U.S. Department of Health and Human Services

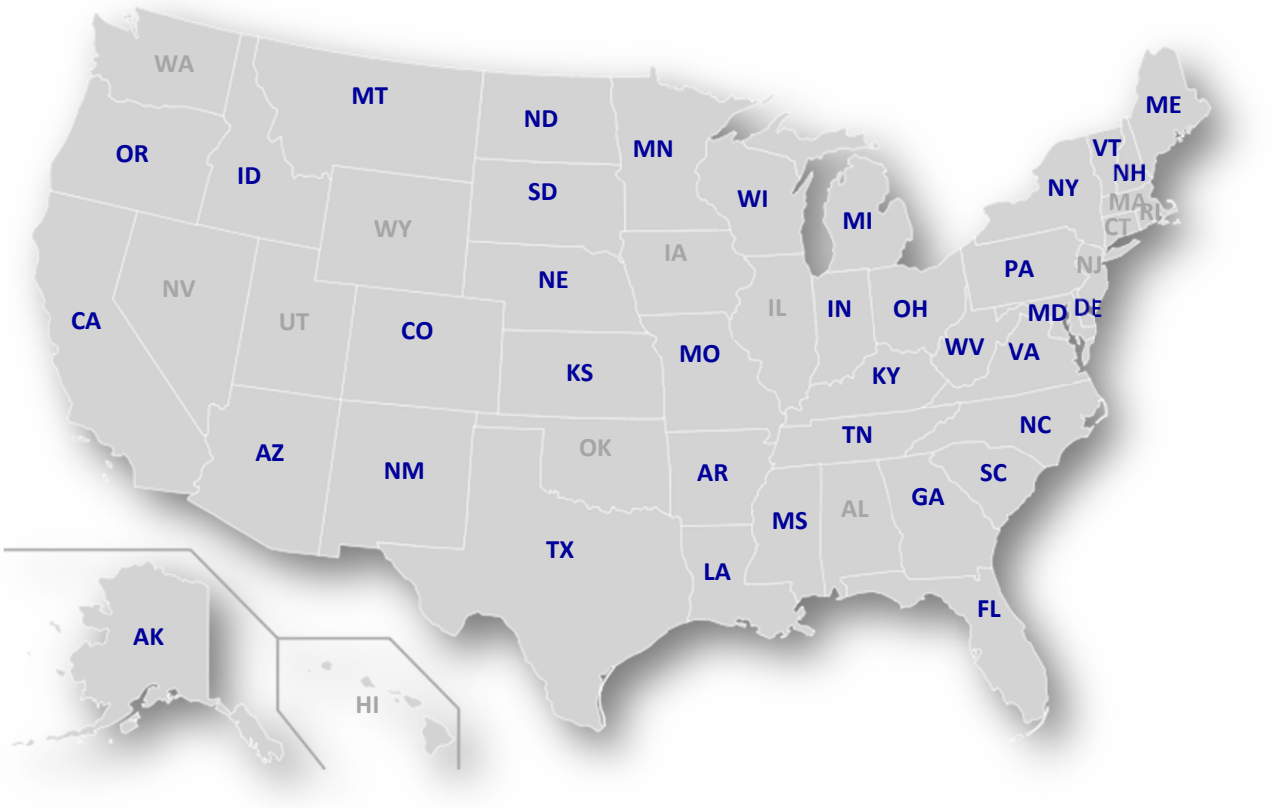
HRSA

Health Resources and Services Administration

Grantee Directory

Rural Health Care Services Outreach Grant Program

2012 - 2015



Health Resources and Services Administration • 5600 Fishers Lane, Rockville, MD 20857 • 301-443-0835

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Grantee Directory

Rural Health Care Services Outreach Grant Program

The Rural Health Care Services Outreach Program is authorized by Section 330A of the Public Health Service Act (42 U.S.C. 254c), as amended. The program supports projects that demonstrate creative or effective models of outreach and service delivery in rural communities. Funding can be used to meet a broad range of health care needs from health promotion and disease prevention to expanding oral and mental health services to case management for rural HIV patients. These projects address the needs of a wide range of population groups including, but not limited to, low-income populations, the elderly, pregnant women, infants, adolescents, rural minority populations and rural populations with special health care needs. The community being served must be involved in the development and ongoing operations of the program, to appropriately address the needs of the population. All projects are responsive to any unique cultural, social, religious and linguistic needs of the target population.

The emphasis of this grant program is on service delivery through collaboration, adoption of an evidence-based or promising practice model, demonstration of health outcomes, replicability and sustainability. Proposed projects have an outcomes-oriented approach that will enhance and sustain the delivery of effective health care in rural communities by tracking specific health indicators that will demonstrate the impact of their project at the end of their grant period. Projects are based on evidence-based or promising practice models and demonstrate health status improvement in rural communities. Outreach projects can take the framework of an evidence-based or promising practice model and tailor it to their community's need and organization.

This directory provides contact information and a brief overview of the seventy initiatives program funded under the Rural Health Care Services Grant Program in the 2012-2015 funding cycle.

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by State)

State	Grant Organization Name	Page
Alaska		
	PeaceHealth DBA Ketchikan General Hospital	1
Arizona		
	El Centro for the Study of Primary & Secondary Education	4
	Mariposa Community Health Center, Inc.	6
Arkansas		
	Siloam Springs Regional Health Cooperative, Inc.	8
California		
	Lake County Tribal Health, Inc.	10
	Nevada County Behavioral Health	12
	Woodlake Union Elementary	14
Colorado		
	Telluride Medical Center Foundation	16
Delaware		
	La Red Health Center, Inc.	18
Florida		
	Heartland Rural Health Network, Inc.	20
	Rural Health Network of Monroe County Florida, Inc.	22
Georgia		
	Georgia Southern University	25
	Irwin County Board of Health	27
	Meadows Regional Medical Center, Inc.	29
Idaho		
	St. Mary's Hospital, Inc.	32
Indiana		
	Indiana Rural Health Association, Inc.	34
Kansas		
	Unified School District #498 Marshall County Kansas	36
Kentucky		
	Ephraim McDowell Health Care Foundation, Inc.	38
	Lake Cumberland District Health Department	40
	Lotts Creek Community School, Inc.	42
	Marcum and Wallace Memorial Hospital	45
	Montgomery County Health Department	48
	Office of Vocational Rehabilitation	51
	Unlawful Narcotics Investigations, Treatment, & Education	54
Louisiana		
	Hospital Service District No. 1-A of the Parish of Richland	56
	Innis Community Health Center, Inc.	59
	Louisiana Tech University	62
Maine		
	Mount Desert Island Hospital	64
Maryland		
	Allegany Health Right, Inc.	66
Michigan		
	Spectrum Health United Hospital	69
	Sterling Area Health Center	71
	Upper Great Lakes Family Health Center	73
	Western Upper Peninsula Health Department	75
Minnesota		
	County of Koochiching	77
	Mississippi Headwaters Area Dental Health Center	79
Mississippi		
	Central Mississippi Residential Center	81
Missouri		
	Citizens Memorial Hospital District	84
	Freeman Neosho Hospital	86
	Health Care Coalition of Lafayette County	88

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by State)

State	Grant Organization Name	Page
	Northeast Missouri Health Council	90
Montana		
	Butte Silver Bow Primary Health Care Clinic, Inc. AKA Butte Community Health Center	92
	Granite County Hospital District	94
	Madison Valley Medical Center	96
	Missoula City/County Health Dept/Partnership HC	99
Nebraska		
	Nebraska Association of Local Health Directors	101
	Public Health Solutions	104
New Hampshire		
	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
	Mid-State Health Center	109
	North Country Health Consortium	111
New Mexico		
	Ben Archer Health Center	114
	Hidalgo Medical Services	116
New York		
	Chautauqua County Health Network	119
	Chautauqua Opportunities, Inc.	122
North Carolina		
	Partnership for Children of the Foothills/McDowell County Partnership for Children and Families, Inc.	125
Ohio		
	Fostoria Community Hospital	128
	Trinity Hospital Twin City	130
Oregon		
	La Clinica del Cariño Family Health Center, dba One Community Health	132
	Samaritan North Lincoln Hospital	134
Pennsylvania		
	Armstrong-Indiana-Clarion Drug and Alcohol Commission	136
	Community Guidance Center/Clearfield-Jefferson Community Mental Health Center, Inc.	138
South Carolina		
	Newberry County Hospital Foundation	140
South Dakota		
	Delta Dental Plan of South Dakota	143
	Sacred Heart Health Service	145
	University of South Dakota Department of Dental Hygiene	147
Tennessee		
	Buffalo Valley, Inc.	149
Texas		
	Madison County	151
Vermont		
	Behavioral Health Network of Vermont	154
	Bi-State Primary Care Association	157
Virginia		
	Giles Free Clinic	159
West Virginia		
	Future Generations	161
Wisconsin		
	ABC for Rural Health, Inc.	163

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

Access: Primary Care

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Florida	Heartland Rural Health Network, Inc.	20
Idaho	St. Mary's Hospital	32
Indiana	Indiana Rural Health Association, Inc.	34
Kentucky	Marcum & Wallace Memorial Hospital	45
Kentucky	Montgomery County Health Department	48
Michigan	Sterling Area Health Center	71
Michigan	Upper Great Lakes Family Health Center	73
Missouri	Citizens Memorial Hospital District	84
Missouri	Health Care Coalition of Lafayette County	88
Montana	Butte Silver Bow Primary Health Care Clinic Inc. aka Butte CHC	92
Montana	Madison Valley Medical Center	96
Nebraska	Public Health Solutions	104
New Mexico	Ben Archer Health Center	114
New Mexico	Hidalgo Medical Services	116
New York	Chautauqua County Health Network	119
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
Pennsylvania	Community Guidance Center	138
South Dakota	Sacred Heart Health Services	145
South Dakota	University of South Dakota Department of Dental Hygiene	147
Tennessee	Buffalo Valley, Inc.	149
Vermont	Behavioral Health Network of Vermont	154
Vermont	Bi-State Primary Care Association	157
Virginia	Giles Free Clinic	159

Access: Specialty Care

State	Grant Organization Name	Page
Alaska	PeaceHealth Ketchikan Medical Center	1
Idaho	St. Mary's Hospital	32
Kentucky	Marcum & Wallace Memorial Hospital	45
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
Ohio	Fostoria Community Hospital	128
Pennsylvania	Community Guidance Center	138
South Dakota	Sacred Heart Health Services	145
Virginia	Giles Free Clinic	159

Aging

State	Grant Organization Name	Page
Missouri	Freeman Neosho Hospital	86
Nebraska	Public Health Solutions	104
New Hampshire	Mid-State Health Center on behalf of Central NH Health Partnership	109
New York	Chautauqua County Health Network	119
South Carolina	Newberry County Hospital Foundation	140
South Dakota	Sacred Heart Health Services	145

Behavioral/Mental Health

State	Grant Organization Name	Page
Arizona	El Centro For the Study of Primary & Secondary Education	4
California	Lake County Tribal Health Consortium	10

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

California	Nevada County Behavioral Health	12
California	Woodlake Unified School District	14
Delaware	La Red Health Center	18
Idaho	St. Mary's Hospital	32
Kentucky	Montgomery County Health Department	48
Michigan	Sterling Area Health Center	71
Michigan	Upper Great Lakes Family Health Center	73
Minnesota	Mississippi Headwaters Area Dental Health Center D/B/A Northern Dental Access Center	79
Mississippi	Central Mississippi Residential Center (CMRC)	81
Missouri	Citizens Memorial Hospital District	84
Missouri	Health Care Coalition of Lafayette County	88
Montana	Butte Silver Bow Primary Health Care Clinic Inc. aka Butte CHC	92
Montana	Madison Valley Medical Center	96
Nebraska	Public Health Solutions	104
New Mexico	Ben Archer Health Center	114
Pennsylvania	Armstrong-Indiana-Clarion Drug and Alcohol Commission	136
Pennsylvania	Community Guidance Center	138
Tennessee	Buffalo Valley, Inc.	149
Texas	Madison County	151
Vermont	Behavioral Health Network of Vermont	154
Virginia	Giles Free Clinic	159
Wisconsin	ABC for Rural Health, Inc.	163

Children's Health

State	Grant Organization Name	Page
Arizona	El Centro For the Study of Primary & Secondary Education	4
Indiana	Indiana Rural Health Association, Inc.	34
Kentucky	Lotts Creek Community School, Inc.	42
Michigan	Spectrum Health United Hospital	69
Michigan	Western Upper Peninsula Health Department	75
Minnesota	County of Koochiching	77
New Mexico	Ben Archer Health Center	114
North Carolina	Partnership for Children of the Foothills	125
Wisconsin	ABC for Rural Health, Inc.	163

Chronic Disease: Cardiovascular

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Colorado	Telluride Medical Center Foundation	16
Florida	Heartland Rural Health Network, Inc.	20
Idaho	St. Mary's Hospital	32
Kentucky	Ephraim McDowell Health Care Foundation, Inc.	38
Kentucky	Lake Cumberland District Health Department	40
Kentucky	Lotts Creek Community School, Inc.	42
Kentucky	Marcum & Wallace Memorial Hospital	45
Kentucky	Montgomery County Health Department	48
Michigan	Sterling Area Health Center	71
Nebraska	Public Health Solutions	104
New Hampshire	Mid-State Health Center on behalf of Central NH Health Partnership	109
Ohio	Fostoria Community Hospital	128
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
South Carolina	Newberry County Hospital Foundation	140

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

Chronic Disease: Diabetes

State	Grant Organization Name	Page
Arizona	Mariposa Community Health Center	6
California	Nevada County Behavioral Health	12
Colorado	Telluride Medical Center Foundation	16
Florida	Heartland Rural Health Network, Inc.	20
Georgia	Georgia Southern University	25
Georgia	Irwin County Board of Health	27
Georgia	Meadows Regional Medical Center	29
Idaho	St. Mary's Hospital	32
Kentucky	Lake Cumberland District Health Department	40
Kentucky	Lotts Creek Community School, Inc.	42
Kentucky	Marcum & Wallace Memorial Hospital	45
Kentucky	Montgomery County Health Department	48
Louisiana	Hospital Service District No. 1-A of the Parish of Richland	56
Maine	Mount Desert Island Hospital	64
Michigan	Sterling Area Health Center	71
Missouri	Health Care Coalition of Lafayette County	88
Nebraska	Public Health Solutions	104
New Hampshire	Mid-State Health Center on behalf of Central NH Health Partnership	109
New Mexico	Ben Archer Health Center	114
New York	Chautauqua Opportunities, Inc.	122
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
South Carolina	Newberry County Hospital Foundation	140
South Dakota	Sacred Heart Health Services	145

Chronic Disease: Other

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Kentucky	Montgomery County Health Department	48
Michigan	Sterling Area Health Center	71

Community Health Workers /Promotoras

State	Grant Organization Name	Page
Arizona	Mariposa Community Health Center	6
Florida	Heartland Rural Health Network, Inc.	20
Idaho	St. Mary's Hospital	32
Kentucky	Lotts Creek Community School, Inc.	42
Kentucky	Marcum & Wallace Memorial Hospital	45
Kentucky	Montgomery County Health Department	48
Maine	Mount Desert Island Hospital	64
Maryland	Allegany Health Right, Inc.	66
Michigan	Spectrum Health United Hospital	69
Michigan	Sterling Area Health Center	71
Nebraska	Public Health Solutions	104
New Mexico	Ben Archer Health Center	114
New Mexico	Hidalgo Medical Services	116
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
Texas	Madison County	151
Vermont	Bi-State Primary Care Association	157
West Virginia	Future Generations	161

Coordination of Care Services

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Florida	Heartland Rural Health Network, Inc.	20

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

Idaho	St. Mary's Hospital	32
Indiana	Indiana Rural Health Association, Inc.	34
Kentucky	Ephraim McDowell Health Care Foundation, Inc.	38
Kentucky	Marcum & Wallace Memorial Hospital	45
Maine	Mount Desert Island Hospital	64
Maryland	Allegany Health Right, Inc.	66
Michigan	Sterling Area Health Center	71
Michigan	Upper Great Lakes Family Health Center	73
Minnesota	Mississippi Headwaters Area Dental Health Center D/B/A Northern Dental Access Center	79
Missouri	Citizens Memorial Hospital District	84
Missouri	Health Care Coalition of Lafayette County	88
Missouri	Northeast Missouri Health Council	90
Nebraska	Public Health Solutions	104
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
New Hampshire	Mid-State Health Center on behalf of Central NH Health Partnership	109
New Mexico	Ben Archer Health Center	114
New York	Chautauqua County Health Network	119
Ohio	Fostoria Community Hospital	128
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
Pennsylvania	Armstrong-Indiana-Clarion Drug and Alcohol Commission	136
Pennsylvania	Community Guidance Center	138
Tennessee	Buffalo Valley, Inc.	149
Vermont	Behavioral Health Network of Vermont	154

Emergency Medical Services

State	Grant Organization Name	Page
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
Ohio	Fostoria Community Hospital	128

Health Education and Promotion

State	Grant Organization Name	Page
Arizona	Mariposa Community Health Center	6
Arkansas	Siloam Springs Regional Health Cooperative, Inc.	8
California	Nevada County Behavioral Health	12
Florida	Heartland Rural Health Network, Inc.	20
Georgia	Georgia Southern University	25
Georgia	Meadows Regional Medical Center	29
Idaho	St. Mary's Hospital	32
Kansas	Unified School District #498 Marshall County Kansas	36
Kentucky	Ephraim McDowell Health Care Foundation, Inc.	38
Kentucky	Lake Cumberland District Health Department	40
Kentucky	Lotts Creek Community School, Inc.	42
Kentucky	Montgomery County Health Department	48
Louisiana	Louisiana Tech University	62
Louisiana	Hospital Service District No. 1-A of the Parish of Richland	56
Maine	Mount Desert Island Hospital	64
Maryland	Allegany Health Right, Inc.	66
Michigan	Spectrum Health United Hospital	69
Michigan	Sterling Area Health Center	71
Michigan	Western Upper Peninsula Health Department	75
Minnesota	County of Koochiching	77
Mississippi	Central Mississippi Residential Center (CMRC)	81
Missouri	Citizens Memorial Hospital District	84
Missouri	Northeast Missouri Health Council	90

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

Nebraska	Nebraska Association of Local Health Directors	101
Nebraska	Public Health Solutions	104
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
New Mexico	Ben Archer Health Center	114
New York	Chautauqua Opportunities, Inc.	122
Ohio	Fostoria Community Hospital	128
Ohio	Trinity Hospital Twin City	130
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
Oregon	Samaritan North Lincoln Hospital	134
Pennsylvania	Armstrong-Indiana-Clarion Drug and Alcohol Commission	136
Pennsylvania	Community Guidance Center	138
South Dakota	University of South Dakota Department of Dental Hygiene	147
West Virginia	Future Generations	161

Health Information Technology

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Nebraska	Public Health Solutions	104
New York	Chautauqua County Health Network	119
Ohio	Fostoria Community Hospital	128
Vermont	Behavioral Health Network of Vermont	154
Wisconsin	ABC for Rural Health, Inc.	163

Health Professions Recruitment and Retention/Workforce Development

State	Grant Organization Name	Page
Alaska	PeaceHealth Ketchikan Medical Center	1
Montana	Madison Valley Medical Center	96
Nebraska	Nebraska Association of Local Health Directors	101
Nebraska	Public Health Solutions	104
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
New Mexico	Ben Archer Health Center	114
Vermont	Behavioral Health Network of Vermont	154
Wisconsin	ABC for Rural Health, Inc.	163

Integrated Systems of Care

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Delaware	La Red Health Center	18
Florida	Heartland Rural Health Network, Inc.	20
Idaho	St. Mary's Hospital	32
Kentucky	Marcum & Wallace Memorial Hospital	45
Michigan	Upper Great Lakes Family Health Center	73
Missouri	Citizens Memorial Hospital District	84
Missouri	Freeman Neosho Hospital	86
Missouri	Health Care Coalition of Lafayette County	88
Montana	Butte Silver Bow Primary Health Care Clinic Inc. aka Butte CHC	92
Montana	Madison Valley Medical Center	96
Nebraska	Public Health Solutions	104
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
New Mexico	Hidalgo Medical Services	116
New York	Chautauqua County Health Network	119
Ohio	Fostoria Community Hospital	128
Pennsylvania	Armstrong-Indiana-Clarion Drug and Alcohol Commission	136
Pennsylvania	Community Guidance Center	138
Tennessee	Buffalo Valley, Inc.	149
Vermont	Behavioral Health Network of Vermont	154

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

Maternal/Women's Health

State	Grant Organization Name	Page
California	Lake County Tribal Health Consortium	10
California	Woodlake Unified School District	14
Minnesota	County of Koochiching	77
Tennessee	Buffalo Valley, Inc.	149

Migrant/Farm Worker Health

State	Grant Organization Name	Page
Kentucky	Montgomery County Health Department	48
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
Vermont	Bi-State Primary Care Association	157

Oral Health

State	Grant Organization Name	Page
Florida	Rural Health Network of Monroe County FL, Inc.	22
Kentucky	Lake Cumberland District Health Department	40
Kentucky	Lotts Creek Community School, Inc.	42
Kentucky	Montgomery County Health Department	48
Louisiana	Innis Community Health Center, Inc.	59
Maryland	Allegany Health Right, Inc.	66
Michigan	Sterling Area Health Center	71
Minnesota	Mississippi Headwaters Area Dental Health Center D/B/A Northern Dental Access Center	79
Missouri	Northeast Missouri Health Council	90
Montana	Granite County Hospital District	94
Montana	Missoula City/County Health Dept/Partnership HC	99
New Hampshire	North Country Health Consortium	111
North Carolina	Partnership for Children of the Foothills	125
South Dakota	Delta Dental Plan of South Dakota	143
South Dakota	University of South Dakota Department of Dental Hygiene	147
Tennessee	Buffalo Valley, Inc.	149
Virginia	Giles Free Clinic	159

Pharmacy Assistance

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Georgia	Irwin County Board of Health	27
Kentucky	Lotts Creek Community School, Inc.	42
Michigan	Sterling Area Health Center	71
Nebraska	Public Health Solutions	104
Pennsylvania	Community Guidance Center	138

Physical Fitness and Nutrition

State	Grant Organization Name	Page
Arizona	Mariposa Community Health Center	6
Arkansas	Siloam Springs Regional Health Cooperative, Inc.	8
California	Nevada County Behavioral Health	12
Florida	Heartland Rural Health Network, Inc.	20
Georgia	Irwin County Board of Health	27
Georgia	Meadows Regional Medical Center	29
Kansas	Unified School District #498 Marshall County Kansas	36
Kentucky	Lake Cumberland District Health Department	40
Kentucky	Lotts Creek Community School, Inc.	42
Louisiana	Louisiana Tech University	62

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

Louisiana	Hospital Service District No. 1-A of the Parish of Richland	56
Maine	Mount Desert Island Hospital	64
Michigan	Spectrum Health United Hospital	69
Michigan	Sterling Area Health Center	71
Michigan	Western Upper Peninsula Health Department	75
Nebraska	Public Health Solutions	104
Ohio	Trinity Hospital Twin City	130
Oregon	La Clinica del Cariño Family Health Center, dba One Community Health	132
Oregon	Samaritan North Lincoln Hospital	134
West Virginia	Future Generations	161

School Health

State	Grant Organization Name	Page
Kentucky	Lotts Creek Community School, Inc.	42
Maine	Mount Desert Island Hospital	64
Michigan	Western Upper Peninsula Health Department	75

Substance Abuse

State	Grant Organization Name	Page
Arizona	El Centro For the Study of Primary & Secondary Education	4
California	Lake County Tribal Health Consortium	10
California	Nevada County Behavioral Health	12
Kentucky	Marcum & Wallace Memorial Hospital	45
Kentucky	Unlawful Narcotics Investigations, Treatment, & Education	54
Michigan	Sterling Area Health Center	71
Mississippi	Central Mississippi Residential Center (CMRC)	81
Missouri	Citizens Memorial Hospital District	84
Montana	Butte Silver Bow Primary Health Care Clinic Inc. aka Butte CHC	92
Pennsylvania	Armstrong-Indiana-Clarion Drug and Alcohol Commission	136
Tennessee	Buffalo Valley, Inc.	149
Texas	Madison County	151
Wisconsin	ABC for Rural Health, Inc.	163

Telehealth

State	Grant Organization Name	Page
Delaware	La Red Health Center	18
Florida	Heartland Rural Health Network, Inc.	20
Georgia	Georgia Southern University	25
Maine	Mount Desert Island Hospital	64
Michigan	Upper Great Lakes Family Health Center	73
Missouri	Citizens Memorial Hospital District	84
Missouri	Health Care Coalition of Lafayette County	88
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center	106
New Mexico	Hidalgo Medical Services	116
South Carolina	Newberry County Hospital Foundation	140
South Dakota	Sacred Heart Health Services	145
Texas	Madison County	151
Vermont	Behavioral Health Network of Vermont	154

Transportation to health services

State	Grant Organization Name	Page
California	Nevada County Behavioral Health	12
Kentucky	Marcum & Wallace Memorial Hospital	45
Maine	Mount Desert Island Hospital	64
Michigan	Sterling Area Health Center	71

2012 - 2015 Rural Health Outreach Grantees Grant Recipients

(Listed by Focus Areas)

Minnesota	Mississippi Headwaters Area Dental Health Center D/B/A Northern Dental Access Center	79
Nebraska	Public Health Solutions	104
New Hampshire	Mid-State Health Center on behalf of Central NH Health Partnership	109
New Mexico	Ben Archer Health Center	114
South Carolina	Newberry County Hospital Foundation	140
Virginia	Giles Free Clinic	159
Other		
State	Grant Organization Name Focus Area	Page
Kentucky	Office of Vocational Rehabilitation Focus Area: Access to assistive technology and durable medical equipment	51

Alaska

PeaceHealth Ketchikan Medical Center

Grant Number:	D04RH23609					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	PeaceHealth Ketchikan Medical Center				
	Address:	3100 Tongass Avenue				
	City:	Ketchikan	**State:**	Alaska	**Zip code:**	99901
	Tel #:	907-228-8300				
	Fax #:					
	Website:	http://www.peacehealth.org/ketchikan				
Primary Contact Information:	**Name:**	Shannon Updike				
	Title:	Regional Vice President of Patient Care				
	Tel #:	907-228-8300, ext. 7734				
	Fax #:					
	Email:	supdike@peacehealth.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,822
	May 2013 to Apr 2014	$149,799
	May 2014 to Apr 2015	$144,792

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Alaska State Hospital and Nursing Home Association	Anchorage	AK	Not for Profit Corporation 501(c)(6)
	Alaska Regional Hospital	Anchorage	AK	Hospital
	Alaska Native Medical Center	Anchorage	AK	Hospital
	Alaska Providence Medical Center	Anchorage	AK	Hospital
	Bartlett Regional Medical Center	Juneau	AK	Hospital
	Fairbanks Memorial Hospital	Fairbanks	AK	Hospital
	PeaceHealth Ketchikan Medical Center	Ketchikan	AK	Hospital

The communities/counties the project serves:	Specific areas include Southeast Alaska including Ketchikan Gateway Borough, Outer Ketchikan and Prince of Wales Island, City/Borough of Juneau; Anchorage and the Matanuska Valley; Fairbanks Borough. In general, project will benefit all communities in Alaska.

The target population served:	**Population**	**Male**	**Female**
	Infants	X	X
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives	X	X
	Asians	X	X
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders	X	X
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	X
	Access: Specialty Care	X	Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	ASHNHA partnered with the NorthWest Perioperative Consortium (NWPC) of Seattle, Washington. Their model was based, in part, upon the evidence based materials from the Association Operating Room Nurses (AORN). NWPC has been very successful with their consortium having continuously operated it for several years. For the Perinatal program Alaska is utilizing the evidence based modules from the Association of Women's Health, Obstetrics and Neonatal Nurses entitled the Perinatal Orientation and Education Program (POEP). This is the foundation from which the instructors are adapting materials from their facilities and their own experiences.
Description of the project:	Alaska is an exceptionally large and rural state, much of it designated as "frontier". The long distances between facilities in Alaska combined with weather and transportation challenges directly affect access and often create a lower quality of care for rural Alaskans. The state has a population of 710,000 with Alaska Natives/American Indians representing about 15% of that number. A growing shortage of health care workers has become a serious challenge for health systems throughout the state. Retention and recruitment of well trained nurses is a major challenge that negatively impacts both access and quality of care. The Alaska Sub-Specialty Nursing Consortium (AKSNC) plans to develop a new and sustainable approach for ensuring that Alaska hospitals have a trained and available nursing workforce to meet the needs of the population. A severe shortage of qualified peri-operative (surgical) nurses exists and has resulted in a high reliance on temporary staffing (travelers) to fill critical positions in operating and recovery rooms. The lack of a stable nursing workforce is both expensive and unsatisfactory for Alaska communities. There is an on-going demand for training and monitoring and a high degree of staff turnover in these positions. This circumstance clearly increases the risk of medical errors and adverse patient outcomes. The AKSNC plans to develop a sustainable model for training nurses that will ameliorate the critical nursing staff shortages in Alaska. Initially the program will focus on peri-operative (surgical) nurse training. The AKSNC project is based on a best practice model developed by the Northwest Perioperative Consortium (NWPC) in Seattle, WA. The model is being tailored to meet the challenges and needs of Alaska rural hospitals with vast geographic and travel distances. AKSNC selected the NWPC model due to its success rate, and also because it is predicated on a consortium model with shared ownership and responsibility. The model is primarily staffed by consortium members with focused expertise. The modified NWPC model will reduce travel for classroom instruction and will rely on video-conferencing during the practicum training. AKSNC initiated two additional focus areas for sub-specialty nursing education. • Perinatal Services (1st cohort of nurse interns will finish 14 week training on June 27, 2014 • Gero-Prep training leading to geriatric nursing certification with 30 nurses involved across multiple facilities.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn Building 17W-31B				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

Arizona

El Centro For the Study of Primary & Secondary Education

Grant Number:	D04RH23571					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Non Profit Community-Based Organization					
Grantee Organization Information:	**Name:**	El Centro For the Study of Primary & Secondary Education				
	Address:	321 Avenue B				
	City:	San Manuel	**State:**	Arizona	**Zip code:**	85631
	Tel #:	520-385-3028				
	Fax #:	520-385-3029				
	Website:	www.adelantejuntos.org				
Primary Contact Information:	**Name:**	Manuel Guzman				
	Title:	Project Director				
	Tel #:	520-882-6216 x 7389				
	Fax #:	520-622-4787				
	Email:	manny@luzsocial.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Superior Unified School District	Pinal	AZ	Public Schools
	Florence School District	Pinal	AZ	Public Schools
	Pinal County Sheriff's Office	Pinal	AZ	Law Enforcement
	Pinal County Juvenile Justice Center	Pinal	AZ	Juvenile Court Systems

The communities/counties the project serves:	Superior and Florence Arizona

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Sembrando Salud Substance Abuse Curriculum for 6-12th grades
Description of the project:	Project STOP is a prevention project aimed at reducing and preventing underage drinking. Our outreach grant provides the resources and staffing to conduct both school and community based services that teach students in grades 6-12 the negative physical, emotional and social consequences of alcohol use. The classroom curriculum, Sembrando Salud (Sowing the Seeds of Health) takes a public health approach to educating youth about the cultural values and community norms that inadvertently contribute to lax attitudes about underage drinking. An incentive component designed to promote participation and encourage long term (participation after 10 week classroom sessions) engagement awards youth with STOP bucks that can be used at local businesses or the project's "STOP" store. Our 1st Outreach grant also was a major factor in getting support from local and state entities that made the opening of a youth recreation center possible. We are now able to offer after school tutoring to help kids improve their academic performance, recreational activities, games and equipment that provide a protective factor against substance use and mentoring opportunities for youth from single parent homes.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Arizona

Mariposa Community Health Center

Grant Number:	D04RH23596					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Community Health Center					
Grantee Organization Information:	**Name:**	Mariposa Community Health Center				
	Address:	1852 N Mastick Way				
	City:	Nogales	**State:**	Arizona	**Zip code:**	85621
	Tel #:	520-375-6050				
	Fax #:					
	Website:	www.mariposachc.net				
Primary Contact Information:	**Name:**	Susan Kunz				
	Title:	Director of Health Promotion and Disease Prevention				
	Tel #:	520-375-6050				
	Fax #:	520-761-2153				
	Email:	skunz@mariposachc.net				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Carondelet Holy Cross Hospital	Santa Cruz	AZ	Hospital
	Southeast Arizona Area Health Education Center	Santa Cruz	AZ	Non-Profit
	Nogales Community Food Bank	Santa Cruz	AZ	Non-Profit
	Nogales Community Development	Santa Cruz	AZ	Non-Profit
	UA Prevention Research Center	Santa Cruz	AZ	University

The communities/counties the project serves:	Santa Cruz County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	X

	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe) Nutrition Counseling	X
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:

- evidence based *Pasos Adelante* curriculum - modified to add more diabetes specific information
- Patient-Centered Medical Home (PCMH) model for coordinated diabetic care
- Promotoras de Salud (Community Health Workers)

Description of the project:

Mariposa Community Health Center (MCHC), a Federally Qualified Health Center, will form a consortium **Vivir Mejor! (Live Better!) System of Diabetes Prevention and Care** with five health sector and community partners: a critical access hospital, an AHEC, a public housing authority, a food bank and a community development corporation. Santa Cruz County is contiguous with the U.S.-Mexico border and is a medically-underserved, low income, Spanish-speaking, Hispanic/Latino, immigrant community with an elevated prevalence of obesity and diabetes morbidity and mortality.

The goal of Vivir Mejor! is to establish an integrated system of diabetes care within Santa Cruz County that will enhance the health status and quality of life among Hispanic/Latino diabetics through improved primary care, enhanced self-management, increased family involvement/support and state-of-the art continuing medical education. This goal will be fulfilled through seven objectives, or strategies, over three years that utilize one evidence-based program, two evidence-based best practices and one promising practice that will improve diabetes control and decrease diabetes risk.

- Replication of the *Pasos Adelante (Steps Forward) Curriculum* for diabetes risk reduction (evidence-based program)
- Use of Patient Centered Medical Home for coordinated diabetic care (evidence-based practice)
- Use of Promotoras de Salud (Community Health Workers) as language and culture appropriate peer educators (evidence-based practice)
- Capacity building among diabetics as Lay Leaders to provide peer education and support (promising practice)

Office of Rural Health Policy Project Officer:

Name:	Shelia Tibbs				
Title:	Senior Public Health Analyst				
Tel #:	301-443-4304				
Email:	stibbs@HRSA.gov				
Address:	5600 Fishers Lane				
City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:

Name:	John Butts, MPH				
Title:	Technical Assistance Consultant				
Tel #:	404-413-0283				
Fax #:	404-413-0316				
Email:	jbutts@gsu.edu				
Address:	14 Marietta Street, NW, Suite 221				
City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Arkansas

Siloam Springs Regional Health Cooperative, Inc.

Grant Number:	D04RH23614					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Nonprofit Rural Health Network					
Grantee Organization Information:	**Name:**	Siloam Springs Regional Health Cooperative, Inc.				
	Address:	P.O. Box 1568				
	City:	Siloam Springs	**State:**	Arkansas	**Zip code:**	72761
	Tel #:	479-549-3143				
	Fax #:	479-549-3243				
	Website:	www.bridgestowellness.org				
Primary Contact Information:	**Name:**	Emerson M. Goodwin				
	Title:	Executive Director				
	Tel #:	479-549-3143				
	Fax #:	479-549-3243				
	Email:	office@bridgestowellness.org or egoodwin@bridgestowellness.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,997
	May 2013 to Apr 2014	$149,974
	May 2014 to Apr 2015	$149,970

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Siloam Springs Regional Hospital	Benton	AR	Hospital
	Community Physicians Group	Benton/ Adair	AR OK	Medical Clinics
	Community Clinic	Benton	AR	FQHC
	Arkansas Department of Health	Benton	AR	State Government
	John Brown University	Benton	AR	University
	Siloam Springs School District	Benton	AR	K-12 Public School District
	Simmons Foods	Benton/ McDonald	AR MO	Larger Business
	Ozark Electronics	Benton	AR	Small Business
	Ozark Guidance	Benton	AR	Behavioral Health
	Siloam Springs Chamber of Commerce	Benton	AR	Business Advocate

The communities/counties the project serves:	Benton & Washington Counties in Arkansas, Adair, Delaware & Cherokee Counties in Oklahoma

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		

	Uninsured		X	X
	Underinsured		X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Shape Up Somerville, MA.; Virgin Health Miles, and Albert Lea, MN served as our best and promising practices.
Description of the project:	*Eat Better Move More* is designed to make it fun, easy and rewarding to make healthier food choices and increase physical activity. Main program services are 1) community events that raise awareness and excitement about healthy eating and moving your body, 2) fun, small-group, hands-on cooking classes called Culinary Delights; and 3) *Move More* physical activity teams (like walking clubs). An easy-to-use web-based system to track eating and activity choices will enable participants to earn points toward awards. While we will promote activities community-wide and anticipate serving many individuals not associated with our Business Partners, BTW has an extensive plan to deliver *Eat Better Move More* as a workplace wellness initiative in order to reach many participants quickly and to tap into built-in social support networks among participants who are co-workers.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Eric T. Baumgartner, MD, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	504-813-3688				
	Fax #:	504-301-9801				
	Email:	etbaumgartner@bellsouth.net				
	Address:	P.O. Box 307				
	City:	Abita Springs	**State:**	Louisiana	**Zip code:**	70420

California

Lake County Tribal Health Consortium

Grant Number:	D04RH23589					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Tribal Health Clinic					
Grantee Organization Information:	**Name:**	Lake County Tribal Health Consortium				
	Address:	P.O. Box 1950				
	City:	Lakeport	**State:**	California	**Zip code:**	95451
	Tel #:					
	Fax #:					
	Website:	www.lcthc.com				
Primary Contact Information:	**Name:**	Patricia Hubbard				
	Title:	4Ps Plus Program Director				
	Tel #:	707-263-8382 ext. 1303				
	Fax #:					
	Email:	phubbard@lcthc.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Health Leadership Network	Lake	CA	Policy Council
	Lake County Public Health Services	Lake	CA	Public Health
	Lake County Behavioral Health Services	Lake	CA	Substance Abuse/Mental Health
	Lake County Department of Social Services	Lake	CA	Child Welfare
	Lake Family Resource Center	Lake	CA	Family Resource Center
	Lake County Office of Education	Lake	CA	K-12 Education

The communities/counties the project serves:	Lake County, CA

The target population served:	**Population**	**Male**	**Female**
	Infants	X	X
	Pre-school children	X	X
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		X
	Caucasians		
	African Americans		
	Alaska Natives	X	X
	Asians		
	Hispanics		
	Native Americans	X	X
	Pacific Islanders		
	Uninsured		
	Underinsured	X	X
	Other: (please describe)		

	Other: (please describe)			
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	X
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Children's Research Triangle, Chicago, IL,, Dr. Ira Chasnoff, focus on FASD prevention (http://www.childstudy.org/prenatal-substance-use-prevent/) Using 4Ps Plus Screening for Prenatal Substance Use, Depression and Domestic Violence (http://www.ntiupstream.com/4psabout/)
Description of the project:	The project's purpose is to reduce prenatal maternal substance use, so that children are born substance-free and raised in safe, nurturing, substance-free homes. It will achieve its purpose by integrating behavioral health with primary care using co-location. This design will increase access to behavioral health services for pregnant and parenting Native women, their partners, children, and extended families. Outreach and referrals will link women, their partners and extended families to the full range of services available to support their healthy choices.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Email:	lkwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Eric T. Baumgartner, MD, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	504-813-3688				
	Fax #:	504-301-9801				
	Email:	etbaumgartner@bellsouth.net				
	Address:	P.O. Box 307				
	City:	Abita Springs	**State:**	Louisiana	**Zip code:**	70420

California

Nevada County Behavioral Health

Grant Number:	D04RH23569					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	County Government					
Grantee Organization Information:	**Name:**	Nevada County Behavioral Health				
	Address:	500 Crown Point Circle, Suite 120				
	City:	Grass Valley	**State:**	California	**Zip code:**	95945
	Tel #:	530-265-1437				
	Fax #:	530-271-0257				
	Website:	mynevadacounty.com				
Primary Contact Information:	**Name:**	Michael Heggarty				
	Title:	Director of Behavioral Health				
	Tel #:	530-470-2784				
	Fax #:	530-271-0257				
	Email:	michael.heggarty@co.nevada.ca.us				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Nevada County Behavioral Health	Nevada	CA	County Govt.
	Sierra Family Medical Clinic	Nevada	CA	FQHC Look-Alike
	Western Sierra Medical Clinic	Nevada	CA	FQHC
	Community Recovery Resources (CoRR)	Nevada	CA	Substance Use Agency
	Common Goals, Inc.	Nevada	CA	Substance Use Agency
	Turning Point Providence Center	Nevada	CA	Non-Profit Community Program
	Sierra Nevada Memorial Hospital	Nevada	CA	Not-For-Profit Hospital

The communities/counties the project serves:	This project will serve individuals in Nevada County.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	X
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other	X	School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology	X	Other: (please describe)	

Evidence Based Model Being Used or Adapted:	We have adapted the IMPACT model to develop and coordinate a person-centered health care home, and coordinate health services for clients.
Description of the project:	The Nevada County Healthy Outcomes Integration Team (HOIT) will build and support healthy futures in which adults ages 18 and older with a serious mental illness (SMI) are able to achieve health, wellness, and recovery through the development of a person-centered health care home. The HOIT is a consortium of health care providers, community partners, individuals with an SMI, and family members. The consortium will work together to integrate services and deliver primary care services at the Behavioral Health Clinic to help individuals take an active role in improving their health outcomes. Each individual with an SMI who is served by HOIT will have access to a range of effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

California

Woodlake Unified School District

Grant Number:	DO4RH26844					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Family Resource Center (school-base)					
Grantee Organization Information:	**Name:**	Woodlake Unified School District				
	Address:	168 N. Valencia				
	City:	Woodlake	**State:**	California	**Zip code:**	93286
	Tel #:	559-564-5212				
	Fax #:	559-564-5301				
	Website:					
Primary Contact Information:	**Name:**	Irma Rangel				
	Title:	Director				
	Tel #:	559-564-5212				
	Fax #:	559-564-5301				
	Email:	irangel@w-usd.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,997
	May 2013 to Apr 2014	$149,996
	May 2014 to Apr 2015	$149,997

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Family HealthCare Network	Tulare	CA	Health Clinic
	Health & Human Services Agency	Tulare	CA	Public Health
	Woodlake Police Department	Tulare	CA	Police Department

The communities/counties the project serves:	Woodlake, CA-Tulare County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		X
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured		
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	

	Aging		Maternal/Women's Health	X
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The Tulare County Health and Human Services Agency launched the Perinatal Wellness Project (PWP), a countywide referral and treatment project passed on "Interventions for Postpartum Depression," (Nursing Best Practices Guidelines, RNAO, 2005). On Point is adapting this model.
Description of the project:	The ***On Point*** Project is a deliberately targeted response to a need in our community for mental health support services throughout the perinatal period, which includes pregnancy-planning, pregnancy, and the post-partum period for one year. Through On Point, the Woodlake Family Resource Center will provide expert holistic case management, by assisting families in accessing healthcare and providing excellence in health services and addressing untreated perinatal mental health needs.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Email:	lkwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Colorado

Telluride Medical Center Foundation

Grant Number:	D04RH23616					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Network					
Grantee Organization Information:	**Name:**	Telluride Medical Center Foundation				
	Address:	P.O. Box 4222				
	City:	Telluride	**State:**	Colorado	**Zip code:**	81435
	Tel #:	970-708-7096				
	Fax #:	970-728-9007				
	Website:					
Primary Contact Information:	**Name:**	Lynn Borup				
	Title:	Executive Director				
	Tel #:	719-480-3822				
	Fax #:	970-728-9007				
	Email:	lynn@telluridefoundation.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,978
	May 2013 to Apr 2014	$149,961
	May 2014 to Apr 2015	$149,979

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Midwestern Colorado Mental Health Ctr	multi	CO	Mental Health Ctr
	Basin Clinic	Montrose	CO	Rural Health Clinic
	Olathe Medical Clinic	Montrose	CO	Rural Health Clinic
	Telluride Medical Center	San Miguel	CO	Community Clinic
	Uncompahgre Medical Center	San Miguel	CO	FQHC
	Telluride Foundation	San Miguel	CO	Community Fnd

The communities/counties the project serves:	Montrose, San Miguel & Ouray

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Colorado Heart Healthy Solutions
Description of the project:	Our Prevention through Care Navigation Outreach program is geared towards improving the quality of health care in the Network's rural service area of southwest Colorado through the implementation of an evidenced-based diabetes and heart disease prevention outreach and navigation program. The Network will adopt Colorado Heart Healthy Solutions, an evidenced-based program, created by the Colorado Prevention Center (CPC), designed to improve the cardiovascular health of adults in Colorado communities. The Network will augment this model with the addition of a stronger diabetic care management component. Under this program, Care Navigators (CN) will be trained in health promotion and motivational interviewing, in order to identify at-risk individuals in our three counties and assist those individuals in decreasing their five-year diabetic and cardiovascular (CVD) risk factors. CNs will act as an extension of the Network clinics by providing screening, education and care management services to noncompliant patients who are at-risk for diabetes and heart disease in the field. In addition, medical providers will receive educational support on evidence-based risk factor control for diabetes and CVD.

Office of Rural Health Policy Project Officer:	**Name:**	Valerie Darden				
	Title:	Captain, United States Public Health Service				
	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0283				
	Fax #:	404-413-0316				
	Email:	jbutts@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Delaware

La Red Health Center

Grant Number:	D04RH23588					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	La Red Health Center				
	Address:	21444 Carmean Way				
	City:	Georgetown	**State:**	Delaware	**Zip code:**	19947
	Tel #:	302-855-1233				
	Fax #:	302-855-2025				
	Website:	www.laredhealthcenter.org				
Primary Contact Information:	**Name:**	Brian Olson				
	Title:	CEO				
	Tel #:	302-855-2020, ext. 1116				
	Fax #:	302-855-2025				
	Email:	bolson@laredhealthcenter.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Mark Borer, PhD	Kent	DE	Psychiatrist
	Brandywine Counseling/Community Services	Statewide	DE	Non Profit MH/SA
	Gerald Gallucci, MD, PhD	Statewide	DE	Med Director-State Agency
	Division of Substance Abuse and Mental Health	Statewide	DE	State Agency
	DE Rural Health Initiative	Kent/Sussex	DE	Non-Profit-Advocacy
	State Office of Rural Health	Kent	DE	State Agency
	Mental Health Association	New Castle	DE	Non-profit
	DE Telemedicine Coalition	Statewide	DE	Coalition

The communities/counties the project serves:	Sussex County, DE

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Cherokee Health Systems, Knoxville, TN Integration BH into PC
Description of the project:	A Consortium of clinical and health policy subject matter experts will guide La Red Health Center's implementation of a three pronged mental health service Expansion; Integration with Primary Care, Psychiatric Consultation Services, and Telemedicine. An evidence-based model will be applied to integrate mental and behavioral health services into primary care thereby enhancing clinical care teams and reaching more clients across all age groups. Provider staff will be trained on effective request for psychiatric cons and use of phone based coordination, and onsite lunchtime case studies. Finally, the use of telemedicine and technology will be introduced to link patients to needed specialty services not available in the County.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Email:	lkwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Florida

Heartland Rural Health Network, Inc.

Grant Number:	D04RH23580					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Rural Health Network					
Grantee Organization Information:	**Name:**	Heartland Rural Health Network, Inc.				
	Address:	1200 West Avon Blvd. Suite 109				
	City:	Avon Park	**State:**	Florida	**Zip code:**	33825
	Tel #:	863-452-6530				
	Fax #:	863-452-6882				
	Website:	www.hrhn.org				
Primary Contact Information:	**Name:**	Kelly Johnson				
	Title:	Project Director				
	Tel #:	863-452-6530				
	Fax #:	863-452-6882				
	Email:	Kelly.johnson@hrhn.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Central Florida Health Care, Inc.	Highlands/Polk /Hardee	FL	FQHC
	Florida Academy of Family Physicians	Highlands/Polk /Hardee	FL	Non Profit
	Highlands County Health Dept.	Highlands	FL	Health Dept.
	Pioneer Medical Center	Hardee	FL	RHC
	Samaritan's Touch Care Center	Highlands	FL	Volunteer Clinic
	Sun N Lake Medical Group	Highlands	FL	RHC

The communities/counties the project serves:	Highlands County, Hardee County, Polk County, Florida. Communities include: Avon Park, Sebring, Lake Placid (Highlands), Wauchula (Hardee), and Frostproof, Ft. Meade (Polk)

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**		
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development			
	Access: Specialty Care		Integrated Systems of Care	X		
	Aging		Maternal/Women's Health			
	Behavioral/Mental Health		Migrant/Farm Worker Health			
	Children's Health		Oral Health			
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance			
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X		
	Chronic Disease: Other		School Health			
	Community Health Workers /Promotoras	X	Substance Abuse			
	Coordination of Care Services	X	Telehealth	X		
	Emergency Medical Services		Transportation to health services			
	Health Education and Promotion	X	Other: (please describe)			
	Health Information Technology		Other: (please describe)			
Evidence Based Model Being Used or Adapted:	Diabetes Master Clinician Program & Healthy Eating for Successful Living In Older Adults					
Description of the project:	There are four main components of our comprehensive chronic disease management program. The first component is the evidence based Florida Academy of Family Physician's Foundation Diabetes Master Clinician Program (DMCP). The DMCP includes an internet based registry that tracks quality of diabetes/CVD care at both patient and provider levels. Through a previous Network Development Grant we established a network of eight primary care providers' offices in Highlands, Hardee, and DeSoto Counties. We are proposing to expand the DMCP to include at least 6 additional practices. The DMCP registry provides patient and provider reports to help better manage goals. The second component is the evidence based Healthy Living Nutrition Program developed by the National Council on Aging. The focus of this program is to maintain or improve participants' wellness, with particular emphasis on chronic diseases. The third and fourth components are promising practice models. We will utilize Community Health Workers to aid in chronic disease education in community based settings. CHWs utilize nationally recognized curriculum to develop case management plans and meet with patients at least bi-weekly to review progress. Practitioners receive updates on their referred patients through monthly case management meetings. The last component involves *remote monitoring that collects data actively or passively by interacting with the patient.* Biometric data is transmitted to a secure data center where it is available for review by project staff and providers. *The patient is notified of potential concerns based on data collected. Referrals to these community based services will be done through consortium members.* The expected program **outcomes** include: appropriate health resource utilization, adoption of healthy behaviors, high quality chronic disease management, and a sustainable program.					
Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Eric T. Baumgartner, MD, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	504-813-3688				
	Fax #:	504-301-9801				
	Email:	etbaumgartner@bellsouth.net				
	Address:	P.O. Box 307				
	City:	Abita Springs	**State:**	Louisiana	**Zip code:**	70420

Florida

Rural Health Network of Monroe County FL, Inc.

Grant Number:	D04RH23611					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Rural Health Clinic, 501-c-3					
Grantee Organization Information:	**Name:**	Rural Health Network of Monroe County FL, Inc.				
	Address:	3706 North Roosevelt Blvd., Suite D				
	City:	Key West	**State:**	Florida	**Zip code:**	33040
	Tel #:	305-517-6613				
	Fax #:	305-517-6617				
	Website:	www.rhnmc.org				
Primary Contact Information:	**Name:**	Daniel E. Smith				
	Title:	President & CEO				
	Tel #:	305-393-9969				
	Fax #:	305-517-6617, ext. 301				
	Email:	dsmith@rhnmc.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Monroe County School District	Monroe	FL	Governmental / Educational Institution
	Southernmost Homeless Assistance League	Monroe	FL	501-C-3 non-profit Co-op
	Local Housing Authority	Monroe	FL	Authority

The communities/counties the project serves:	All Monroe County aka the Florida Keys

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: homeless population	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	

	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Rural Health Network of Monroe County (RHNMC) has been providing dental services for 10 years. Over that period of time the network has come to learn a considerable amount regarding how to structure and manage oral care for its community, including use of technology (eg, EHR). From this experience and perspective RHNMC has established its' own "promising practice model" that has been very successful and has sustained itself over hard economic times, while continuing to provide quality services to its patient base. In 2006 *"A Model Framework for Community Oral Health Programs, Based Upon the Ten Essential Public Health Services"* was published, prepared by the American Association for Community Dental Programs. Its creation was supported by HRSA-MCHB. In an effort to always understand our community and our relationship with the community as an effective working partner, RHNMC has adopted this model framework. The *Framework* provides a context in which to consider the relationship between oral health activities, public health responsibilities, and desired outcomes and describes how oral health can be promoted within the context of 10 essential public health services to improve a community's overall health status."[1] RHNMC has found that by combining our history of providing public health (direct care) services with this model framework we would be able to reach our goals and provide a better service to the local community as a whole. While there are not a lot of resources for establishing evidence based model in rural areas, this framework and our own history provide an excellent approach to a practical working model.
Description of the project:	Monroe County (the Florida Keys) is an island chain, forming a peninsula bordered by the Atlantic Ocean to the east and the Gulf of Mexico to the west, stretching over 120 linear miles from mainland Florida. There is one road in (or out), most of which is 2 lanes, ending in Key West, 150 miles southwest of Miami and 90 miles (via ocean) from Cuba. Countywide today there are 72,241 residents, 32% are uninsured, with 29.2% of the children uninsured (3-1/2 times the national average). The average per capita income is $36,086. Oral Health Disparities & Community Needs**.** In Monroe County, dental disease and lack of access to dental care remains the most critical health care issue. Considerable oral health disparities exist in Monroe among low income and no income populations. Outreach to these populations, with the exclusion of our current HRSA funded school sealant program, is non-existent. In addition, Florida Medicaid ranks at the bottom of all 50 states due, in part, to its low reimbursement rates. Other relative factors include our county's challenging demographics, a poor transportation system, an increasing gap in the cost of living-to income ratio, all coupled with the lack of affordable health insurance and a housing market in distress. Target Population**.** Our work plan focuses on the uninsured, under-insured and at-risk school children, the homeless and economically disadvantaged seniors over the age of 60. Proposed Services**.** There are four components to our program. 1) the development and continued implementation of a comprehensive educational training program; 2) the establishment an oral health assessment and referral mechanism for

[1] Source: "A Model Framework for Community Oral Health Programs", May 2006 by AACDP

	each of the three target populations; 3) providing the students, the homeless and underserved seniors with preventative and restorative oral health care services and a dental home, by utilizing the strengths of consortium members, our three dental clinics, portable dental equipment and a unified community outreach program; and 4) qualifying the success of our program with accurate process and outcome measures through effective evaluation methods.					
Office of Rural Health Policy Project Officer	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	SWarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0283				
	Fax #:	404-413-0316				
	Email:	jbutts@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Georgia

Georgia Southern University

Grant Number:	D04RH23576					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	University					
Grantee Organization Information:	**Name:**	Georgia Southern University				
	Address:	GSU Box 8028				
	City:	Statesboro	**State:**	Georgia	**Zip code:**	30460
	Tel #:	912-478-7254				
	Fax #:	912-478-8649				
	Website:	http://www.georgiasouthern.edu/RHRI				
Primary Contact Information:	**Name:**	K. Bryant Smalley, Ph.D., Psy.D.				
	Title:	Executive Director, Rural Health Research Institute				
	Tel #:	912-478-0868				
	Fax #:	912-478-8649				
	Email:	bsmalley@georgiasouthern.edu				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	East Georgia Healthcare Center	Emanuel	GA	FQHC
	Georgia Partnership for TeleHealth	Ware	GA	Technology, Non-Profit
	Mercer University, Center for Rural Health & Health Disparities	Bibb	GA	University

The communities/counties the project serves:	Candler, Emanuel, Tattnall, and Toombs counties in rural Southeast Georgia

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	

	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	*AADE7 Self-Care Behaviors framework*
Description of the project:	*Project ADEPT* (**A**pplied **D**iabetes **E**ducation **P**rogram using **T**elehealth) is designed to improve the health status of diabetics in rural southeast Georgia by using telehealth to bring direly needed, evidence-based diabetes education services to a high-need four-county service area (Candler, Emanuel, Tattnall, and Toombs). The Project involves a consortium of four experienced members, including 1) the Rural Health Research Institute within Georgia Southern University; 2) East Georgia Healthcare Center (a network of Federally Qualified Health Centers serving a seven-county region of rural southeast Georgia); 3) the Southeastern Telehealth Resource Center (funded by HRSA to provide guidance and support in establishing and maintaining telehealth systems); and 4) the Center for Rural Health & Health Disparities within Mercer University's School of Medicine. *Project ADEPT* is based upon the evidence-based AADE7 Self-Care Behaviors framework developed by the American Association for Diabetes Educators to create measurable behavior change among diabetic patients. The framework, supported by extensive scientific literature, guides patients through seven self-management behaviors critical in effective diabetes self-management. *Project ADEPT* tailors the AADE7 approach to the cultural and economic realities of rural living (for instance, discussing transportation barriers and resource shortages that complicate engaging in some of the AADE7 behaviors). The program is flexible, able to be provided 1) in individual *or* group settings; and 2) in a single, intense session *or* spread out over time. This flexibility helps address the time, resource, and transportation barriers faced by rural residents.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn 17W-31B				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0283				
	Fax #:	404-413-0316				
	Email:	jbutts@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Georgia

Irwin County Board of Health

Grant Number:	D04RH23585					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Public Health					
Grantee Organization Information:	**Name:**	Irwin County Board of Health				
	Address:	407 W 4th Street				
	City:	Ocilla	**State:**	Georgia	**Zip code:**	31774
	Tel #:	229-468-5003				
	Fax #:	229-468-5028				
	Website:	www.Southhealthdistrict.com				
Primary Contact Information:	**Name:**	Bridget Walters, RN, BSN, CDE				
	Title:	Project Director, Diabetes Educator				
	Tel #:	229-468-5003				
	Fax #:	229-468-5028				
	Email:	bridget.walters@dph.ga.gov				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Ben Hill County Board of Health	Ben Hill	GA	Public Health
	Berrien County Board of Health	Berrien	GA	Public Health
	Cook County Board of Health	Cook	GA	Public Health
	Dorminy Medical Center	Ben Hill	GA	Hospital
	Irwin County Hospital	Irwin	GA	Hospital
	Berrien County Hospital	Berrien	GA	Hospital
	Memorial Hospital of Adel	Cook	GA	Hospital
	Irwin Family Medicine	Irwin	GA	Physician's Office
	Berrien County Collaborative	Berrien	GA	Non Profit Community Agency
	Nashville Eye Center	Berrien	GA	Optometrist Office
	Adel Family Medicine	Cook	GA	Physician's Office
	Adel Cook Recreation Department	Cook	GA	Non Profit Community Agency
	South Health District	Lowndes	GA	Public Health

The communities/counties the project serves:	Ben Hill, Irwin, Berrien, and Cook Counties in Georgia

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		

	Hispanics		X	X
	Native Americans			
	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	X
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	National Diabetes Education Program's "Power to Prevent: A Family Lifestyle Approach to Diabetes Prevention"
Description of the project:	Sweet Dreams provides a community disease prevention and education service to target the growing epidemic of type 2 diabetes. The main goals of the project are to increase community awareness of the importance of prevention and early detection of type 2 diabetes through healthy lifestyle habits of good nutrition and physical activity and to reduce the rate of diabetes and its economic burden and improve the quality of life for type 2 diabetics. The "Power to Prevent" curriculum is used to teach a series of twelve classes to the target population. This curriculum includes educational information about healthy eating, physical activity, and diabetes and is designed to target high risk families and teach them how to make healthy lifestyle changes. Facilitators representing African American and Hispanic diabetics will assist the project staff with these classes in an effort to ensure the high risk population is reached. The project plans to work with the counties to ensure that each of them has a safe sidewalk or walking track available that encourages physical activity and the communities will be educated in the benefits of increasing physical activity with everyday activities such as grocery shopping and yard work. Sweet Dreams also provides education to the public through participation in health fairs and the distribution of information and educational items. Medication management and daily blood glucose monitoring is essential for some type 2 diabetics to control blood glucose levels and prevent long term diabetes complications. Sweet Dreams provides testing supply assistance for low-income participants who are uninsured or underinsured along with medication assistance.

Office of Rural Health Policy Project Officer:						
	Name:	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:						
	Name:	Beverly Tyler				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0288				
	Fax #:	404-413-0316				
	Email:	btyler@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Georgia

Meadows Regional Medical Center

Grant Number:	D04RH23599					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Meadows Regional Medical Center				
	Address:	Mercy Medical Clinic, 300 Arlington Drive				
	City:	Vidalia	**State:**	Georgia	**Zip code:**	30474
	Tel #:	912-538-0523				
	Fax #:	912-538-8945				
	Website:	www.meadowsreginal.org				
Primary Contact Information:	**Name:**	Susan McLendon MSN, APRN CNS-BC				
	Title:	Program Coordinator				
	Tel #:	912-538-0523, ext. 304				
	Fax #:	912-538-8945				
	Email:	smclendon@meadowsregional.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Southeast Regional Primary Care Corporation	Toombs	GA	Non-Profit 501c (3) Corporation.
	Meadows Regional Medical Center Community Wellness Department	Toombs	GA	Hospital
	Toombs County Health Department	Toombs	GA	County Public Health Department
	Vidalia City Schools	Toombs	GA	City School System
	Southeast Georgia Communities Project	Toombs, Tattnall, Montgomery, Long, Evans, Candler Counties	GA	Non-Profit 501 c (3) Migrant Worker Advocacy Agency
	Optometry Associates	Toombs	GA	Private Practice Optometry

The communities/counties the project serves:	Toombs, Tattnall and Montgomery Counties of Southeast Georgia

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X

	Alaska Natives			
	Asians		X	X
	Hispanics		X	X
	Native Americans			
	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	
Evidence Based Model Being Used or Adapted:	Our diabetes clinic focused program is based on the success of the "group visit model". Patients attend group self management diabetes education classes on a quarterly schedule and are also seen for a focused diabetes care visit by a clinical nurse specialist the same day. This program is proving to reduce A1c levels and improve self management knowledge. Patients are engaged in self management education and clinical follow up for 12 months or longer as needed. In the community, we are also piloting the National Diabetes Prevention Program (NDPP). This is another group program which is an evolution of the "Power to Prevent" program. This program focuses more on the lifestyle change needed to prevent the onset of type 2 diabetes. It is also more accessible for the facilitator without a medical background. If this program is successful in our pilot group, our organization will transition to the NDPP ongoing and continue outreach to the low income, uninsured population since they have limited access to prevention diabetes education.			
Description of the project:	Meadows Regional Medical Center will provide a Regional Diabetes Outreach Program to service the area of Montgomery, Tattnall and Toombs Counties of Southeast Georgia. The proposed target populations are individuals who are pre-diabetic and confirmed diabetics. Program services and activities will offer medical/educational "group visits" in 3 targeted primary care practices of the region. A regional diabetes support group meeting will be offered weekly. Community presentations that utilize a "train the trainer" model to promote healthy lifestyle changes for weight management, physical activity and healthy nutrition will be offered in area churches. At least 1 large community health fair will be offered in each of the target counties to promote diabetes education, screening and access to care. A regional media campaign will be utilized to offer diabetes prevention and self- management education. Community resource information will be emphasized. The existing community diabetes collaborative will be expanded to include members of the 3 county region. A community needs assessment will be performed for strategic planning and development of ongoing diabetes education programs.			

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tamanna Patel, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Fax #:	404-413-0316				
	Email:	tpatel25@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Idaho

St. Mary's Hospital

Grant Number:	D04RH23615					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Critical access hospital and primary care clinics					
Grantee Organization Information:	**Name:**	St. Mary's Hospital				
	Address:	P. O. Box 137				
	City:	Cottonwood	**State:**	Idaho	**Zip code:**	83522
	Tel #:	208-962-3251				
	Fax #:	208-962-3722				
	Website:	www.smh-cvhc.org				
Primary Contact Information:	**Name:**	Pam McBride				
	Title:	Chief Grants Officer				
	Tel #:	208-816-0794				
	Fax #:	208-476-5385				
	Email:	Pam.mcbride@smh-cvhc.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Clearwater Valley Hospital	Clearwater County	ID	Critical access hospital, primary care clinics
	Public Health – Idaho North Central District	Nez Perce	ID	Public health
	Nimiipuu Health	Nez Perce	ID	Nez Perce Tribe health care agency
	Idaho Primary Care Association	Ada	ID	State facilitator for medical home project
	Saint Alphonsus Regional Medical Center	Ada	ID	Tertiary care center
	Human Needs Council (regional)	Idaho	ID	Region-wide consortium of health and social service agencies
	Clearwater County Human Needs Council	Clearwater County	ID	County-wide consortium of health and social service agencies

The communities/counties the project serves:	Clearwater, Idaho, and Lewis Counties in Idaho

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans		

Alaska Natives			
Asians			
Hispanics			
Native Americans		X	X
Pacific Islanders			
Uninsured		X	X
Underinsured		X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care	X	Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Collaborative care management
Description of the project:	The St. Mary's Hospital Medical Home Plus project will bring enhanced service access and health outcomes to residents of three frontier counties in north-central Idaho. The overall project goal is to increase community health as measured by increases in patients with controlled hypertension, diabetics with controlled blood sugar, and increased depression screening rates. Specific objectives are: 1. 1. Provide intensive, proactive medical management for high-risk patients 2. Create a system to engage community resources for population health. New case management and community resource efforts will be focused first on highest-risk patients with diabetes, cardiovascular disease, and mental health needs. Patients with these comorbid conditions and use of chronic pain medications will be targeted first. Nurse case managers will use a collaborative care model to steer patients towards evidence-based care recommendations. Community resource workers will connect patients with existing community resources and create sustainable communication strategies with all partners. Community resources will be included in patient action plans. Ongoing communication between all partners will lead to more informed community needs assessments and action plans.

Office of Rural Health Policy Project Officer:	**Name:**	Valerie Darden				
	Title:	Captain, United States Public Health Service				
	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0283				
	Fax #:	404-413-0316				
	Email:	jbutts@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Indiana

Indiana Rural Health Association, Inc.

Grant Number:	D04RH23583					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	state rural health association, non profit					
Grantee Organization Information:	**Name:**	Indiana Rural Health Association, Inc.				
	Address:	1418 N 1000 W				
	City:	Linton	**State:**	Indiana	**Zip code:**	47441
	Tel #:	812-478-3919				
	Fax #:	812-232-8602				
	Website:	www.indianaruralhealth.org				
Primary Contact Information:	**Name:**	Dana Stidham				
	Title:	RHC Program Coordinator				
	Tel #:	812-342-6482				
	Fax #:	812-232-8602				
	Email:	dstidham@indianarha.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,319
	May 2013 to Apr 2014	$143,348
	May 2014 to Apr 2015	$123,381

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Indiana Rural Health Association	Greene	IN	Non profit
	Covering Kids and Families of Indiana	Marion	IN	Non profit
	Community Action of Northeast Indiana / Covering Kids and Families of Northeast Indiana	Allen	IN	Non profit
	Neighborhood Health Clinics	Allen	IN	Non profit
	Parkview Noble Hospital	Noble	IN	hospital
	East Noble School Corporation	Noble	IN	school
	Central Noble School Corporation	Noble	IN	school
	Smith-Green School Corporation	Noble-Kosciusko	IN	school
	Affiliated Services Providers of Indiana	Marion	IN	Non profit

The communities/counties the project serves:	Noble County in Indiana

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly		
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		

	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	100% Campaign established by the Children's Defense Fund of Texas Badger Care School Outreach Toolbox developed by Covering Kids and Families of Wisconsin
Description of the project:	The primary focus of the Noble County Outreach Project is to enroll and retain children and their family members in public health or marketplace insurance; adults will be a secondary focus. Anticipated outcomes is to improve efficiency of providing health care services through enhanced collaboration among providers, improve the health status of children and their families through regular access to routine and preventive health care, and reduce the demand for primary care services in the hospital's emergency department. The project will adopt two evidence based practice models, the "100% Campaign," established by the Children's Defense Fund of Texas and the "Badger Care School Outreach Toolbox," developed by Covering Kids & Families of Wisconsin. To encourage coordinator of care and preventive health services, at the time of application, applicants will be asked to select a primary care physician for their medical home. Contact with eligible families throughout Noble County will be through the schools, Parkview Noble Hospital's emergency department and after hours clinic. Finally, outreach and communication materials will be developed to remind families of their recertification date for their public health insurance program. Families will receive a reminder two months prior to their certification renewal date as well as a customized magnet with their recertification date.

Office of Rural Health Policy Project Officer:	**Name:**	Valerie Darden				
	Title:	Captain, United States Public Health Service				
	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Eric T. Baumgartner, MD, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	504-813-3688				
	Fax #:	504-301-9801				
	Email:	etbaumgartner@bellsouth.net				
	Address:	P.O. Box 307				
	City:	Abita Springs	**State:**	Louisiana	**Zip code:**	70420

Kansas

Unified School District #498 Marshall County Kansas

Grant Number:	D04RH23618					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Consortium of School Districts					
Grantee Organization Information:	**Name:**	Unified School District #498 Marshall County Kansas				
	Address:	121 E Commercial St.				
	City:	Waterville	**State:**	Kansas	**Zip code:**	66548
	Tel #:	785-363-2398				
	Fax #:	785-363-2269				
	Website:	www.valleyheights.org/				
Primary Contact Information:	**Name:**	Philisha R Stallbaumer				
	Title:	Project Director				
	Tel #:	785-292-4453				
	Fax #:	785-292-4455				
	Email:	philishas@bluevalley.net				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$ 149,225
	May 2013 to Apr 2014	$ 149,618
	May 2014 to Apr 2015	$ 149,976

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	USD #113 - Prairie Hills	Nemaha	KS	School District
	USD #115 - Nemaha Central	Nemaha	KS	School District
	USD #380 – Vermillion	Marshall	KS	School District
	Marshall County Head Start - Marysville	Marshall	KS	Non-Profit
	Nemaha County Head Start – Sabetha	Nemaha	KS	Non-Profit
	Nemaha County Head Start - Seneca	Nemaha	KS	Non-Profit
	Community Healthcare System Inc. – Frankfort LifeCare Fitness Facility	Marshall	KS	Healthcare Facility
	Community Memorial Hospital	Marshall	KS	Hospital
	Nemaha Valley Community Hospital	Nemaha	KS	Hospital
	Marshall County Health Department	Marshall	KS	Health Department
	Nemaha County Community Health	Nemaha	KS	Health Department
	Blue Valley Telecommunications	Marshall	KS	For-Profit Business

The communities/counties the project serves:	**Marshall County Communities**: Axtell; Blue Rapids; Frankfort; Marysville; Summerfield; Waterville; and Vermillion **Nemaha County Communities:** Centralia; Sabetha; and Seneca

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)		
	School-age children (teens)		
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		

	Pacific Islanders			
	Uninsured			
	Underinsured			
	Other: (please describe)			
	Other: (please describe)			

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	• Sports, Play and Active Recreation for Kids (SPARK) • Action Based Learning • Learning About Nutrition Through Activities (LANA) • Power Panther Preschool • Book in a Bag – Nutrition Literacy Education • Healthy Kids Challenge - Healthy 6, Choose My Plate & Eat a Colorful Variety Every Day
Description of the project:	The focus of the *Healthy Early Learning Project (HELP)* is to provide a collaborative effort in the prevention and onset of early childhood obesity and chronic disease. Services provided and activities conducted will include the following: policy and environmental changes pertaining to nutrition and physical activity; data collection; professional development; technical assistance; education of partners and preschool staff; creation of Health Advisory Teams (HAT); revision and implementation of nutrition and physical education curriculum for preschools; acquisition of nutrition and physical activity resources; media promotion; and community mobilization.

Office of Rural Health Policy Project Officer:						
	Name:	Shelia Tibbs				
	Title:	Rural Health Outreach Project Officer				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:						
	Name:	Rachel Campos, MPH/Beverly Tyler				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0334				
	Fax #:	404-413-0316				
	Email:	rcampos1@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Ephraim McDowell Health Care Foundation, Inc.

Grant Number:	D04RH23572					
Program Type:	Rural Health Care Services Outreach					
Organization Type.	Hospital					
Grantee Organization Information:	**Name:**	Ephraim McDowell Health Care Foundation, Inc.				
	Address:	217 S. Third St.				
	City:	Danville	**State:**	Kentucky	**Zip code:**	40422
	Tel #:	859-239-2429				
	Fax #:	859-239-6760				
	Website:	www.emhealth.org				
Primary Contact Information:	**Name:**	Audrey Lee Powell				
	Title:	Principal Investigator				
	Tel #:	859-239-2429				
	Fax #:	859-239-6760				
	Email:	apowell@emrmc.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$140,000
	May 2014 to Apr 2015	$130,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Ephraim McDowell Health	Boyle	KY	Hospital
	Boyle Co. Health Dept	Boyle	KY	Co. Health Dept
	Garrard Co. Health Dept	Garrard	KY	Co. Health Dept
	Lincoln Co. Health Dept	Lincoln	KY	Co. Health Dept
	Boyle Co. Extension Office	Boyle	KY	Co Extension Office
	Mercer County Health Dept	Mercer	KY	Co Health Dept

The communities/counties the project serves:	Boyle County, Lincoln County, Garrard County, Mercer County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	

	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	American Lung Association – Tobacco Use CDC – BMI standards TSA – Stroke Risk Score Card ADH – Diabetic standards AHA – B/P standards AHA – Cholesterol standards
Description of the project:	Community Services in collaboration with grant partners will offer community-wide awareness, screening activities, and follow-up for risk reduction related to cardiovascular risk factors with a focus on at risk populations, i.e, those with one or more chronic illnesses, elderly, uninsured, underinsured, living below the poverty level, under educated and people of color. Screenings will consistently include cholesterol, glucose, blood pressure, body mass index and on-site consultation with a registered nurse for review of the biometric information and scoring of risk factors. A plan to maintain or improve modifiable risk factors will be developed with the clients, if desired. Screening will occur semi-annually at partner sites with follow-up contact by a registered nurse to offer assistance with the client's health improvement plan based upon the findings at the screening and to offer assistance navigating the health care resources within the region. The anticipated impact for clients includes increased access, increased self-care knowledge, awareness of community resources and professional assistance to navigate the health care services.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Senior Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tanisa Adimu, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Fax #:	404-413-0316				
	Email:	tadimu@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Lake Cumberland District Health Department

Grant Number:	D04RH23590					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Health Department					
Grantee Organization Information:	**Name:**	Lake Cumberland District Health Department				
	Address:	500 Bourne Ave.				
	City:	Somerset	**State:**	Kentucky	**Zip code:**	42501
	Tel #:	606-678-4761				
	Fax #:	606-678-2708				
	Website:	www.lcdhd.org				
Primary Contact Information:	**Name:**	Jamie Lee				
	Title:	RN Diabetes Education Program Coordinator				
	Tel #:	606-678-4761				
	Fax #:	606-678-2708				
	Email:	jamiel.lee@lcdhd.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,197.40
	May 2013 to Apr 2014	$149,823.00
	May 2014 to Apr 2015	$150,000.00

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Western Kentucky University	Warren	KY	University Dental Program
	University of Kentucky	Clinton	KY	Clinton Co. Cooperative Extension Services
	University of Kentucky	Wayne	KY	Wayne Co. Cooperative Extension Services
	Kentucky Department for Public Health	Franklin	KY	Kentucky Worksite Wellness Development
	Clinton County Vocational School	Clinton	KY	Clinton County High School Medicaid Nursing Assistant Program
	Lake Cumberland District Health Department	Pulaski	KY	Diabetes Education Program-Public Health
	Western Kentucky University	Warren	KY	University Public Health Program

The communities/counties the project serves:	Patriot Industries, Clinton and Wayne Counties

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians	X	X

	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Community Guide, Diabetes at Work, Kentucky Diabetes Prevention and Control Program's Self-Management Education, Cooper Clayton Smoking Cessation, Small Steps to Health and Wealth, Eating Better Moving More
Description of the project:	Weekly educational sessions targeting healthy lifestyle interventions, health risk assessments, employee lab and wellness screenings, physical activity walking challenge, flu vaccines, gender specific health events, Diabetes Self- Management Education, Cooper Clayton Smoking Cessation program, dental screenings, collaboration with county extension services for meal planning and healthy cooking tips, and routine project partner networking.

Office of Rural Health Policy Project Officer:						
	Name:	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:						
	Name:	Tamanna Patel, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Fax #:	404-413-0316				
	Email:	tpatel25@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Lotts Creek Community School, Inc.

Grant Number:	D04RH23591					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Non Profit/ School					
Grantee Organization Information:	**Name:**	Lotts Creek Community School, Inc.				
	Address:	5837 Lotts Creek RD				
	City:	Hazard	**State:**	Kentucky	**Zip code:**	40475
	Tel #:	606-785-5819				
	Fax #:	606-785-4850				
	Website:	www.lottscreek.org				
Primary Contact Information:	**Name:**	Alice Whitaker				
	Title:	Director- Lotts Creek Community School				
	Tel #:	606-785-5282				
	Fax #:	606-785-4850				
	Email:	lottscreekwellness@yahoo.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Knott County Extension Agency	Knott	KY	Government
	21st Century Afterschool Program	Knott	KY	School
	Alliance for a Healthier Generation	N/A	N/A	National Non Profit
	Lotts Creek MAP Program	Perry/ Knott	KY	Non Profit

The communities/counties the project serves:	Perry and Knott County Kentucky.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults		
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	

	Children's Health	X	Oral Health	X	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	X	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X	
	Chronic Disease: Other		School Health	X	
	Community Health Workers /Promotoras	X	Substance Abuse		
	Coordination of Care Services		Telehealth		
	Emergency Medical Services		Transportation to health services		
	Health Education and Promotion	X	Other: (please describe)		
	Health Information Technology		Other: (please describe)		

Evidence Based Model Being Used or Adapted:	Lotts Creek uses the WebMd/ University of San Diego model for prescription assistance and community health workers. WebMD flew Lotts creek personnel to San Diego to train in this model, and have continued to provide technical assistance since then. The Alliance for Healthier Generation also provides the SPARK Health and PE curriculum free of charge to the school, as well as training school personnel yearly free of charge in use of the program.
Description of project:	Lotts Creek Community School, Inc., a 501c3 non-profit organization located in Cordia, Kentucky works in conjunction with the local Knott County Board of Education to provide public education for the children of this isolated, poor and underserved region of Kentucky. Not only does Lotts Creek provide education for an enrollment of 350 students in grades K through 12, but it is also a critical community partner providing a variety of outreach programs (medicine assistance, home repair) to the larger community of over 18,177 *households* across Knott and Perry Counties. As a current grantee of the ORHP community based- grant, we will enhance the previous successful grant as well as expanding delivery of new health care services to a youth population and: 1) providing yearly exams for all school aged children to screen for at- risk diabetic and pre diabetic conditions, and to provide services and track the health of the at risk children from semester to semester; 2) providing a school-based and community health program with Linda Combs from Knott County Extension Office continuing monthly classes with the students and community; 3) providing school-based oral health care via the University of Kentucky North Fork's mobile dental unit; 4) providing in-home health and nutrition education by working with UK North Fork Valley to hire a community health worker; 5) serving 50 children year round with a healthy, nutritious weekend meal with a backpack program; 6) making referrals to primary, oral, visual and mental health services as needed; 7) conducting an annual health fair and other wellness events; and 8) promoting and increasing the use of our fitness center and walking track within the school and community, 9) increasing the amount of physical activity and health provided in the school by hiring addition PA staff; and 10) Implementing the Alliance for a Healthier Generation's nutrition based K-12 curriculum. The project serves Knott and Perry Counties in eastern Kentucky which are part of the United States' Central Appalachian region. The target area is characterized by high levels of poverty, low educational attainment and many health disparities. Lotts Creek has added a community health worker to help assist clients with prescription assistance. The health worker was trained by a collaborative effort with the WebMD Health Foundation and the University of San Diego who provide free healthcare and community health workers in inner city San Diego and to veterans. The health worker oversees 190 medicine assistance program (MAP) clients yearly.

Office of Rural Health Policy Project Officer:	**Name:**	Valerie Darden				
	Title:	Captain, United States Public Health Service				
	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Tamanna Patel, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Fax #:	404-413-0316				
	Email:	tpatel25@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Marcum & Wallace Memorial Hospital

Grant Number:	D04RH23595					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Marcum & Wallace Memorial Hospital				
	Address:	60 Mercy Court				
	City:	Irvine	**State:**	Kentucky	**Zip code:**	40336
	Tel #:	606-723-2115 ext. 8210				
	Fax #:	606-723-2951				
	Website:	www.marcumandwallace.org				
Primary Contact Information:	**Name:**	John Isfort				
	Title:	Program Director				
	Tel #:	606-723-2115, ext. 8210				
	Fax #:	606-723-2951				
	Email:	jisfort@marcumandwallace.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Mercy Health Clinics	Estill/Lee	KY	Rural Health Clinic
	White House Clinics	Estill	KY	FQHC
	Juniper Healthcare, Inc.	Lee	KY	FQHC
	Foothills Mobile Health Clinic	Estill	KY	FQHC (Homeless)
	Kentucky River District Health Depart	Lee	KY	Health Department
	West Care	Estill	KY	Substance Abuse
	MESA	Estill	KY	Emergency Physicians Group
	Kentucky Homeplace	Lee	KY	Health Care Advisor Agency
	Estill Development Alliance/Chamber of Commerce/Leadership Lee, Estill, and Powell (LEAP) Counties	Estill/Lee	KY	Community Business Development & Leadership
	Kentucky River Community Care	Lee	KY	Community Mental Health Center
	Bluegrass.org	Estill	KY	Community Mental Health Center
	Estill County Health Department	Estill	KY	Health Department
	Hospice Care Plus	Estill/Lee	KY	Hospice Care/Palliative Care

The communities/counties the project serves:	Irvine, Beattyville and Ravenna Kentucky

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X

	Pregnant Women			
	Caucasians		X	X
	African Americans		X	X
	Alaska Natives			
	Asians			
	Hispanics			
	Native Americans			
	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X
	Other: (please describe)			

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care	X	Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	X
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:

Models that Work/Evidence Based Models

Project HOME network is based on models of collaboration between local hospitals and community health clinics. Two "models that work" used to inform the development of the Project HOME network are the Horizon Health Care System in South Dakota and Northern Collaborative Care in Michigan. Both models were able to effectively coordinate and deliver quality care to their communities through a collaborative approach between participating providers.

With a focus on developing a patient navigation system, the Network identified promising models to base their grant program on. These include the Pima Community Access Program (PCAP) in Arizona and learnings from states (e.g., Utah) that were awarded CMS grants in 2008 to reduce emergency department usage by Medicaid beneficiaries for non-critical conditions.

Description of the project:

Project HOME Network will focus on providing a primary care provider and "medical home" for those patients that are uninsured and underinsured living in Lee and Estill Counties. The uninsured rate in these communities consistently exceeds that of the nation and state. Project HOME will be based on the National Rural Health Association (NRHA) model of collaboration between Critical Access Hospitals (CAH) and Federally Qualified Health Centers to address health disparities in rural Appalachia. In addition, the Health Care Navigator (HCN) model will be used to provide an access mechanism to the health care system for each uninsured patient. It is anticipated that this project will improve the health status of the uninsured population in the proposed project area. Project HOME is a collaborative partnership with several agencies that work together to assist the uninsured population and develop a rural model system of care. The funding from the network outreach grant will be used for the following:

1. To improve access to health care for the uninsured and underinsured in

	Lee and Estill Counties using a Health Care Navigator 2. To develop a medical transportation system for the uninsured and underinsured 3. To provide a mechanism for access to specialty provider care 4. To develop a recruitment & retention program for providers in the service area					
Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn 17W-31B				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0283				
	Fax #:	404-413-0316				
	Email:	jbutts@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Montgomery County Health Department

Grant Number:	D04RH23603					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Local Health Department					
Grantee Organization Information:	**Name:**	Montgomery County Health Department				
	Address:	117 Civic Center				
	City:	Mt. Sterling	**State:**	Kentucky	**Zip code:**	40353
	Tel #:	859-498-3808				
	Fax #:	859-498-0719				
	Website:	Montgomerycountyhealth.com				
Primary Contact Information:	**Name:**	Jan Chamness				
	Title:	Public Health Director				
	Tel #:	859-497-9082				
	Fax #:	859-498-0719				
	Email:	Janm.chamness@ky.gov				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	A.M. "Dutch" Vollmer, DMD	Montgomery	KY	Dentist
	Saint Joseph Mount Sterling	Montgomery	KY	Acute care hosp.
	Pathways	Montgomery, Bath and Menifee	KY	Community Mental Health Centers
	CHES Solutions	Montgomery	KY	Evaluator
	Montgomery Co. Cooperative Extension	Montgomery	KY	Cooperative Extension/ Univ. of Kentucky
	Mt. Sterling/ Montgomery County Industrial Authority	Montgomery	KY	Business Development
	Mt. Sterling/ Montgomery Arts Council	Montgomery	KY	Community Arts Council
	Mt. Sterling/ Montgomery Co. Public Library	Montgomery	KY	Public Library
	Mt. Sterling/ Montgomery Co. Parks & Recreation	Montgomery	KY	Community Parks & Recreation
	Montgomery County Schools	Montgomery	KY	Public School

The communities/counties the project serves:	Montgomery, Bath and Menifee Counties

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		

	Alaska Natives			
	Asians			
	Hispanics		X	X
	Native Americans			
	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	X
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other/Cancer	X	School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	This project uses a community health worker model to provide health education, navigation and chronic disease self-management. This is an Integrated Vertical Rural Health Network Model that utilizes both traditional and non-traditional health care providers. Also included in the scope of this project, CHWs are trained and certified in evidence based training tools such as the Stanford Chronic Disease Self-Management Program, the Stanford Diabetes Self-Management Program, the American Association of Diabetic Educators Level 1 Diabetes Education for CHWs Program, the CDC's Take Charge of Your Diabetes Program, the American Lung Association's Asthma 1-2-3 Program, the National Healthy Homes Training Center & Network's Healthy Homes for CHWs and the National Council for Community Behavioral Healthcare's Mental Health First Aid USA.
Description of the project:	This project targets primarily Hispanics who are migrant and/or undocumented individuals and families with limited access to primary medical and dental care and mental health services because of inadequate English language skills and inability to obtain health insurance. Through the use of CHWs/ Promotoras, we intend to reduce barriers of healthcare access through outreach, health education and partnerships within the community as well as show positive clinical outcomes of those individuals in the target population who have been diagnosed or are at risk for respiratory disease, diabetes, cardiovascular disease, breast and cervical cancer through chronic disease management. This is the third round of funding through the HRSA Rural Health Outreach Program and through expansion of the original program, this in the next logical step in the progression toward sustainability through the successful application of a FQHC and ultimately a healthier community. It is apparent through continual implementation of healthcare reform that the traditional methodologies of healthcare delivery are changing and it is a goal of this program to show a successful non-traditional delivery method that is efficient, cost effective and can be replicated in other rural communities in Eastern Appalachia.

Office of Rural Health Policy Project Officer:	**Name:**	Valerie Darden				
	Title:	Captain, United States Public Health Service				
	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Amanda Philips Martinez, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0293				
	Fax #:	404-413-0316				
	Email:	aphillipsmartinez@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Kentucky

Office of Vocational Rehabilitation

Grant Number:	D04RH23586					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	State Government					
Grantee Organization Information:	**Name:**	Office of Vocational Rehabilitation				
	Address:	275 East Main St., Mail Drop 2-EK				
	City:	Frankfort	**State:**	Kentucky	**Zip code:**	40621
	Tel #:	502-564-4440				
	Fax #:	502-564-6745				
	Website:	www.ovr.ky.gov				
Primary Contact Information:	**Name:**	Carol Weber				
	Title:	Rehabilitation Technology Branch Manager				
	Tel #:	859-372-8428				
	Fax #:	859-371-0012				
	Email:	Carols.weber@ky.gov				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$147,269
	May 2013 to Apr 2014	$146,559
	May 2014 to Apr 2015	$147,063

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Kentucky Appalachian Rural Rehabilitation Network (KARRN)	Fayette	KY	Community Consortium
	Kentucky Assistive Technology Services Network	Franklin	KY	Kentucky Tech Act Program
	University of Kentucky Division of Physical Therapy	Fayette	KY	University
	Appalachian Regional Healthcare System	Fayette	KY	Network of Regional Hospitals
	Kentucky Homeplace	Perry	KY	Appalachian Community Health Worker Initiative
	Kentucky Assistive Technology Loan Corporation	Franklin	KY	Kentucky Alternative Financing Program
	Carl D. Perkins Vocational Training Center	Johnson	KY	Rehabilitation Center
	Cardinal Hill Rehabilitation Hospital	Fayette	KY	Rehabilitation Hospital
	White House Clinics	Jackson Estill	KY	Free Health Clinics

The communities/counties the project serves:	Rural Appalachian Eastern Kentucky: Adair, Bath, Bell, Boyd, Breathitt, Carter, Casey, Clark, Clay, Clinton, Cumberland, Edmonson, Elliott, Estill, Fleming, Floyd, Garrard, Green, Greenup, Harlan, Hart, Jackson, Johnson, Knott, Knox, Laurel, Lawrence, Lee, Leslie, Letcher, Lewis, Lincoln, McCreary, Madison, Magoffin, Martin, Menifee, Metcalfe, Monroe, Montgomery, Morgan, Nicholas, Owsley, Perry, Pike, Powell, Pulaski, Robertson, Rockcastle, Rowan, Russell, Wayne, Whitley, and Wolfe.

The target population served:	**Population**	**Male**	**Female**
	Infants	X	X
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X

	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: individuals with disabilities	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: Access to assistive technology and durable medical equipment	X
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Project CARAT uses a service learning (SL) approach to engage students in the sanitizing and refurbishing of the durable medical equipment and assistive technology (DME/AT). SL allows students to gain valuable understanding about DME/AT, develop leadership skills in the community, and provide an important service to the community. Sanitizing and refurbishing protocol/policies and procedures are based on the Oklahoma ABLE Tech Durable Medical Equipment Reuse Program. This program is being adapted to fit the SL model and to serve a larger geographic area.
Description of the project:	Project CARAT (Coordinating and Assisting the Reuse of Assistive Technology) will help improve the health and quality of life of individuals with disabilities in the Appalachian region of Kentucky through the provision and redistribution of assistive technology and durable medical equipment (DME). To accomplish this goal, the project will develop a reutilization program for assistive technology in the Appalachian region of Kentucky that will identify, obtain, and refurbish assistive technology, develop a library/bank of assistive technology available at low or no cost to address the needs of individuals with disabilities in underserved rural Appalachia, and develop a distribution system for assistive technology to provide the technology to individuals who otherwise would not have access to it.

Office of Rural Health Policy Project Officer:						
	Name:	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

Kentucky

Unlawful Narcotics Investigations, Treatment, & Education

Grant Number:	D04RH24757					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	501 c 3 non-profit1-45					
Grantee Organization Information:	**Name:**	Unlawful Narcotics Investigations, Treatment, & Education				
	Address:	2292 South Highway 27				
	City:	Somerset	**State:**	KY	**Zip code:**	42501
	Tel #:	606-677-6179				
	Fax #:	606-677-6166				
	Website:	www.operationunite.org				
Primary Contact Information:	**Name:**	Debbie L. Trusty				
	Title:	Education Director				
	Tel #:	606-889-0422				
	Fax #:	606-889-0874				
	Email:	dtrusty@centertech.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000.00
	May 2013 to Apr 2014	$150,000.00
	May 2014 to Apr 2015	$150,000.00

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	KY –Alcohol, Substance Abuse Policy	Franklin	KY	State
	KY Office for Drug Control Policy	Franklin	KY	State
	Office of the Court Designated Worker	Rowan	KY	State
	Pike County Schools	Pike	KY	County
	Rockcastle County Schools	Rockcastle	KY	County
	KY Office for Juvenile Services	Pike	KY	State
	Laurel County Health Dept.	Laurel	KY	State

The communities/counties the project serves:	

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		

	Other: (please describe)			
	Other: (please describe)			

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse Prevention	X
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	UNITE utilizes *Health Communication & Social Marketing: Health Communication Campaigns that Include Mass Media & Health-Related Product Distribution*, an evidence-based model cited by the Guide to Community Preventive Services.
Description of the project:	UNITE's "On the Move" is a two-part project. The first is a mobile prevention classroom that travels to schools across the 32 counties that comprise the 5th Congressional District in KY. In addition to students viewing the program in the classroom, we have three stations of activities that teach kids the dangers of distracted or impaired driving. The program is accepted by school districts as part of the KY Core Curriculum and fulfills the requirements for health classes. To date 2982 students in 27 schools have received instruction with this portion of the project. The second part of "On the Move" is community education kits. The first one is aimed at teens and is called "Life with a Record" and teaches kids what they lose with a felony conviction. 880 students have seen this presentation in 9 schools. The second kit will be on Medical Marijuana for the communities and the dangers of marijuana in general for youth. KY did have a Medical Marijuana bill in the last legislative session that is restricted to oil for kids with seizure-related disorders. This issue will come again in the spring 2015 session and we want our citizens and youth to be educated on the topic.

Office of Rural Health Policy Project Officer:						
	Name:	Shelia Warren				
	Title:	Rural Health Outreach Project Officer				
	Tel #:	301-443-0246				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:						
	Name:	Rachel Campos				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0314				
	Fax #:	404-413-0316				
	Email:	rcampos1@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Louisiana

Hospital Service District No. 1-A of the Parish of Richland

Grant Number:	D04RH23582					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Critical Access Hospital					
Grantee Organization Information:	**Name:**	Hospital Service District No. 1-A of the Parish of Richland				
	Address:	407 Cincinnati St				
	City:	Delhi	**State:**	Louisiana	**Zip code:**	71232
	Tel #:	318-878-5171				
	Fax #:	318-878-0922				
	Website:	www.delhihospital.com				
Primary Contact Information:	**Name:**	Jinger Greer				
	Title:	Program Director				
	Tel #:	318-878-0919				
	Fax #:	318-878-0922				
	Email:	Jgreer@delhihospital.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Delhi Rural Health Clinic	Richland	LA	Rural Health Clinic
	Richland Parish Hospital	Richland	LA	Critical Access Hospital
	Morehouse General Hospital	Morehouse	LA	Rural PPS Hospital
	Guaranty Bank & Trust	Richland	LA	Financial Institution
	Franklin Medical Center	Franklin	LA	Rural PPS Hospital
	Union General Hospital	Union	LA	Critical Access Hospital

The communities/counties the project serves:	Richland, Morehouse, Franklin, Tensas, Union

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		

	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X
	Other: Migrant workers		X	X
	Other: (please describe)			

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The project is an expansion of the Richland "TRAC" Pre-Diabetes Prevention Program, which qualified as a Promising Practice Model Program based on the ORHP Rural Health Care Services Outreach Grant Program definition. The model project was successfully developed and implemented as a small-scale pilot project in Richland Parish, Louisiana, and generated positive outcome evaluation results. The Richland project was evaluated rigorously from the beginning by Dr. Erica Labrentz of Labrentz Associates with statistical data analysis conducted by Dr. Dexter Cahoy of LA Tech University. The Richland Promising Practice Model Program was developed based on the American Diabetes Association (ADA) Protocols for Pre-Diabetes and tailored to fit NE LA Rural Communities. The data collected and reported so far has lent evidence that the program could be implemented on a larger scale, and the preliminary results suggest that such a program can delay or prevent the onset of true diabetes among many of the participants with pre-diabetes.
Description of the project:	The NE LA PDP project is an expansion of the Richland TRAC Pre-Diabetes Prevention Program into four additional parishes. The Consortium members partner with local organizations and businesses to offer community and employer based screenings. Individuals with pre-diabetes will be identified and offered the opportunity for additional health screenings and enrollment in the pre-diabetes prevention program. Point of contact education will be provided, as well as appointments made to further explore cholesterol levels, BMI, blood pressure, and perform a 2 hour oral glucose tolerance test. The participants will have an opportunity to complete a 75 question personal wellness profile that will also identify self-reported risk factors and will provide suggestions for reducing those risk factors. Educational materials will be provided monthly and bi-monthly telephone calls will be conducted as a follow-up to the newsletters. Annual rescreening appointments will be conducted to monitor the progression of pre-diabetes. Sustainability components of this project include developing partnerships with local businesses as sponsors of community screening events and the creation of a Certified Diabetes Education Program with Certified Diabetes Educators in each of the parishes.

Office of Rural Health Policy Project Officer:						
	Name:	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Email:	301-443-2803				
	Address:	swarren@hrsa.gov				
	City:	5600 Fishers Lane	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

Louisiana

Innis Community Health Center Inc.

Grant Number:	D04RH23584					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Innis Community Health Center Inc.				
	Address:	6450 LA Highway 1, Suite B				
	City:	Innis	**State:**	Louisiana	**Zip code:**	70747
	Tel #:	225-492-3775	Mobile:	225-921-5196		
	Fax #:	225-492-3782				
	Website:	Innishealth.com				
Primary Contact Information:	**Name:**	Linda Matessino				
	Title:	Executive Director				
	Tel #:	225-492-3775				
	Fax #:	225-492-3782				
	Email:	Linda@inchc.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$137,154
	May 2013 to Apr 2014	$148,214
	May 2014 to Apr 2015	$148,214

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	LA State University - School Of Medicine Dept of Pediatrics	Orleans	LA	Education
	Morehouse Community Health Center, SBHC	Morehouse		Primary Care
	Teche Action Clinic SBHC	St. Mary	LA	Primary Care
	Our Lady of Lake Pediatric Residency Program	East Baton Rouge	LA	Education
	Central LA Area Health Education Agency	Rapids	LA	Health Education Agency

The communities/counties the project serves:	Pointe Coupee Parish, St. Mary Parish, Morehouse Parish

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

<table>
<tr><td rowspan="16">Focus areas of grant program:</td><td>Focus Area:</td><td>Yes</td><td>Focus Area:</td><td>Yes</td></tr>
<tr><td>Access: Primary Care</td><td></td><td>Health Professions Recruitment and Retention/Workforce Dev.</td><td></td></tr>
<tr><td>Access: Specialty Care</td><td></td><td>Integrated Systems of Care</td><td></td></tr>
<tr><td>Aging</td><td></td><td>Maternal/Women’s Health</td><td></td></tr>
<tr><td>Behavioral/Mental Health</td><td></td><td>Migrant/Farm Worker Health</td><td></td></tr>
<tr><td>Children’s Health</td><td></td><td>Oral Health</td><td>X</td></tr>
<tr><td>Chronic Disease: Cardiovascular</td><td></td><td>Pharmacy Assistance</td><td></td></tr>
<tr><td>Chronic Disease: Diabetes</td><td></td><td>Physical Fitness and Nutrition</td><td></td></tr>
<tr><td>Chronic Disease: Other</td><td></td><td>School Health</td><td></td></tr>
<tr><td>Community Health Workers /Promotoras</td><td></td><td>Substance Abuse</td><td></td></tr>
<tr><td>Coordination of Care Services</td><td></td><td>Telehealth</td><td></td></tr>
<tr><td>Emergency Medical Services</td><td></td><td>Transportation to health services</td><td></td></tr>
<tr><td>Health Education and Promotion</td><td></td><td>Other: (please describe)</td><td></td></tr>
<tr><td>Health Information Technology</td><td></td><td>Other: (please describe)</td><td></td></tr>
<tr><td>Evidence Based Model Being Used or Adapted:</td><td colspan="4">The SBHC Dental Outreach program combines and adapts aspects of evidence-based and promising-practice models. In 2011, a HRSA/MCHB sponsored expert panel identified the provision of comprehensive oral health services through school-based health centers as a promising practice (HRSA/MCHB, 2011). The preventive practices provided by our program are evidence-based, particularly fluoride varnish (ADA Council on Scientific Affairs, 2006) and dental sealants (Community Preventative Services Task Force, 2013). Our dental home approach is consistent with the American Academy of Pediatric Dentistry’s policy on the dental home (AAPD, 2012).</td></tr>
<tr><td>Description of the project:</td><td colspan="4">The SBHC Dental Outreach program builds on the experiences of the Building Tomorrow's Smiles (BTS) program made possible through the rural Outreach Grant in 2009. The primary objective was to decrease dental caries through a preventive application of fluoride varnish and improve the oral health of the most vulnerable of Louisiana’ s rural population focusing on children ages 6 months-3 years and was extended to reach those up to 6 years of age. The evaluation of the (BTS) program provided an excellent direction for enhancement and expansion to provide a continuum of care, blending oral health with complete health, increasing the opportunity for access to oral health care, and establishing dental homes through school-based health centers (SBHCs) focusing on children ages 3-13. SBHCs provide a unique ease of access in meeting the needs of these rural underserved areas allowing the consortium partners to reach a greater number of children thereby increasing the potential for community health impact and improving the oral health status of the children. A second focus of this program builds on the effort to educate healthcare providers in the importance and the delivery of comprehensive care which includes dental care. This is done through train-the-trainer education and the creation of electronic learning tools. It is emphasized that comprehensive health means that assessment of the child’s oral health is part of the overall assessment process. Training in pediatric residency programs is also being done with the emphasis on assessing children’s teeth for dental caries and on educating families about preventive oral health. A partnership between Innis Community Health Center, Teche Action Clinic and Morehouse Community Medical Centers and their School Based Health Centers along with the Our Lady of the Lake Regional Medical Center Pediatric Residency Program and Central Louisiana Health Education Center works to accomplish our long-term, overarching goals - to prevent dental caries, improve oral health, and decrease the number of schools days missed by children in rural Louisiana</td></tr>
</table>

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-549-4205				
	Fax #:	301-443-2803				
	Email:	LKwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

Louisiana

Louisiana Tech University

Grant Number:	D04RH23592					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	State University					
Grantee Organization Information:	**Name:**	Louisiana Tech University				
	Address:	Railroad Ave., 1620 Wyly Tower				
	City:	Ruston	**State:**	Louisiana	**Zip code:**	71272
	Tel #:	318-257-3785				
	Fax #:	318-257-2928				
	Website:	www.latech.edu				
Primary Contact Information:	**Name:**	Heather R. McCollum				
	Title:	Assistant Professor				
	Tel #:	318-257-4412				
	Fax #:	318-257-4014				
	Email:	mccollum@latech.edu				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Boys & Girls Club of North Central LA	Lincoln	LA	Non-profit
	Mt. Harmony Baptist Church	Lincoln	LA	Faith-based
	Greater Pleasant Grove Church	Lincoln	LA	Faith-based
	Zion Travelers Baptist Church	Lincoln	LA	Faith-based
	St. Matthew Baptist Church	Claiborne	LA	Faith-based
	Fellowship Baptist Church	Lincoln	LA	Faith-based
	Hopewell Baptist Church	Lincoln	LA	Faith-based

The communities/counties the project serves:	Lincoln and Claiborne Parishes (Counties)

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	

Access: Specialty Care		Integrated Systems of Care	
Aging		Maternal/Women's Health	
Behavioral/Mental Health		Migrant/Farm Worker Health	
Children's Health		Oral Health	
Chronic Disease: Cardiovascular		Pharmacy Assistance	
Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras		Substance Abuse	
Coordination of Care Services		Telehealth	
Emergency Medical Services		Transportation to health services	
Health Education and Promotion	X	Other: (please describe)	
Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Evidence based model is "Strong Me" program. "Strong Me!" incorporates nutrition and health education, a systems science approach, in which participants learn about interconnected roles of food systems and the environment, a non-denominational spirituality component that fits well within the faith-centric culture of the Mid-South, and encourages mindful eating and focuses on family wellness rather than on an individual child.
Description of the project:	Youth4Health is a multi-function community-based program to combat childhood obesity through an integrated approach that includes nutrition, physical activity, and family behavior change to help families and faith communities address the problem of childhood obesity. The long-term goal of this proposal is to reduce the prevalence of overweight and obesity among adolescent children (ages 9-18 years). Aligning with the Healthy People 2020 goals, the purpose of the proposed project is to form a dialogue between families, their adolescent children, and faith communities to develop sustainable childhood obesity prevention strategies through gardening, nutrition and fitness activities at home, and faith facilities. Strategies will include nutrition and fitness education; modifying dietary and physical activity behaviors; gardening, cooking demonstrations, and skill building for the youth and their families. The project is modeled after "Strong Me!" program. "Strong Me!" incorporates nutrition and health education, a systems science approach, in which participants learn about interconnected roles of food systems and the environment, a non-denominational spirituality component that fits well within the faith-centric culture of the Mid-South, and encourages mindful eating and focuses on family wellness rather than on an individual child. To achieve our goals this project is proposing to conduct a total of 3 week camps during summer months for the three years, and after school weekly and monthly meetings to exercise and teach nutrition. Critical to this project is the involvement of parents as change agents at home and the development of leadership in healthy lifestyles among the adolescent participants. This project will be directed by a strong team of experts in nutrition, physical activity and development of community gardens.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

Maine

Mount Desert Island Hospital

Grant Number:	D04RH23604					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Mount Desert Island Hospital				
	Address:	10 Wayman Lane				
	City:	Bar Harbor	**State:**	Maine	**Zip code:**	04609
	Tel #:	207-288-5081				
	Fax #:	207-288-7031				
	Website:	www.mdihospital.org				
Primary Contact Information:	**Name:**	Kim Gourley				
	Title:	Director of Care Management				
	Tel #:	207-801-5010				
	Fax #:	207-288-8438				
	Email:	kim.gourley@mdihospital.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,993
	May 2013 to Apr 2014	$149,993
	May 2014 to Apr 2015	$149,993

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Mount Desert Nursing Association	Hancock	ME	Visiting Nurse association
	Healthy Acadia	Hancock, Washington	ME	Community Health Coalition
	University of New England	Aroostook	ME	University
	Mount Desert Island Hospital	Hancock	ME	Hospital

The communities/counties the project serves:	Hancock and Washington

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	

	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	X
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services	X	Telehealth	X
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	We are using the Diabetes Prevention curriculum based on Diabetes Prevention Program Research Study based out of George Washington University. It is the National Diabetes Prevention program curriculum.					
Description of the project:	Healthy Cooking Classes, Exercises classes, Diabetes Education, Pre-Diabetes Education. Training Volunteers to be health navigators. Telehealth education surrounding diabetes health education.					
Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tamanna Patel, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Fax #:	404-413-0316				
	Email:	tpatel25@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Maryland

Allegany Health Right

Grant Number:	D04RH23556					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Non-profit safety net					
Grantee Organization Information:	**Name:**	Allegany Health Right				
	Address:	153 Baltimore St. #3				
	City:	Cumberland	**State:**	Maryland	**Zip code:**	21502
	Tel #:	301-777-7749				
	Fax #:	301-777-5162				
	Website:	www.allhealtright.org (under construction)				
Primary Contact Information:	**Name:**	Sandi Rowland				
	Title:	Executive Director				
	Tel #:	301-777-7749				
	Fax #:	301-777-5162				
	Email:	sandi@allhealthright.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Allegany County Health Department	Allegany	MD	State Gov. Agency
	Garrett County Health Department	Garrett	MD	State Gov. Agency
	Hyndman Area Health Center	Bedford	PA	FQHC
	Mineral County Health Department	Mineral	WV	State Gov. Agency
	Mountain Health Alliance	Allegany, Bedford, Garrett, Mineral Washington	MD PA MD WV MD	HRSA Funded Network
	Tri-State Community Health Center	Allegany, Fulton, Washington	MD PA MD	FQHC
	Western Maryland Area Health Education Center	Allegany Garrett Washington	MD MD MD	AHEC

The communities/counties the project serves:	Allegany & Garrett Counties in MD; Hancock area of Washington County MD; Mineral County, WV; and the Hyndman area of Bedford County, PA

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians		
	African Americans		

	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: Low-income	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The Regional Oral Health Pathways is an adaptation of the "Pathways" model developed by Drs. Mark and Sarah Redding for the Community Health Access Project in Mansfield, Ohio. ROHP is piloting the use of a Community Health Worker (CHW) using a prevention-focused Pathway to educate members of the target population in oral health self care and support them in getting preventative care with the goal of reducing hospital emergency department visits for dental conditions.
Description of the project:	The Regional Oral Health Pathway (ROHP) collaborative provides oral health self-care education, preventative dental services and care for acute dental problems for low-income uninsured and underinsured adults in a three state five county region in Appalachia. ROHP uses a prevention-based oral health pathway for the region that utilizes an oral health focused Community Health Worker (CHW) to provide education and navigation to services. ROHP provided a customized 160 hour training curriculum for the CHW. ROHP works with local health department dental providers on an hourly rate basis, and a network of private practitioners who offer a greatly reduced treatment rate thereby increasing access to appropriate dental care for adults who would otherwise be unable to afford care. We also participate in Mission of Mercy and other short term dental clinics. In collaboration with the local hospital, we have implemented a referral system to our program for patients presenting with dental needs. In order to the show the impact of this effort, ROHP is measuring the utilization of the emergency department for dental problems. ROHP is also tracking mesures on dental treatment offered through the program and detailed demographic information on clients served through ROHP. ROHP is working on a program to increase awareness of oral health issues among primary care providers and increase oral health exams performed by PCPs through interprofessional collaboration and training between the dental and medical communities.

Office of Rural Health Policy Project Officer:						
	Name:	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Fax #:	301-443-2803				
	Email:	LKwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

Michigan

Spectrum Health United Hospital

Grant Number:	D04RH23621					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Spectrum Health United Hospital				
	Address:	615 S Bower				
	City:	Greenville	**State:**	Michigan	**Zip code:**	48838
	Tel #:	616-754-6185				
	Fax #:	616-754-6407				
	Website:	www.spectrumhealth.org/united-lifestyles				
Primary Contact Information:	**Name:**	Jodie Faber				
	Title:	Director				
	Tel #:	616-754-6185				
	Fax #:	616-754-6407				
	Email:	Jodie.faber@spectrumhealth.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$149,893
	May 2014 to Apr 2015	$149,617

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Spectrum Health Gerber Memorial	Newaygo	MI	Hospital
	Spectrum Health Reed City Hospital	Osceola	MI	Hospital
	Greenville Public Schools	Montcalm	MI	School
	Hesperia Community Schools	Newaygo	MI	School
	Reed City Public Schools	Osceola	MI	School
	Together We Can	Osceola	MI	Coalition
	Newaygo Cty Health Improvement Council	Newaygo	MI	Coalition
	Montcalm Human Services Coalition	Montcalm	MI	Coalition
	Spectrum Health United Hospital	Montcalm	MI	Hospital

The communities/counties the project serves:
Greenville Public Schools District, Greenville, MI, Montcalm County Hesperia Community Schools District, Hesperia, MI, Newaygo County Reed City Public Schools District, Reed City, MI, Osceola County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

	Other: (please describe)			
	Other: (please describe)			

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	FitKids360 – this promising practice model is managed by Health Net of West Michigan in Grand Rapids, MI. It was formally managed by First Steps in Grand Rapids and recently merged when Kent Health Plan and CHAP decided to become Health Net of West Michigan. We have modified this model to include a community health worker, extended length of sessions and included a 1 week summer "'camp".
Description of the project:	We will implement the childhood obesity education curriculum Rural Fit Kids. Rural Fit Kids is a promising practice that utilizes evidence-based techniques to reduce childhood obesity. Rural Fit Kids teaches children how to improve behavioral, nutrition, and exercise habits that have been linked to overweight and obesity in children. Rural Fit Kids consists of a 12-week course and a 1-week follow-up course and includes in-home visits by a Community Health Worker to reiterate what was taught in the courses. Over three years, we will attempt to enroll 360 children in Rural Fit Kids. Each site will enroll 40 children per year and 120 children over three years.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

Michigan

Sterling Area Health Center

Grant Number:	D04RH23622					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Sterling Area Health Center				
	Address:	725 East State St.				
	City:	Sterling	**State:**	Michigan	**Zip code:**	48659
	Tel #:	989-654-2072				
	Fax #:	989-654-2348				
	Website:	STERLINGHEALTH.NET				
Primary Contact Information:	**Name:**	Susan Kaderle				
	Title:	Network Director				
	Tel #:	989-569-6001 ext.1730				
	Fax #:	989-358-3756				
	Email:	SKADERLE@ALCONAHC.ORG				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,939
	May 2013 to Apr 2014	$148,933
	May 2014 to Apr 2015	$149,745

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Sterling Area Health Center	Arenac	MI	FQHC
	Alcona Health Center	Alcona	MI	FQHC
	Northeast Health Plan	Ogemaw	MI	Health Plan

The communities/counties the project serves:	Arenac, Iosco, Ogemaw, Alcona, Oscoda

The target population served:	**Population**	**Male**	**Female**
	Infants	X	X
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	

Aging		Maternal/Women's Health	
Behavioral/Mental Health	X	Migrant/Farm Worker Health	
Children's Health		Oral Health	X
Chronic Disease: Cardiovascular	X	Pharmacy Assistance	X
Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
Chronic Disease: Cancer	X	School Health	
Community Health Workers /Promotoras	X	Substance Abuse	X
Coordination of Care Services	X	Telehealth	
Emergency Medical Services		Transportation to health services	X
Health Education and Promotion	X	Other: (please describe)	
Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The project mirrors the model outlined in the 2011 HRSA Community Health Workers Evidence Based Models Toolkit "Care Coordinator/Manager Model"
Description of the project:	The purpose of the MI- Connect Network is to implement a rural demonstration of the Community Health Worker program in Alcona, Arenac, Iosco, Ogemaw, and Oscoda Counties in the Northeast section of Michigan's Lower Peninsula. The program will be under the umbrella of the MI-Connect Network. The Network was formed in response to the unmet community needs in Northern Michigan. The three founding members; Alcona Citizens for Health DBA Alcona Health Center (AHC), Sterling Area Health Center (SAHC), and St. Joseph Tawas Hospital (SJTH) have a long standing collaborative relationship and have a formal Memorandum of Agreement in place. St. Joseph Tawas Hospital decided to no longer participate in the Network, we did add Northeast Health Plan to our group. The service area faces serious challenges for health care access due to high rates of under- and uninsured individuals, widespread economic and social deprivation, joblessness, underemployment, geographic isolation, harsh climate, lack of transportation resources, health care personnel recruitment and retention challenges, and a large elderly population with extensive health care needs. MI-Connect will administer the demonstration program that will recruit, train, employ and assign Community Health Workers (CHWs) to provide a range of services to improve access to health care and health care outcomes. CHWs will provide outreach to the rural medically underserved population that includes un- and under-insured persons, and a disproportionately high percentage of elderly people with high rates of chronic disease. The CHWs will facilitate linkages and help maintain communication between patients with cancer or chronic illness, their families, their physicians, and the health care system, and link them with additional supports to meet their basic needs, thus improving their health outcomes and increasing their quality of life.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Catherine Liemohn, MPP				
	Title:	Technical Assistance Consultant				
	Tel #:	770-641-9940				
	Fax #:	770-641-0799				
	Email:	liemohn@bellsouth.net				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Michigan

Upper Great Lakes Family Health Center

Grant Number:	D04RH23623					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC Look-Alike					
Grantee Organization Information:	**Name:**	Upper Great Lakes Family Health Center				
	Address:	135 E M-35				
	City:	Gwinn	**State:**	Michigan	**Zip code:**	49849
	Tel #:	906-346-9275				
	Fax #:	906-346-5616				
	Website:	www.uglhealth.org				
Primary Contact Information:	**Name:**	Donald Simila				
	Title:	CEO/CFO				
	Tel #:	906-361-2451				
	Fax #:	906-346-5616				
	Email:	Donald.Simila@UGLHealth.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Great Lakes Recovery Centers	Marquette	MI	Behavioral Health
	Upper Peninsula Health Plan	Marquette	MI	Medicaid Managed Care

The communities/counties the project serves:	Marquette County, Michigan

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X

	Aging		Maternal/Women's Health		
	Behavioral/Mental Health	X	Migrant/Farm Worker Health		
	Children's Health		Oral Health		
	Chronic Disease: Cardiovascular		Pharmacy Assistance		
	Chronic Disease: Diabetes		Physical Fitness and Nutrition		
	Chronic Disease: Other		School Health		
	Community Health Workers /Promotoras		Substance Abuse		
	Coordination of Care Services	X	Telehealth	X	
	Emergency Medical Services		Transportation to health services		
	Health Education and Promotion		Other: (please describe)		
	Health Information Technology		Other: (please describe)		

Evidence Based Model Being Used or Adapted:	*Four Quadrant Clinical Integration Model*
Description of the project:	*Cross-walk: Integrating Behavioral Health within the Primary Care Setting:* The target population is patients age 13 and over who are served by Upper Great Lakes Family Health Center. Sub-populations, defined for system changes and performance improvement monitoring purposes, are patients ages 13 – 17; patients ages18 – 64; and patients 65 and over. *Needs*: Residents of the service area are susceptible to undiagnosed, untreated and undertreated behavioral health issues as a result of their demographics and limited accessible resources. They have limited access to psychiatry, advanced psychological and substance abuse services. The primary health care setting is not well positioned to adhere to best practices for behavioral health services and coordination. *Model & Services*: Partners will adapt the Four Quadrant Clinical Integration Model and Evidence-Based Practices (Second Revision February 2006) and progress from Level Two Integrated Behavioral Medical Care clinic to Level Five as defined by Doherty, et al. Services will include evidence-based screening, behavioral health and substance use/abuse services co-located and embedded within a primary care setting, individual and group therapy, and increased access to psychiatric and advanced psychological through telemedicine. *Outcomes:* Outcomes include increased communication among practitioners, evidence-based screening, decreased depression and/or substance abuse symptoms, increased compliance with referral and treatment recommendations, and a sustainable integrated health system.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Michigan

Western Upper Peninsula Health Department

Grant Number:	D04RH23624					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Local Health Department (local government agency)					
Grantee Organization Information:	**Name:**	Western Upper Peninsula Health Department				
	Address:	540 Depot Street				
	City:	Hancock	**State:**	Michigan	**Zip code:**	49930
	Tel #:	906-482-7382				
	Fax #:	906-482-9410				
	Website:	www.wuphd.org				
Primary Contact Information:	**Name:**	Ray Sharp				
	Title:	Manager, Community Planning and Preparedness				
	Tel #:	906-482-7382, ext. 163				
	Fax #:	906-482-9410				
	Email:	rsharp@hline.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	BHK Child Development Board	Houghton	MI	Non-profit agency
	Dollar Bay Schools	Houghton	MI	Public school district
	Lake Linden-Hubbell Schools	Houghton	MI	Public school district
	Houghton-Portage Township Schools	Houghton	MI	Public school district
	L'Anse Area Schools	Baraga	MI	Public school district
	Bessemer Area Schools	Gogebic	MI	Public school district
	Hancock Area Schools	Houghton	MI	Public school district
	Copper Country ISD Learning Center	Houghton	MI	Public school district

The communities/counties the project serves:	Baraga, Gogebic, Houghton, Keweenaw and Ontonagon counties, Michigan

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)		
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		

	Native Americans		X	X
	Pacific Islanders			
	Uninsured			
	Underinsured			
	Other: (please describe)			
	Other: (please describe)			

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	X
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Comprehensive Approach To Child Health (CATCH) curriculum
Description of the project:	The CATCH UP Project will improve the quality of health education and wellness programs in K-5 schools and summer and after-school programs, with emphasis on promoting healthy behaviors including good dietary habits and adequate physical activity, with a long-term goal of preventing childhood obesity and chronic disease. Services will include providing comprehensive health curriculum and teacher training, facilitating policy and system changes in schools through comprehensive school health committees, providing health education programs and events in schools and communities, and providing voluntary child health screenings and health report cards.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Rural Health Outreach Project Officer				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Rachel Campos, MPH/Beverly Tyler				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0334				
	Fax #:	404-413-0316				
	Email:	rcampos1@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Minnesota

County of Koochiching

Grant Number:	D04RH23568					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	County Public Health and Human Services					
Grantee Organization Information:	**Name:**	County of Koochiching				
	Address:	1000 5th Street				
	City:	International Falls	**State:**	Minnesota	**Zip code:**	56649
	Tel #:	218-283-7000				
	Fax #:	218-283-7013				
	Website:					
Primary Contact Information:	**Name:**	Ric Schaefer				
	Title:	Program Director				
	Tel #:	218-591-1302				
	Fax #:	866-822-2598				
	Email:	Ricschaefer.sc@gmail.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Koochiching County Community Services	Koochiching	MN	County
	Lake County Public Health and Human Services	Lake	MN	County
	Cook County Public Health and Human Services	Cook	MN	County
	Carlton County Public Health and Human Services	Carlton	MN	County

The communities/counties the project serves:	Carlton, Cook, Lake and Koochiching Counties in Minnesota

The target population served:	**Population**	**Male**	**Female**
	Infants	X	X
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults		X
	Elderly		
	Pregnant Women		X
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	X
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Promising Practice - STEEP™ (Steps Toward Effective Enjoyable Parenting) including Seeing is Believing®
Description of the project:	This project will improve upon existing family home visiting programs currently provided in each of the participating counties. Grant funding will allow for the continuation of home visiting for pre-natal and postpartum home visiting while implementing components of STEEP™ (Steps Toward Effective Enjoyable Parenting) including Seeing is Believing® which provides an opportunity for parents to learn about child development and parent-child interaction in a way that is supportive, and encouraging through videotaping child/parent interactions.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tanisa Adimu, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Fax #:	404-413-0316				
	Email:	tadimu@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Minnesota

Mississippi Headwaters Area Dental Health Center
D/B/A/ Northern Dental Access Center

Grant Number:	D04RH23601					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Community Access Dental Clinic					
Grantee Organization Information:	**Name:**	Mississippi Headwaters Area Dental Health Center D/B/A Northern Dental Access Center				
	Address:	1405 Anne Street NW				
	City:	Bemidji	**State:**	Minnesota	**Zip code:**	56601
	Tel #:	218-444-9646				
	Fax #:	218-444-9252				
	Website:	www.northerndentalaccess.org				
Primary Contact Information:	**Name:**	Jeanne Edevold Larson				
	Title:	Executive Director				
	Tel #:	218-444-9646				
	Fax #:	218-444-9252				
	Email:	Jeanne.Larson@northerndentalaccess.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,200
	May 2013 to Apr 2014	$148,300
	May 2014 to Apr 2015	$149,900

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Community Resource Connections	Beltrami	MN	Nonprofit
	Evergreen Youth & Family Services	Beltrami	MN	Youth Mental Health outreach

The communities/counties the project serves:	Rural, northwestern Minnesota, including the counties of Beltrami, Cass, Clearwater, Koochiching, Polk, and more. Communities include Bemidji, Blackduck, Cass Lake, Red Lake, Bagley, Clearbrook, Crookston, Thief River Falls, Mahnomen and more

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

	Other: (please describe)			
Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	• Ruby Payne Bridges Out of Poverty community framework; • The 4 C's of Information and Referral; • Mental Health and Screening Referral Capacity for Children; • The Dental Home Model; and • Community Health Worker Integration
Description of the project:	The funded project connects marginalized populations with the oral and mental health care available in our community. Granted funds add an expanded safety net beneath the most vulnerable patients and augment dental care with integrated patient support and outreach that will assure patient success. Through a consortium of three providers,—we serve the target population with dental care, mental health screenings (and referrals where necessary), and insurance counseling and community support referrals to help reduce barriers to care.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Fax #:	301-443-2803				
	Email:	LKwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

Mississippi

Central Mississippi Residential Center

Grant Number:	D04RH23563					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	State operated Community Mental Health Center					
Grantee Organization Information:	**Name:**	Central Mississippi Residential Center (CMRC)				
	Address:	601 Northside Drive				
	City:	Newton	**State:**	Mississippi	**Zip code:**	39345
	Tel #:	601-693-4201				
	Fax #:	601-683-4210				
	Website:	www.cmrc.state.ms.us				
Primary Contact Information:	**Name:**	Debbie J. Ferguson				
	Title:	Director				
	Tel #:	601-683-4201				
	Fax #:	601-683-4210				
	Email:	dferguson@cmrc.state.ms.us				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Care Lodge	Lauderdale	MS	Domestic Violence Shelter
	Newton Police Department	Newton	MS	Law Enforcement
	Newton County Extension Office MSU	Newton	MS	4-H Youth
	MS Department of Mental Health	Hinds	MS	State Agency
	MS Attorney General's Office	Jackson	MS	State Agency
	East Central Community College	Decatur	MS	Community College

The communities/counties the project serves:	Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Scott, & Smith Counties.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives	X	X
	Asians	X	X
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders	X	X
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	While IGU is modeled after the evidence-based SOS Signs of Suicide Prevention Program, it has been significantly adapted to meet the needs of youth in rural Mississippi. In addition to suicide prevention, IGU includes presentations about drug and alcohol abuse, self-injury, healthy dating relationships, bullying and cyber bullying and healthy coping skills. These topics are integrated into a dynamic day-long program designed to deliver results without disrupting class time. Through IGU students learn how to better cope with challenging situations, why it is important to seek help, and what resources are available. During this single-day intervention program, students are addressed by dynamic speakers who us a mix of motivational messages and dialogue. This intensive, integrated format has yielded a high level of student satisfaction and preliminary evaluation results show statistically significant results.
Description of the project:	This educational community health outreach program bridges a gap in youth mental health services. Students travel to CMRC during school hours as 8th graders and again as 10th graders to learn about mental health issues such as: suicide prevention, dating violence, self-injurious behavior (cutting), bullying, and alcohol and drug abuse. The focus of these presentations is to educate participants on mental health issues, the importance of early identification, promotion of coping techniques and how to assess services. CMRC and Consortium members have partnered with regional schools to provide professional presenters who are not only knowledgeable in their field but also able to connect with the students. Topics for presentation are chosen annually by the consortium based on student evaluations as well as feedback from technical advisory members. The students involved in this program live in rural areas and are impacted by racial, ethnic, socioeconomic and geographic disparities, which only serve to increase the stigma associated with receiving mental health care. Since the program's inception four years ago it has grown from serving 400 students to 3,000 students annually. Due to the increase in program participants as well as requests from additional schools to be included, grant funding was sought to expand the program from schools in the three counties currently served to schools in a nine county area.

Office of Rural Health Policy Project Officer:						
	Name:	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Email:	lkwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Tanisa Adimu, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Fax #:	404-413-0316				
	Email:	tadimu@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Montana

Citizens Memorial Hospital District

Grant Number:	D04RH23566					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Healthcare System with Hospital and Clinics					
Grantee Organization Information:	**Name:**	Citizens Memorial Hospital District				
	Address:	1500 N. Oakland				
	City:	Bolivar	**State:**	Missouri	**Zip code:**	65613
	Tel #:	417-326-6000				
	Fax #:	417-328-6242				
	Website:	www.citizensmemorial.com				
Primary Contact Information:	**Name:**	Angela Davison				
	Title:	Program Director				
	Tel #:	417-328-6561				
	Fax #:	417-777-1434				
	Email:	adavis@citizensmemorial.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Burrell Behavioral Health	Greene	MO	Large Mental Health Provider
	Polk County Health Center	Polk	MO	Public Health Center

The communities/counties the project serves:
Bolivar, MO/Polk County; Buffalo, MO/Dallas County; Greenfield, MO/Dade County; Hermitage, MO/Hickory County; Humansville, MO/Polk County; Pleasant Hope, MO/Polk County; Stockton, MO/Cedar County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce	

			Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services	X	Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Patient Centered Medical Home Model and Cherokee Health Model demonstrating integrated Behavioral Health Care in Primary Care Settings
Description of the project:	Show-Me Healthy People (SMHP) will serve rural residents in seven Southwest Missouri counties by funding consultative services based out of Polk County, Missouri. The SMHP Network is a consortium comprised of a rural hospital, a not-for-profit mental health service provider, and a public health department. Proposed services include assessments by behavioral health specialists and mental health providers in conjunction with primary care at the request of providers or patients. This will include service integration and education, brief education about the patient's physical condition, and a brief mental health assessment to evaluate the need for further mental health care in conjunction with primary care. The program's outcomes include better mental health coverage for an increased number of assessed patients, increased treatment compliance, and decreased rates of ER usage and readmission. The project has been tailored to include service via videoconferencing capabilities that will allow a larger population to be served by one consultant. Telehealth services will build on those currently provided by the rural hospitals that have proven to be a cost effective solution for gaining the most benefit.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Project Officer				
	Tel #:	301-594-4205				
	Email:	LKwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Missouri

Freeman Neosho Hospital

Grant Number:	D04RH23574					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Critical Access Hospital					
Grantee Organization Information:	**Name:**	Freeman Neosho Hospital				
	Address:	113 West Hickory St				
	City:	Neosho	**State:**	Missouri	**Zip code:**	64850
	Tel #:	417-451-1234				
	Fax #:	417-347-0649				
	Website:	www.freemanhealth.com/neosho				
Primary Contact Information:	**Name:**	Gwynn Caruthers				
	Title:	RELI Project Coordinator				
	Tel #:	417-347-7354				
	Fax #:	417-347-9880				
	Email:	glcaruthers@freemanhealth.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Access Family Care	Newton	MO	FQHC
	Barton County Memorial Hospital	Barton	MO	CAH
	Freeman Health System	Newton	MO	Acute Care Hospital
	McCune Brooks Regional Hospital	Jasper	MO	CAH
	Ozark Center	Jasper	MO	Behavioral Health Center

The communities/counties the project serves:	Barton, Jasper, Newton and McDonald counties. Lamar, Carthage, Joplin, and Neosho are some of the larger towns in the area.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X

	Underinsured		X	X
	Other: Life Limiting Illness		X	X
	Other: (please describe)			

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging	X	Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: Palliative/Advance Care Planning	X
	Health Information Technology		Other: End of Life Medical Health Coordination	X

Evidence Based Model Being Used or Adapted:	Physician Orders for Life Sustaining Treatment (POLST) End-of-Life Nursing Education Consortium University of Washington survey tools Board Certification in Hospice and Palliative care for physicians and nurses
Description of the project:	This project will increase the awareness of and provision of palliative care in the critical access hospital in the southwest corner of Missouri. During year three that at least 1 nurse from each critical access hospital will obtain certification in Hospice and Palliative Nursing (CHPN). As well an order set (POLST) will be initiated in the rural areas in the primary care setting with the development of communication strategies in regards to advance care planning. Advance care planning in the outpatient setting will empower people to work in conjunction with the medical community to plan their health based on individual values, goals and preferences.

Office of Rural Health Policy Project Officer	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn Building 17W – 31 B				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

Missouri

Health Care Coalition of Lafayette County

Grant Number:	D04RH23579					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Rural Health Network					
Grantee Organization Information:	**Name:**	Health Care Coalition of Lafayette County				
	Address:	825 S Business HWY 13				
	City:	Lexington	**State:**	Missouri	**Zip code:**	64067
	Tel #:	660-259-2440				
	Fax #:	660-259-2440				
	Website:	www.hccnetwork.org				
Primary Contact Information:	**Name:**	Toniann Richard				
	Title:	Executive Director				
	Tel #:	660-259-2440				
	Fax #:	660-259-2440				
	Email:	toniann@hccnetwork.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Lafayette Regional Health Center	Lafayette	MO	CAH
	Pathways Community Behavioral Health	Lafayette	MO	Mental Health
	Fitzgibbon Hospital	Saline	MO	Hospital
	Carroll County Hospital	Carroll	MO	CAH
	I-70 Community Hospital	Saline	MO	CAH

The communities/counties the project serves:	Lafayette, Carroll and Saline County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X

	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	HCC focused this project by adapting elements of Project Access Dallas.In 2002, the Dallas County Medical Society in collaboration with several community partners created a community service program called Project Access Dallas. The heartbeat of the program is compassionate care for the community's uninsured patients who struggle daily with the challenges of poverty and who have no access to health care. The program is a network of volunteer physicians, partnering hospitals, community charity health clinics, and ancillary partners who volunteer to care for working poor patients. Physicians, hospitals, or ancillary partners who sign up to volunteer in the program determine their level of participation by agreeing to donate their services to see a set number of patients per year. Patients are referred for enrollment in the program from volunteer physicians, partnering charity health clinics, and partnering hospitals. Because of the generous donated services of partners, when a patient is enrolled in Project Access Dallas, he/she is assigned a primary care physician; receives $750 a year in pharmacy benefits; and has access to free specialty care, labs, ancillary procedures, care coordination, and inpatient hospital care.
Description of the project:	This project will expand methods of providing health care information and education as well as intervention using Telemedicine for diabetes and depression; Increase knowledge levels about using Telemedicine to support primary and specialty health care with providers, patients and consumers; Improve health outcomes of patients with diabetes and/or depression; Sustain the program beyond grant period to continue and expand services and broaden to include other chronic illnesses. We will reach 700 uninsured patients over three years. The program incorporates baseline measures (demographics, PIMS, other) and monitoring occurs every 90 days for individual screening. We will follow each patient from beginning to end, revealing a picture of progress, care received, medicines prescribed, and status updates. We will also be able to compare clinical results by groups of people, e.g., gender, age group, uninsured. We are particularly interested in gaining new insights into those individuals who suffer from both diabetes and depression and will be able to evaluate their health status and progress against other patient groups.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	SWarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0283				
	Fax #:	404-413-0316				
	Email:	jbutts@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Missouri

Northeast Missouri Health Council

Grant Number:	D04RH23608					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Northeast Missouri Health Council				
	Address:	1416 Crown Dr.				
	City:	Kirksville	**State:**	Missouri	**Zip code:**	63501
	Tel #:	660-627-5757				
	Fax #:	660-627-5802				
	Website:	www.nmhcinc.org				
Primary Contact Information:	**Name:**	Mandy Herleth				
	Title:	Grants Coordinator				
	Tel #:	660-627-5757, ext. 30				
	Fax #:	660-627-5802				
	Email:	mherleth@nmhcinc.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Northeast Missouri Area Health Education Center	Adair	MO	Health Care Education, Workforce Dev.
	Northeast Regional Medical Center	Adair	MO	Regional Hospital
	Adair County Health Department	Adair	MO	County Health Dept.
	Clark County Health Department	Clark	MO	County Health Dept.
	A.T. Still University	Adair	MO	Medical/Dental School

The communities/counties the project serves:	Adair, Clark, Knox, Lewis, Schuyler, Scotland

The target population served:	**Population**	**Male**	**Female**
	Infants	X	X
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly		
	Pregnant Women		X
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Following HRSA's *Oral Health Disparities Collaborative* model, the Oral Health Alliance is targeting pregnant women and children ages 0-5 through health department and Women, Infant and Children (WIC) clinics. A dental hygienist is providing oral health screenings and education at monthly WIC clinics and identifying patients that need follow-up care. In addition, WIC nurses are being trained on the importance of oral health during pregnancy and for children focusing on proper oral health care and prevention measures. The nurses in turn are then able to educate their clients on how to take care of their teeth and their children's teeth and gums. The nurses are also taught how to look into the children's mouth and identify problem areas.
Description of the project:	The Northeast Missouri Health Council (NMHC) will partner with the Oral Health Alliance to expand oral health services for two vulnerable/ underserved populations in a rural six-county region of northeastern Missouri: *1) pregnant women, infants, and children*, and *2) special needs individuals*. NMHC and the Alliance will engage medical providers, regional hospitals, county health departments, WIC, Head Start, schools, and disabled services organizations to facilitate program referrals for individuals in need of basic oral health care services (e.g., screenings, fluoride varnishing, and exams). In addition, a 6-county awareness campaign will target pregnant women/infants/children via traditional information-sharing, community-based programs, medical-dental collaboration, and innovative social media tools (e.g., mobile texting and social networking programs widely used by the target population). Care coordination/patient navigation will be provided with the dental home model of care will be emphasized.

Office of Rural Health Policy Project Officer:						
	Name:	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:						
	Name:	Tamanna Patel, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Fax #:	404-413-0316				
	Email:	tpatel25@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Montana

Butte Silver Bow Primary Health Care Clinic Inc.

Grant Number:	D04RH23562					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Butte Silver Bow Primary Health Care Clinic Inc. aka Butte CHC				
	Address:	445 Centennial				
	City:	Butte	**State:**	Montana	**Zip code:**	59701
	Tel #:	406-723-4075				
	Fax #:					
	Website:					
Primary Contact Information:	**Name:**	Jessica Hoff				
	Title:	CEO				
	Tel #:	406-723-4075				
	Fax #:					
	Email:	jhoff@buttechc.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Drug Court Butte Judge Krueger	Silver Bow	MT	Drug court
	Butte Silver Bow Health Department	Silver Bow	MT	Health Department
	MCDC state hospital	Silver bow	Mt	Substance abuse inpatient hospital

The communities/counties the project serves:	Butte Silver Bow county; Butte Montana

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Motivational Interviewing Cognitive Behavioral Therapy Dialectical Behavioral Therapy Focused Acceptance and Commitment Therapy
Description of the project:	Integrated substance abuse program into a primary care medical setting. The project will bring licensed addiction counselors and behavioral health counselors to a place where a large percentage of SW Montanans seek medical, dental, pharmacy, case management and pediatric care for themselves and their families. The project believes that a collaborative team approach is the best way to bring access, help and hope to individuals and communities impacted by the devastation of substance abuse. The project will employ evidence-based models so that treatment is timely 'at the time of the primary care visit' and support over the longer period through individual and group treatment and support groups. This project will work with a consortium of three respected community partners: a health department, an in-patient treatment center and a state drug court to provide a coordinated effort for treatment for substance abuse in this rural community.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tanisa Adimu, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Fax #:	404-413-0316				
	Email:	tadimu@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Montana

Granite County Hospital District

Grant Number:	D04RH23578					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Granite County Hospital District				
	Address:	P.O. Box 729				
	City:	Philipsburg	**State:**	Montana	**Zip code:**	59858
	Tel #:	406-859-3271				
	Fax #:	406-859-6528				
	Website:	www.gcmedcenter.org				
Primary Contact Information:	**Name:**	Sharon Fillbach				
	Title:	Program Director				
	Tel #:	406-859-3271				
	Fax #:	406-859-6528				
	Email:	sharon.fillbach@granitecmc.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Dr. Russell Blackhurst	MIssoula	MT	Dental Practice
	Missoula County Public Health	Missoula	MT	County Health Office

The communities/counties the project serves:	Granite County all residents

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	

	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The project is based on the "dental home" concept promulgated by the American Academy of Pediatric Dentistry (2010). Following the "safety net dental clinic" model (National Maternal and Child Oral Health Resource Center, 2012), the project created a dental home for residents of Granite County by establishing a fixed-base dental clinic.					
Description of the project:	The project established a fixed-base dental clinic with two chairs that now operates 2-3 days per week. The fixed clinic replaced a former mobile unit, and enhances our dental capabilities and the services that we can provide. The project also provides fluoride treatments and varnishes for all students in Granite County through outreach to schools. This outreach also included oral health education and promotion programming targeting 4th & 5th grade students in Granite County.					
Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Fax #:	301-443-2803				
	Email:	LKwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

Montana

Madison Valley Medical Center

Grant Number:	D04RH23594					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Madison Valley Medical Center				
	Address:	305 North Main				
	City:	Ennis	**State:**	Montana	**Zip code:**	59729
	Tel #:	406-682-6862				
	Fax #:	406-682-4756				
	Website:	http://www.mvmedcenter.org/				
Primary Contact Information:	**Name:**	Kaye Norris				
	Title:	Project Director				
	Tel #:	406-243-6246				
	Fax #:	406-243-4141				
	Email:	kaye.norris@umontana.edu				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,426
	May 2013 to Apr 2014	$149,189
	May 2014 to Apr 2015	$148,474

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Western Montana Area Health Education Center	Missoula	MT	Non-Profit Advocacy
	The University of Montana	Missoula	MT	School
	Powel County Medical Center	Powel	MT	Critical Access Hosp
	Clark Fork Valley Hospital	Sanders	MT	Critical Access Hosp
	St. John's Lutheran Hospital	Lincoln	MT	Critical Access Hosp
	Frances Mahon Deaconess Hospital	Glasgow	MT	Critical Access Hosp
	Northwest Community Health Center	Libby	MT	FQHC

The communities/counties the project serves:	Currently, Madison Valley County, Powel County, Sanders County, Lincoln County. Three more counties will be added over the 3 year project.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	X
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Integrating mental health services into primary has been well documented to improve health outcomes, increase patient satisfaction, and reduce costs. According to a 2010 report completed by the Milbank Fund (www.milbank.org), "Integrating mental health services into a primary care setting offers a promising, viable, and efficient way of ensuring that people have access to needed mental health services. Additionally, mental health care delivered in an integrated setting can help to minimize stigma and discrimination, while increasing opportunities to improve overall health outcomes." The evidence for integrated behavioral health care is now so extensive that researchers and policy-makers are urging us to shift from a research approach to implementation. Collins, C, Hewson, DL,Munger, R, and Wade, T. " Evolving Models of Behavioral Health Integration in Primary Care." Milbank Memorial Fund, (May 2010). Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Arch Intern Med. 2006 Nov 27;166(21):2314-21.
Description of the project:	Montana is the fourth largest state in total area (147,040 square miles) and of this land mass, frontier areas encompass 90 percent of the state. Montana has only six cities and towns with populations over 20,000. The rural and frontier character of Montana is even more clearly demonstrated by the fact that 420,000 (42%) live outside of incorporated cities and towns. Montanans who live outside of the six largest cities and who are not on Medicaid have little or no access to behavioral health services. This is the situation for 72.7% of the population who live in rural Montana and who rely on the primary care services available from the 44 critical access hospitals with rural health clinics. State Offices of Rural Health have identified suicide, stress, depression, and anxiety disorders, and lack of access to mental and behavioral health care, as major rural health issues. The Montana Office of Rural Health has conducted health needs assessments in each of the 48 communities where critical access hospitals are located. The quantitative and qualitative data from these surveys show that behavioral health services including acute and addictive services rank as a high or very high concern in each and every community. Through the "Rural Behavioral Health-Primary Care Collaborative", a behavioral health team consisting of a pre-licensed psychologist and a pre-licensed clinical social worker will be employed by 7 hospitals and integrated clinically with the other primary care providers at their rural health clinics. The team will obtain pre-license supervision from licensed University of Montana faculty via tele-supervision and distance education until they are eligible for licensure after which time they will be permanent employees of the hospital. This project will result in the development of infrastructure to provide behavioral health services that are integrated into primary care in Montana's rural and frontier communities. Additionally, it will provide the experience required for licensure for psychology and social work graduates, thereby

	allowing them to independently practice in rural areas. Finally, it will enable Critical Access Hospitals to recruit behavioral health professionals to address a workforce shortage. Since this project is easily duplicated, rural communities across the nation can use the model to improve access to behavioral health services, integrate behavioral medicine into primary care, and improve health outcomes.					
Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Email:	lkwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Montana

Missoula City/County Health Dept/Partnership HC

Grant Number:	D04RH23602					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	501c3					
Grantee Organization Information:	**Name:**	Missoula City/County Health Dept/Partnership HC				
	Address:	323 West Alder Street				
	City:	Missoula	**State:**	Montana	**Zip code:**	59802
	Tel #:	406-258-4191				
	Fax #:	406-258-4180				
	Website:	www.co.missoula.mt.us/phc				
Primary Contact Information:	**Name:**	Kim Mansch				
	Title:	Executive Director, Partnership Health Center				
	Tel #:	406-258-4191				
	Fax #:	406-258-4180				
	Email:	manschk@phc.missoula.mt.us				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Seeley Swan Hospital District	Missoula	MT	Hospital District
	Providence Saint Patrick Hospital	Missoula	MT	Hospital

The communities/counties the project serves:	The Seeley Swan Valley, located in Missoula County, will be served by this project.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease:		Pharmacy Assistance	

	Cardiovascular			
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The dental clinic model utilized is endorsed by the Health Resources and Services Administration and the National Network for Oral Health Access (NNOHA)—a nationwide network of dental providers who care for patients in safety-net systems and whose members are committed to improving the overall health of the country's underserved individuals through increased access to oral health services—the model has proven to be cost-effective with quality results. Services offered are a comprehensive array of primary dental care, including preventive, restorative, surgical, and rehabilitative services. While emphasis is placed on preventive care and oral hygiene instruction, much of the capacity of their clinic was initially spent on non-preventive care, including a high demand for emergency and acute dental care needs. Emergent needs are transitioning to preventative care over time. The proposed new dental clinic allows for more accessibility, which will translate to more time for preventative care.
Description of the project:	The Seeley Swan Hospital District, Providence Saint Patrick Hospital and Partnership Health Center have formed a consortium to address the dental needs of Seeley Lake, a rural community located within Missoula County 55 miles outside of the City of Missoula. Services to be offered are a comprehensive array of primary dental care, including preventive, restorative, surgical, and rehabilitative services. While emphasis will be placed on preventive care and oral hygiene instruction, much of the capacity of the clinic will initially be spent on non-preventive care, including a high demand for emergency and acute dental care needs. Emergent needs will transition to preventative care over time. The proposed new dental clinic will allow for more accessibility, which will translate to more time for preventative care. This will be accomplished by increasing the capacity of dental services in Seeley Lake with dental providers, support staff, and equipment, resulting in more available appointments to meet the demand for services. Over the long-term, the availability of comprehensive oral healthcare services will lead to a reduction in the need for urgent care and an improvement in the oral health status of the target population.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-549-4205				
	Fax #:	301-443-2803				
	Email:	LKwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

Nebraska

Nebraska Association of Local Health Directors

Grant Number:	D04RH23605					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Non-profit					
Grantee Organization Information:	**Name:**	Nebraska Association of Local Health Directors				
	Address:	2310 Sheridan Blvd				
	City:	Lincoln	**State:**	Nebraska	**Zip code:**	68502
	Tel #:	402-326-3400				
	Fax #:					
	Website:	www.nalhd.org				
Primary Contact Information:	**Name:**	Susan Bockrath				
	Title:	Executive Director, NE Association of Local Health Directors				
	Tel #:	402-326-3400				
	Fax #:					
	Email:	susanbockrath@nalhd.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Central District Health Dept.	Hall/Merrick/Hamilton	NE	Health Dept.
	South Heartland District Health Dept.	Adams, Clay, Webster, Nuckolls	NE	Health Dept.
	Loup Basin Public Health Dept.	Blaine, Loup, Garfield, Wheeler, Valley, Greeley, Custer, Sherman, Howard	NE	Health Dept.
	Four Corners Health Dept.	Polk, Butler, York, Seward	NE	Health Dept.
	Panhandle Public Health Dept.	Duel, Dawes, Box Butte, Sheridan, Banner, Morrill, Garden, Kimball, Cheyenne, Sioux	NE	Health Dept.
	Two Rivers Public Health Dept.	Dawson, Buffalo, Gosper, Phelps, Kearney, Harlan, Franklin	NE	Health Dept.
	Three Rivers Public Health Dept.	Dodge, Washington, Saunders	NE	Health Dept.
	Elkhorn Logan Valley Public Health Dept.	Madison, Stanton, Cuming, Burt	NE	Health Dept.
	East Central District Health Dept.	Boone, Nance, Platte, Colfax	NE	Health Dept.
	Northeast Nebraska Public Health	Cedar, Dixon, Wayne, Thurston	NE	Health Dept.
	West Central District Health Dept.	Keith, Arthur, Grant, Hooker,	NE	Health Dept.

		Thomas, McPherson, Logan, Lincoln		
	North Central District Health Dept.	Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Antelope, Pierce	NE	Health Dept.
	Public Health Solutions	Fillmore, Saline, Thayer, Jefferson, Gage	NE	Health Dept.
	Scotts Bluff County Health Dept.	Scotts Bluff	NE	Health Dept.
	University of Nebraska Medical Center, College of Public Health	Douglas	NE	University
	Nebraska Department of Health and Human Services, Office of Health Disparities and Health Equity	Lancaster	NE	State Agency

The communities/counties the project serves: Please see above.

The target population served:

Population	Male	Female
Infants		
Pre-school children		
School-age children (elementary)		
School-age children (teens)		
Adults	X	X
Elderly	X	X
Pregnant Women		X
Caucasians	X	X
African Americans	X	X
Alaska Natives		
Asians	X	X
Hispanics	X	X
Native Americans		
Pacific Islanders		
Uninsured	X	X
Underinsured	X	X
Other: (please describe)		
Other: (please describe)		

Focus areas of grant program:

Focus Area:	Yes	Focus Area:	Yes
Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev	X
Access: Specialty Care		Integrated Systems of Care	
Aging		Maternal/Women's Health	
Behavioral/Mental Health		Migrant/Farm Worker Health	
Children's Health		Oral Health	
Chronic Disease: Cardiovascular		Pharmacy Assistance	
Chronic Disease: Diabetes		Physical Fitness and Nutrition	
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras		Substance Abuse	
Coordination of Care Services		Telehealth	
Emergency Medical Services		Transportation to health services	
Health Education and Promotion	X	Other: (please describe)	
Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	We are adapting selected sections of the AHRQ Health Literacy Universal Precautions Toolkit, the CDC Clear Communication Index, and the 10 Attributes of Health Literate Health Care Organizations. Our project was a featured practice model at the Institute of Medicine's Workshop Implications of Health Literacy for Public Health.					
Description of the project:	The Nebraska Association of Local Health Directors, a 501c3 organizations with 19 Local Health Directors, representing 87% of the counties in Nebraska, will utilize the grant funding to initiate the consortium: Nebraska Association of Local Health Directors Outreach Partnership to Improve Health Literacy. Health literacy is a bi-directional phenomenon that requires skills on the part of both consumers and providers. It is defined as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions. Health literacy issues affect everyone across the range of socio-demographic characteristics, including, but not limited to age, educational status, income level, English language proficiency, geographic location and insurance status. It is estimated that 90% of the population would benefit from health communication strategies that address health literacy. A study by the US Department of Education found that only 12% of adults are proficient in health literacy, 53% fall into the intermediate range and 36% had basic or below basic health literacy. A growing body of research shows that those with "Basic" or "Below Basic" health literacy levels utilize preventive services less often, are misdiagnosed often due to poor patient-provider communications, have less effective management of chronic conditions, experience higher mortality rates, have a greater number of medical errors, are less compliant with treatment, experience longer hospital stays, are more likely to have unnecessary emergency room visits and respond poorly in public health emergencies. The CDC has recognized that it is vital for public health professionals to understand and address gaps between health information and the services they provide and people's skills in order to improve the health of individuals and the population. The NALHD Consortium will focus on assisting Nebraska's health departments in developing an organizational culture that understands health literacy and has the skills and resources to better tailor health communications and interventions to its target population at their health literacy level. Activities will include assessment, education, training, development of specific plans for targeting local populations and provision of other resources.					
Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn Bldg. 17W-29C				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tamanna Patel, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Fax #:	404-413-031				
	Email:	tpatel25@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Nebraska

Public Health Solutions

Grant Number:	D04RH23610					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Consortium of local health department and 6 critical access hospitals					
Grantee Organization Information	**Name:**	Public Health Solutions				
	Address:	995 E Highway 33, Ste. 1				
	City:	Crete	**State:**	Nebraska	**Zip code:**	68333
	Tel #:	402-826-3880				
	Fax #:	402-826-4101				
	Website:	www.phsneb.org				
Primary Contact Information:	**Name:**	M Jane Ford Witthoff				
	Title:	Health Director				
	Tel #:	402-826-3880				
	Fax #:	402-826-4101				
	Email:	jane@phsneb.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Fillmore County Hospital	Fillmore	NE	Hospital
	Beatrice Community Hospital	Gage	NE	Non-Profit Hospital
	Jefferson Community Health Center	Jefferson	NE	County Hospital
	Crete Area Medical Center	Saline	NE	Non-Profit Hospital
	Warren Memorial Hospital	Saline	NE	City Owned Hospital
	Thayer County Health Services	Thayer	NE	County Hospital
	Public Health Solutions	5 County	NE	District Health Dept

The communities/counties the project serves:	All communities within the counties of Fillmore, Gage, Jefferson, Saline, and Thayer in Nebraska.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)people of all cultures and race	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce	X

			Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging	X	Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	X
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology	X	Other: (please describe)	

Evidence Based Model Being Used or Adapted:	SF-12 Health Survey; Patient Activation Measure Assessment Tool (PAM-13); Lincoln ED Connection program; Pathways Model; National Diabetes Education Program; National Diabetes Education Risk Assessment Form.
Description of the project:	This project will establish collaborative care coordination, case management program and preventive services among 6 rural hospitals and a local health department. The project will work to reduce the use of the ER for primary care and increase the number with medical homes. In addition, through case management and collaboration those enrolled will improve compliance, increase self-care and the use of preventive services. Overall the inappropriate use of ER and uncompensated care will be reduced.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn 17W-31B				
	City:	Rockville	**State:**	MD	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0283				
	Fax #:	404-413-0316				
	Email:	jbutts@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Hampshire

Mary Hitchcock Memorial Hospital/ Dartmouth-Hitchcock Medical Center

Grant Number:	D04RH23597					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Non-profit Organization					
Grantee Organization Information:	**Name:**	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Cntr				
	Address:	1 Medical Center Drive				
	City:	Lebanon	**State:**	New Hampshire	**Zip code:**	03756
	Tel #:	603-650-5000				
	Fax #:					
	Website:	www.dartmouth-hitchcock.org				
Primary Contact Information:	**Name:**	Sarah N. Pletcher				
	Title:	Project Director/Principal Investigator				
	Tel #:	603-653-0424				
	Fax #:	603-727-7462				
	Email:	Sarah.n.pletcher@hitchcock.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$175,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Dartmouth-Hitchcock Medical Center	Grafton	NH	Level I Trauma and Academic Center
	New London Hospital	Merrimack	NH	CAH (Rural)
	Upper Connecticut Valley Hospital	Coos	NH	CAH (Rural)
	Weeks Medical Center	Coos	NH	CAH (Rural)
	Northeastern Vermont Regional Hospital	Caledonia	VT	CAH (Rural)
	Cottage Hospital	Grafton	NH	CAH (Rural)
	Valley Regional Hospital	Sullivan	NH	CAH (Rural)
	Alice Peck Day Memorial Hospital	Grafton	NH	CAH (Rural)
	Gifford Medical Center	Orange	VT	CAH (Rural)
	Mt. Ascutney Hospital and Health Center	Windsor	VT	CAH (Rural)
	Springfield Hospital	Windsor	VT	COM (Rural)
	North Country Hospital	Orleans	VT	CAH (Rural)
	Brattleboro Memorial Hospital	Windham	VT	COM (Rural)
	Cheshire Medical Center	Cheshire	NH	COM (Rural)
	Grace Cottage Hospital	Windham	VT	CAH (Rural)
	Monadnock Community Hospital	Hillsborough	NH	CAH (Rural)
	Speare Memorial Hospital	Grafton	NH	CAH (Rural)

The communities/counties the project serves:	Eleven counties throughout New Hampshire and Vermont with a total population of 979,219.

The target population served:	**Population**	**Male**	**Female**
	Infants	X	X
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X

	Adults		X	X
	Elderly		X	X
	Pregnant Women			X
	Caucasians		X	X
	African Americans		X	X
	Alaska Natives			
	Asians			
	Hispanics		X	X
	Native Americans		X	X
	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X
	Other: (please describe)			
	Other: (please describe)			

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	X
	Access: Specialty Care	X	Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	X
	Emergency Medical Services	X	Transportation to health services	
	Health Education and Promotion	X	Other: Provider Education	X
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Outreach Department of the Eastern Maine Medical Center (http://www.emmc.org/outreach.aspx); Project ECHO at the University of New Mexico (http://echo.unm.edu/); eEmergency at the AVERA Health System in South Dakota (http://www.avera.org/ecare/eemergency/); Georgia Trauma Commission (http://www.georgiatraumacommission.org/); Emergency Care at Fletcher Allen / the University of Vermont (http://www.fletcherallen.org/services/emergency_department/); Trauma & Surgical Critical Care at the University of Arizona (http://www.uahealth.com/services/trauma-surgical-critical-care); Trauma at the Good Samaritan Hospital in Nebraska (http://www.gshs.org/body.cfm?id=87)
Description of the project:	The focus of the grant program is to improve emergency and trauma care provided in northern New England through support of local care via the expansion of telemedicine and educational services; and improving the quality and value of care provided in connection with patient transfers and tertiary care. This program will focus on the following services and activities: 1) Establish CREST Tele-ED: an emergency department-based Trauma Telemedicine Consult service • Implement a telemedicine network offering 24/7, live, two-way video consult of trauma patients in rural hospital emergency departments 2) Strengthen rural emergency healthcare through provider education, skills training, quality improvement, and best practices / protocol sharing • Create a Virtual Library as an online, multimedia platform for lectures, skill training videos, podcasts, etc. • Enhance and expand access to educational offerings • Support a rural rotation for emergency medicine residents and students 3) Broaden rural emergency network through expansion, linkages, sustainability and strategic planning

Office of Rural Health Policy Project Officer:	**Name:**	Sheila M. Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Email:	swarren@hrsa.gov				
	Address:	MailStop Code: Parklawn, 17W-29C, HRSA/ORHP, 5600 Fishers Ln				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20852
Technical Assistance Consultant's Contact Information:	**Name:**	Catherine Liemohn, MPP				
	Title:	Technical Assistance Consultant				
	Tel #:	770-641-9940				
	Fax #:	770-641-0799				
	Email:	liemohn@bellsouth.net				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Hampshire

Mid-State Health Center

Grant Number:	D04RH23600					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC Look-Alike					
Grantee Organization Information:	**Name:**	Mid-State Health Center on behalf of Central NH Health Partnership				
	Address:	101 Boulder Point Drive, Suite 1				
	City:	Plymouth	**State:**	New Hampshire	**Zip code:**	03264
	Tel #:	603-536-4000				
	Fax #:	603-536-4001				
	Website:	www.midstatehealth.org				
Primary Contact Information:	**Name:**	Sharon Beaty, CEO				
	Title:	Vice President of CNHHP				
	Tel #:	603-536-4000				
	Fax #:	603-536-4001				
	Email:	sbeaty@midstatehealth.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$135,645.00
	May 2013 to Apr 2014	$147,202.40
	May 2014 to Apr 2015	$148,857.25

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Speare Memorial Hospital	Grafton	NH	Hospital
	Mid-State Health Center	Grafton	NH	FQHC Look-Alike
	Genesis Behavioral Health	Grafton	NH	Community Mental Health Center
	Pemi-Baker Community Health	Grafton	NH	Medicare Certified Home Health Agency
	Newfound Area Nursing Association	Grafton	NH	Medicare Certified Home Health Agency
	Community Action Program Belknap-Merrimack Counties	Regional	NH	Community Action Program
	Communities for Alcohol and Drug-Free Youth	Grafton	NH	Substance Abuse Prevention Coalition

The communities/counties the project serves:	Alexandria, Ashland, Bridgewater, Bristol, Campton, Danbury, Dorchester, Ellsworth, Grafton, Groton, Hebron, Holderness, Lincoln, New Hampton, Orange, Plymouth, Rumney, Thornton, Waterville Valley, Wentworth, and Woodstock.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X

	Underinsured		X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging	X	Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion		Other: Care Transitions	X
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The Project model is based on elements of the following evidence-based care transitions models: BOOST; Project Red; Eric Coleman's Care Transitions Model.
Description of the project:	The Plymouth Area Transition Team Project seeks to provide area residents at risk for hospital readmission and unnecessary Emergency Department visits with care transition services to ameliorate these types of encounters with the health care system. The Project uses a full-time Transition Care Manager to provide inpatients who are identified as high-risk with the enhanced support required to achieve positive health outcomes post-discharge. The Transition Care Manager will work across multiple settings to ensure that patient and provider education empowers and reinforces self-care strategies. The inter-agency interface between the Transition Care Manager and the Plymouth Area Transition Team members will facilitate the implementation of assessment and quality improvement activities needed to ensure the highest level of care transition processes within our community. The Transition Care Manager will begin to plan for discharge at the time of admission, meeting with patients/families and the hospital Discharge Team to determine the most appropriate post-discharge treatment plan. Post-discharge follow-up by the Transition Care Manager will include telephone contact and in-home visitation of the patient, as well as inter-disciplinary communications with facilities providing care to the patient. Assessment of patients' need for success will include social issues and barriers to adequate follow-through on treatment plan goals, especially transportation barriers, which have been identified as a significant factor in patients' inability to adhere to treatment plans in our community. The Transition Care Manager will serve as a "barriers resource', assisting in obtaining needed transportation and networking of transportation resources.

Office of Rural Health Policy Project Officer:						
	Name:	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:						
	Name:	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

New Hampshire

North Country Health Consortium

Grant Number:	D04RH23607					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Rural Health Network					
Grantee Organization Information:	**Name:**	North Country Health Consortium				
	Address:	262 Cottage Street, suite 230				
	City:	Littleton	**State:**	New Hampshire	**Zip code:**	03561
	Tel #:	603-259-3700				
	Fax #:	603-444-0945				
	Website:	Nchcnh.org				
Primary Contact Information:	**Name:**	Nancy Frank				
	Title:	Executive Director				
	Tel #:	603-259-3700				
	Fax #:	603-444-0945				
	Email:	nfrank@nchcnh.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Coos County Family Health Services	Coos	NH	FQHC
	Ammonoosuc Community Health Services	Grafton	NH	FQHC
	Indian Stream Community Health Services	Coos	NH	FQHC
	Northern Human Services	Coos	NH	Community Mental Health Agency
	Mid-State Health Center	Grafton	NH	FQHC "look alike"
	Catholic Charities	Coos/Grafton	NH	Social Service Organization
	State Office of Rural Health	Statewide	NH	State Agency

The communities/counties the project serves:	Coos and Northern/Central Grafton Counties

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		

	Uninsured		X	X
	Underinsured		X	X
	Other: (please describe)			

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The Molar Express Expansion Project incorporates a promising practice (dental disease management initiative) and an evidence-based model (sealant initiative) into service deliver for children. The Dental Sealant Initiative is based on recommendations from the American Dental Association Council on Scientific Affairs' first evidence-based clinical recommendations for the use of sealants. The expert panel concluded that sealants are effective to prevent the initiation and progression of dental caries. The Molar Express Expansion Project has increased the number of children with access to preventive and restorative dental care, including dental sealants. The promising practice implemented through the Expansion Project is an enhanced dental disease management initiative focused on risk-based treatment and patient education. The practice initiative has been an adapted CAMBRA model (Caries Management By Risk Assessment). The key components are a treatment plan that combines restorative treatment with preventive measures and ongoing patient education.
Description of the project:	This project involves the Molar Express, a mobile public health dental clinic, which has been providing services predominantly to Medicaid eligible children in school settings in New Hampshire's North Country since 2005. The Molar Express is operated by the North Country Health Consortium, a mature, vertical, rural health network, dedicated to improving access to health care to the citizens of Northern and central New Hampshire. The goal of the Rural Health Care Services Outreach Grant Program is to provide oral health care services to children who are uninsured and underinsured, and who otherwise would not have access to care. The Molar Express expansion project extends its service area and number of at-risk children that will be served. It will enhance the service delivery model to incorporate new prevention and management protocols based on caries risk assessment, initiate a dental sealant program, and improve oral health knowledge through a comprehensive program of education on good oral health.

Office of Rural Health Policy Project Officer:						
	Name:	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	SWarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

New Mexico

Ben Archer Health Center

Grant Number:	D04RH23559					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Ben Archer Health Center				
	Address:	P.O. Box 370				
	City:	Hatch	**State:**	New Mexico	**Zip code:**	87937
	Tel #:	575-267-3080				
	Fax #:	575-267-1747				
	Website:	www.Bahcnm.org				
Primary Contact Information:	**Name:**	Kara Bower				
	Title:	Program Director				
	Tel #:	575-373-3096				
	Fax #:	575-373-1029				
	Email:	kbower@bahcnm.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners	**Partner Organization**	**County**	**State**	**Organizational Type**
	Luna County Health Council	Luna	NM	Health Council
	Binational Health Council	Luna	NM	Health Council
	NM State Department of Health, Public Health	Luna	NM	Health Department
	NM State Department of Health, Office of Border Health	Luna	NM	Health Department
	Luna County Healthy Start	Luna	NM	Early Childhood
	Deming Senior Center	Luna	NM	Senior Services
	Southern NM Promotora Committee	Luna	NM	Community Health Worker
	Andrew Sanchez Center	Luna	NM	Senior Services

The communities/counties the project serves:	Luna County, New Mexico

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**		
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	X		
	Access: Specialty Care		Integrated Systems of Care			
	Aging		Maternal/Women's Health			
	Behavioral/Mental Health	X	Migrant/Farm Worker Health			
	Children's Health	X	Oral Health			
	Chronic Disease: Cardiovascular		Pharmacy Assistance			
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition			
	Chronic Disease: Other		School Health			
	Community Health Workers /Promotoras	X	Substance Abuse			
	Coordination of Care Services	X	Telehealth			
	Emergency Medical Services		Transportation to health services	X		
	Health Education and Promotion	X	Other: (please describe)			
	Health Information Technology		Other: (please describe)			
Evidence Based Model Being Used or Adapted:	• Stanford School of Medicine Chronic Disease Management Model • Eye Movement Desensitization and Reprocessing (EMDR)					
Description of the project:	Different components of this project will serve different population groups to include; patients diagnosed with diabetes, persons at risk of developing diabetes, the vulnerable populations of seniors and young children, Spanish-speaking immigrants and non-immigrants, isolated and hard to reach county residents, and people exposed to border violence. The following health issue areas are being directly addressed by this project: improved access and increased usage and availability of behavioral health services, increased rates of senior adult and childhood immunizations, decreased prevalence of diabetes, and complications of diabetes. Project staff will develop and implement a multi-dimensional comprehensive community evidence-based approach to diabetes management and prevention, to include diabetes management classes for patients and families, prevention education in the schools, development of implementation of a protocol to address diabetes related depression, and a community exercise campaign. The project will include the recruitment and development of new promotoras both in Luna County and the Palomas Promotora Corps. The project will implement a culturally-appropriate promising practice immunization methodology utilizing door-to-door outreach campaigns. This project will respond to the growing need for behavioral health services in the community of Columbus resulting from the violence along the US/Mexico border. Expected outcomes of the proposed services to the community's health status include a reduction the onset of diabetes and complications from diabetes, improved behavioral health of Luna County residents to include a reduction in depression related to diabetes, an increase in immunization rates among senior adults and young children, and an increase in the workforce and capacity of promotoras in Palomas, Mexico and Luna County.					
Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-2803				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tanisa Adimu, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Fax #:	404-413-0302				
	Email:	tadimu@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New Mexico

Hidalgo Medical Services

Grant Number:	D04RH23581					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	Hidalgo Medical Services				
	Address:	530 DeMoss St.				
	City:	Lordsburg	**State:**	New Mexico	**Zip code:**	88045
	Tel #:	575-542-8384				
	Fax #:	575-542-8251				
	Website:	www.hmsnm.org				
Primary Contact Information:	**Name:**	Carmen Maynes				
	Title:	Community Organizational Development Director				
	Tel #:	575-494-4754				
	Fax #:	575-534-0594				
	Email:	cmaynes@hmsnm.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	La Frontera	Grant/Hidalgo/ Luna/Catron	NM	Core Service Agency – Mental Health Services
	Gila Regional Medical Services	Grant	NM	Hospital

The communities/counties the project serves:	Grant and Hidalgo counties. Patients living in the surrounding Counties may also receive services if they need care coordination after receiving care at any of the consortium service sites.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The Healthy Community Connections program is based on the principle that when an individual reaches their wellness capacity all systems attached to that individual benefit, including the individual itself. The program follows the care coordination model that has already proved capable of improving people's health outcomes through an initial assessment, home visits and follow up throughout the month and every month. In addition, the community connector establishes a relationship with the service providers who are part of the care team. These relationships serves as a bridge between the client and the services that they need to reach a healthier outcome. While patient advocacy is an important role for the Community Connectors, assisting the client with learning self-management of their own issues is the highest priority of each Community Connector.
Description of the project:	Access to quality care for uninsured individuals remains a major problem. There is a strong link between the uninsured status and access to preventive care, primary care, acute care, and chronic illness management; uninsured individuals have are at an increased risk of adverse health outcomes, such as health and functional decline, the existence of preventable health problems, advanced disease at time of diagnosis, and premature death. Individuals living in poverty tend to have more chronic illnesses and health complications, and make greater demands on the health care system. Currently, the uninsured rate for adults in New Mexico is at 18.9% after ACA efforts. Data from May 2014 according to data from Be Well NM, this number compared to new 13.4% for the US after ACA efforts. The Consortium will target uninsured patients of Hidalgo Medical Services between the ages of 19 – 64 with identified diagnoses including, hypertension, diabetes, depression and anxiety. Individuals will be referred to the Community Connection program and will receive intense care coordination from Community Connectors. The Community Connections program is a social/medical care coordination model that integrates social supportive services and health needs of individuals and families. Community Connectors will work with the referred individual and family member to improve health outcomes by providing health education, medical home establishment, assisting individuals and families with social needs such as transportation, medication assistance, energy assistance, cash assistance, and assistance in applying for publicly funded insurance programs. The goal of the program is: The Community Connections Consortium members will collaborate to provide care coordination services to uninsured individuals and families, including access to primary care and social support services, which will improve the quality of life of program participants.

Office of Rural Health Policy Project Officer:	**Name:**	Valerie Darden				
	Title:	Captain, United States Public Health Service				
	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Amanda Philips Martinez, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0293				
	Fax #:	404-413-0316				
	Email:	aphillipsmartinez@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New York

Chautauqua County Health Network

Grant Number:	D04RH23564					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Rural Health Network					
Grantee Organization Information:	**Name:**	Chautauqua County Health Network				
	Address:	200 Harrison St.				
	City:	Jamestown	**State:**	New York	**Zip code:**	14701
	Tel #:	716-338-0010				
	Fax #:	716-338-9740				
	Website:	www.cchn.net				
Primary Contact Information:	**Name:**	Ann Abdella				
	Title:	Executive Director				
	Tel #:	716-338-0010				
	Fax #:	716-338-9740				
	Email:	abdella@cchn.net				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Chautauqua County Office for the Aging	Chautauqua	NY	Government
	Heritage Ministries	Chautauqua	NY	Healthcare Facility
	Lakeshore Nursing Facility	Chautauqua	NY	Healthcare Facility
	Long Term Care Council	Chautauqua	NY	Consortium

The communities/counties the project serves:	Chautauqua County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults		
	Elderly	X	X
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		
	Other: Medicare FFS	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging	X	Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology	X	Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Guided Care Nursing (John Hopkins School of Public Health); Patient Centered Medical Home (NCQA); Patient Activation Measure (Insignia Health); Care Transitions Intervention (Eric Coleman Model); Chronic Care Model (The MacColl Center for Healthcare Innovation); Early Phase Aging and Disability Resource Center; and Health Information Exchange
Description of the project:	The project is called **Chautauqua Health Connects**, an "intra-county" health information exchange to support high quality care management. This project emerged from the Long Term Care Council of Chautauqua County (LTCC), which received an ORHP Planning Grant in 2010. Through that process, a Strategic Plan was developed for rebalancing the continuum of long term care services. Funding will be used to advance the goal of improving coordination of services for seniors and allowing them to remain in their homes. Chautauqua County Health Network will collaborate with roughly twenty-four healthcare organizations to create the infrastructure and resources needed to achieve this goal. **Chautauqua Health Connects** involves linking organizations through a HIPPA compliant web-based health information exchange, training and deploying Nurse Care Managers and/or care coordinators, and standardizing communication procedures between organizations. The exchange will enable the electronic transfer of secure messages and referrals, improving information flow and strengthening communications among health care providers and community based services. Organizations will be trained on the importance of implementing best practices that will affect positive healthcare goals. Tools include but are not limited to: Patient Centered Medical Home, Aging and Disabilities Resource Centers, Chronic Disease Self Management, Guided Care Solutions, the Chronic Care Model, and health information exchange. While the plan will encompass all Medicare fee for service individuals it will devote special attention on approximately 900 complex chronically ill Medicare fee for service beneficiaries.

Office of Rural Health Policy Project Officer:						
	Name:	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn Building 17W – 31B				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

New York

Chautauqua Opportunities Incorporated

Grant Number:	D04RH23565					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Community Action Agency					
Grantee Organization Information:	**Name:**	Chautauqua Opportunities Incorporated				
	Address:	17 West Courtney Street				
	City:	Dunkirk	**State:**	New York	**Zip code:**	14048
	Tel #:	716-366-3333				
	Fax #:	716-366-7366				
	Website:	www.chautauquaopportunities.com				
Primary Contact Information:	**Name:**	Tarra C. Johnson				
	Title:	Health Support Services Manager				
	Tel #:	716-366-8176 Ext. 3307				
	Fax #:	716-366-4502				
	Email:	tcjohnson@chautopp.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Information Resources and Associates	Wyoming	NY	Consultant
	Health & Nutrition Educator	Chautauqua	NY	RN
	Lakeview SICF	Chautauqua	NY	Correctional Facility
	Salamanca Youth Bureau	Cattaraugus	NY	Youth Bureau
	Chautauqua Lake Children's Center	Chautauqua	NY	Day Care – Chautauqua Lake School District
	Lakeshore Family Center	Chautauqua	NY	Daycare – Silver Creek School District

The communities/counties the project serves:	Chautauqua County, NY; Cattaraugus County, NY

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: Obesity Prevention	X
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	CATCH We Can! The Group Lifestyle Balance (GLB) Program American Diabetes Association – DSME Program
Description of the project:	Obesity prevention activities will target children in schools because they are an ideal place for reaching the greatest number of young people. Individuals that are at high risk for becoming diabetic will be targeted for diabetes prevention activities that focus on weight loss. Diagnosed diabetics will be provided with case management that will help them to self-manage their disease and prevent associated conditions such as high blood pressure, heart disease, kidney disease, or foot ulcers. Our comprehensive approach will utilize several evidence-based models: • CATCH Kids Club (CKC) is a physical activity and nutrition education program for elementary school-aged children (grades K–5) in after school or summer-care settings. CATCH uses a coordinated approach to help children adopt healthier dietary and physical activity behaviors by positively influencing the health environments of recreation programs, schools, and homes. • We Can! (Ways to Enhance Children's Activity and Nutrition) provides activities and programs that encourage improved nutritional choices, increased physical activity, and reduced screen time in youth ages 8-13. • The *School Health Index* (SHI) will be used when working with School health Advisory Committees (SHAC's) to conduct a Needs Analysis of health and wellness policies and practices. • The Group Lifestyle Balance (GLB) Program is a comprehensive lifestyle behavior change group–based program that will be delivered to pre-diabetic clients under the program • Diabetes self-management education and prevention activities will follow Guiding Principles that were developed by the American Diabetes Association in its *Standards of Medical Care in Diabetes 2009.* These guiding principles form the basis of the National Diabetes Education Program and are based on a high level of evidence. • The model includes the services of a bilingual Community Health Worker (CHW) to deliver community-based obesity prevention education, assistance with identifying clients with gestational diabetes, and translation services.

Office of Rural Health Policy Project Officer:						
	Name:	Shelia Tibbs				
	Title:	Rural Health Outreach Project Officer				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Rachel Campos, MPH/John Butts, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0334				
	Fax #:	404-413-0316				
	Email:	rcampos1@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

North Carolina

Partnership for Children of the Foothills

Grant Number:	D04RH25707					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Non-profit					
Grantee Organization Information:	**Name:**	Partnership for Children of the Foothills				
	Address:	338 Withrow Road, Suite B				
	City:	Forest City	**State:**	North Carolina	**Zip code:**	28043
	Tel #:	828-245-2802				
	Fax #:	828-245-8473				
	Website:	www.pfcfoothills.org				
Primary Contact Information:	**Name:**	M. Barry Gold				
	Title:	Executive Director				
	Tel #:	828-245-2802				
	Fax #:	828-245-8473				
	Email:	barry@pfcfoothills.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$148,378
	May 2013 to Apr 2014	$148,910
	May 2014 to Apr 2015	$149,471

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Rutherford-Polk-McDowell District Health Department	Rutherford, Polk, McDowell	NC	Public Health District
	North Carolina Oral Health Section	Rutherford, Polk, McDowell	NC	NC DHHS
	Mission Children's Hospital	Buncombe	NC	Regional non-profit hospital system
	Rutherford Regional Medical Center	Rutherford	NC	Hospital
	Polk County NC Pre-K and Head Start Programs	Polk	NC	Public Schools
	Rutherford Head Start	Rutherford	NC	Public Schools
	McDowell Technical Community College	McDowell	NC	Community College
	Centro Unido	McDowell	NC	Non-profit
	Corpening Memorial YMCA	McDowell	NC	Non-profit

The communities/counties the project serves:	McDowell, Rutherford and Polk counties in Western North Carolina

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)		
	Adults		
	Elderly		
	Pregnant Women		X
	Caucasians	X	X

	African Americans		X	X
	Alaska Natives			
	Asians		X	X
	Hispanics		X	X
	Native Americans			
	Pacific Islanders			
	Uninsured		X	X
	Underinsured		X	X
	Other: (please describe)			
	Other: (please describe)			

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The Dental Home Model: Screening, Education, Referral, Case Management & Restorative Services. The project focuses on the concept of identifying and establishing young children with dental homes as an oral health prevention strategy. The Dental Home is supported by the American Academy of Pediatric Dentistry and the American Dental Association as a best practice.
Description of the project:	Healthy Smiles: Early Childhood Dental Outreach targets children enrolled in child care centers with limited oral exams and education. It also provides education and outreach to expectant mothers, children not enrolled in child care, and the Latino community through community dental screenings and education events. The project focuses on the concept of identifying and establishing young children with dental homes as an oral health prevention strategy. The Dental Home is supported by the American Academy of Pediatric Dentistry and the American Dental Association as a best practice. It builds upon three evidence-based strategies for dental health, which include fluoridation of drinking water, fluoride varnishing and sealant projects. The Healthy Smiles project is similar to the Carolina Dental Home promising-practice model, but targets children in child care settings instead of through primary care practices. We will provide 965 children with access to new and expanded programs and services each year, including limited oral exams, assistance with Medicaid enrollment, case management for establishing a dental home, and restorative dental services if needed. Kindergarteners that need restorative dental care who were not enrolled in early childhood programs may also receive assistance.

Office of Rural Health Policy Project Officer:						
	Name:	Lilly Smetana				
	Title:	Public Health Analyst				
	Tel #:	301-443-6884				
	Email:	301-443-2803				
	Address:	lsmetana@hrsa.gov				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Tanisa Adimu, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Fax #:	404-413-0316				
	Email:	tadimu@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Ohio

Fostoria Community Hospital

Grant Number:	D04RH23573					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Fostoria Community Hospital				
	Address:	501 Van Buren St.				
	City:	Fostoria	**State:**	Ohio	**Zip code:**	44830
	Tel #:	419-435-7734				
	Fax #:					
	Website:	www.promedica.org				
Primary Contact Information:	**Name:**	Amy L. Preble RN, BSN, MBA				
	Title:	Director Emergency Services				
	Tel #:	419-436-6854				
	Fax #:	419-436-6671				
	Email:	amy.preble@promedica.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$149,967
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Bixby Hospital	Lenawee	OH	Hospital
	Herrick Hospital	Lenawee	OH	Hospital
	Madison Twp Fire/EMS	Lenawee	OH	County
	Lenawee Health Network	Lenawee	OH	County
	Toledo Hospital Cath Lab	Lucas	OH	Hospital
	ProMedica Transportation Network	Lucas	OH	Hospital
	Northwest Ohio Cardiology Consultants	Lucas	OH	Physician Group
	Emergency Physicians of Northwest OH	Seneca	OH	Physician Group
	Seneca County EMS	Seneca	OH	County
	Fostoria Fire/EMS	Seneca	OH	City

The communities/counties the project serves:	City of Fostoria (Seneca, Hancock, Wood Counties in Ohio), Lenawee County in Michigan

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care	X	Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services	X	Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology	X	Other: (please describe)	

Evidence Based Model Being Used or Adapted:	American Heart Association "Get with the Guidelines" recommendations. Door to PCI time recommendations and Door to Door to PCI time recommendations for patients demonstrating elevated ST segment on 12 lead EKG.
Description of the project:	Develop and implement STEMI network, using technology, to connect first responders to Emergency Departments to transmit 12-lead EKGs. Develop processes and protocols to efficiently move these critically ill patients through the health care system. Placement of AEDs, patient transport, and education is also an important aspect of the program.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Project Officer, Community-Based Division				
	Tel #:	301-443-0246				
	Email:	SWarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact	**Name:**	Catherine Liemohn, MPP				
	Title:	Technical Assistance Consultant				
	Tel #:	770-641-9940				
	Fax #:	770-641-0799				
	Email:	liemohn@bellsouth.net				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Ohio

Trinity Hospital Twin City

Grant Number:	D04RH23617					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Trinity Hospital Twin City				
	Address:	819 N. First Street				
	City:	Dennison	**State:**	Ohio	**Zip code:**	44621
	Tel #:					
	Fax #:					
	Website:	www.trinitytwincity.org				
Primary Contact Information:	**Name:**	Tiffany Poland				
	Title:	Project Coordinator				
	Tel #:	740-922-7471				
	Fax #:	740-922-6945				
	Email:	tpoland@trinitytwincity.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$125,000
	May 2014 to Apr 2015	$100,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Trinity Health System	Jefferson	OH	Hospital
	Holmes County General Health District	Holmes	OH	Health Department
	Dr. Timothy McKnight	Tuscarawas	OH	Medical Office

The communities/counties the project serves:	Tuscarawas, Carroll, Harrison, Jefferson and Holmes Counties, Ohio

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	

Children's Health		Oral Health	
Chronic Disease: Cardiovascular		Pharmacy Assistance	
Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras		Substance Abuse	
Coordination of Care Services		Telehealth	
Emergency Medical Services		Transportation to health services	
Health Education and Promotion	X	Other: (please describe)	
Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:

The Fit for Life curriculum closely resembles that of the Weight-Wise Program, an evidence-based best practice model conducted by the Center for Health Promotion and Disease Prevention at the University of North Carolina at Chapel Hill. Weight-Wise is a research-tested, behavioral weight management program designed to help women lose weight safely by focusing on changing lifestyle behaviors to promote weight loss.

Description of the project:

Trinity Hospital Twin City's Fit for Life Program provides health education and promotion through Fit for Life wellness and disease prevention classes designed specifically for adult men and women who want to learn how to lead healthy lifestyles. These adults receive a 12 week session of classes that meet once weekly for 60 minutes on such lecture topics as stress management, nutrition, healthy eating, reading food labels, fitness, disease prevention, healthy aging and more. In the Fit for Life Program, individual instruction is provided by the Program Director, who is a Medical Doctor and Board Certified Family Practitioner. Additional Fit for Life professional presenters include a chiropractor, dietitian, psychologist, renowned coach, fitness instructor, and wellness educator.

The ultimate goal of the Fit for Life classes is not necessarily weight loss; the ultimate goal is to improve overall health, with weight loss being a natural outcome. Fit for Life project success is evaluated through participant satisfaction surveys and knowledge tests and the results of specific health measurements including weight, waist circumference, body mass index (BMI), body fat percentage, cholesterol and blood pressure.

Secondly, the Fit for Life Program provides a standardized curriculum for replication of Fit for Life as a best practice. Specifically, the Project Director and staff work with editors, printers and adult curriculum specialists to formalize the existing Fit for Life curriculum that was developed by Project Director Dr. McKnight. Products of the standardization will be a manual for trainers and a manual for Fit for Life participants. Dr. McKnight will educate staff from the consortium member agencies utilizing a train the trainer approach. The new trainers will, in turn, conduct their own Fit for Life classes within their counties of Carroll, Harrison and Holmes.

Third, Trinity Hospital Twin City's Fit for Life Program provides health and wellness information on the Hospital website at www.trinitytwincity.org in order to improve access to health information.

Office of Rural Health Policy Project Officer:

Name:	Shelia Tibbs				
Title:	Senior Public Health Analyst				
Tel #:	301-443-4304				
Email:	STibbs@hrsa.gov				
Address:	5600 Fishers Lane				
City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:

Name:	Beverly Tyler				
Title:	Technical Assistance Consultant				
Tel #:	404-413-0288				
Fax #:	404-413-0316				
Email:	btyler@gsu.edu				
Address:	14 Marietta Street, NW, Suite 221				
City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Oregon

La Clinica del Cariño Family Health Center

Grant Number:	D04RH23587					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	FQHC					
Grantee Organization Information:	**Name:**	La Clinica del Cariño Family Health Center, dba One Community Health				
	Address:	849 Pacific Ave.				
	City:	Hood River	**State:**	Oregon	**Zip code:**	97031
	Tel #:	541-386-6380				
	Fax #:	541-386-1078				
	Website:	www.lcdcfh.org				
Primary Contact Information:	**Name:**	Paul Moyer				
	Title:	PA-c., Health Promotion Manager				
	Tel #:	541-386-6380, ext.1325				
	Fax #:	541-386-1078				
	Email:	pmoyer@lcdcfh.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Providence Hood River Memorial Hospital	Hood River	Oregon	Hospital & clinical Health Services
	Klickitat County Health Department	Klickitat	Washington	County Health Department
	The Next Door, Inc.'s "Nuestra Comunidad Sana"	Hood River & Wasco	Oregon	Non-profit, Social Services Agency

The communities/counties the project serves:	Hood River, Wasco, Klickitat, Skamania

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: Monolingual Spanish or English speaking	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**		
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development			
	Access: Specialty Care		Integrated Systems of Care			
	Aging		Maternal/Women's Health			
	Behavioral/Mental Health		Migrant/Farm Worker Health	X		
	Children's Health		Oral Health			
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance			
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X		
	Chronic Disease: Other		School Health			
	Community Health Workers /Promotoras	X	Substance Abuse			
	Coordination of Care Services	X	Telehealth			
	Emergency Medical Services		Transportation to health services			
	Health Education and Promotion	X	Other: (please describe)			
	Health Information Technology		Other: (please describe)			
Evidence Based Model Being Used or Adapted:	Promising Practices: (1) Community educational series curriculum, "Steps to Wellness/Pasos a Salud" (2) CHW/RN chronic disease clinical-care coordination team					
Description of the project:	Our project will provide community health education opportunities to low-income people focusing on diet, physical exercise, and stress reduction utilizing our 12-week wellness course curriculum. We will also expand our in-clinic patient care coordination and outreach activities to enhance management and prevention of hypertension, dyslipidemia, obesity and diabetes. Specific activities will include: teaching tools for prevention and self-management of chronic diseases, teaching exercise options and promoting weekly exercise planning individually, teaching healthy nutritional practices, objectively measuring for early detection and monitoring glucose levels, blood pressures, lipid levels, BMIs as well as individual's self-management plans and actions in an overall effort to stress the importance of these measurements and healthy behavioral changes. Where possible these measurements and knowledge exchanges will be in conjunction with participant's Primary Care Medical Homes and/or medical providers. These activities will occur in various settings, e.g., during community member screenings in orchards, in-clinic labs for wellness course participants, in-clinic patient care coordination team encounters, and weekly wellness course presentations in 12 week series.					
Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Beverly Tyler				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0288				
	Fax #:	404-413-0316				
	Email:	btyler@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Oregon

Samaritan North Lincoln Hospital

Grant Number:	D04RH23613					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Critical Access Hospital					
Grantee Organization Information:	**Name:**	Samaritan North Lincoln Hospital				
	Address:	3043 NE 28th Street				
	City:	Lincoln City	**State:**	Oregon	**Zip code:**	97367
	Tel #:	541-994-3661				
	Fax #:					
	Website:					
Primary Contact Information:	**Name:**	JoAnn Miller				
	Title:	Community Health Promotion Director				
	Tel #:	541-768-7330				
	Fax #:	541-451-7578				
	Email:	jomiller@samhealth.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,165
	May 2013 to Apr 2014	$149,387
	May 2014 to Apr 2015	$149,782

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Lebanon Community School District	Linn	OR	Public School
	Neighbors For Kids	Lincoln	OR	Non-Profit
	Yachats Youth & Family Program	Lincoln	OR	Non-Profit
	Oregon State University	Benton	OR	University
	Lincoln County Health & Human Services	Lincoln	OR	Health Department
	Linn County Health Administration	Linn	OR	Health Department
	East Linn Health Center	Linn	OR	FQHC
	Samaritan Lebanon Community Hospital	Linn	OR	Hospital
	Samaritan Pacific Communities Hospital	Lincoln	OR	Hospital
	Community Services Consortium	Lincoln	OR	Non-Profit
	Lincoln Community Health Center	Lincoln	OR	FQHC
	Samaritan Albany General Hospital	Linn	OR	Hospital
	Benton County Health Department	Benton	OR	Health Department
	Sweet Home School District	Linn	OR	Public School
	Philomath School District	Benton	OR	Public School
	Community Outreach, Inc.	Linn	OR	Non-profit
	Oregon Cascades West Council of Gov.	Lincoln	OR	Non-profit

The communities/counties the project serves:	Lincoln and Linn Counties Oregon

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X

	Alaska Natives			
	Asians		X	X
	Hispanics		X	X
	Native Americans			
	Pacific Islanders			
	Uninsured			
	Underinsured			
	Other: (please describe)			
	Other: (please describe)			

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The evidence based model being used is called the Coordinated Approach to Child Health (CATCH). CATCH is backed by 25 years of research and experience of providing nutrition education, physical activities, outreach to parents, classroom curriculum, afterschool programs and early childhood services. The goal of CATCH is to teach children to be healthy throughout their lifetime.
Description of the project:	The project will implement an evidence-based physical fitness and nutrition program called Coordinated Approach to Child Health (CATCH) in 12 in-school programs, seven after-school programs and three early childhood programs in Lincoln and Linn Counties in Oregon. The target population is low-income children, however the programs are open to all children in each setting. Approximately 4,000 children will receive physical fitness and nutrition education and services throughout the life of the grant.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Rural Health Outreach Project Officer				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Rachel Campos, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0334				
	Fax #:	404-413-0316				
	Email:	rcampos1@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Pennsylvania

Armstrong-Indiana-Clarion Drug and Alcohol Commission

Grant Number:	D04RH23557					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Private, Non-Profit 501(c)3					
Grantee Organization Information:	**Name:**	Armstrong-Indiana-Clarion Drug and Alcohol Commission				
	Address:	10829 US Route 422, P.O. Box 238				
	City:	Shelocta	**State:**	Pennsylvania	**Zip code:**	15774
	Tel #:	724-354-2746				
	Fax #:	724-354-3132				
	Website:	www.aidac.org				
Primary Contact Information:	**Name:**	Kami Anderson				
	Title:	Executive Director				
	Tel #:	724-354-2746				
	Fax #:	724-354-3132				
	Email:	kanderson@aicdac.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	ARC Manor	Armstrong	PA	D & A Treatment
	Armstrong County Memorial Hospital	Armstrong	PA	Hospital
	Armstrong-Indiana-Clarion Drug and Alcohol Commission	Armstrong	PA	Single County Authority

The communities/counties the project serves:	Armstrong County in Western Pennsylvania in year one. Once implemented and operational, plans are to expand to Indiana and Clarion Counties in Pennsylvania.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Care Coordinator/Manager Model
Description of the project:	The Nurse Navigator and Recovery Specialist Outreach program is intended to enhance rural physical and behavioral health care service delivery. The program will utilize the components of the Care Coordinator/Manager Model with the only adaptation of this model being the primary focus will be on clients with a Substance Abuse or Dependence diagnosis. The program will pair the case management services of a peer recovery specialist with the expertise of a Registered Nurse who can better understand the health care system and the resources that are needed and available within the rural communities. The services to be provided will include: the recruitment, training, and employment of a full-time Registered Nurse who will serve as the Nurse Navigator; recruitment, training, and employment of two Certified Recovery Specialists; provision of whole health and resiliency education to clients in active addiction; direct coordination of physical and behavioral health planning for clients referred to the program; training of treatment agency staff on primary health culture and needs issues; all levels of substance abuse treatment services; outreach services for the coordination of physical and behavioral health services; case management services; and data collection, evaluation, and submission of outcome data to the Consortium.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Pennsylvania

Community Guidance Center

Grant Number:	D04RH26834					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Community Mental Health Center					
Grantee Organization Information:	**Name:**	Community Guidance Center				
	Address:	100 Caldwell Drive				
	City:	DuBois	**State:**	Pennsylvania	**Zip code:**	15801
	Tel #:	814-371-1100				
	Fax #:	814-375-0120				
	Website:	www.thecgc.com				
Primary Contact Information:	**Name:**	Christina Martz				
	Title:	Director of Administration				
	Tel #:	(814) 371-1100 ext 296				
	Fax #:	814-375-0120				
	Email:	cmartz@thecgc.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$149,381
	May 2014 to Apr 2015	$149,746

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Genoa Healthcare	Clearfield	PA	Pharmacy
	DuBois Regional Medical Center	Clearfield	PA	Hospital

The communities/counties the project serves:	Clearfield and Jefferson Counties, Pennsylvania

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care	X	Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	X
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The project utilizes the Four Quadrants Clinical Integration Model. This model locates the primary care practice within the behavioral health clinic, and is considered a promising practice. The model was adapted from Horizon House in Philadelphia, Pennsylvania, wherein a primary care provider was co-located in a mental health clinic. This, however, was in an urban area, while the current model is provided in a rural behavioral health setting. The presence of physical health care in the behavioral health provider, known as "reverse co-location", had not been extensively validated.
Description of the project:	The Physical and Behavioral Health Integrated Care Project will focus on providing a unified and seamless access to primary physical healthcare for consumers struggling with moderate to severe mental health concerns, particularly those individuals with serious and persistent mental Illness (SPMI). The integrated care program will serve Clearfield and Jefferson counties in rural North Central Pennsylvania. The proposed program addresses the needs of the Serious and Persistent Mentally Ill population over the age of 14 in this geographic area. Presently a program does not exist to provide the target population with a "one stop shop" of healthcare (i.e. physical and behavioral health and pharmacy). This population tends to ignore their physical health, leading to a lifespan up to 20 years shorter than the average individual. The integrated care program will provide a single location where the consumer can receive coordinated care from a physician, a psychiatrist, and their associated clinical staffs. At the end of their appointment, the consumer will be able to get prescriptions filled on-site, by a pharmacist who will be able to monitor all their medications. The clinical staffs will collaborate on each consumer regularly to ensure the highest quality of care.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

South Carolina

Newberry County Hospital Foundation

Grant Number:	D04RH23606					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Newberry County Hospital Foundation				
	Address:	2669 Kinard Street				
	City:	Newberry	**State:**	South Carolina	**Zip code:**	29108
	Tel #:	803-405-7425				
	Fax #:	803-276-6885				
	Website:	www.NewberryHospital.org				
Primary Contact Information:	**Name:**	Debra Roberts				
	Title:	VP Patient Care				
	Tel #:	803-405-7161				
	Fax #:	803-276-6885				
	Email:	Debra.Roberts@NewberryHospital.net				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$100,578
	May 2013 to Apr 2014	$90,155
	May 2014 to Apr 2015	$0

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Newberry County Memorial Hospital	Newberry	SC	Hospital
	Amedisys Home Health of Newberry	Newberry	SC	Home Health
	Springfield Place & J.F. Hawkins	Newberry	SC	Skilled Nursing Care Facility
	Free Medical Clinic	Newberry	SC	Free Clinic

The communities/counties the project serves:	Newberry County

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians		
	Hispanics	X	X
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging	X	Maternal/Women's Health	

	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	X
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:

The goals of the *Promoting Patient Self-Management with Telehealth (PPSMT)* are aligned with the Healthy People 2010 initiative goal to "improve the health, function and quality of life of older adults, who are at high risk for developing chronic illnesses." PPSMT was modeled after the rural Nebraska – St. Francis Medical Center Foundation's "Staying Well at Home" (SWAH) project, which used telehealth monitors to help seniors live independently, avoid re-hospitalization, and maintain quality of life. PPSMT adapted the SWAH model to accommodate patients in Newberry County by:

- Forming a rural healthcare network with a home health agency that provides tele-monitoring for Cardiac Heart Failure (CHF) patients and patients with uncontrolled diabetes. Also included in the network are a skilled nursing care facility and the counties Free Medical Clinic.
- Increasing awareness among physicians, caregivers, patients and other community members in Newberry County about the tele-monitoring service.
- Educating patients and caregivers on ways to improve their quality of life through disease management with "lunch-n-learn" classes. Classes are held once a month and cover disease management, diet and medications. Transportation is provided when necessary.

Description of the project:

An existing consortium which includes lead agency Newberry County Memorial Hospital (NCMH), Amedisys Home Health Care (Newberry) and Springfield Place Skilled Nursing Care Facility (Newberry) will conduct regular meetings to develop the network infrastructure among physicians, other healthcare professionals, patients and caregivers. This infrastructure will result in heightened community awareness of Newberry County telehealth services. These services will enable homebound patients and their caregivers in Newberry County to be connected through electronic monitoring to nurses, who can intervene as needed. The nurses will use this communication technology to provide education, offer consultation, assess patients, supervise procedures and monitor patients with chronic conditions that can be controlled, but not cured at home. Existing training, educational and marketing materials will be customized to be culturally appropriate for both Spanish and English speaking populations. These materials will be distributed to service organizations, churches and health fairs to market the program effectively to the community and to educate patients about how they can take a more active role in assessing and self-managing their own health through telehealth. Hospital risk-assessment and referrals from the Free Medical Clinic will determine eligibility of patients for the Promoting Patient Self-Management with Telehealth (PPSMT) program. Telehealth monitors will then be established in their homes and patients and caregivers will be educated about the equipment and self-managed care in an effort to help these patients function more independently. An outside evaluator will monitor project proceedings and complete reports providing quantative and qualitative analysis. Results will be used to adjust and strengthen program as needed to ensure significant improvement of patients' understanding of and care for their chronic conditions through preventative, self-managed care. This in turn will lead to a sizeable reduction in costly re-hospitalizations.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

South Dakota

Delta Dental Plan of South Dakota

Grant Number:	D04RH23570					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Non-profit					
Grantee Organization Information:	**Name:**	Delta Dental Plan of South Dakota				
	Address:	720 N. Euclid Ave.				
	City:	Pierre	**State:**	South Dakota	**Zip code:**	57501
	Tel #:	605-224-7345				
	Fax #:	605-224-0909				
	Website:	www.deltadentalsd.com				
Primary Contact Information:	**Name:**	Connie Halverson				
	Title:	VP, Public Benefit				
	Tel #:	605-494-2547				
	Fax #:	605-224-0909				
	Email:	Connie.halverson@deltadentalsd.com				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Prairie Community Health, Inc.	Dewey	SD	Rural Community Health Center
	Rural Community Health, Inc.	Stanley	SD	Rural Community Health Center

The communities/counties the project serves:	Counties: Corson, Dewey, Meade, Perkins, Ziebach, Hyde, Lyman, Potter, Stanley, Hughes

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly		
	Pregnant Women		X
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	

	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The project is designed based upon the Tioga County Health Department's Mobile Dental Services model, an evidenced based model detailed on the National Association of City and County Health Officials model practices database. The Tioga Mobile Dental Service model was selected as it closely parallels the work of Delta Dental and its mobile program.
Description of the project:	The Frontier Oral Health Delivery Project partners include Delta Dental of South Dakota, Prairie Community Health, Inc., and Rural Community Health, Inc. who have joined together to improve oral health in a nine-county area in central and northwest South Dakota that currently has extremely limited access to oral health care. The project is providing underserved people in the region direct access to quality preventive and restorative dental services through a mobile dental program, as well as preventive health and education services using a roving dental hygienist who provides care to the area during the times the mobile unit is not the area. The project is incorporating teledentistry to increase the number of persons receiving direct services.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-549-4205				
	Fax #:	301-443-2803				
	Email:	SWarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

South Dakota

Sacred Heart Health Services

Grant Number:	D04RH23612					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Sacred Heart Health Services				
	Address:	501 Summit				
	City:	Yankton	**State:**	South Dakota	**Zip code:**	57078
	Tel #:	605-688-8000				
	Fax #:					
	Website:	www.avera.org				
Primary Contact Information:	**Name:**	Mr. Anthony Erickson				
	Title:	Executive Director, Senior Services				
	Tel #:	605-688-8920				
	Fax #:					
	Email:	Anthony.erickson@avera.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Avera Sacred Heart Hospital	Yankton	SD	Hospital
	Avera Health	Lincoln	SD	Health System
	Evangelical Lutheran Good Samaritan Society	Minnehaha	SD	Health System
	Avera Queen of Peace Hospital	Davison	SD	Hospital
	Avera Marshall Regional Medical Services	Lyon	MN	Hospital
	Avera St. Luke's Hospital	Brown	SD	Hospital

The communities/counties the project serves:	Aberdeen, SD (Brown County); DeSmet, SD (Kingsbury County); Irene and Wakonda, SD (Clay County); Yankton, SD (Yankton County); and Marshall, MN (Lyon County).

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured		
	Underinsured		
	Other: (please describe)		
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care	X	Integrated Systems of Care	
	Aging	X	Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Over the past decade, studies have demonstrated significant benefits of telemedicine utilization in long term care facilities. (Weiner et al. 2004 & Laflamme et al. 2004). In particular, the project was developed based on experiences of a 2003 clinical trial testing the efficacy of unscheduled, nighttime videoconferencing in a 240 bed Indiana nursing home versus other forms of intervention including telephone consultations.
Description of the project:	The South Dakota eResidential Facilities Healthcare Services Access Project is designed to improve access to high quality outpatient health care services for elderly and disabled residents living in rural residential long term care, assisted living, and rehabilitation facilities. The Project will link facilities to urgent care and specialty medical services through video and data interfaces, delivering needed healthcare services via telehealth.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Email:	swarren@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Karen H. Wakeford, MPA				
	Title:	Technical Assistance Consultant				
	Tel #:	229-889-9632				
	Fax #:	229-889-0025				
	Email:	Wakeford@mchsi.com				
	Address:	1211 West Third Avenue				
	City:	Albany	**State:**	Georgia	**Zip code:**	31707

South Dakota

University of South Dakota Department of Dental Hygiene

Grant Number:	D04RH23619					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	University					
Grantee Organization Information:	**Name:**	University of South Dakota Department of Dental Hygiene				
	Address:	414 E. Clark St.				
	City:	Vermillion	**State:**	South Dakota	**Zip code:**	57069
	Tel #:	605-677-5379				
	Fax #:	605-677-5638				
	Website:	www.usd.edu/dh				
Primary Contact Information:	**Name:**	Ann Brunick				
	Title:	Chairperson and Professor				
	Tel #:	605-677-5580				
	Fax #:	605-677-5638				
	Email:	Ann.Brunick@usd.edu				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$144,825
	May 2013 to Apr 2014	$145,264
	May 2014 to Apr 2015	$145,563

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	allPOINTS Health Services	Union	SD	FQHC
	Alcester-Hudson School District	Union	SD	School
	Beresford School District	Union	SD	School
	Scotland School Districts	Bon Homme	SD	School
	Centerville School District	Turner	SD	School
	Elk Point/Jefferson and Dakota Valley School Districts	Union	SD	School
	Viborg-Hurley School District	Turner	SD	School
	Irene-Wakonda School Districts	Clay	SD	School
	Vermillion School District	Clay	SD	School

The communities/counties the project serves:	

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Evidence-based oral health prevention measures being used include school-based delivery methods, basic screening surveys, fluoride varnish and sealant application. Pre-and post-assessment mechanisms are also in place.
Description of the project:	The University of South Dakota Department of Dental Hygiene has designed a preventive oral health program to address the disparities in access to dental care in southeastern South Dakota. The program will provide school-based preventive dental services to low-income, uninsured, school-age children with no dental home.

Office of Rural Health Policy Project Officer:	**Name:**	Sheila Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-6884				
	Fax #:	301-443-2803				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tamanna Patel, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Fax #:	404-413-0316				
	Email:	tpatel25@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Tennessee

Buffalo Valley, Inc.

Grant Number:	D04RH23561					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Behavioral Health Organization					
Grantee Organization Information:	**Name:**	Buffalo Valley, Inc.				
	Address:	PO Box 879				
	City:	Hohenwald	**State:**	Tennessee	**Zip code:**	38462
	Tel #:	931-796-5427				
	Fax #:	931-796-5124				
	Website:					
Primary Contact Information:	**Name:**	Deborah A Hillin				
	Title:	Senior Vice President				
	Tel #:	615-975-0196				
	Fax #:	615-333-2048				
	Email:					

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Dr. Joe Hall	Lewis	TN	Medical
	Tri-County Dental Center	Marshall	TN	Dental

The communities/counties the project serves:	Lewis and Marshall Counties

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults		X
	Elderly		X
	Pregnant Women		X
	Caucasians		X
	African Americans		X
	Alaska Natives		X
	Asians		X
	Hispanics		X
	Native Americans		X
	Pacific Islanders		X
	Uninsured		X
	Underinsured		X
	Other: Homeless		X
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	X
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	

	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Integration of Mental Health/Substance Abuse and Primary Care and references from Evolving Model of Behavioral Health Integration in Primary Care.
Description of the project:	This project is to encourage creative and lasting collaborative relationships among a three party consortium of health providers in a two county rural area in middle Tennessee to ensure that the applicant organization, Buffalo Valley, Inc. (BVI), receives regular input from relevant, concerned partners to address the health needs of the target population of low income and homeless women by providing evidence based integrated out-patient substance abuse treatment, primary health care and dental services to the target population. The consortium will provide innovative integrated primary health care services, out-patient substance abuse treatment and dental services to 200 low income, very low income and homeless women per year in a two country rural service area.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-594-4205				
	Fax #:	301-443-2803				
	Email:	lkwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Tanisa Adimu, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Fax #:	404-413-0316				
	Email:	tadimu@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Texas

Madison County

Grant Number:	D04RH23593					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Madison County					
Grantee Organization Information:	**Name:**	Madison County				
	Address:	101 W. Main St., Rm. 110				
	City:	Madisonville	**State:**	Texas	**Zip code:**	77864
	Tel #:	936-348-2670				
	Fax #:	936-348-2690				
	Website:	http://www.co.madison.tx.us/				
Primary Contact Information:	**Name:**	Jennifer Shaver				
	Title:	Project Director				
	Tel #:	936-349-0714				
	Fax #:	936-349-0135				
	Email:	jshaver@st-joseph.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,931
	May 2013 to Apr 2014	$149,972
	May 2014 to Apr 2015	$149,927

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Madison County	Madison	Texas	County Govt.
	The Center for Community Health Development at Texas A&M Health Science Center	Brazos	Texas	Health Science Center
	The Counseling Psychology Program at Texas A&M University	Brazos	Texas	Public University
	The Brazos Valley Council on Alcohol and Substance Abuse	Brazos	Texas	Non-profit Organization
	Madison County Health Resource Commission	Madison	Texas	County Entity
	Madison St. Joseph Health Center	Madison	Texas	Non-profit hospital

The communities/counties the project serves:	Madison County, Texas

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives	X	X
	Asians	X	X
	Hispanics	X	X
	Native Americans		
	Pacific Islanders	X	X
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	X
	Coordination of Care Services		Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Two assets for the Madison Outreach and Service through Telehealth (MOST) Network critical to its success was building on the prior foundation evidenced-based model in a neighboring county that was successful, and utilizing the long-standing expertise of a Network partner in community health worker models to promote and implement outreach activities to the Hispanic population.
Description of the project:	The Madison Outreach and Service through Telehealth (MOST) Network, a network of community organizations and service providers committed to improving access to mental health and substance abuse services in Madison County for rural and underserved residents through a sustainable infrastructure and community health outreach. The network includes Madison County, Madison County Health Resource Commission, Brazos Valley Council on Alcohol and Substance Abuse (BVCASA), the Center for Community Health Development, the Counseling and Psychology Program at Texas A&M University, and Madison St. Joseph Health Center. Through the proposed grant, the MOST Network will use telehealth technology, as piloted by a neighboring county, and a community health worker component to expand and maintain a sustainable infrastructure to address the mental health and substance abuse needs of the residents of Madison County. By adapting the successful telehealth program, both the Counseling Psychology Program and BVCASA can provide intake, assessment, screening, counseling, referral, and education services. In addition, community health workers will aid in the outreach and educational efforts of the often hidden Hispanic community which has traditionally been underserved in Madison County. Madison County is home to 13,664 residents. This county can be described as an agricultural, family-oriented community with a small town feel where everyone knows everyone. In a recent health assessment, Madison County residents identified alcohol and illegal drug use among the top ten community issues, and depression was one of the top six chronic diseases. The MOST Network proposes actions to improve access to care to address these identified issues for rural and underserved residents.

Office of Rural Health Policy Project Officer:						
	Name:	Sheila Warren				
	Title:	Public Health Analyst				
	Tel #:	301-443-0246				
	Fax #:	301-443-1330				
	Email:	swarren@hrsa.gov				
	Address:	Parklawn 17W-31B				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Wadia Joseph Hanna, MD, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	678-714-6568				
	Fax #:	678-714-6568				
	Email:	hannaw@bellsouth.net				
	Address:	4025 McGinnis Ferry Rd				
	City:	Suwanee	**State:**	Georgia	**Zip code:**	30024

Vermont

Behavioral Health Network of Vermont

Grant Number:	D04RH23558					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Behavioral Health Membership Network					
Grantee Organization Information:	**Name:**	Behavioral Health Network of Vermont				
	Address:	137 Elm Street				
	City:	Montpelier	**State:**	Vermont	**Zip code:**	05602
	Tel #:	802-262-6124				
	Fax #:	802-223-5523				
	Website:	www.bhnvt.org				
Primary Contact Information:	**Name:**	Simone Rueschemeyer				
	Title:	Director				
	Tel #:	802-262-6124				
	Fax #:	802-223-5523				
	Email:	simoner@bhnvt.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$145,968
	May 2013 to Apr 2014	$148,435
	May 2014 to Apr 2015	$149,912

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Clara Martin Center	Orange	VT	Community Mental Health Center
	Northwestern Counseling and Support Services	Franklin	VT	Community Mental Health Center
	Little Rivers Health Care	Orange	VT	FQHC
	Northern Tier Center for Health	Franklin	VT	FQHC
	Bi-State Primary Care Association	Statewide	VT	Primary Care Association
	Behavioral Health Network of Vermont	Statewide	VT	Provider Network

The communities/counties the project serves:	Bradford, Vermont (Orange County) and St. Albans, Vermont (Franklin County)

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	X
	Access: Specialty Care		Integrated Systems of Care	X
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology	X	Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The National Council for Community Behavioral Healthcare (The National Council) has stated evidence-based elements for a partnership model resulting in bi-directional care. The foundations for these elements are based on evidence from the IMPACT model, the Chronic Care Model, the PCARE study and the HARP project. The Open Any Door Consortium has taken the partnership model and modified it to include three additional elements: an enhanced and formally structured referral system based on the Four Quadrant Model; brief intervention/consultation via telemedicine; and educational opportunities for patients, staff, clinicians and providers. It has been tailored specifically to meet the needs of the individual communities.
Description of the project:	The purpose of Open Any Door / Realizing Bi-Directional Care (Open Any Door) is to implement and measure a model of care delivery that increases access to, and improves coordination between, mental health and primary care. Open Any Door is a bi-directional model of care delivery that addresses the mental and primary care health needs of those requiring intensive or specialized services thus resulting in improved access and health outcomes as well as potentially significant cost savings. Through Open Any Door, the HRSA funded nurse at the CMHC works with care coordinators to identify clients with moderate to serious mental health diagnoses who are either not seeing a primary care provider or who do not have established relationships with a primary care provider. Through Open Any Door, complete up to date medication and problem lists are maintained, a primary care provider for all adult clients at the CMHC is identified, care is coordinated with a primary care provider either at the CMHC or at another primary care site, clients without a primary care provider are referred to the appropriate setting, and basic medical information is gathered. A primary care office is set up at the CMHC and a part-time nurse practitioner from the FQHC sees clients at the CMHC to enable access to primary care for those who will not seek services in a primary care setting or who feel more comfortable seeing a primary care provider at the CMHC. Home visits are conducted for those not able or willing to come to the center and all adults are screened for depression at the FQHCs. Open Any Door also focuses on using telehealth equipment to enable consultations between primary care physicians and psychiatrists. Work is also being conducted to enable the electronic exchange of information between providers. Open Any Door provides health education to clients and educational materials to patients and providers in both the FQHC and the CMHC on the benefits and availability of both primary care and mental health services. Focus groups are held to identify barriers to access to primary care and innovative ideas for implementation. In addition the program provides direct educational sessions with pilot members and a statewide training via the BHN telehealth integration training program. Yearly evaluations are conducted, inclusive of provider and client surveys, to continuously improve the program.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220

Vermont

Bi-State Primary Care Association

Grant Number:	D04RH23560					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Primary Care Association					
Grantee Organization Information:	**Name:**	Bi-State Primary Care Association				
	Address:	61 Elm St				
	City:	Montpelier	**State:**	Vermont	**Zip code:**	05602
	Tel #:	802-229-0002				
	Fax #:	802-223-2336				
	Website:	www.bistatepca.org				
Primary Contact Information:	**Name:**	Kate Simmons				
	Title:	VRHA Project Director				
	Tel #:	802-229-0002, ext. 217				
	Fax #:	802-223-2336				
	Email:	ksimmons@bistatepca.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,999
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$149,999

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Open Door Clinic	Addison	VT	Free Clinic
	VT Migrant Education Program, UVM	Washington	VT	University Extension

The communities/counties the project serves:	Migrant farmworkers and their families in the following Vermont counties: Addison, Franklin, Grand Isle, Washington, Orleans, and Caledonia.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured		
	Underinsured		
	Other: Migrant farmworkers and family members	X	X
	Other: (please describe)		

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	

	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	X
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Outreach, using a community health worker, lay health promoter, or outreach worker, is an evidence-based model proven to reduce barriers to care, improve appropriate use of health services, and improve health status for underserved populations. This model can be used reactively, to manage disease, or proactively to increase access for populations who may be isolated by fear, linguistic, or cultural differences. Community health workers are often individuals respected within their communities, bilingual/bicultural, and able to navigate the health care system.
Description of the project:	The Vermont Rural Health Alliance, a program of Bi-State Primary Care Association is working with two consortium partners, the University of Vermont's Migrant Education Program (VMEP), and the Open Door Clinic (ODC) to reduce barriers to health care for the migrant farmworker population in Vermont. The project will leverage existing relationships and resources at VRHA, ODC, and VMEP to develop immediate capacity to provide care coordination for farmworkers through outreach at 80 farms each year, including distribution of access guides, completion of emergency contact cards, health referrals, and follow-up services. Cultural capacity and knowledge changes will be measured through accessibility assessments and technical assistance to health centers and other health care access points, and surveys with farmers and farmworkers. Bridges to Health will work closely with universities and coalitions to grow a volunteer pool to further support the outreach efforts to migrant farmworkers. The Bridges consortium will carry out evaluation, quality improvement, and sustainability plans.

Office of Rural Health Policy Project Officer:	**Name:**	Valerie Darden				
	Title:	Captain, United States Public Health Service				
	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Amanda Philips Martinez, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0293				
	Fax #:	404-413-0316				
	Email:	aphillipsmartinez@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Virginia

Giles Free Clinic

Grant Number:	D04RH23577					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Free Clinic					
Grantee Organization Information:	**Name:**	Giles Free Clinic				
	Address:	219 Buchanan St.				
	City:	Pearisburg	**State:**	Virginia	**Zip code:**	24134
	Tel #:	540-381-0820				
	Fax #:	540-382-3391				
	Website:	www.nrvfreeclinic.org				
Primary Contact Information:	**Name:**	Michelle Brauns				
	Title:	Chief Executive Officer				
	Tel #:	540-381-0820				
	Fax #:	540-382-3391				
	Email:	mbrauns@nrvfreeclinic.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$150,000
	May 2014 to Apr 2015	$150,000

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Giles Free Clinic	Giles	VA	Free Clinic
	Giles Health and Family Services	Giles	VA	Transportation Provider
	Family Dental Clinic of the New River Valley	Giles	VA	Dental Clinic

The communities/counties the project serves:	Giles County, VA

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)		
	School-age children (teens)		
	Adults		
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care	X	Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care	X	Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	

	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	X
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	This program is modeled after the promising practice of **Non-Emergency Community Medical Transportation.** This model has been shown to be effective in addressing gaps and needs in a community setting and improving the health status of the residents of the community. In particular, the St. Mary's Medical Assistance Transportation Program was used as a model.. St. Mary County medical transportation program was named a Model for Practice with regard to access to primary care in rural areas and received the Outstanding Rural Health Program Award at the Maryland Rural Health Summit in 2007. Our model has been tailored to meet the specific needs of Giles County, to take advantage of available resources, and to be responsive to the prevalent Appalachian culture.
Description of the project:	The Giles Health Network (G-NET) has implemented a non-emergency community medical transportation system serving Giles County, Virginia. Giles County is a picturesque region of Appalachian America, with rolling hills, cliffs, rivers and streams. This rural area is, unfortunately, quite poor and topographically isolated. It is also culturally insulated due to the predominant Appalachian culture which presents multiple barriers to health care consumption. The member organizations of our rural health network have developed this program in response to data that demonstrate that transportation is a leading barrier to the receipt of health care services by our target population: low-income, uninsured and underinsured persons. Both oral health care and behavioral health care are prominent needs of the community, and addressing the transportation barrier will immediately improve access to both. The resultant transportation program, named *Giles REACH: Rural Equity in Access for Community Health*, was designed by and for health care consumers, is culturally appropriate, solves logistical problems for local health care organizations, and greatly expands access to primary health care services. Ultimately, the health status of the entire County will improve. Giles REACH is governed and implemented by an outreach Consortium composed of three separate health organizations: The Giles Free Clinic, Giles Health and Family Services, and the Family Dental Clinic of the New River Valley. Each contributes critical expertise and performs key responsibilities in the management and ongoing operation of the program.

Office of Rural Health Policy Project Officer:	**Name:**	Linda Kwon				
	Title:	Public Health Analyst				
	Tel #:	301-549-4205				
	Fax #:	301-443-2803				
	Email:	LKwon@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John A. Shoemaker, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	888-331-0529				
	Fax #:	888-331-0529				
	Email:	ta@jasmph.com				
	Address:	35640 North 11th Avenue				
	City:	Desert Hills	**State:**	Arizona	**Zip code:**	85086

West Virginia

Future Generations

Grant Number:	D04RH23575					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Community-based organization					
Grantee Organization Information:	**Name:**	Future Generations				
	Address:	390 Road Less Traveled				
	City:	Franklin	**State:**	West Virginia	**Zip code:**	26807
	Tel #:	304-358-2000				
	Fax #:	304-358-7384				
	Website:	www.future.org				
Primary Contact Information:	**Name:**	Nicky Bassford Fadley				
	Title:	Project Director				
	Tel #:	304-358-2000				
	Fax #:	304-358-7384				
	Email:	nbassford@future.org				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$150,000
	May 2013 to Apr 2014	$148,105
	May 2014 to Apr 2015	$145,731

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	West Virginia University Research Corporation	Monongalia	WV	Higher education
	WV Partnership of African American Churches	Kanawha	WV	Nonprofit
	Big Creek People in Action	McDowell	WV	Nonprofit
	LEAD Community Organization	Logan	WV	Nonprofit
	REACHH Family Resource Center	Summers	WV	Nonprofit
	Child Protect of Mercer County	Mercer	WV	Nonprofit
	Community Connections	Mercer	WV	Nonprofit
	West Virginia Warrior Virtue Society	Boone	WV	Nonprofit

The communities/counties the project serves:	Boone, Logan, McDowell, Mercer, and Summers Counties in West Virginia

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children		
	School-age children (elementary)	X	X
	School-age children (teens)		
	Adults	X	X
	Elderly		
	Pregnant Women		
	Caucasians		
	African Americans		
	Alaska Natives		
	Asians		
	Hispanics		
	Native Americans		
	Pacific Islanders		
	Uninsured	X	X
	Underinsured		
	Other: Low-income	X	X

Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	X
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Evidence Based Model Being Used or Adapted:	Community Health Worker (CHW) models, including the Health Educator Model and Community Organizer Model, as described in the *Community Health Workers Evidence-Based Models Toolbox* published by the HRSA Office of Rural Health Policy in August 2011 (available at: http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf).
Description of the project:	*The West Virginia Community Health Workers Network* partners with rural, community-based organizations wanting to develop new health promotion programs. Project staff work with a designated staff person at each partner organization and coordinate the provision of technical assistance to build their capacity as a Health Educator and/or Community Organizer CHW. Project staff provide some technical assistance directly and refer some requests to other organizations in the Network and outside the Network. Some of the key types of technical assistance our community-based partners need are help with project planning and budgeting, communications and marketing, evaluation, and fundraising. Additionally, partners receive a sub-grant of up to $10,000 to assist with implementing their health promotion projects. Partners provide at least a 1:1 match in cash and in-kind contributions.

Office of Rural Health Policy Project Officer:	**Name:**	Shelia Tibbs				
	Title:	Public Health Analyst				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Amanda Philips Martinez, MPH				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0293				
	Fax #:	404-413-0316				
	Email:	aphillipsmartinez@gsu.edu				
	Address:	14 Marietta Street, NW, Suite 221				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Wisconsin

ABC for Rural Health, Inc.

Grant Number:	D04RH23555					
Program Type:	Rural Health Care Services Outreach					
Organization Type:	Not-for-Profit, public interest law firm					
Grantee Organization Information:	**Name:**	ABC for Rural Health, Inc.				
	Address:	100 Polk County Plaza, Suite 180				
	City:	Balsam Lake	**State:**	Wisconsin	**Zip code:**	54810
	Tel #:	715-485-8525				
	Fax #:	715-485-8501				
	Website:	http://www.safetyweb.org/				
Primary Contact Information:	**Name:**	Michael Rust				
	Title:	Chief Operating Officer				
	Tel #:	715-485-8525				
	Fax #:	715-485-8501				
	Email:	miker@co.polk.wi.us				

Project Period:	**Beginning Year**	**Ending Year**
	2012	2015

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	May 2012 to Apr 2013	$149,583
	May 2013 to Apr 2014	$149,586
	May 2014 to Apr 2015	$149,893

Consortium Partners:	**Partner Organization**	**County**	**State**	**Organizational Type**
	Polk County Health Department	Polk	WI	Government
	Polk County Human Services Department	Polk	WI	Government
	St. Croix Regional Medical Center	Polk	WI	Hospital/Med. Center
	Peace Tree Clinic	Polk	WI	Clinic

The communities/counties the project serves:	Primarily Polk County, WI, but two partners, the hospital and the clinic, may serve patients from neighboring counties. Those clients will be eligible for services.

The target population served:	**Population**	**Male**	**Female**
	Infants		
	Pre-school children	X	X
	School-age children (elementary)	X	X
	School-age children (teens)	X	X
	Adults	X	X
	Elderly	X	X
	Pregnant Women		X
	Caucasians	X	X
	African Americans	X	X
	Alaska Natives		
	Asians	X	X
	Hispanics	X	X
	Native Americans	X	X
	Pacific Islanders		
	Uninsured	X	X
	Underinsured	X	X

Focus areas of grant program:	**Focus Area:**	**Yes**	**Focus Area:**	**Yes**
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Dev.	X
	Access: Specialty Care		Integrated Systems of Care	

Aging		Maternal/Women's Health	
Behavioral/Mental Health	X	Migrant/Farm Worker Health	
Children's Health	X	Oral Health	
Chronic Disease: Cardiovascular		Pharmacy Assistance	
Chronic Disease: Diabetes		Physical Fitness and Nutrition	
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras		Substance Abuse	X
Coordination of Care Services		Telehealth	
Emergency Medical Services		Transportation to health services	
Health Education and Promotion		Other: (please describe)	
Health Information Technology	X	Other: (please describe)	

Evidence Based Model Being Used or Adapted:	The RealBenefits program used by the Boston Public Health Commission and identified by the National Association of County & City Health Officials (NACCHO) as a Model Practice.
Description of the project:	The Western Wisconsin Mental Health and Substance Abuse Benefits Counseling Project will develop, test, and implement new technology and a new strategy to measurably promote greater access to mental health coverage and treatment for patients. The project will work with patients and prospective patients at three mental health and substance abuse counseling provider locations in Polk County. Peace Tree Counseling is a Wisconsin Licensed Behavioral Health Clinic in Osceola. Counseling and Psychological Services in St. Croix Falls is the behavioral health unit at the county's largest (of three) hospital/medical center complexes. Mental Health/Chemical Dependency Services in Balsam Lake is the behavioral health unit of Polk County government. During the project's initial phase, partners will review benefits vetting protocols at each of the three clinics to establish a baseline for the project. Partners will then establish a template and protocol for identifying, reviewing, and cataloging all benefits and eligibility denials, delays, limitations and terminations according to provider type, payer type, coverage descriptions, and patient diagnosis. Provider liaisons will assist the partners to recruit clinical patients and prospective patients for review. We will catalogue benefits and eligibility limitations with reference to private policy language and to public health benefit administrative rules and governing statutes. We will also review limitations in the light of federal and state mental health parity laws, federal health care reform rules, and state mandates. We will pay particular attention to providers' use of the federal EPSDT program for BadgerCare Plus and Medicaid-enrolled children under age 21. (EPSDT- Health Check in Wisconsin - is the Early Prevention, Screening, Diagnosis, and Treatment Program of Medicaid.) In addition, ABC will construct and deploy a mental health benefits algorithm for its patented My Coverage Plan process – an interactive, web-based health benefits screener. Next, ABC will deploy the full range of its legal advocacy services with consenting patients seeking to challenge benefits limitations or secure eligibility by pursuing informal and formal appeals. Overall, the project will seek to establish fidelity between initial benefits vetting, use of the on-line screener and final advocacy results to craft suggested advancements to the providers' benefits vetting practices. We will sustain project activities by demonstrating the cost benefit of pro-actively providing benefits counseling interventions, by deploying new technology, and by providing training for providers.

Office of Rural Health Policy Project Officer:	**Name:**	Christina Villalobos				
	Title:	Public Health Analyst				
	Tel #:	301-443-3590				
	Email:	cvillalobos@hrsa.gov				
	Address:	5600 Fishers Lane				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857

Technical Assistance Consultant's Contact Information:	**Name:**	Lynne Kernaghan				
	Title:	Technical Assistance Consultant				
	Tel #:	478-474-0095				
	Fax #:	478-474-8515				
	Email:	kernaghanl@cox.net				
	Address:	128 Hampton Way				
	City:	Macon	**State:**	Georgia	**Zip code:**	31220