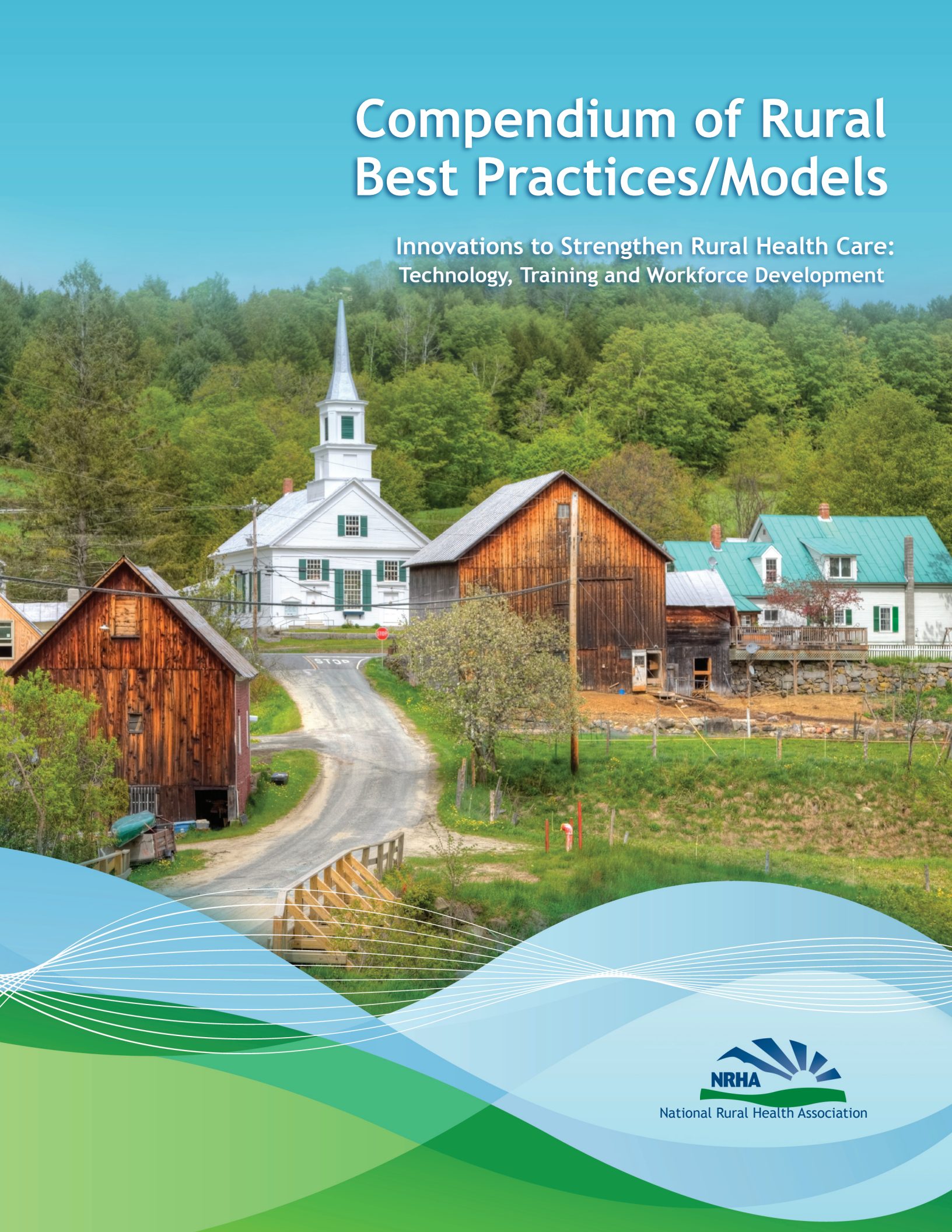
Compendium of Rural Best Practices/Models

Innovations to Strengthen Rural Health Care: Technology, Training and Workforce Development



NRHA
National Rural Health Association

NATIONAL RURAL HEALTH ASSOCIATION

COMPENDIUM OF RURAL BEST PRACTICES/MODELS

Innovations to Strengthen Rural Health Care: Technology, Training and Workforce Development

A document developed by the National Rural Task Force

PREFACE

The National Rural Task Force developed a document that can be used in a prescriptive manner by federal agencies, states and local health and health-related agencies for setting priorities for rural technology, training and workforce development.

This document is envisioned to be "living" and dynamic, designed for ongoing use and modification by various entities. Opportunities for change are built into the document, allowing it to serve as an evolving national rural technology, training and workforce development compendium.

The National Rural Task Force's efforts are going to be helpful as Congress looks at what programs are working and how to build on them. With the compendium, we are beginning to compile a lot of these programs and provide Congress with anecdotal information.

National Rural Recruitment and Retention Network (3RNet)
www.3rnet.org

Service area: 50 United States, the Cherokee Nation and the Commonwealth of Northern Mariana Islands

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Purpose:

3RNet works to improve rural and underserved communities' access to quality health care through recruitment of physicians and other health care professionals, development of community-based recruitment and retention activities and national advocacy relative to rural and underserved health care workforce issues. 3RNet is the national leader for community-based health professional recruitment and retention, using interactive technology and communication.

Overview:

Each member acts autonomously, and their recruitment efforts are supported by national promotional efforts and technical support of the 3RNet. In addition to providing organizational members and their communities with a national identity, 3RNet offers substantial recruitment resources that would be too costly for any single state/territory/nation to support. These resources include:

- Organizational members whose combined years of experience constitute an extremely broad knowledge base which is freely shared,
- A national web site through which state members can be easily reached,
- A registration capability to automatically and immediately inform the member of an interested candidate,
- A capacity for communities to post their opportunities for easy access by candidates,
- An easily edited page where each member can publish pertinent information, pictures and related links,
- A database that members can query to determine which professionals are seeking positions,
- A page with important links to other rural health resources,
- A page dedicated to guiding physicians who have J-1 visas
- And many other functions

Members of 3RNet include nonprofit State Offices of Rural Health, Primary Care Organizations, Primary Care Associations and Area Health Education Centers. National Health Service Corps became a partner in 2007. Several members are located in family practice residencies and are university-based.

In addition to recruitment, retention and tracking, 3RNet offers continuing education services to its members. Staff present at state and national meetings on recruitment and retention and workforce issues as they relate to rural and underserved populations. 3RNet staff and members also provide technical assistance and extensive training in recruitment and retention to rural and underserved communities. Members offer seminars that discuss effective ways to analyze communities from various dimensions: clinical, lifestyle and economics.

Summary:

The 3RNet annual survey is conducted by the National Resource Center (NRC), an independent group that evaluates nonprofit agencies.

- 2005: 4,299 postings, 11,914 applications and 715 placements
- 2006: 7,125 postings, 12,965 applications and 734 placements
- 2007: 5,700 postings, 15,382 applications and 681 placements
- 2008: 5,894 postings, 16,513 applications and 1,023 placements
- 2009: 5,449 postings, 22,227 applications and 1,253 placements
- 90 percent of placements by members are in HPSAs or MUAs

Effectiveness:

Since 2005, as measured by NRC, members report a satisfaction rating of 8.3 to 9.2 on a 10-point scale, with 10 being the highest rating. Lack of funding and staff resources are the biggest hurdles members report. Challenges and barriers are related to lack of primary care physicians nationally. Rural underserved communities also have a variety of challenges due to size and remoteness.

Funding:

Membership dues and HRSA/ORHP

Calaveras County Workforce Education and Training Plan
www.co.calaveras.ca.us/cc/Departments/BehavioralHealthServices.aspx

Service area:California

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Purpose:

Calaveras County Behavioral Health Services (CCBHS) aims to address entry-level and clinical occupational shortages as well as a lack of rural cultural competency. It sponsored two new certificate programs in psychology, a new rural mental health master's in social work program and several tuition programs to assist participants with educational expenses.

Overview:

CCBHS provides mental health and substance abuse programs in a rural community with a population of approximately 47,000. Primary recipients are those with serious mental illness, co-occurring disorders, and those mandated by the court for substance abuse treatment. CCBHS currently has 51 employees, including 10 part-time staff and 28 who provide direct services.

Calaveras County has occupational shortages due to rural geographic barriers and lack of accessible educational opportunities with no colleges or universities within the county. Licensed or licensed-eligible clinical positions comprise the most chronic shortages faced by CCBHS. For positions requiring a master's degree, there are considerably fewer applicants compared to those requiring a bachelor's degree or less education. Those who do apply often do not have a working knowledge of rural and/or ethnic cultures. Hiring qualified entry level, fiscal and leadership staff, and those with lived mental health experience is difficult, resulting in significant shortages when positions are vacant.

CCBHS realized the need to create an Educational Career Ladder for the entry and growth of those with lived experience and to "grow our own" from a strong base of bachelor's-level staff through the creation of several programs funded by the Mental Health Services Act (Proposition 63):

1. Two new psychology programs at Columbia College, located in a neighboring county. In collaboration, CCBHS and Tuolumne County Behavioral Health Department (TCBHD) presented a curriculum by the California Association of Social Rehabilitation Agencies (CASRA) to Columbia as two, 12-unit certificates, one in peer support and one in psychosocial rehabilitation. CCBHS and TCBHD felt the typical 18- to 36-unit programs might overwhelm mental health consumers or those returning to school after several years. As a result, in the fall 2008 these 12-unit certificates became the first of their kind in California and were the locally recognized first-step to entry-level positions in both counties.

2. A new master's in social work (MSW) program at Sacramento State University. As part of local needs assessments, staff noted the inaccessibility of master's level clinical programs for rural communities. Other needs included a central location for classes, minimal travel and an emphasis on rural mental health, which would also be a first for California. Several rural counties and a central region workforce partnership sponsored a three-year rural mental health MSW program at Sacramento State. While the university is an hour and a half away, it meets only 10 weekends a year. This program started in the fall of 2009 and became a significant step in the advancement of bachelor's-level staff.

3. Tuition reimbursement programs. CCBHS created four locally funded programs to support its Educational Career Ladder. The community college reimbursement program is ideal for Columbia programs or any community college curricula. The bachelor's loan assistance program will assume a year of student loans in return for a year of service. The master's loan assumption program works with the Office of Statewide Health Planning and Development (OSHPD) to match funds for student loans, typically two years for two years of service for

clinical staff only. Scholarships for school expenses are also available for underserved populations, such as Miwoks and Latinos.

Summary:

Both educational programs were the first of their kind in California. Other innovations included the program coordinator interviewing all staff regarding career and educational goals and subsequently becoming the informal in-house academic adviser assisting staff and consumers with scheduling, registration and other paperwork. Encouraging staff and consumers to attend classes as cohorts has led to study/support groups and has created significant bonds, particularly for staff. Three Latina women were provided scholarships; two have since graduated.

Effectiveness:

One of the most significant indicators of success for CCBHS is that 40 percent of mental health staff returned to school since these programs have been implemented. For a small, rural county this has had a huge impact on morale and individual staff outlook regarding advancement. The first staff cohort to attend the peer support program at Columbia College recently graduated, and all decided to obtain the second certificate in psychosocial rehabilitation. Being exposed to college has inspired consumer staff to continue their education and to encourage others to do the same.

Funding:

CCBHS funded these programs through the Mental Health Services Act. The department was allocated $450,000 of Workforce Education and Training funds for a 10-year period. CCBHS set aside funds to administer the programs at Columbia; however registration has covered the cost so the department has not had to pay anything for the program itself. Since several counties share the cost to administer the Sacramento State program, the cost has been considerably less than expected, which is approximately $16,000 annually. Most staff and consumers have been attending community college, which is relatively inexpensive to reimburse. Thus the $24,000 allocated for community college reimbursement has been minimally impacted. The match from OSHPD allows CCBHS to double its amount for the master's loan assumption program from a $30,000 total allocation to $60,000. Additional funds are dedicated to staff salaries (part-time coordinator and fiscal support) as well as staff, consumer and community training.

County of San Bernardino Department of Behavioral Health Workforce Education and Training Program

www.sbcounty.gov/dbh

Service area: California

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Purpose:

The Workforce Education and Training component of the Mental Health Services Act was created to address identified shortages in occupations and skill sets and individuals with unique cultural and linguistic competence who provide services in the public mental health system and to provide education and training for all individuals who provide or support services in the public mental health system, including fostering leadership skills.

Overview:

During the workforce needs assessment conducted to request funding, the County of San Bernardino Department of Behavioral Health (DBH) discovered:

- Disproportionate amount of pre-licensed staff to licensed staff,
- Lack of bilingual staff in direct service positions,
- Loss of staff to state prison systems,
- Large number of hard to fill positions, especially in rural areas of the county, and
- Low number of staff close to retirement.

The Workforce Education and Training Program was created to address these findings as well as develop a qualified workforce in all parts of the county.

Summary:

Expansion of the training program to become more comprehensive as a workforce development program has included efforts to develop distance learning methods. San Bernardino is the largest geographic county in the contiguous United States which causes travel challenges for staff when training is held in one location, the traditional DBH method. DBH opened a state-of-the-art training institute to minimize travel. While some learners still prefer face-to-face training, it is not always practical. DBH obtained software to enable web-based learning. The first live/web combo training was in May 2010. Participants chose whether to travel to the training or participate online, a first for DBH, with future enhancements being developed to allow streaming video so web users can see the presenter live.

DBH partnered with California State University-San Bernardino (CSUSB) to develop core competencies for clinical staff. The purpose of this project is to better identify skills needed by clinicians in a public mental health system and be able to offer training courses to staff at different levels of expertise. A committee consisting of staff from the CSUSB School of Social Work and DBH intern programs developed draft competencies broken down by age group and utilized comprehensive staff surveys to validate the competencies. Future trainings will be planned and advertised to staff based on the competency addressed within the training curriculum.

Outreach to high schools has included attending career fairs, networking with high school counselors and partnering with local Regional Occupational Programs (ROP). DBH engaged five teachers of health career classes in job shadowing activities for all aspects of DBH for a week. The teachers then incorporated a mental health component into their curriculum, which included requiring students to give a presentation about a mental illness.

DBH employs a volunteer services coordinator who developed relationships with several vocational schools throughout the county. DBH now offers placements for paraprofessional staff in the billing office, medical records and clinic front offices. Additionally DBH worked with the local Workforce Investment Board to offer placements for a summer youth employment program, which significantly assisted program operations in maintaining high productivity levels during times of staffing challenges due to budget issues.

In fiscal year 2009/10, the internship program had six psychology, six bachelor's of social work, eight master's

of social work and 13 marriage and family therapist interns, for a total of 32 non-employee interns. Not only were interns able to gain valuable experience in a large county mental health system, they were able to develop mentorships with seasoned staff that they can draw on throughout their career development.

The employee educational internship program is another successful program for developing existing staff. Current county employees can complete their field placement during work hours in another program while receiving their salary and benefits. This past year, 11 employee interns, including three in their second year placement and eight in their first year, participated.

One of the biggest areas of concern identified in the workforce needs assessment was the high number of pre-licensed staff. The license exam prep program was created to assist staff in becoming licensed. The Workforce Investment Board received federal stimulus funds which DBH was able to utilize to help pay for this program. Almost 60 DBH and contract agency staff members received license exam prep materials at no charge. Results included more than 20 staff passing their exam with a much greater first-time passing rate than statistics generally show.

A memorandum of understanding was developed with the county hospital, Arrowhead Regional Medical Center, to partner on a psychiatric residency program. Two residents are in the program. Both are completing full-time rotations through DBH in a variety of outpatient settings and programs, facilitating the acquisition of critical knowledge and skill sets necessary for navigating full continuums of community mental health care and recovery-based service modalities.

Effectiveness:

The Workforce Education and Training program is recognized county-wide for its efforts at promoting the behavioral health workforce. New collaborations with local universities, ROP programs, health care coalitions, the Workforce Investment Board and other partner agencies did not exist prior to the program being created. The license exam prep program was awarded the National Association of Counties Achievement Award for 2010 for its successful strides toward developing increasingly qualified staff.

Funding:

Mental Health Services Act, Workforce Education and Training component

Siskiyou County Mental Health Services Act Programs I and II
www.co.siskiyou.ca.us/BHS/MHSA/mhsa.aspx

Service area: California

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Purpose:

Leveraging funding from California's groundbreaking Mental Health Services Act (MHSA), Siskiyou County aims to transform the way public mental health services are delivered by utilizing extensively trained consumers and consumer family members, with bachelor's degrees or less education, to provide mental health services within 10 rural communities at a reduced annual cost of less than $1,500 per client. These personal services coordinators would provide mental health services and supports to Siskiyou County's severely mentally ill residents who have historically not been served or underserved by the public mental health system.

Overview:

Siskiyou County is nestled in the northern most part of California and is one of the five largest counties geographically in the state, with an area of 6,300 square miles. Siskiyou County has a population of about 44,300, or only seven people per square mile. Federally labeled a "frontier" county, due to its extremely remote setting, most of the residents live in small towns or outside of an incorporated city, along the I-5 corridor yet far away from the county seat of Yreka.

Siskiyou County MHSA Program I has 10 Family/Community Resource Centers located in 10 outlying rural communities. These intergenerational hubs of community activity and support have developed their programs to reflect the uniqueness of their location, with some centers offering up to 70 service and support programs.

Siskiyou County's MHSA Program II provides clinical services, supervision and consumer service documentation management and facilitates the MHSA grant process.

Siskiyou County contracts with the Community Services Council, which developed memorandums of understanding with 10 resource centers in 10 rural communities to deliver mental health services and support to historically underserved residents. In fiscal year 2008/09, the estimated service population was 2,800 clients. Because of this innovative program, members no longer need to travel nearly two hours one way for a 15- to 50-minute mental health therapeutic and/or case management service.

Clinical and support staff at the centers, under the clinical supervision of MHSA Program II, hire local residents, who are consumers and/or consumer family members who become personal services coordinators for the program. Each coordinator receives 80 hours of MHSA new employee training. The MHSA system administrator also provides bi-monthly 1.5-hour clinical staffing and training at each community location and clinical emergency response and direction.

Summary:

Since the MHSA inception in 2005, Siskiyou County has provided case management and clinical services to residents who are and/or at risk of severe and/or severe and persistent mental illness, without any attempted and/or completed suicides and/or short-term/long-term hospitalization services. Siskiyou County MHSA was successfully able to reduce the annual cost of these services to $614 per client in 2008/09.

Siskiyou County needed to address and overcome several challenges to accomplish this goal. Siskiyou County Behavioral Health Services began MHSA Programs I and II with three core value commitments:

1. Avoid duplicating and supplanting existing county services and data/fiscal collection systems.
2. Reduce stigma and transportation barriers for residents who needed and wanted mental health services and support.
3. Recruit, hire and extensively clinically train local consumers and/or consumer family members to provide case management services and supports that

were culturally, gender and GLBT sensitive.

As with any new programs, the MHSA programs needed to address challenges over the last five years. This unique MHSA partnership has allowed these challenges to be identified, addressed and resolved with remarkable speed. Three of the major challenges are detailed below.

Challenge 1. How to secure contracts, provide quality cultural, gender- and GLBT-sensitive clinical services, collect services and fiscal documentation with 10 resource centers that are 501 (c) (3) organizations, and not utilize the traditional Mental Health Organizational Services Providers Contractor relationship.

Response: The First Five Commission and the Community Services Council have been organizing and funding resource centers spread throughout 10 rural communities. The Community Services Council, in addition to other services, provides oversight for the network of resource centers.
Siskiyou County Behavioral Health director and MHSA system administrator met with the executive directors and directors of the Community Services Council and the 10 resource centers.
The results of that meeting and subsequent meetings was a decision that Siskiyou County Behavioral Health Services would contract with the Community Services Council, which would then create memorandums of understanding with the 10 resource centers for MHSA services and support delivery; and provide liaison support; and collect the service and fiscal data management for Siskiyou County Behavioral Health Services. Siskiyou County Behavioral Health Services MHSA Program II would provide clinical training and supervision, organize and manage consumer documentation, facilitate the MHSA grant writing process as well as administratively supervise MHSA Program I.

Challenge 2. How to provide clinical training and supervision to insure the services being provided met county, state and federal documentation requirements, quality assurance standards, were HIPAA compliant, and were being delivered with an ethical, culturally, gender- and GLBT-sensitive approach.

Response: Siskiyou County Behavioral Health Services MHSA Program in partnership with the Community Services Council and the resource centers developed and implemented a MHSA 80-hour new employee training that was to be completed by all directors and personal services coordinators. The coordinators (consumers and/or consumer family members) would be employees of the centers but clinically supervised by the MHSA system administrator and would be providing MHSA services and supports within 10 rural communities. The MHSA Program II clinical team would also provide face-to-face clinical staffing in each center a minimum of two times per month, provide on-call clinical emergency support and training; and provide monthly four-hour trainings for personal services coordinators.

Challenge 3. How to accurately collect and report the non-duplicated service and fiscal data that would blend with the county and state documentation and reporting systems, without overloading the existing county services and fiscal data system.

Response: The Community Services Council, in partnership with Siskiyou County Behavioral Health Services and the 10 resource centers, began developing a service and fiscal data collection system that started out utilizing paper and was completed and tabulated by hand. The next step was to develop a web-based system that could be submitted, tabulated and correlated electronically. This electronic system should become integrated and active by Oct. 1, 2010. This data, which can be blended with the data from Siskiyou County Behavioral Health Services data, will be correlated and distributed to Siskiyou County Behavioral Health Services on a quarterly and annual basis.

Effectiveness:

This innovative and transformative MHSA Program I, under the leadership and support of MHSA Program II staff, is a "game changer," particularly during these last four years of California's financial crisis. It reduced annual cost per client. Many counties are cutting mental health staff and subsequently providing fewer mental health services. This program, because it has been able to deliver mental health services at an annual cost per client of under $650, has been able to maximize the funding and increase the number of Siskiyou County residents it serves.

The program requires clients to partner by completing the mutually agreed upon assigned weekly homework assignments. Starting with the first visit, clients are informed about the program benefits and the partnership

relationship agreements, which include completed assignments required in order to receive those benefits. This conveys two important messages to the client:

1. This not a "government handout program."
2. The client must see the value and be willing to reinvest in themselves, and when appropriate, their families and their community.

This relationship agreement sets the tone of the partnership in that it begins to address any perceptions that the client is a victim and begins then to move function forward by acknowledging that the service provider is a coach in assisting the client with their goals. The responsibility for moving forward is the client's, not the service provider's. It also acknowledges that a significant part of the "moving function forward" is the belief that each client has something of value to give to others, whether it's their family or their community.

For example, MHSA began working with four different severe mentally ill adult residents who were at various stages of unemployment and homelessness. MHSA provided services and supports which then assisted these clients with securing housing, employment and a driver's license. During the process the four clients got together and decided that they wanted to do something special with their "give back to the community" project. They contacted local grocery stores and secured enough donations to serve a complete turkey dinner with all the trimmings to 80 low-income families. The total cost to the program was under $25. They have continued this project each of the last three years and last year served more than 172 low-income residents in their community. They now move through their community with dignity, respect and pride.

This program has flourished despite federal, state and county financial crisis impacts, staff changes, resource center director changes, MHSA funding cuts and state cuts. The MHSA system administrator meets monthly with the resource center directors and the Community Services Council, who have become adept at developing and implementing rapid response options to not only county resident needs but also to state, county, Community Services Council and resource center infrastructure needs. The integrity and quality of the program is reviewed by the MHSA system administrator through bi-weekly, on-site supervision, documentation review, client interviews and client surveys.

This program is transferable if there is county and community grass roots buy-in and commitment. The county public mental health services delivery system and all of its bureaucratic support systems must be willing to be transformed. The county does not have an organizational provider contract with the centers but with the Community Services Council that has memorandums of understanding with the centers. This program would not be successful and/or sustainable without the partnership with the Community Services Council. The program has a policy and procedure operations training manual, complete with locally developed 80 hours of training videos.

Funding:

The Siskiyou County Behavioral Health Services MHSA Program I and II are funded through the state's voter-approved Proposition 63 which levied an additional 1 percent tax on annual incomes in excess of $1 million, as well as the Med-i-Cal funding stream.

The majority of the funding is through Prop. 63's MHSA Community Services and Supports fund and augmented with the MHSA Prevention and Early Intervention and IT funds with additional training and education funding support from the MHSA Workforce and Education fund.

During the last several years of the California financial crisis these funds have been targeted, unsuccessfully, for reassignments and cuts. The MHSA funding will need to survive another year or two of insecurity but then should remain a viable financial resource for sustainability and further innovative and transformative mental health and co-occurring disorder service delivery systems development and implementation.

Jichi Medical University
www.jichi.ac.jp/english/

Service area: Japan

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Purpose:

Jichi Medical University aims to improve rural health access.

Overview:

18-year-olds are selected for medical school by the prefecture and by Jichi Medical Univesrity (JMU) and enter six years dedicated to rural health access, then two or three years of graduate training, and then six or seven years of obligation to the most underserved locations in the prefecture (85 percent rural, 15 percent urban). The completion of obligation has been 95 percent for 3,000 graduates in the past 35 years.

Summary:

The cohort effect is strong, keeping the medical students within their prefecture union during medical school and training. Graduates train Jichi students, and the students become colleagues and replacements.

Effectiveness:

In the six or seven years of obligation, Jichi graduates spend 5.5 FTE years in areas with limited health access. This is three to four times the total 35-year career contribution of the best U.S. pipeline medical schools accomplished before the obligation is completed. Then Jichi graduates spend another 10 years in most needed health access during their final 30 years. This ends up being about 50 percent of their entire workforce effort as a physician. U.S. physicians average about one to two years during their career. By the end of their careers, about half of Jichi graduates are still serving areas with limited health access, and 70 percent are still in the prefecture that supported them. Jichi graduates actually tend to prefer the prefectures that have lower concentrations of physicians.

Funding:

Federal: 50 percent; 47 prefectures: 50 percent. It covers the cost of education and training and the cost of living during training.

Delta Area Rural Transit System
www.aehcommunityhealth.org/darts

Service area: Mississippi

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Purpose:

Delta Area Rural Transit System (DARTS) provides access to affordable rural general public transportation through passenger service, vehicle maintenance, transit system management and other related services. DARTS serves individuals, groups and businesses representing all ages, genders and economic, social and ethnic backgrounds.

Overview:

DARTS opened in 1990 with two minivans. At the start, DARTS only offered transportation to people who needed medical care. However, in 1993, DARTS won funding from the Mississippi State Department of Transportation and seized the opportunity to open its buses to the general public. The rationale behind the expansion was simple; DARTS' officials felt that the same people who needed rides to doctors' offices may also need reliable transportation to get to and from work. DARTS tailored its services to transport local residents in need of transportation to and from jobs at local penitentiaries and casinos located along the Mississippi River.

Today, DARTS operates 28 multi-passenger vehicles that connect people with promising jobs, training opportunities, health care, ADA, work activities, shopping centers, cultural events, schools and human services agencies in Coahoma, Desoto, Quitman, Panola, Tallahatchie, Tate and Tunica counties.

The phenomenal growth that DARTS has experienced is due to the following:

- Expansion of the regional job market and the increased need for affordable employment transportation,
- Proactive coordination of services with employment agencies, local employers, human service agencies and potential customers, and
- Aggressive efforts to gain capital and operating funds from various organizations such as the Mississippi Department of Transportation and other local municipalities.

DARTS charges minimal fees for both their one- and two-way trips. People scheduling pre-arranged and reoccurring trips sometimes ride at no cost. Because of the great need for the services offered by DARTS in some cases patron fares are paid by the Department of Human Services, Medicaid or Medicare. In addition, senior citizens who utilize DARTS transportation system often receive special discounts as a result of supplements offered by their county governments.

Successes: DARTS achieved multiple funding resources to develop a regional maintenance facility, maintained long standing collaborative relationships with businesses and the mental health community and has low turnover of professional drivers. DARTS received more than $1 million in American Recovery and Reinvestment Act funds for new vehicles.

Challenges: How to be sustainable in light of the rising cost of fuel and insurance while maintaining the same level of service; lack of local match funding; marketing and service visibility; recruitment of trained drivers and providing continuous safety

record; no volunteers; lack of access to technology, i.e. infrastructure and professional staff.

Effectiveness:

DARTS provided 99,314 one-way trips in 2009, of which 58,357 were for disabled and mental health patients, 29,129 for employment, and the balance for medical, training and recreational purposes. DARTS has maintained an excellent safety record.

Funding:

Mississippi Department of Transportation, American Recovery and Reinvestment Act, County Boards of Supervisors, fares and fees, Human Services contracts, state multi-modal grants and the Children's Health Fund.

Hidalgo Medical Services
www.hmsnm.org

Service area: New Mexico

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Purpose:

Hidalgo Medical Services (HMS) is a federally qualified health center/community health center in southwest New Mexico. HMS provides comprehensive primary care and family support services to the residents of the Southwest, with 11 clinics in Hidalgo and Grant Counties. Hidalgo County, as well as special populations in Grant County, are designated by HRSA as Health Professional Shortage Areas for medical, dental and mental health primary care services. Additionally, Hidalgo County and a portion of Grant County are designated as Medically Underserved Areas. For 10 years, until HMS began providing medical services in Hidalgo County in 1995, there was not a single primary care provider for approximately 5,000 people. Fifteen years later, HMS remains the only medical provider in Hidalgo County.

When vacancies occur, it takes HMS between one year and 18 months to recruit a physician and six months to recruit a mid-level provider. Many HMS providers are National Health Service Corps (NHSC) scholars or loan repayment obligors. While NHSC helps health centers such as HMS to meet the community need for providers, it can results in high turnover if providers are not prepared to practice and live in a rural setting over the long term. During the past five years, the majority of providers who completed their NHSC obligations and chose to remain in the service area are Grant County natives or previously resided in similar rural New Mexico communities.

In order to meet the long-term health care needs of residents in southwest New Mexico, HMS is focusing on rural health training using the rural health professional career pathways (or pipeline) model. The model is a well-established concept which consists of four phases. In phase one, efforts are made to encourage secondary students raised in rural communities to enter the health professions. Phase two follows rural students through undergraduate education and includes their selection, sometimes preferential, into medical schools. Phase three provides rural training experiences during medical school and residency. Finally, phase four includes recruitment of providers to rural practices combined with a mix of retention strategies. Ideally, rural students enter these pathways at phase one and are ultimately retained in or near their rural communities of origin. However, individuals, including those of non-rural origin, but with an interest in rural practice, can enter the pathways at any stage.

Overview/summary:

HMS' current recruitment and training strategies cover all four phases of the pathways model. HMS director of human resources and marketing, sometimes accompanied by an HMS provider, conducts presentations, promoting a variety of health care careers, education and training programs and the University of New Mexico combined BA/MD program, at Grant and Hidalgo county high schools and at the Western New Mexico University career fair. During the 2009/10 school year, HMS also conducted a nine-session course on health careers at Lordsburg High School in Hidalgo County. Additionally, local high school and college students have the opportunity to complete internships and Americorps positions at HMS.

HMS partners with University of New Mexico in Albuquerque, N.M.; Memorial Medical Center in Las Cruces, N.M.; and Arizona School of Dentistry and Oral Health at A.T. Stills University in Mesa, Ariz., to train primary care health professionals. Currently HMS trains approximately six family medicine residents, eight to 10 pediatric residents, six dental students, 10 dental residents, five physician assistant students and one medical student annually in rotations ranging from four to eight weeks. New Mexico does not have a dental school, and HMS is currently the only organization training dental students

in the state. HMS maintains contact with many of these students and residents throughout their training in order to facilitate recruitment to HMS.

HMS also employs a variety of strategies to retain current HMS providers. Because a sense of professional stagnation and isolation is often cited as a reason providers leave practice in rural areas, HMS encourages continued professional development opportunities. A prime example of this is the partnership between HMS and University of New Mexico to implement Project ECHO (Extension for Healthcare Outcomes). Project ECHO uses tele-video technology to connect rural providers with urban health care specialists in order to co-manage chronic diseases in rural patients. This allows patients to receive care from their primary care providers in their own community while benefiting from the technical expertise of a health care specialist. Additionally Project ECHO provides rural providers, including those at HMS, the opportunity to engage with other medical professionals and gain additional depth of knowledge regarding specific chronic diseases.

Research has found that rural training, particularly longer periods of rural training, is a predictor of later medical practice in a rural community and that rural origin and rural training are significant, independent predictors of rural practice. Why do medical graduates choose rural careers? Recruiting and retaining physicians in very rural areas. In light of these findings, HMS' future plans include an expanded dental rotation program with Arizona School of Dentistry and Oral Health, exploring the feasibility of an HMS dental residency program and establishment of a 1-2 family medicine residency program in partnership with Memorial Medical Center.

Effectiveness:

Over the years, HMS has recruited several providers through training relationships with University of New Mexico and Memorial Medical Center. Additionally, HMS recently recruited its first dentist from Arizona School of Dentistry and Oral Health, who completed a rural rotation with HMS. HMS has a waiting list of dentists seeking employment at the organization. HMS expects that recruitment and retention of primary care providers will continue to be facilitated by expanded rural training opportunities in the future.

Funding:

HMS receives a contract of $64,000 from the New Mexico Department of Health Office of Primary Care and Rural Health each year to support residency and student training. This year, the University of New Mexico dental residency program will provide financial support for dental resident rotations and compensate for teaching time. The remainder of the funding for pediatric and family medicine residents and dental and other students, including housing costs, are provided by HMS resources. Total HMS program costs exceed $250,000.

Lifestyles and Values Impact Diabetes Awareness (LaVIDA)
hmsnm.org/lv_index.htm

Service area: New Mexico

Contact information:

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Purpose:

Diabetes in Hispanic Americans is a serious health challenge because of the increased prevalence of diabetes in this population, the greater number of risk factors for diabetes in Hispanics, the greater incidence of several diabetes complications, and the growing number of people of Hispanic ethnicity in the United States.

The Lifestyles and Values Impact Diabetes Awareness (LaVIDA) program began in 2001 to reduce the health disparity in Grant and Hidalgo counties in New Mexico. The program is managed and operated by Hidalgo Medical Services (HMS), the central coordinating agency of the REACH 2010 grant.

The following statistics illustrate the magnitude of diabetes among Hispanic Americans:

- In 2000, of the 30 million Hispanic Americans, about 2 million had been diagnosed with diabetes.
- About 10.2 percent of all Hispanic Americans have diabetes.
- On average, Hispanic Americans are 1.9 times more likely to have diabetes than non-Hispanic whites of similar age.
- Diabetes is particularly common among middle-aged and older Hispanic Americans. For those 50 or older, about 25 to 30 percent have either diagnosed or undiagnosed diabetes.
- Diabetes is twice as common in Mexican American adults as in non-Hispanic whites.

Having risk factors for diabetes increases the chance that a Hispanic American will develop diabetes. Risk factors that seem to be more common among Hispanics include a family history of diabetes, gestational diabetes, impaired glucose tolerance, hyperinsulinemia and insulin resistance, obesity and physical inactivity.

Higher rates of the diabetes complications nephropathy (kidney disease), retinopathy (eye disease) and peripheral vascular disease have been documented in studies of Mexican Americans, whereas lower rates of myocardial infarctions (heart attacks) have been found.

LaVIDA is a bilingual public awareness campaign that encourages people at risk for diabetes to have a simple, painless test done at a clinic or by a doctor. In this way, diabetics or people at risk of diabetes can understand the condition and the lifestyle choices they make which may impact their health.

The vision of LaVIDA is to see "generations of people free of the impact of diabetes through innovation and ownership of family health." LaVIDA's mission is to build a team of community members and health professionals working to improve the quality of life for people living with diabetes through community outreach and family participation.

Overview:

LaVIDA, administered through Hidalgo Medical Services, is designed to raise the level of diabetes awareness and demonstrate that lifestyle choices and changes can have a positive impact on overall health. Raising awareness is particularly important in this region because statistical trends show Hispanic Americans are at a greater risk of diabetes, and Hispanics represent approximately one half of the population in southwest New Mexico.

The project is a collaboration of many community partners, which has resulted in a Holistic Integrated Diabetes Intervention offering more than 30 services, including outreach, community prevention, pre-education barrier reduction and post-education support. Partners include Hidalgo Medical Services, Grant County Department of Health, Gila Regional Medical Center, Southwest Outreach for Diabetes and the New Mexico Department of Health.

Demographics:

- The total population of Grant and Hidalgo counties is more than 61,000 people.

- More than half of this population is of Hispanic origin.
- It is estimated that 14 percent of people living in this area may have diabetes.

Since its inception, LaVIDA has:

- Established diabetes resource centers in Grant and Hidalgo counties.
- Staffed these resource centers with promotoras that are supported by contractors, volunteer agencies and community members.
- Continuously evaluated its activities.
- Provided services, such as
  - diabetic education classes offered through Gila Regional Medical Center,
  - diabetic patient support,
  - peer/family support,
  - development of change agents and
  - improving the availability of healthy foods in public places.

Consumer benefits include:

- Free diabetes education classes,
- Cooking classes,
- Resource centers equipped with English and Spanish pamphlets, brochures, books, magazines, newsletters and Internet access,
- Referral services to other agencies and resources in the community,
- Better A1c,
- Ongoing support system and
- Empowerment for lifestyle changes.

Summary:

LaVIDA education classes are the foundation of the program. These four intensive classes, developed by diabetes educators, provide the ultimate learning experience for people with or at risk for diabetes.

Supermarket tours help participants learn how to read and understand food labels enabling them to choose healthy options.

Tobacco cessation classes are offered in eight sessions of information and support designed to help participants quit smoking. Nicotine replacement is available.

The "Active and Alive" program teaches people how and why to be active and how activity fits into their lives and awards prizes along the way. Residents may join classes led by experienced instructors or join community activity clubs.

LaVIDA support groups were developed to expand on LaVIDA education classes. They include 12 sessions designed to empower participants to take control of many aspects of their health care.

The VIVA NM Restaurant Program was implemented to give community members diabetes- and heart-friendly menu options at local restaurants.

Effectiveness:

Many diabetics in our communities have benefited greatly by taking advantage of LaVIDA. The diabetic populations in Grant and Hidalgo counties are learning how to manage their illness through lifestyle changes.

LaVIDA results:

- 55.8 percent of participants indicated that they follow a healthful eating plan at least five days a week.
- 90 percent of participants stated they had their HbA1c levels checked at their most recent medical visit.
- 44.1 percent of participants indicated they engage in at least 30 minutes of physical activity for at least five days a week.
- 67.9 percent of participants stated they tested their blood sugar level daily for at least five of the last seven days.

At HMS, providers refer diabetic patients to the LaVIDA Diabetes Resource Center for education and support. Patients benefit from the following tools:

- One-on-one sessions with a promotora for assessment and further referrals
- One-on-one sessions with a diabetes educator
- Diabetes education classes (four sessions)
- Supermarket tours (hands-on label reading)
- Support groups
- Active and Alive (physical activity program)
- Home visits
- Advocacy and follow-up with providers and clients
- Care coordination

Funding:

Center for Disease Control REACH US program

Compendium of Rural Best Practices/Models
Innovations to Strengthen Rural Health Care: Technology, Training and Workforce Development
EVALUATION

1. Please rank each statement:	**Strongly agree**	**Agree**	**Disagree**
The compendium content was concise.			
Information presented increased my knowledge.			

2. Please list three things the compendium provided that were new to you.

1. _____

2. _____

3. _____

3. How useful was the compendium to you.

☐ Very useful ☐ Useful ☐ Somewhat useful ☐ Not useful

4. What is your overall satisfaction with the compendium?

☐ Very satisfied ☐ Satisfied ☐ Not satisfied

5. Any additional comments on the compendium you would like to share:

_____

_____

_____

Return by mail or fax to:
Rosemary McKenzie – NRHA
521 East 63rd Street
Kansas City, MO 64110
816-756-3144 (FAX)
Thank you for completing the evaluation form.