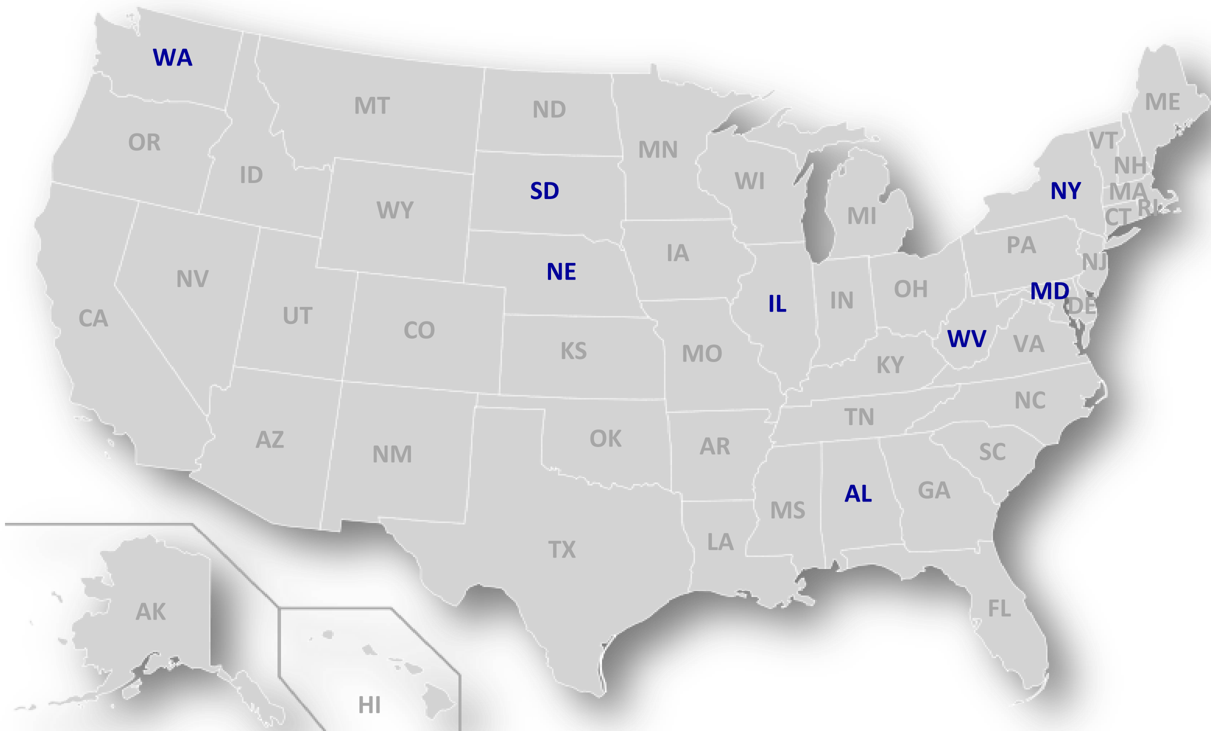
Grantee Directory

Rural Health Care Coordination Network Partnership Grant Program

2015 - 2018



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

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

Grantee Directory

Rural Health Care Coordination Network Partnership Grant Program
2015 - 2018

The purpose of the Rural Health Care Coordination Network Partnership Program is to support the development of formal, mature rural health networks that focus on care coordination activities for the following chronic conditions: diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. Health care coordination for people living with chronic conditions is vital to providing high quality care, especially in rural areas where access to health care is an issue.

This program is authorized under Section 330A(f) of the Public Health Service (PHS) Act (42 U.S.C. 254(c)(f)), as amended. This authority permits the Federal Office of Rural Health Policy to support grants for eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to: (i) achieve efficiencies; (ii) expand access to, coordinate, and improve the quality of essential health care services; and (iii) strengthen the rural health care system as a whole.

The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. Care coordination is identified by the Institute of Medicine as a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American health care system. Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for everyone: patients, providers, and payers. Care coordination is especially important in the changing health care landscape where payments increasingly focus on value. The ultimate goal of the program is to promote the delivery of coordinated care in the primary care setting. Grantees are required to develop innovative approaches, demonstrate improved outcomes, and employ evidenced-based models in the application of care coordination strategies to address the prevalence and management of diabetes, CHF, and COPD.

This Directory provides contact information and a brief overview of the eight (8) initiatives funded under the Rural Health Care Coordination Network Partnership Grant Program in the 2015 – 2018 funding cycle.

2015 - 2018 Rural Health Care Coordination Network Partnership Grant Recipients

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Alabama

Tombigbee Healthcare Authority

Grant Number:	G07RH2886-01-00					
Organization Type:	Healthcare Authority					
Grantee Organization Information:	Name:	Tombigbee Healthcare Authority				
	Address:	105 Hwy 80 East				
	City:	Demopolis	State:	AL	Zip code:	36732
	Tel #:	334-287-2673				
	Website:	www.bwwmh.com				
Primary Contact Information:	Name:	Kimberly Catlin				
	Title:	Program Director				
	Tel #:	334-287-2673				
	Email:	kcatlin@bwwmh.com				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	September 2015 to August 2016	$199,909
	September 2016 to August 2017	$197,509
	September 2017 to August 2018	$197,509

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Bryan W. Whitfield Memorial Hospital	Marengo	AL	Hospital
	*Hale County Hospital	Hale	AL	Hospital
	*Travis Clinic	Marengo	AL	Clinic
	*Hale County Hospital Clinic	Hale	AL	Clinic
	*Rush Medical Group Livingston	Sumter	AL	Clinic
	*Greene County Physicians Clinic	Greene	AL	Clinic

The communities/counties the project serves:		
	Greene	Hale
	Sumter	Marengo

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	X
	Pre-school Children		African Americans	X
	School-age children (elementary)		Latinos	X
	School-age children (teens)		Native Americans	
	Adults	X	Pacific Islanders	
	Elderly	X	Uninsured	
	Pregnant Women		Other: (please describe)	

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

	Obstructive Pulmonary Disease (COPD)			
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The Tombigbee Healthcare Authority HealthStart Comprehensive Wellness Program (HCWP) provides care coordination and care transition for individuals with Diabetes, Congestive Health Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD) in four counties in Alabama's Black belt. The Tombigbee Healthcare Authority is partnering with agencies in Greene, Hale, Marengo and Sumter counties to address the need for care coordination through: 1) developing an integrated program to improve health outcomes for patients with a comprehensive care coordination strategy; 2) establishing and monitoring four outcome measures for each chronic condition - Diabetes Mellitus, CHF and COPD; 3) planning for long term sustainability; and 4) educating and engaging patients and their caregivers and disseminating information to the public, including the Medicare and Medicaid populations in Alabama's Delta Region.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model used to provide care coordination program services is the Improving Chronic Care Model (ICCM). This model encourages high-quality chronic disease care and fosters productive patient-physician interactions.

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Illinois

Gibson Area Hospital & Health Services

Grant Number:	G07RH28864					
Organization Type:	Hospital					
Grantee Organization Information:	**Name:**	Gibson Area Hospital & Health Services				
	Address:	1120 N. Melvin St				
	City:	Gibson City	**State:**	IL	**Zip code:**	60936
	Tel #:	217-784-2600				
	Website:	http://gibsonhospital.org				
Primary Contact Information:	**Name:**	Amanda McKeon, MHA				
	Title:	Project Director				
	Tel #:	217-784-2567				
	Email:	Amanda_mckeon@gibsonhospital.org				

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	September 2015 to August 2016	$200,000
	September 2016 to August 2017	$200,000
	September 2017 to August 2018	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Community Resource & Counseling Center (CRCC)*	Ford	IL	Health Department
	County Board	Ford	IL	Local Government
	Board of Health	Ford	IL	Health Department
	Ford County Public Health Department (FCPHD)*	Ford	IL	Health Department
	Gibson City Melvin Sibley Community Unit School District 5*	Ford	IL	School
	Iroquois West Community Unit School District*	Iroquois	IL	School
	Paxton-Buckley-Loda Community Unit School District 10*	Ford	IL	School
	Blue Ridge Community Unit School District 18*	DeWitt	IL	School
	Illinois Knights Templar Home*	Ford	IL	Nursing Home
	Heritage Health Hoopeston*	Vermillion	IL	Nursing Home
	The Medicine Shoppe Pharmacy*	Ford	IL	Pharmacy
	Scott's Family Pharmacy, Inc*	Ford	IL	Pharmacy

The communities/counties the project serves:		
	Ford County	Vermillion County
	Iroquois County	DeWitt County
	Livingston County	Champaign County
	McLean County	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Infants		Caucasians	X
	Pre-school Children	X	African Americans	
	School-age children (elementary)	X	Latinos	X
	School-age children (teens)	X	Native Americans	

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

Description of the project:

Gibson Area Hospital & Health Services, consortium members, and primary care practices in rural communities are working together to identify patients with Type 2 Diabetes, CHF, and COPD and provide care coordination services that are facilitated by Community Health Workers (CHWs) within a referral center. Care coordination activities are determined by a care plan that has been developed by the Personal Care Provider in conjunction with the patient. The services to be provided include, but are not limited to: mental health counseling, therapeutic and education groups, community case management, psychiatric services, crisis intervention, and referral of individuals to primary care providers. A primary goal of the care coordination initiative is to expand delivery of health care and health-related services through consortium members and the referral center.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Care Coordination program is employing Community Health Workers (CHW) as front line staff who are trusted and connected members of the community to facilitate and provide care coordination activities for patients referred for services. The CHWs serve as a liaison and intermediary between health and social services and the community to facilitate access to services that support provision of the Care Coordination program. CHWs build individuals and community capacity by increasing health knowledge and self-sufficiency through a range of activities including outreach, community education, information counseling, social support and advocacy. Participants in the Consortium are developing and utilizing a referral center and implementing and tracking numerous Performance Improvement Measures. Consortium partners are implementing programs that incorporate elements of the Patient Centered Medical Home (PCMH), Partnership, Information Technology, and CHW models in order to meet community needs identified by the Gibson Area Hospital and Health Services Community Needs Assessment. These models are being utilized to improve the health of individuals with chronic disease(s) and improve population health. The primary care practices that are members of the Consortium will become PCMH recognized and utilize the elements of PCMH to enhance access to care, primary care provider (PCP) selection and use, and care coordination. Participants will learn how to apply a variety of change strategies within their health care delivery system and achieve those changes through quality improvement methodologies.

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	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Maryland

County of Worcester

Grant Number:	G07RH28862					
Organization Type:	Health Department					
Grantee Organization Information:	**Name:**	County of Worcester				
	Address:	6040 Public Landing Road				
	City:	Snow Hill	**State:**	MD	**Zip code:**	21863
	Tel #:	410-632-1100				
	Website:	Worcesterhealth.org				
Primary Contact Information:	**Name:**	Andrea Mathias, MD				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	September 2015 to August 2016	$200,000
	September 2016 to August 2017	$200,000
	September 2017 to August 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Atlantic General Hospital*	Worcester	MD	Hospital
	McCready Hospital*	Somerset	MD	Hospital
	Peninsula Regional Medical Center*	Wicomico	MD	Hospital
	Somerset County Health Department*	Somerset	MD	Health Department
	Wicomico County Health Department*	Wicomico	MD	Health Department

The communities/counties the project serves:		
	Somerset County	Worcester County
	Wicomico County	

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	
	Pre-school Children		African Americans	
	School-age children (elementary)		Latinos	
	School-age children (teens)		Native Americans	
	Adults	X	Pacific Islanders	
	Elderly	X	Uninsured	X
	Pregnant Women		Other: (please describe) High Utilizers of ER With Primary or Secondary Diagnosis of Diabetes, COPD or CHF	X

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

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

Description of the project:

Home visiting care coordination services are offered to high risk, high cost residents of all three counties, focusing on patients with diabetes, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF) who frequently utilize the emergency room for management of their chronic diseases. The care coordination interventions are evidence-based and include: home visits, medication reconciliation, coordination with the primary care provider and specialists, personalized chronic disease education, and facilitated referrals to financial assistance and health insurance coverage resources.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Guided Care-A New Nurse-Physician Partnership on Chronic Care is the evidence based model for the Care Coordination program. This is the same model implemented with our successful pilot project, the Tri County Diabetes program, which engaged high utilizers who frequented the emergency room for management of their chronic disease.

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Technical Assistance Consultant's Contact Information:	**Name:**	Kati Keebaugh				
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	Email:	kkeebaugh@gsu.edu				
	Website:	http://www.ruralhealthlink.org/				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Nebraska

South East Rural Physician Alliance

Grant Number:	G07RH28865					
Organization Type:	Physician Network					
Grantee Organization Information:	**Name:**	South East Rural Physician Alliance				
	Address:	995 E. Hwy 33, Ste. 2				
	City:	Crete	**State:**	NE	**Zip code:**	68333
	Tel #:	402-826-3737				
	Website:	http://www.serpa-ne.org/				
Primary Contact Information:	**Name:**	Joleen Huneke				
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	Email:	jthserpa@rccn.info				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	September 2015 to August 2016	$200,000
	September 2016 to August 2017	$200,000
	September 2017 to August 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Butler County Clinic*	Butler	NE	Primary Care Clinic
	Central Nebraska Medical Clinic*	Custer	NE	Primary Care Clinic
	Columbus Family Practice Associates*	Platte	NE	Primary Care Clinic
	Fillmore County Medical Center*	Fillmore	NE	Rural Health Clinic
	Lifecare Family Medicine of Bellevue*	Sarpy	NE	Primary Care Clinic
	Lincoln Family Medical Group*	Lancaster	NE	Primary Care Clinic
	Lincoln Family Wellness*	Lancaster	NE	Primary Care Clinic
	McCook Clinic*	Red Willow	NE	Primary Care Clinic
	Midlands Family Medicine*	Lincoln	NE	Primary Care Clinic
	Plum Creek Medical Group*	Dawson	NE	Primary Care Clinic

	Site	County	State	Type
	Family Medical Center of Hastings*	Adams	NE	Primary Care Clinic
	York Medical Clinic*	York	NE	Primary Care Clinic
	Family Practice Associates*	Buffalo	NE	Primary Care Clinic
	States Family Practice*	Lincoln	NE	Primary Care Clinic

The communities/counties the project serves:		
	Adams	Saline
	Buffalo	Butler
	Custer	Dawson
	Gosper	Fillmore
	Frontier	Hamilton
	Hitchcock	Howard
	Jefferson	Keith
	Lancaster	Lincoln
	Nuckolls	Platte
	Polk	Red Willow
	Sarpy	Seward
	Thayer	York

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Infants		Caucasians	X
	Pre-school Children	X	African Americans	X
	School-age children (elementary)	X	Latinos	X
	School-age children (teens)	X	Native Americans	X
	Adults	X	Pacific Islanders	X
	Elderly	X	Uninsured	X
	Pregnant Women		Other: (please describe)	
	Anyone with Diabetes and CVD	X	Other: (please describe)	

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

Description of the project:

The Rural Health Care Coordination Partnership is a service offered by the South East Rural Physician Alliance-Independent Physician Association (SERPA-IPA), a Network of rural health providers located across Nebraska. This project trains Care Coordinators currently employed in each individual partner clinic in additional skills to meet the needs of patients experiencing cardiovascular or diabetes problems. The SERPA-Accountable Care Organization (SERPA-ACO) will share the value of care coordination, acting as a local leader in the Patient-Centered Medical Home (PCMH) activities.

Evidence Based/ Promising Practice Model Being Used or Adapted:

SERPA-IPA's program is based upon practices established by Community Care of North Carolina (CCNC), widely recognized for its innovative statewide medical home and care management model. The CCNC program has found significant health benefits and health care cost savings through local care coordination in several disease processes, including, but not limited to, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and congestive heart failure. The basic cornerstones of this program, including its focus on providing education, training, networking, tools, standardized processes, and process and outcome data to local care coordinator teams embedded in primary care practices, are similar to the foundation that has been established and will be expanded by SERPA-IPA. Unlike CCNC, SERPA-IPA focuses on establishing diabetes and congestive heart failure programs at this time, and all care coordinators are employed by the local primary care practice, and not affiliated with the Department of Health and Human Services (DHHS) or another outside agency. SERPA-IPA will review the processes and tools established by CCNC and other national programs before formally adopting its own. Like CCNC, SERPA-IPA has already established relationships between payers, SERPA-IPA and private practices to develop and implement standards, as well as secure and analyze outcomes data.

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	Kati Keebaugh				
	Tel #:	404-413-0324				
	Email:	kkeebaugh@gsu.edu				
	Website:	http://www.ruralhealthlink.org/				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

New York

Chautauqua County Health Network

Grant Number:	G07RH28861				
Organization Type:	Rural Health Network				
Grantee Organization Information:	**Name:**	Chautauqua County Health Network			
	Address:	200 Harrison Street			
	City:	Jamestown	**State:** NY	**Zip code:**	14701
	Tel #:	716-338-0010			
	Website:	www.cchn.net			
Primary Contact Information:	**Name:**	Ann Morse Abdella			
	Title:	Executive Director			
	Tel #:	716-338-0010			
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Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	September 2015 to August 2016	$200,000
	September 2016 to August 2017	$200,000
	September 2017 to August 2018	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Brooks Memorial Hospital*	Chautauqua	NY	Hospital
	TLC Health Network*	Chautauqua	NY	Hospital
	WCA Hospital*	Chautauqua	NY	Hospital
	Westfield Memorial Hospital*	Chautauqua	NY	Hospital
	Family Health Medical Services*	Chautauqua	NY	Physician Practice
	Jamestown Primary Care*	Chautauqua	NY	Physician Practice
	Tri-County Family Medicine*	Chautauqua	NY	Physician Practice
	The Chautauqua Center*	Chautauqua	NY	FQHC
	The Resource Center*	Chautauqua	NY	Article 28 Clinic
	TLC Primary Care*	Chautauqua	NY	Article 28 Clinic
	Hospice Chautauqua County*	Chautauqua	NY	Hospice

The communities/counties the project serves:	Chautauqua County	Western Cattaraugus County
	Southern Erie County	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Infants		Caucasians	X
	Pre-school Children		African Americans	X
	School-age children (elementary)		Latinos	X
	School-age children (teens)		Native Americans	X
	Adults	X	Pacific Islanders	
	Elderly	X	Uninsured	X
	Pregnant Women		Other: (please describe)	

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

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

Description of the project:

The project partnership is implementing a county-wide care coordination initiative for patients diagnosed with diabetes, congestive heart failure and chronic obstructive pulmonary disease (COPD). The goal is to further develop Patient-Centered Medical Home (PCMH) care coordination processes based on the MacColl Institute framework to improve clinical outcomes and reduce avoidable hospitalizations. A blend of evidence-based models have been chosen and include: ProvenHealth Navigator, Vermont Blueprint for Health, and Choices for Life.

Using the ProvenHealth Navigator model, primary care practices identify staff to be trained as Health Managers who will provide disease management and care coordination including referrals to a Community Health Team. As our hospitals brace for reduced inpatient and ED volume as a result of DSRIP efforts, the Community Health Team concept from Vermont Blueprint for Health is a promising practice that allows us to pilot using hospital-based, outpatient services in a new and innovative way. It is thought that as hospitals adjust to less inpatient volume, there may be excess staff capacity that could be used to aid in community-based disease management. As Health Managers in the PCMH identify patients that need additional support, a Community Health Team will be available to provide care to the patient. The utilization of palliative care and hospice services will also be explored for the development of a Community Health Team. The Choices for Life model is being employed to encourage discussion and decisions among patients and their families prior to chronic illness affecting their quality of life.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Proven Health Navigator (PHN): Developed by Geisinger, the goal of PHN is to provide care across the member's lifespan and health care needs using integrated population management. The PHN program seeks to meet the needs of the patient and align the intensity of the resource with the needs of that patient. However, the approach isn't only for high-risk patients. It involves population risk stratification and segmentation using predictive modeling, with an emphasis on preventive care, and focusing on those most at risk. Based on this risk segmentation, different level interventions are deployed including preventive care, disease management, and case management. Of note, Geisinger distinguishes between disease management and case management. The roles need to be separate as they require different skill sets. The most complex cases will continue to be handled by Guided Care Nurses (The John Hopkins Model), while Health Managers, nurses with disease management skills, target moderate-risk members for screenings, medication management, referrals to community-based services, etc.

Vermont Blueprint for Health (VBH): VBH offers a promising practice in the form of a Community Health Team (CHT), a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations with the goal of providing citizens with the support they need for well-coordinated preventive health services and coordinated linkages to available social and economic support services. Coordination between primary care and CHT staff strengthen network interactions with a larger array of medical and non-medical providers in the community and help people link more seamlessly with the services they need. CHTs provide primary care patients with more direct and unhindered access to diverse staff such as nurse care coordinators, social workers, counselors, dieticians, health educators, and others. The CHT is flexible in terms of staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support

that patients need in their efforts to live as fully and productively as possible. The CHT functions as extenders of the primary care practices they support and their services are available to all patients.

Choices for Life (CFL): Choices for Life is one component of the High Desert Medical Group's Connection for Life Program that yields a multidisciplinary, continuum based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Choices for Life serves the special needs of patients with critical or terminal conditions as they experience the reality of a life limiting disease. The mission and vision of Choices For Life is to empower patients and their families to make choices related to their disease processes, to support them as they experience the reality of a progressive life-limiting disease, and to provide comfort and support to patients and their loved ones with the help of a dedicated team of healthcare professionals trained in the delivery of Palliative and Hospice care. Patients and their families are encouraged to discuss and make decisions in advance about their preferences for treatment when an illness begins to affect their quality of life. The Choices for Life team assists patients to prepare Advanced Directives. The Choices for Life program includes education regarding hospice care. Additionally, the case management team coordinates all non-hospice related care and works closely with the hospice team to see that patient needs are met. Other Choices for Life services include but are not limited to providing tools for maintaining independence, information for long-term care, clinical, social, and supportive needs.

Federal Office of Rural Health Policy Project Officer's Contact Information:	**Name:**	Sara Afayee				
	Tel #:	301-945-4169				
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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	**State:**	Maryland	**Zip code:**	20857
Technical Assistance Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0283				
	Email:	jbutts@gsu.edu				
	Website:	http://www.ruralhealthlink.org/				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

South Dakota

Avera St. Mary's Hospital

<table>
<tr><td>Grant Number:</td><td colspan="6">G07RH28860</td></tr>
<tr><td>Organization Type:</td><td colspan="6">Hospital</td></tr>
<tr><td rowspan="5">Grantee Organization Information:</td><td>Name:</td><td colspan="5">Avera St. Mary's Hospital</td></tr>
<tr><td>Address:</td><td colspan="5">801 E. Sioux</td></tr>
<tr><td>City:</td><td>Pierre</td><td>State:</td><td>SD</td><td>Zip code:</td><td>57501</td></tr>
<tr><td>Tel #:</td><td colspan="5">605-224-3452</td></tr>
<tr><td>Website:</td><td colspan="5">www.averastmarys.org</td></tr>
<tr><td rowspan="4">Primary Contact Information:</td><td>Name:</td><td colspan="5">Ellen Lee</td></tr>
<tr><td>Title:</td><td colspan="5">Vice President Foundation</td></tr>
<tr><td>Tel #:</td><td colspan="5">605-224-3452</td></tr>
<tr><td>Email:</td><td colspan="5">Ellen.Lee@Avera.org</td></tr>
<tr><td rowspan="4">Expected funding level for each budget period:</td><td colspan="3">Month/Year to Month/Year</td><td colspan="3">Amount Funded Per Year</td></tr>
<tr><td colspan="3">September 2015 to August 2016</td><td colspan="3">$193,804</td></tr>
<tr><td colspan="3">September 2016 to August 2017</td><td colspan="3">$197,958</td></tr>
<tr><td colspan="3">September 2017 to August 2018</td><td colspan="3">$114,066</td></tr>
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*Indicates partners who have signed a Memorandum of Understanding</td><td>County</td><td>State</td><td>Organization Type</td></tr>
<tr><td colspan="3">Avera St. Mary's Hospital*</td><td>Hughes</td><td>SD</td><td>Hospital</td></tr>
<tr><td colspan="3">South Dakota Urban Indian Health*</td><td>Hughes</td><td>SD</td><td>Federally Qualified Health Center (FQHC)</td></tr>
<tr><td colspan="3">Vilas Pharmacy*</td><td>Hughes</td><td>SD</td><td>Pharmacy</td></tr>
<tr><td rowspan="7">The communities/counties the project serves:</td><td colspan="3">Potter County</td><td colspan="3">Lyman County</td></tr>
<tr><td colspan="3">Sully County</td><td colspan="3">Jones County</td></tr>
<tr><td colspan="3">Hyde County</td><td colspan="3">Stanley County</td></tr>
<tr><td colspan="3">Hand County</td><td colspan="3">Tripp County</td></tr>
<tr><td colspan="3">Hughes County</td><td colspan="3">Gregory County</td></tr>
<tr><td colspan="3">Buffalo County</td><td colspan="3">Charles Mix County</td></tr>
<tr><td colspan="3">Brule County</td><td colspan="3"></td></tr>
<tr><td rowspan="8">The target population served:</td><td colspan="2">Population</td><td>Yes</td><td colspan="2">Population</td><td>Yes</td></tr>
<tr><td colspan="2">Infants</td><td></td><td colspan="2">Caucasians</td><td>X</td></tr>
<tr><td colspan="2">Pre-school Children</td><td></td><td colspan="2">African Americans</td><td></td></tr>
<tr><td colspan="2">School-age children (elementary)</td><td></td><td colspan="2">Latinos</td><td></td></tr>
<tr><td colspan="2">School-age children (teens)</td><td></td><td colspan="2">Native Americans</td><td>X</td></tr>
<tr><td colspan="2">Adults</td><td>X</td><td colspan="2">Pacific Islanders</td><td></td></tr>
<tr><td colspan="2">Elderly</td><td></td><td colspan="2">Uninsured</td><td></td></tr>
<tr><td colspan="2">Pregnant Women</td><td></td><td colspan="2">Other: (please describe)</td><td></td></tr>
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<tr><td colspan="2">Access: Specialty Care</td><td></td><td colspan="2">Integrated Systems of Care</td><td></td></tr>
<tr><td colspan="2">Aging</td><td></td><td colspan="2">Maternal/Women's Health</td><td></td></tr>
<tr><td colspan="2">Behavioral/Mental Health</td><td></td><td colspan="2">Migrant/Farm Worker Health</td><td></td></tr>
</table>

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

Description of the project:

The *Completing the Circle Project* is a collaborative effort of three health care providers in rural South Dakota: Avera St. Mary's Hospital, South Dakota Urban Indian Health, and Vilas Pharmacy. The project creates a formal network between these three entities which have a history of collaboration with each other, allowing them to utilize the resources, strengths, and capabilities of each other to provide the highest quality care to rural patients. The project serves patients in 13 counties in central South Dakota at six different clinic locations and provides coordinated care (i.e., care coordination) services for eligible Type 2 diabetic patients who need assistance managing and controlling their disease. Eleven of the 13 counties are extremely rural and are designated as "frontier" by the US Census Bureau.

The project connects patients with an RN Coordinator, a Clinical Care Specialist, Social Worker, and Certified Diabetes Educator who will communicate between the patient and his/her primary care provider and other necessary resources to remove the patient's barriers to health care success. The focus of the project is to provide high need patients, many of whom are the highest users of the emergency room and hospital and often the costliest patients, with individualized diabetes care. Coordinated care representatives record the patient's biometric health measures; help the patient identify barriers to health care success; and develop a personal care plan that includes goals developed by the patient that he/she can work toward. The coordinated care representatives help the patient address the identified barriers and achieve set goals in ways that are most effective for the patient.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The *Completing the Circle Project* is based on the Patient-Centered Medical Home (PCMH) evidence-based model. The PCMH model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, the Agency for Healthcare Research and Quality (AHRQ) defines a medical home not simply as a place but as a model of organization of primary care that delivers the core functions of primary health care. The medical home encompasses five functions and attributes: Comprehensive Care, Patient-Centered, Coordinated Care, Accessible Services, Quality and Safety.

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	Organization:	Federal Office of Rural Health Policy				
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Technical Assistance Consultant's Contact Information:	**Name:**	John Butts				
	Tel #:	404-413-0283				
	Email:	jbutts@gsu.edu				
	Website:	http://www.ruralhealthlink.org/				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	**State:**	Georgia	**Zip code:**	30303

Washington

Critical Access Hospital Network

Grant Number:	G07RH28863					
Organization Type:	Critical Access Hospitals					
Grantee Organization Information:	**Name:**	Critical Access Hospital Network				
	Address:	714 West Pine Street				
	City:	Newport	**State:**	WA	**Zip code:**	99156
	Tel #:	509- 447-2441, ext. 4226				
	Website:					
Primary Contact Information:	**Name:**	Jac Davies				
	Title:	Program Manager				
	Tel #:	509-998-8290				
	Email:	jacjdavies@comcast.net				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	September 2015 to August 2016	$200,000
	September 2016 to August 2017	$200,000
	September 2017 to August 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	* Pend Oreille County Public Hospital District	Pend Oreille	WA	1 Critical Access Hospital (CAH) and 2 Rural Health Clinics (RHC)
	* Lincoln County Public Hospital District	Lincoln	WA	1 Critical Access Hospital (CAH) and 3 Rural Health Clinics (RHC)
	* East Adams County Public Hospital District	Adams	WA	1 Critical Access Hospital (CAH) and 2 Rural Health Clinics (RHC)
	* Odessa Memorial Healthcare Center	Lincoln	WA	1 Critical Access Hospital (CAH) and 1 Rural Health Clinics (RHC)
	* Molina Healthcare	Statewide	WA	Medicaid Managed Care Organization
	* Empire Health Foundation	Ferry, Stevens,	WA	Charitable Foundation

<table>
<tr><td></td><td></td><td>Pend Oreille, Spokane Adams, Whitman</td><td></td><td></td></tr>
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<table>
<tr><td rowspan="8">The target population served:</td><td>Population</td><td>Yes</td><td>Population</td><td>Yes</td></tr>
<tr><td>Infants</td><td>X</td><td>Caucasians</td><td>X</td></tr>
<tr><td>Pre-school Children</td><td>X</td><td>African Americans</td><td>X</td></tr>
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<tr><td>Elderly</td><td>X</td><td>Uninsured</td><td></td></tr>
<tr><td>Pregnant Women</td><td>X</td><td>Other: (please describe)</td><td></td></tr>
<tr><td rowspan="14">Focus areas of grant program:</td><td>Focus Area:</td><td>Yes</td><td>Focus Area:</td><td>Yes</td></tr>
<tr><td>Access: Primary Care</td><td></td><td>Health Professions Recruitment and Retention/Workforce Development</td><td>X</td></tr>
<tr><td>Access: Specialty Care</td><td></td><td>Integrated Systems of Care</td><td></td></tr>
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<tr><td>Chronic Disease: Diabetes</td><td>X</td><td>Physical Fitness and Nutrition</td><td></td></tr>
<tr><td>Chronic Disease: Chronic Obstructive Pulmonary Disease (COPD)</td><td>X</td><td>School Health</td><td></td></tr>
<tr><td>Community Health Workers /Promotoras</td><td></td><td>Substance Abuse</td><td></td></tr>
<tr><td>Coordination of Care Services</td><td>X</td><td>Telehealth</td><td></td></tr>
<tr><td>Emergency Medical Services</td><td></td><td>Transportation to health services</td><td></td></tr>
<tr><td>Health Education and Promotion</td><td></td><td>Other: (please describe)</td><td></td></tr>
<tr><td>Health Information Technology</td><td></td><td>Other: (please describe)</td><td></td></tr>
</table>

Description of the project:

In collaboration with Empire Health Foundation and Molina Healthcare, the Critical Access Hospital Network (CAHN) is implementing an integrated care model to improve the health status of individuals diagnosed with diabetes, congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD) in three rural counties in eastern Washington. The program targets three underserved populations: low income, seniors and minority. Key activities include strategies for creating a pathway to a transformed, high performing rural health system through (1) health system development and workforce redesign, (2) new partnerships, and (3) new designation standards. These strategies will sustain the integrative models, improve the health of their communities and strengthen the local rural health system.

Specifically, the program coordinates comprehensive health and support services through development of patient centered health home models. This evidence-based integrated delivery model deploys care coordinators to manage rural population health with real time data analytics/disease registries. The rural facilities (CAHs and RHCs), partnering with Molina Healthcare and Empire Health Foundation, use claims data to identify individuals who are currently high utilizers of services and who may benefit from individualized care management planning. Care coordinators will receive training and oversight on targeted projects such as: high-risk patient outreach, inappropriate emergency department utilization reduction, missed appointments reduction, and tertiary network development. Health outcomes and patient activation measures (PAMs) are monitored to ensure the proper level of support is provided to achieve quality care performance standards. Throughout the program period, Molina Healthcare and the CAHN will explore financing models to support the rural facilities' transition to value based health systems. By year three of the proposed program, the rural health clinics will obtain National Committee on Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition. In addition to improving the quality of care delivery, PCMH positions the organizations to be responsive to health care reform, support Meaningful Use attestation, and most importantly strengthen their viability in the uncharted waters of Accountable Care Organizations and value-based payment reforms.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The program is guided by two evidence based practices (1) Patient Centered Medical Home and (2) Care Coordination Model of the MacColl Center for Health Care Innovation at the Group Health Research Institute,

The Patient-Centered Medical Home is an approach to providing comprehensive primary care for people of all ages and medical conditions. It is a way for a physician-led medical practice, chosen by the patient, to integrate health care services and provide accessible, continuous, comprehensive, family-centered, coordinated, and compassionate care.

The MacColl Center's Care Coordination Model expands the perspective of Patient Centered Medical Homes and considers the major external providers and organizations with which a PCMH must interact--medical specialists, community service agencies, and hospital and emergency facilities—and focuses on the elements that appear to contribute to successful referrals and transitions.

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	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	State:	Maryland	Zip code:	20857
Technical Assistance Consultant's Contact Information:	Name:	Kati Keebaugh				
	Tel #:	404-413-0324				
	Email:	kkeebaugh@gsu.edu				
	Website:	http://www.ruralhealthlink.org/				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

West Virginia

Williamson Health and Wellness Center

Grant Number:	G07RH28867
Organization Type:	Federally Qualified Health Center (FQHC)

Grantee Organization Information:						
	Name:	Williamson Health and Wellness Center				
	Address:	152 E. 2nd Street				
	City:	Williamson	**State:**	WV	**Zip code:**	25661
	Tel #:	304-236-5902				
	Website:	www.williamsonhealthwellness.com				

Primary Contact Information:		
	Name:	Dino Beckett
	Title:	CEO
	Tel #:	304-236-5902
	Email:	Cdbeckett.do@gmail.com

Expected funding level for each budget period:	**Month/Year to Month/Year**	**Amount Funded Per Year**
	September 2015 to August 2016	$200,000
	September 2016 to August 2017	$200,000
	September 2017 to August 2018	$200,000

Consortium Partners:	**Partner Organization** *Indicates partners who have signed a Memorandum of Understanding	**County**	**State**	**Organization Type**
	Dr. Mannueel Abbas, WHWC*	Mingo	WV	Federally Qualified Health Center (FQHC)
	Kermit Primary Care*	Logan	WV	Clinic
	Dr. Vallaiappan Somasundaram, Williamson ARH Hospital*	Mingo	WV	Hospital
	WHWC*	Mingo	WV	Federally Qualified Health Center (FQHC)
	Vicki Hatfield, Williamson Family Care*	Mingo	WV	Clinic
	Dr. A Patnaik, Cardiac Care Center*	Mingo	WV	Specialty Care
	Robin Browning, Appalachian Psychology Associates*	Mingo	WV	Behavioral Health
	Jerome Cline, WHWC*	Mingo	WV	Federally Qualified Health Center (FQHC)
	Traci Booth, Williamson Family Care*	Mingo	WV	Clinic
	Comprehensive Health Solutions*	Mingo	WV	Clinic
	Teresa Robinson, Williamson ARH Hospital*	Mingo	WV	Hospital
	Williamson Memorial Hospital*	Mingo	WV	Hospital

The communities/counties the project serves:		
	Logan County, WV	Pike County, KY
	Mingo County, WV	

The target population served:	**Population**	**Yes**	**Population**	**Yes**
	Infants		Caucasians	X
	Pre-school Children		African Americans	

School-age children (elementary)		Latinos	X
School-age children (teens)		Native Americans	
Adults	X	Pacific Islanders	
Elderly	X	Uninsured	X
Pregnant Women	X	Other: (please describe)	

Focus areas of grant program:

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

Description of the project:

The Central Appalachian Health Alliance (CAHA) was formed in 2011 as a result of the Mingo County Diabetes Coalition (now a program of Williamson Health and Wellness Center) being selected to formalize and expand its Community Health Worker (CHW) care coordination model as part of Duke University's CMS Health Care Transformation project – the Southeastern Diabetes Initiative (SEDI). The network represents a vast majority of the health care providers within the tri-county region and has developed collaborative relationships with key stakeholders throughout Central Appalachia. The network's primary initiative has been the implementation of a CHW care coordination model that is rapidly gaining national attention for its success at improving the health status of patients with chronic disease, reducing the overall prevalence of chronic disease, generating cost-savings within the health care environment, and promoting systems change that supports fully integrated, patient-centered care models with multi-disciplinary team treatment planning that addresses the whole patient. As the SEDI project's 3-year project period comes to an end, the network is uniquely positioned to implement its lessons learned and further develop its CHW model as a best practice for addressing chronic disease in rural communities across the nation. The network has five years of statistical data to support the tremendous success of the CHW model and dissemination of information related to its value locally as well as replicability regionally and nationally.

Williamson Health and Wellness Center, on behalf of Central Appalachian Health Alliance, is expanding its CHW care coordination model to be fully integrated in an FQHC primary care setting; further enhance the HIT infrastructure to support CHW interventions; adopt a formal CHW training and certification process; continue to work with key stakeholders in developing third party reimbursement mechanisms for the future viability of the program.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The program incorporates two evidence-based approaches, the Transitional Care Model and Care Transition Program, into its community health worker (CHW) model.

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	Name:	Sara Afayee
	Tel #:	301-945-4169
	Email:	safayee@hrsa.gov

<table>
<tr><td></td><td>Website:</td><td colspan="5">http://www.hrsa.gov/</td></tr>
<tr><td></td><td>Organization:</td><td colspan="5">Federal Office of Rural Health Policy</td></tr>
<tr><td></td><td>City:</td><td>Rockville</td><td>State:</td><td>Maryland</td><td>Zip code:</td><td>20857</td></tr>
<tr><td rowspan="6">Technical Assistance Consultant's Contact Information:</td><td>Name:</td><td colspan="5">Beverly A. Tyler</td></tr>
<tr><td>Tel #:</td><td colspan="5">404-413-0288</td></tr>
<tr><td>Email:</td><td colspan="5">btyler@gsu.edu</td></tr>
<tr><td>Website:</td><td colspan="5">http://www.ruralhealthlink.org/</td></tr>
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