DOCUMENT RESUME

ED 451 000 RC 022 856

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TITLE The Outreach Sourcebook, Volume 5: Rural Health Demonstration Projects, 1995 to 1998.
INSTITUTION Health Resources and Services Administration (DHHS), Rockville, MD. Office of Rural Health Policy.
PUB DATE 2000-01-00
NOTE 91p.
AVAILABLE FROM Full text at Web site: http://ftp.hrsa.gov/ftp/ruralhealth/orhpvol5.pdf.
PUB TYPE Reports - Descriptive (141)
EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS Community Health Services; Consortia; Demonstration Programs; Federal Aid; Health Education; Health Programs; *Health Promotion; *Health Services; Medical Education; *Outreach Programs; Professional Continuing Education; Program Descriptions; *Rural Areas; School Health Services
IDENTIFIERS Access to Health Care

ABSTRACT

In 1995, the federal Office of Rural Health Policy awarded 3-year outreach demonstration grants to 25 projects to provide direct primary and preventive health care services to rural residents in 20 states. The grant program allows recipients to test innovative ideas against persistent problems of rural health care, such as provider shortages, fragmented delivery systems, and geographic isolation. Recipients must form a consortium of three or more local institutions or agencies to work together toward project goals. Overall, the projects addressed a broad range of rural health care needs. Over half focused on specific needs of mothers, infants, children, and adolescents. Rural minorities, including Hispanics, African Americans, and Native Americans, were the primary beneficiaries in nine projects, and eight projects addressed the needs of the elderly. Seven projects focused their activities in rural schools, which are convenient and effective sites for rural service delivery. Almost every project provided some type of health promotion/education programming for the public, and over half provided continuing education opportunities to health professionals. Three noteworthy programs developed a Nevada statewide network of community health nurses to provide health education to rural students and adults; taught cardiopulmonary resuscitation (CPR) to 10 percent of the population in the project's rural New York service area; and developed a one-stop referral system improving access to care for Grand Junction, Colorado, children aged birth to 18. Short descriptions of the 25 projects summarize activities and include innovative features, obstacles encountered, reasons for success, and contact information. (Contains title and subject indexes.) (SV)

HRSA
Health Resources and Services Administration

OFFICE OF RURAL HEALTH POLICY

THE OUTREACH SOURCEBOOK

VOLUME 5

RURAL HEALTH DEMONSTRATION PROJECTS

1995 TO 1998

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JANUARY 2000

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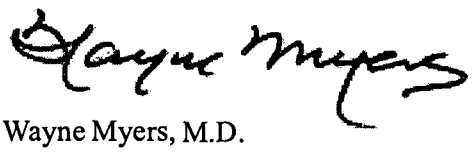
PREFACE

The Office of Rural Health Policy's grant program continues to grow and provide access to care to the neediest citizens of this country. With more than 400 grants awarded since the start of the program, consortia in rural communities are developing innovative health care delivery systems to improve the care and quality of life of their communities.

Volume V summarizes the experiences of the grantees initially funded in 1995. It addresses a broad range of rural health care needs. As a group, these grantees were extremely successful in reaching their program goals and in securing the continuation of the activities after their Federal funding ended.

This report is a summary of the individual grantees' experiences, a narration of what worked and what did not work, and a description of what the grantees did to refocus their energies and resources and to reevaluate their goals and objectives to meet the needs of their particular communities. The product is a portrait of the creative and innovative programs that a group of dedicated, collaborating people can produce.

It is my hope that those reading this report will find it a valuable source of innovative and creative approaches to improving the rural health care delivery system.



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In September 1995, the Office of Rural Health Policy (ORHP) awarded outreach demonstration grants to 25 projects located in 20 States. (A map showing their locations follows this overview.) These projects have provided direct primary and preventive health care services to an estimated 195,000 rural residents during the 3-year grant period. In addition, many thousands more have benefited from the enhanced knowledge and skills gained by their health care providers in continuing education opportunities. Most projects have succeeded in securing their financial viability after the grant, ensuring better access to health care in their communities for many years to come.

The outreach grant program has allowed recipients to test innovative ideas against the most persistent problems in rural health care. Provider shortages, fragmented delivery systems, cultural and language barriers, uninsured populations, and geographic isolation are just some of the challenges these projects have encountered. With the help of dedicated professionals and volunteers and community support, these projects have fashioned creative solutions to provide vital services to their communities. Many have already witnessed measurable improvements in the health of the people they serve. A brief summary of the projects is presented here, followed by their individual stories.

Taken as a whole, these projects address a broad range of rural health care needs, including primary and preventive health care, emergency medical services (EMS), hospice care, dental care, substance abuse treatment, mental health counseling, and programs for those with developmental and learning disabilities. Social concerns that affect public health are also addressed, including family violence, teen pregnancy, teen delinquency, access to public and private health care benefits, and the special needs of the elderly and their caregivers.

More than half these projects focus specifically on the needs of mothers, infants, children, and adolescents. Rural minorities, including Hispanics, African-Americans, and Native Americans, are the primary beneficiaries in nine projects. Eight projects address the specific needs of the elderly and their caregivers. Almost every project provides some kind of health promotion or education programming for the public.

Although most projects focus their efforts within a single county or several adjacent counties, some provide specialized services to larger areas. The Rural Education and Community Health project in Nevada (Project 16), for example, developed a statewide network of 32 community health nurses who provide health education programs throughout the State's 15 rural and frontier counties. Nearly 15,000 adults participated in the project's health education programs, and an additional 10,000 rural students took part in the project's heart-health curriculum. Another outreach project, The Electronic Network for the Coordination of EMS Data and Education (Project 15) in Montana, established a statewide computer network linking 103 ambulance services and 6,500 EMS providers.

ORHP awards these demonstration grants to a wide variety of organizations, including hospitals, local health departments and other government agencies, community health clinics, Native American tribal organizations, and universities. Recipients are required to form a consortium of three or more separately owned, local institutions that will work together to meet project goals. The purpose of this requirement is to foster cooperation in rural communities and

the sharing of scarce resources. Consortium members can be health care providers, government agencies, educational institutions, or any other actively participating organization—public or private, profit or nonprofit.

The consortium arrangement has played a crucial role in the success of these projects. By combining their strengths and resources, consortia members have found that they can explore innovative ideas, solve problems, develop networks and referral patterns, and deliver comprehensive services more effectively than can individual members acting alone. As the grant period progressed, many of these successful networks expanded to include more agencies, creating an even larger pool of expertise and resources. By the end of the grant period, a large number of projects had proven so fruitful that members were planning to continue or even expand their collaborative efforts.

Although some consortia had been established long before applying to the outreach grant program, in a majority of projects the relationships formed under the grant represent the first time these agencies have worked together on a formal basis. This arrangement created some challenges, particularly when members had strong philosophical differences. "A consortium comprising members with disparate goals is not an effective consortium," noted one project director. Consortia can succeed, he continued, only when members set clear goals and have well-defined roles.

Each project is encouraged to become self-sufficient by the end of the grant period, and this group of grantees has been particularly successful in meeting this goal. As of August 1998 (the end of the grant period), 21 of the 25 projects (84 percent) had secured funding for continuing all grant-related services after their outreach grant expires. Of these 21, 3 expect to be fully self-sufficient through reimbursement of services (i.e., Medicaid, Medicare, private insurance) or service contracts. The other 18 plan to supplement their revenues with additional funds from local, State, and Federal sources; fundraising; grants; and in-kind contributions from consortium members. Of the remaining four projects, three were waiting to hear from funding sources but were confident that some project activities would continue after the grant period, and one planned to offer only limited services.

Probably the most frequently cited secret for success mentioned by project directors is the ability to remain flexible and responsive to the actual needs and available resources in the community. Many projects conducted focus groups during the initial phase of the grant. Others formed ongoing advisory committees to ensure that project activities meet identified needs within their target populations. Projects that extend these efforts continue to reap the rewards of community support and participation.

One project that has experienced an especially high degree of community participation is Save My Neighbor (Project 17), in Potsdam, New York. More than 3,500 individuals—a remarkable one-tenth of the population living in this project's service area—participated in the cardiopulmonary resuscitation (CPR) courses offered by the project. In a survey taken shortly before the grant period ended, 6 percent responded that they had already had the unfortunate opportunity to use the skills they learned in their CPR class.

Many of the projects described in this book are replicable in a wide variety of American communities, and it is hoped that the experiences described here will help other health care providers as they implement similar programs. One particularly noteworthy project is B4 Babies and Beyond Healthy Start Program (Project 4) in Grand Junction, Colorado. The project is designed to improve access to care for children from birth to age 18 living in Mesa County. It offers a one-stop referral system that provides information and assists clients in accessing financial aid programs for which they are eligible. The project also assigns children to 1 of 69 primary care physicians who participate in the Children's Provider Rotation system implemented by the project, which includes all but one physician in the area. In 1998 the B4 Babies and Beyond Program was recognized by the U.S. Department of Health and Human Services in its Models That Work campaign. The campaign showcases and promotes the replication of six innovative, grassroots programs that have proven strategies to provide better, lower cost health care for America's neediest citizens. The B4 Babies and Beyond Program was recognized as the model that excelled in child health outreach. The program coordinator attributes much of this project's success to its solid statistical-gathering system: "Being able to determine if the program has had an impact on health-related issues, and being able to measure that impact, has aided in sustaining community support and in obtaining funding."

Several projects are designed to address social concerns that affect public health, particularly child abuse and neglect and domestic violence. Risk factors associated with these problems are present in many rural underserved areas, including high rates of poverty, unemployment, substance abuse, and teen pregnancy. In response to a growing number of reports of child abuse and neglect in Ross County, Ohio, a diverse network of service providers formed the Child Protection Center (Project 20) with the goal of preventing, detecting, and treating child sexual abuse through a local, coordinated response. A pediatrician, nurse, social worker, child therapist, and community outreach specialist provide services to the child and his or her family. The local sheriff's department, police department, and prosecutor's office also collaborate with the project. The program is innovative in that all the participating agencies provide services at one location in a coordinated fashion. During the grant period, the number of reported cases that Ross County Children's Services was able to substantiate more than doubled. Some of this improvement can be directly attributed to the activities of the outreach project, notes the project director.

Seven outreach projects have focused their activities in rural schools, and most have found these sites to be effective places for service delivery. In many rural areas, the school is the hub of the community, making it a convenient place to provide health care services not only to children and adolescents but also to parents and other community members. The Rockingham County Student Health Centers project in Eden, North Carolina (Project 18), for example, established a full-time student health center in each of the county's four high schools. A multidisciplinary team of providers delivers comprehensive health care at the school health centers; the health care includes treatment, prevention, education, and referral. About 4,000 students attend the 4 high schools, and the project experienced more than 51,000 visits to the health centers during the grant period.

PROGRAM OVERVIEW

One of the unusual aspects of the student health center project is that its lead agency is a hospital and not a public health department. The hospital administrator, who also served as project director, notes that "As managed care becomes more prevalent in our society, hospitals will need to take on increasing roles in the area of health promotion and wellness. School-based health centers can serve as model sites in this expanded service area." The project succeeded, he continues, because it invited all county health agencies to join the consortium early in the project's development. "The consortium brought a broad base of support and provided the student health centers with additional credibility, which allowed them to grow and flourish."

Two projects used mobile medical clinics to deliver needed health care services to remote areas. The HealthQuest project (Project 6) is especially noteworthy for its cooperative structure. Six diverse health and social service organizations in north central Indiana shared the use of a mobile medical clinic to provide services to underserved rural populations, including an Amish community and the migrant farmworker population. The joint effort demonstrates that cooperative ventures can help facilitate improvements in the delivery of health care. All the participating agencies experienced an increased demand for their primary and preventive health care services as a result of the mobile medical unit. During the grant period, the project experienced almost 18,000 client encounters including more than 1,200 new Women, Infants, and Children/Maternal and Child Health clients and more than 200 Hispanic migrant workers who had never before received care in the United States.

Three projects turned to telecommunication technologies to bridge the distance barrier. They use telephone lines to transmit real-time audio and video between a number of sites on a network. The James B. Haggin Memorial Hospital Telemedicine Project (Project 11) in Harrodsburg, Kentucky, for example, uses telemedicine technology to deliver specialty care to citizens of rural central Kentucky. Through the telemedicine network, patients at the rural hospital receive consultations with specialists at the University of Kentucky Medical Center, a tertiary care center located 40 miles away in Lexington. The project also uses the network to provide continuing medical education programs to rural health care providers. In addition, during the final year of the grant, the project set up school-based telemedicine sites in one middle school and one elementary school in Harrodsburg. Typically, school nurses served as presenters for consultations with specialists at the university medical center. Telemedicine at the schools soon became well accepted and applied; within a short period, usage climbed to 10 to 15 telemedicine consultations per month.

Almost every project offers some form of health promotion and education programming, either to the general public or to health professionals. This focus on education ensures lasting benefits to the community even if the project is unable to continue after the grant period. More than half the projects provide continuing education opportunities to health professionals. Also, 22 of the 25 offer health education programs to the public in addition to one-on-one patient education. These public education programs cover more than four dozen health topics, ranging from conflict resolution, to farm safety, to teen health concerns. The most common topics are nutrition, cardiovascular health, alcohol and other substance abuse, medication management and compliance, and elderly health issues.

The handful of programs mentioned above represents just some of the innovative outreach activities conducted by this industrious group of grantees. Together, they have filled a crucial niche in this Nation's rural health care system and will continue to do so for many years to come. Successful grantees have worked hard to understand what is unique about their community and have paid close attention to local needs and values in developing their programs. This process is ongoing, and the benefits increase with time because the more capably a project serves its community, the more likely it will gain long-term support. As these projects finish their outreach grants and proceed into the next phase of development, community support is probably the most valuable asset they could possess.

AHA	American Heart Association
AIDS	Acquired Immunodeficiency Syndrome
CME	Continuing Medical Education
CPR	Cardiopulmonary Resuscitation
ECT	Emergency Care Technician
EKG	Electrocardiogram
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EPSDT	Early Periodic Screening and Diagnostic Treatment
HIV	Human Immunodeficiency Virus
IHS	Indian Health Service
MCH	Maternal and Child Health
STD	Sexually Transmitted Disease
WIC	Women, Infants, and Children

Caribou
MAINE
Potsdam
NEW YORK
Oak Hill
OHIO
Chillicothe
Harrodsburg
KENTUCKY
Eden
NORTH CAROLINA
Hartsville
SOUTH CAROLINA
Bluffton
INDIANA
Balsam Lake
WISCONSIN
Vandalia
ILLINOIS
Crookston
MINNESOTA
Grastinger
IOWA
Centerville
Osceola
Russell
KANSAS
Fort Totten
NORTH DAKOTA
Box Elder
Bozeman
MONTANA
COLORADO
Grand Junction
Springerville
ARIZONA
Carson City
NEVADA
Shelton
WASHINGTON
John Day
OREGON
Juneau
Homer
ALASKA

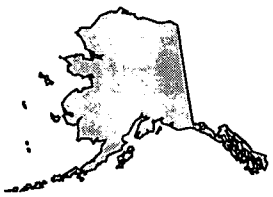
The South Peninsula Hospital in Homer, Alaska, established the Community Health Outreach Program to provide much-needed support and education to the nearly 900 elderly and disabled individuals living in the lower Kenai Peninsula. South Peninsula Hospital is the only hospital serving the 100-mile-diameter area.

The two most successful components of the project have been a medication management program and a volunteer visitors program. A walk-in clinic established in the home health department of the hospital assists seniors in managing their medications and in setting up their medication organizer boxes. The Volunteer Visitor Program has helped decrease isolation for 24 homebound seniors. In addition to providing social interactions, the volunteers work with the homebound clients on home maintenance projects and gardening. A project survey reveals that the program has significantly elevated the mood levels of its clients.

The project also established a number of support groups and education programs for elderly clients and their families. A Caregiver Support Group and a Hospice Grief Support Group met regularly and were well attended. The project also offered, at various times, a Financial Planning Forum, an Alzheimer's Disease Forum, and an Advanced Directives and Planning Forum. Other educational programs included a Medicaid Application Process Workshop, a Stages of Grief Workshop, and a Grief and End of Life Decisions Workshop.

Finally, the project conducted outreach activities and built relationships with some of the small villages in the region. Project staff make monthly visits to the villages of Port Graham and Nanwalek and have been successful in opening the lines of communication with the village council, village health aides, and village counselors. "Community networking consumes much time, energy, and resources," notes the project director. "We need to plan for more allocation in those areas." The project has also established a resource library that includes books, publications, and videos available for lending. The library was established at the Friendship Assisted Living Facility where the caregiver support group meets monthly.

ALASKA



Community Health Outreach Program

South Peninsula Hospital

Homer, Alaska

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PROJECT 1

Community Health Outreach Program

South Peninsula Hospital, located in Homer, serves as the lead agency for the project. Other consortium members include the Hospice of Homer, a volunteer organization; Homer Senior Center, Inc., a nonprofit agency that provides housing, meals, transportation, and adult day-care services; and Chugachmiut, a nonprofit branch of the Chugach regional native association. A community mental health center provides consultation on individual cases.

The project has gained valuable experience in working with volunteers, notes the project manager. "Volunteers should be compensated even though they are not receiving money," she says. "There are many nonmonetary incentives to help volunteers feel like irreplaceable members of the team." Interest in volunteering tends to wane during the summer months in this area. In the future, the project will look for ways to keep volunteers connected with the program without giving up their summer activities.

Another lesson learned was that the success of the initial visit often determined whether the volunteer would continue with the program. To help break the ice, staff members often accompany the volunteer on the initial visit and encourage the volunteer and client to come up with a home maintenance project they could do together. "In general," writes the project manager, "the more clear the roles, the routine, and the schedules, the more likely the 'match' will succeed."

One of the most valuable benefits of the project was the increased collaboration between consortium members. In addition to holding quarterly consortium meetings, the project also sponsors a regular Senior Breakfast Meeting attended by representatives from nine agencies working with the elderly. Through this forum, these agencies have received information on Medicaid regulations and hospice care and have developed a clearer understanding of elder care needs in the community. Since the establishment of the forum, duplication of services between agencies has also diminished.

South Peninsula Hospital and Hospice of Homer will continue to offer the project's support groups and educational programs after the grant period. Project staff are continuing to seek funding for the volunteer visitors and the medication management programs.

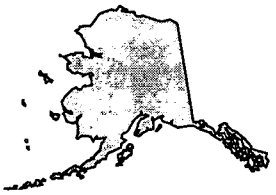
A consortium of Federal, State, university, and nonprofit agencies implemented innovative programs designed to reduce injuries and deaths to commercial fishing, fish processing, and aquaculture employees in rural Alaska. The commercial fishing industry is one of the most hazardous occupations in the United States, and the State of Alaska has the highest fatality rate in the industry—200 fatalities per 100,000 workers per year in 1991 and 1992. Alaska also has the highest drowning rate in the country—almost six times the national average. More than 1,100 individuals lost their lives in drowning and boating fatalities in Alaska during the 1980s, accounting for 23 percent of all unintentional injury deaths.

In addition to being at risk for drowning, employees of commercial fishing and aquaculture also risk near-drowning, hypothermia, and frostbite. Aquaculture personnel incur lacerations from marine organisms and abrasions from marine substrate that can lead to serious infections. Shellfish farmers come in contact with potentially deadly marine biotoxins that can cause paralytic staphylococcus infections, amnesiac poisoning, and diuretic shellfish poisoning.

To address these safety problems, the consortium first collected and analyzed data on injuries and fatalities among commercial fisheries, shellfish farms, aquaculture sites, and fish hatcheries. Data were collected from the statewide Alaska Trauma Registry, Bureau of Vital Statistics Cause of Death data, and Worker's Compensation data for the years 1982 to 1996. Data were also gathered from self-reporting surveys sent to shellfish farms, aquaculture sites, and hatcheries. Through analysis of the data, project personnel identified clusters of injuries and then developed and implemented strategies to prevent or mitigate these injuries in the future.

Since the project's inception in October 1996, it has developed and provided 14 workshops and courses on various topics, including commercial fishery safety, marine safety, dive safety, survival training, first aid, and the effects of substance abuse on marine safety.

ALASKA



Injury Prevention in Commercial Fisheries and Aquaculture Industries

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Almost 1,200 individuals participated in these training courses during the first 2 years of the grant period. The courses are designed to address safety issues of specific groups. For instance, one course was targeted to fishermen working on small, near-shore fishing vessels and to whalers of the Arctic Ocean (46 participants). Another course targeted specific types of commercial fishing operations (58 participants). Search-and-rescue personnel working in southeast Alaska were provided a course in survival (13 participants). High school teachers in several seaside communities were provided a 2-day marine safety training course, and a lesson and activity manual on marine safety was developed for students in kindergarten through 12th grade. More than 400 high school students have participated in various marine safety activities sponsored by the project.

In addition, the project published and distributed a number of safety manuals and articles statewide. These publications cover dive safety, aquaculture safety, sleep deprivation, and diving emergency guidelines.

The project's consortium is headed by the Alaska Department of Health and Social Services, Division of Public Health, Section of Community Health and Emergency Medical Services. Other consortium members are the Alaska Marine Safety Education Association (AMSEA), a nonprofit organization; University of Alaska Marine Advisory Programs; National Institute for Occupational Safety and Health; Alaska Activity; and Alaska Area Native Health Service, a Federal agency.

"Much of the project's success can be attributed to the makeup of the consortium," writes the project manager. "The balance of knowledge and expertise among consortium members, the members' commitment to the reduction of injuries and death in the fisheries and aquaculture industries, the members' previous collaboration on similar projects, and the members' support of each other's efforts proved to be the keys to success."

A statewide network of 350 instructors provided much of the marine safety and injury prevention training for the project. These instructors were trained through the AMSEA Marine Safety Instructor and Marine Drill

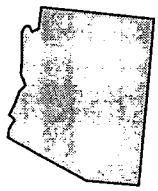
Injury Prevention in Commercial Fisheries and Aquaculture Industries

Instructor courses. They live in communities throughout the State and therefore have the advantage of training people from their own communities or regions. The use of these instructors also reduced the project's travel costs significantly. During the first 2 years of the grant period, more than 500 individuals took these courses for the purpose of becoming instructors.

Although it is too soon to evaluate the impact of these courses on fatality and injury statistics, preliminary data suggest a significant reduction in drowning fatalities in the commercial fishing industries in 1997 and 1998. Unfortunately, the project had difficulty obtaining baseline data from the aquaculture industry, and the data, it did obtain were incomplete. As a result, it will not be possible to evaluate the efficacy of the injury prevention strategies for this industry.

All project activities will continue after the grant period with support from various State funding sources. The consortium will continue to work actively together to gather and analyze injury data and provide marine safety educational activities. A new Federal grant will fund the continuation and expansion of the water safety instruction program in the public schools.

ARIZONA



Improving Diagnostic Testing Services for Rural Communities

White Mountain Regional Medical Center

Springerville, Arizona

Two health care providers in distant communities worked together through this outreach project to address a very specific problem in rural health care delivery—the need for prompt analysis of diagnostic laboratory tests.

The Health Horizons outpatient clinic in St. Johns, Arizona, did not have the facilities to interpret laboratory specimens on-site. Before this outreach project, most of the clinic's patients would have to drive 28 miles to the White Mountain Regional Medical Center in Springerville to have laboratory diagnostic tests. Some patients under certain insurance plans would have their specimens drawn at the clinic and then sent by courier 200 miles away to a hospital in Phoenix for analysis. The average transit time for laboratory samples was 12 hours, during which time the specimens often deteriorated or were lost in transit.

To address this problem, the project created a courier service to bring the clinic's laboratory specimens and x-rays to the White Mountain Regional Medical Center twice a day for interpretation and analysis. The courier also returns the test results and x-rays to the clinic in St. Johns twice a day.

The Health Horizons clinic owned an x-ray machine and processor before the outreach project began, but no one was licensed to operate the equipment. Patients with fractures had to drive the 28 miles to the hospital in Springerville for x-rays. The project has provided an x-ray technologist to the Health Horizons clinic to take and process the x-rays as well as a phlebotomist to collect the laboratory specimens and prepare them for transport.

The changes made under this grant have significantly improved the turnaround time for laboratory test results and x-ray interpretations for patients in St. Johns. Specimens collected at the clinic there are now transported to the White Mountain Regional Medical Center within 4 hours of collection 100 percent of the time. Results are generated and reported within 12 hours of collection 80 percent of the time. (The rest require additional cultures or testing.) During the 3-year grant period, the project collected and interpreted 1,152 laboratory tests for 415 patients at the Health Horizons clinic. It has also taken and interpreted 256 x-rays for 212 patients.

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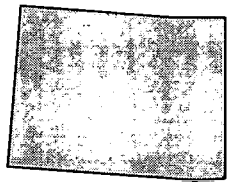
Improving Diagnostic Testing Services for Rural Communities

The project faced several challenges. Recruiting the x-ray technician and the phlebotomist was the greatest difficulty. The remoteness of the area, the pay scale offered, and a lack of money to reimburse the travel expenses of applicants to come for an interview kept many applicants away. The advanced age of the x-ray equipment was also a problem. On several occasions, vendors could not find parts to repair the equipment, and eventually the project had to replace the unit. "In the future, we will have the equipment evaluated and have money built into the budget for repairs," writes the project manager.

Leading the project's consortium is the White Mountain Regional Medical Center, a fully accredited, nonprofit rural facility that serves 14 small, geographically isolated, rural communities in eastern Arizona and western New Mexico. Other participants in the consortium are Health Horizons, Inc., which operates the outpatient clinic in St. Johns, and the City of St. Johns, which owns the clinic space and x-ray machine. According to the project manager, one reason that the project succeeded is that the community and health care providers are committed to the project's goals and to working through unforeseen problems.

The diagnostic testing services created under this grant will continue to improve and expand after the grant period. The White Mountain Special Healthcare District (the tax district in southern Apache County) has received a grant to build a new health care facility in St. Johns. The new facility will contain new x-ray equipment and a new laboratory capable of performing limited onsite diagnostic test procedures. White Mountain Regional Medical Center will continue to provide the phlebotomist and x-ray technician. Reimbursement is expected from Medicare, Medicaid, various insurance providers, and patients paying out-of-pocket. To increase productivity, the phlebotomist and x-ray technologist are being cross-trained to perform limited duties of each other's positions.

COLORADO



B4 Babies and Beyond Healthy Start Program

Hilltop Community Resources, Inc.

Grand Junction, Colorado

B4 Babies and Beyond is an award-winning program designed to improve access to health care for children from birth to age 18 living in Mesa County, Colorado. The project offers a one-stop referral system that provides information and assists clients in accessing financial aid programs for which they are eligible. The project also assigns children to 1 of the 69 primary care physicians who participate in the Children's Provider Rotation System implemented by the project.

In 1998, the B4 Babies and Beyond program was recognized by the U.S. Department of Health and Human Services in its Models That Work campaign. The campaign showcases and promotes the replication of six innovative, grassroots programs that have proven strategies to provide better, lower cost health care for America's neediest citizens. B4 Babies and Beyond was recognized as the model that excelled in child health outreach. It could be replicable in a wide variety of American communities.

The child-care component of B4 Babies and Beyond is modeled after its highly successful prenatal-care component (formerly known as B4 Babies), which was supported by an outreach grant from 1991 to 1994. The prenatal program has continued to succeed and has had a significant impact on birth outcomes in Mesa County. In 1997, 43 percent of Mesa County births were to its clients. The rate of low-birth-weight babies to B4 Babies' clients was 5.3 percent compared with 7.5 percent for the county. The B4 Babies program has had tremendous experience in building and strengthening collaborative programs in the community, and it has been able to use the same or similar systems to implement the new child-care component.

According to the 1990 census, more than 20 percent of Mesa County's youth younger than age 18 live below the Federal poverty level (doubled from a decade earlier), and 34 percent of the youth in Grand Junction, the county's largest city, live below that level. Many of the county's families either do not know about or do not understand how to access the low-cost health care programs available to them. B4 Babies is designed to overcome the common barriers of low-income families to receiving health care. These barriers include their literacy level and inability to fill out necessary forms, their lack of knowledge about available programs,

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B4 Babies and Beyond Healthy Start Program

their extreme fear of social services and other State agencies, and the long distances inherent in the area's semirural environment. Yet another barrier is their sense of independence and pride and the perceived stigma of applying for "welfare programs." To address these barriers, B4 Babies and Beyond strives to provide services in a manner that treats clients with dignity and encourages them toward self-sufficiency.

When a new client contacts the B4 Babies and Beyond program, a staff member conducts an initial screening over the phone to ascertain the individual needs of the family. Then an intake appointment for the client is set up, generally within 5 working days, and the client gets clear instructions on the information to bring to the appointment. Families with sick children are given a program appointment and a health care appointment, usually on the same day but at least within 24 hours of calling. At the appointment, an intake worker assists the client in completing the applications, gathering verifications, and determining eligibility for public insurance programs. These programs include the Colorado Child Health Plan (Federal Children's Health Insurance Program), Baby Care Kids Care Medicaid, Ribicoff Children's Program, Colorado Indigent Care Program, and private insurance programs.

Program staff attempt to match clients with the provider of their choice and also look at the special medical and financial needs a family might have. They also refer clients to other programs that are appropriate for the individual client. The most common are Women, Infants, and Children Supplemental Foods, Young Parents Program, Jobs Program, Family Planning, low-income housing, food stamps, parenting classes, Aid to Families with Dependent Children or the new Temporary Assistance for Needy Families programs, and Low-Income Energy Assistance Program. Bilingual-bicultural staff are available for appointments and followup services. More than 90 percent of the program's clients are within 185 percent of poverty, and no reimbursement is received for services offered by this program.

Referrals to the program come from several of its consortium members, including the Marillac Clinic, the Mesa County Health Department, and school nurses throughout

B4 Babies and Beyond Healthy Start Program

the Mesa County School District. Other consortium members include the Rocky Mountain Health Maintenance Organization, the Independent Physicians Association (a local organization), the Colorado Migrant Health Program, the Center for Enriched Communication (a counseling program), and St. Mary's Family Practice (a medical clinic). Leading the consortium is Hilltop Community Resources, Inc., a local organization that provides professional nonprofit management services to community-based organizations that foster self-sufficiency and quality of life. In addition, Dr. Suzanne Tucker and Gretchen Sigafoos have assisted the project in gathering birth outcome information and in creating statistical reports.

The project has a large outreach component that includes presentations to social service providers and other referring agencies, back-to-school nights, school nurses, and health fairs; mailings to schools and State and county health departments; public service announcements on television; and articles and advertising in print media. More than 24,000 brochures and applications were distributed to all students in the Mesa County School District in its 1998 fall enrollment package.

One of the key elements in the successful implementation of the project has been the commitment of active, dedicated, and concerned providers. Sixty-nine local physicians and 21 residents participate in the provider rotation, accounting for all but 1 physician in the area. Although many physician practices are closed and do not accept new clients who call on their own, the physicians continue to accept new clients coming through the provider rotation. The project has worked hard to educate physicians about the reimbursement available through the Colorado Child Health Plan. "In addition to seeing that each family had a primary care provider, we also made it our goal to see that the providers were cared for," notes the program coordinator.

Key to this project's sustainability is its solid statistical gathering system. According to the program coordinator, "Being able to determine if the program has had an impact on health related issues, and being able to measure that impact, has aided in sustaining community support and obtaining funding."

B4 Babies and Beyond Healthy Start Program

The most challenging aspect of the project, and a mark of its success, is the number of children applying for services. During the 3-year grant period, the project served 3,499 children, more than 3 times the projected number. The community response was so overwhelming, and program staff so stretched to capacity, that the project had to limit outreach activities during the last year of the grant. A particular challenge has been the 10 to 12 uninsured children each week who need a program appointment and a health care appointment on the same day because they are ill. "The need continually surpasses our expectations," notes the program coordinator. Despite the tremendous success of this program, it is estimated that of the 21,798 children in the Mesa County School District, 7,200 children are eligible for the Baby Care Kids Care Program or the Colorado Child Health Plan (within 185 percent of poverty) but are not currently enrolled.

Hilltop Community Resources has designed and implemented a unified and comprehensive fundraising program that includes foundation and corporate development, major donor campaigns, endowments, special events, and community education. The organization is committed to supporting the B4 Babies and Beyond program in its funding campaigns.

When the Fayette County Health Department in south-central Illinois originally planned its SELF program (Self-Esteem Lifting for Families—an outreach counseling program for students, young adults, and the homebound elderly), it envisioned professional counseling services complemented by a small home-visiting program. What the consortium never anticipated, however, was that this volunteer program would give rise to a half-dozen programs involving almost 200 volunteers and reaching more than 10,000 individuals. In 1997, this constellation of volunteer programs, known as GEM (Volunteers Going the Extra Mile), won first place in the Governor's Hometown Awards competition and placed second in the National Association of County and City Health Officials J. Howard Beard Awards competition. The program's volunteer coordinator won a five-county senior citizen's award for her contributions. In 1995, the SELF program won the Illinois Rural Health Association Exemplary Project award.

The first GEM volunteer program, Home Visitors, now has a core of 35 adults who have spent more than 5,000 hours with more than 200 homebound senior citizens. In an offshoot of this program, called Jr. GEMs, junior high school students visit patients in nursing homes. As a tide of volunteerism spread throughout the county, additional programs evolved to include hospice; Mothers Outreach to Mothers (MOMs); Partners in Reading, in which volunteers read to first-, second-, and third-graders; and RNs en Route, in which retired registered nurses show health education videos to homebound patients.

To highlight a few of the programs, the Partners in Reading program assigned an adult or older student to read to a child once a week during the noon hour. Within 12 months of the grant award, four schools were participating. By the end of the grant cycle, the program expanded to three school districts and involved more than 150 trained volunteers. Information has yet to be gathered on the effects of the program on academic achievement, but teachers and principals have noted remarkable improvement in the children, including greater self-confidence and social skills, heightened interest in school, and increased enjoyment of books and reading.

ILLINOIS

SELF—Self-Esteem Lifting for Families

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SELF—Self-Esteem Lifting for Families

The MOMs program was initiated because the health department no longer had funds to make routine home visits to every newborn. The program used trained outreach mothers to visit new mothers, taking coupons, newborn baby supplies, and written information about available health services. The volunteers assessed the home situation and the relationship between mother and infant. An ongoing relationship is often established that offers emotional support, guidance, and friendship and helps reduce the stress of parenting. Health department staff make followup visits as necessary.

The project's hospice program trained 32 volunteers to assist dying patients and their families. Also, a new GEM program, started the third year of the grant project, trained 35 high school students to tutor elementary students.

The professional component of the project also achieved great success. Lutheran Child and Family Services, an experienced social service agency, was subcontracted to provide counseling services during the grant period. As of August 1997, the project's full-time counselor had provided counseling services to clients who included 8 homebound senior citizens, 26 unwed mothers, and 20 probationers or status offenders offered counseling as an alternative to the court system.

The project also sponsored a teen pregnancy prevention project, a teen aid conference, child abuse prevention activities, and violence prevention activities. School counselors hired for the grant period counseled 406 students and 20 parents. Other project activities for youth included summer day camps for 150 at-risk elementary children, classroom activities to improve self-esteem for 2,000 students, and support groups and special events for teens.

Project staff feel that both the professional and volunteer components of this program would work well in other rural settings. The volunteer component could be started with minimal dollars, "even less than $1,000," according to the project administrator, "provided a good volunteer coordinator is found." This person must know how to make volunteers feel important and appreciated and how to match volunteers with compatible recipients.

SELF—Self-Esteem Lifting for Families

Unhappy volunteers do not stay long. Funds are needed for name tags, coffee, postage, newsletters, and small tokens of appreciation for volunteers.

The Fayette County Health Department leads the project's consortium. Other members include the Fayette County Hospital, the probation department, and four school districts. Although Lutheran Child and Family Services was not an official consortium member, it provided direct services, participated in all meetings, and was primarily responsible for the success of the program.

Although the formal consortium dissolved in August 1997, all members have continued to collaborate in programs of interest, and almost all the project's activities continued after the grant period. Lutheran Child and Family Services will continue to provide professional counseling services. Outreach grant-supported counseling in the schools ended in May 1998; however, as a direct result of having counselors in the schools, two of the four school districts have hired full-time counselors. Three very successful components of GEM—Home Visitors, Jr. GEMs, and Partners in Reading—will continue under the direction of the volunteer coordinator and with the support of private funding. The Fayette County Health Department will operate the hospice program. Lutheran Child and Family Services will continue its project activities with two grants from the Illinois Department of Children and Family Services. One grant will support the counseling program for unwed mothers, and the other will support the MOMs program, which is expanding into neighboring counties.

INDIANA

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A diverse coalition of health care providers in north-central Indiana has formed an innovative partnership in which members share the costs of a medical mobile unit to provide health care to underserved rural populations. The joint effort demonstrates that cooperative ventures can help facilitate improvements in the delivery of health care. Since the implementation of HealthQuest, all the participating agencies have experienced an increased demand for their primary and preventive health care services. Outcomes include more than 1,200 new Women, Infant, and Children/ Maternal and Child Health clients, more than 200 Hispanic migrant workers who have never received care in the United States, and almost 18,000 client encounters.

"Each member of the consortium offers a unique expertise to the mission of HealthQuest and addresses an identified need in the population served," comments the project coordinator. The Caylor-Nickel Medical Center, a not-for-profit hospital, serves as the consortium's lead agency. The consortium's other five members are Jay County and Randolph County Hospitals; Community and Family Services, Inc., a nonprofit agency that provides WIC/MCH services; Indiana Health Centers, Inc., a nonprofit agency that serves migrant and seasonal farm workers; and the nonprofit Aging and In-Home Services, Inc.

The project serves the residents of six medically underserved counties in north-central Indiana, including an Amish community in Adams County and the migrant farmworker population during the summer growing season. Services are targeted to the needs of the elderly, women, infants and children, migrant farmworkers, the unemployed, and the uninsured and underinsured.

The Caylor-Nickel Foundation purchased the first medical mobile unit for the project, with input from all the partnership agencies on the floor plan, design, and equipment. The project used its rural health outreach grant to help purchase a second medical mobile unit and pay the salaries of its nurse, social worker, and driver/clerk. Each consortium member uses one of the units on specific days and pays an affordable per diem rate for its use. Staff from Community and Family Services, for example, use the unit

HealthQuest

every Wednesday through Friday to provide WIC/MCH services in 12 small, rural communities each month. During the 3-year grant period, the agency provided services in 8,151 client encounters and provided 4,060 immunizations on board the unit.

Indiana Health Centers uses the unit to deliver bilingual health care at the migrant worker camps on Tuesday evenings during the growing season. Appointments are made for workers from a central office, but walk-ins are also encouraged. Because the unit is taken to the camps, workers do not have to take time off from the factories or fields and travel long distances for health care. Agency staff noted a significant decrease in appointment "no-shows" since they started offering services on-site. During the 3-year grant period, the agency provided services in 665 client encounters on board the unit.

One day each month, Aging and In-Home Services uses the unit to visit a Council on Aging facility in a rural community. A registered nurse provides blood pressure, cholesterol, and glucose screenings. She also offers education about medication compliance and other health issues of the elderly through face-to-face teaching, written handouts, and videos. During the 3-year grant period, nurses paid with grant funds provided screenings in 1,160 client encounters.

Jay County and Randolph County Hospitals occasionally use the unit with their own staff to provide services in their communities and at local businesses and industries.

Caylor-Nickel Medical Center, the project's lead agency, uses the unit to provide screenings in five small communities. A registered nurse, whose salary is covered by the medical center and the outreach grant, performs screens and offers educational information to the residents.

With the outreach grant award, the Caylor-Nickel Foundation purchased a second medical mobile unit with two exam rooms for primary care. The medical center and Community and Family Services use this unit to provide primary care in four small, rural communities each week. Grant funds cover the salaries of the mobile unit's nurse, social worker, and driver/clerk. In addition, several college

HealthQuest

nursing programs place registered nurses on the mobile unit, providing valuable educational opportunities to nurses pursuing advanced degrees. During the 3-year grant period, project staff provided primary care in almost 4,200 client encounters.

An important key to the success of this project has been the support and involvement of the communities it serves. Service organizations, local governments, community agencies, local schools, and private citizens were involved in the planning and implementation of the project and continue to refer clients and suggest new sites and services. The majority of physicians in each town were supportive, but some perceived the project as a financial threat. The consortium spent time (in some cases, years) discussing the advantages of this service with these specific physicians. Currently, the vast majority are pleased with the project and refer clients.

Community and Family Services, Indiana Health Centers, and Caylor-Nickel Medical Center remain in partnership and have expanded the services provided on board the mobile units. The Caylor-Nickel Foundation will underwrite the salaries of the mobile unit staff as a writeoff for nonprofit status. The second unit has been certified as a Rural Health Clinic, which has increased its reimbursement revenue. The project coordinator states, however, that the mobile unit will never be self-supporting. "Any mobile primary care unit will always need some sustainable funding source," he says. Therefore, project staff continue to seek grants and ask foundations for support.

A consortium of 6 rural hospitals, 2 community colleges, an emergency medical services (EMS) education school, and 54 volunteer ambulance services have developed a coordinated system of trauma care for a 10-county region in south-central Iowa. Activities include the implementation of a uniform EMS training curriculum, triage and trauma treatment protocols, and improved communication among EMS and hospital providers throughout the region. Particular emphasis has been placed on improving prehospital and hospital trauma care through the training of emergency medical technicians (EMTs), nurses, and physicians.

Although the region has a high rate of agricultural injuries and fatalities, prehospital EMS providers are in short supply. Before the outreach grant, for example, 2 of the 10 counties in the area had no EMTs/paramedics, and 3 others had fewer than 5.

The outreach project coincides with the implementation of a statewide Iowa Trauma Plan, which will, among other things, set training standards for all EMS personnel, including physicians. "This dovetailed nicely with our project," writes the director, "particularly in the areas of training, trauma/ triage protocols, and continuous quality improvement activities. If a project were to 'start from scratch' on these issues, implementation would be more difficult."

One of the most important activities of the project was the creation of a unified EMS training program for the region. Mercy School of EMS in Des Moines (which trains EMS instructors), Indian Hills Community College, and Southwestern Community College now offer a unified EMS/ trauma curriculum for prehospital and hospital emergency personnel. Before the outreach grant, these three entities provided EMS education but worked independently of each other. The collaboration between these schools resulted in an efficient sharing of personnel and resources (e.g., training equipment, facilities), which in turn reduced costs. The rural hospitals also benefited from these training programs because dwindling financial resources severely limited their ability to provide training opportunities.

A total of 655 EMTs, nurses, and physicians received EMS training during the 3-year grant period. Training for EMTs consisted of a 16-hour EMT-B transitional program

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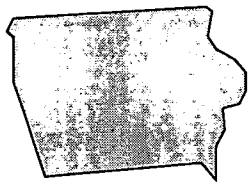

Southern Iowa Rural Outreach EMS/Trauma Consortium

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Southern Iowa Rural Outreach EMS/Trauma Consortium

(341 EMTs took the course, more than twice the projected number), and a 16-hour Pre-Hospital Trauma Life Support course (127 EMTs). In addition, 12 EMTs completed the rigorous 1,000-hour paramedic training program. Training for nurses consisted of a 16-hour Physician Designee course (73 nurses) and a 16-hour Trauma Nurse Core Curriculum (66 nurses). Eleven physicians completed a 16-hour Advanced Trauma Life Support program.

The project placed significant emphasis on training future EMS instructors to further its sustainability after the grant. Twenty-two EMTs have been trained to teach the Pre-Hospital Trauma Life Support Course, and seven nurses have been trained to teach the Trauma Nurse Core Curriculum course.

Other project activities included a continuous quality improvement program for assessment and enhancement of rural EMS as well as a public education program dealing with how and when to access emergency services targeted to the elderly and those at risk for agricultural injuries.

All project staff are employed by health care providers in the region and will continue their work after the grant period. The community colleges and the Mercy School of EMS will continue to provide EMS training courses. A tuition or registration fee will be charged to cover expenses. Course instructors will be EMTs and nurses trained as instructors during the grant period.

A partnership between a community action agency and six rural school districts established preventive health clinics in the schools of six northwest Iowa counties, significantly improving the access and availability of preventive health care for children 0 to 18 years of age. Before the outreach project began, the barriers of distance, poor transportation, and traditional clinic hours often prevented parents from obtaining preventive health care for their children. To address this need, the consortium established school-based clinics that provide comprehensive well-child screenings and immunization services during late afternoon and evening hours.

A family nurse practitioner serves as director for the Healthy Child Project and is responsible for providing professional services as well as for implementing, managing, and coordinating the project. The six participating school systems range in size from 200 to 1,450 students and, before the outreach project began, had either no or minimal school nursing services. Project staff traveled anywhere from 20 to 45 minutes to reach a clinic site. Although the program was initially designed to provide services to low-income children, it was decided before the clinics were opened to expand services to all schoolchildren to prevent stigmatization of the low-income children.

Services provided at the clinics include comprehensive well-child health screenings, height and weight measurements and growth pattern determinations, urinalyses, screenings for hemoglobin level and blood pressure, vision development screenings (0 to 6 years), dental hygiene education, nutrition assessment and counseling if necessary, and thorough health histories followed by physical examinations. Project staff also provide immunizations and case management services and make referrals to appropriate health care providers and service agencies.

During the 3-year grant period, the nurse practitioner provided 289 clinic visits throughout the six school districts and served 1,922 children (unduplicated count). Services included 2,149 physical examinations and 64 referrals. In total, 1,934 children received immunizations, 1,231 were screened for spinal problems, and 72 received vision

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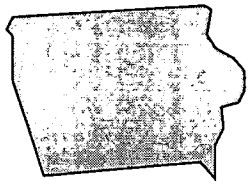

Healthy Child Project

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Healthy Child Project

screenings. In addition, the nurse practitioner served as a resource for the school health staff and assisted with the schools' health education programs and other health screenings.

Upper Des Moines Opportunity, Inc. (UDMO), a community action agency, serves as the project's lead agency. The agency's Maternal and Child Health and Head Start directors served as consultants to the project director and provided case management services. Six school districts participated in the consortium, each providing space for the clinic and assigning a staff person to schedule appointments and provide information to students and parents.

The project encountered two significant obstacles. First, the medical community in two school districts did not support the project, even after meetings in which the project director explained the project's goals and objectives. The medical offices maintained that medical care was accessible and that they were meeting the needs of the community. In these two communities, the schools opted not to participate in the program. The project found two other school districts to participate in the program.

Second, with the advent of managed care in Iowa in 1995, the State's Maternal and Child Health program began the process of moving from a direct care delivery system to coordinating care and finding a medical home for each client. UDMO made the transition to care coordination in 1996, the second year of the outreach project. Through meetings with the State, the project learned that if the Healthy Child Project provided services to any Child Health client in the schools, the client would not be able to participate in the State's Child Health program (because each participant could have only one medical home). Insurance companies do not reimburse for well-care exams, and Medicaid was also moving toward managed care. With this change, the project was no longer able to generate revenue.

Other organizations considering similar projects should bear these issues in mind, writes the project director. "To succeed, the project needs the full support and participation of the medical community and any managed care organization, and a means to generate revenue."

Healthy Child Project

One other important lesson learned by the project is that, at least in this region, low-income children do not necessarily have the least access to preventive health care services. Low-income children have access through either a Child Health program or Medicaid. (Whether the parents choose to access the health system for preventive services is another issue.) "The children who do not generally receive preventive health screenings," writes the project director, "are the children of parents whose health insurance does not cover well-child exams. Or [they are] the children of parents who cannot afford health insurance and are not eligible for any State or Federal health program."

During the third year of the grant, the project initiated two programs for parents and preteens called Girl Talk and Guy Talk. The four-session programs provided factual information about sexuality and encouraged communication about sexual attitudes, feelings, and values between parents and children. The programs were offered in 2 counties during the first year and had 44 participants.

The school clinics will not continue after the grant period because of their inability to generate revenue under managed care. The Girl Talk and Guy Talk programs will continue, funded by an abstinence grant from the State of Iowa and program fees.

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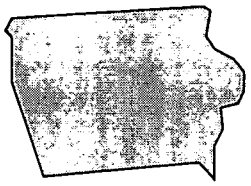

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The Rural Bridges Project is an innovative outreach program designed to assess and address the specific needs of unlicensed direct caregivers (namely, certified nurse assistants and home care aides) in four rural Iowa counties. The philosophy of the project is that addressing the needs of the caregivers will result in better care for patients and cost savings for employers and taxpayers. The project provides a number of services for direct caregivers, including support groups, mental health services, networking opportunities, recognition, and education.

In addition to the physically and emotionally demanding nature of their work, direct caregivers also experience inflexible schedules, inadequate pay and benefits (median wage is $6.40/hr), minimal training, and the stigmatization and devaluation of the work by society in general. Quality of care is compromised because of a shortage of qualified direct care workers and high staff turnover rates (80 percent average), which result in higher costs for employers. Meanwhile, health care trends such as managed care are creating a greater demand for this level of worker in the name of cost savings.

During the project's implementation, an introductory meeting was held for the roughly 600 direct care workers in the region, of whom 295 attended. Of those, 195 agreed to participate in the project by completing the assessment surveys and by attending as many of the intervention programs as possible. In addition, 26 of the 27 health care facilities and home health care providers in the area agreed to track their nurse aide staff turnover rates and to encourage their direct care staff to participate. Assessment tools used by the project include the Brayfield and Rothe job satisfaction scale, the Maslach stress scale, and the Rosenberg self-esteem scale. Facilities used the Stryker Gordon formula to measure staff turnover rates.

The project provided mental health counseling, education, and referral to 71 direct care providers (36 percent of the original 195 participants), including certified nurse assistants, home care aides, and in some instances, their spouses or children. CrossRoads Mental Health Center, a consortium member, provided the services. The project also delivered a variety of educational programs on team-building,

Rural Bridges Project

self-worth, conflict resolution, professionalism in direct care, and many health-related topics. These were delivered through support group meetings, miniconferences, and in-house presentations. During the 3-year grant period, the project delivered 139 programs to 1,530 attendees.

The project coordinated four countywide support groups for direct care workers, with an average attendance of about five participants. In addition, the project's public awareness campaign held each June helped raise consciousness concerning the valuable role these caregivers play in the overall health care delivery system. Activities included mayoral proclamations, media coverage, and health care facilities organizing their own celebrations and acknowledgment of caregivers. The project also developed a Support and Education Group Handbook, a Self-Worth pamphlet, and a Caring Tips flyer for caregivers of Alzheimer's patients.

Clarke County Hospital, a rural hospital in Osceola, administers the project; and the Iowa CareGivers Association, a nonprofit professional association for direct care workers, manages the project and coordinates activities. Other consortium members are the Alzheimer's Association, a nonprofit community service organization, and CrossRoads Mental Health Center, a local provider of mental health care.

One of the greatest challenges faced by the project was the high turnover rate in many health care facilities. Project staff had difficulty building momentum in facilities that had rapid turnover of management and administrative staff as well as direct care staff.

Project staff also learned the importance of taking into consideration the inflexible schedules of the direct care workers. As stated earlier, their work is physically and emotionally exhausting, and they simply do not have the time to plan or attend monthly meetings, notes the project director. "While assessment revealed that direct caregivers believe there is a need for such a support system or network, we sometimes spent a lot of time planning and coordinating meetings with only two or three actually attending. Our focus in the future will be on how we can provide that support in a way that will be most convenient for them." One option under consideration is a 1-day regional meeting,

Rural Bridges Project

to be held quarterly, with time for education, networking and sharing of information. Programs would be given in the morning and repeated in the evening to accommodate various work schedules.

Finally, the project learned the importance of enlisting local participants to establish objectives and plan interventions and programs. This is crucial for getting local-level support and buy-in early on, notes the project director. "One must present the 'big picture' and convey how these issues affect us all."

The Iowa CareGivers Association has signed a contract with the Iowa Department of Human Services to continue to expand efforts initiated under the grant. The association also established a foundation with the sole purpose of raising money to fund education, recognition, and support programs for direct care workers. This foundation will support the Rural Bridges Project as well as other programs in the region that have similar objectives. Consortium members will continue to provide their support and technical assistance.

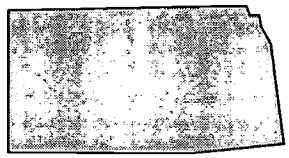
Six remote farming communities in Russell County, Kansas, now have an organized network of trained first responders to provide immediate emergency care in the event of a cardiac arrest. The first responders administer early cardiopulmonary resuscitation (CPR) and defibrillation while the ambulance is on its way. According to the American Heart Association, these emergency measures can significantly improve a patient's chances for survival.

More than 30 percent of the residents in Russell County are elderly, compared with the State average of 14 percent. Many live in outlying communities more than 30 minutes from the nearest ambulance service, located in the towns of Russell and Lucas. Before this outreach grant began, these small communities had no formal first responder network or equipment available to provide emergency care. Rather than wait for an ambulance, it was not unusual for residents to rely on private vehicles to get to the hospital after a cardiac arrest, with no treatment or care being provided en route. First Responder Network has attempted to address this problem by organizing a network of first responders to provide lifesaving care within minutes of the patient calling 9-1-1.

The project focused its efforts in two areas. First, it provided much-needed CPR courses free of charge throughout the county. In addition to teaching CPR and providing certification, these courses also identified the risk factors of a heart attack. Before this outreach project, it had been 5 years since any CPR courses had been available in these small communities. TEAM EMS, a consortium member, provided the instructors and promoted the classes. Forty-nine CPR courses were offered during the grant period, in which 414 individuals were certified. Eleven persons also became CPR instructors. Having instructors is essential for the continuation of the project after grant funding expires.

Second, the project trained and certified first responders in six rural communities throughout the county. Many of these students were volunteer firefighters active in their communities. Other students had completed the CPR course and decided to receive further training. Seventy-five

KANSAS



First Responder Network

Russell County Healthcare, Inc.

Russell, Kansas

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First Responder Network

students completed the 65-hour program and were certified as first responders during the grant period. This enabled the project to establish a team of first responders in six of the seven communities targeted in the grant. (The seventh community demonstrated little interest in the project. Interestingly, this was the one community that did not have a local fire department, which, in every other community, had proven invaluable in generating local support for the project.)

The project equipped each first responder with a pager on the fire department frequency. It also purchased emergency equipment and placed it in a central location in each community, usually the fire station. The equipment included oxygen, a jump kit, an automatic defibrillator, and an emergency medial services (EMS)-frequency radio used to communicate with the responding ambulance. When the 9-1-1 operator receives an EMS call in an area covered by the First Responder Network, the local first responders are paged at the same time the ambulance is paged. The first responders arrive on the scene within minutes, assess the patient, provide emergency stabilization, and update the responding ambulance by radio.

Probably the most important key to this project's success has been the involvement of the Russell County Fire Chiefs' Association. The fire chiefs in the small communities took an active role in setting up CPR classes as well as in developing community interest in the First Responder Network. They also provided the resources and facilities for the CPR classes and outreach locations for first responder equipment. "They were the local experts in the small towns [who] helped to ensure the success and acceptance of the outreach project," writes the project director.

As word of the First Responder Network spread throughout the county, more people became comfortable calling 9-1-1, knowing that emergency care would arrive within minutes. As a result, use of EMS increased by as much as 300 percent in some communities. This actually became a financial burden to the local fire departments, which were unprepared for the increased fuel consumption and call-out hours caused by the First Responder Network. (The fire departments pay their fire fighters/first responders for every run.) The project solved the dilemma by arranging

First Responder Network

for EMS to reimburse the local fire departments for first responder hours. The increase in ambulance utilization offsets this expense for the EMS agency.

Leading the project's consortium is Russell County Healthcare, Inc., a not-for-profit, community-based health care organization. Other consortium members are Russell Regional Hospital, a not-for-profit county hospital; the Russell County Fire Chiefs' Association; and TEAM EMS, a not-for-profit organization that educates EMS providers and the public.

One unplanned benefit of the First Responder Network has been a new camaraderie between the rural fire departments and the EMS agency. The county's disaster response capabilities have also improved significantly now that many of the volunteer firefighters are also certified first responders.

The CPR training and First Responder Network will continue after the grant period. The EMS agencies will continue to reimburse the local fire departments for first responder hours, and the CPR training will be funded by class fees with additional support from Russell Regional Hospital. Fundraising in several communities has generated donations for additional training and upgrading of equipment as necessary.

This outreach project uses telemedicine technology to deliver specialty care and continuing medical education to citizens of rural central Kentucky. The newly established network provides a two-way, full-motion video link between the James B. Haggin Memorial Hospital, a rural, nonprofit hospital in Harrodsburg, and the University of Kentucky Medical Center, a tertiary care center located 40 miles away in Lexington. Through the telemedicine network, patients at the rural hospital receive consultations with specialists at the university medical center, and health care providers receive continuing medical education programs.

After a yearlong implementation phase, the project began offering telemedicine services at the end of 1996. During the following 2 years, 223 patients received specialty consultations through the telemedicine network. The most common application was teleradiology (199 consults), which uses the system's capacity to transmit high-resolution x-ray images between sites. The remaining consultations were in the fields of child psychiatry, dermatology, home health, and postoperative followups. The project also used the telemedicine system to provide continuing education for health care providers (500 hours), facilitate administrative meetings (160 hours), offer community health education (7 hours), and start a cancer support group (1 hour). In the future, the project plans to expand into the areas of cardiology, preoperative anesthesia, and emergency consultations.

During the final year of the grant, the project also set up school-based telemedicine sites in one middle school and one elementary school in Harrodsburg. Telemedicine at the schools has been well accepted and applied—within a short period, usage climbed to 10 to 15 telemedicine consultations per month. Typically, school nurses served as presenters for consultations with specialists at the university medical center.

Each consortium member played a distinct role in the success of the project. The James B. Haggin Memorial Hospital served as the project's lead agency. It provided the equipment, facility, advertising, and evaluation of the project. The University of Kentucky Medical Center developed and provided the continuing medical education programs as well as the medical staff for specialty consultations. The

KENTUCKY

James B. Haggin Memorial Hospital Telemedicine Project

James B. Haggin Memorial Hospital

Harrodsburg, Kentucky

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PROJECT 11

James B. Haggin Memorial Hospital Telemedicine Project

Bluegrass Mental Health and Mental Retardation Board, a mental health care organization, provided referrals for psychiatry consultations.

The most difficult challenge faced by the project was the slow acceptance of telemedicine by physicians at the rural hospital. There was some resistance to changing referral patterns, notes the project's telemedicine coordinator. However, specialists at the university medical center were cooperative with the program, and preliminary patient evaluations suggest a high level of satisfaction with the telemedicine consultations.

The telemedicine project used grant funds to cover the costs of the continuing education programs and the support groups. For its specialty consultations, however, it began billing third-party insurance providers $60 per half-hour in January 1998. As of September 1998, the project had received one Medicaid reimbursement with others pending.

The school-based telemedicine project is expected to continue after the end of the grant period with funds from the James B. Haggin Memorial Hospital and the school system. The project will continue to provide specialty services through the telemedicine network and bill third-party insurance providers. The continuing medical education of health care providers will also continue, although the project plans to lower costs by shifting from telephone to satellite transmission. The project also plans to contract videoconferencing services to other area organizations.

MAINE

Senior Reach Aroostook Mental Health Services, Inc.

Caribou, Maine

Five nonprofit organizations in Aroostook County, Maine, have implemented a constellation of programs to improve services to older adults with mental illness and cognitive impairments. The project also offers support to their caregivers. Aroostook County is Maine's most rural region and covers more than 6,000 square miles. Almost 12,000 elderly persons live in the county, 22 percent of whom have incomes below the Federal poverty level.

The project comprised multiple initiatives, including mental health and behavioral health services for long-term-care facility residents, public and professional educational programs, screening and assessment services for older adults living in their own homes, in-home respite care, and increased coordination among service providers.

During the grant period, project staff provided screenings to approximately 90 residents of Aroostook County's boarding home and nursing facility. These screenings resulted in 140 referrals for service. Project staff also conducted more than 1,700 individual counseling sessions with residents of the facility and 96 counseling sessions with family members of residents.

The Senior Reach project also provided in-home screening and assessment services to 222 families caring for older adults with Alzheimer's disease or related dementias. Based on these screenings, project staff provided more than 580 referrals for services and gave caregivers information tailored to their concerns, such as how to anticipate and resolve problem behaviors. Some of the most common referrals were for in-home respite services (more than 100 households), caregiver training (110 households), and support groups (90 households). Other common referrals were for neurological or psychiatric evaluation, adult day-care services, and physician services.

The project also provided in-home respite services for seniors who did not qualify for reimbursement under other programs such as Medicaid. About 13 to 30 homes received respite services each month, with a monthly average of 16 hours of caregiver support per household. All told, the project provided more than 9,500 hours of respite care.

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Senior Reach

Surveys of households receiving this service reported feeling less stress, strain, or pressure as a consequence of these services.

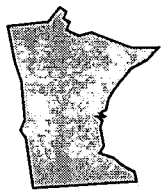
In its final component, the Senior Reach project offered numerous educational opportunities directed to area professionals, paid and unpaid caregivers, and the general public. More than 900 individuals attended the project's 48 educational sessions during the grant period. These sessions addressed both clinical and caregiving issues pertaining to dementia and depression, medication management, and behavior management. The project also provided in-service training at various agencies that work with the elderly.

Aroostook Mental Health Services, Inc., a private, nonprofit mental health and substance abuse service provider, leads the project's consortium. Other members are Northern Maine Medical Center, Cary Medical Center, Aroostook Home Health Agency, and Aroostook Area Agency on Aging.

One significant benefit of the outreach project was the improved communication and collaboration among the approximately two dozen service providers working with older adults in Aroostook County. A survey taken of the 5 consortium members and the approximately 20 other providers reports increased referrals to other organizations, increased joint client assessment, and more frequent joint monitoring and followup. The agencies also credited Senior Reach with helping increase knowledge and familiarity among participating agencies, improving service delivery, and serving as an impetus for other collaborative ventures.

Senior Reach's respite care component is expected to receive some funding from the State after the grant period; other project activities will continue on a fee-for-service basis. The five consortium members will continue to work together to maximize their efforts and to meet the needs of the rural elderly.

MINNESOTA



Domestic Abuse Treatment Program

Northwestern Mental Health Center, Inc.

Crookston, Minnesota

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The Domestic Abuse Treatment Program is a comprehensive batterer's treatment program designed to reduce the risk of further injury or harm to victims of domestic violence throughout seven counties in rural northwestern Minnesota. The project's consortium consists of an inclusive array of organizations that deal with domestic abuse, including law enforcement, hospitals and medical providers, social service and welfare agencies, judicial and criminal justice personnel, mental health treatment providers, and victim advocacy agencies.

An important component of the project is a treatment program for perpetrators of domestic violence that teaches them new skills and helps motivate them to use these skills to live in nonabusive ways. During the 3-year grant period, the project has provided court-mandated treatment to 331 individuals (313 male and 18 female) and voluntary treatment to 25 individuals.

To fully address the problem of domestic abuse, the project adopted a comprehensive approach involving all agencies that deal with batterers. First, it assisted and encouraged those agencies to develop and implement strategies to identify perpetrators of domestic violence. Second, it created linkages between those agencies to hold abusers accountable for their behavior and to bring them into a treatment system. Northwestern Mental Health Center, Inc., the project's lead agency, directed the treatment program and coordinated all the collaborative efforts under the grant. The agency established treatment sites in Crookston, Thief River Falls, Mahnomen, and East Grand Forks, making treatment available throughout most of northwestern Minnesota.

The agencies involved in the project developed an intricate communication network to ensure that all men and women who batter are held accountable and receive treatment. Law enforcement personnel received specialized training for responding to family violence and established clear policies and procedures for officers to respond to family violence. Judges and county and State's attorneys participated in the program by developing and implementing their own policies for prosecuting and sentencing those found guilty of violent acts. The criminal justice system, including

Domestic Abuse Treatment Program

probation and parole, established clear requirements for mandated treatment as well as a system of communication with treatment providers to ensure that offenders complete mandated treatment programs. Cooperative efforts with local jails allow those serving sentences for violence to obtain treatment while incarcerated. Victims of domestic violence provide feedback to treatment providers via the victim advocate system.

Finally, the project provided training and education in domestic abuse issues to 57 service providers, including community law enforcement, health care providers, social service agencies, and criminal justice system personnel. Program staff also established community outreach and prevention programs targeted to the workplace and to students from elementary to high school.

The project encountered and surmounted several obstacles in its implementation. One issue was the distance that clients traveled to receive treatment. Project staff established cooperative agreements with agencies in other locations so that treatment was available in each rural locality. Courthouses and social service agencies, most of which were consortium members, assisted with the process. Another issue was the existence of multiple legal jurisdictions over the seven-county area, all of which had their own reporting and enforcement policies. To address this problem, the coordinating agency established a database system to track people who were mandated into the program. This system allowed the project to quickly notify the judicial and legal systems regarding the offender's progress and completion of the treatment program, regardless of the multiple legal jurisdictions that might be involved.

Weather also had a significant impact on service delivery as well as on the numbers of victims reporting domestic abuse. Flooding in 1997 displaced a large percentage of the population, and the winter before that was one of the worst in northwestern Minnesota history. These factors compounded transportation and attendance issues for participants as well as project staff. Following these natural disasters, many victims of domestic violence who had left their abusers had little choice but to return to abusive households because of the loss of their homes or jobs.

Domestic Abuse Treatment Program

Victim agencies began to report an increase in victim-reported domestic violence. One of the major goals of the program was to ensure that the legal and criminal systems were aware of and responding to this increase. The project also undertook many prevention efforts in response to this increase.

The project's consortium functioned as planned, and the number of agencies willing to participate continued to expand throughout the grant period. "Having most of the affected agencies participating in the goal-defining process and also having them active in all stages of implementation had a very positive impact," notes the program coordinator. "Without the cooperation of all involved, it would have taken much longer to organize this program over such a large geographical area and across so many jurisdictions."

It was originally hoped that user fees would support the program after the grant period, but it soon became apparent that this would preclude many people from lower socioeconomic groups from receiving treatment. The project implemented a sliding-fee scale; however, this supports less than one-tenth of the program costs. The project is currently exploring permanent funding options such as State funding, county flat-rate fees, other grant sources, and the possibility of forming a foundation to permanently subsidize program costs.

MONTANA

Chippewa Cree Health Center Telemedicine Program

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The Chippewa Cree Health Center in northern Montana has joined the REACH (Realizing Education and Community Health) Montana Telemedicine Network, creating a vital link to a tertiary care hospital in Great Falls and seven other rural hospitals. The health center is on the Chippewa Cree Indian Reservation and provides health care services to approximately 4,000 Indian people in a 3-county area whose average income is 70 percent below Federal poverty level. The project's goal is to use telemedicine to increase access to health care services, particularly specialty medicine. Geographical isolation, severe winter weather, and the long travel distances make access to health care extremely difficult in frontier Montana.

REACH Montana is a consortium of health care providers linked to each other through telemedicine technology that includes two-way, full-motion video. The REACH Network hub site is Benefis Healthcare, a tertiary care hospital in Great Falls. Before the outreach grant, the REACH Montana Telemedicine Network served seven small rural hospitals and a rural referral center in the north-central region of the State. Through this demonstration project, REACH expanded the consortium to include the Chippewa Cree Health Center, located in Rocky Boy.

The Chippewa Cree Health Center connected to the REACH intranet in January 1998, during the third year of funding. Although the connection occurred much later than expected, delays were caused by the acquisition process of acceptable bids. Once the system was installed, training needs were minimal because staff members were already comfortable using the Internet. One continuing challenge has been the high costs of transmission. The project's consortium continues to search for affordable line costs and funding to cover the expense.

Since its implementation, the Chippewa Cree Health Center used the interactive video network primarily to provide continuing education opportunities for its health professionals. The health center received the training programs from Benefis Healthcare in Great Falls. Training programs included continuing education opportunities for physicians, health care professionals' training for medical and

Chippewa Cree Health Center Telemedicine Program

dental staff, certified nursing assistant education for personal care attendants, and emergency medical services (EMS) education for EMS staff.

The health center has begun to explore the medical application of the telemedicine network. Twice a month, a psychiatrist at Benefis Healthcare provides consultations over the network to patients on the reservation. As of May 1999, the health center had conducted only six other telemedicine consultations. Most of these involved followup care for patients who were treated by specialists at Benefis Healthcare and were discharged to their homes.

Many health care providers on the reservation remain reluctant to use the high-tech equipment. Several providers have expressed concerns that their patients' privacy and confidentiality might be compromised. "Procedures for protection of privacy and confidentiality need to be clearly defined for the patients," writes the Rocky Boy Health Board planner. Nevertheless, she continues, "telemedicine has the potential to alleviate many of the problems associated with rural isolation. We have only begun to explore the advantages of connecting low-resource areas to high-resource areas."

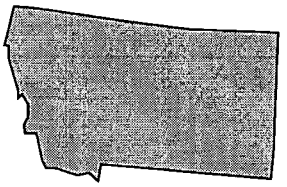
Leading the project's consortium is the Rocky Boy Health Board, which oversees the Chippewa Cree Health Center. Benefis Healthcare develops and transmits the educational programs over the network, assists with startup activities, provides technical assistance, and trains rural health care providers to use the technology. The other members of the REACH consortium (seven small rural hospitals and a rural referral center) helped organize the expansion site at Rocky Boy and assisted with project implementation. They will also assist with the project's final evaluation.

After the grant period, the Chippewa Cree Health Center will continue to use the interactive video system for medical consultations and for continuing education programs for health care professionals, with support from tribal funds. In the future, the health center plans to purchase equipment that will allow the transmission of high-resolution x-ray images to remote diagnostic centers. It also plans to form

interfaces with other computer networks, such as the Indian Health Service network and a network of health care providers in southern Montana.

Chippewa Cree Health Center Telemedicine Program

MONTANA



The Electronic Network for the Coordination of EMS Data and Education

Critical Illness and Trauma Foundation, Inc.

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A remarkable public-private partnership in Montana has established a statewide computer network that links 103 ambulance services and 6,500 emergency medical services (EMS) providers across the State. The "electronic community" provides ambulance personnel with unrestricted and easy access to state-of-the-art training, communication, and data collection and analysis as well as connections to the State EMS office and other supporting agencies. Before the establishment of this outreach project, geographic and financial barriers prevented the State's EMS providers (85 percent of whom are volunteers) from receiving adequate training and support. This project has attempted to overcome those barriers to ensure that Montana's residents and visitors receive the best emergency medical care available.

The TENCODE (The Electronic Network for the Coordination of EMS Data and Education) project provided a multimedia computer and software to every ambulance service that chose to participate (103 of the State's 121 ambulance services) and provided onsite orientation and training. Individuals and agencies involved in emergency medical services communicate on the network through an electronic bulletin board established and maintained by project staff. The project also developed and distributed electronic data-collection software for patient recordkeeping as well as four interactive CD-ROM training programs approved for continuing education credit. The CD-ROM training programs have been distributed to the ambulance services both within and outside Montana and have proven a valuable method for people to learn in their own homes or offices and on their own schedules.

The project has received national attention from the EMS field. In fact, project staff have made several presentations highlighting the project to regional, national, and international audiences, including the 1998 Fourth World Congress on Injury Prevention in Amsterdam. One of the project's most noteworthy aspects is its strong public-private partnership. The Critical Illness and Trauma Foundation (CIT) is a private, nonprofit foundation whose mission is to improve the well-being of those at risk for, or affected by, sudden illness or trauma. Together with the Montana EMS

The Electronic Network for the Coordination of EMS Data and Education

and Injury Prevention Section (EMSIPS), a State agency responsible for overseeing the State's emergency medical services, the two organizations successfully solicited major funding for the project. In 1995, CIT received an award from the Office of Rural Health Policy Outreach Program, and EMSIPS received an award from the Injury and Emergency Medical Services Branch, Maternal and Child Health Bureau. The two projects were immediately combined and convened a joint oversight committee.

Joining these two agencies in the consortium are the State's three Regional Trauma Advisory Committees, Montana EMS Association, Montana State University (MSU) Office of Distance Learning and Telecommunications, MSU Virtual Medical Center, Montana Academy of Pediatrics, and Montana Office of Highway Traffic Safety.

For most ambulance personnel, TENCODE provided an exceptional system for communication. Users can post messages and receive immediate feedback. For example, participants have used the network to request assistance in finding equipment or onsite training being offered elsewhere in the State. They also ask questions about treatment protocols and other subjects.

Perhaps the largest obstacle faced by the project was that some users simply are not comfortable with computers. A focus group held in September 1998 addressed why some participants do not use the system on a regular basis. Reasons included inability to "get in," passwords, computer ignorance, and lack of training. In response, CIT and EMSIPS staff are taking every possible opportunity to provide ongoing training at EMS conferences and while visiting ambulance services across the State. Other problems arose from too many well-meaning but uninformed users installing software or changing the configurations, which rendered the system inoperable or at least made it function poorly. Extended warranty and service contracts with equipment manufacturers have proven invaluable for solving these types of problems.

According to the project director, the project's exemplary public-private partnership succeeded in part because members understood that flexibility was crucial when dealing with different types of agencies. "Timelines can serve as a guideline, but they do not always allow for the needs of

The Electronic Network for the Coordination of EMS Data and Education

different agencies, such as varying levels of approval, bidding requirements, and other contract obligations," he writes. "The TENCODE project avoided problems by openly discussing delays and challenges and working together to overcome them. We adjusted the project as needed."

The project is currently expanding to add interactive desktop videoconferencing technology to individual ambulance service computers. The U.S. Department of Commerce's Telecommunications and Information Infrastructure Assistance Program is funding this component. The technology will allow ambulance personnel and medical control physicians to conduct face-to-face quality improvement sessions throughout the State. The project will also use the technology to provide different types of continuing education as well as provide additional training and technical support in the use of the existing hardware and software.

The consortium is also seeking funding to expand the system to include companion computer systems in the hospital emergency departments so that patient care data gathered in the field can be seamlessly merged with that gathered in the emergency department.

The TENCODE system continues to be used for continuing education and is proving to be a great vehicle for disseminating important information. For example, the Montana Board of Crime Control has initiated two projects that will use the system. The first is an interactive CD-ROM program on training emergency medical technicians to handle intimate partner violence. The second is the development of a companion Web page that will contain more information about resources for ambulance personnel and the victims they encounter in their work.

Researchers are also considering using the TENCODE network as a resource for gathering extremely useful data from ambulance runs across the State. Suggested research projects have included regional and local data linkage, suicide surveillance, and agricultural injury surveillance.

A consortium of Nevada health providers has developed a statewide infrastructure to provide health promotion and education activities throughout the State's 15 rural and frontier counties. Nevada has some of the worst health statistics in the Nation, particularly in the areas of alcoholism, drinking and driving, cirrhosis of the liver, high cholesterol, and chronic obstructive pulmonary disease. Before this outreach project began, there were no health educators in the state's rural and frontier areas, and culturally appropriate disease prevention programs were needed for its Hispanic and tribal communities. Called REACH (Rural Education and Community Health), this project has provided health education to roughly 125,000 rural residents since its implementation in June 1996.

With one full-time health coordinator, one half-time nutritionist, and one half-time clerical assistant, the project's first task was to identify realistic and reasonable methods of service delivery. Because it was not feasible for the primary staff to provide direct health education programs on a regular basis to all rural areas, the project adopted a train-the-trainer approach and recruited 32 community health nurses throughout the State to provide health education programs to their communities. These nurses provide primary care and preventive health services in 18 clinics and 54 satellite sites such as schools. Often, they are the only providers of public health services in isolated frontier areas.

Each community clinic conducts several annual health promotion campaigns for the REACH project: nutrition in March and September, cancer prevention in April and October, and tobacco use prevention in May and November. The project's health educator also travels to all rural areas to conduct assessments, provide training, build networks, and participate in community health fairs. As of December 1998 (6 months before the grant's conclusion), the community health nurses and the health educator had provided educational programs to about 13,500 community members and school-age children. In addition, nearly 14,600 rural residents had participated in 41 education and outreach events, including health fairs.

NEVADA

Rural Education and Community Health

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PROJECT 16

Rural Education and Community Health

The Nevada State Health Division's Bureau of Community Health Services serves as the project's lead agency. Other members of the consortium are the Area Health Education Center, the Nevada Office of Rural Health, Nevada Hispanic Services, Nevada Rural Health Centers, the American Heart Association (AHA), and the Bureau of Alcohol and Drug Abuse. Members of the consortium have agreed to conduct joint activities whenever possible and to focus on the development of a rural infrastructure for health promotion and education. Efforts are under way to include consistent representation from Nevada's tribal communities.

The project's consortium collaborated on a number of health promotion activities under the grant. Nevada Hispanic Services provided health education, outreach, and interpreter services to more than 2,500 Latinos. In another train-the-trainer program, AHA provided training on the Heart Power curriculum to 400 rural teachers in grades K to 8, and subsequently, more than 10,000 rural students participated in the Heart Power programs. The Cooperative Extension Service provided training on the Team Nutrition curriculum to rural elementary school teachers and youth leaders, and an estimated 15,000 students participated in Team Nutrition activities.

In addition to health promotion and education activities, consortium members sponsored more than 1 dozen professional training workshops with almost 1,000 participants. Targeted groups include community action leaders, community health nurses, Hispanic volunteers, and university health education majors.

In another innovative project, REACH asked local students to design book covers with antitobacco messages. The project produced and distributed more than 46,000 of these covers to middle school students in rural Nevada. The project also sponsored 17 youth focus groups that drew 155 teens from around the State. Participants discussed tobacco use, nutrition, and teen pregnancy. Currently, REACH is working with the Intertribal Council of Nevada to produce two videos: one on Indian Health Service programs and how to access services and one on Native American disease prevention and traditional healing methods. The video package will be distributed to more than 55 tribal clinics and to health professionals who work with Native American

Rural Education and Community Health

populations. During the final 6 months of the grant period, Nevada Rural Health Centers will conduct work site health education programs for employees of two mining companies. These programs are expected to reach a minimum of 200 workers and their families.

Despite the large number of individuals reached by this project, still more could be done, concludes the project coordinator. "All consortium members acknowledge that more direct health education programs and services must be available in rural communities," she writes. "More health educator positions are also needed."

The 32 community health nurses will continue their in-kind participation with REACH after the end of the grant period. The communication linkages and networks established during the project will also continue. In addition, a newly formed statewide health education network (HEdNet) is expected to enhance collaborative health promotion and education activities for Nevada's citizens. The REACH consortium is currently researching future funding opportunities. Funds from a Preventive Health and Health Services Block Grant will support the project coordinator position.

More than 3,500 people have received cardiopulmonary resuscitation (CPR) training through the Save My Neighbor program based in rural Potsdam, New York. This number represents a remarkable one-tenth of individuals living in the service area of Canton-Potsdam Hospital, the project's lead organization. Potsdam is located in St. Lawrence County, a vast, 2,840-square-mile county bordering the St. Lawrence Seaway and the Canadian border.

The Save My Neighbor program was developed to provide an essential link in what the American Heart Association (AHA) calls the "Chain of Survival." The Chain of Survival is composed of four links: (1) early access to care, (2) early CPR, (3) early defibrillation, and (4) early advanced care. In 1994, St. Lawrence County strengthened the first link in the chain by implementing a countywide 9-1-1 emergency system. Save My Neighbor was designed to strengthen the second link. The more that rural residents are trained in CPR, the better the chances that someone can begin this lifesaving technique immediately following a heart attack.

To reach as many people as possible, the project adopted a train-the-trainer approach. It provided CPR instructor training to 35 individuals, who then taught CPR classes for the project on a volunteer basis. The chosen curriculum was the "Heartsaver" course developed by AHA. Classes were offered at no cost to the participants and were held in people's living rooms, restaurants, bank lobbies, church basements, and public locations in conjunction with area festivals. To increase participation during the third year of grant funding, the project assisted area businesses, churches, and community groups in developing their own CPR training programs. Twenty of these organizations sponsored the instructor training of one of their members; now these trainers teach CPR to their groups.

Canton-Potsdam Hospital leads the project's consortium. Representatives from three area rescue squads, local chambers of commerce, the Cornell Cooperative Extension, the Migrant Education Outreach Project, and the Canton-Potsdam County Public Health Department complete

NEW YORK

Save My Neighbor
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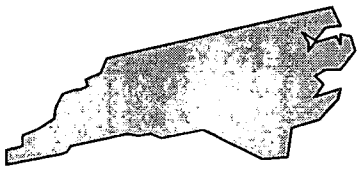
Save My Neighbor

the consortium. Initially, the rescue squads provided the majority of the instructors for the campaign. The rescue squads also provided the consortium with first-hand knowledge of the requirements for saving lives in the field. As the project progressed, each consortium member sponsored the training of at least one CPR instructor.

The project's half-time coordinator maintains a database of classes, equipment, instructors, and people who have completed CPR training. This database proved valuable in the evaluation phase of the project. A survey was mailed to nearly 2,500 individuals who had taken the CPR training through the outreach project. Of the approximately 400 people who responded, more than 25 (about 6 percent) reported that they had had the unfortunate opportunity to use the skills they learned in their CPR class.

CPR training will be provided after the grant period by the Canton-Potsdam Hospital; local rescue squads; and the businesses, churches, and community groups that sponsored CPR instructors. Participants will be charged between $10 and $20 to cover the costs of course materials and training equipment. The hospital will continue to make training equipment available to all affiliated instructors. Project staff members are currently pursuing funding opportunities for this program.

NORTH CAROLINA



Rockingham County Student Health Centers

Morehead Memorial Hospital

Eden, North Carolina

Morehead Memorial Hospital of Eden, North Carolina, has collaborated with existing county services to establish a student health center in each of the county's four high schools. The consortium recognized that although the county public health department and mental health department provide low-cost health services, high school students often find it difficult to access these services because of the lack of transportation and because the clinics operate during hours when students are expected to be in school. To address these barriers, a multidisciplinary team of providers delivers comprehensive health care at the schools, including education, treatment, prevention, and referral.

The student health centers are open on school days from 7:30 a.m. to 4:00 p.m. and are staffed by either a full-time nurse practitioner or registered nurse. An additional nurse practitioner, social worker, health educator, and mental health counselor rotate among the health centers during the week. Physicians are available for immediate phone consultation at all times, and they review the charts of students treated each week.

Available medical services include laboratory tests, acute care services, dental screenings, gynecological services, education on pregnancy prevention and nutrition, social work, counseling, immunizations, sports physicals, health education, and referrals. All services are offered free to students; however, parental consent is necessary for treatment except in the event of an emergency. (At the close of the 1997-1998 school year, 87 percent of students had that consent.) During the grant period, the project experienced 51,406 visits to the health centers. About 4,000 students in grades 9 through 12 attend the 4 high schools.

One of the unusual aspects of this project is that its lead agency is a hospital and not the public health department. The project director, who is a hospital administrator, notes that "As managed care becomes more prevalent in our society, hospitals will need to take on increasing roles in the area of health promotion and wellness. School-based health centers can serve as model sites in this expanded service area." Other consortium members are the Annie Penn Hospital, Rockingham County Schools, Rockingham County

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Rockingham County Student Health Centers

Department of Public Health, and Rockingham County Department of Mental Health. These agencies provide direct, in-kind contributions to the project. The project also maintains an advisory board that includes representatives from the consortium members as well as from the Department of Social Services, Cooperative Extension Services, parents, students, and clergy.

"Establishing the consortium early on and inviting all county health agencies to be a part of this consortium most definitely made a difference in the success of this project," writes the project director. "The consortium brought a broad base of support and provided the centers with additional credibility, which allowed them to grow and flourish."

In addition to health care, the project provided health education to the students in a variety of ways, including visits to ninth-grade health classes by a health center staff member, a health center bulletin board, and an extensive health education video library available to all teachers for classroom use. Many educational activities focused on reducing behaviors that pose health risks to teens, particularly alcohol and other drug abuse, cigarette smoking, and violence. The health centers also promoted sexual abstinence and use several pregnancy prevention programs, including Baby Think It Over dolls (infant simulators), empathy bellies (pregnancy simulators), and a video titled "A Conversation About Teen Pregnancy."

The project also implemented school-based smoking cessation programs and a program that trained peer mediators to help reduce the incidence of violence. During the first year of the grant period, the project also implemented the Rockingham County Teen Court Program, which used positive peer pressure to help reform violent students. Statistics indicate that students who go through Teen Court as opposed to the traditional juvenile justice system are less likely to be repeat offenders. This successful program now operates under separate funding.

The project used a variety of evaluation methods to assess student health needs and risk behaviors. The information gained from these studies allows the project to revise or delete programs depending on their effectiveness and add new programs when the need arises. For example,

Rockingham County Student Health Centers

when an annual survey revealed that nearly half the county's high school students do not wear seat belts, the project launched a major campaign at each school to increase seat belt usage. Students organized the campaign and monitored seat belt usage in the school parking lots. They also distributed "buckle-up" key chains and installed signs around the schools reminding students to wear seat belts.

The school-based health clinics have benefited both students and parents, writes the project director. "Students can get health care without missing school, which increases their potential for academic success. And parents can be confident their children are receiving quality health care without having to take time off from work. In today's society, where most children come from homes with either two working parents or a single parent, this is an important service."

The consortium will continue to provide comprehensive health care at the school-based clinics after the grant period. All services provided on-site will remain free to students. Funding for at least the next 2 years is secure through a Kate B. Reynolds grant and contributions from consortium members.

NORTH DAKOTA

Spirit Lake Sioux Mobile Prevention Project

Little Hoop Community College

Fort Totten, North Dakota

A consortium of health providers on the Spirit Lake Reservation in North Dakota established a mobile health clinic to provide preventive health services and education to the reservation's 5,500 Sioux residents. It also implemented a community development program that focuses on decreasing substance abuse, child abuse, and domestic violence in the community and on building collaborative relationships among community agencies.

The reservation covers about 450 square miles and includes four small communities and scattered housing units. About 125 babies are born on the reservation every year. The only physicians on the reservation practice at the Indian Health Service (IHS). Poverty, unemployment, lack of transportation, and low educational levels all contribute to a pattern of seeking health care for illnesses rather than accessing preventive health services. Although IHS and the Maternal and Child Health Program offer free immunizations, parents typically neglect to immunize their children until they reach Head Start age. Preventive health care for children from kindergarten through junior high school is also frequently neglected.

To address these needs, project staff took a 32-foot mobile clinic out to the small communities to provide nursing and preventive health care. A registered nurse, licensed practical nurse, and secretary staffed the mobile unit. Services provided on board include immunizations, head checks for lice, blood sugar checks, pregnancy tests, other nursing services, and referrals to IHS in Fort Totten. Through the efforts of the outreach project, approximately 90 percent of children ages 0 to 2 on the reservation are current with their immunizations.

Mobile unit staff also provided Early Periodic Screening Diagnostic and Treatment (EPSDT) screening in cooperation with the Early Childhood Tracking, Maternal and Child Health, and Healthy Start programs. The EPSDT screenings test for growth and development problems in pediatric and adolescent patients. Dr. Terry Dwelle, a Commission Corps Officer and pediatrician, guided the development of this program and conducted the physical exams.

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Spirit Lake Sioux Mobile Prevention Project

The consortium also implemented a community development program aimed at improving communication between agencies and decreasing substance abuse, child abuse, and domestic violence in the community. The project was implemented under the guidance of Phil Lane and Dr. Michael Bopp of the Four Worlds International Institute in Lethbridge, Alberta, Canada. The two men visited the reservation on several occasions to meet with community members and to evaluate the unresolved human and community issues there. They identified three major areas of concern:

1. Children and youth are in crisis, as indicated by alarmingly high levels of suicide attempts (some successful), alcohol and other drug abuse, antisocial and criminal behavior, and just-under-the-surface hurt, depression, and anger. Youth report that about 90 percent of them on the reservation use alcohol and other drugs and that they feel there is really nowhere to turn for healing. It was recognized that children were in crisis because families and the community were in crisis.
2. The community has experienced a long series of shocks and hurts over the years, including natural disasters; cultural, spiritual, political, and economic oppression and injustices; disease; and grueling poverty. All these have added layer upon layer of trauma and hurt. This hurt comes out in the everyday life of the community in such forms as habitual mistrust, backbiting and gossip, low self-esteem, high levels of disunity and other forms of political stress, economic dependency, addictions, and violence toward self and others.
3. Agencies are not working together. They generally tend to work in their own corners, isolated from and somewhat mistrustful of the others. Hence, although agencies might have resources and human energy to help the community, their impact has been severely limited.

In response to these issues, agencies and community leaders are working to build constructive, collaborative relationships and to develop a "curriculum of community wellness." Some specific activities include increasing recreation opportunities and safe places for young people to

Spirit Lake Sioux Mobile Prevention Project

go and implementing an interagency program to help youth deal with substance abuse, suicide, depression, physical and sexual abuse, and other related issues. In addition, Jerome DeWolfe, a community health specialist with IHS in the Aberdeen area, was invited to implement a pilot project on alcohol and other drug use prevention at the reservation's Four Winds School.

"We are currently very challenged with the process of community development," writes the project director. "It is a concept much larger than we are prepared for, but we are working on it daily and seeking advice and counsel problems arise."

Leading the project's consortium is the Little Hoop Community College in Fort Totten. Other consortium members are the State Maternal and Child Health Program; Early Childhood Health Tracking Program; IHS; Healthy Start program; and Family Health Coalition, an alcohol and other drug use prevention program.

The consortium is applying for grants and other funding opportunities to sustain the project after the grant period. It is also considering merging the mobile clinic/screening program with another existing program under which it could bill third-party payers. Community development activities will continue, under the guidance of Dr. Dwelle.

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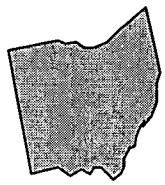

Child Protection Center of Ross County

Ross County Children's Services

Chillicothe, Ohio

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Like many rural underserved areas, Ross County, Ohio, struggles with significant risk factors associated with child abuse and neglect, including high rates of poverty, unemployment, domestic violence, substance abuse, and teen pregnancy. Between 1991 and 1995, the county experienced an increase in the number of reports of child abuse and neglect, in line with the national trend. In the face of this growing problem, however, there were still significant gaps in the services available for sexually abused children. In response to this need, a diverse network of service providers formed the Child Protection Center of Ross County with the goal of preventing, detecting, and treating child sexual abuse through a local, coordinated response. The project serves children up to the age of puberty who have been sexually or physically abused as well as their families.

The Child Protection Center conducts interviews and physical examinations of abused children and provides support through counseling and home visits. This is all done in a child-friendly atmosphere using a multiagency, multidisciplinary approach. A pediatrician, nurse, social worker, child therapist, and community outreach specialist provide services to children and their families. The children and their families are supported throughout the process, including the legal process, if necessary.

The Child Protection Center evolved considerably as an organization during the grant period. It became a separate 501(c)3 corporation, making it a tax-exempt, not-for-profit organization, and its consortium became the board of directors. Originally, the service area was Ross County with the intention of expanding to surrounding counties. The project has added Pike County, and three other counties have expressed interest in accessing services.

Since its implementation, the Child Protective Center has provided medical and psychosocial assessments for 134 children. Three of these were for physical abuse, and 131 were for sexual abuse. During the grant period, the number of reported cases that Children's Services were able to substantiate rose from 7 percent in 1994 (before the grant) to 15 percent in 1997. Some of this improvement can be

Child Protection Center of Ross County

directly attributed to the Child Protective Center. The number of prosecutions for adult felony sex offenses involving children rose from 11 in 1995 to 15 in 1997.

Education and prevention were also important components of this project. During the grant period, center staff gave 10 presentations to schools and 23 presentations and workshops to various community groups. Staff members also made home visits to provide information and education to families.

The Child Protection Center used a variety of innovative methods for service delivery. First, having different agencies and disciplines at one location providing services in a coordinated fashion is a relatively new concept in child abuse programs and one that is clearly better for the child and the family, remarks the project director. Even the collaborative nature of the project is new for Ross County. "The development of a program where seven different agencies work together to improve the services that each provides is innovative for this community," she writes. "There are no other programs in our area with this kind of approach."

Each consortium member made an important contribution to the project. Ross County Children's Services, a child welfare program, serves as the project's lead agency and fiscal agent. Adena Regional Medical Center provides staff and the space for the clinic. Scioto Paint Valley Mental Health Center provides a child therapist. Family Healthcare, Inc., provides a physician. The Ross County Sheriff's Department and the Chillicothe Police Department both contribute at monthly consortium meetings. The Ross County Prosecutor's Office educates and assists physicians who work with the project as well as local pediatricians. Two community liaisons have also been added to the consortium, including one physician.

Another innovative component of the project was that it had a pediatrician conduct the interview as well as the physical exam, which differs from many other child abuse programs. Doing the interview this way is beneficial because pediatricians are recognized as experts in child development and can address the child's developmental age and ability to tell the difference between the truth and a lie. The physician conducts the interview before the physical exam. This allows

Child Protection Center of Ross County

the physician to have a more focused exam based on what was revealed during the interview. Some children have chosen to add to their disclosure during the exam. If a case of abuse goes to court, the pediatrician can testify about what the child disclosed in the interview as well as to the findings from the physical exam.

Perhaps the greatest challenge faced by the project was gaining acceptance from other agencies as the program was developing. The investigators at Children's Services were unsure of the interviewing skills of the physician and social worker at first. As the program gained acceptance, Children's Services began making referrals for the exam and interview, and the agency is now one of the biggest promoters of the program. Law enforcement and the prosecutor's office were also slow in committing themselves. But they grew to recognize and appreciate the program as some of the cases went to court and the project's records and testimony made a difference. Another way the project gained the acceptance of other agencies was by staff attending conferences together and by developing individual relationships that provided an understanding of the process from the perspective of other agencies.

It is expected that similar projects would work very well in other rural settings because they are likely to have some of the same risk factors for abuse as Ross County and the same problem of requiring travel to larger cities for services. Notes the project director, "Turf battles are one issue that will most likely need to be addressed. A second challenge may be developing trust and respect for the way the other organizations are providing their services. It is difficult to break out of traditional ways of doing things and to see beyond the scope of how a particular job is usually done or beyond the scope of the individual project."

All the activities that were developed with this program will continue after the grant. The Child Protection Center is now a separate, not-for-profit organization. It has received grant funding from the United Way, Attorney General's Office (through the State Victims Assistance Act/Victims of Crime Act), and National Network of Children's Advocacy Centers. The project receives some reimbursement for

Child Protection Center of Ross County

services because it is required by State law to bill the municipality where the sexual assault occurred. In addition, the project plans to apply for other grants in the near future and is also in the process of developing an annual fundraising program, which will include a mail solicitation and an annual special event.

A new collaboration involving private nonprofit health care providers and government agencies in Jackson County, Ohio, has made important improvements to the county's available health care services, with a particular emphasis on serving the poor, elderly, and uninsured members of the community. Jackson County is located in the Appalachian region of south-central Ohio, and more than half its residents live below the 200-percent poverty level.

The Health Access, Network and Development (HAND) consortium includes the local health department, hospital, two physician offices (which have become Rural Health Clinics), a community action agency, and the senior citizen's agency. Before the establishment of the HAND consortium, these organizations operated independently and at times considered each other as competition. During the course of the project, however, these agencies formed working relationships so that now each is aware of the services provided by the others, and each refers patients to the other agencies as needed.

The outreach grant allowed each consortium member to expand its services. The Oak Hill Community Medical Center, a private, nonprofit rural hospital, served as the project's lead agency and was responsible for administering and evaluating the project. The Jackson County Rural Health Clinic, which operates in two locations, provided the practice sites for the one full-time and one part-time nurse practitioner recruited through the grant. These nurse practitioners conducted 1,654 patient visits during the grant period. The Jackson County Health Department coordinated and staffed a tuberculosis control program during the first 2 years of the grant period. (Funding came from other sources during the third year.) Staff conducted 9,248 tuberculosis skin tests for the program and provided medications and chest x-rays when needed. During the project's third year, the health department used grant funds to maintain the county's immunization/vaccination program, in which 5,550 immunizations and vaccinations were given. Jackson-Vinton Community Action provided guidance, structure, and experience from its previous medication program to the project's pharmacy program. The Jackson County Board on

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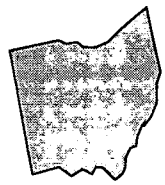

Health Access, Network and Development

Oak Hill Community Medical Center

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Health Access, Network and Development

Aging provided transportation for nonemergency medical visits for 470 patients. All consortium members provided sites and staff for the project's communitywide patient education and preventive health program (17,885 patient encounters).

In other grant-related activities, Oak Hill Community Medical Center purchased teleradiology equipment so that it could receive radiology interpretation from a distant medical center 24 hours a day. As of September 1999, the hospital had used the equipment to transmit nearly 4,200 x-rays and other diagnostic images. The project also offered diabetes screenings and dietary consultations at local supermarkets and established free pharmacy and dental programs for individuals living at 125 percent of the Federal poverty level. The pharmacy and dental programs served 1,876 and 137 patients, respectively.

During the second year of the grant, the Jackson County Rural Health Clinic applied for and received Federal designation as a Rural Health Clinic for both its clinics. To receive this designation, the clinics had to create a framework of services, as well as establish a computerized patient information management system to keep track of patient, program, and financial data. With this designation, the clinics are eligible to participate in the Ohio Care Plan (Ohio's health care reform plan for indigent, low-income, and uninsured residents). However, as of September 1998, the State had not implemented the program in its rural areas.

One of the keys to this project's success was "the strong leadership that truly valued the contributions and survival of the other agencies participating in the consortium," writes the grant coordinator. "An effort was made to make consortium membership a 'win-win' situation for each agency involved."

After the grant period, the Rural Health Clinics will receive reimbursement for nurse practitioner services from Medicare, Medicaid, private insurance, and self-pay. The Rural Health Clinic status will allow for the continuation of all the primary services established under the grant with the exception of the free dental and pharmacy programs.

OREGON

Grant County Rural Outreach Network

Blue Mountain Hospital District

John Day, Oregon

Blue Mountain Hospital, located in John Day, Oregon, is the only medical facility within Grant County's 4,530-square-mile area. Many residents of this rural, frontier county must travel more than 30 miles on poor roads to reach the hospital—for some, the trip can take 90 minutes or more. Before the establishment of this outreach project, there were no other publicly funded clinics in the county.

The Blue Mountain Hospital District designed the Grant County Rural Outreach Network to improve access to preventive and primary health care in the four remote communities of Monument, Seneca, Dayville, and Long Creek. The hospital provides a physician assistant who works 1 day per week in each community, taking along the necessary medical supplies in a specially equipped van. Each community provides volunteer clerical staff, a facility suitable for examinations and routine medical care, and community outreach. Services provided at the clinics include complete physical exams, EKG (electrocardiogram) monitoring, Pap tests, prostate screenings, immunizations, prenatal care, postnatal care, followup, and health education. Patient volume has been steady at the clinics during the grant period, with an average of nearly 700 patient visits a year.

The Blue Mountain Hospital District leads the project's consortium. Other members are the communities of Monument, Dayville, Long Creek, and Seneca, as well as the Strawberry Wilderness Clinic, a family practice group. The project decided to close the clinic in Seneca because there were, on average, only two patients being seen per month. (This is probably because Seneca was the closest to John Day of the four communities.)

The project encountered two problems. The first was obtaining medical histories for the patients being seen in the outreach clinics. Although some of the patient's scheduled appointments and their records were brought from the main clinic in John Day, many were walk-in patients who did not know their own history or the medications they were taking. Encouraging appointments helped, but this continues to be a problem.

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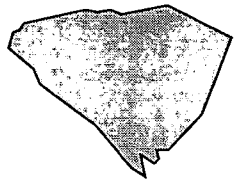
Grant County Rural Outreach Network

The second problem was getting blood samples and specimens to the laboratory on a timely basis. Test results were delayed or compromised because the physician assistant did not return to John Day every day. Occasionally, the project used volunteers who traveled to John Day to transport blood or specimens. These problems could be resolved with a courier service, notes the project director; however, the additional cost does not justify this solution.

The project made a significant impact in the community involving more than just improving access to health care, writes the project director. It has enhanced the economic stability of the county by providing a necessary service, thereby making the county more attractive to people considering relocation.

The clinics generate some revenue through fee-for-service reimbursement, but they are not self-sustaining. The original budget had anticipated 10 patient visits a day; however, the clinics currently average only 4.7 patient visits per day. At this time, the Blue Mountain Hospital District will continue to support the clinics financially. Their long-term viability will depend on how much the communities use the clinics. It is hoped that through additional promotion, plus word-of-mouth success stories, patient volume and revenue will increase in future years. The Blue Mountain Hospital Board of Directors has agreed to act as a foundation board and, if necessary, raise private funds to ensure that this project is sustained until the effort is self-sustaining.

SOUTH CAROLINA



Project SIDE Effects

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The practice of using numerous medications (i.e., polypharmacy) can exact a dramatic toll on the physical well-being of the older patient and, consequently, on the health care system. One study shows that 17 percent of elderly patients' admissions to an acute care hospital were the result of adverse drug reactions, and another 11 percent were caused by noncompliance. Both adverse drug reactions and noncompliance are known to be associated with seeing more than one physician and with using numerous medications. If an elder is seeing more than one physician, each physician may be unaware of what the others are prescribing. Overmedication and drug duplication can ensue, and these can cause reversible cognitive dysfunction such as confusion or dementia. Regrettably, cognitive impairments in the elderly may be erroneously attributed to old age or to the irreversible condition of Alzheimer's disease. Over-the-counter medicines that the elderly use to self-medicate may also aggravate the problem.

Project SIDE (Substance-Induced Dementia in the Elderly) Effects aims to reduce the risk of dementia caused or exacerbated by polypharmacy in persons 65 years of age or older living in noninstitutionalized settings in six South Carolina counties. The project's target population includes African-Americans, Caucasians, and Native Americans, with special emphasis placed on targeting members of the Pee Dee Indian Tribe. By reducing adverse drug interactions in its elderly clients, the project hopes to improve their physical and mental health, reduce the number of emergency hospital admissions because of polypharmacy, and reduce the number of premature nursing home placements of elders who are cognitively impaired from substance-induced dementia.

During the grant period, the project provided polypharmacy screenings and mini-mental-status evaluations to 465 seniors. A licensed master's-level social worker (LMSW) visited the home of each client and conducted a "brown bag" pharmaceutical inventory—so named because the client is asked to place all current medicines in a bag for inspection, including prescription, over-the-counter, and herbal medicines. A pharmacist from the McLeod Family Medicine Center performed an evaluation of the medicines

Project SIDE Effects

for potential drug interactions. If the pharmacist identified a problem, the pharmacist notified the client's primary care physicians and, on orders from the physicians, recommended less toxic drug use to the client.

During the visit, the social worker also identified unmet needs and made referrals to appropriate agencies and community services. For Native American clients, a liaison from the Pee Dee Indian Association assisted the SIDE Effects' LMSWs in performing Native American client home visits for assessments and case management. The Pee Dee Indian Association also provided transportation to health care appointments for the project's Native American clients. During the grant period, the project provided 90 units of transportation and 205 referrals.

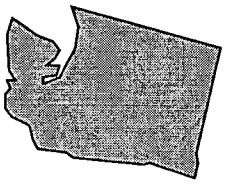
Leading the project's consortium is CareSouth Carolina, Inc., a community health center. Other consortium members include the McLeod Family Medicine Center; Pee Dee Indian Association, a private nonprofit group; University of South Carolina School of Public Health; and Area Health Education Center.

The greatest obstacle faced by the project was perhaps the legitimate concern of clients that their physicians would feel that their professional judgment was being challenged if a potential problem was identified. Some clients hesitated to consent to have the pharmacologist contact their physicians if any problems were noted for fear that the physicians would no longer desire to continue their doctor-patient relationship. To address this issue, pharmacists from the McLeod Family Medicine Center held training sessions for physicians, pharmacologists, nurses, social workers, and other health care providers regarding geriatric polypharmacy. The pharmacists stressed that under no circumstances were credentials being challenged, and they encouraged the health care professionals to view the outreach project as a partnership to reduce polypharmacy. The project also videotaped one geriatric polypharmacy training session and disseminated it to several physicians in the Pee Dee region.

CareSouth Carolina will continue to provide polypharmacy case management and referrals to clients and bill third-party payers for LMSW services. The organization is also applying for another grant to implement this program in a rural and economically disadvantaged area of South Carolina.

Project SIDE Effects

WASHINGTON



Health Outreach and Education Initiative

South Puget Intertribal Planning Agency

Shelton, Washington

Five tribes in southwest Washington improved their tribal health care programs and shared the benefits with each other. The goal of this collaboration was to improve access to health care and health education services for all Indian people in the region. Each tribe within the South Puget Intertribal Planning Agency received funds to carry out a specific component of the outreach project. This intertribal group consists of the Nisqually Indian Tribe (the consortium's lead agency), Shoalwater Bay Indian Tribe, Chehalis Indian Tribe, Squaxin Island Indian Tribe, and Skokomish Indian Tribe. All tribes have new tribal health clinics that provide medical and dental care, but it has been an ongoing challenge to find adequate funding to support all the clinic activities.

The Nisqually Indian Tribe focused its efforts under the grant on implementing quality assurance methods to improve staff performance and patient care services. A full-time quality assurance coordinator joined the Nisqually Health Clinic staff and developed a quality assurance resource guide that was distributed to all five tribes. The entire health clinic staff participated in an eight-session training program concerning quality assurance and performance improvement, taught by specialists from the St. Peter Hospital Family Practice in Olympia. The tribe also used grant funds to pay St. Peter Hospital Family Practice to provide medical consultation and backup (preceptorship) services for the clinic's three midlevel practitioners during all hours that the clinic is open. In addition, a physician provided consultations at the clinic one half-day per week to see complex problems not in need of immediate referral.

The Squaxin Island Tribe developed a child care manual to be used in parenting classes at the Child Care Development Center. The manual was well accepted by the community, writes the project director, because it is community-based and includes pictures of local families. The tribe presented the manual to the other tribes in the South Puget Intertribal Planning Agency and to health care providers throughout the region to inform them of this educational tool for parents. The tribe plans to update and improve the manual annually. The Squaxin Island Tribe also used the outreach grant to offer cultural activities that encourage community health and social cohesion. Tribal

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Health Outreach and Education Initiative

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Skokomish Health Administrator

elders guided the meetings and classes held at the tribe's new community hall. Activities included a clothing bank, food bank, language classes, and basket classes.

The Skokomish Indian Tribe used its grant funds to develop more effective program linkages and referral systems between medical services and mental health and substance abuse treatment services. After conducting networking meetings, field interviews, and surveys of programs, the tribe developed a referral manual to be distributed to all programs servicing the five tribes. Staff developed the philosophy of the manual through interviews with elders throughout the Puget Sound Territory, cultural research and archives, and interviews with administrators in the Department of Health and Social Services. "The compiled information allowed the development of a referral manual with a specifically Native American philosophy, taking into account the traditional feelings surrounding physical health and referrals to participating agencies," writes the project director. Each tribe received a completed manual plus inservice training on implementing the manual.

The Shoalwater Bay Tribe developed several health education programs, as well as a number of cultural activities, under the grant. Diabetes education workshops for adults and children included nutritional education, blood sugar testing, well foot clinics, and the formation of walking clubs. Other workshops addressed anger and conflict resolution. A new program offered incentives to women to use preventive health services such as Pap tests and mammograms. Cultural activities included classes in mask-making for a women's healing group, basket-making, regalia-making, drum-making, and videotaping the Shoalwater Bay sobriety powwow.

After 2 years in the grant cycle, the tribal health centers had provided health care to the following numbers of individuals: Chehalis, 738; Nisqually, 1,069; Shoalwater Bay, 259; Skokomish, 878; and Squaxin Island, 770.

The linkages between agencies and tribal programs initiated under this grant will continue after the outreach grant expires. All consortium members have ongoing fundraising activities.

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This innovative project was designed to help families seeking eligibility for public and private health care benefits in Polk County, Wisconsin. All too often, families face obstacles that result in unchallenged, incorrect denials, writes the project director. In some cases, needed care is postponed or skipped. In other cases, some care is delivered, but the bills go unpaid or partially paid, and families end up in collection actions. The project was designed to demonstrate the effectiveness of locating a professional health care financing advocate right in a busy private health clinic setting. The counselor conducted a family-by-family review of patients' potential eligibility for any third-party payer benefits. Patient education, application assistance, and appeals could follow. Within a year, the clinic realized a substantial improvement in health care access; an enhanced relationship with the community; reductions in bad debts, collection actions, and write-offs; and significant boosts in third-party receipts.

A full-time patient advocate was placed in the River Valley Medical Center, a private health care clinic in St. Croix. The position was supported with matching funds from the clinic and the outreach grant. The clinic quickly became an active service site. Within 1 year of the grant cycle, the patient advocate was making 40 to 80 brief contacts each day and taking on about 168 formal cases each year. Most of the individuals who received brief services were pregnant women and people with disabilities, and nearly all the individuals who received formal services were children younger than age 6.

Probably the most impressive result of the project is that within 18 months, collections increased 46 percent on behalf of patients identified as "self-pay" or "patient responsibility." This increase was noted not by facility or project staff, but by the clinic's accounting firm during its annual reviews. Although nearly all this increase resulted from newly captured third-party eligibility, staff at the clinic also attribute part of the increase to the vast improvement in clinic/patient relations created by the full-time, accessible benefits counselor.

The program was designed so that the patient advocate could be accessible from the moment a family called to make an appointment. Referrals to the patient advocate came from

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all parts of the facility, and all clinic staff members were encouraged to consider themselves part of a patient advocacy effort designed to help both patients and the clinic. Accounts listed as "self pay" or whose benefits indicated some "patient responsibility" were flagged at the time the appointment was made. Each day, the patient advocate received a 5-day appointment schedule, complete with billing codes, so that she could anticipate which families might require assistance and even arrange for third-party coverage in advance of the appointment. In addition, the patient advocate also followed up on all families who were facing collection actions or who were in the "aged receivables" category. The clinic's list of aged receivables diminished significantly because of this new level of review. The patient advocate coordinated her efforts with the hospital by reviewing the chart pull-list for surgeries. By reviewing the charts ahead of the scheduled surgery, the advocate was often able to arrange for third-party coverage in advance of the day of the operation.

This program's design is a specific advancement of an idea already tested at public health agencies by the primary consortium members. Since 1988, ABC for Health, Inc., a private, nonprofit, public interest law firm, provided family health benefits counseling in rural public health settings in Polk County and in neighboring Barron County. The effort was successful in securing hundreds of thousands of dollars in health care reimbursement for families, in cataloging scores of successful financing strategies and "niche" programs that were underused traditionally, and in disclosing numerous systems faults by which the medical assistance eligibility process in Wisconsin failed to deliver deserved eligibility. Repeated attempts were made over the years to pass this expertise to staff at Wisconsin clinics and hospitals. These efforts were not as successful as anticipated, chiefly because trained staff kept all their old duties and only gave family health benefits counseling with limited energy—too limited to achieve results.

In 1994, ABC for Health started an innovative program at the Dean Medical Center in Madison that created a full-time family health benefits counselor position as part of a community care program. The clinic would subsidize care for indigent and uninsured patients only if those individuals

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were truly ineligible for other third-party benefits as ascertained by the benefits counselor. Although hugely successful, the program had one unsatisfying element in that too often families did not receive counseling services until they were overdue for payment or they had waited too long to appeal a denial.

The project at the River Valley Medical Center was designed to improve on these past models. The project hired a full-time patient advocate and placed her at the clinic so that patients could receive benefits counseling and advocacy when the need first arose.

It is interesting to note that two other clinics in the consortium received training in patient advocacy but did not make a specific full-time staff commitment. These clinics did not experience the many benefits seen at the River Valley Medical Center. However, both sites, on learning the results at the River Valley Medical Center, have decided to dedicate a full-time staff member to benefits counseling. "We now know it is not sufficient simply to train facility accounts staff on health care access advocacy," writes the project director. "In order to achieve some success, the facility must devote a staff person fully to this activity." The full-time effort is necessary, he continues, because the work requires a formal casework approach, including detailed retrieval and review of rules and regulations, policies, contracts, denials, and explanations of benefits.

Leading the project's consortium is the Polk County Health Department, which provided support staffing and backup services. ABC for Health provided project management, benefits counseling training, and case support including legal services. River Valley Medical Center and the St. Croix Valley Memorial Hospital provided the project centerpiece: a full-time patient advocate. Other health care organizations participating in the consortium were the Amery Regional Medical Center and the Osceola Medical Center. Additional members were the Polk County Department of Social Services, Polk County Office on Aging, St. Croix Tribal Health Department (Chippewa Nation), and Northern Pines Community Programs (a State-mandated mental health provider). These agencies participated in project planning.

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In another project activity, ABC for Health and other consortium members participated in establishing benefits counselor positions at all 11 Wisconsin tribes in conjunction with a Robert Wood Johnson Foundation-funded health care management grant and the Great Lakes Intertribal Council.

After the outreach grant expires, ABC for Health will continue its involvement in consortium activities with funding from the Wisconsin Bureau of Health, Robert Wood Johnson Foundation, and Otto Bremer Foundation of St. Paul, Minnesota. Both the Amery Regional Medical Center and the St. Croix Tribe Contract Health Office have now hired full-time family health benefits counselors. The position at the St. Croix Tribe will receive funding from Wisconsin Medicaid Outreach for 1 year after the grant period. The River Valley Medical Center has decided to expand its benefits counseling staff to three full-time employees. As it has for over a decade, the Polk County Health Department will continue to support its own full-time family health benefits counselor. The consortium plans to continue its activities as a work group focused on consumer access to third-party payer eligibility and benefits availability. The format will be monthly case conferences.

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