications. Patients were able to maintain routine health care regimens through screenings, medications, followup, and education. Twenty-five percent of the mental health patients continue to maintain outpatient care. This project taught the Phelps County community that patients who

are offered low cost health care will try to improve and maintain their health and achieve improvements in chronic disease maintenance.

Potential for Replication

Due to the nationwide shortage of dentists, primary care providers, and mental health services in rural areas and a growing uninsured population, the Community Care Clinic project model is adaptable to many other rural communities. However, the short 3-year span of the grant period makes it more realistic and beneficial for a community clinic to concentrate efforts on providing continuous and accessible health care delivery than to undertake an indepth health promotion and education program.

After the Grant

In order to maintain self-sufficiency, the clinic submitted an application to become an extension of the Community Health Center in Richland, Missouri, roughly 40 miles away. The application was submitted in November 2002. Meanwhile, each of the coalition members has committed to provide financial support and in-kind services within their resource availability into the future. Coalition members are seeking out numerous resources to provide medications and services to continue the full functioning of the clinic until applications for funding results have been received.

PROJECT 21—FORT PECK COMMUNITY COLLEGE RURAL HEALTH OUTREACH

Target Service Area

The Fort Peck Reservation is home to two separate Indian nations, each composed of numerous bands and divisions. The Sioux divisions of Sisseton/Wahpetons, the Yantonais, and the Teton Hunkpapa are all represented, as are the Assiniboine bands of Canoe Paddler and Red Bottom. The reservation, located in the extreme northeast corner of Montana on the north side of the Missouri River, is 110 miles long and 40 miles wide.

Network Objectives

The Fort Peck Community College Rural Health Outreach project was established to improve the health and fitness level of the tribal adult population of the Fort Peck Reservation and eligible individuals over the age of 14 living adjacent to the reservation. Specifically, the project was designed to facilitate changes in high-risk behavior and to eliminate or reduce specific risk factors such as obesity and high blood pressure through a comprehensive program of health promotion and disease prevention activities.

Network Innovations and Results

Some of the program's innovations included aerobics classes, weight training, personal wellness profiles, health fairs, nutrition counseling, school presentations, a diabetic cooking class, a community survey, yoga classes, data collection, and private record keeping of participants' activities. The project's goal—to offer services to 675 individuals over the 3-year program—was surpassed by more than 600 percent. A total of 4,845 clients participated in the program.

Lessons Learned

Initially, establishing an exercise program proved to be difficult due to lack of available workout equipment (treadmills, weights, etc.), trained aerobic instructors, and weight trainers. Three of the consortium's five members, Fort Peck Community College, Indian Health Services, and Tribal Health collaborated to buy workout equipment. The other two consortium members, Brockton School District #55 and Wolf Point Boys and Girls Club, provided facilities for the project's activities.

MONTANA



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Potential for Replication

Collaboration was key to the success of the Fort Peck Community College Rural Health Outreach program. Our project model will work in similar settings if the personnel work together and are dedicated to achieving the project's goals.

After the Grant

Due to the success of the project's volunteer recruitment and training, trained volunteers are in place and committed to continuing many of the project's activities such as aerobics, weight lifting, and walking clubs. Other activities, including nutrition counseling and wellness profiles, will continue through the results of fund-raising activities and grant-writing efforts of the consortium partners.

Target Service Area

Rural Montana faces numerous barriers to emergency medical services (EMS) accessibility including financing and funding, ability to provide around the clock services, recruitment and retention of staff, data collection and quality improvement, medical control, and training. Availability of new training curricula for Emergency Medical Technician-Intermediate (EMT-I) from the National Highway Traffic Safety Administration prompted the need for a project to help rural communities transition to a new level of EMS training.

Network Objectives

The Critical Illness and Trauma Foundation, Inc., the Burns Telecommunications Center of Montana State University, and the Emergency Medical Services and Injury Prevention Section of the Montana Department of Health and Human Services developed the EMT-I Transition Project to help rural EMS providers integrate into the community and transition to the new training and care standards set forth in EMT-I. The network developed a series of interactive tools, field-tested those tools, and facilitated community integration efforts in a number of rural Montana communities. Issues to be solved included where to locate EMS service administrations and organizations, how closely should EMS organizations interface with community systems, and the level of response and care that each community perceived as essential and was willing to support. This broad-based project involved the full spectrum of a community's health care system, public safety agencies, school systems, governmental representatives, the media, and the community at large.

Network Innovations and Results

The result of this EMS community integration project was the completion of a short- and long-term vision document for each community that summarizes the EMS integration process and outcomes and outlines next steps for the community to undertake in order to achieve improved EMS levels of advanced care appropriate to the needs and resources of each community.

The project has been very successful. More than 20 rural communities are currently at one stage or another of completion of the EMS community integration project. To date, eight

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**MONTANA EMT-I TRANSITION
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communities have completed the entire process and upgraded EMS services.

Lessons Learned

In response to the EMT-I project, one of the project partners—the Montana Department of Public Health and Human Services Emergency Medical Services and Injury Prevention Section—has undergone a major revision of the rules and regulations concerning levels of EMS training and certification. This process will result in a system that will be more flexible in meeting the needs of rural communities, commensurate with their resources, while maintaining high expectations for quality of care issues.

Potential for Replication

Since many of the issues facing rural EMS are similar to those facing rural Critical Access Hospitals (CAH) and other health delivery systems, the EMS community integration process has been accepted as being essential not only to the promotion of quality EMS in rural communities but to building relationships between CAH and EMS. To that end, two rural flexibility grant programs (Montana and Kansas) are providing resources for the long-term continuation of these processes in their States. Two additional States (Colorado and Nebraska) are currently planning for such activities with future rural flexibility resources. These activities speak highly of the perceived importance and usability of the EMT-I project model and help secure the continuation of the effort to improve EMS systems across rural areas of the country.

After the Grant

The project members anticipate increased funding from the Montana Health Research and Education Foundation and the Kansas Board of EMS for the continuation and expansion of the EMS community integration activities.

Target Service Area

Richland County, situated at the base of the Missouri and Yellowstone Rivers in eastern Montana, covers 2,084 square miles and has a population of 9,667. Half of the county's residents live in Sidney, the county seat, with the rest scattered throughout the rural countryside and in the region's five smaller communities. The county is designated a frontier area with 4.6 persons per square mile. Richland County's population is 90 percent Caucasian, 5 percent Hispanic, and 5 percent Native American; 25 percent of the population is over age 54 and this number is expected to rise over the next 20 years. The county offers only limited services to older adults and is served by the Area Agency on Aging, which covers 48,000 square miles and 17 counties.

A 1994 community assessment indicated that a large number of patients were being admitted and readmitted to the hospital within 30 days of discharge. Many of these readmissions would have been preventable had senior citizens been receiving more prevention services from the county's public health services and the Commission on Aging. No agency in the area provided a coordinated approach to identify and assist seniors who may be at high risk for hospitalizations due to preventable health conditions related to poor nutrition, medication noncompliance, and similar medical and social contributing factors.

Network Objectives

The Richland Health Network, a consortium of the Sidney Health Center, the Richland County Health Department, and the Richland County Commission on Aging, was designed to provide a coordinated approach to health screening, assessment, and education, as well as case management for residents aged 55 and older who are at risk for preventable hospitalizations.

MONTANA



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Network Innovations and Results

Using a nurse and social worker team case management model to address community needs and provide solutions beyond the walls of a healthcare facility, the Network sought to move clients from more costly direct services into less expensive population-based services. The Network provided psychosocial and nursing services, home visiting, and advocacy through the nurse and social worker team. The project developed a collaborative communication system between partners and a database of nearly 30 percent of the older adults in the community. Health screenings included blood pressure, cholesterol screening, oximeter readings, blood sugar testing, and screenings for nutrition, hearing, and osteoporosis.

Network staff outreach efforts included collaborating with nontraditional partners to provide health screenings and promotions at such locations as Ag Day seminars, county fairs, museums, and local businesses. Through these programs, the project distributed over 3,000 pieces of health promotional information.

The project was successful in meeting its objectives. By August 2002, 695 individuals had been assessed through home visits or wellness screenings. An additional 478 health screenings were conducted at various health fairs and other events throughout the county. During the project's operation, 14 percent of the general population over age 54 were rehospitalized during the targeted 30–90 day time range. During the same period, only 8 percent of the clients served by the Network's case management program were rehospitalized within the 30–90 day range.

Lessons Learned

Although the Richland Health Network design was based on the evaluation of a community assessment, utilization of a focus group or advisory group early on would have laid the groundwork for more community involvement and support. A longer initial planning phase would have helped establish a stronger foundation and would have benefited the project's overall outcome. Since many programs and funding streams focus on specific diseases, concentration on one or a few specific chronic diseases or problems may have been easier for the project to sustain.

Potential for Replication

The Network was successful in sharing its model of care, successes, and challenges with local, State, and national care conferences in Montana, North Dakota, and Colorado. In addition, at the 2002 National Council on Aging/American Society on Aging conference, the National Coalition on Rural Aging featured the Richland Health Network as a “Best Practice Program” in rural aging.

Networking with different programs and services provides a solid foundation on which to build a project using this model since funding sources often favor collaborating groups. The critical components of the project model—public health agencies, aging services, medical services, and psychosocial services—exist in some form in most areas.

After the Grant

Although efforts to procure funding for case management services were unsuccessful, the Richland Health Network will continue. In July 2002, the Network received notification of the approval of a 10-year, \$1 million grant to begin a Retired Senior and Volunteer Program in Richland and McCone counties in Montana. This grant, although of homeland security focus, will continue to provide some level of health promotion and home visiting for seniors. The Network also received a State grant for fire and fall prevention activities with an emphasis on the senior population.

Diabetes is one of the major causes of rehospitalization in the Richland Health Network’s clients. Consequently, the Network is working to add a Diabetic Management Program to its services. Additionally, through limited funding, the Network will continue to provide home visiting nursing services and screenings at senior centers, though on a limited basis. Collaborating with other area programs and agencies, the program’s staff will also continue to provide community-based health promotion activities.

Target Service Area

West Wendover is a rural city located on the Utah-Nevada border. The city is unique in that the State line bisects the city creating Wendover, Utah, and West Wendover, Nevada. While truly one community, the division created by the State line results in a myriad of problems in providing social services due to each county and State having different rules, regulations, and budgets. West Wendover is completely isolated from mental health services, which are only available 120 miles away in the county seat.

Network Objectives

Four consortium members—the City of West Wendover, the Primary Children’s Hospital Child Protection Team, Brigham Young University (BYU) School of Social Work, and Valley Mental Health—created the Rural Health Outreach Program to provide local access to mental health services and to provide a school-based program teaching resiliency and social skills to school-aged children and their parents in West Wendover. The program was conducted in the four local schools—two elementary schools and two junior high/high schools.

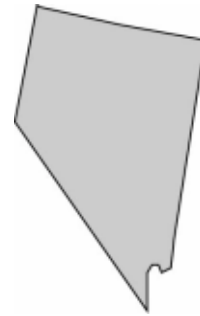
Network Innovations and Results

Conducting the resiliency and social skills program in school during the school day proved to be challenging but successful. One licensed social worker (LCSW) and three Masters in Social Work (MSW) graduate students from BYU traveled to West Wendover to conduct classes and provide clinical therapy and group therapy to children and parents. BYU provided qualified, bilingual students for the project and the students fulfilled the fieldwork requirement for their studies at BYU.

Project staff made home visits to participants at the beginning and end of the school year to complete the child’s social skills assessment—used for evaluation—and to receive parental consent for the child to participate in the program.

In two of the four schools, the project was delivered as a pullout program meaning that teachers, counselors, school administrators, and parents referred students who were having difficulty. In one of the schools, the program was taught in a regular class and all students in that class received the program.

NEVADA



**RURAL HEALTH OUTREACH
GRANT PROGRAM
WEST WENDOVER, NV**

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An evaluation conducted by the University of Utah College of Nursing showed that there was significant improvement in the behavior and social skills of all the students who participated in the school outreach program. School counselors also noted better attendance by the students enrolled in the program on the day the program was conducted. There is also evidence of better academic performance in students enrolled in the program.

Lessons Learned

One of the significant challenges to implementing a school-based program is the lack of available time during the children's school day. Many programs compete for a student's time and administrators are reluctant to add another one to the day's activities. Offering the mental health services as a pullout program or after-school activity were concessions that enabled the program to go forward in three schools. However, there would be greater benefit to all students if the program were conducted on a universal basis during regular school hours rather than as a pullout or after-school program only for students who have been identified as currently having problems. Also, there exists a stigma in the Hispanic community against mental health services or "outside interference" into the family. While the availability of culturally competent, bilingual MSW students made a difference with these families, overall, their view did not change. Lastly, inability to pay for mental health services and ineligibility for State Medicaid was a significant barrier to some clients and a factor in the sustainability of the program.

Potential for Replication

As part of their coursework, two of the BYU MSW students who conducted the school outreach program in the West Wendover program spent their summer placement in Mexico and Russia where they successfully piloted our school outreach program model, showing that this project model does work well in other settings. Collaboration among consortium partners and relationships with State and county agencies responsible for delivering mental health and social services to the community is crucial to initial training of program staff and project implementation.

After the Grant

The program will continue in the Utah schools since the teachers have been trained and the appropriate materials have already been provided. The superintendent of the Elko County School District has expressed interest in continuing the school program after the grant funding ends and particulars will be discussed during the final year of activities. The continuation of the LCSW is tenuous since social services are not self-supporting with pay-for-service funding. A bill was introduced during January 2003 in the Nevada legislative session to fund a satellite office in Wendover for local implementation of State health and welfare services. The Nevada Office of Rural Health's Rural Health Outreach Grant for Interdisciplinary Training has available funds for a bilingual LCSW in Wendover if one can be recruited.

Target Service Area

Cheshire County is a rural area located in the southwestern corner of New Hampshire. The county is comprised of one city—Keene, population 22,000—and 22 towns with populations ranging from 650 to 5,500 residents. Increased life expectancy and an aging baby boom generation have increased the demand for long-term care services especially among the isolated senior population.

Network Objectives

Through a consortium of health service providers spearheaded by Home Healthcare, Hospice & Community Services (HCS), the Community Life for Seniors project established a point of contact for the elderly population to access all needed health and social services available in the community with the specific goal of enabling elderly individuals to remain in as close to normal living circumstances for as long as appropriate and desirable. The project's early intervention program was designed for elders who are not receiving long-term care services but who are at increased risk of becoming injured or isolated within the county. Achieving the goal of the early intervention program involved: (1) identifying elders who were truly at risk of needing community and long-term care facilities; (2) screening those elders for risks and the interventions that were within the project's scope to provide; (3) providing followup assessment to ensure that screened seniors received the recommended services; and (4) providing ongoing care coordination to monitor the individual's needs and to ensure that the appropriate services were received.

Network Innovations and Results

The concept of locating and identifying elders before they get into the healthcare system due to illness or accident was innovative. A single point of contact for isolated elders that involved three to five area agencies working together on individual clients is also innovative in itself.

Specific services provided through the project included a 12-week exercise, strength training, and balance program with 90 enrollees; educational sessions on topics such as kitchen health, fall prevention, medication safety, safe winter walking, and exercise; referrals for chore services and minor home repairs; personal case management by an assigned team member who ensured client

NEW HAMPSHIRE



**COMMUNITY LIFE FOR SENIORS
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needs were assessed and appropriate services were provided; screening and assessment of clients; and active identification of at-risk elders.

Lessons Learned

Trying to keep seniors at home is a very complex and involved process. Deep knowledge of all services available and the ability to adjust the process for clients who do not qualify for the help they need are paramount. The project employed multiple strategies in an effort to maximize the odds for success. In the future, it might be useful to maintain data on the number of clients receiving each combination of services in order to determine which intervention combinations are most effective.

Potential for Replication

There are two challenges to using the Community Life for Seniors project model: (1) initially it is difficult to find the clients; (2) once the clients are numerous, the long-term problem is to find a way to continue to fund the services and maintain the regular contact needed to keep ahead of any developing health or safety issues for seniors that may lead to loss of independence. Starting with the less isolated seniors is an easier approach to finding clients. Once the community buys into the services being offered, a steady stream of leads and referrals will follow, bringing in the more isolated cases. Including a social worker in the daily operations is essential to program success, especially with more complex clients. Maintaining enough staff to keep up with the growing caseload is essential; however, developing a permanent funding source for that level of staffing is a challenge.

After the Grant

Several elements of the project will continue after the grant. Clients who were admitted to the Community Life for Seniors project will continue to be followed by outreach staff. Additionally, HCS staff will continue to supervise and support six sites for the 12-week exercise program. Volunteers will lead the exercise program after the initial 12 weeks. Using the tools developed for the project, HCS staff will continue to conduct home safety and nutrition assessments. These assessments take a minimal amount of time to complete and therefore will not pose an extra expense.

PROJECT 26—A WELLNESS PARTNERSHIP FOR A HEALTHY MCKINLEY COUNTY

Target Service Area

McKinley County, New Mexico, has the second lowest per capita income and the highest standard mortality rate for diabetes in the State. McKinley County's population is 72 percent Native American and 12 percent Hispanic. Diabetes occurs three times more often in the Hispanic population and 10 times more often in the Native American population than in the non-Hispanic White community. Diabetes, the sixth leading cause of death in New Mexico, greatly impacts the Native American and Hispanic populations in the county.

Network Objectives

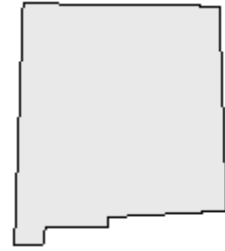
Rehoboth McKinley Christian Health Care Services, Inc. (RMCHCS), Gallup McKinley County School District, and Gallup McKinley Diabetes Advisory Council partnered to form the Wellness Partnership for a Healthy McKinley County: A Health Education Program for Hispanic and Native American Youth. The project goal was to improve the wellness of the community by developing healthy living skills in the 10- to 12-year-old population, and specifically to incorporate diabetes awareness activities into this target group's school day.

Network Innovations and Results

The project involved an innovative education program using high school students to mentor elementary students in diabetes prevention techniques. The role model method of peers teaching peers is an effective tool for teaching diabetes prevention. High school mentors (Peer Promotura Mentors or PPM) were trained to teach the signs, symptoms, and risks of diabetes, as well as preventive nutrition and exercise strategies to fourth- and fifth-grade elementary school students using a modified Diabetes Management Program curriculum developed by RMCHCS. Efforts to involve the entire community in diabetes awareness included family fun nights, awards dinners, poster contests, a diabetes awareness parade, a magic show, a health and exercise fair, and other events.

Subjective outcome data has shown that the high school PPMs benefited from the program. Improvement in organizational skills, self-esteem, and behavior were noted anecdotally. As one student put it, "I would feel like a hypocrite if I weren't trying to do what I was asking the kids to do."

NEW MEXICO



**A WELLNESS PARTNERSHIP
FOR A HEALTHY MCKINLEY
COUNTY
MCKINLEY COUNTY, NM**

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Lessons Learned

Block scheduling (1.5 hour blocks of academics that covered two semesters of work) prevented ideal high school science, health, and biology classes from participating. The elementary school faculty also were protective of their limited time to teach core curriculum. Finding a compromise that allowed high school students to enter elementary schools at mutually convenient times posed a challenge. Creative solutions were found by adapting community resources, including collaborating with the Gallup Branch of the University of New Mexico that offers a Nursing Assistant Program for high school students and was willing to participate. The Gallup High School National Honor Society and the Key Club participated in after school and summer programs. And the more flexible Central High School with broader student body diversity supplied students in a health careers class, a science class, and a “ROPES” class.

Evaluation feedback indicated that there was a wide range of ability in the PPMs. Therefore, it would be helpful to enroll students in a semester-long peer mentor class on an interest/ability basis and award a letter grade as incentive. Teachers need to be encouraged to use their expertise to augment and develop mentors’ skills and confidence.

When it became apparent that some PPMs generally allowed laxer classroom behavior than teachers normally allow, PPMs were given Classroom Management Skills training. PPMs also needed bus transportation from the high school to the elementary schools. Inclement weather and differences in teacher in-service days compounded non-routine bus scheduling. Closer communication with the bus barn improved the consistent transportation of PPMs.

Potential for Replication

The project has shown the success of a Peer Mentor Model for diabetes prevention. The basic model will work in any community, especially in small rural communities where families are close and where schools are the focus of family activity. Because this was a pilot project, it has been a dynamic work in progress. The essential issues of the model in a vast rural setting are: establishing convenient time scheduling to conduct instruction; maintaining consistent transportation for PPMs between the high school and the elementary schools; ensuring parental involvement when parents

are already overextended with work, church, and other extracurricular activities; and finding available certified diabetes educators and dieticians to work with the program. The curriculum needs to be published and field-tested in its standardized form, and then refined. The project's ultimate challenge to is remove these barriers to replication.

After the Grant

The Gallup McKinley County School system was awarded a grant to institute physical education and music programs in each of the elementary schools. The school system will now apply for a grant to train the newly instituted physical education teachers to implement the wellness and diabetes prevention program. The high school may soon require community service hours for all students to graduate, which would allow a vehicle for the Peer Mentor Model to continue. Central High School has added this project to their permanent curriculum. Lastly, RMCHCS and members of the consortium will continue to meet monthly to support health and wellness activities in the community with the aim of reducing or one day eradicating the incidence of diabetes.

PROJECT 27—NORTHLAND INTEGRATED NETWORK SYSTEMATIC DISEASE MANAGEMENT MODEL PROJECT

Target Service Area

Much of western North Dakota meets the definition of a frontier with a population density of less than six persons per square mile. Large areas have a population density of one person or fewer per square mile. There are 34 counties in western and central North Dakota, 29 of which are designated Health Professional Shortage Areas for primary care.

Network Objectives

The Northland Integrated Network—composed of 17 member partners, including hospitals, clinics, one health agency, and one health department—serves approximately 201,000 people in 34 counties in western and central North Dakota. The network's primary objective was to provide improved care services to residents with chronic diseases in rural and frontier areas by implementing a disease management process and tracking patients' participation and care services received. The project focused on diabetes and asthma.

Network Innovations and Results

The project succeeded very well in terms of the Diabetes and Adult Prevention Tracking and Improvement projects with 17 clinics participating with a total of 2,125 diabetic patients. Three clinics with a total of 600 patients participated in Adult Prevention Services. Patient services were tracked using several standards of care: clinic visits; A1c frequency and value; microalbumin, lipid, eye, and foot exams; and diabetic education or visits with a dietician. In the first year, patients were seen more than once per year 31 percent of the time; in the last year, this increased to 75 percent. Similarly, A1c measurements were taken more than once per year 31 percent of the time in the first year and 56 percent in the last year. A1cs over 8 were reduced from 41 percent of the diabetic population to 34 percent. Results were more significant for clinics that had no experience with disease management. Annual microalbumin increased from 21 percent to 48 percent, lipids from 9 percent to 38 percent, eye exams from 14 percent to 32 percent, and foot exams from 22 percent to 55 percent. Failure to have a visit with a diabetic educator was reduced from 94 percent to 81 percent and failure to visit a dietician was reduced from 97 to 89 percent. These latter two standards reflect the major areas of concern.

NORTH DAKOTA



**NORTHLAND INTEGRATED
NETWORK SYSTEMATIC
DISEASE MANAGEMENT MODEL
PROJECT
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Lessons Learned

In terms of diabetic education in rural areas, small communities do not have an on-site dietician to provide education, nor do they have sufficient patients to “grow” a certified diabetic educator. The cost of travel, coupled with small numbers of patients means that the Nationally Recognized Diabetes Education Centers are not willing or able to provide services in the outlying rural areas. Also, diabetes education is not reimbursable by Medicare when conducted via Telemedicine and seniors are unwilling to pay for the service as they think Medicare does or should pay for it. While the network made improvements through the existing system, the scientific evidence supports education as a means of making further improvements that translate into better health outcomes for patients.

Another lesson of the project was that with almost no managed care, providers in North Dakota have not been forced into quality improvement. Some clinic administrators have not been convinced that there is a distinct positive financial outcome to conducting disease management which more than offsets the cost of conducting these efforts despite information provided by this project about the business case for conducting disease management.

Potential for Replication

Other rural settings can and should be using quality improvement and documenting their success. Software such as that used by this project or the Bureau of Primary Health Care software that is user-friendly and offers benchmarking and reminder capability is necessary in order for rural providers to continue to be reimbursed in the future. Main barrier issues include access to personal computers, willingness to invest in Access or other software, and willingness to invest in improved care, better outcomes, and increased financial viability. This type of project requires a network information systems function to support local rural providers.

After the Grant

All current local disease tracking and improvement will be continued locally. In addition, the network will pursue additional disease management activities with the Department of Health and the Q10. Specifically, network members are working to develop a statewide Diabetes Registry that will allow shared lab values in a HIPAA-compliant environment. The network will work with the regional American Diabetes Association (ADA) office and other State providers on the issue of rural diabetic education.

Target Service Area

Harney County, Oregon, is a vast rural area of over 10,000 square miles with a population of 7,600. Harney County is the largest in Oregon and the ninth largest county in the United States. The city of Burns has a population of approximately 2,900 and houses all of the county's medical services. Consequently, some county residents live over 100 miles from health care services. The economy of Harney County is made up primarily of ranching, manufacturing, and lumber.

Network Objectives

Consortium partner members Harney District Hospital, Harney County Health Office, High Desert Medical Center, and Crane Union High School designed the Harney County Rural Health Outreach Program to expand and enhance an established mobile primary clinic through patient education, increased trips per month, and increased patient visits per trip through a dial-a-ride program.

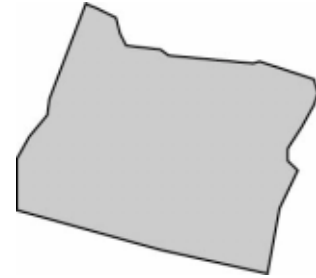
Services provided by the project included primary health care such as well child exams, physicals, vaccinations, general health care, patient education, and transportation. The target population was comprised of women, children, low-income residents, Native Americans, and others.

Network Innovations and Results

The main goal of the project—to increase patient access through increased availability of the mobile clinic—was accomplished. The mobile clinic made 90 trips during the 3-year grant period as opposed to 72 during the prior 3-year period. At an average of 10 patients per trip, the clinic served 900 patients, 180 more than previously served in the same period.

The project's innovative method of service delivery was attempting to provide a dial-a-ride program. An earlier survey indicated that some potential patients were unable to access the mobile clinic due to lack of transportation. The project established a group of volunteer drivers to pick up and deliver these patients to the clinic. However, after establishing the network of drivers and advertising heavily for patient riders, there was no response or usage and eventually the program was dismantled. The survey results and/or the project's interpretations were apparently in error.

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**HARNEY COUNTY RURAL
HEALTH OUTREACH PROGRAM
HARNEY COUNTY, OR**

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The patient education programs also were underutilized despite adequate advertising. Low population levels and daytime interferences such as work and school led to poor attendance and the programs were terminated.

Lessons Learned

The most significant lesson learned was that a needs survey is critically important to the outcome of any project and should be done in such a manner as to ensure dependable results. The project's survey was inaccurate and therefore the results used to design the programs led to lack of success in the project's two secondary goals.

Potential for Replication

The Harney County Rural Health Outreach Program model would work well in other rural areas. Furnishing primary health care services closer to home to geographically isolated residents increases the likelihood that patients will seek care sooner, resulting in more effective and less costly treatment. However, areas with low population levels and, consequently, low volume will need support from outside funding. A major challenge to the success of this type of project is maintaining a competent staff in typically understaffed rural areas. Also, distance and weather are hard on equipment leading to expensive maintenance and repair costs.

After the Grant

The mobile primary clinic will continue using hospital subsidies and possible future grants. Trips made per month may revert to two depending on funding, but services will remain at the same level. Although the dial-a-ride program has been shelved, the education programs will continue as needs are identified. The consortium will remain in place to coordinate activities of the mobile clinic.

Target Service Area

The Coquille Valley is situated in the rugged mountainous terrain of Coos County in southwestern Oregon and supports a population base of 12,000 residents dispersed over 540 square miles. The Coquille Valley communities are Coquille, Myrtle Point, Powers, and Bridge, which collectively share six primary care providers who practice at three distinct sites. The region is characterized by significant health disparities. Residents of the Coquille Valley have a high rate of illiteracy, poverty, unemployment, and the State's lowest per capita income level (\$11,000). In 1997, the suicide attempt rate for adolescents aged 10 to 17 was 434.1 per 100,000 compared to a statewide rate of 221.3; 35 percent of the region's children live in poverty.

Network Objectives

In response to rising health disparities and a paucity of mental health care services, the Coquille Valley Primary Health Care Task Force—comprised of the Coquille Valley Hospital District; Powers Rural Health Clinic; Valley Health, P.C.; and the Coquille School District—implemented the Integrated Primary and Behavioral Health Care project. The project provided case management, integrated behavioral health care, risk reduction services, provider retention initiatives, and transportation for targeted low-income and working-poor families.

Network Innovations and Results

This innovative project featured nurse case management, and counseling services. The program retained two part-time registered nurses, both of whom were pursuing graduate studies in mental health. Space limitations at the two primary care practices prevented stationing the nurses in these settings. Accordingly, the nurses were out-stationed at a variety of community sites but closely integrated their case management and behavioral interventions with primary care providers. Collectively, the project employed four part-time persons, three of whom were pursuing graduate studies in mental health, thereby creating a “grow-your-own” model to address the community's challenges associated with its Mental Health Professional Shortage Area designation.

OREGON



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Risk reduction efforts focused on mental health issues among the adolescent population, and a series of Clear Choices activities for all ages focusing on cardiac health and general fitness, cancer awareness, and diabetes education and prevention. The provider retention initiative was successful in assisting to recruit and retain the services of a mid-level practitioner for the duration of the program and beyond at the Powers Rural Health Clinic. The transportation element, originally assigned to Coquille Valley Hospital, was subcontracted to the local transportation authority, resulting in enhanced services with lesser degrees of liability.

Lessons Learned

Project and consortium personnel performed all project-related management and utilization data tracking by hand. If the project were to be replicated, it would be more efficient to establish an electronic data tracking system at the beginning of the project and implement it throughout.

The project's greatest difficulty in implementation occurred when office space could not be made available at the primary care practices for integrated primary/behavioral health case management services, resulting in a potential loss of fidelity to the original project design. Office space for project staff should be secured before program implementation begins.

Potential for Replication

This project could be replicated with great success in other rural communities that suffer from a shortage of mental health professionals. While it was not the intent of the project to grow its own mental health practitioners, the project did capitalize on the fact that three individuals from the local rural community were willing to enroll in graduate studies in the behavioral sciences. Many rural communities will not have a readily available supply of health professionals who are willing to spend personal resources for graduate studies, or travel long distances to regional universities. As a direct result of securing three local health professionals, the project was required to do little recruiting. Consequently, the community stands a much better chance of retaining these professionals, who have chosen to live here, for years to come.

After the Grant

Mental and behavioral health services will continue on a delimited basis after the expiration of Federal grant assistance. These services are provided in the charitable sector on a sliding-fee-scale basis and will be somewhat self-sustaining, but only to the degree that sliding fees are capable of covering the modest costs associated with this activity. Integrated case management services will also continue on a delimited basis, in direct proportion to the willingness of the mental health nurses to continue their practice of coordinating services with the primary care providers.

The project's transportation services will continue at full scale on an indefinite basis. Traditional public transportation resources will absorb ongoing operating costs. Risk-reduction activities are the only project component that will not continue.

Target Service Area

North Curry County is a rural, remote, and isolated area of the southern Oregon Coast. Port Orford, population 1,000, has an unemployment rate above 60 percent and is the only incorporated town in the area. Two smaller communities in the target service area include Langlois and Sixes River. Over 50 percent of county residents have no health insurance coverage. Highway 101, the only ground access, is often closed during winter by slides, high winds, fallen trees, or massive road movement. The local hospital and county health district are headquartered 30 miles away from these communities.

The area's local health clinic had gone through a variety of changes, none of which were fiscally sound, leaving the residents of North Curry County in need of local health care services.

Network Objectives

The Rural Health Outreach project was established to ensure local health care coverage for residents of remote North Curry County. The project's overriding mission was to stabilize the local clinic while providing health promotion and prevention opportunities in the core areas of heart, breathing, cancer, and diabetes. Project partners included Curry General Hospital, North Curry Family Center, Curry Family Medical Clinic, Curry County Health Department, and Port Orford Community Ambulance Services.

Network Innovations and Results

The grant funded a variety of services to the community, which were predominantly prevention oriented. These included women and men's health screenings, diabetes screenings and education, a Youth Health Fair, school health screenings, blood pressure screenings, home visits to families with newborns, equipment for health care providers, subsidies for physician salaries, several "Walk On!" health promotion events, dances, and hikes.

OREGON



**RURAL HEALTH OUTREACH
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The project succeeded in meeting its goals of keeping primary health care available in Port Orford; increasing use of the local clinic; providing significant efforts in the diagnosis, treatment, and prevention of heart and pulmonary disease, cancer and diabetes; and establishing understanding of the need for preventive health care. During each year of the project, patient contacts grew by 25 percent. Screenings aided in early health risk detection and in supporting positive prevention approaches to heart, diabetes, respiratory, and cancer complications.

Lessons Learned

Community consortium member participation was pivotal to the success of the program. Through the consortium, the grant project flowed from within the community and the area it was designed to serve. Without this community involvement, the program would have appeared to be imposed from the outside. As it was, one problem encountered by the project was the difficulty in finding a volunteer from the ambulance corps who had the time and interest in becoming an active consortium member. Including ambulance service representatives in followup project process discussions helped resolve this issue.

Potential for Replication

This project model relies heavily on community buy-in and participation. Decisions about what the project goals would be and how they would be met came from community needs assessments and informal communication that identified specific community needs. Consequently, this project model would work well in other rural community settings where the impetus behind the project is locally driven and the community participates in identifying, promoting, and achieving project goals.

After the Grant

Many activities of the Rural Health Outreach project will continue through sponsorship by local agencies and resources. Most significantly, the Curry Health District will retain the project manager to organize at least one activity per month such as health screenings and the popular “Backyard Walks.” Other project components that will continue through sponsorship of local agencies include: the “Walk On!” program, student health screenings at schools, men’s and women’s health screenings sponsored by the Rotary Club of Port Orford, the community All-Age Dance, stabilized salaries for primary care providers, diabetes education, and health education and screenings for seniors sponsored by the Port Orford Senior Center.

Target Service Area

Clatsop and Tillamook Counties encompass nearly 2,900 square miles along the northwest tip of Oregon. Small, unincorporated communities are scattered throughout the mountains and in between larger communities along the coast and rivers. Only one city in the region has a population over 5,000. All cities are connected by Highway 101 and are often subject to high winds, coastal storms, road closures, and power outages that isolate residents and complicate health service delivery.

As of 2000, 16 percent of the Nation's population were over age 60. Clatsop and Tillamook Counties both have senior populations above the national average: Clatsop County's senior population stands at 20 percent, Tillamook's at 26 percent. The American Psychiatric Association estimates that 20 percent of all seniors in the United States are afflicted with mild depression and that at least 15 to 20 percent suffer from mental health issues that require some type of intervention. The rural isolation of Clatsop and Tillamook Counties, coupled with the higher senior populations, put the region at increased risk for depression as well as alcohol and drug addiction.

Network Objectives

The Senior Mental Health Network, composed of 16 agencies and professional organizations that provide services to seniors in the region, developed the Senior Peer Counseling Project to serve seniors age 60 and above who were suffering from mild to moderate situational depression. Clients were matched with trained Senior Peer Counselors above 52 years of age. Seniors who could benefit from peer counseling were identified to the project through consortium members, family, friends, and self-referral. Peer Counselors met with their clients weekly for 1 hour and twice monthly in supervisory sessions with the project coordinator.

Specific goals of the consortium were to improve mental and physical well-being of senior citizens and to strengthen and expand the Senior Mental Health Network within the project area.

Network Innovations and Results

One project innovation was partnering with existing organizations for co-training activities. Organizations offered their existing training to Senior Peer Counselors and their volunteers were offered training in Peer Counseling in return. This broadened

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CLATSOP AND TILLAMOOK
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the scope of the training efforts and allowed for increased community awareness of the project and the subject of depression among the senior population. The project also partnered with the Senior Companion Program to provide friendly visitors, light chore services, and limited transportation, which led to more referrals.

The project employed a depression scale to measure a client's state of depression prior to offering services and then again when services were completed. There was a 23 percent positive increase in test scores after clients received services. The project goal was to support up to 210 seniors through peer counseling. Although the number of referrals was lower than anticipated, approximately 200 seniors actually benefited from the project through counseling, training, or referrals.

Lessons Learned

Geographic location of participants proved to be not only a logistics problem but also a cultural one. Participants in the remote areas of the region were more culturally insulated and isolated. Ideation of strength in independence and the social stigmas associated with mental health issues were predominant in this group of participants. Admitting to depression and reaching out for help to a public agency proved very difficult for these individuals. Cultural barriers associated with geographic location were further enhanced by the reluctance of religious communities to seek help outside the church for mental health support and further complicated by an inferred mistrust of Government agencies.

Physician support and involvement was not as strong as anticipated and was not successfully resolved during the project. Referrals were made consistently from hospital home health services and hospital social workers. Had physicians made the referrals before hospital staff saw the clients, intervention could have been provided earlier.

Turnover for Senior Peer Counselors was higher than anticipated, mostly due to uncontrollable issues such as medical problems and family commitments. However, a few members cited burnout as the predominant reason for leaving the project. Transference issues that arise from working with depressed individuals near their own age can be a strong influence on Peer Counselors and should be addressed on a continual basis in supervisory meetings and in-service training. Driving long

distances to counsel clients and aging of volunteers also offer challenges that should be considered in any rural area when trying to recruit and maintain trained Peer Counselors.

Potential for Replication

Operating a Senior Peer Counseling program in a rural area presents unique challenges of logistics and culture. However, this project demonstrated that there is a need that can be filled by this type of program. Quite often, Senior Peer Counseling is the only resource available to isolated seniors suffering from depression and offers them a link to their communities. Housing a project of this type in a more community-based senior organization such as a Senior Center may help overcome the public stigma of seeking outside help for mental health issues as discussed earlier.

After the Grant

After this grant expires, one of the consortium members, North Coast Senior Services (NCSS), will use carry-over funds to sustain the project for another 8 months at its current size. Future plans to maximize the use of trained counselors include expanding the project to provide counseling to family caregivers and families dealing with the early stage of Alzheimer's disease and related disorders. Since geographic location is one of the biggest challenges and drives up project costs, it may be necessary to scale back the area served by Peer Counselors. Ideally this cutback will lead to reduced turnover thus cutting costs in training and recruitment efforts.

Target Service Area

Outbreaks of two vector borne diseases—dengue fever and leptospirosis—have been reported with increasing regularity in the Republic of Palau. Dengue fever epidemics occurred in 1988 (type 2) and 1995 (type 4). Confirmed cases of leptospirosis have been reported every year since 1995 reaching a peak of 16 cases in 2000. The Government of Palau recognized the need to increase public awareness of these diseases so that communities could undertake preventive efforts to protect the Republic’s residents. While Palau is usually recognized for its mountainous landscape and beautiful scenery, vector-borne diseases put residents at increased risk for severe illness—and even death.

Network Objectives

In 1999, the Republic of Palau implemented the Vector Control and Prevention Program, which targeted the nearly 20,000 people who live in Palau. The program was designed to educate individuals and communities about the steps they can take to prevent vector borne diseases, and to help control future outbreaks that may jeopardize the health of those who call Palau home. The foundation for the project was a consortium of organizations that were in a position to implement vector control and prevention strategies. The consortium included the Division of Environmental Health, the Bureau of Agriculture and Mineral Resources, and the Palau Community Action Agency.

In each year of the project, consortium members focused on specific vectors. In the first year, focus was on household rats, as well as rats found on household farms, small-scale farms, and commercial farms. In the second year, consortium members focused on mosquitoes, cockroaches, and swine. In the third year, consortium members planned to shift their attention to fleas and ticks found on dogs, flies, and other possible vectors such as horses, cattle, and monkeys. Each control and prevention program for each vector was augmented by a public education and awareness campaign on the health hazards posed by certain animals, and the techniques that can control and prevent reproduction of the most dangerous insects.

PALAU PW



VECTOR CONTROL AND PREVENTION PROGRAM REPUBLIC OF PALAU

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Network Innovations and Results

The Republic used a wide range of nontraditional media to communicate critical public health messages to Palau's residents. These strategies included incorporating key prevention messages into culturally relevant songs, T-shirts, hats, essay contests, and water bottles. The project also used traditional products such as brochures, videos in local languages, educational games, live radio programs, and Earth Day celebrations. The project also taught residents that they could use *Gliricidia* tree leaves as rat poison, and it even provided low-cost septic tanks for many of the Republic's piggeries.

The Vector Control and Prevention Program reached every household, farm, and school in the Republic of Palau. Results of community surveys and interviews indicate that rodent and mosquito control programs were successful in raising public awareness. All sectors of the community demonstrated increased knowledge of the role of rodents and mosquitoes as disease vectors, as well as ways to control these vectors.

Lessons Learned

Unfortunately, the original project goals were too ambitious. The project was unable to tackle the vectors slated for the third year of the program because the activities associated with the first 2 years of the project took more time and effort than originally thought. The project hopes to address those vectors as soon as possible in the future.

Potential for Replication

The project could be replicated in other communities at high risk for vector borne diseases. However, perhaps the most important message is that education awareness projects must take into account the cultural norms of the target audience, the values they hold dear, and their perceptions of those delivering the message. Failure to consider these issues can affect the degree to which public health initiatives achieve the desired results.

After the Grant

The Vector Control and Prevention Program is now the Vector Control and Prevention Unit under the Division of Environmental Health in the Palau Ministry of Health. The activities started under the Rural Health Outreach grant will continue and be supported by local funding.

PROJECT 33—WILLIAMSBURG SCHOOL HEALTH IMPROVEMENT PROJECT

Target Service Area

Williamsburg County is a rural area located in the Pee Dee region of South Carolina, 72 miles from the Atlantic Ocean. In 1999, there were an estimated 10,720 children under age 18 in the county. Of these, 2,850 were White, 7,860 were African American, and 20 were of other races. The area's 3,010 preschoolers under age 6 comprise 8.2 percent of the county's overall population and represent 6.9 percent of the White population and 8.9 percent of African Americans. Over 36.1 percent of all the area's children and youth live below the poverty level. A rough 1997 Census Bureau estimate of child poverty was 39 percent.

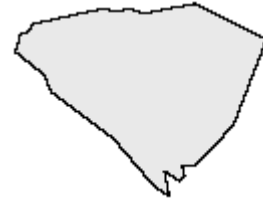
Network Objectives

The Williamsburg County School District, the Williamsburg County Health Department, and Black River Health Care are the three consortium members who joined forces to create the Williamsburg School Health Improvement Project. The project's primary objectives were to refer students without primary health care to primary care physicians; conduct health screening procedures by a school nurse as outlined in the protocol for school health services; provide early periodic screening, diagnosis, and testing services to eligible students enrolled in grades kindergarten through sixth; provide hospitalization intervention for ambulatory-sensitive conditions in children under age 18; conduct health promotion sessions for the 13 county schools; provide counseling intervention services for substance abuse, child abuse, reproductive issues, and violence in each of the 13 county schools; and conduct home visits to provide family support services to families of school students in the 13 local schools.

Network Innovations and Results

The consortium successfully achieved its objectives outlined above. It also provided immunizations for staff members, first aid and CPR training to children and staff, and Occupational Safety & Health Administration (OSHA) training to district staff members. Furthermore, the project provided teachers and staff with nutrition and health information. Students who were identified with a need for counseling or home visits received assistance coordinating these services.

SOUTH CAROLINA



**WILLIAMSBURG SCHOOL
HEALTH IMPROVEMENT
PROJECT
WILLIAMSBURG COUNTY, SC**

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After the Grant

The consortium will seek to continue offering the services supported by the Outreach Grant through funding and reimbursements from Medicaid, the Middle School grant, private insurance providers, the local school board, family support services, and other grants.

Target Service Area

Beaufort and Jasper Counties, South Carolina, cover approximately 1,271 square miles of rural terrain that include small islands and remote areas with varied distances between health and social services providers. In Beaufort County, 40 percent of the youth are non-White and 20 percent live in poverty. In Jasper County, 66 percent of the youth are non-White and 33 percent live below poverty level. The area has a lack of access to primary and preventive health and social services for youth, a lack of transportation for health care services during daytime hours, an increasing rate of teen pregnancy in Jasper County, and a large proportion of “working poor” without adequate health insurance. According to Kids Count (1998), South Carolina ranks 48th out of 50 States on a national composite ranking for 10 child well-being measures. All of the schools in the target area qualify as Chapter One schools with many students receiving free or reduced lunches.

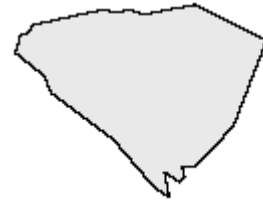
Network Objectives

The Youth Health Initiative was formed to increase access to health and social services and to improve health and social outcomes and educational performance of school-aged youth in Beaufort and Jasper Counties who do not receive health and social services. Beaufort-Jasper-Hampton Comprehensive Health Services (BJHCHS) partnered with Beaufort County School District (BCSD) and Jasper County School District (JCSD) to form the three-member school-based program.

Network Innovations and Results

School-based health clinics were established in six schools in Beaufort and Jasper Counties. BJHCHS, the only health care safety net provider in the service area, provided medical services and overall management of operations and finances of the program. Specific health and social services offered included physical examinations, diagnosis and treatment of illness and minor injuries, immunization updates, mental health services, and referrals to specialty care and social services including Medicaid, CHIP entitlements, and handicapped services. Teen counseling was also provided. Successful program innovations included: (1) free immunizations by the South Carolina Department of Public Health

SOUTH CAROLINA



YOUTH HEALTH INITIATIVE BEAUFORT AND JASPER COUNTIES, SC

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for all youth in the targeted schools resulting in all students being up to date on immunizations, (2) a registration form for each student entering the program for easy identification and logging, (3) a \$35 annual fee from each youth in the program to sustain the program, (4) a screening assessment intake form on each enrolled student, (5) the availability of a social worker to identify and enroll students eligible for Medicaid or CHIP and to perform case management on all enrollees, and (6) teen programs delivered to youth in the targeted schools. Teen pregnancy decreased over the grant period and is assumed to be attributed to the program's increased teen educational programs and counseling services.

Lessons Learned

High school students are reluctant to fill out Medicaid and S-CHIP forms on their own and are lax in telling their parents. Therefore, students were offered the incentive of extra class credit if they returned the completed form by the due date. An available social worker greatly enhances the effectiveness of a health team because she/he can enroll eligible children in Medicaid/S-CHIP and can make appropriate referrals for needed care. Collecting project data on illness-related absenteeism, test scores, and other information was not possible due to the lack of human resources in the small rural schools. Collaborations with State agencies and Kids Count are ways to facilitate data collection on certain health and social outcomes. One targeted school did not participate because the school nurse refused to take on additional responsibilities. Early buy-in from school nurses is essential for program success. Small rural communities are reluctant to offer sex education in the schools. Therefore, the availability of teen counseling services and educational programs is essential for addressing teen issues.

Potential for Replication

Children in rural areas need available health care services during school hours since some do not have a regular clinician or cannot get to health care appointments due to lack of transportation or working parents. Consequently, school-based clinics can work well in other rural communities. Enrolling eligible children in CHIP and Medicaid, providing immunizations through State agencies, and providing referrals for health problems are valuable mechanisms for addressing health care and social needs of rural, school-aged youth. Small rural school systems should assess their available space for conducting services before planning any program and consider using creative alternatives for providing space such as using a nearby church or public facility.

After the Grant

The three-member network is committed to continuing the Youth Health Initiative and all school-based health services will continue past the funding cycle with the possibility of adding three new schools. The program has received a grant from Healthy Schools/Healthy Communities to facilitate continuation. Dental services will be added to the school-based health program. Program income from enrollment fees and Medicaid/S-CHIP will also assist in sustaining the program.

PROJECT 35—FACILITATING HEALTH CARE FOR SPECIAL NEEDS CHILDREN IN SOUTHWEST WASHINGTON STATE

Target Service Area

The six-county service area is a 7,600 square mile region of southwest Washington State with a combined population of roughly 300,000. Five of the counties are designated Health Professional Shortage Areas, and two of the counties are Medically Underserved Population Areas. Welfare reform was implemented in Washington with a 5-year lifetime entry in the program. The 5-year limit for initial participants was ending as the grant period was ending.

Network Objectives

High unemployment, local and State budget cuts, and a projected \$2 billion shortfall in State Government encouraged the formation of a public-private partnership consortium comprised of Lewis County Children with Special Needs (LCCSN), the Children's Hospital & Regional Medical Center in Seattle with a satellite clinic in Olympia, and the University of Washington School of Pediatric Dentistry in Seattle. The project's specific goals were to: (1) identify children with special healthcare needs in six rural Southwest Washington counties and ensure medical and dental care; (2) strengthen partnerships that would allow for provision of locally provided medical and dental care; (3) evaluate the benefits and challenges of outreach to rural special needs children; and (4) establish innovative outreach care models.

Network Innovations and Results

The project consortium developed survey instruments, policies, procedures, and data forms and then contacted health departments, schools, and local medical and service providers to introduce project services and encourage referral of children with special needs. Because State law permits sharing of information between health departments and LCCSN, the consortium developed a special project with the Department of Social & Health Services and Children's Administration staff in six counties for referrals of children in foster care. It is estimated that nearly every child in foster care has special health care needs.

WASHINGTON



**FACILITATING HEALTH CARE
FOR SPECIAL NEEDS CHILDREN
IN SW WASHINGTON STATE
CENTRALIA, WA**

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When a referral was received, a project nurse contacted the family of the special needs child to conduct a health care needs survey and determine the necessary services and referrals. After intake was completed, nurses assigned case management priorities that determined contact timelines for families. In cases of mental health needs, families needed reinforcement of the importance of early intervention.

Project results are positive. Children with special care needs were identified and, although most families reported they were receiving primary medical care, there was a critical need for increased mental health and dental services. The development of sustainable services during and after the grant was a project priority. With grant-funded staff support, the project aided many specific outreach programs both in providing services and in program development. The project also facilitated delivery of numerous medical services into the community including nutrition counseling from a registered dietician, family-based team meetings with people involved in the care of children with special needs, dental services for children with special needs and their families, access to baby and child dentistry, and identifying gaps in mental health services through the aid of police, health, and juvenile departments.

Lessons Learned

The two significant barriers to project success were confidentiality of records and transience of families. Staff limitations in participating agencies prevented the careful assessment of records and the ability to contact parents for permission to release records. As a result, outreach staff were prevented from accessing information that would help identify program participants in need of services. Packets sent to families by outreach staff brought almost zero return. Because families move frequently and telephones are often disconnected, project nurses spent valuable time locating and contacting target families.

In retrospect, funding to develop a network prior to the outreach grant could be helpful in identifying core community advocates to develop a strategic plan to implement the outreach program, particularly in such a large geographical area. Another option might be to reduce the geographical area and include enough time to develop the strategic plan considering the lessons learned about the failure of families to respond when there is no personal contact due to their often-transient lifestyles.

Potential for Replication

The project model can bring communities together in a family-based system of care. National and regional dentist and nurse shortages compounded by decreasing numbers of doctors particularly affect rural communities. Furthermore, resources available to individual entities continue to decrease, making joint efforts to promote early intervention for children not only vital, but also mandatory for the success of this type of project.

After the Grant

Lewis County Children with Special Needs (a.k.a. Pope's Kids Place) will continue its services as a pediatric medical clinic, dental referral service, and respite center. A no-cost extension has been granted until July 2003. Therefore, reduced project staff hours will be committed to further development of dental programs, continued staff support for a new larger medical clinic, the construction of a dental clinic, the hospital-based pediatric dental service, and other dental services for children with special needs in the target service area. Because dental services for Medicaid-eligible and low-income children were so minimal before the outreach project, this represents the most successful program component.

Efforts will continue to identify funding to support existing programs and those yet to be developed. Project staff remain committed to continuing the effort to improve the lives of children with special health care needs and those living in poverty and other adverse conditions.

PROJECT 36—LINCOLN PRIMARY CARE CENTER RURAL OUTREACH GRANT PROGRAM

Target Service Area

Lincoln County is a rural, underserved, and disadvantaged area of West Virginia where many residents lack access to effective acute, chronic, and preventive care. The services offered by the Lincoln Primary Care Center were available to all residents of Lincoln County, West Virginia, as well as people living in surrounding areas. More than half of those served were female, and the vast majority of clients were adolescents and adults.

Network Objectives

The Lincoln Primary Care Center used its Rural Health Outreach Grant funds to improve access to care and the coordination of services for Lincoln County residents. To achieve these goals, the Lincoln Primary Care Center formed a partnership with Harts Medical Center, another community health center in the county; the Lincoln County Board of Education; the Lincoln County Health Department; and the Lincoln Ambulance Authority. In addition, the project engaged two regional partners—the Robert C. Byrd Center for Rural Health at the Marshall University School of Medicine, and Cabell Huntington Hospital. Other major goals for the project included:

- Increasing the satisfaction, retention, and effectiveness of area health care providers
- Improving the emergency medical system
- Establishing clinics targeting special populations
- Developing an after-hours telephone access system for triage and information
- Reducing unhealthy behaviors
- Augmenting local public health programs
- Promoting collaboration among the partners

Network Innovations and Results

One of the biggest challenges facing local health care providers is accessing patient hospitalization information. The Lincoln Primary Care Center implemented two innovative programs. The first project involved creating a secure, online system for primary care providers to access hospitalization records. The second project consisted of developing a secure, Internet-based system for health

WEST VIRGINIA



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GRANT PROGRAM
LINCOLN COUNTY, WV**

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care providers to access medical literature. By making this information available to local providers, the project hoped to improve the quality of care that patients received and to promote recruitment and retention of providers serving in the area.

The Web-based systems described above succeeded in helping providers access information about hospitalized patients and in creating a clinical information system to keep providers abreast of new advances in medicine. Other key project accomplishments included:

- Providing American Heart Association-certified training for emergency medical personnel, as well as external defibrillators
- Establishing specialized health care clinics at the Lincoln Primary Care Center for populations with unique health care needs including adolescents, older residents, and diabetics
- Implementing the After Hours Telephone Information System
- Providing computer equipment to the Lincoln County Health Department.

The Adolescent Clinic recorded 251 encounters, while the Geriatric Clinic recorded 528 encounters. In addition, the Diabetes Education Program sponsored 64 education and counseling sessions to educate residents about proper management of diabetes and the importance of a health-positive lifestyle.

Lessons Learned

The evaluation component of the project revealed many lessons learned. First, it is very important to have good communication and cooperation among members of the consortium. Next, it is important to hold regularly scheduled meetings to discuss project goals and progress. Finally, consortium members should be flexible and aware that there are different ways to achieve the same goals.

Potential for Replication

This type of project can be easily replicated in other rural communities as long as there are enough resources in the community to form such a partnership. It is important for other communities to realize that regular communication between and among the partners is critical to achieving project goals, measuring progress, and addressing challenges of mutual concern.

After the Grant

Most project activities will continue after grant funding expires. However, the After Hours Telephone Information System will be discontinued because of a lack of participation and insufficient resources for advertising and marketing the service.

Target Service Area

More and more children are at risk for developing type 2 diabetes. It is estimated that 13 percent of children aged 6–11 years old and 14 percent of adolescents aged 12–19 are overweight. Contributing factors include an increase in fast food and soda consumption and a decrease in activity levels among youth.

The Ho-Chunk Nation of Wisconsin is an ethnic group at greater risk for developing diabetes. Approximately 29 percent of the 5,600 tribal members report having diabetes. The rate of obesity is particularly high among Ho-Chunk children. A 1999 study conducted by the Ho-Chunk Healthcare Center indicated that 32.2 percent of children aged 5–14 were over the 95th percentile for obesity (weight-for-age).

Network Objectives

The Ho-Chunk Youth Fitness Program was developed to prevent or delay the onset of diabetes by reducing the rate of obesity among the children of the Ho-Chunk Nation. Consortium partners that implemented the program include the Ho-Chunk Nation Health Department, the University of Wisconsin Pediatric Fitness Clinic, and the Black River Falls, Baraboo, and Wisconsin Dells School Districts. While the primary goal of the project was to prevent type 2 diabetes, the Fitness Program strove to educate tribal youth about the benefits of physical activity and proper nutrition. The program targeted all Native and non-Native children between the ages of 6 and 18 in the Baraboo, Black River Falls, and Wisconsin Dells School Systems.

Network Innovations and Results

The Ho-Chunk Youth Fitness Program was housed in two locations, the House of Wellness in Baraboo and the Community Center in Black River Falls. The University of Wisconsin-Madison Pediatric Fitness Clinic provided training and support. Ho-Chunk Nation medical staff were trained by a pediatric endocrinologist on how to perform medical evaluations for overweight children. The University of Wisconsin also provided statistical analysis of the data obtained from the project. A referral system was set up with school nurses that targeted overweight children and their families. Upon acceptance into the Ho-Chunk Fitness Program, each child completed medical, nutrition, and fitness evaluations, and nutrition

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counseling. Participants in the Wisconsin Dells and Baraboo areas were picked up after school and brought to the House of Wellness for a 90-minute nutrition/fitness class.

The program used many innovative methods to educate program participants on the importance of good nutrition and an active lifestyle and taught how to make simple lifestyle changes to achieve healthy outcomes. In addition to the nutrition and fitness classes, methods included informative grocery shopping tours, family nights, in-home counseling sessions, low-fat cooking tips, a low-fat class recipe book, physical activities such as tag, kickball, weight lifting, and snow shoeing, and a community garden. Program participants and their families were responsible for upkeep of the garden but were able to harvest many types of fruits and vegetables in return.

To assess program results, pre-and post-tests were conducted every 6 months. Fasting insulin, glucose, cholesterol, body composition, and fitness levels were assessed. In a cohort study of 38 children over a 24-week period, pre- and post-test fasting insulin levels were compared. The results were significant at the $p < .01$ level. This was a positive finding to support the impact of diet modification and exercise on insulin levels.

Overall the program met its objectives. However, Ho-Chunk participation was lower than originally anticipated. Of the 77 program participants, 43 percent were tribal children.

Lessons Learned

Transportation was a challenge from program inception. Two of the school districts could not help with transportation due to geographical and logistical restraints. The Fitness Center attempted to “piggyback” on the Ho-Chunk Nation Casino Shuttle System. However, this did not work because the busiest time for the casino shuttle overlapped with the times needed by the Fitness Program. Eventually, the Ho-Chunk Nation donated one of its “retired” casino buses with the understanding that the Fitness Program would be responsible for vehicle maintenance, repairs, and insurance. As the project expanded, it outgrew the minibus. With carryover monies from Year 1 of the grant, the program was able to purchase a yellow school bus to aid in transportation.

Potential for Replication

With adequate staff, transportation, and community support, the Ho-Chunk Fitness Program for Youth model could be duplicated in other rural settings. The rise in childhood obesity and the healthcare costs associated with obesity-related issues makes this project model extremely timely. In tribal settings, program designers should not overlook the importance of gaining the trust and buy-in from community elders. Without including elders in the decision-making process, it may be difficult to recruit adequate numbers of tribal children into a program.

After the Grant

The Ho-Chunk Youth Fitness Program has received several awards for its work. The American Association for World Health awarded the program in recognition of its leadership in creating a successful and innovative physical activity promotion program for an at-risk population. The Ho-Chunk Youth Fitness Program now plans to expand into other tribal communities throughout the Ho-Chunk Nation in Wisconsin. This expansion will mean the need for additional staff and increased parent participation. The consortium members are seeking additional funding through Federal and foundation grants to continue the current program and its future endeavor, the Ho-Chunk Youth and Family Fitness Project.

Target Service Area

Four counties in central Wisconsin—Portage, Waupaca, Waushara, and Marquette—are essentially rural and sparsely populated. The local economy relies heavily on agriculture, agri-processing, and tourism. There is no public transportation system except a limited bus route within the City of Stevens Point. Of the area’s residents eligible for Medicaid, only 12 to 38 percent actually receive dental care in the four-county service area, leaving a large portion of individuals unserved. Local and national sources indicate that the major reason for this shortfall is the lack of dentists accepting Medicaid patients due to low reimbursement levels and heavy paperwork requirements.

Furthermore, the problem of inadequate fluoride levels in drinking water varies from county to county. In Marquette County, the only fluoridated water supply is in the City of Motello, which serves 12 percent of the county population. All other households procure water from private wells. Public health officials estimate the need for fluoridated water or supplements ranges from 80 percent of the population in Marquette County to 25 percent in Waushara County.

Network Objectives

CAPS Services (CAP), a community action agency; Family Health Medical and Dental Center (FHM&DC), a Federally funded health clinic; and the local public health departments in the area’s four counties are partner members of the Rural Health Initiative project. Together, the consortium provided dental health services to low-income residents including: outreach, transportation to dental appointments using Head Start buses, affordable dental care, and preventative fluoride supplements.

Network Innovations and Results

The project provided several innovative solutions to the lack of affordable dental care problem in the area. First and foremost, patients were transported from the target counties to the FHM&DC in Wautoma for dental assessment and followup treatment 1 day per week. CAP used its Head Start buses to provide transportation from two Head Start Centers on Fridays when buses were not otherwise in use. Area residents living in areas with low fluoride levels

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were encouraged to have their water tested. Project staff linked those who requested testing with their county's public health staff who then administered the fluoride supplement component. Participants received testing kits free of charge.

Lessons Learned

The first significant lesson learned was the extent of the lack of dental care for low-income residents of the area. The demand for services was overwhelming. Secondly, the project revealed a great need for fluoride assistance, particularly in Marquette County where only one city has fluoridated water. The worse cases of poor oral health also came from Marquette County, possibly as a consequence of the lack of fluoridated water.

The project's main barrier to success was the occurrence of no-shows. Reasons for no-shows varied and included apathy, lack of reliable transportation, and time conflicts. Consequently, the Project Coordinator increased the number of telephone reminders as one solution. Clinic staff also maintained a list of on-call patients who could come from nearby to fill empty appointment slots as needed.

Potential for Replication

The Rural Health Initiative model is suitable for replication in other rural counties where there is the presence of Head Start and a rural health center. This project sought to make the most cost effective use of these available resources (e.g., the Head Start buses and the clinic). One major barrier to success of this model is the potential for no-shows. Other areas considering implementing this type of program should assess the distance from patients' homes to the clinic. Long bus rides, waiting time, and return trip times increase the chances of time conflicts. Also, as more parents move into the labor market and work longer hours due to welfare reform programs, adding night or evening service may help solve the no-show issue.

After the Grant

The specific activities of this project will not continue beyond the grant phase. Instead, new opportunities for dental services in the target service area have emerged. Two of the consortium members have expanded their services and will offer dental care. The Family Health Medical and Dental Center is adding five new operatories, an additional full-time dentist, and support staff. CAP anticipates this expansion will allow the clinic to serve more residents of the southernmost portions of the target service area. The remaining portions will be served by the new dental center developed by CAP and its two partners. Located in Stevens Point, this new clinic will serve area patients enrolled in Medicaid and BadgerCare.

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