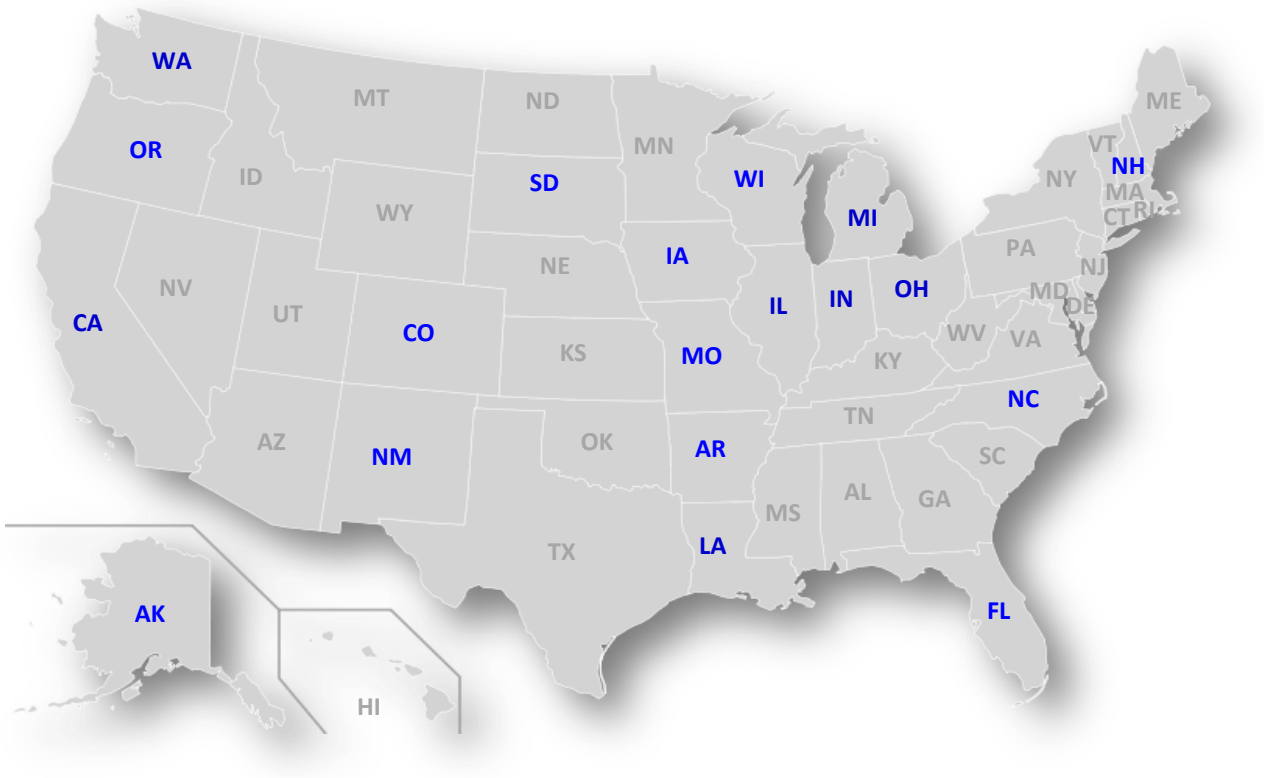
U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Grantee Directory

Small Health Care Provider Quality Improvement Grant Program

2013 - 2016



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

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Grantee Directory

Small Health Care Provider Quality Improvement Grant Program

The purpose of the Small Health Care Provider Quality Improvement Grant Program is to provide three years of funding support to rural primary care providers for implementation of quality improvement activities. Quality health care is the provision of appropriate services to individuals and populations that are consistent with current professional knowledge, in a technically competent manner, with good communication, shared decision-making and cultural sensitivity.

This program is authorized by Title III, Public Health Service Act, Section 330A(g) (42 U.S.C. 254c(g)), as amended by Section 201, P.L. 107-251, and Section 4, P.L. 110-355. This authority directs the Office of Rural Health Policy to support grants that expand access to, coordinates, restrains the cost of, and improves the quality of essential health care services, including preventive and emergency services, through the development of health care networks in rural and frontier areas and regions. Across these various programs, the authority allows the Health Resources and Services Administration to provide funds to rural and frontier communities to support the direct delivery of health care and related services, to expand existing services, or to enhance health service delivery through education, promotion, and prevention programs.

While many quality improvement initiatives focus on inpatient and hospital care, quality improvement is also needed in the primary care environment. Timely disease treatment and management in the outpatient setting can improve patient health and decrease costs by preventing emergency care and hospital admissions. The ultimate goal of quality improvement is to foster the development of an evidence-based culture and delivery of coordinated care among the entire medical team ranging from physicians to the front desk staff.

The ultimate goal of the Small Health Care Provider Quality Improvement Grant Program is to promote the development of an evidence-based culture and delivery of coordinated care in the primary care setting. Additional objectives of the program include: improved health outcomes for patients; enhanced chronic disease management; and better engagement of patients and their caregivers.

Organizations participating in the program are required to utilize an evidence-based quality improvement model, perform tests of change focused on improvement, and use health information technology (HIT) to collect and report data. HIT may include an electronic patient registry (EPR) or an electronic health record (EHR), and is a critical component for improving quality and patient outcomes. With HIT, it is possible to generate timely and meaningful data which helps providers track and plan care. This program does not support funding for an EHR, but grantees may use funds to develop or purchase a module or interface or customize reports to support collection of data.

This directory provides contact information and a brief overview of the 29 initiatives funded under the Small Health Care Provider Quality Improvement Grant Program in the 2013-2016 funding cycle.

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Alaska

Cross Road Medical Center

Grant Number	G20RH26385					
Grantee Organization Name	Cross Road Medical Center					
Address	P.O. Box 5					
	City:	Glennallen	State:	AK	Zip-code:	99588
Grantee organization website	www.crossroadmc.org					
Grantee Project Director	Name:	Sherri Cox				
	Title:	Clinical Manager/Director of Nursing				
	Phone:	907-822-3203				
	Fax:	907-822-5805				
	Email:	scox@crossroadmc.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	The Valdez-Cordova Census Area which includes:					
	Chistochina		Mendeltna			
	Chitina		Mentasta Lake			
	Copper Center		Nelchina			
	Copperville		Paxson			
	Gakona		Silver Springs			
	Glennallen		Slana			
	Gulkana		Tazlina			
	Kenny Lake		Tolsona			
	Lake Louise		Tonsina			
	McCarthy		Willow Creek			
The target population served	Target populations served are patients with cancers, heart disease, stroke, lower respiratory disease, unintentional injuries and deaths, and suicide.					
Focus Areas	Chronic Disease Management and Prevention		Patient Centered Medical Home Certification			
Health Information Technology System	SuccessEHS					
Quality Improvement Model	Plan-Do-Study-Act (PDSA)					
Description of the Quality Improvement project	In an effort to attain Level 1 in Patient Centered Medical Home (PCMH) Certification, Cross Road Medical Center's (CRMC) is striving to improve on all of the nine clinical measures set forth by the U.S. Department of Health and Human Services. The purpose of CRMC's Small Health Care Provider Quality Improvement project is to transform health care delivery to be patient- and quality-driven by improving patient outcomes, reducing costs throughout the system, ensuring access to routine and urgent care and promoting efficient transitions to care services. CRMC also addresses the ongoing difficulty that frontier/rural residents have in accessing the health care they need. These residents frequently experience overwhelming medical, physical and emotional issues which are discouraging. The CRMC Care Coordination Team coordinates, integrates, and streamlines healthcare					

	services in order to improve the quality of care for patients who have ongoing health issues. The team also supports patients in their efforts to maintain a healthy lifestyle. With the accomplishment of these goals and the dedication of CRMC staff to the Copper Basin population, our program will be sustainable. Our sustainable business model is based on the PCMH principle that with increased quality and integrated health care, patients will be drawn to and return to our community health center.					
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	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Tamanna Patel				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
	Email:	tpatel25@gsu.edu				
	Website:	www.ruralhealthlink.org				
	Address:	14 Marietta Street, Suite 221				
	City:	Atlanta	State:	Georgia	Zip-code:	30303

Alaska

Providence Health & Services-Washington

Grant Number	G20RH26402					
Grantee Organization Name	Providence Health & Services - Washington					
Address	1915 East Rezanof Drive					
	City:	Kodiak	State:	AK	Zip-code:	99615
Grantee organization website	http://www2.providence.org/pages/default.aspx					
Grantee Project Director	Name:	LeeAnn Horn				
	Title:	Chief Nurse Executive				
	Phone:	907-486-9567				
	Fax:	907-486-2336				
	Email:	leeann.horn@providence.org				
Project Period	09/01/2013 – 07/31/2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$146,305				
	Sept 2014 to Aug 2015:	$120,898				
	Sept 2015 to Aug 2016:	$130,251				

Network Partners	Organization Name	City/County	Organization Type
	Kodiak Community Health Center (KCHC)	Kodiak Island	Non-profit Federally Qualified Health Center

The communities/counties that the Quality Improvement project serves	Residents of Kodiak Island and surrounding villages that seek primary healthcare services through Kodiak Community Health Center	
The target population served	Kodiak Community Health Center patients (18 years of age and older) found to have used emergency and/or inpatient hospital services one or more times during the last 14 months (including those at high risk for hospital readmission).	
	Patients with multiple medically complex chronic health conditions, many of whom are Limited English Proficient, including Filipino and Hispanic populations.	
	Patients who are primarily uninsured and underinsured.	
Focus Areas	Care coordination	Chronic Diseases Management
Health Information Technology Systems	Epic OCHIN: Epic Electronic Health Record Solution	
Quality Improvement Model	Plan, Do, Study, Act (PDSA)	

Description of the Quality Improvement project	Using the Johns Hopkins University model of Guided Care Chronic Care Management, an experienced Registered Nurse has been fully integrated into the primary care setting at KCHC to work alongside primary care providers to provide complex health care coordination for up to 60 of their high-risk patients. The RN is responsible for full project development and implementation under the guidance of the Executive Director (KCHC) and Project Director/Chief Nurse Executive (PKIMC). The RN completed a 6-weeks online training through Johns Hopkins University to obtain her Guided Care Nursing certificate. The RN fully coordinates Guided Care program enrollment by completing an initial health assessment for each patient in their home or clinic setting. Through collaboration with both the patient and primary care provider, the RN creates an evidenced-based comprehensive care guide and action plan for each enrolled patient in support of disease self-management and behavior modification interventions. The RN further facilitates patient navigation within the healthcare system. She advocates for patient health care accountability through the provision of patient education; acts as the liaison for access to community resources; coordinates the continuity of patient care with external healthcare organizations, specialty care providers and facilities; coordinates transitional care for patients and their families following hospital discharge and emergency department visits; promotes clear communication among care teams and treating providers by ensuring awareness regarding patient care plans; and is responsible for program outreach both within the primary care setting as well as through community venues.					
Office of Rural Health Policy Project Officer information	Name:	Ann Ferrero				
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	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Tanisa Adimu				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Email:	tadimu@gsu.edu				
	Website:	www.ruralhealthlink.org				
	Address:	14 Marietta Street, Suite 221				
	City:	Atlanta	State:	Georgia	Zip-code:	30303

Arkansas

Magnolia Regional Medical Center

Grant Number	G20RH26395					
Grantee Organization Name	Magnolia Regional Medical Center					
Address	101 Hospital Drive					
	City:	Magnolia	State:	AR	Zip-code:	71753
Grantee organization website	www.magnoliarmc.org					
Grantee Project Director	Name:	Margaret West				
	Title:	CEO				
	Phone:	870-235-3211				
	Fax:	870-235-3551				
	Email:	mwest@magnoliarmc.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$149,390				
	Sept 2014 to Aug 2015:	$147,565				
	Sept 2015 to Aug 2016:	$149,821				

Network Partners	Organization Name	City/County	Organization Type
	University of Arkansas Medical Services-South (UAMS-South)	Magnolia, Columbia	PCMH, Clinic

The communities/counties that the Quality Improvement project serves	Columbia County, AR	Ouachita County, AR
	Lafayette County, AR	Nevada County, AR
	Webster Parrish, LA	Union County, AR
The target population served	Patients with chronic conditions who initiate at Magnolia Regional Medical Center (MRMC) and discharge to our partner organization UAMS-South.	
Focus Areas of the grant program	Care Coordination	Patient Centered Medical Home
	Care Transitions	Chronic Disease Management
	Smoking/Tobacco Cessation	
Health Information Technology Systems	Computerized Programs and Systems Inc. (CPSI)	
Quality Improvement Model	Chronic Care Model	
Description of the Quality Improvement project	The purpose of this project is to redesign the delivery of healthcare to improve lives of patients with chronic diseases and to reduce healthcare costs in our community. The funds received have been utilized to hire and train two referral coordinators to coordinate referrals for transitions of care, assess patient needs, identify barriers to care and provide follow-up post referral. We have partnered with University of Arkansas Medical Sciences-South (UAMS-South) for patient referrals. Once referred to UAMS-South, patients are connected with a primary provider at UAMS-South to assist in managing their chronic illnesses and improving their wellness culture. Establishing a medical home for patients and connecting them with a primary care provider will lower their risk of hospital readmission.	

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California

Clinicas de Salud del Pueblo, Inc.

Grant Number	G20RH26384					
Grantee Organization Name	Clinicas de Salud del Pueblo, Inc.					
Address	1166 K Street					
	City:	Brawley	State:	CA	Zip-code:	92227
Grantee organization website	http://www.cdsdp.org/					
Grantee Project Director	Name:	Dr. Afshan N Baig MD				
	Title:	Chief Medical Officer				
	Phone:	760-344-9951 Ext. 10133/10150				
	Fax:	760-344-4092				
	Email:	NuriB@cdsdp.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	Imperial County					
The target population served	Patients with chronic conditions					
Focus Areas	Chronic Disease Management of patients with diabetes and hypertension		Patient Centered Medical Home			
Health Information Technology Systems	i2i Tracks					
Quality Improvement Model	Chronic Care Model					
Description of the Quality Improvement project	Clinicas de Salud del Pueblo (CDSDP), a Federally Qualified Health Center operates 11comprehensive primary care sites in California's Imperial and Riverside counties, including a new immediate care Open Access Clinic in Brawley, CA. CDSDP is piloting the Chronic Care Model at its Calexico clinic site with the expectation of generalizing the model across CDSDP's system of care during the project period. CDSDP serves a very high-poverty population and one that experiences a high incidence of chronic disease. In addition to the adoption of the Chronic Care Model, CDSDP will develop a system-wide electronic health record and adopt the Patient Centered Medical Home model. This will enhance the organization's ability to provide high-quality care while maximizing the value of organizational resources and capacity to better integrate care with other regional providers. Our resources are modest per population size and geographic area, and patients face significant barriers to accessing those services (educational, financial, transportation and cultural). It becomes critical to develop effective chronic care systems at the primary-care service level to empower patients as the most effective agents in the management of their health.					
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California

Quartz Valley Indian Reservation

Grant Number	G20RH26403					
Grantee Organization Name	Quartz Valley Indian Reservation					
Address	9024 Sniktaw Ln.					
	City:	Fort Jones	State:	CA	Zip-code:	96032
Grantee organization website	http://www.qvir.com					
Grantee Project Director	Name:	Kyle Nelson				
	Title:	Executive Director				
	Phone:	(530) 468-4470				
	Fax:	(530) 468-4478				
	Email:	chm@qvir.com				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$148,810				
	Sept 2014 to Aug 2015:	$149,267				
	Sept 2015 to Aug 2016:	$149,622				

Network Partners	Organization Name	City/County	Organization Type
	NA		

The communities/counties that the Quality Improvement project serves	Quartz Valley Indian Reservation	Siskiyou County
	Scott Valley	Siskiyou County
	Fort Jones	Siskiyou County
The target population served	Quartz Valley Indian Reservation	Native American
	Chronic conditions (diabetes, cardiovascular disease, cancer)	Condition focus
	Depression	Condition focus
Focus Areas	Chronic Disease Management	Care Coordination
	Depression	
Health Information Technology Systems	Resource and Patient Management System (RPMS)	Electronic Health Record of the Indian Health Services
Quality Improvement Model	Chronic Care Model	

Description of the Quality Improvement project

Quartz Valley Indian Reservation - Anav Medical Clinic patients have high incidence of diabetes, cardiovascular disease, and cancer that is the leading cause of mortality among Native Americans. Chronic depression is also a serious problem. The project utilizes a Quality Improvement Manager and Quality Improvement Evaluator to establish a comprehensive quality assurance infrastructure for the management and prevention of diseases, and provision of a Quality Improvement Action Plan.

The Chronic Care Model serves as the basis for the Quality Improvement project using the clinic's electronic patient registry incorporated in the Indian Health Services' Resource and Patient Management System (RPMS). The project focuses primarily on depression, diabetes mellitus, cardiovascular disease, and cancer.

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	City:	Atlanta	State:	Georgia	Zip-code:	30303

California

Tulare Community Health Clinic

Grant Number	G20RH26410					
Grantee Organization Name	Tulare Community Health Clinic					
Address	1201 N Cherry Street					
	City:	Tulare	State:	CA	Zip-code:	93274
Grantee organization website	www.tchci.com					
Grantee Project Director	Name:	Dawn Wells				
	Title:	Grant Specialist				
	Phone:	559-816-3612				
	Fax:	559-684-8550				
	Email:	dawells@tchci.com				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	California State University, Fresno	Fresno, CA	University

The communities/counties that the Quality Improvement project serves	Tulare City (Tulare County)	Surrounding rural communities
The target population served	All ages (prenatal through geriatrics)	Low income
	Chronic conditions	Migrant and Seasonal Farm Workers
	Hispanic	Primarily insured by Medicaid
Focus Areas	Care Coordination	Immunizations
	Clinical depression screening	Patient-Centered Medical Home
	Chronic Care Management	Obesity (BMI)
	Colorectal	Pap test
	Diabetes	Quality Improvement
	Hypertension	Tobacco screening & intervention
Health Information Technology Systems	NextGen	I2i electronic disease registry
Quality Improvement Model	Model for Improvement	

Description of the Quality Improvement project	Tulare Community Health Clinic applied for this Small Health Care Provider Quality Improvement Grant Program with the goal of establishing an evidence-based culture and delivery of patient centered care in the health center. The project will integrate the Institute for Health Care Improvement's evidence based *Model for Improvement* into the health center's existing Quality Assurance-Quality Improvement Program. The *Model for Improvement* is a strategy to systematically and effectively manage change. The model has two parts which utilize techniques for small changes tested over time, resulting in improved care delivery and improved patient outcomes. Performance will be tracked monthly at the Quality Assurance-Quality Improvement (QAPI) Committee meetings. TCHC plans to utilize the NextGen electronic health record and i2i Tracks electronic disease registry systems to collect and report data on selected clinical measures with the outcomes of meeting or exceeding Health People 2020 standards. The evidence based *Model for Improvement* will strengthen the health center's quality improvement infrastructure, leading to a balance of quality, efficiency, and profitability which will result in sustainability through the attainment of NCQA Patient Centered Medical Home (PCMH) level 3 recognition by the end of the grant project period.					
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Colorado

Summit Community Care Clinic, Inc. (SCCC)

Grant Number	G20RH26407					
Grantee Organization Name	Summit Community Care Clinic, Inc. (SCCC)					
Address	P.O. Box 4337					
	City:	Frisco	State:	CO	Zip-code:	80443
Grantee organization website	www.summitclinic.org					
Grantee Project Director	Name:	Helen Royal				
	Title:	Behavioral Health and Quality Improvement (QI) Director				
	Phone:	970-668-6883				
	Fax:	970-668-6699				
	Email:	hroyal@summitclinic.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	Eagle County		Park County			
	Grand County		Summit County			
	Lake County					
The target population	All SCCC patients are included. They are mostly uninsured or covered by Medicaid.					
Focus Areas	Meaningful Use		Patient Centered Medical Home			
Health Information Technology Systems	Aprima Electronic Health Record and Practice Management		Dentrix Electronic Dental Record			
	Clearpoint Strategy to manage data					
Quality Improvement Model	Plan, Do, Study, Act (PDSA)					
Description of the Quality Improvement project	SCCC earned the designation of Federally Qualified Health Center-LA (FQHC-LA) in 2011. Since that time, the practice has grown significantly. Previously, SCCC had a Quality Assurance program which was focused on compliance, and not on health outcomes. There were aspects of a quality improvement (QI) program, including a Patient Advisory Committee and other patient engagement forums, but nothing concrete or formal. The grant from the Office of Rural Health Policy has focused on creating a formal QI program at SCCC. This included hiring a QI Manager to manage day-to-day operations of the program, as well as a Data Coordinator who manages reporting and all data requests. This included training on PDSA cycles for the QI Manager, and then the entire SCCC Staff. Grant deliverables include number of trainings performed for all staff, number of PDSA cycles completed, and number of health outcomes improved. As an FQHC-LA, SCCC follows the same reporting guidelines as a regular FQHC, and submits Uniform Data System (UDS) data annually. There are 13 different clinical quality measures as part of the UDS. In addition, SCCC is attesting to Meaningful Use Stage 1 in 2014 and will apply for PCMH in 2015. These are also responsibilities of the QI Manager and Data Coordinator.					

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Georgia Health Policy Center Technical Assistance Consultant information	Name:	Deana Farmer				
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Florida

St. Johns River Rural Health Network, Inc.

Grant Number	G20RH26406					
Grantee Organization Name	St. Johns River Rural Health Network, Inc.					
Address	480 W Lowder St.					
	City:	Macclenny	State:	FL	Zip-code:	32063
Grantee organization website	http://stjohnsriverrhn.org					
Grantee Project Director	Name:	Nikole M Helvey / Monifa Charles				
	Title:	Director				
	Phone:	904-301-3678 ext. 107				
	Fax:	904-301-3682				
	Email:	Monifa_Charles@hpcnef.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$149,942				
	Sept 2014 to Aug 2015:	$174,942				
	Sept 2015 to Aug 2016:	$149,942				

Network Partners	Organization Name	City/County	Organization Type
	Florida Department of Health Nassau	Nassau	Health Depart.
	Florida Department of Health Clay	Clay	Health Depart
	Florida Department of Health Bradford	Bradford	Health Depart
	Florida Department of Health Baker	Baker	Health Depart
	Florida Department of Health Union	Union	Health Depart

The communities/counties that the Quality Improvement project serves	Countywide Baker	Countywide Nassau
	Countywide Bradford	Countywide Union
	Countywide Clay	
The target population served	Ages 18-64	Underserved
	Chronic conditions	Uninsured
Focus Areas	Care Coordination	Chronic Disease: Diabetes, CVD
Health Information Technology Systems	Diabetes Master Clinician Program Registry	
Quality Improvement Model	Critical Pathways	
Description of the Quality Improvement project	Rural Health Network is building on the successes of Project Turning Point by working directly with each of the five primary care partners to identify and fully integrate targeted, evidence-based quality improvement strategies into their routine clinical workflows that aim to drive improved outcomes across all three of the primary diabetes clinical indicators of hemoglobin A1c, blood pressure, and blood cholesterol. Registry data and evaluation findings serve as the basis for the Network's dedicated project team and the primary care clinical teams to collaboratively prioritize and select specific evidence-based quality interventions in each site using a critical pathways approach that maps the unique processes in each location and identifies specific points for intervention. St. Johns River Rural Health Network contracts directly with the Medical Director of the Diabetes Master Clinician Program (DMCP) to facilitate targeted periodic training sessions with the clinical teams; and has a registered nurse "change agent" in place to provide on-site technical assistance and ensure effective implementation of the selected strategies consistently across all sites.	

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	Email:	aferrero@hrsa.gov				
	Website:	http://www.hrsa.gov/ruralhealth/index.html				
	Address:	5600 Fishers Lane, Room 17W21-B				
	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Tamanna Patel				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0306				
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	Address:	14 Marietta Street, Suite 221				
	City:	Atlanta	State:	Georgia	Zip-code:	30303

Illinois

Knox, County of

Grant Number	G20RH26392					
Grantee Organization Name	Knox, County of Galesburg					
Address	1361 W Fremont St.					
	City:	Galesburg	State:	IL	Zip-code:	61401
Grantee organization website	http://knoxcountyhealth.org/					
Grantee Project Director	Name:	Michele Fishburn				
	Title:	Director of Compliance and Quality Management				
	Phone:	309-344-2224; ext. 222				
	Fax:	309-344-5049				
	Email:	fishburn@knoxcountyhealth.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	Knox County					
The target population served	Patients with chronic disease					
Focus Areas	Care coordination		Meaningful Use compliance			
	Care management		Patient Centered Medical Home			
	Children's Oral Health					
Health Information Technology Systems	Greenway PrimeSuite					
Quality Improvement Model	Plan-Do-Study-Act (PDSA)					
Description of the Quality Improvement project	Knox County Health Center (KCHC) staff received training for quality through a one and a half day initial training, two follow up webinars, and four learning collaboratives which resulted in two quality improvement projects completed in the study phase of the Plan Do Study Act Model for Improvement. One team's goal is to reduce the number of no show appointments for regular child dental cleanings and the other team's focus is on completing the revenue cycle in a timelier manner. Presently, both teams are continuing to follow the implementation of their improvement theories. In January, 2015, both teams will be able to complete their projects through the Act phase where they will decide to adopt, modify or abandon the change they implemented to reach their goals. From the training provided this past year and the experience the two teams gained, a culture of quality improvement (QI) is beginning to unfold as staff understand the importance and value of the process. Future QI projects will continue to be facilitated by the Director of Compliance and Quality Management and the Quality Improvement Coordinator.					
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	Address:	5600 Fishers Lane, Room 17W21-B				
	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Deana Farmer				
	Title:	Technical Assistance Consultant				
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	Email:	dfarmer13@gsu.edu				
	Website:	www.ruralhealthlink.org				
	Address:	14 Marietta Street, Suite 221				
	City:	Atlanta	State:	Georgia	Zip-code:	30303

Indiana

Boone County Community Health Clinic, Inc.

Grant Number	20RH26382					
Grantee Organization Name	Boone County Community Health Clinic, Inc.					
Address	416 W. Camp Street					
	City:	Lebanon	State:	IN	Zip-code:	46052
Grantee organization website	http://www.boonecountyclinic.org/					
Grantee Project Director	Name:	Todd Jones				
	Title:	CEO/CFO				
	Phone:	765-483-4469				
	Fax:	765-483-4495				
	Email:	tjones@boonecountyclinic.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$148,556				
	Sept 2014 to Aug 2015:	$149,786				
	Sept 2015 to Aug 2016:	$149,779				

Network Partners	Organization Name	City/County	Organization Type
	N/A		

The communities/counties that the Quality Improvement project serves	Boone County	Montgomery County
	Clinton County	
The target population served	Chronic Conditions	Pregnant Women
	Low-Income	Uninsured
	Medicaid	Under-Insured
Focus Areas	Care Coordination	Hypertension
	Depression	Obesity
	Diabetes	Tobacco Use
Health Information Technology Systems	iSalus Electronic Medical Record	
Quality Improvement Model	Lean Healthcare	

Description of the Quality Improvement project

The purpose of the project is coordinate healthcare through evidence-based quality improvement activities that achieve better health, better healthcare and lower cost. The goals are: to improve financial and operational efficiency within a Nurse Practitioner (NP) led clinic using Lean Healthcare quality improvement strategies and optimizing the use of the electronic medical record (EMR); improve patient healthcare outcomes focusing on clinical indicators for management of diabetes, hypertension, and asthma as well as reduction of obesity and smoking; and to improve patient engagement and satisfaction by improving access to care, ongoing provider support and lowering out of pocket expenses.

The evaluation effort for this project will include monitoring the Performance Improvement Measurement System (PIMS) measures as well as other performance indicators on a quarterly basis to assess the impact and success of the project. Quarterly PIMS measures and reports will be included in monthly provider meetings as well as quarterly staff meetings to share the success and progress with all the other clinic staff. These results will be used to determine any changes in policy/procedures that may need to be made to improve outcomes or patient satisfaction.

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Georgia Health Policy Center Technical Assistance Consultant information	Name:	Deana Farmer				
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	Address:	14 Marietta Street, Suite 221				
	City:	Atlanta	State:	Georgia	Zip-code:	30303

Iowa

Madison County Memorial Hospital

Grant Number	G20RH26394					
Grantee Organization Name	Madison County Memorial Hospital					
Address	300 W Hutchings St.					
	City:	Winterset	State:	IA	Zip-code:	50273
Grantee organization website	www.madisonhealth.com					
Grantee Project Director	Name:	Marcia Hendricks				
	Title:	Chief Executive Officer				
	Phone:	515-462-2373				
	Fax:	515-973-8158				
	Email:	mhendricks@madisonhealth.com				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$82,091				
	Sept 2014 to Aug 2015:	$209,820				
	Sept 2015 to Aug 2016:	$146,562				

Network Partners	Organization Name	City/County	Organization Type
	Mercy Medical Center-Des Moines' Accountable Care Organization	Des Moines/ Polk County	Medical Center/ ACO
	Grinnell Regional Medical Center	Grinnell/ Poweshiek County	Medical Center
	Knoxville Community Hospital	Knoxville/ Marion County	Medical Center
	Clarinda Regional Health Center	Clarinda/ Page County	Medical Center
	Monroe County Hospital	Albia/ Monroe County	Medical Center
	Wayne County Hospital	Corydon/ Wayne County	Medical Center
	*Each of these rural hospitals included in this project are members of the Mercy Health Network.		

The communities/counties that the Quality Improvement project serves	Madison County, Iowa	Page County, Iowa
	Marion County, Iowa	Poweshiek County, Iowa
	Monroe County, Iowa	Wayne County, Iowa
The target population served	Patients with chronic conditions	
Focus Areas	Cardiovascular Disease	Hypertension
	Diabetes	Obesity
	Health Coaching	Tobacco Use
Health Information Technology Systems	McKesson Population Manager	MedVentive
Quality Improvement Model	Office-Based Health Coach Model	

Description of the Quality Improvement project	Madison County Memorial Hospital's three-year HRSA Small Health Care Provider Quality Improvement grant is helping fund the implementation of an office-based health coach quality improvement model at six rural primary care clinic systems in southern and western Iowa. This project is led by Madison County Memorial Hospital with program partners including Clarinda Regional Health Center, Wayne County Hospital, Grinnell Regional Medical Center, Knoxville Community Hospital, Monroe County Hospitals and Clinics and Mercy Medical Center-Des Moines' Accountable Care Organization. Each partner is a member of Mercy Health Network, a consortium of health care providers working together to improve the delivery of health care services and reduce costs. The therapeutic relationship that develops between a patient and their coach is the cornerstone of the program. This grant utilizes an evidence-based quality improvement model which integrates health coaching to change patient behavior and tracks outcomes through a disease registry system. The health coach model provides a revolutionary shift away from fragmented, disease-specific care to a fully coordinated, whole person approach to chronic disease management. The health coach model uses concepts derived from Wagner's Chronic Care Model to improve clinical quality and patient outcomes such as use of a disease registry to inform services, empowering patients to manage their own health, and use of internal and community resources to support health goals. Key components of the health coach model are: overseeing the disease registry; pre-visit chart review; self-management support; coordination of care; and quality improvement methods.					
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	City:	Atlanta	State:	Georgia	Zip-code:	30303

Louisiana

DeSoto Healthcare Center, Inc.

Grant Number	G20RH26387-02-00					
Grantee Organization Name	DeSoto Healthcare Center, Inc.					
Address	7356 Highway 509					
	City:	Mansfield	State:	LA	Zip-code:	71052
Grantee organization website	www.desotohealthcare.kk5.org					
Grantee Project Director	Name	Detries Morris, APRN, FNPc				
	Title:	Chief Executive Officer				
	Phone:	318-871-1633				
	Fax:	318-871-1677				
	Email:	dmorrisdhc@att.net				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$148,600				
	Sept 2014 to Aug 2015:	$147,800				
	Sept 2015 to Aug 2016:	$149,992				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	DeSoto Parish					
The target population served	Patients with chronic diseases		Tobacco use			
Focus Areas	Diabetes		Hypertension			
	Hyperlipidemia		Obesity			
Health Information Technology Systems	Practice Fusion					
Quality Improvement Model	Chronic Care Model		FOCUS-Plan Do Study Act (PDSA)			
Description of the Quality Improvement project	Project PUSH implements quality improvement activities by: 1) restructuring of program, 2) improving utilization of current resources, 3) expanding screening capabilities, and 4) promoting health and wellness. The evidence-based quality improvement model utilized will be the Chronic Care Model. The FOCUS-PDSA methodology is used to test change that results in improvement: Find the problem; Organize the team; Clarify the current knowledge of the process; Understand the process & causes of poor quality; Select improvement opportunities–Plan the change; Do or implement the change; Study & analyze data based on anticipated improvement due to change; Act by implementing improved process through policy and procedure and systematic spread and change or repeating PDSA until expected improvement is achieved based on measurable outcome. Each problem is prioritized based on problem affecting the largest volume, cost and problem prone or frequency of occurrence. As DeSoto Healthcare Center continues to seek improvement opportunities, we also will apply for accreditation with the National Committee for Quality Assurance (NCQA). Project PUSH utilizes Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as the Disease Management & Wellness and Health Promotion by NCQA as objective measures. DHC utilizes its current implemented certified Office of the National Coordinator for Health Information Technology electronic medical records to collect, monitor & report data.					

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	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Tamanna Patel				
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	City:	Atlanta	State:	Georgia	Zip-code:	30303

Michigan

MidMichigan Health

Grant Number	G20RH26397					
Grantee Organization Name	MidMichigan Health					
Address	4000 Wellness Drive					
	City:	Midland	State:	MI	Zip-code:	48670
Grantee organization website	www.midmichigan.org					
Grantee Project Director (primary contact person for your grant)	Name:	Mary Greeley MS, RD, CDE				
	Title:	Director of Collaborative Care				
	Phone:	989-488-5469				
	Fax:	989-839-1626				
	Email:	Mary.greeley@midmichigan.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$149,669				
	Sept 2014 to Aug 2015:	$149,307				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	N/A		

The communities/counties that the Quality Improvement project serves	Gladwin County	
The target population served	All patients attributed to the Gladwin RHC Primary Care Offices	
Focus Areas	Care management for patients of various risk levels	
Health Information Technology Systems	Crimson Care Disease Registry	
Quality Improvement Model	Model for Improvement	
Description of the Quality Improvement project	MidMichigan Health, a non-profit health system headquartered in Midland, Michigan, was awarded a Small Health Care Provider Quality Improvement grant to promote the development of an evidence-based culture and delivery of coordinated care that improves the health outcomes for patients served by rural primary care providers in Gladwin County. Additionally, chronic disease management will be enhanced and patients and their caregivers will be better engaged. MidMichigan Health is dedicated to providing quality, comprehensive health care throughout the middle of Michigan and beyond with medical centers in Midland, Gratiot, Clare and Gladwin counties, as well as urgent care centers, home care, nursing homes, physicians, medical offices and other specialty health services. Six of the fourteen counties it serves have been federally designated Health Professional Shortage Areas or Medically Underserved Areas because of the number of and types of physicians available for its rural and low income populations. Indicative of the age and incomes of those served across the system of care, 61.7% of overall revenue was from Medicare and Medicaid last year. The focus of the HRSA project is on Gladwin County where its affiliate MidMichigan Medical Center-Gladwin is a Critical Access Hospital (CAH) and where MidMichigan Physician Group (MPG) primary care providers are located. The HRSA grant project will utilize the Model for Improvement to test the efficacy of using a Tiered Care Management Model to identify and address chronic disease issues among the approximately 8,000 patients served with the ultimate goal of improving outcomes and providing patient education support in a sustainable and cost effective manner.	

	By embedding a Care Management Team in the primary care setting, the health care team will be provided with the additional support necessary to improve the health of the community of patients. This team will consist of a Panel of Community Resource Specialists that will utilize the Crimson Care Disease Registry to identify gaps-in-care and perform basic outreach to ensure health care needs are met. This individual will also help to connect patients to community resources to improve overall health. The Care Management Team will be led by a Nurse Care Manager who will identify and engage high risk patients to reduce or prevent readmissions, improve self-management skills, and coordinate care across all settings. Through the implementation of this model we hope to improve outcomes, reduce the onset of preventable chronic disease, and enhance care coordination.					
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	Address:	5600 Fishers Lane, Room 17W21-B				
	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Catherine R. Liemohn				
	Title:	Technical Assistance Consultant				
	Tel #:	770-641-9940				
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	City:	Atlanta	State:	Georgia	Zip-code:	30303

Michigan

Upper Peninsula Heath Care Network

Grant Number	G20RH26411					
Grantee Organization Name	Upper Peninsula Heath Care Network (UPHCN)					
Address	228 W. Washington St. Ste. 2					
	City:	Marquette	State:	MI	Zip-code:	49855
Grantee organization website	www.uphcn.org					
Grantee Project Director	Name:	Germaine Stefanac, RN				
	Title:	Project Director				
	Phone:	906-250-0517				
	Fax:	906-225-7690				
	Email:	gstefanac@uphp.com				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	Baraga County Memorial Hospital	Baraga	Rural Health Clinic (RHC)
	Dickinson County Healthcare System	Dickinson	6 RHCs
	Mackinac Straits Health System	Mackinac	RHC
	Munising Memorial Hospital	Alger	RHC
	Northstar Health System	Iron	4 RHCs
	OSF St. Francis Hospital	Delta	3 RHCs
	Portage Health	Houghton	3 RHCs
	Upper Great Lakes Family Health Center	Marquette	Federally Qualified Health Center
	MI WI Family Practice Assoc. PC	Dickinson	RHC
	Riverside Medical Associates PC	Chippewa	RHC
	Superior Family Medical Assoc.	Chippewa	RHC
	Aspirus Keweenaw Hospital	Houghton	RHC
	Schoolcraft Memorial Hospital	Schoolcraft	RHC
	Western UP Health Department	Ontonagon	Health Department
	LMAS Health Department	Baraga	Health Department

The communities/counties that the Quality Improvement project serves	Alger	Iron
	Baraga	Mackinac
	Chippewa	Keweenaw
	Delta	Luce
	Dickinson	Marquette
	Gogebic	Schoolcraft
	Houghton	
The target population served	Patients served in 14 Upper Peninsula counties that visit 24 RHCs; 1 FQHC; and two Health Departments	
Focus Areas	Smoking Cessation	Hypertension
	Cardiovascular disease	Obesity
	Diabetes	

Health Information Technology Systems	Allscripts				eMD's	
	CPSI				IpatientCare	
	Practice Partner				Others to be added in Yrs 2 & 3: eCW, Epic and Healthland	
Quality Improvement Model	Lean for Clinical Redesign eCollaborative					
Description of the Quality Improvement project	UPHCN's quality improvement project provides quality-improvement training activities in Critical Access Hospital-affiliated provider offices, Rural Health Clinics, Federally Qualified Health Centers and health departments utilizing the "Lean for Clinical Redesign eCollaborative" evidence-based quality improvement model. This training consists of development of a LEAN Goal & Action plan, on-site work sessions and workflow mapping to include additional sustainability quality initiative programs. Our initial health system improvement focus is on smoking cessation due to the higher adult smoking rates prevalent in the Upper Peninsula of Michigan. Additional clinical improvement activity will include: diabetes, hypertension, cardiovascular disease and obesity. Another important element of our quality initiative is our meaningful-use expertise. Our QI field staff has a high degree of experience with the electronic health record incentive program established through the Office of the National Coordinator for Health Information Technology. As a result, they work closely to train and assist staff in the provider offices on data collection and reporting. This training is critical for improving quality and patient outcomes, as well as ensuring sustainability of quality initiatives. As on-going training occurs, practice staff understands the benefits of the data collection and reporting beyond just meeting the meaningful use requirements. UPHCN is confident that our quality improvement efforts will result in improved health outcomes, enhanced disease management, better engagement of patients and providers, and sustainable improvements in health care delivery for the residents of Michigan's Upper Peninsula.						
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Missouri

Cox Medical Center Branson/Skaggs Medical Center

Grant Number	G20RH26404					
Grantee Organization Name	Cox Medical Center Branson/Skaggs Medical Center					
Address	525 Branson Landing Blvd.					
	City:	Branson	State	MO	Zip-code:	65616
Grantee organization website	www.coxhealth.com					
Grantee Project Director	Name:	Carol Myers				
	Title:	Nurse Care Manager				
	Phone:	417-335-7075				
	Fax:	417-335-7544				
	Email:	Carol.Myers@coxhealth.com				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$142,000				
	Sept 2014 to Aug 2015:	$148,100				
	Sept 2015 to Aug 2016:	$148,100				

Network Partners	Organization Name	City/County	Organization Type
	Faith Clinic	Branson	Uninsured clinic
	Taney County Health Department	Branson	Health Department
	Stone County Health Department	Branson West	Health Department

The communities/counties that the Quality Improvement project serves	Branson	Taney County
	Forsyth	Taney County
	Rockaway Beach	Taney County
	Miriam Woods Village	Taney County
	Kissee Mills	Taney County
	Branson West	Stone County
	Reeds Spring	Stone County
	Kimberling City	Stone County
	Lampe	Stone County
	Blue Eye	Stone County
The target population served	Chronic conditions	Medicare population
	Medicaid population	
Focus Areas	Behavioral Health	Obesity
	Care Management	Patient Centered Medical Home
	Diabetes	Smoking
	Hypertension	
Health Information Technology Systems	Centricity	Phytel Outreach
Quality Improvement Model	LEAN	

Description of the Quality Improvement project	Skaggs Community Hospital Association (Skaggs), located in Branson, Missouri, will conduct the Primary Care Quality Improvement Initiative to improve the quality of primary care delivery in eight primary care clinics through healthcare redesign using a replicable Patient Centered Medical Home model, specifically that of the Missouri Medical Home Collaborative (MMHC). The Primary Care Quality Improvement Initiative will improve care management by automating population health management through Phytel Outreach; using patient data collected through automation and Centricity patient electronic health records (EHR) to determine gaps in care and breakdowns in quality; and utilizing the evidence-based quality improvement model of LEAN in underperforming clinics. Goals of the project include: Improving population health, decreasing county-wide rates of chronic disease, and integrating public health into primary care. Objectives include: develop replicable system for automating the health management in four primary care patient centered medical homes, coordinate and provide care management in four primary care patient centered medical homes, develop a replicable system for quality improvement in four primary care patient centered medical homes.					
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	Title:	Technical Assistance Consultant				
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Missouri

Ozarks Medical Center

Grant Number	G20RH26400					
Grantee Organization Name	Ozarks Medical Center (OMC)					
Address	1100 Kentucky Avenue, P.O. Box 1100					
	City:	West Plains	State:	MO	Zip-code:	65775
Grantee organization website	www.ozarksmedicalcenter.com					
Grantee Project Director	Name:	Jo Wagner				
	Title:	Documentation Integrity Director				
	Phone:	417-256-9111				
	Fax:	417-257-5820				
	Email:	Jo.wagner@ozarksmedicalcenter.com				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$149,969				
	Sept 2014 to Aug 2015:	$149,699				
	Sept 2015 to Aug 2016:	$149,699				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	Oregon County, Missouri					
The target population served	Dually diagnosed patients in the Thayer Missouri Clinic (Dual- diabetes and Cardiovascular)					
Focus Areas	Cardiovascular disease		Health/ Wellness Coaching			
	Care Coordination		Patient Center Medical Home			
	Diabetes					
	Disease Management					
Health Information Technology Systems	Allscripts					
Quality Improvement Model	Model for Improvement					
Description of the Quality Improvement project	Project IMPACTS is a case management program focused on the care of patients of the OMC Thayer Medical Clinic who have been dually diagnosed with heart disease and diabetes. A Registered Nurse Patient Advocate evaluates patients and works with them on an individualized SMART goal plan to provide the education and tools they need to better manage their health. Since the program inception, 318 patients have been enrolled in the program with 155 actively engaged. Activities include support groups, SMART goals, healthy cooking, grocery shopping trips and individualized activities as needed. Patients receive blood pressure machines, glucometers and strips to ensure that they have all of the necessary tools to successfully manage their disease.					
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	City:	Rockville	State:	Maryland	Zip-code:	20857

Georgia Health Policy Center Technical Assistance Consultant information	Name:	Deana Farmer				
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Missouri

Pike County Memorial Hospital

Grant Number	G20RH26401					
Grantee Organization Name	Pike County Memorial Hospital					
Address	2305 Georgia St.					
	City:	Louisiana	State	MO	Zip-code:	63353
Grantee organization website	pcmh-mo.org					
Grantee Project Director	Name:	Lisa Pitzer, RN				
	Title:	Director Medical-Surgical Unit				
	Phone:	573-754-5531, ext. 154				
	Fax:	573-754-5423				
	Email:	lpitzer@pcmhmo.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	Eastern Mo Health Services	Louisiana/Pike	Rural Health Clinic
	Pike Co. Health Dept.; Home Health & Hospice	Bowling Green/Pike	County Health Dept., Home Health and Hospice
	Twin Pikes YMCA	Louisiana/Pike	Community fitness, youth development center

The communities/counties that the Quality Improvement project serves	Pike County Illinois	Pike County Missouri
The target population served	Adult patients with targeted chronic diseases seen in the outpatient clinics, hospital emergency department and inpatient hospital unit	
Focus Areas	Anxiety	Obesity
	Chronic Care Self-Management	Tobacco Use
	Care Coordination	Heart disease (coronary artery disease, hyperlipidemia)
	Diabetes mellitus	Hypertension
	Depression	
Health Information Technology Systems	HIT for Emergency Department and Hospital Inpatients: Paragon/McKesson	HIT for Outpatient Clinic Patients: Greenway
Quality Improvement Model	Stanford Model for Chronic Care	

Description of the Quality Improvement project	The overall goal of the grant is to increase the number of adult patients screened, diagnosed, and receiving early intervention and ongoing follow-up care to improve health status. The primary target population includes individuals who frequent the emergency room, have an inpatient admission for chronic disease, and have been screened and determined to be at risk for diabetes. Grant activities include care navigation, improving health literacy, engaging patients in chronic disease management, and use of electronic clinical information systems to better track and monitor patient care and progress. Care navigation includes assisting patients and families with financial, social, physical, and emotional barriers that impact health and the delivery of health care by linking them to services that enable them to better manage their care and improve their health status. Examples include nutritional counseling, fitness workshops, mental health services, home visits, education on disease prevention and management, support groups, transportation assistance, etc. Patients with chronic disease diagnoses will be identified and enrolled into disease self-management programs and receive intensive intervention in terms of patient contact, health education, and sustained follow-up. Collaborating community partners and resources are included in the disease management program. The electronic medical record used by the hospital will be expanded and modified and an electronic medical record will be launched in the outpatient clinics. The project is open to any current or future patient that accesses services through Pike County Memorial Hospital and/or Eastern Missouri Health Services for the provision of health care and to any resident served in Pike County by Pike County providers. Any physician or organization will be able to make a referral to the program.					
Office of Rural Health Policy Project Officer information	Name:	Ann Ferrero				
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	Website:	http://www.hrsa.gov/ruralhealth/index.html				
	Address:	5600 Fishers Lane, Room 17W21-B				
	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Tanisa Adimu				
	Title:	Technical Assistance Consultant				
	Tel #:	404-413-0302				
	Email:	tadimu@gsu.edu				
	Website:	www.ruralhealthlink.org				
	Address:	14 Marietta Street, Suite 221				
	City:	Atlanta	State:	Georgia	Zip-code:	30303

New Hampshire

Mary Hitchcock Memorial Hospital

Grant Number	G20RH26396					
Grantee Organization Name	Mary Hitchcock Memorial Hospital					
Address	1 Medical Center Drive					
	City:	Lebanon	State:	NH	Zip-code:	03756
Grantee organization website	http://med.dartmouth-hitchcock.org/telehealth.html					
Grantee Project Director	Name:	Sarah N Pletcher				
	Title:	Principal Investigator, Medical Director, Center for Telehealth				
	Phone:	603-653-0424				
	Fax:	603-727-7462				
	Email:	Sarah.N.Pletcher@hitichcock.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$149,603				
	Sept 2014 to Aug 2015:	$148,252				
	Sept 2015 to Aug 2016:	$146,429				

Network Partners	Organization Name	City/County	Organization Type
	New London Hospital Associates	New London/ Merrimack	CAH
	Newport Health Center	Newport/Sullivan	Rural Health Clinic
	Groveton Physician Offices	Groveton/Coos	Rural Health Clinic
	Weeks Physician Offices	Lancaster/Coos	Rural Health Clinic
	Whitefield Physician Offices	Whitefield/Coos	Rural Health Clinic
	North Stratford Physician Offices	North Stratford/Coos	Rural Health Clinic

The communities/counties that the Quality Improvement project serves	Counties: Merrimack, Sullivan, Coos	
	Communities: Bradford, Newbury, Sunapee, Croydon, Grantham, Goshen, Lempster, Wilmont, Washington, New London, Springfield, Sutton, Newport, Groveton, Lancaster, Whitefield	
The target population served	Patients with chronic conditions	Elderly
	Adults	Underinsured
	Uninsured	Hypertension
Focus Areas	Diabetes	Cardiovascular Disease
Health Information Technology Systems	Insight	
Quality Improvement Model	Lean Six Sigma	Define, Measure, Analyze, Improve and Control (DMAIC) Project Management Methodology

<table>
<tr><td>Description of the Quality Improvement project</td><td colspan="6">The overwhelming rurality of New Hampshire tends to isolate primary care providers and clinics from continuing medical education and continuing nursing education training opportunities which constrains the quality of primary care in the area. The lack of resources and support often results in low provider satisfaction and high staff turnover. Existing resources in the area are not equipped to provide ongoing quality improvement training that engages rural primary care providers in improving best practice treatment and disease management in outpatient settings.

With the rapidly evolving landscape in healthcare today, it is essential that rural primary care providers and organizations alike be prepared to engage in continuous quality improvement programs, participate in pay-for-performance and other incentive programs, such as Patient-Centered Medical Home, Meaningful Use, and Accountable Care Organizations. It is also essential that rural primary care providers adopt an evidence-based culture and delivery of coordinated care in the primary care setting.

To address these quality improvement needs, Dartmouth-Hitchcock will leverage teletechnology to train primary care doctors in rural and underserved areas to treat complex chronic illnesses locally and to provide staff with quality improvement process change management.

The New England Rural Quality Consortium (NERQC) will regionalize Dartmouth-Hitchcock's Value Institute to expand the capacity of integrated performance improvement throughout northern New England and support robust identification, prioritization, preparation, and execution of initiatives from a population health management approach. NERQC's goals are as follows:

• Improve outcomes of patients with chronic conditions in the primary care setting.
• Improve the sharing of evidence-based best practices and protocols for chronic conditions.
• Improve patient and provider satisfaction as a result of improved quality and efficient care.
• Strengthen the Telehealth network to include ongoing education, outcomes-sharing, and measurement of financial impact.</td></tr>
<tr><td rowspan="8">Office of Rural Health Policy Project Officer information</td><td>Name:</td><td colspan="5">Ann Ferrero</td></tr>
<tr><td>Title:</td><td colspan="5">Small Health Care Provider Quality Improvement Program Coordinator</td></tr>
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<tr><td>City:</td><td>Rockville</td><td>State:</td><td>Maryland</td><td>Zip-code:</td><td>20857</td></tr>
<tr><td rowspan="8">Georgia Health Policy Center Technical Assistance Consultant information</td><td>Name:</td><td colspan="5">Catherine Liemohn</td></tr>
<tr><td>Title:</td><td colspan="5">Technical Assistance Consultant</td></tr>
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<tr><td>City:</td><td>Atlanta</td><td>State:</td><td>Georgia</td><td>Zip-code:</td><td>30303</td></tr>
</table>

New Hampshire

North Country Health Consortium

Grant Number	G20RH26398					
Grantee Organization Name	North Country Health Consortium					
Address	262 Cottage Street					
	City:	Littleton	State:	NH	Zip-code:	03561
Grantee organization website	www.nchcnh.org					
Grantee Project Director	Name:	Nancy Frank				
	Title:	Executive Director				
	Phone:	603-259-3700				
	Fax:	603-444-0945				
	Email:	nfrank@nchcnh.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	Ammonoosuc Community Health Svcs.	Littleton/Grafton	FQHC
	Coos County Family Health Services	Berlin/Coos	FQHC
	Indian Stream Health Center	Colebrook/Coos	FQHC
	Mid-State Health Center	Plymouth/Grafton	FQHC

The communities/counties that the Quality Improvement project serves	Berlin & Surrounding Towns	Littleton & Surrounding Towns
	Colebrook & Surrounding Towns	Plymouth & Surrounding Towns
	Coos and Northern Grafton Counties	
The target population served	Patients with Chronic Conditions	
Focus Areas	Chronic Disease Management	
Health Information Technology Systems	eMD	SuccessEHD
	GE Centricity	
Quality Improvement Model	Clinical Microsystems Model	Chronic Disease Self-Management - ("Better Choices, Better Health" - Stanford University Model)

Description of the Quality Improvement project	The goal of this initiative is to promote the development of an evidence-based culture and delivery of coordinated care in the primary care setting. This initiative provides support to rural primary care providers who are implementing quality improvement strategies to improve the health outcomes of obese adults in rural northern New Hampshire. North Country Health Consortium staff will work with four FQHCs to: 1) provide coaching on the Clinical Microsystems Quality Improvement model; 2) offer training in Motivational Interviewing for FQHC staff; 3) create an Obesity Prevention Toolkit to serve as a resource for both patients and providers; and 4) establish and/or strengthen Chronic Disease Self-Management Programs in each of the FQHC service areas. Aggregate data from the four community health centers will be used to measure the effectiveness of strategies developed to improve health outcomes of the target population. Achieved outcomes and methodology will be shared at state-wide, regional, and national meetings frequented by North Country Health Consortium and project participants.					
Office of Rural Health Policy Project Officer information	Name:	Christina Villalobos				
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Georgia Health Policy Center Technical Assistance Consultant information	Name:	Deana Farmer				
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New Mexico

Hidalgo Medical Services

Grant Number	G20RH26390					
Grantee Organization Name	Hidalgo Medical Services					
Address	530 East DeMoss Street					
	City:	Lordsburg	State:	NM	Zip-code:	88065
Grantee organization website	http://www.hms-nm.org					
Grantee Project Director	Name:	Linda Smith				
	Title:	Compliance Coordinator				
	Phone:	575- 597-2720				
	Fax:	575 -313-8237				
	Email:	lsmith@hmsnm.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	Hidalgo County, New Mexico		Grant County, New Mexico			
The target population served	Patients with chronic conditions in Grant and Hidalgo counties in southwestern New Mexico					
Focus Areas	Diabetes		Hypertension			
	Cardiovascular Disease		Obesity			
	Tobacco Use		Clinical Depression			
	Influenza Immunizations		Care Coordination			
Health Information Technology Systems	eClinical Works		BridgIT			
Quality Improvement Model	Model for Improvement					

Description of the Quality Improvement project	Hidalgo Medical Services (HMS) proposes to improve chronic disease management of diabetes, hypertension, cardiovascular disease, obesity, and tobacco use through a multi-strategy quality improvement project. This project includes health information technology components within the HMS electronic health record system, eClinicalWorks (eCW). HMS will improve patient recall for recommended preventive and management appointments, laboratory tests, and studies. HMS will implement the eClinical Messenger module of eCW, which enables HMS to set up alerts for services due soon and automatically call or send a text message to patients to remind them to schedule an appointment for these services. HMS will utilize existing Community Health Workers (CHWs) to follow up with non-responsive patients and help them to set up appointments as well as identify and address potential socio-economic barriers to care. HMS will develop templates and flowsheets in eCW that enable patients and providers to develop plans of care within structured data fields. This will allow HMS to track the development and follow-through of plans of care and will enable providers across multiple service types to coordinate plans of care and communicate needed services. This includes better integration of CHW services with clinical care.					
Office of Rural Health Policy Project Officer information	Name:	Natassja Manzanero				
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North Carolina

FirstHealth of the Carolinas

Grant Number	G20RH26388					
Grantee Organization Name	FirstHealth of the Carolinas					
Address	P.O. Box 3000					
	City:	Pinehurst	State:	NC	Zip-code:	28374
Grantee organization website	www.firsthealth.org					
Grantee Project Director	Name:	Roxanne Elliott				
	Title:	Policy Director				
	Phone:	(910) 715-3487				
	Fax:	(910) 715-5054				
	Email:	rmelliott@firsthealth.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000 (are submitting carryover from year one)				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	Consortium consists of internal FirstHealth partners		

The communities/counties that the Quality Improvement project serves	Hoke County	
	Montgomery County	Richmond County
The target population served	Low-income patients	
	Patients with Chronic Conditions	Uninsured patients
Focus Areas	Care Transition	Chronic Disease Management
	Diabetes	
Health Information Technology Systems	Athena	
Quality Improvement Model	Chronic Care Model	

Description of the Quality Improvement project

FirstHealth is implementing a population health management model through the development of a multidisciplinary approach to care in a transition care clinic environment.

FirstHealth will open three transition care clinics (one per county in the service region). The clinics will implement a multidisciplinary approach to care with pharmacists, health coaches, diabetes educators/registered dietician, respiratory therapist, physician, nurse and front desk personnel. The clinics will utilize the huddle method to formulate a care plan. The shared care plans will be integrated into patient treatment and electronic medical record system.

Patients will be treated for up to 30 days in the transition care clinic and then discharged to a primary care home upon improved disease management indicators. The clinic's staff will implement the Chronic Care Model and strive to link patients both to medical as well as clinical resources. Again, this approach will be integrated into the shared care plans. Patients will be discharged with a copy of their shared care plan, and a copy will be sent to the primary care provider to enhance continuity of care and linkage to programs/resources.

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	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Eric Baumgartner				
	Title:	Technical Assistance Consultant				
	Tel #:	504-813-3688				
	Email:	etbaumgartner@bellsouth.net				
	Website:	www.ruralhealthlink.org				
	Address:	14 Marietta Street, Suite 221				
	City:	Atlanta	State:	Georgia	Zip-code:	30303

North Carolina

Greene County Health Care, Inc.

Grant Number	G20RH26389					
Grantee Organization Name	Greene County Health Care, Inc.					
Address	7 Professional Drive					
	City:	Snow Hill	State:	NC	Zip-code:	28580
Grantee organization website	http://www.greenecountyhealthcare.com/					
Grantee Project Director	Name:	Doug Smith				
	Title:	CEO				
	Phone:	252-747-8162				
	Fax:	252-747-8163				
	Email:	dsmith@greenecountyhealthcare.com				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	Kinston Community Health Care	Kinston, NC / Lenoir County	FQHC
	Bakersville Community Medical Clinic	Bakersville, NC / Mitchell County	FQHC
	West Caldwell Health Council	Lenoir, NC / Caldwell County	FQHC
	Ocracoke Health Center	Ocracoke, NC / Hyde County	FQHC
	Engelhard Medical Center	Engelhard, NC / Hyde County	FQHC
	Black River Health Services	Burgaw, NC / Pender County	FQHC
	Greene County Health Care	Snow Hill, NC / Greene County	FQHC
	Community Health and Wellness Center of Greater Torrington	Torrington, CT / Litchfield County	FQHC
	Nuestra Clinica Del Valle	SanJuan, TX / Hidalgo County	FQHC

The communities/counties that the Quality Improvement project serves	Same as above	
The target population served	Diabetic	OB/GYN
	Hypertension	Pediatric
	Mental/Behavior Health	Uninsured
	Migrant	
Focus Areas	Obesity	Immunizations
	Cardio Vascular Disease	Meaningful Use
	Depression	Patient-Centered Medical Home
	Hypertension	Tobacco Cessation
Health Information Technology Systems	MicroMD Electronic Medical Record	We use both the Electronic Medical Record and Practice Management to

		pull reports along with Cognos Software to run customized reports from our Datawarehouse.
Quality Improvement Model	Focus/Plan Do Study Act (PDSA)	
Description of the Quality Improvement project	We currently have nine network members that are actively participating in the Quality Improvement (QI) initiative made possible by the Small Health Care Provider Quality Improvement Grant. All sites have data available and are able to report QI results and goals. QI meetings are held at each site by local QI teams and Network QI conference calls are scheduled monthly to discuss any issues that may arise. At this time we have around 120 billing/rendering providers that are entering discrete, retrievable data in the Electronic Medical Record. The data entered by these providers allows Community Partners HealthNet to run reports for our network members on a provider by provider basis to help identify staff that may need more individualized training to help improve patient care and the patient's overall experience. By using Quality Improvement to help improve patient outcomes and core measures pertaining to Meaningful Use and Patient Centered Medical Home certification, management of our network sites will see the need to invest in Quality Improvement. Through the investment in QI, we hope to be able to help each site achieve the financial incentives pertaining to Meaningful Use and Patient Centered Medical Home. The following are a few of the activities we are using to help our network members understand the importance of QI in healthcare: • Working with CEO's and QI staff at each site to set achievable goals to build confidence and staff morale concerning the QI initiative. • Create scheduled reports to show QI success as well as areas that need improvement. • Monthly individual site and network QI conference calls to share information on training, implementation of Plan-Do-Study-Act cycles, and new information regarding Meaningful Use, Patient-Centered Medical Home or QI initiatives. • Sharing data to allow network members to discuss different methods to obtain data that will improve patient care and quality of care.	
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	Address:	5600 Fishers Lane, Room 17W21-B
	City:	Rockville — State: Maryland — Zip-code: 20857
Georgia Health Policy Center Technical Assistance Consultant information	Name:	Eric Baumgartner
	Title:	Technical Assistance Consultant
	Tel #:	504-813-3688
	Email:	etbaumgartner@bellsouth.net
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	City:	Atlanta — State: Georgia — Zip-code: 30303

Ohio

Holmes County Health District

Grant Number	G20RH26391					
Grantee Organization Name	Holmes County Health District					
Address	85 N. Grant Street, Suite B					
	City:	Millersburg	State:	OH	Zip-code:	44654
Grantee organization website	http://www.co.holmes.oh.us/health/					
Grantee Project Director	Name:	Matt Falb				
	Title:	Project Coordinator				
	Phone:	330-674-5035				
	Fax:	330-674-2528				
	Email:	mfalb@holmeshealth.org				
Project Period	2013 – 2016					
Expected funding level	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	East Holmes Family Care	4 sites in Holmes County	Primary care practice
	Holmes Family Medicine	Millersburg/Holmes	Primary care practice
	Millersburg Clinic	Millersburg/Holmes	Internal medicine practice
	Pomerene Family Care	Millersburg/Holmes	Primary care practice

The communities/counties that the Quality Improvement project serves	Holmes County	
The target population served	Patients with chronic conditions	
Focus Areas	Diabetes	Preventive health and screening
	Chronic Disease Management	Meaningful Use
Health Information Technology System	Allscripts	
Quality Improvement Model	Chronic Care Model	

Description of the Quality Improvement project	The focus of the quality improvement project is to increase capacity among primary care practices in Holmes County to plan, implement, and evaluate quality improvement projects. A workgroup of a physician, nurse, and office manager from each of the four participating practices oversees the development and implementation of Quality Improvement projects. During year 1, the workgroup identified patients with diabetes as the focus area and selected disease management measures to review as a group. Due to varying levels of capacity to query data and customize electronic health records systems (Allscripts) among the practices, an electronic health record customization subgroup was formed to review data and training needs. One person from each practice is assigned to the customization subgroup which meets regularly to discuss standardization of query methods and reporting templates. The result has been increased knowledge on how to query data in Allscripts and enhanced reliability of reporting feedback to providers. During year 2, the Quality Improvement workgroup decided to focus on preventive health and screening measures. Another focus during year two is promoting the use of the patient portal and assisting practices with meeting Meaningful Use standards.					
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	Address:	5600 Fishers Lane, Room 17W21-B				
	City:	Rockville	State:	Maryland	Zip-code:	20857
Georgia Health Policy Center Technical Assistance Consultant	Name:	Beverly A. Tyler				
	Title:	Technical Assistance Consultant				
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	Email:	btyler@gsu.edu				
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Ohio

ProMedica Defiance Care Navigation

Grant Number	G20RH26386					
Grantee Organization Name	ProMedica Defiance Care Navigation					
Address	1200 Ralston Ave.					
	City:	Defiance	State:	OH	Zip-code:	43512
Grantee organization website	http://www.promedica.org/defiance					
Grantee Project Director	Name:	Debbie Lush				
	Title:	Director of Care Navigation				
	Phone:	419-291-1304				
	Fax:	419-480-6888				
	Email:	debbra.lush@promedica.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$144,539				
	Sept 2014 to Aug 2015:	$147,014				
	Sept 2015 to Aug 2016:	$149,903				
Network Partners	Organization Name			City/County		Organization Type
	N/A					
The communities/counties that the Quality Improvement project serves	Defiance County			Paulding County		
	Fulton County			Putnam County		
	Henry County			Williams County		
The target population served	Patients with 3 or more of the following specific chronic conditions: Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Heart Failure, Hyperlipidemia, Hypertension, and Renal Failure					
Focus Areas	Care Navigation			Patient-Centered Medical Home		
	Health/wellness coaching					
Health Information Technology Systems	Allscripts Enterprise (EMR)					
Quality Improvement Model	ProMedica Defiance Care Navigation					
Description of the Quality Improvement project	The primary goal of the ProMedica Defiance Care Navigation project is to address the health care needs of the rural and underserved populations surrounding ProMedica Defiance Regional Hospital (DRH), a critical access hospital in Defiance, Ohio, by expanding the interdisciplinary health care team currently led by ProMedica Physician's Group Defiance (PPG). The primary objectives of this project are (1) Decrease admissions and emergency department visits in the target population by 20% (2) Improve patient health literacy/knowledge of disease management as evidenced by a 20% increase in the number of patients who adhere to medication regimens and recommended treatment regimens; and (3) Create a balanced community network of care between community and health care providers as evidenced through social network analysis. Patient must have 3 of the following 6 co-morbidities to be eligible: • Diabetes • Hypertension • Hyperlipidemia • COPD • Heart failure					

	• Renal failure Our Care Navigator utilizes multiple strategies to identify eligible patients for navigation; administers a comprehensive assessment to identify patient barriers and create a patient-centered, individualized care plan; educates patients on their disease process using self-management techniques and motivational interviewing strategies; facilitates engaged and goal focused primary care appointments; collaborates with specialists; provides telephonic and face-to-face education to patients regarding their condition and care plan; provides patients with hospital and community resources; and, provides smooth transition of care for navigated patients when hospitalized back to primary care office.					
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	City:	Atlanta	State:	Georgia	Zip-code:	30303

Ohio

Trinity Hospital Twin City

Grant Number	G20RH26409					
Grantee Organization Name	Trinity Hospital Twin City					
Address	819 N. First Street					
	City:	Dennison	State:	Ohio	Zip-code:	44621
Grantee organization website	www.trinitytwincity.org					
Grantee Project Director	Name:	Robin Brown & Jennifer Demuth				
	Title:	Project Director and Grant Coordinator (semi co-director) respectively				
	Phone:	740-922-7450, ext. 2106 for Robin and ext. 2198 for Jennifer				
	Fax:	740-922-6945				
	Email:	rbrown@trinitytwincity.org; jdemuth@trinitytwincity.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$126,500				
	Sept 2015 to Aug 2016:	$101,500				

Network Partners	Organization Name	City/County	Organization Type
	Trinity Health System	Steubenville, Jefferson County, Ohio	Hospital
	The Ohio State University Extension Office Tuscarawas County	Tuscarawas County	Extension office/educational

The communities/counties that the Quality Improvement project serves	Tuscarawas County	Coshocton County
	Harrison County	Carroll County
The target population served	Patients with diabetes	
Focus Areas	Diabetes	Chronic Disease Management
Health Information Technology Systems	E Clinical Works	BRIDGE-IT
Quality Improvement Model	Plan, Do, Study, Act (PDSA)	
Description of the Quality Improvement project	Trinity Hospital Twin City located in rural Tuscarawas County, Ohio, is implementing the Program for Diabetes Care Quality in the hospital's group physician practice, Trinity Medical Group. The Program provides comprehensive treatment and education, transforming the care we provide for persons with diabetes in our rural communities through systematic application of the Care Improvement Model and accelerates improvement through the adoption of the Model for Improvement's Plan-Do-Study-Act (PDSA) framework. We work in consortia with the Trinity Health System (which includes two hospitals and one group physician practice) in Steubenville, Ohio, to implement health information technology (HIT) solutions that systematize evidence-based care for diabetic patients. We overcome barriers to access to care by taking diabetes self-support and education out of the physician office and into numerous small towns and outlying areas with the addition of a certified diabetes educator, working in consortia with the Ohio State University Extension Office-Tuscarawas County. The goal of the project is to provide comprehensive treatment and education that transforms the care we provide for persons with diabetes in our rural communities.	

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Oregon

Northeast Oregon Network

Grant Number	G20RH26399					
Grantee Organization Name	Northeast Oregon Network					
Address	1802 4th Suite A					
	City:	La Grande	State:	OR	Zip-code:	97850
Grantee organization website	www.neonoregon.org					
Grantee Project Director	Name:	Lisa Ladendorff				
	Title:	Executive Director				
	Phone:	541-624-5101				
	Fax:	541-624-5105				
	Email:	lladendorff@neonoregon.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$150,000				
	Sept 2014 to Aug 2015:	$150,000				
	Sept 2015 to Aug 2016:	$150,000				

Network Partners	Organization Name	City/County	Organization Type
	Winding Waters Clinic	Enterprise, Wallowa	Primary Care Clinic
	Wallowa Valley Center for Wellness	Enterprise, Wallowa	Behavioral Health Clinic

The communities/counties that the Quality Improvement project serves		
	Joseph	Wallowa County
	Enterprise	Wallowa County
	Lostine	Wallowa County
	Wallowa	Wallowa County
	Imnaha	Wallowa County
	Troy	Wallowa County

The target population served	Adults with diabetes, hypertension, low patient activation scores, tobacco use and obesity, primarily Caucasian population	
Focus Areas of the grant program	Chronic Disease Management	Obesity
	Diabetes	Tobacco
	Hypertension	
Health Information Technology Systems	Utilizes the EPIC Electronic Health Record system for data collection of quality measures.	
Quality Improvement Model	LEAN and STEPPS quality improvement processes.	
Description of the Quality Improvement project	The Wallowa County Patient Activation Project is designed to address excess rates of hypertension and diabetes in the population by utilizing CQI disciplines and behavioral counseling within a primary care setting to achieve the following goals: • Increased patient self-efficacy as a result of lifestyle behavior changes through the utilization of patient activation interventions provided by trained behaviorists in the primary care setting. • Improved patient health outcomes achieved by focusing on social determinants of health via health literacy assessments and educational campaigns, along with development of community nutrition programming. • Long-term sustainability of the system achieved through a reduction in the overall cost of care and reinvestment of realized savings in prevention, health education and patient activation interventions.	

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South Dakota

Avera St. Benedict Health Center

Grant Number	G20RH26405					
Grantee Organization Name	Avera St. Benedict Health Center					
Address	401 W. Glynn Drive					
	City:	Parkston	State:	SD	Zip-code:	57366
Grantee organization website	www.averastbenedict.org					
Grantee Project Director	Name:	Melissa Gale				
	Title:	Behavioral Health Provider				
	Phone:	605-928-7961				
	Fax:	605-928-4417				
	Email:	Melissa.Gale@avera.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$149,996				
	Sept 2014 to Aug 2015:	$149,956				
	Sept 2015 to Aug 2016:	$102,550				

Network Partners	Organization Name	City/County	Organization Type
	Avera St. Benedict Certified Rural Health Clinic	Parkston	Rural Health Center
	ASB Certified Rural Health Clinic	Lake Andes	Rural Health Center
	Andes Central School District	Lake Andes	School District
	Parkston School District	Parkston	School District
	Parkston Ministerial Association	Parkston	Non-Profit

The communities/counties that the Quality Improvement project serves	Charles Mix Counties, SD	Hutchinson County, SD
	Douglas County, SD	
The target population served	Hutterian Brethren	Patients with diabetes
	Native Americans	School Children grades 4-5
Focus Areas	Chronic Disease Management	Diabetes prevention in children
Health Information Technology Systems	Chronic Disease Electronic Management System	Meditech/LSS Data System
Quality Improvement Model	Chronic Care Model	

Description of the Quality Improvement project	The purpose of the *Facing Diabetes: Quality Improvement in Rural South Dakota Project* (*Facing Diabetes Project)* is to improve the quality of life for adults and children with or at risk for diabetes in rural South Dakota. The project will focus on diabetes patients and 4-5th grade school children in three counties in South Dakota: Hutchinson, Charles Mix, and Douglas. All three of these counties have very high rates of diabetes and heart disease as well as adult and child obesity. The area also has very high percentages of adult smoking, physical inactivity, excessive drinking and fast food restaurants and very low access to healthy foods, which are all factors that can lead to the development of diabetes in children and adults. Poverty and limited access to health professionals in the area often results in chronic illnesses, like diabetes, to be mismanaged causing further health complications and higher health care costs. The *Facing Diabetes Project* will focus on improving the quality of life for those with or at risk for diabetes in the service region through specialized diabetes education and coordinated diabetes management support. The project is based on the evidence-based quality improvement model, The Chronic Care Model, which identifies six elements of a health care system that encourage high-quality chronic disease care: community, health system, self-management support, delivery system design, decision support, and clinical information systems. The *Facing Diabetes Project* involves a partnership between two Rural Health Clinics, two school districts, and a ministerial association in south-central South Dakota. The project consists of two main components: 1) coordinated care appointments for adults in the Rural Health Clinics; and 2) prevention and education sessions in two school districts in the area aimed at 4-5th graders, as well as Hutterite Colony children in the service area. Both components will be coordinated by a Diabetes Care Team including a Diabetes Educator/Registered Nurse, a Dietician, and a Behavioral Health Specialist.					
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Washington

Sunnyside Community Hospital

Grant Number	G20RH26408					
Grantee Organization Name	Sunnyside Community Hospital					
Address	1016 Tacoma Ave					
	City:	Sunnyside	State:	WA	Zip-code:	98944
Grantee organization website	http://sunnysidehospital.org					
Grantee Project Director	Name:	Ruth Stalcup				
	Title:	Physician Services and Clinic System Administrator				
	Phone:	509-837-1541				
	Fax:	509-837-1321				
	Email:	Ruth.Stalcup@sunnysidehospital.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$149,310				
	Sept 2014 to Aug 2015:	$149,310				
	Sept 2015 to Aug 2016:	$149,310				

Network Partners	Organization Name	City/County	Organization Type
	Nuestra Casa	Sunnyside/Yakima	
	Swoffard and Halma	Sunnyside/Yakima	
	Molina		

The communities/counties that the Quality Improvement project serves	Grandview	Granger
	Mabton	Outlook
	Sunnyside	Zillah
The target population served	Patients with multiple chronic conditions	Hispanic populations
Focus Areas	Hypertension	Diabetes
	Asthma	Cardiovascular disease
	Obesity	Tobacco use
Health Information Technology Systems	Centricity	DocLink
Quality Improvement Model	Lean Model	Chronic Care Model

Description of the Quality Improvement project	The Lower Yakima Quality Improvement Partnership (LYQIP) is a consortium of providers located in the Lower Yakima Valley region of rural, central Washington State. LYQIP includes Sunnyside Community Hospital and Clinics (SCHC), a critical access hospital that currently operates seven clinics (five of the clinics will be part of the consortium) and employs 20 primary care providers; two private clinics in the region (Mid-Valley Community Clinic and Swofford & Halma Clinic, with a total of 11 providers); and Nuestra Casa, a local non-profit organization founded in 2003 to serve the unique needs of the Hispanic community. Collectively, we estimate that the primary care providers participating in the Partnership currently provide more than 75% of all adult primary care in the region. Over time, our goal is to include other local primary care providers. In addition, the primary care practices have outreached to the largest Medicaid Managed Health Care Plan serving the region, and they have offered their endorsement. When they become a full partner, their processes, protocols, data and QI expertise will be invaluable. LYQIP was formed specifically to enhance a seamless, coordinated system of care that will improve outcomes through enhanced screening and chronic disease management for the diverse Lower Yakima communities. The goals of the LYQIP align with the Triple Aim: 1) reduce the rate of advanced chronic disease, 2) reduce the costs of inpatient and emergency department utilization associated with managing these diseases and 3) employ care management and outreach strategies (for screening, education, etc.) that will be widely accepted and utilized by the large Hispanic population in the Valley. Consistent with grant requirements, LYQIP's Quality Improvement efforts will utilize components of two evidence-based models, the Lean Model and the Chronic Care Model. Combined, these models will allow LYQIP to make a real difference in our community. We will begin by focusing on hypertension, specifically diagnosing and controlling the condition before it creates a significant disease. Outcomes expected include: earlier identification of hypertension, better control of hypertension, reduction in ED visits for issues related to hypertension, reduction in hospital stays for advanced hypertension and hypertension-related diseases, identification and management of other chronic diseases identified through enhanced care coordination, and specific improvements in culturally appropriate care management among our community's large Hispanic population. As a result of these interventions, it is expected that healthcare costs of treating advanced hypertension and hypertension-related disease will decrease and the population's health will improve significantly. An additional goal of the Partnership is to, once cost savings and improved health are documented, extend reach to other payers (including Medicare and Medicaid) to participate in shared savings initiatives. Importantly, Washington State has committed to the participation of both Medicaid expansion and dual-eligible efforts. According to the Kaiser Foundation, in the Lower Yakima Valley more than 32% of the population is expected to gain improved access under Medicaid expansion. It is access to these shared savings that will allow us to sustain the care management and outreach programs long after grant funding ends to provide better care and realize the Triple Aim.					
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Wisconsin

The Lakes Community Health Center

Grant Number	G20 RH26393					
Grantee Organization Name	The Lakes Community Health Center					
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	City:	Iron River	State:	WI	Zip-code:	54847
Grantee organization website	http://northlakesclinic.org/					
Grantee Project Director	Name:	Jason Akl				
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	Fax:	715 372-5067				
	Email:	jakl@northlakesclinic.org				
Project Period	2013 – 2016					
Expected funding level for each budget period	Sept 2013 to Aug 2014:	$144,906				
	Sept 2014 to Aug 2015:	$126,743				
	Sept 2015 to Aug 2016:	$128,864				
Network Partners	Organization Name		City/County		Organization Type	
	N/A					
The communities/counties that the Quality Improvement project serves	Ashland County		Sawyer County			
	Bayfield County		Washburn County			
	Rural Douglas County					
The target population served	All patients of the health center and chronic disease populations in the medical practice					
Focus Areas	Patient-Centered Medical Home Certification at all medical sites		Hypertension			
	Cardiovascular Disease		Obesity			
	Diabetes		Tobacco Use			
Health Information Technology Systems	GE Centricity		Reporting software – I2I tracks			
Quality Improvement Model	Model for improvement					

Description of the Quality Improvement project	The mission of the NorthLakes Community Clinic is to respond to our community's health care needs with an integrated array of services. Our Vision is that everyone will have the resources they need to enhance their health and well-being. Our key strategies are to work with area partners to address health care needs, provide a Patient Centered Health Care Home, grow responsibly and strategically and be visible and accessible to all members of our community. Our Quality Improvement program is centered on a foundation that the process for the delivery of health care and services can be continuously improved. Through the QI program, The NorthLakes Community Clinic aims to help patients achieve optimal benefits by obtaining the most appropriate care in the most appropriate setting. Through the QI grant the NorthLakes clinic is looking to implement an inclusive EPR (electronic patient registry) and clinical reporting software module that integrates with the existing Electronic Health Records. Specifically, the Lakes is interested in i2i Tracks registry software that would integrate with our existing Electronic Medical Record and practice management systems. The expanded QI program will improve process and outcomes of clinical care, especially the Clinical Measures for quality improvement in diabetes, hypertension, cardiovascular disease, smoking cessation and obesity. Through the efficient use of resources we will build a robust chronic disease registry spanning the nine thousand square mile area we will serve.					
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