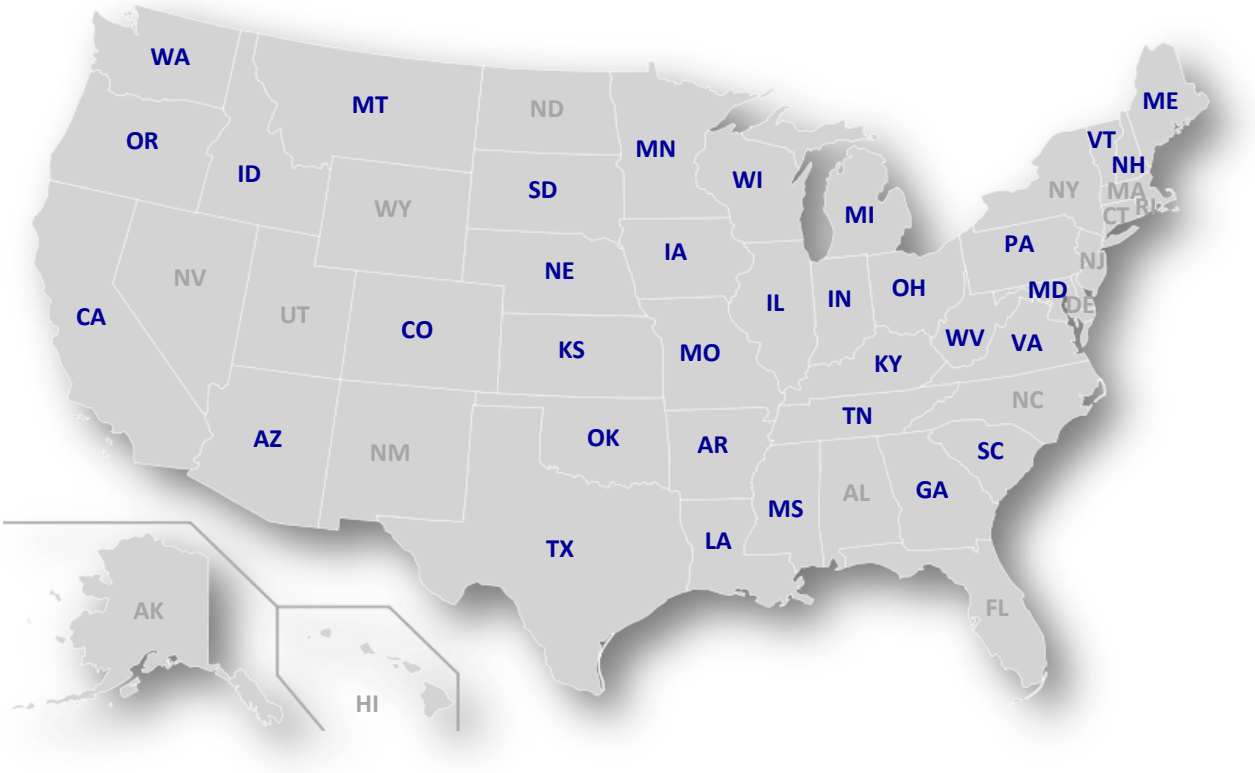
U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

Grantee Directory

Rural Health Care Services Outreach 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

2015-2018 Rural Health Care Services Outreach Grant

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

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

This Directory provides contact information and a brief overview of the sixty initiatives funded under the Rural Health Care Outreach Services grant program in the 2015 – 2018 funding cycle.

2015 - 2018 Rural Health Outreach Grantees Grant Recipients

(Listed by State)

2015 - 2018 Rural Health Outreach Grantees Grant Recipients

(Listed by State)

Arizona

Mariposa Community Health Center

Grant Number:	D04RH28385					
Organization Type:	Community Health Center					
Grantee Organization Information:	Name:	Mariposa Community Health Center				
	Address:	1852 N Mastick Way				
	City:	Nogales	State:	AZ	Zip code:	85621
	Tel #:	520-375-6050				
	Website:	www.mariposachc.net				
Primary Contact Information:	Name:	Susan Kunz				
	Title:	Chief of Health and Wellness				
	Tel #:	520-375-6050				
	Email:	skunz@mariposachc.net				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Carondelet Holy Cross Hospital*	Santa Cruz	AZ	Hospital
	Southeast Arizona Area Health Education Center*	Santa Cruz	AZ	Non-Profit
	Nogales Community Food Bank*	Santa Cruz	AZ	Non-Profit
	Nogales Community Development*	Santa Cruz	AZ	Non-Profit
	AZ Prevention Research Center*	Santa Cruz	AZ	University
	Santa Cruz County Superintendent of Schools	Santa Cruz	AZ	Schools
	University of Arizona Cooperative Extension, Santa Cruz*	Santa Cruz	AZ	University
	Santa Cruz County Community Development Department*	Santa Cruz	AZ	Local government
	Adolescent Wellness Network*	Santa	AZ	Non-Profit

		Cruz		
	Cosechando Bienestar (Harvesting Well-being)*	Santa Cruz	AZ	Non-Profit
	WIC*	Santa Cruz	AZ	Non-Profit
	Rio Rico Community Center	Santa Cruz	AZ	Non-Profit

The communities/counties the project serves:	All of Santa Cruz County (Nogales, Rio Rico, Tumacacori, Carmen, Patagonia, Sonoita and Elgin)

The target population served:

Population	Yes	Population	Yes
Infants		Caucasians	
Pre-school Children		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		Physical Fitness and Nutrition	X
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras	X	Substance Abuse	
Coordination of Care Services	X	Telehealth	
Emergency Medical Services		Transportation to health services	
Health Education and Promotion		Other: (please describe)	
Health Information Technology		Other: (please describe)	

Description of the project:

The Vivir Mejor! Consortium was established in the fall of 2011 as a system of diabetes prevention and care in Santa Cruz County, Arizona—a rural, U.S.-México border community. The focus of the current HRSA Rural Health Care Outreach Services Program grant is to specifically address healthy eating as one of the obesity prevention and reduction strategies identified in the Santa Cruz County Health Improvement Plan (CHIP) published in May 2013. The goal of this Vivir Mejor! (Live Better!) initiative is to promote healthy eating by increasing access to healthy foods, teaching healthy food preparation and changing dietary patterns and norms in order to prevent and reduce obesity risk among Santa Cruz County residents. Weekly classes on cardiovascular disease prevention are delivered by Community Health Workers. A new program activity is the healthy food cooking class. This hands-on approach is used to

teach nutrition education and can help participants apply what they learn in the classroom in their daily lives. Vivir Mejor! supports access to healthy food by incentivizing utilization of the local food system such as the Farmer's Market and the Food Bank. Trained Lay Leaders extend the program reach in the community by having informal health education classes in neighborhood venues. Additionally, Vivir Mejor! includes an obesity prevention component that specifically targets youth through weekly health and nutrition classes and physical activity sessions. The Community Care Coordinator (aka, Patient Navigator) program, located in the Nogales clinic, has expanded to the Rio Rico clinic site and provides home visits to high risk patients with chronic diseases.

Evidence Based/ Promising Practice Model Being Used or Adapted:

1. *Su Corazon Su Vida* Curriculum- promote heart health and reduce obesity and chronic disease risk
2. *La Vida Buena* Curriculum - promote healthy eating to reduce diabetes risk among children and adolescents
3. Patient-Centered Medical Home (PCMH) model for coordinated diabetic care
4. Promotoras de Salud (Community Health Workers)
5. Use of incentives to encourage purchase and consumption of fresh fruits and vegetables among low income families via food security instruments and/or at local farmers markets
6. Use of Lay Leaders to extend services and build community capacity via trained community members as peer educators

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Technical Assistance Consultant's Contact Information:	Name:	John Butts, MPH				
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	Email:	jbutts@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Arizona

Rio Rico Medical & Fire District

Grant Number:	D04RH28429					
Organization Type:	Fire-based Emergency Medical Services					
Grantee Organization Information:	Name:	Rio Rico Medical & Fire District				
	Address:	822 Pendleton Drive				
	City:	Rio Rico	State:	AZ	Zip code:	85648
	Tel #:	520-281-8421				
	Website:	www.rioricofire.org				
Primary Contact Information:	Name:	Matt Eckhoff				
	Title:	Program Director				
	Tel #:	520 761-0104				
	Email:	meckhoff@rioricofire.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$184,730
	May 2016 to Apr 2017	$185,675
	May 2017 to Apr 2018	$182,665

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Carondelet Holy Cross Hospital	Santa Cruz	AZ	Critical Access Hospital
	*Southeast Arizona Area Health Education Center	Santa Cruz	AZ	AHEC
	*Arizona Poison and Drug Information Center	Pima	AZ	University-based

The communities/counties the project serves:	Project is planned to progressively grow to accommodate the entirety of Santa Cruz County, Arizona by year 3.

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	X
	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	X
	Access: Specialty Care		Integrated Systems of Care	

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

Description of the project:

Through training current firefighter/paramedics in community paramedicine practices, identifying and recruiting individuals aged 55 and older who suffer from chronic disease and/or are considered high-utilization emergency services users, and implementing a community paramedicine intervention, it is our hope that the program will improve the health and quality of life of our participants. CHIPP intervention activities include the delivery of in-home chronic disease and medication management education, referral to appropriate healthcare resources, monitoring of chronic disease, and removal of environmental and/or fall hazards by bilingual community paramedics. CHIPP intervention activities will improve health and quality of life for CHIPP participants by: increasing medication adherence, reducing serious falls that require EMS intervention, increasing number of participants with primary care providers, reducing ED transports for low-acuity needs, and reducing the hospital readmission rates. Furthermore, the cost savings of CHIPP, in terms of reduced EMS and ED usage, will be realized upon evaluation of the program.

Community healthcare paramedics are the hub in this healthcare delivery model: they are at the center and connect CHIPP participants, Carondelet Holy Cross Hospital, EMS, health education resources, Arizona Poison and Drug Information Center, and primary care providers to each other. They foster communication between the participant and healthcare providers and resources. In addition, they help ensure effective delivery of healthcare services and participant adherence to medical recommendations.

Community healthcare paramedics will implement intervention activities tailored to the specific participants' needs. All participants will receive interventions related to medication adherence, environmental and fall hazards, chronic disease education, and referral to appropriate health resources.

Evidence Based/ Promising Practice Model Being Used or Adapted:

CHIPP Promising Practice Model:
The Community Healthcare Integrated Paramedicine Pilot Project in Rio Rico, Arizona is based off of the Community Paramedicine Model: "a new model of community-based healthcare in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations."[1] The model was developed in response to the lack of access to primary care in rural areas and high utilization of costly emergency services for primary care needs.[1] In the past few years many departments in the United States have turned to the Community Paramedicine Model as a method to reduce Emergency Medical Services (EMS) use for non-emergencies and address the burgeoning primary care needs of rural communities.

The Community Paramedicine Model has been widely used in Australia and Canada for many years though a formal program was not implemented in the United States until 2009.[2] *The International Roundtable on Community Paramedicine* developed a curriculum for Community Paramedicine in the United States, and pilot programs were implemented in Minnesota and Colorado in 2009 and 2010 respectively.[2] Since 2009, many rural counties have adopted the Community Paramedicine Model, and two programs have been nationally recognized for their accomplishments. The Rural Assistance Center recognizes both Eagle County

Paramedic Services in Colorado and Humboldt General Hospital EMS Rescue in Winnemucca, Nevada as examples of successful Community Paramedicine programs.[3]

Eagle County Paramedic Services has a five year grant for their Community Paramedicine pilot project and collaborates with local physicians and the Eagle County Health Department to be the "eyes and ears" of the physician in the homes of patients.[4] Community Paramedics go out into the community and follow up with patients upon hospital discharge. They conduct environmental evaluations and provide chronic disease and medication management among other duties.[5] Community Paramedics also work with the Health Department to assist with immunizations and health screenings in the home. The pilot program was featured at the 6th annual *International Roundtable on Community Paramedicine* in 2010.[4]

The Community Paramedicine program through Humboldt General Hospital EMS Rescue was created in order to reduce Emergency Department visits and hospital readmissions. "When patients call 9-1-1 to have HGH EMS Rescue take them to the emergency room because they are experiencing adverse symptoms related to poor management of a chronic disease, responders have the option of treating and releasing the patient home rather than bringing that patient into the hospital for an unnecessary visit. The program also offers in-home flu shots, blood pressure checks, blood sugar checks and much more."[5] The director of the program was recognized as one of the "10 Innovators" in the development of EMS in 2011 by the *Journal of Emergency Medical Services*.[5]

As the Community Paramedicine Model is fairly new in the United States, many of these programs are still in the implementation stage and have not been evaluated; hence there is a dearth of data in the peer-reviewed literature on the success of such programs. The effects of one community paramedicine in the United States have been published in a peer-reviewed journal. The article abstract is given below:

TITLE
Effects of an emergency medical services-based resource access program on frequent users of health services[7]

BACKGROUND:
A small group of adults disproportionately and ineffectively use acute services including emergency medical services (EMS) and emergency departments (EDs). The resulting episodic, uncoordinated care is of lower quality and higher cost and simultaneously consumes valuable public safety and acute care resources.

OBJECTIVE:
To address this issue, we measured the impact of a pilot, EMS-based case management and referral intervention termed the San Diego Resource Access Program (RAP) to reduce EMS, ED, and inpatient (IP) visits.

METHODS:
This was a historical cohort study of RAP records and billing data of EMS and one urban hospital for 51 individuals sequentially enrolled in the program. The study sample consisted of adults with ≥ 10 EMS transports within 12 months and others reported by prehospital personnel with significant recent increases in transports. Data were collected over a 31-month time period from December 2006 to June 2009. Data were collected for equal pre- and post-enrollment time periods based on date of initial RAP contact, and comparisons were made using the Wilcoxon signed-rank test. Overall use for subjects is reported.

RESULTS:
The majority of subjects were male (64.7%), homeless (58.8%), and 40 to 59 years of age (72.5%). Between the pre and post periods, EMS encounters declined 37.6% from 736 to 459 ($p = 0.001$), resulting in a 32.1% decrease in EMS charges from $689,743 to $468,394 ($p = 0.004$). The EMS task time and mileage decreased by 39.8% and 47.5%, respectively, accounting for 262 ($p = 0.008$) hours and 1,940 ($p = 0.006$) miles. The number of ED encounters at the one participating hospital declined 28.1% from 199 to 143, which correlated with a 12.7% decrease in charges from $413,410 to $360,779. The number of IP admissions declined by 9.1% from 33 to 30, corresponding to a 5.9% decrease in IP charges from $687,306 to $646,881. Hospital length of stay declined 27.9%, from 122 to 88 days. Across all services, total charges declined by $314,406.

CONCLUSIONS:
This pilot study demonstrated that an EMS-based case management and referral program was an effective means of decreasing EMS transports by frequent users, but had only a limited impact on use of hospital services.

The Community Paramedicine Model is a promising practice, as very few programs in the United States have been evaluated. Community Paramedicine literature, however, will be published within the next few years as EMS departments evaluate the effectiveness of their pilot programs.

Works Cited

1. Kizer KW, Shore K, Moulin A. Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care. University of California Davis Institute for Population Health Improvement. 2013.
2. Krumperman K. History of Community Paramedicine. Journal of Emergency Medical Services. 2010.
3. Community Paramedicine. Rural Assistance Center. 2014. Available from http://www.raconline.org/topics/community-paramedicine/faqs#models.
4. Helseth C. Community Paramedics Widen Medical Services in Rural Areas. Rural Assistance Center. November 2010. Available from http://www.raconline.org/rural-monitor/paramedics-widen-medical-services/.
5. Up Front: Peter Runyon Community Paramedics Program. Eagle County Paramedic Services. 2010. Available at http://eaglecounty.granicus.com/MediaPlayer.php?view_id=15&clip_id=640.
6. EMS Rescue: About Us. Humboldt General Hospital. 2014. Available at http://www.hghospital.ws/Our_Services/EMS_Rescue/About_Us.aspx.
7. Tadros AS, Castillo EM, Chan TC, et al. Effects of an emergency medical services-based resource access program on frequent users of health services. Prehosp Emerg Care 2012;16:541-7.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Arizona

Summit Healthcare Regional Medical Center

Grant Number:	D04RH28414					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Summit Healthcare Regional Medical Center				
	Address:	2200 E Show Low Lake Road				
	City:	Show Low	State:	AZ	Zip code:	85901
	Tel #:	928-537-6829				
	Website:	www.summithealthcare.net				
Primary Contact Information:	Name:	Angie Kolling				
	Title:	Chief Marketing & Development Officer				
	Tel #:	928-537-6829				
	Email:	akolling@summithealthcare.net				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$177,614
	May 2016 to Apr 2017	$177,614
	May 2017 to Apr 2018	$177,614

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Summit Healthcare Regional Medical Center	Navajo	AZ	Hospital
	Community Counseling Centers, Inc.	Navajo	AZ	Mental Health/Substance Abuse
	Banner Behavioral Health Hospital	Maricopa	AZ	Behavioral Health
	Southwest Telehealth Resource Center	Pima	AZ	Telemedicine Organization
	Arizona Telemedicine Program	Pima	AZ	Telemedicine Organization
	Navajo County Juvenile Detention Center	Navajo	AZ	Juvenile Detention Center
	Navajo County Correctional Facilities	Navajo	AZ	County Organization

The communities/counties the project serves:	Navajo County – Show Low, Pinetop, Lakeside, Heber-Overgaard, Holbrook, Snowflake, Taylor

The target population served:	Population	Yes	Population	Yes
	Infants	X	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	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	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	X
	Coordination of Care Services		Telehealth	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 project goes beyond the plenary and formative phases to establish and implement a tele-psychiatric network, with clinical sites located in the offices of Primary Care Providers, adult and juvenile detention facilities to meet both adult and pediatric mental health needs. Once established, this rural tele-psychiatric system can bring critically needed health care specialists from across medical disciplines to this underserved rural area, alleviating some of the effects of the shortage of health professionals, and serving as a model for the development of other telemedicine projects.

This project will allow project partners to collaborate in the implementation of a sustainable, self-supporting network of behavioral health and medical specialty providers, caring for patients across a rural, medically underserved region, through the proven model of telemedicine. A population without access to quality behavioral and medical specialists will know the reality of excellent care that transcends time and distance.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Summit Healthcare Rural HealthCare Patient-Driven Outpatient Behavioral Health Models of Care. Many individuals receiving care for physical health conditions also experience behavioral health conditions that impact health outcomes. Currently behavioral health care and physical health care are operating independently for the majority of patients in the White Mountain areas. This gap in care often results in poor disease management and increased use of emergency room and hospital services as well as reduced productivity and quality of life. In addition patients who need behavioral health care may avoid treatment related to stigma that can currently exist. Integrating behavioral healthcare across the continuum and in all aspects of healthcare will reduce this stigma and foster better health outcomes. As highlighted by the Health Research and Educational Trust (HRET) in Partnership with the American Hospital Association (AHA):

- There is not one size fits all model, as provider capabilities and community needs are different in each community
- The healthcare environment is changing rapidly and status quo is not a strategy for organizations to stay viable
- Each hospital and care system can choose multiple paths

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Arkansas

ARcare

Grant Number:	D60RH25754					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	Name:	ARcare				
	Address:	P.O. Box 497				
	City:	Augusta	State:	AR	Zip code:	72006
	Tel #:	870-347-2534				
	Website:					
Primary Contact Information:	Name:	Joey Miller				
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	Tel #:	870-347-2534				
	Email:	Joey.miller@arcare.net				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	5/1/2015 – 4/30/2016	$200,000
	5/1/2016 – 4/30/2017	$190,523
	5/1/2017 – 4/30/2018	$197,748

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	ARcare*	Cross/Woodruff	AR	FQHC
	Caldwell Pharmacy*	Cross	AR	Pharmacy
	Legacy Hospice*	Cross	AR	Skilled Care

The communities/counties the project serves:	Counties: Cross

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	X
	Elderly	X	Uninsured	X
	Pregnant Women		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	X	Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	

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

Description of the project:

ARcare, a 501(c) (3) non-profit entity in north central Arkansas, will open a Longevity Center to serve older adults in Cross County, Arkansas. This Center will be co-located within an existing primary care clinic operated by the applicant but will focus on the unique needs of patients age 50 and older in a county with high rates of poverty, a high percentage of older residents, and which lacks any specialized elder care. ARcare is an important provider of primary care in 11 Arkansas counties, where health care providers are scarce and residents experience health disparities. The proposed Longevity Center will be ARcare's second such Center and will provide physical activity, falls management, nutrition, and chronic disease self-management programs. The first Center opened in ARcare's hometown of Augusta, Arkansas in May 2014. The project is modeled after the lessons being learned from launching that first Longevity Center.

The goal is to *Improve Health Outcomes and Quality of Life for Cross County Older adults.* The expected outcomes include reducing falls, reducing medication errors/interactions, increasing chronic disease self-management, increasing mobility and physical activity, and decreasing number of nights of hospitalization, among others.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The proposed Longevity Center and the planned services and activities are based on the National Council on Aging meta-collection of evidence-based practices. The title of the document is "Empowering Older People to Take More Control of Their Health Through Evidence-Based Prevention Programs: A Capping Report. (2013)" (Herein after referred to as "Report."). The model is considered a multi-factorial approach to elder care. ARcare proposes to modify the models by adding a Licensed Clinical Social Worker to the provider team to provide case management and help patients overcome potential barriers to participation, such as transportation

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	City:	Atlanta	State:	Georgia	Zip code:	30303

California

Palo Verde Hospital

Grant Number:	D04RH28425					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Palo Verde Hospital				
	Address:	250 N. First Street				
	City:	Blythe	State:	CA	Zip code:	92225
	Tel #:	760-922-4115				
	Website:	www.paloverdehospital.org				
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	Title:	CEO				
	Tel #:	760-921-5151				
	Email:	Sandra.anaya@paloverdehospital.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Palo Verde Hospital District*	Riverside	CA	Healthcare
	Palo Verde Unified School District	Riverside	CA	School
	Desert Learning Center*	Riverside	CA	School
	Rec-n-Crew*	Riverside	CA	Recreation Center

The communities/counties the project serves:	Blythe; Riverside County

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

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

			Nutrition	
	Chronic Disease: Other		School Health	X
	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:

This is a community outreach program which will provide diabetic screening, prevention, and education for school-age children, kindergarten through 5th grade. Health and education classes will be held daily during the school day and multicultural learning will be provided to children and parents to promote proper nutrition, increased activity, and increased knowledge of diabetes and related risk factors in a primarily high-risk Hispanic population. Case management of children who are identified to be high risk will be initiated with referrals made to physicians, specialists, and nutritionists. Children will be monitored over time to measure improvement in health status.

Education and instruction will be provided to educators, cafeteria workers, and parents to help reduce those risk factors known to increase the risk of obesity and other comorbidities.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Bienstar Health Program which is a school-based model designed to prevent the development of diabetes in low income Mexican American children. The program encourages healthy lifestyle changes among this population who are known to be high risk for developing type two diabetes mellitus. The Bienstar Program addresses personal factors such as knowledge and belief to impart three health behavior factors that are associated with diabetic prevention: decreasing dietary saturated fat intake, increasing dietary fiber intake, and increasing physical activity. This is achieved through culturally appropriate education of adults and children.

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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:	Rachel Campos				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

California

Redwood Community Action Agency

Grant Number:	D04RH28428					
Organization Type:	Nonprofit Community Agency					
Grantee Organization Information:	Name:	Redwood Community Action Agency				
	Address:	904 G Street				
	City:	Eureka	State:	CA	Zip code:	95501
	Tel #:	707 269-2000				
	Website:	www.rcaa.org				
Primary Contact Information:	Name:	Lorey Keele				
	Title:	Community Services Director				
	Tel #:	707 269-2052				
	Email:	lkeele@rcaa.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$199,864
	May 2016 to Apr 2017	$199,512
	May 2017 to Apr 2018	$199,723

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Bayview Consulting	Humboldt	CA	Business
	*California Center For Rural Policy	Humboldt	CA	Non Profit
	*Changing Tides	Humboldt	CA	Non Profit
	*Humboldt County Office Of Education	Humboldt	CA	School
	*Northcoast Childrens Services	Humboldt	CA	Non Profit
	Humboldt County Department Of Public Health	Humboldt	CA	Government

The communities/counties the project serves:	

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)		Native Americans	X
	Adults		Pacific Islanders	X
	Elderly		Uninsured	X
	Pregnant Women	X	Other: (please describe)	
			Other: (please describe)	

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

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

Description of the project:

Redwood Community Action Agency's TOOTH Plus Rural Health Care Services Outreach Program is a consortium of community organizations that includes three nonprofits focused on children's health, the county Office of Education, community health consultants for five community based organizations, and an independent contractor who coordinates the countywide Oral Health Initiative, Pediatric Oral Health and Leadership Team and the Dental Advisory Group for the county health department.

The consortium partners seek to improve the state of oral health in rural Humboldt County through expansion of community-based early intervention tactics that include preventative education, screenings, and fluoride varnish services in preschool settings. The program also includes a county-wide public media campaign to increase the oral health literacy of the county's daycare providers, parents and community at large.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The promising practice models that will be used for TOOTH Plus are identified in the brief, *Promising Practices to Improve Access to Oral Health Care in Rural Communities,* issued through the NORC Walsh Center for Rural Health Analysis in February 2013. The associated health promotion and dental disease activities are also evidenced-based and endorsed by the American Academy of Pediatric Dentistry. TOOTH Plus is based on the design of the California Children's Dental Disease Prevention Program (CCDDPP) which was replicated in 31 counties from 2004-2009 with the goal of contributing to the achievement of the Healthy People 2010 Oral Health Objectives.

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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Colorado

All American Families DBA Families Plus

Grant Number:	D04RH28293					
Organization Type:	Nonprofit Mental Health Specialty Clinic					
Grantee Organization Information:	Name:	All American Families DBA Families Plus				
	Address:	115 Grand Avenue				
	City:	Delta	State:	CO	Zip code:	81416
	Tel #:	970-874-0464				
	Website:	www.familiesplus.net				
Primary Contact Information:	Name:	Brenda K. Holland				
	Title:	Executive Director				
	Tel #:	970-874-0875				
	Email:	Brenda.k.holland@gmail.com				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*All American Families d/b/a Families Plus	Delta	CO	Non-Profit Mental Health Specialty Clinic
	*Delta County Memorial Hospital	Delta	CO	Hospital
	*Stoney Mesa Family Practice	Delta	CO	Medical Group Practice

The communities/counties the project serves:	Delta County, CO

The target population served:	Population	Yes	Population	Yes
	Infants	X	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	
	Elderly		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	X	Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	

	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	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 Delta Outreach Consortium consists of All American Families d/b/a Families Plus (a Mental Health Specialty Clinic), Stoney Mesa Family Practice (a rural primary medical home), and Delta County Memorial Hospital. Together, these organizations manage 10 outpatient facilities. The purpose of this project is to address the fragmentation and scarcity of health care in this rural county with improved systems of delivery that integrate behavioral and physical health care. The Families Plus program uses Wraparound strategies to deliver physical, dental, and behavioral health care to the hard-to-reach children in Delta County and to improve their social determinants of health. The primary medical homes have no internal behavioral health capacity and few outside providers to whom to refer. These clinics will integrate behavioral health services into their primary care services. As this project advances, the Families Plus program will upgrade their processes to high quality wraparound levels so that more children with complex disorders can gain access to health care; the Consortium will work with insurance systems to manage maximal billing for mental health care in order to establish sustainability of the new behavioral health care services being provided; Families Plus will provide supervised, trained behavioral health care professionals to provide behavioral care in an increasing number of primary medical homes. The project will provide training and consultation to allow these primary medical homes to integrate their behavioral health and physical health treatments for children and depressed adults; and Families Plus consultants and staff will provide training and coaching to primary medical home staff to understand and implement practices of "patient-centered care" using the Wraparound model. Through this project, behavioral health disorders will be identified and treated in primary medical homes, resulting in the improvement or elimination of these disorders as demonstrated through repeated behavioral measures.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Wraparound is the overall promising practice that will be implemented across all target populations by the Delta Outreach Consortium. Wraparound is a system of collaboration by professionals with the family or patient that draws these family members into directing and guiding their own services and care. The Families Plus program will use wraparound extensively in providing for the health care needs of children with complex needs. Primary medical homes will also draw wraparound practices into their regular outpatient practices so as to achieve person-centered care. In addition to the Wraparound Model, several brief behavioral evidence-based treatments will be provided in the primary medical homes. These will be Heartmath, Cool Kids, Trauma Focused Cognitive Behavioral Treatment, MoodGym, and Cognitive Behavioral Treatment for Depression. Dr. John VanDenBerg, one of the founders of the Wraparound Model, has been a volunteer consultant to the Families Plus program since 2013, when he retired to Delta County, Colorado. He brings with him 30 years of extensive expertise and knowledge about implementing the Wraparound Program and achieving outstanding outcomes through his formative work in rural Alaska as well as in the other 49 states. He wrote the first professional article on Wraparound and has over 25 publications in journals relating to services for high-risk children and families. Dr. VanDenBerg is a consultant on this grant.

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Colorado

Tri-County Health Network

Grant Number:	D04RH28378					
Organization Type:	Network					
Grantee Organization Information:	Name:	Tri-County Health Network				
	Address:	P.O. Box 4222				
	City:	Telluride	State:	CO	Zip code:	81435
	Tel #:	970-708-7096				
	Website:	www.tchnetwork.org				
Primary Contact Information:	Name:	Lynn Borup				
	Title:	Executive Director				
	Tel #:	970-708-7096				
	Email:	lynn@telluridefoundation.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Center for Mental Health*	Multi	CO	Mental Health Center
	Basin Clinic*	Montrose	CO	Rural Health Clinic
	River Valley Family Health Center*	Montrose	CO	FQHC
	Telluride Medical Center*	San Miguel	CO	Community Clinic
	Uncompahgre Medical Center*	San Miguel	CO	FQHC
	Telluride Foundation*	San Miguel	CO	Community Foundation
	Montrose Memorial Hospital*	Montrose	CO	Regional Medical Center

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

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

Description of the project:

Tri-County Health Network's (TCHNetwork) Community Health Worker (CHW) Outreach program, is designed to improve healthcare services in four counties of rural/frontier, southwest Colorado by decreasing the risk of cardiovascular disease (CVD) and diabetes. Modeled after the Colorado Heart Healthy Solutions program, CHWs will provide biometric screenings to underserved residents at convenient locations to identify and decrease risk for CVD or diabetes and offer self-management tools and peer support to improve overall health. In addition, CHW Outreach program services and activities will include: 1) offering bilingual/bicultural health literacy support; 2) performing diabetic retinopathy tele-screening; 3) teaching chronic disease self-management program classes (CDSMP) in both English and Spanish; 4) teaching Cooking Matter classes; and 5) developing a rural restaurant health options program.

Evidence Based/ Promising Practice Model Being Used or Adapted:

1) Community Health Worker (CHW) model
2) Colorado Heart Health Solutions (CHHS) program created by the Colorado Prevention Center (CPC) proven to reduce risk of CVD in rural communities
3) Chronic Disease Self-Management Program (CDSMP) - CHWs train in both the English and Spanish curriculum for this 6 week Stanford School of Medicine evidence-based chronic care management program.
4) Cooking Matters for Adults EXTRA for Diabetes - CHWs are trained to coordinate and conduct this hands-on, six-week cooking-based nutrition education program that empowers individuals with the skills, knowledge, and confidence needed to identify and prepare healthy and affordable meals.
5) Digital Retinopathy Tele-screening – Tele-screenings, based on evidence based guidelines, remove barriers to care and are critical for early detection and intervention to prevent the progression of diabetic retinopathy
6) Rural Restaurant Health Options Program – modeled after the University of Iowa Prevention Research Center for Rural Health's "Health Options Program" as a low maintenance and cost-effective way to increase awareness of already existing healthy menu options through the use of table signs.

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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Georgia

Tanner Medical Center, Inc.

Grant Number:	D04RH28416					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Tanner Medical Center, Inc.				
	Address:	705 Dixie Street				
	City:	Carrollton	State:	GA	Zip code:	30117
	Tel #:	770-836-9666				
	Website:	www.tanner.org				
Primary Contact Information:	Name:	Kimberly Johnson				
	Title:	Program Manager, Willowbrooke at Tanner				
	Tel #:	770-812-8926				
	Email:	kjohnson@tanner.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$198,783
	May 2016 to Apr 2017	$194,283
	May 2017 to Apr 2018	$194,283

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Willowbrooke at Tanner (Behavioral Health Division of Tanner Medical Center, Inc.)	Carroll	GA	Hospital; Behavioral Health
	Carroll County School System*	Carroll	GA	School
	Haralson County School System*	Haralson	GA	School
	Heard County School System*	Heard	GA	School

The communities/counties the project serves:	Carroll, Haralson and Heard Counties in Georgia

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	
	Pre-school Children		African Americans	
	School-age children (elementary)	X	Latinos	
	School-age children (teens)	X	Native Americans	
	Adults	X	Pacific Islanders	
	Elderly		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	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	

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

Description of the project:

Tanner's Outreach Program will support the efforts of the West Georgia Regional School-Based Behavioral Health Consortium, a partnership between Willowbrooke at Tanner (the behavioral health division of Tanner Medical Center, Inc.) and the Carroll, Haralson and Heard County School Systems, as they work collaboratively to expand the continuum of school-based behavioral health care services and supports, from prevention to intensive intervention, for students in rural communities in Carroll, Haralson and Heard counties. These multi-tiered behavioral health interventions will be directed at enhancing environments, broadly training and promoting social and emotional learning and life skills, preventing emotional and behavioral problems, identifying and intervening in these problems early on and providing intervention for established problems. Tanner will embed three behavioral health therapists in nine rural schools within the Carroll, Haralson and Heard County School Systems to provide a variety of school-based behavioral health services to students, including classroom consultation/observation; support groups; parent education; in-service trainings; assessment and diagnostic evaluations; individual, group and family therapy; treatment planning and coordination and referrals to appropriate behavioral health/community services. School staff/personnel will collaborate with the school-based behavioral health providers by: informing and implementing universal prevention interventions that include school-wide programs that foster safe and caring learning environments and engage students, promote social, emotional and behavioral learning, and develop connections between school, home and community; actively participating in behavioral health consultation and teacher/staff education; and referring students in need of behavioral health services. By engaging school and behavioral health system partners in planning, implementing, evaluating, sustaining and continuously monitoring and improving school-based behavioral health services and supports, based on locally determined needs, Tanner's Outreach Program project will build and enhance the local capacity to improve the quality of practice and achieve positive behavioral health (and academic) outcomes for area children and adolescents.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Tanner's Outreach Program will employ the nationally-recognized and research-driven promising practice model of the Interconnected Systems Framework (ISF) to blend education and behavioral health systems and resources toward depth and quality in prevention and intervention within a multi-tiered framework, allowing for greater efficiency and effectiveness by focusing on: shared leadership; a layered continuum of supports; universal screening and progress monitoring; evidence-based instruction, intervention and assessment practices; data-based problem solving and decision-making; and family, school and community partnering.

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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Idaho

St Luke's McCall, Ltd.

Grant Number:	D04RH28434					
Organization Type:	Health System and Primary Care Clinic					
Grantee Organization Information:	Name:	St Luke's McCall, Ltd.				
	Address:	1000 State Street				
	City:	McCall	State:	ID	Zip code:	83638
	Tel #:	208-630-2200				
	Website:	http://www.stlukesonline.org/mccall/				
Primary Contact Information:	Name:	Jennifer Yturriondobeitia				
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	Tel #:	208-899-9012				
	Email:	yturrioj@slhs.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	St. Luke's McCall	Valley	ID	A 15-bed critical access hospital and medical clinics.
	St. Luke's McCall Foundation	Valley	ID	Provides grant writing, grant management and consortium coordination.
	McCall Fire & EMS	Valley	ID	Provides *fire, rescue, and EMS services to the community.*
	Donnelly Fire Department	Valley	ID	Provides fire protection, emergency medical care and community preparedness.
	Adams County Health Clinic	Adams	ID	A FQHC that provides high quality health care services to residents of Adams County.
	Community Care Clinic	Adams	ID	Provides free primary care to uninsured residents.

The communities/counties the project serves:	Rural Outreach Care Coordination Collaborative (ROCCC)

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

	Elderly	X	Uninsured	
	Pregnant Women	X	Other: (please describe)	

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

ROCCC will develop a "Health Neighborhood" based on the Patient Centered Medical Home (PCMH) and Patient Centered Medical Home Neighborhood (PCMH-N) evidence based models. The project would build on the existing strengths of the rural communities to form networks and collaborations for the good of the whole. Rural Outpatient Care Coordination Collaborative (ROCCC) builds on that common way of doing business. ROCCC's six consortium members (2 regional EMS providers, St. Luke's McCall Foundation, St. Luke's McCall, Adams County FQHC, and Community Care Clinic) will create a community health neighborhood by; 1) building a team-based care model, 2) embedding a nurse care coordinator, community health worker, and behavioral health consultant in the primary care clinic, and 3) engaging community involvement with ROCCC to improve population health management. ROCCC will pursue designation for Tier 3 Patient Centered Medical Home to expand clinical impact and increase the financial sustainability.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Team-Based Care: Based on the Institute of Medicine & adapted from TeamStepps model
Patient Centered Medical Home: Based on NCQA standards & American College of Physicians
Integrated Behavioral Health: Based on Primary Care Behavioral Health model from Robinson and Strosahl
Nurse Care Coordination: Based on the Intensive Outpatient Care Program (IOCP) or also known as Ambulatory Intensive Care Unit (AICU)
Community Health Worker: Based on Pathways Model by Redding

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Idaho

St. Mary's Hospital

Grant Number:	D04RH28412					
Organization Type:	Critical access hospital (CAH)					
Grantee Organization Information:	Name:	St. Mary's Hospital				
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	City:	Cottonwood	State:	ID	Zip code:	83522-0137
	Tel #:	208-962-3251				
	Website:	www.smh-cvhc.org				
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	Email:	Pam.mcbride@smh-cvhc.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Clearwater Valley Hospital*	Clearwater	ID	CAH
	Syringa Hospital District*	Idaho	ID	CAH
	Nimiipuu Health*	Nez Perce	ID	Tribal health
	Public Health – Idaho North Central District*	Nez Perce	ID	Public health
	Saint Alphonsus Regional Medical Center*	Ada	ID	Hospital
	Human Needs Council*	Idaho	ID	Social service
	Clearwater County Human Needs Council*	Clearwater	ID	Social service
	Snake River Community Clinic	Nez Perce	ID	Free clinic

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

The target population served:	Population	Yes	Population	Yes
	Infants	X	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	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: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The Health-Able Communities project will introduce new health screening services, as an extension of local primary care clinics. Outreach will be conducted at community venues at times convenient to residents and facilitated by Community Health Workers (CHWs). CHWs will administer basic screenings and deliver individual results, accompanied by customized – and culturally effective – preventative health or self-care guidance. CHWs will refer participants with abnormal or out-of-range screening results to an appropriate provider. They will serve as a "warm front door" into medical homes, by assisting participants to overcome barriers to visiting the provider of their choice. CHWs will refer all participants to community-based nutrition, fitness, and other wellness resources. They will be housed at consortium partner sites.

The Project Director and CHWs will lead residents to fill gaps in local wellness resources. Simple projects may include community gardens, cooking classes, and stress-reduction retreats. These projects alone will not erase health barriers or elevate health indicators overnight. However, they will represent additional resources for wellness and serve as highly visible demonstration projects to increase resident awareness of the need to adopt healthier lifestyles. Marketing surrounding the "grand opening" of these opportunities will be accompanied by outreach messages surrounding nutrition, fitness, and lifestyle choices.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The model for the CHW program is drawn from guidance issued by HRSA, the CDC, and best practices identified by Sinai Health System. The "pre-primary care" CHW roles for the project were selected from numerous evidence-based functions in which these non-clinical personnel have been shown to be effective. The project is expected to increase screening rates, increase resident awareness of their individual health risks, increase health literacy and links to community health and wellness resources, increase referrals to primary care, and increase the number of high-risk residents empaneled in primary care to receive chronic disease management.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Illinois

Sinnissippi Centers, Inc.

Grant Number:	DO4RH28432					
Organization Type:	Community Mental Health Center					
Grantee Organization Information:	Name:	Sinnissippi Centers, Inc.				
	Address:	325 Illinois Route 2				
	City:	Dixon	State:	IL	Zip code:	61021
	Tel #:	815-284-6611				
	Website:	www.sinnissippi.com				
Primary Contact Information:	Name:	Gloria Martin				
	Title:	Director, Child and Adolescent Services				
	Tel #:	815-284-6611 ext. 254				
	Email:	gloriamartin@sinnissippi.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	5/1/2015 - 4/30/2016	$200,000
	5/1/2016 - 4/30/2017	$200,000
	5/1/2017 - 4/30/2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Kreider Services*	Lee	IL	Social Service, Developmental Disabilities
	Katherine Shaw Bethea Hospital (KSB)*	Lee	IL	Medical: hospital and clinics
	Lee County Health Department	Lee	IL	Health Department
	Lee County Special Education Association	Lee	IL	Special Education
	Ogle County Special Education Association	Lee, Ogle	IL	Special Education

The communities/counties the project serves:	Counties: Lee, Ogle, Whiteside, Carroll

The target population served:	Population	Yes	Population	Yes
	Infants	X	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		Pacific Islanders	X
	Elderly		Uninsured	X
	Pregnant Women		Other: (please describe)	

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

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

Description of the project:

The Family Care Coordination Project (FCCP) is designed to serve children ages 0 to 18 who are exhibiting developmental, emotional, social, and /or behavioral concerns. The FCCP provides support to children and families seeking services at a newly developed Pediatric Developmental Center (PDC) located in the area. The primary focus of this project is children with complex needs and their families who are experiencing difficulty engaging in or continuing with services due to limited resources, isolation, family stress/disruption, lack of awareness of the importance of assessment and treatment services, fear of stigma, or language barriers. The FCCP enables more families to engage in and benefit from services being provided through the PDC as well as other child serving providers throughout the four-county service region.

Family Care Coordinators and a Parent Support Coordinator: (i) reach out to families to assist with linking and supporting connection to the PDC, (ii) assist other area pediatricians and family practice providers in supporting their practice towards a more family-focused medical home, (iii) provide community-based outreach to support families in understanding available resources and the benefit of engaging in and remaining in services. It is the intent of this project to provide robust care coordination to those families most at risk of not engaging in or continuing with services needed by at-risk children in order to increase the delivery of restorative services as early as possible in a child's life. Research supports that care coordination is a key component of improving efficiency, effectiveness and outcomes for children with social, emotional, behavioral, and developmental challenges.

Family Care Coordinators and a Parent Support Coordinator meet with each family to assess the needs of the entire family using appropriate interview and screening tools. Based on their assessment, staff assist the family in developing a care plan for accessing needed resources and services for the at-risk child as well as the entire family. This project provides families with the opportunity to meet with other parents for support, education and peer-to-peer problem solving.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The practice models used with the Family Care Coordination Project (FCCP) are care coordination and parent support using the Strengthening Families model which strives to increase protective factors in families. *The Rural Assistance Center, Care Coordination Toolkit 2014* describes several care coordination models which are consistent with the care coordination model used by this project. Strengthening Families is described as "a research informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs and communities in building five protective factors." The Parent Support Coordinator is also trained to provide Parent Cafes described as using "intimate, guided conversations as a tool and process to support parents in understanding and building their own protective factors" (www.CSSP.org).

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	Organization:	Georgia Health Policy Center				
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Illinois

Stephenson County Health Department

Grant Number:	D04RH28413					
Organization Type:	Health Department					
Grantee Organization Information:	Name:	Stephenson County Health Department				
	Address:	10 West Linden Street				
	City:	Freeport	State:	IL	Zip code:	61032
	Tel #:	815-235-8271				
	Website:	www.stephensonhealth.com				
Primary Contact Information:	Name:	Craig Beintema, MS, LEHP, CPHA				
	Title:	Public Health Administrator				
	Tel #:	815-235-8353				
	Email:	craig.beintema@aeroinc.net				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$199,268
	May 2016 to Apr 2017	$197,813
	May 2017 to Apr 2018	$199,848

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Stephenson County Health Department*	Stephenson	IL	Health dept.
	Carroll County Health Department*	Carroll	IL	Health dept.
	University of Illinois College of Medicine at Rockford*	Winnebago	IL	University
	Freeport Health Network*	Stephenson	IL	Hospital

The communities/counties the project serves:	Stephenson and Carroll

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	X
	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	X
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other	X	School Health	
	Community Health Workers /Promotoras		Substance Abuse	

	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

Level 1 -- At the individual level we will implement the evidence-based TOPS program at community and worksite settings. In Year 1, we will recruit 20 sites: 10 community and 10 worksite locations to implement TOPS. Starting in the 1st quarter of Year 2, an additional 20 sites will be added on an on-going basis. Each TOPS site will have a minimum of 4-6 and up to 8-10 participants, and will receive a scale and a BP cuff. Additional incentives of water bottles, pedometers, and tote bags will be provided to participants. Each TOPS site will elect a coordinator/TOPS leader who will assist with data collection and recruiting participants, and who will receive a small stipend each year.

Level 2 – Community level interventions will involve conducting community-based presentations at local libraries, church groups, health events, etc., to increase awareness about chronic disease risk and ways to address lifestyle factors such as physical activity and nutrition that can impact this risk. We will use previously developed modules that have been implemented in rural community settings - Heart-to-Heart (HH)2. HH was designed in modules to allow peer educators to conduct sessions one-on-one or in groups in 15 minute sessions. A total of eight modules were developed, four focusing on physical activity and four on nutrition, with interactive worksheets to support each module.

Level 3 – Population level interventions: Implement a broad-based media campaign using a social marketing approach including local newspaper ads, billboards, radio spots, mass-mailing of magnets, printed materials and a social media campaign targeting all residents in Stephenson and Carroll Counties. Social marketing uses commercial marketing techniques to influence voluntary behavior of the target audience to attain a health benefit. Social marketing can promote behavior change in several ways – by encouraging individuals to adopt a new behavior, reject a potentially harmful behavior, modify a current behavior or abandon an old behavior. All of these techniques have been shown to be very effective in improving health behaviors. A population-based media campaign could reach residents who could not be accessed through the level 1 and 2 interventions. The objectives of the campaign will be to disseminate messages about lifestyle changes to reduce obesity and chronic disease risk with maximum coverage in the rural two-county area and to demonstrate a positive change in awareness and knowledge about these issues amongst adults in the target area.

We will collaborate with a multi-media marketing firm – M45 from the local Freeport area to develop the campaign. The partners in this project will provide ongoing input into the development and implementation, including the types of media, images, and campaign messages. Health messages related to healthy living, obesity, and reducing chronic disease risk will be disseminated throughout Stephenson and Carroll Counties via print advertisements, radio public service announcements (PSAs), billboards located in strategic areas, a text messaging program, and other social media. The campaign will also have a presence through representation at community events such as county fairs, festivals, and high school football games.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The overall goal of the project is to promote healthy lifestyles using an evidence-based, multi-level program to reduce obesity and chronic disease risk for adult men and women living in rural Stephenson and Carroll Counties in Illinois. The goal will be addressed by implementing programming using three strategies set in the context of the socio-ecological model. The project will include a*n individual level intervention* using the evidence-based TOPS (Taking Off Pounds Sensibly) program at community locations such as churches and at small- and medium-sized worksites; *a community level intervention* by conducting community-based presentations at local libraries, church groups, and health events to increase awareness about obesity and chronic disease risk using a previously developed and tested curriculum Heart-to-Heart 2; and *a system level intervention* by implementing a broad-based media campaign including local newspaper ads, billboards, radio spots, mass-mailing of refrigerator magnets, printed materials and a social media campaign targeting all residents in Stephenson and Carroll Counties.

By implementing this multi-level program, we expect to increase the awareness and knowledge of the population of Stephenson and Carroll Counties regarding obesity, chronic disease and its relationship to physical activity, healthy eating, and lifestyle behavior change. Expected outcomes include: reduced BMI, reduced weight, increased physical activity, and increased consumption of fruits and vegetables in participants of the TOPS program. At a population level, we anticipate increased awareness about the issues related to obesity and chronic disease.

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Illinois

Transitions of Western Illinois

Grant Number:	D04RH28417					
Organization Type:	Community Mental Health Center					
Grantee Organization Information:	Name:	Transitions of Western Illinois				
	Address:	P.O. Box 3646				
	City:	Quincy	State:	IL	Zip code:	62305
	Tel #:	217-223-0413				
	Website:	www.twi.org				
Primary Contact Information:	Name:	Mark Schmitz, LCSW				
	Title:	Associate Executive Director				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$200,000
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Adams County Health Department*	Adams	IL	Health Dept
	Blessing Health System*	Adams	IL	Hospital / Primary Care
	Quincy Medical Group*	Adams	IL	Primary Care
	SIU School of Medicine*	Adams	IL	Primary Care
	United Way of Adams County*	Adams	IL	Nonprofit
	Transitions of Western Illinois*	Adams	IL	Community Mental Health Center

The communities/counties the project serves:	Adams County, IL

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

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

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

Description of the project:

The project will enhance services to people in Adams County, IL who have difficulty utilizing the health system and managing chronic health issues, including those with serious and persistent mental illnesses. Grant funding will enable community health workers (CHW's) to assist individuals by: helping them resolve barriers they may face engaging in needed healthcare, supporting them with selection of health related goals, and encouraging them as they make needed changes to take a more active role in their health. The CHW's working in the project will serve as liaisons between the consumer and healthcare providers, as well as provide health education to the target population. Specific assistance they provide will include: facilitating communication between healthcare providers and the consumer, providing the consumer with information on health and community resources, assisting consumers with scheduling and keeping health care appointments / labs, and working with consumers on creating and adhering to a care management plan.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project will utilize evidence based Community Health Workers which are a cost effective method for improving the health of people with complex social and medical needs. For individuals served who have a serious mental illness, the CHW services will be further tailored by expanding the role of existing mental health case managers into whole health case managers and by the use of Peer Recovery Support Specialists to deliver the evidence-based Wellness Recovery Action Planning (WRAP).The expected outcomes of the project will be improved compliance with healthcare directives and improved health outcomes, as well as reduced emergency room usage and a reduction in healthcare costs.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Indiana

Affiliated Service Providers of Indiana, Inc.

Grant Number:	D04RH28392					
Organization Type:	Behavioral Health Network					
Grantee Organization Information:	Name:	Affiliated Service Providers of Indiana, Inc.				
	Address:	850 N. Harrison Street				
	City:	Warsaw	State:	Indiana	Zip code:	46580
	Tel #:	317-735-0019				
	Website:	www.Aspin.org				
Primary Contact Information:	Name:	Kathy Cook				
	Title:	CEO				
	Tel #:	317-471-1890				
	Email:	kcook@aspin.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$199,399
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Four County Counseling Center	Cass	IN	CMHC
	Bowen Center	Kosciusko	IN	CMHC
	Centerstone of Indiana	Wayne	IN	CMHC
	Wabash Valley Alliance	Tippecanoe	IN	CMHC

The communities/counties the project serves:	Counties: Cass, White, Wabash, Huntington, Wayne, Fayette

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

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

	Coordination of Care Services		Telehealth	
	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 utilization of community health workers dually trained as Health Insurance Marketplace Navigators will support enrollment in health care coverage; assist communities in planning healthcare events; and provide education to improve health and insurance literacy in six rural Indiana counties form the targeted service area: Cass, Huntington, Wabash, Wayne, Fayette, and White Counties. All counties are HPSAs; all have high rates of uninsured, chronic disease, and tobacco use complicated by high ratios of population to primary care providers, low levels of education and generally poor economies. The target population is primarily white adults living in poverty between the ages of 18-64 indicating greater need for medical care, health insurance coverage, and preventive screenings. Community assessment identified concerns for health coverage, mental health access, tobacco cessation, and lack of knowledge of insurance and chronic disease management. Our consortium members include four community mental health centers: Four County Counseling Center, Bowen Center, Centerstone of Indiana, and Wabash Valley Alliance.

Evidence Based/ Promising Practice Model Being Used or Adapted:

"Community Health Workers (CHW) Offer Culturally Tailored Interactive Workshops and Counseling to Filipino Americans" (ARHQ, 2014) supports the use of community health workers to lead interactive workshops to increase positive health behavior and identify effectiveness in rural environments. The targeted population differs in that it is primarily White and rural. "Promising Practices for Rural Community Health Worker Programs" (Infante, Knudson, Brown, 2011) identifies roles CHWs can undertake such as enrollment specialists and educators. Evidence identified the use of navigators who conduct individual and group enrollment processes as emerging practice ("Measures to Increase Health Insurance Coverage in Children" by Meng, Yuan, Wang, & Garner, 2012). Methods will be adapted for adult rural populations. An October 14, 2014, HRSA webinar, "The Affordable Care Act and You: Planning for the Next Open Enrollment Period" identified best practices for marketing health insurance enrollment. Referrals to the Indiana Tobacco Quitline will provide entrée to evidence-based smoking cessation supports such as nicotine replacement therapy cited by Laniado-Laborin (2010) as a best practice.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Iowa

Child Abuse Prevention Services, Inc.

Grant Number:	D04RH28398					
Organization Type:	Nonprofit Organization					
Grantee Organization Information	Name:	Child Abuse Prevention Services, Inc.				
	Address:	811 E. Main Street				
	City:	Marshalltown	State:	Iowa	Zip code:	50158
	Tel #:	641-752-1730				
	Website:	www.capsonline.us				
Primary Contact Information:	Name:	Linda Havelka				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$199,826
	May 2016 to Apr 2017	$199,195
	May 2017 to Apr 2018	$199,728

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Central Iowa Healthcare (formerly MMSC)*	Marshall	IA	Hospital
	McFarland Clinic P.C.*	Marshall	IA	Medical Clinic
	Primary Health Care, Inc.*	Marshall	IA	Federally Qualified Health Center
	Marshalltown Obstetrics & Gynecology*	Marshall	IA	Medical Clinic
	Child Abuse Prevention Services*	Marshall	IA	501(c)(3)

The communities/counties the project serves:	Marshall County, Iowa

The target population served:	Population	Yes	Population	Yes
	Infants	X	Caucasians	
	Pre-school Children	X	African Americans	
	School-age children (elementary)	X	Latinos	
	School-age children (teens)		Native Americans	
	Adults	X	Pacific Islanders	
	Elderly		Uninsured	
	Pregnant Women	X	Other: (please describe) SOUTHEAST ASIAN REFUGEES	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		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

Marshall County, population 39,311, is located in rural Central Iowa. The county's population has remained stable over the past 50 years however the demographics of the population have shifted dramatically. This demographic shift is resultant of an increase in Hispanic immigrants beginning in 1995 and the recent increase of Southeast Asian Refugees as both of these minority groups have come to Marshall County due to the availability of jobs in the meat processing industry. These changes have resulted in an increase in the number of people living in poverty.

The target population of the Refugee Health Connections Project is Southeast Asian Refugees with children prenatal to age 5 that have settled in Marshall County, Iowa. For the past 5 years, ethnic refugees from Burma have been the largest group resettled to Iowa. This population group comes to the United States and Iowa with numerous disparities as a result of their ethnicity, language barriers, low education and literacy levels, low socio-economic level, and the challenges that are a result of being a refugee.

The project provides training to increase understanding of the Southeast Asian Refugee population and improve cultural competence. A task force comprised of local primary health care providers assess, secure/develop culturally and linguistically appropriate health education materials and disseminate them among all health care providers to improve health literacy. A Health Educator provides health education in a group format among each of the language groups to increase knowledge of health care. Through home visitation, Community Health Workers/Lay Health Workers deliver health and parenting education, family support and care coordination to meet the individual needs of each family.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Parents as Teachers: The Parents as Teachers (PAT) model is an evidence-based home visiting model designed to ensure young children are healthy, safe and ready to learn. The PAT model has four components, each closely interrelated and integrated: personal visits, group connections, child screenings and resource network.

Outreach and Enrollment Agent Model: In the Outreach and Enrollment Agent Model, Community Health Workers (CHW) conduct intensive home visits to deliver psychosocial support, promote maternal and child heath, conduct environmental health and home assessments, offer one-on-one advice, and make referrals. They also help individuals to enroll in government sponsored programs.

Lay Health Worker Model: In this model, Community Health Workers (CHW) are members of the target population that share many of the same social, cultural and economic characteristics. As trusted members of their community, lay health workers provide culturally appropriate services and serve as a patient advocate, educator, mentor, outreach worker, and translator. They are often the bridge between the diverse populations they serve and the health care system.

Care Coordinator/Manager Model: As a care coordinator, Community Health Workers (CHW) help individuals with complex health conditions to navigate the health care system. They liaise between the target population and a variety of health, human and social services organizations. They may support individuals by providing information on health and community resources, coordinating transportation, and making appointments and delivering appointment reminders. Additionally, CHW's may work with patients to develop a care management plan and use other tools to track their progress over time (e.g., food and exercise logs).
Health Educator Model: In this model, Community Health Workers (CHW) deliver health education to the target population related to disease prevention, screenings, and health behaviors. Community Health Workers may teach educational programs in the community about chronic disease prevention, nutrition, physical activity, and stress management, and also provide health screenings.

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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:	Tanisa Adimu				
	Tel #:	404-413-0302				
	Email:	tadimu@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Kansas

Community Health Center of Southeast Kansas

Grant Number:	D04RH28400					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	Name:	Community Health Center of Southeast Kansas				
	Address:	3011 N Michigan				
	City:	Pittsburg	State:	KS	Zip code:	66762
	Tel #:	620-231-9873				
	Website:	www.chcsek.org				
Primary Contact Information:	Name:	Jason Wesco				
	Title:	Executive Vice President				
	Tel #:	620-240-5076				
	Email:	jwesco@chcsek.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Health Partnership Clinic*	JO/MI/FR	KS	FQHC
	Four County Mental Health*	MG/WI/EL/CQ/CO	KC	CMHC
	Windsor Place*	MG/AL	KS	LTC
	New Beginnings*	CQ/GR/EL/WI	KS	CDDO

The communities/counties the project serves:	Counties: Franklin, Miami, Linn, Anderson, Woodson, Wilson, Bourbon, Crawford, Neosho, Wilson, Montgomery, Labette, Cherokee

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	X	Other: (please describe) Individuals With Medicaid Waivers	X

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

	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The Oral Health Outreach project will address the oral health needs of Medicaid waiver beneficiaries (the frail elderly, individuals with physical and disabilities and Severely Emotionally Disturbed children, for example) and persons diagnosed as Seriously Mentally Ill (SMI) in 13 Eastern Kansas counties. The Community Health Center of Southeast Kansas (CHC/SEK)—a federally-qualified Community Health Center—is the lead organization, in conjunction with consortium members: Health Partnership Clinic (federally-qualified Community Health Center), Four County Mental Health (local area mental health provider), Windsor Place At-Home Care (long-term care facility), and New Beginnings Enterprises (community developmental disability organization). CHC/SEK has the largest dental outreach program in the state and a substantial history of working collaboratively to meet the needs of vulnerable individuals in the region. The project builds on CHC/SEK's proven track record of providing high quality, affordable and accessible dental outreach services. The goal of the Oral Health Outreach project is improving access to comprehensive dental outreach services, to improve overall quality of life of those with disabling conditions through improved oral health.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project consortium members will adapt the promising practice "Oral Health Disparities Collaborative" model to provide comprehensive dental service delivery using a portable mode of care. This was promulgated as part of HRSA's report, *Health Disparities Collaboratives: A National Quality Effort to Improve Outcomes for All Medically Underserved People*, specifically it's *Oral Health Disparities Collaborative Implementation Manual*.

Federal Office of Rural Health Policy Project Officer:	Name:	Shelia Tibbs				
	Tel #:	301-443-4304				
	Email:	stibbs@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	State:	Maryland	Zip code:	20857
Technical Assistance Consultant's Contact Information:	Name:	John A. Shoemaker, MPH				
	Tel #:	888-331-0529				
	Email:	ta@jasmph.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Kansas

Valley Heights School District #498

Grant Number:	D04RH28390					
Organization Type:	School District					
Grantee Organization Information:	Name:	Valley Heights School District #498				
	Address:	121 E. Commercial, P.O. Box 89				
	City:	Waterville	State:	KS	Zip code:	66548
	Tel #:	785-363-2398				
	Website:	http://www.valleyheights.org				
Primary Contact Information:	Name:	Philisha Stallbaumer				
	Title:	Project Director				
	Tel #:	785-292-4453				
	Email:	philishas@bluevalley.net				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$199,574
	May 2016 to Apr 2017	$192,117
	May 2017 to Apr 2018	$184,267

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Pawnee Mental Health	X		Mental Health
	Nemaha Valley Community Hospital	X		Hospital
	USD #498 Valley Heights	X		School District
	USD #380 Vermillion	X		School District
	Blue Valley Telecommunications	X		Communications Company

The communities/counties the project serves:	Portions of Nemaha and Marshall County serving the communities of Vermillion, Frankfort, Centralia, Corning, Waterville and Blue Rapids.

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

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

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

Description of the project:

Valley Heights, USD #498, has formed a partnership and memorandum of agreement (MOA) with USD #380 Vermillion, Pawnee Mental Health Center, Nemaha Valley Community Hospital, and Blue Valley Telecommunications in an initiative called *Schools That Care.* These school districts, health care entities and the telecommunications business make up a Consortium subcommittee called the Health Education Action Partners (HEAP) and serve six small rural communities in Northeast Kansas.

These partners will collaborate to improve mental health through education, prevention, early intervention and by ensuring access to appropriate, quality mental health services for K-12th grade students. *Schools That Care* will use the evidence-based Kansas Multi-Tiered Systems of Support model to provide activities that benefit partners and the communities served by the grant to increase access to mental health services while improving the health status of rural residents. Goals will be met through grant activities and include the following: policy and school climate changes; professional development; technical assistance; education of partners and school staff; building Prevention Teams; enhanced School Improvement Teams; providing mental health evidence-based programs/curriculum; media promotion; and community mobilization. The grant activities will allow partners (HEAP) to take the actions needed in order to develop and maintain sustainable prevention and early intervention mental health strategies in schools.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Proposed evidence based/promising practice models being used include: Kansas Multi-Tier Systems of Supports; Kansas social, Emotional and Character Development Model Standards; Mental Health first Aid; Alcohol EDU for High School; SOS Signs of Suicide; and the Olweus Bullying Prevention Program.

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	City:	Rockville	State:	Maryland	Zip code:	20857
Technical Assistance Consultant's Contact Information:	Name:	Deana Farmer				
	Tel #:	404-413-0299				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Kentucky

Montgomery County Health Department

Grant Number:	D04RH28376					
Organization Type:	Health Department					
Grantee Organization Information:	Name:	Montgomery County Health Department				
	Address:	117 Civic Center				
	City:	Mt. Sterling	State:	KY	Zip code:	40353
	Tel #:	859-498-3808				
	Website:	http://montgomerycountyhealth.com/				
Primary Contact Information:	Name:	Keisha Cornett				
	Title:	Health Education Coordinator				
	Tel #:	859-497-2408				
	Email:	Keishar.cornett@ky.gov				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	A.M. Dr. Vollmer III, DMD*	Montgomery	KY	Dentistry
	Saint Joseph Mount Sterling Hospital*	Montgomery	KY	Hospital
	Pathways, Inc.*	Montgomery, Bath, Menifee, Morgan, Rowan	KY	Mental Health Services
	CHES Solutions Group*	Fayette	KY	Program Evaluation, data collection and analysis
	Montgomery County Cooperative Extension Service*	Montgomery	KY	Population Education
	Mt. Sterling/ Montgomery County Industrial Authority*	Montgomery	KY	Economic Development
	Mt. Sterling/ Montgomery County Arts Council*	Montgomery	KY	Arts
	Mt. Sterling/ Montgomery County Public* Library	Montgomery	KY	Population Education
	Mt. Sterling/ Montgomery County Parks and Recreation*	Montgomery	KY	Recreation
	Montgomery County Schools*	Montgomery	KY	Education
	Sterling Health Solutions*	Montgomery, Bath, Menifee	KY	Health Care
	St. Claire Regional Medical Center*	Montgomery, Bath, Menifee, Morgan,	KY	Health Care

		Rowan		
	Northeast Kentucky Regional Health Information Organization*	Morgan	KY	Technology, EHR

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

Description of the project:

The Montgomery County Health Department intends to expand its existing rural health outreach project to increase health care access to low-income, uninsured and underinsured populations in a five county area (Montgomery, Bath, Menifee, Rowan and Morgan Counties) of rural eastern Kentucky, with a continued emphasis placed on the growing and underserved Latino population. The health department plans to reach project goals by introducing Community Health Workers (CHWs) into consortium partner facilities. By placing a CHW in the Emergency Departments at St. Joseph Mount Sterling Hospital and St. Claire Regional Medical Center and one in the local Federally Qualified Health Center, Sterling Health Solutions, a larger portion of the target population will benefit from increased access to care. Approximately 500 persons will be served over the course of the project. The project is expected to generate important community benefits and outcomes, such as: Increased access to care among the project's target populations; Enhanced coordination of care and care navigation among health, human and social service providers; Increased utilization of peer-to-peer oriented services; Improvements in mental and behavioral health status among clients with such needs; Increased client self-efficacy in navigating the health care system and managing chronic disease; Improvement in health status among clients; and improvement in chronic disease clinical measures for consumers diagnosed with or are at risk for respiratory disease, diabetes, cancer and cardiovascular disease. The activities that will be conducted in order to accomplish these benefits include, but are not limited to: Strengthen partnerships with consortium members and providers through collaboration and promotion of the project; Hiring and training additional CHWs; Provide health education classes on the topics of asthma and diabetes throughout project period for the target

population; Educate providers about the need for policy and personnel changes that will enable them to provide more culturally-appropriate services to the target population; Use of CHWs to educate, connect, and assist patients in regard to navigating and accessing the health care and social services systems; Educate local business and industry leaders and farm owners about the need to create a work atmosphere that is conducive to a healthy lifestyle and assist them in starting wellness programs for employees; Partner with Parks and Recreation, local gyms, and other agencies to provide affordable recreation opportunities for the target population, especially those enrolled in the program who are diagnosed with or at risk for chronic disease; Provide opportunities for the community to learn about Latino culture through the fine arts, literature, sports and recreation activities; Provide all program and educational materials in Spanish; Select and monitor clinical outcomes to determine if client's chronic disease status is improving; Conduct regular analysis of current trends in funding availability; Obtain professional training in long-term sustainability planning; Conduct a Return On Investment analysis through an external evaluator; and, Provide an evidence base that shows potential for replication through use of an external evaluator for data collection and analysis.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The central health care concept, care delivery vehicle and evidence-based practice (EBP) for this project is the Community Health Worker (CHW) model. CHWs are community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health.[i] CHWs are employed to deliver interventions that address a wide range of health issues including, but not limited to health and nutrition, child health and prenatal care, asthma, immunizations, sexual behaviors, diabetes, cardiovascular disease, and cancer.[ii] Validated through numerous studies throughout the country, it is a well-proven, community-based model that has encountered much success while being particularly cost effective. The CHW model was chosen for this project because it is strengths-based in areas where the project demonstrates the most intense needs. Well-trained CHWs tend to be particularly effective in delivering quality care and services among rural/remote populations who suffer from a variety of conditions while also having specific linguistic/culturally specific delivery needs. Thus, the CHW model is almost tailor-made for a project such as this. It was also chosen because the Montgomery County Health Department has had several years of very positive experience using CHWs in the field and among the project's target population.

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	Organization:	Federal Office of Rural Health Policy				
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Technical Assistance Consultant's Contact Information:	Name:	Amanda Phillips Martinez				
	Tel #:	404-413-0293				
	Email:	Aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

[i] Witmer, A., Seifer, S.D., Finocchio, L., Leslie, J., & O'Neil, E.H. (1995). Community health workers: Integral members of the health care work force. *American Journal of Public Health*, 85.

[ii] U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions (2007). *Community health worker national workforce study*. Retrieved from ftp://ftp.hrsa.gov/bhpr/workforce/chw307.pdf.

Kentucky

Mountain Comprehensive Care Center, Inc.

Grant Number:	1 D04RH28406-01-00					
Organization Type:	FQHC					
Grantee Organization Information:	Name:	Mountain Comprehensive Care Center, Inc.				
	Address:	104 South Front Ave.				
	City:	Prestonsburg	State:	KY	Zip code:	41240
	Tel #:	606-886-8572				
	Website:	www.Mtcomp.org				
Primary Contact Information:	Name:	Suzanne Daniels				
	Title:	Program Director				
	Tel #:	606-788-1345				
	Email:					

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Big Sandy Health Care	Floyd	KY	FQHC
	Highlands Regional Medical Center	Floyd	KY	Hospital

The communities/counties the project serves:	Floyd County, Kentucky and Central Appalachian Region.

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	X
	Elderly		Uninsured	X
	Pregnant Women		Other: (please describe)	

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

	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe) Case Management	X
	Health Information Technology		Other: (please describe)	

Description of the project:

MCCC will operate a rural health / primary care clinic and provide integrated preventative and primary medical care, behavioral health care, case management and enabling services in a holistic healthcare system for homeless and very low income persons of all ages, but primarily will be adults.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Chronic Care Model (CCM) which has been applied to a variety of chronic illnesses, health care settings and target population and the Patient-Centered Medical Home (PCMH) which is grounded in the CCM and found widespread applications as a framework to improve the quality of care of outcomes for people with chronic health conditions and is effective with patients who have complex health needs.

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Technical Assistance Consultant's Contact Information:	Name:	Dr. Wadia Joseph Hanna				
	Tel #:	678-714-6568				
	Email:	hannaw@bellsouth.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Kentucky

Northeast Kentucky Regional Health Information Organization

Grant Number:	D04RH2847					
Organization Type	Member organization					
Grantee Organization Information:	Name:	Northeast Kentucky Regional Health Information Organization				
	Address:	151 University Drive				
	City:	West Liberty	State:	KY	Zip code:	41472
	Tel #:	1-855-385-2089				
	Website:	www.nekyrhio.org				
Primary Contact Information:	Name:	Julie Stephens				
	Title:	Project Director				
	Tel #:	606-824-0480				
	Email:	j.stephens@nekyrhio.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Morgan County ARH Hospital	Morgan	KY	Hospital/RHC
	Montgomery County Health Department	Montgomery	KY	Health Dept.
	Bon Secours Kentucky-Bellefonte Physician Services	Greenup	KY	Clinic
	Pathways, Inc.	Boyd	KY	Mental Health
	Primary Plus	Lewis	KY	FQHC
	St. Claire Regional Family Medicine	Rowan	KY	RHC's
	Sterling Health Solutions	Montgomery	KY	FQHC
	Kentucky Rural Health Information Technology Network	Knox	KY	Health IT

The communities/counties the project serves:	

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	X
	Pre-school Children		African Americans	X
	School-age children (elementary)	X	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	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	

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

Description of the project:

NeKY RHIO will provide consultation on the evidence based practice of the National Committee for Quality Assurance's (NCQA) Patient Centered Medical Home (PCMH) model to network members in an effort to increase the quality outcomes for patients in the region. Through the grant, we will be able to leverage our partnerships to further foster collaboration among primary care providers, behavioral/mental health and specialty providers to better coordinate care for the patients. This consultation will also support all member organizations in applying for NCQA's PCMH recognition.

Evidence Based/ Promising Practice Model Being Used or Adapted:

We are using the National Committee on Quality Assurance (NCQA)'s Patient Centered Medical Home (PCMH) model.

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Technical Assistance Consultant's Contact Information:	Name:	Dr. Wadia Joseph Hanna				
	Tel #:	678-714-6568				
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Louisiana

Innis Community Health Center Inc.

Grant Number:	DO4RH28380					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	Name:	Innis Community Health Center Inc.				
	Address:	6450 LA Hwy 1				
	City:	Innis	State:	Louisiana	Zip code:	70747
	Tel #:	225-492-3775				
	Website:	www.Innishealth.org				
Primary Contact Information:	Name:	Linda Matessino				
	Title:	Grants Project Director				
	Tel #:	225-921-5196				
	Email:	Linda@inchc.og				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County-Parish	State	Organization Type
	Morehouse Community Medical Center	Morehouse	LA	FQHC
	Teche Action Clinic	St. Mary	LA	FQHC
	Catahoula Hospital Service District #2 dba Sicily Island Community Health Center	Catahoula	LA	FQHC
	Winn Community Health Center	Winn	LA	FQHC
	Central Louisiana Area Health Education Center	Rapids	LA	AHEC

The communities/counties the project serves:	Counties: Ponte Coupee, St. Mary, Catahoula, Winn, Morehouse,

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)		Native Americans	
	Adults		Pacific Islanders	
	Elderly		Uninsured	X
	Pregnant Women		Other: (please describe)	
			Other: (please describe)	

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

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

Description of the project:

Research and evaluations have demonstrated that school-based health centers (SBHCs) greatly enhance children's access to health care. One proven strategy for reaching children at high-risk for dental disease is to provide oral and dental health services in school-based health centers and to support linkages with health care professionals and other dental partners in the community.

In order to reach the broader population of children in need of these services, Innis Community Health Center has chosen to integrate oral health into SBHCs in order to gain easier access to the children during well child /comprehensive physicals screening exams. The Building Tomorrow's Smiles Program Too (BTS2) program will continue the work established by the Innis Community Health Center and its consortium partners by adding two additional partners to use the evidence-based practice of fluoride varnish application coupled with the promising practice model of dental case management into school based health center settings in rural areas in Louisiana.

This project will target children of all ages (3-19) enrolled in school based health centers, further leveraging this "captive audience" through their enrollment in these health centers to receive preventive dental services as an integral part of their comprehensive physical exams. In addition, this model will create more opportunities to teach the importance of good oral health practices to children as well as to their parents, thereby decreasing their risk for poor oral health and impacting their future oral health status. Referral and case management is key to achieving improved outcomes in oral health, and these services will be another important addition to our program.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence based practices that are the foundation for the project include fluoride varnish application and case management. Fluoride varnish is effective in preventing caries on permanent teeth and has recently been shown to prevent or reduce caries in the primary teeth of young children. The CDC and the ADA strongly recommend fluoride varnish because of consistent, good quality, patient-oriented evidence. Fluoride varnish application in the primary care setting has been recommended by the US Preventive Services Task Force. Case management is an effective tool for improving oral health outcomes. A collaborative process of assessment, planning, facilitation, and care coordination, case management is designed to meet the child's comprehensive oral health needs through communication and linkage to available resources. Case management activities will support the individual elements of achieving a dental home and will assist families in overcoming barriers to engagement in that dental home.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Maine

Aroostook County Action Program

Grant Number:	DO4RH28394					
Organization Type:	Community Action Program					
Grantee Organization Information:	Name:	Aroostook County Action Program				
	Address:	P.O. Box 1116 ; 771 Main Street				
	City:	Presque Isle	State:	Maine	Zip code:	04769
	Tel #:	207-764-3721				
	Website:	www.acap-me.org				
Primary Contact Information:	Name:	Carol Bell				
	Title:	Project Director				
	Tel #:	207-554-4129				
	Email:	cbell@acap-me.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$129,316
	May 2016 to Apr 2017	$132,833
	May 2017 to Apr 2018	$183,907

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Penobscot Indian Nation*	Penobscot	ME	Tribal
	Houlton Band of Maliseet*	Aroostook	ME	Tribal
	Aroostook Band of Micmac*	Aroostook	ME	Tribal
	Passamaquoddy: Indian Township*	Washington	ME	Tribal
	Passamaquoddy: Pleasant Point*	Washington	ME	Tribal

The communities/counties the project serves:	Counties: Washington, Aroostook, Penobscot

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	X
	Adults	X	Pacific Islanders	
	Elderly		Uninsured	
	Pregnant Women		Other: (please describe)	
			Other: (please describe)	

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

	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	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 project will increase compliance with the diabetic retinopathy standards of care through the use of a cost-effective program of systematic, high-quality retinal examinations to all diabetes patients at each of the five clinics using a mobile configuration of the Indian Health Services- Joslin Vision Network Tele-ophthalmology Program (IHS JVN). The project will schedule and conduct retinal examinations for patients with diabetes in one or two day clinics in each of five Tribal communities, twice per year.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project's telemedicine examinations for diabetic retinopathy will follow the standard protocol provided by the IHS-JVN in its national program. This program is well-established and evidence-based (www.ihs.gov/teleophthalmology/). Since its inception in 2001, the program has provided care to 100 clinics in 25 states, and performed over 100,000 diabetic retinal eye exams.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Maine

Healthy Acadia

Grant Number:	D04RH28404					
Organization Type:	Community Health Organization (Non-profit 501c3)					
Grantee Organization Information:	Name:	Healthy Acadia				
	Address:	140 State St. Suite 1				
	City:	Ellsworth	State:	ME	Zip code:	04605
	Tel #:	207-667-7171				
	Website:	www.healthyacadia.org				
Primary Contact Information:	Name:	Elsie Flemings				
	Title:	Executive Director				
	Tel #:	207-667-7171				
	Email:	elsie@healthyacadia.org				

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

Consortium Partners:	Partner Organization * Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Mount Desert Island Hospital	Hancock	ME	Hospital
	*Blue Hill Memorial Hospital	Hancock	ME	Hospital
	*Downeast Community Hospital	Washington	ME	Hospital
	*Maine Coast Memorial Hospital	Hancock	ME	Hospital
	*Bucksport Regional Health Center	Hancock	ME	FQHC
	*Regional Medical Center in Lubec	Washington	ME	FQHC
	*St. Croix Regional Family Health Center Maine Center for Disease Control Downeast Public Health Council Public Health Research Institute, Inc.	Washington Wash/ Han Wash/ Han	ME ME ME	FQHC MECDC PHC Evaluation

The communities/counties the project serves:	The project serves the Downeast District, which includes Washington and Hancock Counties.

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	
	Aging		Maternal/Women's Health	

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

Description of the project:

The Consortium will implement and expand evidence-based health improvement programs throughout Downeast Maine to help prevent the onset of diabetes, manage chronic diseases and chronic pain, and lead healthier lives. The Consortium will utilize three evidence-based programs: 1) The CDC's Diabetes Prevention Program lifestyle change program; 2) The Stanford Chronic Disease Self-Management Program; and 3) The Stanford Chronic Pain Self-Management Program. The project will use these evidence-based programs to address significant priority health issues as identified by local community health needs assessments, and it builds upon chronic disease risk prevention and care management strategies that Consortium partners have undertaken over the last several years. The proposed science-driven, collaborative programs will bring sustainable improvements to the health of communities across the Downeast region of Maine.

Evidence Based/ Promising Practice Model Being Used or Adapted:

National Diabetes Prevention Program: The CDC-led National Diabetes Prevention Program (DPP) is an evidence-based lifestyle change program for those at risk for developing type 2 diabetes. Comprised of 16 Core Sessions and 6 post-core sessions, the DPP teaches participants strategies for incorporating physical activity into daily life and eating healthy. Trained lifestyle coaches work with participants to identify emotions and situations that can sabotage their success, and the group process encourages participants to share strategies for dealing with challenging situations. Research has shown that the program has helped participants make modest behavior changes that in turn enable them to lose 5% to 7% of their body weight. These lifestyle changes have reduced the risk of developing type 2 diabetes by 58% in people with pre-diabetes. The goal of the Consortium will be to increase the number of trained lifestyle coaches and master trainers to effectively implement the DPP lifestyle change intervention. The benefit of this partnership will be to increase access to the lifestyle change intervention for people at high-risk for type 2 diabetes to delay or prevent the onset of type 2 diabetes.

Chronic Disease Self-Management Program (CDSMP) (Stanford University School of Medicine) The CDSMP is a series of workshops lasting two and a half hours, once a week, for six weeks, in different community settings and environments (e.g. senior centers, churches, libraries and hospitals). As part of the program, individuals with one or more chronic health problems attend the group sessions together. Two trained leaders lead the workshops, one or both of whom are non-health professionals with chronic diseases themselves. There are a number of topics covered in each session, including: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, 6) decision making, and, 7) how to evaluate new treatments. The CDSMP classes are highly participative and supportive, and have been found to be successful at building the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

Chronic Pain Self-Management Program (CPSMP) (Stanford University School of Medicine) The CPSMP follows the CDSMP model, with workshops lasting two and a half hours and offered once a week, for six weeks, in different community settings. Two trained leaders also facilitate workshops, one or both of whom are peers with chronic pain themselves. The subject matter is focused on methods and techniques for properly dealing with chronic pain and associated issues (e.g. frustration, fatigue, proper use of pain medications, communication issues with family, friends, and health providers, etc.). Currently, there are no CDSM or CPSM programs offered in Hancock or Washington Counties. Based on previous experience with the DPP in Hancock County, it is clear that there is a

significant demand for community-based self-management programming that relies on group dynamics to instill behavior change and self-efficacy.						
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	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Maine

Mount Desert Island Hospital

Grant Number:	D04RH28377					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Mount Desert Island Hospital				
	Address:	10 Wayman Lane				
	City:	Bar Harbor	State:	Maine	Zip code:	04609
	Tel #:	207-288-5081				
	Website:	www.MDIHOSPITAL.ORG				
Primary Contact Information:	Name:	Claire Babcock				
	Title:	Project Coordinator				
	Tel #:	207-288-5081 ext. 7804				
	Email:					

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Community Health & Counseling	Hancock	ME	Home Health
	Hancock County Homecare	Hancock	ME	Homecare

The communities/counties the project serves:	Hancock County

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

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

	Coordination of Care Services		Telehealth	X
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The "Integrated Community Care Model Supported by Telehealth Technology" project will expand the services available to non-homebound patients in Hancock County, improve patient care in community-based settings including access to mental/behavioral health counseling, and utilize tele-health in home monitoring for high risk patients. The project will provide integrated care and education to promote self-management of chronic diseases and reduce emergency department and hospital admissions.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The proposed project will utilize the Community Health Worker Model for their Care Delivery Team. The benefit of this evidence-based framework is that rural communities are able to modify the roles and responsibilities of the CHW, allowing the program expectations to fall within more than one model, in order to address community needs and health priorities. This model is effective in improving health outcomes, and in referrals of patients to socio-economic needs available to them. The CHW model has demonstrated reduced rates of readmission to hospitals, and reduced rates of emergency department usage.

Telehealth Applications for Complex Care is a model of care applicable for telehome monitoring of patients with complex health issues, including those with dual-diagnosed mental/healthcare needs. Hancock County is a rural region with communities that are isolated. The homecare agencies, Hancock County HomeCare and Community Health & Counseling Services are already in place, and this partnership project will improve delivery of care by providing home care for patients that are in need on in-home care, without regard for whether their insurer distinguishes between homebound and non-homebound; the use of telehomecare
monitors, and remote monitoring of patients by RNs will increase the number of patients that be cared for by each RN, thus increasing efficiency, addressing workforce shortage concerns, and also reducing the cost of care per patient.

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Maryland

Garrett County Memorial Hospital

Grant Number:	D04RH28402					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Garrett County Memorial Hospital				
	Address:	251 North 4th Street				
	City:	Oakland	State:	MD	Zip code:	21550
	Tel #:	301-533-4000				
	Website:	www.gcmh.com				
Primary Contact Information:	Name:	Lara Wilson				
	Title:	Program Director				
	Tel #:	301-533-4106				
	Email:	lwilson@gcmh.com				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Garrett County Health Department	Garrett	MD	Health Department
	*Garrett County Community Action Committee	Garrett	MD	Community Development and Rural Programming Agency
	*West Virginia University Medical Center	Monongalia	WV	Hospital
	*American Cancer Society	Allegheny	MD	Non-Profit Health Advocacy

The communities/counties the project serves:	Garrett and Allegheny Counties in Maryland; Preston, Grant, Mineral, and Tucker counties in West Virginia; Somerset and Fayette Counties in Pennsylvania			
The target population served:	Population	Yes	Population	Yes
	Infants	X	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	X	Other: (please describe)	
Focus areas of grant program:	Focus Area:	Yes	Focus Area:	Yes
	Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care	X	Integrated Systems of Care	
	Aging		Maternal/Women's Health	

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

Description of the project:

The Garrett Regional Cancer Patient Navigator Program will implement specific strategies and evidence-based models to provide individualized support, care coordination, empowerment, and advocacy to patients seeking cancer care services in the region in order to assure that the need of the community's cancer patients are met. The vision of the Cancer Patient Navigator Program is for the Navigator to become the central point for coordinating communication with all care team members, to ensure that community cancer patients receive quality care, and assist cancer patients, caregivers, and families in 'bridging gaps' within the healthcare system. Garrett County has higher mortality rates for Breast and Colorectal Cancers than the rest of the state of Maryland. It is for this reason that the Cancer Patient Navigator Program will have a primary focus on the prevention and treatment for these cancers.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The evidence-based model used for the Cancer Patient Navigator Program is the Cancer Patient Navigation (CPN) toolkit from the Kansas Comprehensive Cancer Control & Prevention's Kansas Cancer Partnership. This model was recognized for its excellence on the RAC Online Rural Community Health Gateway as a pillar for evidence-based program models for replication nationally. The CPM toolkit was developed by a statewide workgroup made up of representative from cancer center and advocacy groups as part of the work of the Kansas Cancer Partnership. The product was developed by the team in 2008 and published online in 2009. The tool has been used most extensively in Kansas in a strategic initiative of the Midwest Cancer Alliance (MCA). The MCA is a membership- based network of 21 cancer centers, hospitals, and research organizations across Kansas and western Missouri.

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Maryland

Somos Inc.

Grant Number:	D04RH28433					
Organization Type:	Health-related non-profit					
Grantee Organization Information:	Name:	Somos Inc.				
	Address:	P.O. Box 185				
	City:	Crisfield	State:	MD	Zip code:	21817
	Tel #:	443-493-0062				
	Website:	www.somosinc.org				
Primary Contact Information:	Name:	Kerry Palakanis				
	Title:	Executive Director				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$196,990
	May 2017 to Apr 2018	$199,999

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	MAC, Inc.	Wicomico	MD	Social Service
	Crisfield Clinic	Somerset	MD	Clinic
	University of Maryland Medical Center	Balitmore	MD	Hospital
	Somerset County Public Schools	Somerset	MD	Schools

The communities/counties the project serves:	Crisfield in Somerset County.

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

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

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

Description of the project:

Crisfield Cares has a simple purpose – to provide primary care and specialty care to the target population through the creation of telemedicine clinics. This project seeks to provide a high quality and cost effective solution to two primary challenges: access to primary care for school aged children and access to specialty care for all residents. This program proposes to increase access to care and reduce barriers by placing telemedicine equipment in two rural schools and one rural public housing site. Telemedicine will be utilized in conjunction with the Community Health Worker (CHW) model to enhance services and assist patients in resourcing to meet their health needs.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Crisfield Cares is based on the evidenced-based model of providing care to poor and rural areas through telemedicine. Once considered a novelty, telemedicine is now a mainstream treatment practice and is reimbursable in Maryland. While there is significant research on the use of telemedicine in rural health care – community health center, school based clinics, chronic disease management, etc.

The community health worker (CHW) model is also utilized as a component of the plan. The CHW will help expand service provision through patient education and informal counseling, coordinate care, assist patients in verifying eligibility for public assistance programs including Medicare and Medicaid, provide assistance with outreach efforts, and assist clinic staff with outreach efforts.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Michigan

Harbor Beach Community Hospital

Grant Number:	D04RH28403					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Harbor Beach Community Hospital				
	Address:	210 S. First Street				
	City:	Harbor Beach	State:	MI	Zip code:	48441
	Tel #:	989-479-3201				
	Website:	www.hbch.org				
Primary Contact Information:	Name:	Trish VanNorman				
	Title:	Project Director				
	Tel #:	989-712-0203				
	Email:	tvannorman@hbch.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Harbor Beach School District*	Huron	MI	School
	Eastern Huron Ambulance*	Huron	MI	Ambulance
	Huron County DHHS*	Huron	MI	Human Service
	Harbor Beach Food Pantry	Huron	MI	Food Pantry

The communities/counties the project serves:	The town of Harbor Beach and the surrounding areas.

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	X
	Elderly	X	Uninsured	X
	Pregnant Women		Other: (please describe)	
			Other: (please describe)	

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

	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe) working with those in poverty to move them into jobs through skills training and health education	X
	Health Information Technology		Other: (please describe)	

Description of the project:

The Community Connections initiative is located in the rural area of Michigan, referred to as the "Thumb". The focus of this initiative is improving health status for the target population. The Community Connections initiative will enable vulnerable populations to improve their health status through model programs that have been shown to empower individuals toward self-sufficiency. Community Connections utilizes a holistic, participant-centered service approach. Participants are actively engaged in assessing their own needs, setting goals, and selecting services that will help them meet those goals. Services include wellness screenings, referrals to existing programs, individual education, information services, enrollment assistance, establishing medical homes, service navigation, case management, life skills training, ongoing support, and life coaching.

Awareness and outreach are central to the initiative's sustainability approach and are used to recruit participants, create a volunteer network, and build public support. Four organizations have partnered for the project: Harbor Beach Community Hospital, Harbor Beach Community Schools, Department of Human Services, and Eastern Huron Ambulance Services. Additional organizations and individuals are involved in the project by accepting referrals, making referrals, participating in the leadership team, and volunteering.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Bridges Out of Poverty, a Ruby Payne Production, offers a comprehensive approach to understanding the dynamics that cause and maintain poverty from the individual to the systemic level. Bridges Out of Poverty uses the lens of economic class and provides concrete tools and strategies for a community to prevent, reduce, and alleviate poverty. Bridges brings people from all sectors and economic classes together to improve job retention rates, build resources, improve outcomes, and support those who are moving out of poverty. The evidence-based model has been integrated into the Communities Connections program design.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Minnesota

CentraCare Health – Long Prairie

Grant Number:	D04RH28397-01-00					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	CentraCare Health – Long Prairie				
	Address:	20 9th Street SE				
	City:	Long Prairie	State:	MN	Zip code:	56347
	Tel #:	320-732-2141				
	Website:	http://www.centracare.com/locations/long-prairie/				
Primary Contact Information:	Name:	Dan Swenson				
	Title:	CEO/Administrator				
	Tel #:	320-732-7210				
	Email:	swensond@centracare.com				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$189,654
	May 2016 to Apr 2017	$199,991
	May 2017 to Apr 2018	$156,540

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	CentraCare Health – Melrose*	Stearns	MN	Community Hospital/Clinic
	CentraCare Health – Paynesville*	Stearns	MN	Community Hospital/Clinic
	CentraCare Health – Sauk Centre*	Stearns	MN	Community Hospital/Clinic
	Chippewa County – Montevideo Hospital*	Chippewa	MN	Community Hospital/Clinic
	Glacial Ridge Health System*	Pope	MN	Community Hospital/Clinic
	Lakewood Health System*	Todd	MN	Community Hospital/Clinic
	Swift County – Benson Hospital*	Swift	MN	Community Hospital/Clinic
	Tri-County Health Care*	Wadena	MN	Community Hospital/Clinic
	CentraCare Health – Sauk Centre Home Care*	Stearns	MN	Home Health Agency
	Chippewa County Montevideo Hospital Home Care*	Chippewa	MN	Home Health Agency
	Glacial Ridge Home Care*	Pope	MN	Home Health Agency
	Knute Nelson Home Care*	Douglas	MN	Home Health Agency
	Lake Region Home Health*	Kandiyohi	MN	Home Health Agency
	Lakewood Health System – Home Services*	Todd	MN	Home Health Agency

	Swift County Benson Home Health Care*	Swift	MN	Home Health Agency
	Todd County Public Health Home Care*	Todd	MN	Home Health Agency
	CentraCare Health – St. Cloud Hospital*	Stearns	MN	Hospital

The communities/counties the project serves:	Todd, Stearns, Chippewa, Pope, Swift, Wadena

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	
Pregnant Women		Other: (please describe)	
		Other: (please describe)	

Focus areas of grant program:

Focus Area:	Yes	Focus Area:	Yes
Access: Primary Care		Health Professions Recruitment and Retention/Workforce Development	
Access: Specialty Care	X	Integrated Systems of Care	
Aging		Maternal/Women's Health	
Behavioral/Mental Health		Migrant/Farm Worker Health	
Children's Health		Oral Health	
Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
Chronic Disease: Diabetes		Physical Fitness and Nutrition	
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras		Substance Abuse	
Coordination of Care Services	X	Telehealth	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 Tele-neurology Patient Navigator Program will be implemented to improve access to care and health outcomes among patients recovering from stroke or TIA residing in rural Minnesota. The program links patients to community agencies for services in order to provide a holistic approach to meeting the needs of the patient and/or caregiver and/or bringing new services into the community (tele-neurology and Patient Navigator). For example, the Patient Navigator will refer patients and/or caregivers to local social service agencies as individual treatment plans are created. Patients and/or caregivers in need of mental health providers, food banks, housing assistance provider, etc. will be referred into the local community. The program only enhances patient outcomes and ensures that people who might not ordinarily receive a service actually do enroll in the needed services.

A Patient Navigator will focus on eliminating barriers to stroke recovery by customizing a recovery plan, thus, ensuring that the needs of the patient and/caregiver are addressed in a timely manner. Recovery plans may consist of, but are not limited to: obtaining medications; obtaining durable equipment; connecting patient and/or caregiver with community supports (support groups, respite care, etc.); linking neurology with primary care provider and/or assistance with establishing a medical home; providing patient and/or caregiver education; ensuring patient follow up from medical appointment recommendations; making the patient's home accessible; arranging speech, physical, occupational, and respiratory therapies; and ensuring that caregivers have the training, equipment, and

physical ability to assist their loved one.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The program uses the following evidenced based models:

- *A Review of the Evidence for the Use of Telemedicine Within Stroke Systems of Care: A Scientific Statement From the American Heart Association/American Stroke Association* Lee H. Schwamm, Robert G. Holloway, Pierre Amarenco, Heinrich J. Audebert, Tamilyn Bakas, Neale R. Chumbler, Rene Handschu, Edward C. Jauch, William A. Knight IV, Steven R. Levine, Marc Mayberg, Brett C. Meyer, Philip M. Meyers, Elaine Skalabrin and Lawrence R. Wechsler. *Stroke.* 2009; 40:2616-2634; originally published online May 7, 2009

As the title suggests, *A Review of the Evidence for the Use of Telemedicine Within Stroke Systems of Care: A Scientific Statement From the American Heart Association/American Stroke Association* reviews the use of telemedicine from primary prevention of stroke programs, notifications and response of EMS, EMS tele-medicine for stroke, Acute Stroke Evaluation, Including the Hyperacute and Emergency Department Phases, Feasibility and Reliability of Performing Neurological Assessment Over Tele-stroke Systems in acute and non-acute settings. Recommendations that pertain to the propose program include:

1. "High-quality videoconferencing is reasonable for performing a general neurological examination by a remote examiner comparable to that between different face-to-face examiners
2. Implementation of telestroke consultation in conjunction with stroke education and training for healthcare providers can be useful for increasing the use of intravenous tPA at community hospitals without access to adequate onsite stroke expertise
3. Compared with traditional bedside evaluation and use of intravenous tPA, the safety and efficacy of intravenous tPA administration based solely on telephone consultation without CT interpretation via teleradiology are not well established."

The study fully supports the Tele-neurology Patient Navigator Program. It supports the use of telemedicine for stroke recovery. It also notes that limited research is available on tele-neurology. Therefore, information from this program would be very valuable to understanding opportunities for telemedicine in stroke rehabilitation.

- *Health Navigators Support Self-Management With Primary Care Patients, Leading to Improved Behaviors and Lower Utilization*. https://innovations.ahrq.gov/profiles/health-navigators-support-self-management-primary-care-patients-leading-improved-behaviors

The *Health Navigators Support Self-Management With Primary Care Patients, Leading to Improved Behaviors and Lower Utilization* states "as members of the care team, health navigators establish close, supportive relationships with patients through in-person visits and phone calls, helping them set health related goals and access medical and community-based services and resources to help achieve these goals." In the case study, better self-management skills were noted: "The program improved patients' self-management behaviors related to diabetes. Among 797 diabetic patients who had not previously performed self-care, 82 percent began checking their blood sugar levels regularly, 90 percent began checking their feet regularly, 52 percent who had not previously had an eye examination got one, and 45 percent who had never received formal diabetes education attended a self-management session". Better health outcomes were noted when several cohorts of patients receiving health navigator services experienced better outcomes. For example, 42% of depressed patients reported improvements in symptoms after working with health navigators. Thirty-seven percent of chronic pain patients reported improvement in their pain management. The navigator program resulted in lower ED and inpatient utilization: "In the 6 months after beginning to work with health navigators, patients experienced a 50 percent decline in both ED visits and inpatient admissions." Although a diabetes program was studied, it should be noted that the program result can be transferred to other chronic health conditions i.e. stroke recovery.
The patient navigator evidenced base model supports the patient navigation in the proposed program. It provides a model for a patient navigator (RN case management) in which it is safe to assume that navigation may lead to better self-management, better outcomes, and reduced readmissions.

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Minnesota

Mississippi Headwaters Area Dental Health Center
DBA Northern Dental Access Center

Grant Number:	D04RH28375					
Organization Type:	Nonprofit, community access dental clinic					
Grantee Organization Information:	Name:	Mississippi Headwaters Area Dental Health Center DBA Northern Dental Access Center				
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	Tel #:	218-444-9646				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$200,000
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	* Legal Services of Northwest Minnesota	Beltrami	MN	Nonprofit Legal Services
	* Community Resource Connections	Beltrami	MN	Council of Nonprofits
	* Beltrami County Health and Human Services	Beltrami	MN	Local Unit of Government

The communities/counties the project serves:	Counties: Beltrami, Clearwater, Polk, Kittson, Pennington, Hubbard, Red lake, Mahnomen, Norman, Marshall, Roseau, Cass, Lake of the Woods

The target population served:	Population	Yes	Population	Yes
	Infants	X	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	X	Other: (please describe)	
			Other: (please describe)	

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

	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness -Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: Health-harming legal issues	X
	Health Information Technology			

Description of the project:

Our project, Improving Determinants of Health Among Vulnerable Populations, incorporates three major strategies and multiple related activities to achieve our goal of reducing health disparities in our rural region on northwest Minnesota.

Connect uninsured and newly insured people with health care services: Consortium partners enroll uninsured people through navigation services that are funded through the State of Minnesota. The project adds a Lead Patient Advocate to the insurance counseling team. This person works with regional health care institutions to identify avenues and linkages to key entry points for newly insured to address specific barriers to seeking health care, that are reported by our target population. Patient advocates and community health interns then help patients make the calls, help identify the most relevant provider match to patient needs, help set appointments, and share patient information where appropriate.

Connect pregnant women and babies (birth to age 3) to a dental home: The project conducts robust promotion efforts to dispel myths that surround dental care during pregnancy and infancy and to promote healthy behaviors. Additional activities include welcome 'happy birthday' oral health kits at area hospitals for newborns and their mothers; transportation assistance to appointments; case management to address barriers; and more.

Provide legal information and access to people with barriers and/or health-harming legal situations: Despite the documented connection between health and legal needs, there is rarely a coordinated effort to address these problems in concert. Our project's medical-legal partnership bridges the divide. It integrates the expertise of health and legal professions and staff to address and prevent health-harming legal needs. Activities include training health care team to identify health harming social and legal needs, identifying patients' health-harming social and legal needs through screening procedures, treating individual patients' health-harming social and legal needs—ranging from triage to legal representation; and transforming clinical practice and institutional policies to recognize and treat and prevent health-harming social and legal needs.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project incorporates several evidence-based/promising practice models. Chief among these are the following.

Medical-Legal Partnership and I-HELP: A modified approach to Medical-Legal Partnership (MLP) leads a number of the strategies in this project. Based on guidance and resources from the National Center for Medical-Legal Partnership (NCMLP), the project provides a road map to developing a partnership that can address the unique barriers faced by our target population, many of which entail legal complexities beyond the expertise of health and human service providers. IHELP is a framework that screens for the most prevalent health-harming legal needs among the target population. This framework provides an understandable, common language for all consortium members and other community partners working to support the target population. With this type of issue sorting and/or triage, the legal services available can be distributed efficiently and proportionately.

Ruby Payne Bridges Out of Poverty Community Framework: This framework employs poverty research in the design of a continuum of strategies for building prosperous and healthy communities. The Ruby Payne framework helps our staff understand the mental models of poverty, middle class, and wealth. It is a new lens through which we can view ourselves, our clients, and our community. Northern Dental Access Center is rooted in the Ruby Payne framework which allows us to focus our patient strategies on the theory that poverty is about economics and culture, not about race or ethnicity. The framework helps front-line staff with skills that improve relationships

with patients and embraces the knowledge that financial resources are just one of the eight physical and emotional struggles that people in poverty face.

Perinatal Oral Health Practice Guidelines/ Age 1 Dental Home/Caries Risk Assessment: These three intertwined best-practice models inform our strategies to affect the health of pregnant women and babies from birth to age 3. Extensive research and cross-discipline research contributes to Perinatal Oral health Practice Guidelines, presented by the California Dental Association Foundation and the American College of Obstetricians and Gynecologists (District IX). The American Association of Pediatric Dentists recommends that every child should be seen by a dentist before the first birthday, or when the first tooth erupts. Thus, it is particularly important to refer and follow up on children who have risk indicators, and this is best accomplished through establishment of a dental home relationship between patient and dentist. Tangentially, the use of a Caries (tooth decay) Risk Assessment (CRA) is recommended as a universal tool to assure all children receive appropriate oral care (e.g., low socioeconomic status, lack of age-appropriate oral hygiene efforts by parents).

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Mississippi

Delta Health Alliance, Inc.

Grant Number:	D04RH28444					
Organization Type:	Nonprofit, 501(c)(3)					
Grantee Organization Information:	Name:	Delta Health Alliance, Inc.				
	Address:	435 Stoneville Road; P.O. Box 277				
	City:	Stoneville	State:	MS	Zip code:	38776
	Tel #:	662-686-7004				
	Website:	www.Deltahealthalliance.org				
Primary Contact Information:	Name:	Shenetta Drone				
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	Tel #:	662-686-3861				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$199,856
	May 2016 to Apr 2017	$199,615
	May 2017 to Apr 2018	$199,590

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	South Sunflower Hospital	Sunflower	MS	Hospital
	North Sunflower Medical Center	Sunflower	MS	Hospital
	Indianola Family Medical Group	Sunflower	MS	Clinic
	Leland Medical Clinic	Washington	MS	Clinic
	The Sunflower Clinic	Sunflower	MS	Clinic
	MS Center for Justice	Multiple	MS	Law Firm/Advocacy
	University of Southern MS	Forrest	MS	College
	Delta Fresh Food Initiative	Sunflower	MS	Coalition
	Social Services Collaborative	Sunflower	MS	Collaborative

The communities/counties the project serves:	Bolivar, Sunflower and Washington Counties

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	X
	Elderly	X	Uninsured	X
	Pregnant Women		Other: (please describe)	
			Other: (please describe)	

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

	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotors		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 Delta Care Transitions project will provide care to improve health outcomes for at-risk patients with diabetes, heart disease, COPD, or pneumonia at or after discharge. The project will provide the following services and activities:

- Educational programs relating to obtaining health insurance, prescription assistance and other social services
- Care Transition Health Coaches (at minimum 2) to deliver patient navigation, care coordination, health education to project participants
- Assist the hospitals in developing or refining policies and discharge protocols
- Assist the communities in developing outreach programs to educate the community on the importance of establishing and maintaining health homes.

Anticipated outcomes include improved health care delivery; improved post-discharge outcomes for patients with chronic illness; and reduced rates of 30-day readmissions.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Dr. Eric Coleman's Care Transitions Intervention (CTI) evidence-based 4 week program model will be adopted, with a regionally interconnected EHR system for improved provider and patient communication. This model allows for patients with complex care needs to receive specific training on self-management skills, supported by a Care Transitions Health Coach, to ensure their needs are met during the transition from hospital to home. Each Health Coach will maintain a patient load of 20-25.

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Mississippi

Tallahatchie General Hospital & Extended Care Facility

Grant Number:	D04RH28415					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Tallahatchie General Hospital & Extended Care Facility				
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	City:	Charleston	State:	MS	Zip code:	38655
	Tel #:	662 647 5535				
	Website:	www.mytgh.com				
Primary Contact Information:	Name:	Dr. Catherine Dane Woodyard, PhD, CHES				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$193,296
	May 2016 to Apr 2017	$168,351
	May 2017 to Apr 2018	$168,351

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Tutwiler Community Education Center*	Tallahatchie	MS	Community Center
	Southern Discount Drugs*	Tallahatchie	MS	Pharmacy
	Tallahatchie Wellness Center *	Tallahatchie	MS	Wellness Center
	Charleston Rural Health Clinic*	Tallahatchie	MS	Clinic
	University of MS Center for Population Studies*	Lafayette	MS	University
	University of MS Pharmacy Administration Department	Lafayette	MS	University
	Tallahatchie Early Learning Alliance	Tallahatchie	MS	Non-Profit
	Charleston Elementary School	Tallahatchie	MS	School
	Charleston Arts and Revitalization Effort	Tallahatchie	MS	Non-Profit

The communities/counties the project serves:	Tallahatchie County. Charleston, Webb, Glendora, Sumner, and Tutwiler

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	X
	Pre-school Children		African Americans	X
	School-age children (elementary)	X	Latinos	
	School-age children (teens)		Native Americans	
	Adults	X	Pacific Islanders	
	Elderly		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	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
	Chronic Disease: Other	X	School Health	X
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe) Access to food/produce	X
	Health Information Technology		Other: (please describe) Health Fair	X

Description of the project:

Tallahatchie Wellness services and activities include: (1) An annual 3-month community wellness challenge, focused heavily on all aspects of wellness, in which participants receive a health assessment as well as access to weekly educational workshops, group fitness classes, cooking demonstrations and access to a personal trainer, registered dietician and health coach; (2) An after school youth program using the Coordinated Approach to Child Health (CATCH) curriculum; (3) The Tallahatchie Food Expansion and Education Program (TFEP) which includes 3 annual cohorts of a 6-week cooking class to teach healthy eating principles to low income families, a wellness garden to grow fresh produce to address food security issues, cooking demonstrations and an annual fresh foods expo where we will provide a taste testing of healthy foods grown in the garden; (4) An annual health fair where we will combine a health fair into a community carnival in order to increase participation rates. Follow up care will be provided to residents whose biometric measures are not at healthy levels and for those who do not have health insurance, they will be connected to an insurance navigator; (5) a worksite wellness program for the employees of TGH with the aim to expand to additional worksites within the community; (6) four annual cohorts of the Chronic Disease Self-Management Program (CDSMP) which is a 6-week workshop in which participants learn to become better self-managers of their conditions, increase self-efficacy and ultimately improve their health status and disease states. Monthly follow-up support and sustainability groups will be held following completion of the 6 week workshop in order to provide continued social support and encouragement as well as to review topics learned in the course. Monthly follow-up groups will vary in content and include things such as group outings, cooking demonstrations, group fitness, and opportunities to talk to providers.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Tallahatchie Wellness is using the following evidence-based models: the Chronic Disease Self-Management Program (CDSMP), Cooking Matters™, and the Coordinated Approach to Child Health (CATCH) curriculum. Additionally, we are utilizing the Tallahatchie Wellness Challenge, a promising practice model.

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Missouri

Northeast Missouri Health Council

Grant Number:	D04RH28388					
Organization Type:	Federally Qualified Health Center					
Grantee Organization Information:	Name:	Northeast Missouri Health Council				
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	Email:	mherleth@nmhcinc.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	ATSU – Missouri School of Dentistry and Oral Health	Adair	MO	Dental School
	Clark County Nursing Home	Clark	MO	Long-Term Care Facility
	Heartland RSVP	Adair	MO	Senior Volunteer Agency
	Kirksville Manor Care Center	Adair	MO	Long-Term Care Facility
	Northeast Missouri Area Agency on Aging	Adair	MO	Services for the Aging

The communities/counties the project serves:	Adair, Clark, Knox, Lewis, Mercer, Putnam, Schuyler, Scotland, Sullivan Counties

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

Description of the project:

This project seeks to expand oral health services for the vulnerable and underserved elderly population, both in and out of residential facilities, in a rural 9-county region of northeast Missouri. The Alliance will engage medical providers, nursing homes, a dental school, an elder volunteer organization, and a regional elder advocacy organization to facilitate program referrals for seniors in need of oral health care services. Oral health treatment will be provided at NMHC's Northeast Dental clinic in Kirksville (Adair County) and Kahoka Dental clinic (Clark County), and screenings/preventive care will be delivered at nursing homes, senior centers, and other facilities hosting community-based screenings. The wheelchair tilt operatory at Northeast Dental will enable wheelchair-bound seniors the ability to receive oral health care close to home rather than driving distances of 100+ miles or more each way. Care coordination/patient navigation will help ensure patient follow-through on self-management goals, as well as encourage long-term care facilities to continue/complete residents' treatment plans. Heartland RSVP will coordinate senior volunteers to provide comfort, encouragement and companionship to elderly patients as they await treatment and screenings. Referring clients for oral health services, serving as a liaison to agency partners and contract agencies, and distributing and promoting oral health materials and community education programs will be the Northeast Missouri Area Agency on Aging's role. Finally, the involvement of A.T. Still University's Missouri School of Dentistry & Oral Health, will nurture long-term development of a rural oral health provider pipeline.

Evidence Based/ Promising Practice Model Being Used or Adapted:

This project is based on the promising practice models initiated through the University of Kentucky College of Dentistry (funded through the Dental Trade Alliance Foundation), and *Smiles for Life* program. Created as a result of a successful pilot project, the University of Kentucky's model recognizes the importance dental professionals, nursing home staff, and one's family has on elderly's oral health. *Smiles for Life* is a national oral health curriculum developed by the Society of Teachers of Family Medicine, and includes geriatric oral health modules for primary care clinicians, based on Accreditation Council for Graduate Medical Education (ACGME) competencies.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Missouri

Ozarks Medical Center

Grant Number:	D04RH28410					
Organization Type:	Hospital 501 (C) 3					
Grantee Organization Information:	Name:	Ozarks Medical Center				
	Address:	1100 Kentucky Avenue				
	City:	West Plains	State:	Missouri	Zip code:	65775
	Tel #:	417-256-9111				
	Website:	www.ozarksmedicalcenter.com				
Primary Contact Information:	Name:	Jo Wagner				
	Title:	Project Supervisor				
	Tel #:	417-256-9111				
	Email:	Jo.wagner@ozarksmedicalcenter.com				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$197,960
	May 2016 to Apr 2017	$195,682
	May 2017 to Apr 2018	$199,518

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	NHC*	Howell	MO	
	West Vue Nursing Home*	Howell	MO	
	Brookehaven*	Howell	MO	

The communities/counties the project serves:	Douglas, Howell, Oregon, Ozark, Shannon, Texas, and Wright

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	X
	Elderly	X	Uninsured	X
	Pregnant Women		Other: Rural	X

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

	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services	X	Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The Improving Transitions of Care project focuses on Medicare beneficiaries who are being discharged from inpatient care at Ozarks Medical Center to nearby nursing and rehabilitation facilities. The consortium includes a hospital and three nursing care facilities which have signed an MOU, with additional supports provided by three physicians who have submitted letters of commitment.
The project utilizes a Care Team approach for better communications among hospital staff, the skilled nursing facilities, clinicians, patients, and their families resulting in a smoother hospital discharge process, visitation within three days of admission to a nursing or rehabilitation care facility, and the development of shared goals of care to be delivered by a social worker and nurse practitioner.
The anticipated outcomes include: improved transitions of care, reduced hospital readmission rates, and reduced unnecessary usage of the emergency department, each of which has been recognized by the Centers for Medicare and Medicaid Services as critically important to health care reform initiatives.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project is based on the evidence-based practice Complex Care Management Program. We have adapted the model to include having a social worker and nurse practitioner (Care Team) who conduct in-person visits rather than phone calls. Additionally, we have layered an element of an evidenced-based practice, Geriatric Floating Interdisciplinary Team, to include the development of shared goals of care with the patient and/or their family. We believe that by developing shared goals of care -- care goals that are collaboratively developed between the medical team and the patient/family -- we can reduce conflicts and unnecessary trips to the emergency department and/or demands for hospital readmission.

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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

Missouri

Washington County Memorial Hospital

Grant Number:	D04RH28419					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Washington County Memorial Hospital				
	Address:	300 Health Way				
	City:	Potosi	State:	MO	Zip code:	63664
	Tel #:	573-438-5451				
	Website:	www.wcmhosp.org				
Primary Contact Information:	Name:	Amber Coleman				
	Title:	Executive Assistant				
	Tel #:	573-438-5451 ext. 257				
	Email:	acoleman@wcmhosp.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$155,376
	May 2016 to Apr 2017	$173,837
	May 2017 to Apr 2018	$179,594

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	University of Missouri*	Boone	MO	Educational
	Washington County Health Department*	Washington	MO	Health

The communities/counties the project serves:	Counties: Washington, Crawford, St. Francois, Iron, Madison, and Reynolds

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

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

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

Description of the project:

The CALM Project provides an intensive, hands-on approach to change child-caregiver knowledge, self-management behaviors and the home environment. It also seeks to expand the community's capacity to address asthma in a coordinated manner.

Most services are provided in-home, one-on-one by the Lead Asthma Educator working in collaboration with hospital emergency room and respiratory staff, school nurses, health department, caregivers, classroom teachers, and primary care providers. Among the included services are: health status assessment (including peak flow and FEV1), tailored education per evidence-based tools (*Missouri School Asthma Manual,* Impact Asthma® and Living with Asthma®), medication use assessment, environmental assessment, a care plan, referral/care coordination (e.g., making appointments), and other follow-up care management services.

Outreach and education activities are held for healthcare providers, in hospitals, clinics, pharmacies, schools, and daycares. Educational Asthma Camp are held annually for children with asthma. Educational Asthma Camp seeks to enrich the lives of children with asthma by creating camp experiences that are memorable, exciting, fun, empowering, physically safe and medically sound.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Coordination of Care Model looks at care coordination from the perspective of a patient-centered medical home (PCMH). It considers the major external providers and organizations with which a facility must interact—medical specialists, community service agencies, and hospital and emergency facilities—and summarizes the elements that appear to contribute to successful referrals and transitions (i.e., assuming accountability, providing patient support, building relationships and agreements among providers that lead to shared expectations for communication and care and developing connectivity via electronic or other information pathways that encourage timely and effective information flow between providers).

An online article in the *Journal of Continuing Education in the Health Professions,* March 2007, titled, The Asthma Dialogues: A model of interactive education for skills is an educational intervention that uses simulated physician-patient encounters as part of a project to improve asthma management by community-based primary care providers. The skills-based interactive training helps to improve learners' care choices.

Other evidenced-based models used are the 2007 Expert Panel's Evidence for Asthma Self-Management, and NIH Asthma Guidelines and GINA Global Initiatives.

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Montana

Granite County Hospital District

Grant Number:	D04RH283840100					
Organization Type:	Critical Access Hospital					
Grantee Organization Information:	Name:	Granite County Hospital District				
	Address:	P.O. Box 729				
	City:	Philipsburg	State:	MT	Zip code:	59858
	Tel #:	406-859-3271				
	Website:	www.gcmedcenter.org				
Primary Contact Information:	Name:	Sharon Fillbach				
	Title:	Program Director				
	Tel #:	409-859-6271				
	Email:	Sharon.fillbach@granitecmc.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Dr. Russell Blackhurst	Missoula	MT	Private Dental Practice
	Missoula City-County Health Department	Missoula	MT	Public Health Department

The communities/counties the project serves:	Counties: Granite, Powell (portions neighboring Granite County)

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	X
	Pre-school Children	X	African Americans	
	School-age children (elementary)	X	Latinos	
	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	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	

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

Description of the project:

The Granite and Powell Counties Dental Collaborative and School-Based Preventative Dental Services project represents a unique partnership of traditional and public healthcare providers that together seek to meet a gap in basic dental services in Granite and Powell counties of rural Montana. Our goal is to expand on current services to improve oral health care access through a school-based program in the small rural schools of these two counties. We plan to expand, enhance, and improve access to dental care for the students in this underserved area by providing oral health risk assessment screenings, teeth cleaning and sealant services, and dental home referrals to all students in the rural schools of Granite and Powell counties. Evaluative measures will help determine the impact of our program and its replicability to other communities, so that other rural and frontier counties can also work to create a sustainable dental home with school-based mobile services.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Our project is based on several evidence-based and promising practices, including the best practice approach endorsed by the Montana Department of Health and Human Services for School-based Dental Sealant (SBDS) programs. Dental sealants have been recognized as an effective community-based intervention for children by the US Community Preventive Services Task Force. The project also incorporates the "dental home" model promulgated by the American Dental Association.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Nebraska

East Central District Health Department

Grant Number:	D04RH28401					
Organization Type:	FQHC, Health Department					
Grantee Organization Information:	Name:	East Central District Health Department				
	Address:	P.O. Box 1028, 4321 41st Ave.				
	City:	Columbus	State:	NE	Zip code:	68602
	Tel #:	402-563-9656				
	Website:	www.ecdhd.ne.gov				
Primary Contact Information:	Name:	Rebecca Rayman				
	Title:	Executive Director				
	Tel #:	402-563-9224				
	Email:	rrayman@ecdhd.com				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	CHI Health Schuyler Clinic	Colfax	NE	Clinic/Hospital
	Good Neighbor Community Health Center	Platte	NE	FQHC
	Columbus Community Hospital	Platte	NE	Hospital

The communities/counties the project serves:	Platte and Colfax counties

The target population served:	Population	Yes	Population	Yes
	Infants	X	Caucasians	X
	Pre-school Children	X	African Americans	X
	School-age children (elementary)	X	Latinos	X
	School-age children (teens)	X	Native Americans	
	Adults		Pacific Islanders	
	Elderly		Uninsured	X
	Pregnant Women	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	X	Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras	X	Substance Abuse	
	Coordination of Care Services		Telehealth	

	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The East Central District Health Department (ECDHD) and the Good Neighbor Community Health Center (GNCHC) are working closely on this project with CHI Health, Schuyler, to address the issue of primarily low-income children who are not receiving preventative health care regularly. The project meets the need of increasing primary care providers by recruiting one full-time pediatrician who will work with one full-time community health worker (evidence-based practice), each of whom will split their time between the Federally Qualified Health Center (FQHC) clinic at ECDHD/GNCHC and the Rural Health Clinic at CHI Health, Schuyler. This represents an enormous contribution to the health care capacity of an area that had no like resources committed to medically unserved or underserved persons prior to receiving this funding. The expected outcomes for the project include: increased access to preventive care for infants, children and adolescents in Platte and Colfax counties; early initiation of regular preventative care for infants; culturally and linguistically appropriate care provided to the target population; movement from an attitude of episodic acute care to one of preventive care among the target population.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Community Health Worker – The use of Community Health Workers has been noted as an evidence-based practice by the Community Preventive Services Task Force. Community Health Workers can increase the level of vaccinations and well-child checks through education and follow-up. The utilization of Community Health Workers can also help overcome transportation barriers by meeting clients in their homes and alleviate concerns about insurance status and payment by offering services on a sliding fee scale. Offering education about preventive health care, including vaccines and other available services, will have a positive impact on the health status of the target population in the two counties.

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New Hampshire

Mid-State Health Center

Grant Number:	D04RH28386					
Organization Type:	FQHC					
Grantee Organization Information:	Name:	Mid-State Health Center				
	Address:	101 Boulder Point Drive, Suite 1				
	City:	Plymouth	State:	NH	Zip code:	03264
	Tel #:	603-536-4000				
	Website:	www.midstatehealth.org				
Primary Contact Information:	Name:	Sharon Beaty				
	Title:	Chief Executive Officer				
	Tel #:	603-536-4000				
	Email:	sbeaty@midstatehealth.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$168,256
	May 2016 to Apr 2017	$189,657
	May 2017 to Apr 2018	$195,735

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Speare Memorial Hospital	Grafton	NH	Critical Access Hospital
	Pemi-Baker Community Health	Grafton	NH	Visiting Nurse Association
	Newfound Area Nursing Association	Grafton	NH	Visiting Nurse Association
	Genesis Behavioral Health	Grafton	NH	Community mental health Center
	Community Action Program – Belknap/Merrimack County	Grafton, Belknap, Merrimack	NH	Social Service Organization
	CADY (Communities for Alcohol and Drug-Free Youth)	Grafton	NH	Substance Misuse Prevention

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

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	X
	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	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotors		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 program, "Ignite – Making Connections that Spark Change," will focus on the development of a collaborative practice intervention model in primary care to improve outcomes and reduce disparities for patients with depression and a co-occurring chronic medical condition. Specifically, implementation of the evidence-based IMPACT model will provide care management intervention for those individuals who are being treated for depression and co-occurring conditions of either diabetes or hypertension. It is expected that the goals and strategies proposed in this project will result in more empowered patients, more continuous and timely health contacts, and improved mental and physical health function through better chronic disease and depression self-management. The project utilizes a full-time, dedicated Care Manager to engage patients in treatment, educate patients and their families, provide proactive follow-up and track clinical measures, monitor medication adherence, facilitate changes and/or adjustments in medications or other treatments if patient is not improving, and provide and/or facilitate access to counseling/psychotherapy as needed. The Ignite Care Manager will have the support of a full-time Medical Assistant to assist with the administrative and clinical portions of the program. The Ignite Care Manager will also serve as program implementation lead and will facilitate the Ignite Inter-Agency Team, a group of consortium and target population representatives. The Inter-Agency Team will provide program review and guidance, will participate in performance improvement work, and will work to resolve program barriers and challenges.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Ignite program will incorporate the nationally-recognized, evidence-based model IMPACT. The IMPACT program core elements are:

1. A care team for participating patients that includes a care manager, primary care clinician, behavioral health provider
2. Collaborative care model in which the patient becomes a part of the care team
3. Development of a treatment plan with the collaborative effort of the entire team, including primary care, behavioral health, psychiatry, care manager, patient/family
4. Designated care manager to facilitate care collaboration and monitoring
5. Designated psychiatrist who consults with the care manager and primary care clinician on the care of patients who do not respond to treatments as expected
6. Measured outcomes to monitor treatment impact
7. Stepped Care – treatment is adjusted as effectiveness is evaluated

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	City:	Atlanta	State:	Georgia	Zip code:	30303

New Hampshire

North Country Health Consortium

Grant Number:	D04RH28387					
Organization Type:	Rural Health Network / Area Health Education Center					
Grantee Organization Information:	Name:	North Country Health Consortium				
	Address:	262 Cottage St. Suite 230				
	City:	Littleton	State:	NH	Zip code:	03561
	Tel #:	603-259-3700				
	Website:	www.nchcnh.org				
Primary Contact Information:	Name:	Nancy Frank, MPH				
	Title:	Executive Director				
	Tel #:	603-259-3700				
	Email:	nfroan@nchcnh.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Coos County Family Health Svc.	Coos	NH	FQHC
	*Ammonoosuc Community Health Services	Coos/Grafton	NH	FQHC
	Catholic Charities	Statewide	NH	Social Services
	Northern Human Services	Coos/Grafton	NH	Social Services
	*MidState Health Center	Grafton	NH	FQHC
	Indian Stream Health Center	Coos	NH	FQHC
	North Country Home Health and Hospice	Grafton	NH	Social Services
	Cottage Hospital	Grafton	NH	Hospital
	Littleton Regional Healthcare	Grafton	NH	Hospital
	Weeks Medical Center	Coos	NH	Hospital
	Upper Connecticut Valley Hospital	Coos	NH	Hospital
	Androscoggin Valley Hospital	Coos	NH	Hospital
	NH AHEC, Dartmouth Medical School	Grafton	NH	Academic Institution
	Grafton County Human Services	Grafton	NH	Social Services
	Tri-County Community Action Program	Coos/Grafton/Caroll	NH	Social Services
	45th Parallel EMS	Coos	NH	Emergency Services
	Androscoggin Valley Home Care	Coos	NH	Social Services
	Morrison Nursing Home	Coos	NH	Elderly and Adult Services
	American Cancer Society	Statewide	NH	Non Profit
	Plymouth State University Center for Rural Partnership	Grafton	NH	Academic Institution
	*Grafton County Senior Citizens	Grafton	NH	Social Services

	Council			
	Granite United Way-Northern Region	Coos/Grafton	NH	Social Services
	White Mountains Community College	Coos/Grafton	NH	Academic Institution
	Speare Memorial Hospital	Grafton	NH	Hospital
	LRG Healthcare	Belknap	NH	Hospital
	Servicelink	Coos/Grafton	NH	Social Services
	Adaptive Sports Partners of the North Country	Grafton	NH	Social Services

The communities/counties the project serves:	Counties: Coos, Grafton

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	
	Pre-school Children	X	African Americans	
	School-age children (elementary)	X	Latinos	
	School-age children (teens)	X	Native Americans	
	Adults		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	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The North Country Health Consortium (NCHC) is a mature, rural health network serving Coos and northern Grafton Counties located in New Hampshire's northern tier. NCHC is the home of the Molar Express, a portable public health dental clinic that has been providing oral health care to the service area for almost ten years. The Molar Express staff, which includes a dentist, program manager, certified public health dental hygienist, care coordinator and dental assistant, travel to and set-up in North Country schools and other community sites in a minivan, which is used to carry portable dental equipment and supplies. These encounters include exams, x-rays, hygiene visits, dental sealants, fluoride applications and restorative procedures. With the Outreach grant funding, Molar Express will expand services to provide preventive and diagnostic oral health care for seniors who participate in programs at Northern Grafton County Senior Centers and coordinate care with two Federally Qualified Health Centers with dental programs. Molar Express will expand capacity to provide enhanced oral health services and care coordination for school- age children and establish an agreement with the University of New England's College (UNE) of Dental Medicine to create training opportunities for students to experience a portable dental clinic.

Evidence Based/ Promising Practice Model Being Used or Adapted:						
The project incorporates several promising practices, including: ElderSmile, a model for dental service delivery for seniors created by the Columbia University College of Dental Medicine; the addition of restorative care to the mobile dental program based on recommendations for atraumatic restorative treatment from the American Dental Hygienists Association, and for interim therapeutic restorations from the American Association for Pediatric Dentistry; and the Institute of Medicine's recommendations for training opportunities for dental students in community-based settings.						
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	City:	Atlanta	State:	Georgia	Zip code:	30303

Northern Mariana Islands

Commonwealth Healthcare Corp

Grant Number:	D04RH28399					
Organization Type:	State Government					
Grantee Organization Information:	Name:	Commonwealth Healthcare Corp				
	Address:	P.O. Box 400509				
	City:	Saipan	State:	MP	Zip code:	96950
	Tel #:	670-236-8201				
	Website:	www.chcc.gov.mp				
Primary Contact Information:	Name:	Rebecca Robles				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$200,000
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization * Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Hardt Eye Clinic*	Saipan	MP	Private Clinic
	Northern Marianas College- Cooperative Research Extension and Education Services*	Saipan	MP	University

The communities/counties the project serves:	Saipan

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

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

Children's Health		Oral Health	
Chronic Disease: Cardiovascular		Pharmacy Assistance	
Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	X
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras	X	Substance Abuse	
Coordination of Care Services		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 Diabetes Referral Management Program is formed by a strong, collaborative group of members who have expanded its health care services to include new and enhanced patient services in rural communities. This program guides itself by using the Genesys HealthWorks Health Navigator Model to link and support at-risk populations to health care services and continues to improve and demonstrate health outcomes and sustainability while also reducing emergency department visits and inpatient utilization.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Genesys HealthWorks Health Navigator Model is an evidence-based model that was selected for this program and utilizes a combination of health coaching, case manager, and care coordinator skills. The Navigators will assist insured and uninsured patients cared for by primary care centers adopt a healthier lifestyle and manage chronic disease. The role of the community health navigators is to establish close, supportive relationships with patients through in-person visits and phone calls, help assisting patients set health-related goals and access medical and community-based services and resources to help achieve these goals.

In addition to the evidence-based curriculum based on the American Association of Diabetes Educators and guidelines of the American Diabetes Association, the program will also utilize the "Manu O Ku" (MOK) Diabetes Self-Management Train-the-Trainer Curriculum and Training. The curriculum is built on 10+ years of community engagement and results from two National Institutes of Health (NIH) funded studies in Hawaii and the Pacific by the Faith in Action Research and Resource Alliance (FARRA). It also facilitated the emersion of a culturally based theory and framework that focuses on the stewardship of the spirit, mind and body. This framework is the foundation of the MOK curriculum with technical and practical lessons adapted to fit the Pacific culture and context from the American Diabetes Association's Life with Diabetes and the National Diabetes Prevention Program's Lifestyle Coach Training Guide.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Ohio

Ohio Northern University

Grant Number:	D04RH28408					
Organization Type:	University					
Grantee Organization Information:	Name:	Ohio Northern University				
	Address:	525 S. Main Street				
	City:	Ada	State:	Ohio	Zip code:	45810
	Tel #:	419-772-2277				
	Website:	www.onu.edu				
Primary Contact Information:	Name:	Steven Martin				
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	Tel #:	419-772-2277				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$187,211
	May 2016 to Apr 2017	$187,211
	May 2017 to Apr 2018	$197,211

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Health Partners of Western Ohio	Hardin	OH	FQHC
	Kenton Hardin Health Department	Hardin	OH	Health Dept
	Hardin Memorial Hospital	Hardin	OH	Hospital

The communities/counties the project serves:	Hardin County, Ohio

The target population served:	Population	Yes	Population	Yes
	Infants	X	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	
	Elderly	X	Uninsured	
	Pregnant Women	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		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	

	Coordination of Care Services	X	Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

The purpose of the present project is to improve the health of citizens of Hardin County, Ohio, a rural community with significant poverty and gaps in health care services. Specifically, this project will use an innovative model that will employ a mobile clinic using a multidisciplinary team of student health care providers under the supervision of licensed professionals to deliver educational outreach and health care services targeting the medically underserved of the county. The clinic will be provided 2-3 times weekly at various locations throughout rural Hardin County, using churches, schools, and other community gathering places. This model overcomes barriers to access (mobile clinic), health professions shortage (student health professionals), and cost (most services provided for free). Health care services that will be routinely provided by the mobile clinic will include 1.) Preventative health education, including nutrition, exercise, tobacco cessation, disease prevention, and health risk reduction; 2.) Reconciliation of medications and medication therapy management, focused on people who suffer from chronic medical conditions, including diabetes, hypertension, hyperlipidemia, asthma, Chronic Obstructive Pulmonary Disease (COPD), and behavioral health disorders; 3.) Immunizations for children and adults, and health screenings/ risk assessments, including assessing Body Mass Index (BMI), cholesterol, blood glucose, hemoglobin A1c, blood pressure, skin lesions, and risks of breast, cervical, and colorectal cancers; 4.) Patients will be referred to a primary medical home whenever possible.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The innovative model to be used for this project takes advantage of existing student health providers: specifically student pharmacists and student nurses.

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Ohio

Ohio University

Grant Number:	D04RH28409					
Organization Type:	Higher education institution					
Grantee Organization Information:	Name:	Ohio University				
	Address:	105 RTEC				
	City:	Athens	State:	OH	Zip code:	45701
	Tel #:	740-593-2289				
	Website:	n/a				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$200,000
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Ohio University Family Navigator Program/ Heritage College of Osteopathic Medicine	Athens	OH	Patient Navigation Program
	Ohio University Depart of Family Medicine/ Heritage College of Osteopathic Medicine	Athens	OH	Higher education
	Southeast Ohio Legal Services (SEOLS)	Athens	OH	Legal services
	University Medical Associates – Diabetes Endocrine Center	Athens	OH	Specialty Care
	OH Health, Athens Medical Associates	Athens	OH	Primary Care
	Ohio University Diabetes Free Clinic	Athens	OH	Free Clinic

The communities/counties the project serves:	Medical Offices in Athens County OH serve residents from surrounding region.

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	X
	Pregnant Women	X	Other: (please describe)	
			Other: (please describe)	

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

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

Description of the project:

A Comprehensive Patient Navigation Program for Rural Appalachia proposes to improve health outcomes (e.g., glycemic and blood pressure control; reduced depression, distress) and lower health care expenditures (e.g., reduced admissions, readmissions, and emergency department utilization) for individuals with type 2 diabetes through the development and coordinated implementation of three programs. Each targets the social determinants contributing to the health disparities in the Appalachian region of southeastern Ohio. We will design, develop, and implement (1) a Diabetes Patient Navigator Program, (2) a Medical Legal Partnership Program, and (3) a Consumer-Engaged Coalition with the autonomy and resources to empower their voice in the design and delivery of innovative health care reforms.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Patient Navigation: The concept of patient navigation was founded and pioneered by Harold P. Freeman in 1990 for the purpose of eliminating barriers to timely cancer screening, diagnosis, treatment, and supportive care. The proposed diabetes patient navigator program shares an intent to address financial, communication, medical systems, psychological, transportation and childcare barriers that Freeman's model recognizes.

Medical Legal Partnership (MLP) Program: Medical Legal Partnership programs are premised on recognizing that health problems can result from unmet legal needs and/or have legal remedies. The National Center for Medical Legal Partnership, at the Milken Institute of Public Health at George Washington University frames legal services as an intervention that improves health and well-being. Our model proposes health care provider partnerships with attorneys to address health care disparities resulting from poverty that may lead to worse health outcomes for low-income families.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Ohio

Trinity Hospital Twin City

Grant Number:	D04RH28379					
Organization Type	Critical Access Hospital					
Grantee Organization Information:	Name:	Trinity Hospital Twin City				
	Address:	819 N. First Street				
	City:	Dennison	State:	Ohio	Zip code:	44621
	Tel #:	740-922-2800				
	Website:	www.trinitytwincity.org				
Primary Contact Information:	Name:	Jennifer Demuth				
	Title:	Grant Coordinator				
	Tel #:	740-922-7450, ext. 2198				
	Email:	jdemuth@trinitytwincity.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$182,131
	May 2017 to Apr 2018	$173,425

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Chrysalis Counseling Center *	Tuscarawas	OH	Mental health agency
	New Philadelphia City Health District*	Tuscarawas	OH	Health department.
	Tuscarawas County General Health District*	Tuscarawas	OH	Health department

The communities/counties the project serves:	Tuscarawas County, Ohio

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		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		Pharmacy Assistance	
	Chronic Disease: Diabetes	X	Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers		Substance Abuse	

	/Promotoras			
	Coordination of Care Services		Telehealth	
	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion	X	Other: (please describe)	
	Health Information Technology		Other: (please describe)	

Description of the project:

Trinity Hospital Twin City's project goal is to reduce the number of rural Tuscarawas County adults who are at risk for diabetes by providing an innovative, comprehensive approach to diabetes prevention through diet, exercise and behavior modification classes. We will provide a diabetes prevention education focus by adapting the Fit for Life promising practice model. The Fit for Life curriculum will be adapted to cater more specifically to those at-risk for diabetes, including the addition of supplemental lifestyle coaching from trained mental health and fitness professionals.

The project builds on the activities of the hospital's current FORHP quality improvement grant project (which provides treatment and education for persons with diabetes) by adding a diabetes prevention component, which is crucial to reducing the number of people diagnosed with diabetes.

The project involves a multi-agency approach where Trinity Hospital Twin City will work in consortia with Chrysalis Counseling Center (a mental health agency) and two local health departments: New Philadelphia City Health District and the Tuscarawas County General Health District.

This project will provide diabetes prevention classes, the services of a patient navigator, lifestyle coaching from mental health and fitness professionals as part of the diabetes prevention classes, community blood glucose and cholesterol screenings, creation of a diabetes prevention interactive web page, and diabetes prevention community awareness half-day seminars.

Services will be offered at Trinity Hospital Twin City at Dennison, Tuscarawas County, Ohio, and at consortium member locations at New Philadelphia and Dover. Services will be offered to adults who are at-risk for diabetes or have been diagnosed with diabetes within the past year. Tuscarawas County has a population of 71,288 adults, and 68.2% are overweight or obese (weight is a prime indicator for diabetes risk).

It is anticipated that our project will result in the following outcomes: those at-risk for diabetes will significantly reduce their chances of developing type 2 diabetes evidenced by at least a 10% reduction of body weight, participation in at least 150 minutes of physical activity each week, and an increase in the amount of healthy foods in their diets

Evidence Based/ Promising Practice Model Being Used or Adapted:

Trinity Hospital Twin City's Comprehensive Diabetes Prevention Project is based on the hospital's own Fit for Life promising practice model. The Fit for Life curriculum was developed by Project Director, Dr. Timothy McKnight, who is a Board Certified Family Practitioner and holds a Master's Degree in Nutrition. Dr. McKnight utilized data from the following sources when developing the curriculum: National Heart, Lung and Blood Institute; Centers for Disease Control; American Diabetes Association; American Heart Association; National Weight Loss Control Registry, and others. According to most academic publications, promising practices or emerging best practices are defined as programs proven to be successful, but for which there may not yet be enough evidence to prove it has resulted in a positive outcome. Fit for Life has produced results consistent with being a promising practice based on the positive results of reduced weight, blood pressure and cholesterol levels experienced by past Fit for Life participants. More than 1,700 adults have completed Fit for Life programming. Data collected demonstrates that the average participant achieved the following results: lost 7 pounds from starting weight, lowered systolic blood pressure by 7 points, lowered diastolic blood pressure by 2.5 points, lowered total cholesterol by 13 points, and lowered triglyceride level by 20 points. Additionally, pre and post behavioral surveys of the participants revealed that the number of participants exercising regularly increased by 40%, the number of participants exercising at least three days a week increased by 60%, and the number of participants eating four or more servings of fruits and vegetables daily increased by 37%. Furthermore, the average session attendance rate for Fit for Life is 81%.

Consisting of 12 weekly sessions, Fit for Life focuses on changing lifestyle behaviors to promote weight loss. A behaviorally-based program designed for adults of all ages, Fit for Life emphasizes a modified DASH eating plan with moderate caloric restriction to promote a 2-4 pound per week weight loss and 150 minutes of moderate physical activity per week.

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Oklahoma

Rural Health Projects, Inc.

Grant Number:	D04RH28430					
Organization Type	Non-Profit					
Grantee Organization Information:	Name:	Rural Health Projects, Inc.				
	Address:	2929 E. Randolph, Room 130				
	City:	Enid	State:	OK	Zip code:	73701
	Tel #:	580-213-3172				
	Website:					
Primary Contact Information:	Name:	Allison Seigars				
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Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$200,000
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	St. Mary's Regional Medical Center*	Garfield	OK	Hospital
	Enid Community Clinic*	Garfield	OK	Free Clinic
	Oklahoma State University Center for Rural Health*	Garfield	OK	University
	Great Salt Plains Health Center*	Alfalfa	OK	FQHC

The communities/counties the project serves:	Garfield, Grant, and Alfalfa Counties in rural, northwest Oklahoma.

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) rural, underserved	X

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

	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	
	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 purpose of the project is to implement a community-based diabetes education program combined with clinical quality improvement support for rural primary practices to improve diabetes self-management and clinical outcomes. This project is a response to the strong need for diabetes education in the target area, identified by both state health statistics and a recent community health needs assessment. The Tri-County Health Improvement Organization (Tri-CHIO) will establish the Community Diabetes Education Outreach Program (CDEOP) to provide comprehensive community-based diabetes education as well as provide support to primary care clinicians to refer patients to the education program and adopt best practices in care for persons with diabetes. Currently there are only two Certified Diabetes Educators (CDEs) in the three county target area in rural Northwest Oklahoma (Garfield, Grant, and Alfalfa counties). The two CDEs, contribute 1.25 FTE to diabetes patient education. The combined effort of the two CDEs is not sufficient to meet the need in Garfield County, much less the other two counties in the target area that have no CDE programs or support. The first priority of the current proposal will be to hire a Certified Diabetes Educator to provide community-based diabetes education for patients in the tri-county service area. The CDEOP will use the National Diabetes Education Program (NDEP) as its curriculum. The second component of the program, assisting primary care providers with best practices in care of persons with diabetes, will be accomplished by utilizing the Primary Care Extension Model (Mold, 2011) as a tool for transmitting promising best practice information from the academic medical research centers to rural-based clinicians. The program utilizes a process called academic detailing coordinated by a Practice Enhancement Assistant (PEA). The CDEOP will employ a Practice Enhancement Assistant to help primary care practices implement identified best practices for diabetes care and maintenance. We believe that this combination of community and primary care practice efforts, based in best practices, will help improve diabetes patient outcomes in the three county area of Garfield, Grant, and Alfalfa Counties in rural Northwest Oklahoma.

Evidence Based/ Promising Practice Model Being Used or Adapted:

By developing and implementing the proposed Community Diabetes Education Outreach Program (CDEOP), the Tri-CHIO will, in addition to providing comprehensive, community-based diabetes education through a CDE, support continuous quality improvement (QI) in primary care practices in Alfalfa, Grant, and Garfield counties. These initiatives will improve health outcomes for persons with diabetes and those at risk of developing diabetes and ultimately improve the health of the residents in these three counties. Specifically, we will utilize the National Diabetes Education Program (NDEP) developed jointly by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). The expected outcomes of the proposed project are that persons with diabetes will be better able to manage their chronic condition through increased knowledge and skills, and clinicians will be better equipped to provide the best clinical care through increased knowledge and awareness of best practices.

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Technical Assistance Consultant's Contact Information:	Name:	Rachel Campos				
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Oregon

Yellowhawk Tribal Health Center

Grant Number:	1DO4RH28421-01-00					
Organization Type:	Tribal Health Center					
Grantee Organization Information:	Name:	Yellowhawk Tribal Health Center				
	Address:	P. O. Box 160				
	City:	Pendleton	State:	Oregon	Zip code:	97801
	Tel #:	541-278-7547				
	Website:	www.yellowhawk.org				
Primary Contact Information:	Name:	Tim Gilbert				
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	Email:	timgilbert@yellowhawk.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to April 2016	$197,852
	May 2016 to April 2017	$198,804
	May 2017 to April 2018	$199,449

Consortium Partners	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	CHI St. Anthony Hospital*	Umatilla	OR	Hospital
	Providence St. Mary Medical Center*	Walla Walla	WA	Hospital
	Umatilla County Health Department*	Umatilla	OR	Health Dept.
	Blue Mountain Community College*	Umatilla	OR	Comm. College
	Lifeways Mental Health Services*	Umatilla	OR	Mental Health
	Yellowhawk Tribal Health Center*	Umatilla	OR	Tribal Clinic
	Morrow County Health Department	Morrow	OR	Health Dept.
	Walla Walla County Health Department	Walla Walla	WA	County Health Department
	Good Shepherd Hospital	Umatilla	OR	Hospital

The communities/counties the project serves:	Communities are Pendleton, Heppner, and La Grande, Oregon and Walla Walla, Washington. Counties are Umatilla, Morrow, Union (Oregon), and Walla Walla (Washington)

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	X
	Pre-school Children		African Americans	X
	School-age children (elementary)	X	Latinos	X
	School-age children (teens)	X	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	X	Health Professions Recruitment and Retention/Workforce Development	X

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

Description of the project:

The Yellowhawk Rural Health Services Outreach Project is a three year collaborative initiative structured to implement an evidence based system of care for Umatilla, Union, and Morrow Counties of Oregon and Walla Walla County, Washington. The project will involve nine partnering agencies with Yellowhawk Tribal Health Center (YTHC) of Pendleton serving as the lead agency. Two part time staff will be hired to coordinate project activities. These are a two day per week Project Manager and a half-time Outreach Nurse. During the three year outreach grant, six major work activities will be completed. These are: 1.) Project staff will strengthen and expand the existing health network by providing training and outreach to improve service delivery, 2.) Expanded physician residency and traineeship programs will be established within the project's four county service area, 3.) Integration of behavioral health services through expansion of local crisis teams, training, and outreach, 4.) Addressing the high rates of cancer that exist in the service area through evidence based practices, coaching, and telemedicine, 5.) Address high rates of heart disease in the service area through community education and evidence based practices, 6.) Ongoing evaluation of the program to facilitate replication. The Yellowhawk Rural Health Network will work closely with its network and Oregon Health and Science University in implementing evidence based practices throughout all three years of the project.

The work activities of the project in year one will be to plan outreach activities of the network, establish residency programs and traineeship within the service area, collect baseline data on needed behavioral health services, and research evidence based practices for cancer and heart disease. In year two evidence based practices will be implemented across the network for cancer and heart disease. Outreach activities will also focus on cancer and heart disease with patient coaching activities to be carried out at YTHC. In year three, a cancer navigator program or other best practices will be started within the service area and quality improvement studies of the cost and impacts of new services including evidence based practices will be completed. Training of staff members of YTHC and other network partners will be ongoing throughout the project. Data collection to facilitate replication will be carried out by the project's evaluator; the Northwest Portland Area Indian Health Board. Sustainability of the network to include new services and addressing gaps in the region's continuum of care will be ongoing priorities of project staff and collaborators.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Yellowhawk Rural Health Network utilizes an evidence based protocol team and is in the process of determining EBP's and best practices to be used by the network over the next three years. The evidence based practices expected to be implemented for the network are over the next three years are listed below:

- Canadian Stroke Best Practice, Stroke Recognition and Response
- AHA Heart Care Program or One Million Hearts for cardiovascular health
- National Comprehensive Cancer Network Guidelines
- JNC7 Guidelines for Stroke and Hypertension

All Evidence Based Practices will be implemented with the Assistance of the Evidence Based Policy Institute of Oregon Health and Science University (OHSU).

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Pennsylvania

Armstrong-Indiana-Clarion Drug and Alcohol Commission, Inc.

Grant Number:	D04RH28382					
Organization Type:	Private Non-Profit 501 (c)(3) Single County Authority					
Grantee Organization Information:	Name:	Armstrong-Indiana-Clarion Drug and Alcohol Commission, Inc.				
	Address:	10829 US Route 422				
	City:	Shelocta	State:	PA	Zip code:	15701
	Tel #:	724-354-2746				
	Website:	www.aidac.org				
Primary Contact Information:	Name:	Kami L. Anderson				
	Title:	Executive Director				
	Tel #:	724-354-2746 ext. 302				
	Email:	kanderson@aicdac.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Armstrong County Memorial Hospital*	Armstrong	PA	Hospital
	Indiana Regional Medical Center*	Indiana	PA	Hospital
	ARC Manor*	Armstrong	PA	Treatment Provider
	The Open Door*	Indiana	PA	Treatment Provider
	Armstrong-Indiana-Clarion Drug and Alcohol Commission, Inc.*	Armstrong Indiana Clarion	PA	Single County Authority Non-Profit
	Clarion Hospital	Clarion	PA	Hospital
	PA Department of Health County Clinics	Armstrong Indiana Clarion	PA	County Health Care Clinic

The communities/counties the project serves:	Armstrong, Indiana, and Clarion Counties in Western Pennsylvania

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

Description of the project:

The Addiction Recovery Mobile Outreach Team (ARMOT) program is a collaboration between the County Hospitals (Armstrong County Memorial Hospital, Indiana Regional Medical Center, Clarion Hospital), the area substance abuse providers (ARC Manor and The Open Door), and the Single County Authority (Armstrong-Indiana-Clarion Drug and Alcohol Commission) to streamline patient access for individuals accessing hospital emergency services, psychiatric units, or inpatient physical health units that may be in need of substance abuse treatment services. The target population is adults and adolescents who are struggling with addiction issues that have been admitted to either emergency departments or inpatient physical health units of area hospitals. The program will start in Indiana and Armstrong Counties in Year 1, and expand to Clarion County in Year 2. Western Pennsylvania has experienced an epidemic of heroin and opiate abuse in the past 8-10 years. PA now has the 7th highest drug overdose mortality rate in the United States, with over 3,000 deaths being heroin-related overdoses. Drug overdose deaths in PA have now exceeded the number of deaths from automobile accidents. The Indiana County ambulance company reports that they have had an average of 90 overdoses in 90 days. The services to be provided through the ARMOT program include establishing a screening and referral system for hospital staff to identify and refer individuals with substance use disorders to the ARMOT team. The Mobile Case Manager will provide a level of care assessment and referral to treatment, if needed, for the referred patient. The Mobile Case Manager will be able to arrange for the patient a transfer and admission to an inpatient licensed treatment facility or an intake appointment with a local Outpatient substance use treatment facility. The peer Recovery Specialist will provide recovery support services to the patient and information and education regarding treatment and addiction to the family members. The ARMOT team members will be providing education to hospital staff on substance use disorders. The expected outcomes of the program are to: establish a screening and referral system for hospital staff to identify and refer individuals with substance use disorders to the ARMOT team; increase the number of patients with substance use disorders that are transferred and admitted from the hospital to inpatient and outpatient substance abuse treatment providers; increase the number of hospital staff educated on substance use disorders; reduce the number of emergency department visits, hospitalizations, and inpatient treatment stays for patients admitted to the program.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The Addiction Recovery Mobile Outreach Team (ARMOT) program will utilize the components of the Care Coordinator/Manager Model which has been identified as a promising practice and is noted in the Rural Assistance Center Community Health Workers Toolkit as a program model. The ARMOT program follows the Care Coordinator/Manager Model to pair the expertise of a Mobile Case Manager with a peer Certified Recovery Specialist who better understands the substance use disorder treatment system and the resources that are needed and available within the rural communities with area hospital and clinic staff for patients identified with substance use disorders. The only modification from the Care Coordinator/Manager model is the specific emphasis on the addiction population.

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Pennsylvania

Butler Healthcare Providers DBA Butler Memorial Hospital

Grant Number:	D04RH28396					
Organization Type:	Hospital					
	Name:	Butler Healthcare Providers DBA Butler Memorial Hospital				
	Address:	1 Hospital Way				
	City:	Butler	State:	PA	Zip code:	16001
	Tel #:	724-283-6666				
	Website:	www.butlerhealthsystem.org				
Primary Contact Information:	Name:	Thomas A McGill, MD				
	Title:	CIO				
	Tel #:	724-284-4025				
	Email:	Athomas.McGill@butlerhealthsystem.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Butler Healthcare Providers DBA: Butler Memorial Hospital*	Butler	PA	Community Hospital
	Clarion Hospital*	Clarion	PA	Community Hospital
	Seneca Medical Center of Butler Health System*	Venango	PA	Physician Practice
	Primary Care Associates*	Butler	PA	Physician Practice
	Butler Medical Providers*	Butler	PA	Physician Practice
	Clarion Hospital Employed Physician Practices DBA Health Services of Clarion, Inc.*	Clarion	PA	Physician Practice

The communities/counties the project serves:	Clarion county; Venango County; Lawrence County; Rural town of Titusville, PA; Rural tracts of Armstrong county, Butler county, and Mercer county

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

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

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

Description of the project:

The program will provide DSME education to rural residents in person, via videoconferencing, and online. This combined education platform will help create a more culturally competent, systematic, and effective care tool; thereby, improving patient outcomes while lowering the cost of disease management for patients, payers, and taxpayers. The purpose of the program is to improve the health status of patients with type 1, type 2 and gestational diabetes within the service area by increasing enrollment in and completion of a (DSME) program

This program addresses the major issues discovered in the needs assessment by employing two main strategies:

- Promoting DSME to clinicians and patients at partnering sites.
- Creating a blended learning delivery model (online education blended with 1:1 health coaching and support groups) using evidenced-based DSME to patients with diabetes in the service area. The program will use distance education best practices and strategies to improve patient knowledge, motivate them to remain engaged, and remind them of important milestones, such as having your HbA1c checked or have a foot exam. This hybrid model will reduce barriers associated with distance, scheduling, and learning styles.

This project will leverage existing partner resources with online education and telemedicine tools to overcome barriers and access issues and promote patient outcomes. An online education tool will be created that will provide group education through an online Guided Episode Management (GEM) tool, referred to as Care Pathway. The Care Pathway will be similar to the experience of taking an online credit course. Participants will be prompted to perform tasks, such as watch a video on self-administering insulin or read a short narrative on meal planning. They will be assessed at relative intervals to determine changes in knowledge and behaviors, and prompted towards personal goal attainment. At the same time each patient will have 1:1 health coaching with DSME staff, either in person at the hospital or over videoconferencing from the location of their choice. Support groups will also be made available over videoconferencing so that more patients can easily participate in this valuable service. DSME staff will receive reports on their patients' progress, monitor clinical outcomes through the shared EMR, and follow up with patients who are not attaining personal goals or who have fallen behind in the Care Pathway.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project uses the evidenced-based model, Diabetes Self-Management Education (DSME). The effectiveness of DSME has been studied in a broad array of settings and applications and is so well documented that it is considered a "critical element of care"[i] by the ADA. The project follows the *National Standards for Diabetes Self-Management Education* from the ADA as well as the American Association of Diabetes Educators' (AADE) Guidelines for the Practice of Diabetes Self-Management Education and Training (DSME/T).

The current DSME program at BMH has been recognized by the ADA since 1999. It should be noted that Motivational Interviewing and

blended learning are also evidenced based practices that have been used with great success with rural populations matching our target population.						
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Pennsylvania

J.C. Blair Memorial Hospital

Grant Number:	D04RH28405					
Organization Type:	Hospital/Health care					
Grantee Organization Information:	Name:	J.C. Blair Memorial Hospital				
	Address:	1225 Warm Springs Avenue				
	City:	Huntingdon	State:	PA	Zip code:	16652
	Tel #:	814-643-8785				
	Website:	www.jcblair.org				
Primary Contact Information:	Name:	Shelly Rivello, LCSW				
	Title:	Director of Behavioral Health Services				
	Tel #:	814-643-8785				
	Email:	srivello@jcblair.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	J.C. Blair Memorial Hospital	Huntingdon	PA	Health care
	J.C. Blair Medical Services *	Huntingdon	PA	Health care
	PinnacleHealth Hospital *	Dauphin	PA	Health care
	Juniata Valley Behavioral and Developmental Services *	Huntingdon-Mifflin-Juniata	PA	Administrative/Human Services
	Juniata Valley Tri-County Drug & Alcohol Abuse Commission *	Huntingdon-Mifflin-Juniata	PA	Administrative/Human Services

The communities/counties the project serves:	Huntingdon County (and surrounding counties) of community members who receive services within J.C. Blair Medical Services practices

The target population served:	Population	Yes	Population	Yes
	Infants	X	Caucasians	X
	Pre-school Children	X	African Americans	X
	School-age children (elementary)	X	Latinos	
	School-age children (teens)	X	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	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care	X	Integrated Systems of Care	X
	Aging		Maternal/Women's Health	X
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular	X	Pharmacy Assistance	

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

Description of the project:

With the funding through the Outreach grant program, JC Blair Memorial Hospital will design and implement a population-based health care approach to integrate behavioral healthcare directly into the physical healthcare setting. Striving to serve healthcare health care providers, patients, and the community, the integrated Behavioral Health-Physical Health (BH-PH) project provides a level of coordinated care and engagement to improve population health, enhance patient experience (access, quality), and reduce/or control costs.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Modeled after the Primary Care Behavioral Health Consultant (PCBH) model, the BH-PH project will utilize evidence-based practice interventions while considering the unique needs of a rural health community. The integrated BH-PH model supports the gateway to additional services while enhancing engagement and patient activation with behavioral changes to achieve a patient's healthcare goals, including improving physical health and mental health functioning. Utilizing a variety of evidence-based interventions, the project strives to improve outcomes, satisfaction (patient and health care provider), and reduce costs while encouraging the most appropriate level of care for treatment.

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	City:	Atlanta	State:	Georgia	Zip code:	30303

Pennsylvania

St. Luke's Miners Memorial Hospital DBA St. Luke's Miners

Grant Number:	D04RH28435					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	St. Luke's Miners Memorial Hospital DBA St. Luke's Miners				
	Address:	360 West Ruddle Street				
	City:	Coaldale	State:	PA	Zip code:	18218
	Tel #:	570-645-2131				
	Website:	http://www.mystlukesonline.org/locations/stl-miners-memorial/index.aspx				
Primary Contact Information:	Name:	Carla M. Arbushites				
	Title:	Assistant Vice President, Development				
	Tel #:	484-526-4136				
	Email:	Carla.Arbushites@sluhn.org				

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$199,820
	May 2016 to Apr 2017	$199,888
	May 2017 to Apr 2018	$199,003

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Panther Valley School District	Carbon	PA	School District
	*The Kellyn Foundation	Northampton	PA	Health Education
	*Weller Health Education Center	Lehigh	PA	Health Education
	14 Acre Farm	Carbon	PA	Farm

The communities/counties the project serves:	Carbon and Schuylkill Counties and surrounding towns

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	
	Pre-school Children		African Americans	
	School-age children (elementary)	X	Latinos	
	School-age children (teens)	X	Native Americans	
	Adults	X	Pacific Islanders	
	Elderly		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	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	X

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

Description of the project:

This collaborative, comprehensive rural health outreach takes place in the economically challenged coal mining and manufacturing Appalachian Region communities in Northeastern Pennsylvania – a Medically Underserved Area of Schuylkill and Carbon counties. This MUA, served by St. Luke's Miners, has serious health and health-related priorities as identified by the Community Needs Assessment: community outreach for targeted health message; chronic disease prevention (obesity, physical activity); chronic disease management (diabetes, asthma); access to care (under/uninsured for medical and dental); mental health; substance abuse. This project will engage students of Panther Valley School District (and also reach their families, teachers, staff, community members) through partnerships, School Based Coordinators, and programs. The project considers the school district to become the hub of the community, providing opportunities for outreach to connect students, families and community members to care and work together to improve health outcomes.

The project is being delivered via a consortium to improve mental health/behavioral health and substance abuse prevention (school-based programs on substance abuse, healthy relationships, depression); improve chronic disease prevention, management and healthy living initiatives (Tail on the Trail, Access to Healthy Foods, Garden as a Classroom); and improve access and connection to health care services (Mobile Youth Health Center with integrated behavioral health). In using the School District as a hub, outreach sessions are planned monthly in order to reach students, families and communities members and to improve access to care, chronic disease prevention and management and behavioral/mental health services. Students, staff and community members are actively involved in assessing, implementing and evaluating initiatives and outreach through focus groups and committees.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The collaborative, comprehensive Adopt a School is tailored using the evidence-based Coalition for Community Schools' Model, including recommendations of school-based coordinators and leadership committees. Integrated behavioral health and primary care is designed using the Primary Care Behavioral Health model of HRSA AHRQ. Mental health programming uses the Adolescent Depression Awareness Program developed at Johns Hopkins Mood Disorders Center. The Adopt a School model will utilize the Center for Disease Control and Prevention (CDC) School Health Index (SHI) to assess needs, develop implementation strategies and programs, and evaluate effectiveness. The Mobile Medical Care and Patient Navigation outreach is modeled after the Harvard Medical College Family Van and the Patient Navigator model from Harlem Hospital Center, both nationally recognized models.

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Pennsylvania

UPMC Bedford Memorial

Grant Number:	D04RH28418					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	UPMC Bedford Memorial				
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	City:	Everett	State:	PA	Zip code:	15537
	Tel #:	814-623-6161				
	Website:	www.upmc.com/locations/hospitals/bedford/Pages/				
Primary Contact Information:	Name:	Paula Thomas				
	Title:	VP Patient Care Services/ CNO				
	Tel #:	814-623-3520				
	Email:	thomasp@upmc.edu				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Home Nursing Agency and Visiting Nursing Association	Blair	PA	Home Health Agency
	*Community Nursing and Home Health	Cambria	PA	Home Health Agency
	*UPMC Bedford Memorial	Bedford	PA	Hospital

The communities/counties the project serves:	Bedford County, PA

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		Pacific Islanders	
	Elderly	X	Uninsured	
	Pregnant Women		Other: (please describe) ALL elderly living in Bedford county	X

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

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

Description of the project:

The Bedford County Mental Health PLUS Program will improve the health outcomes of a large and increasing population of elderly individuals (age 65 and over) living in rural Bedford County, PA with no access to geriatric mental health services, and showing increased prevalence of depression symptoms. Health outcomes will be improved while increasing access to primary care and physician specialist care.
Screening questionnaires will be initiated in the acute care setting to identify the targeted population with depression; homecare patients will be screened and identified; home care psychiatric nurses will be used to conduct a comprehensive evaluation for those individuals with depression symptoms; algorithms will be developed in which findings from these evaluations will trigger further evaluations and access to primary care physicians (PCPs) and/or a tele-psychiatrist for symptom management; and standard clinical practice guides will be used to improve self-care management for these patients with depression.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The consortium is utilizing the research from Jacobs JA, Jones E, Gabella BA, Spring B, Brownson RC.
Tools for Implementing an Evidence-Based Approach in Public Health Practice.

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South Dakota

Delta Dental Philanthropic Fund

Grant Number:	D04RH28424					
Organization Type:	501(c)(3) charitable supporting organization					
Grantee Organization Information:	Name:	Delta Dental Philanthropic Fund				
	Address:	804 N. Euclid Ave., Ste. 101				
	City:	Pierre	State:	SD	Zip code:	57501
	Tel #:	605-494-2547				
	Website:	www.deltadentalsd.com				
Primary Contact Information:	Name:	Connie Halverson				
	Title:	Vice President of Public Benefit				
	Tel #:	605-494-2547				
	Email:	connie.halverson@deltadentalsd.com				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Delta Dental Philanthropic Fund	Hughes	SD	501(c)(3)
	*Badlands Head Start	Perkins	SD	Head Start
	*South Central Child Development	Charles Mix	SD	Head Start
	*Cheyenne River Head Start	Dewey	SD	Head Start
	*Oglala Lakota College Head Start/Early Head Start	Shannon	SD	Head Start
	*Rosebud Sioux Tribe Head Start	Todd	SD	Head Start
	*Rural America Initiatives Pre-natal to Five Head Start	Pennington	SD	Head Start
	*Yankton Sioux Tribe	Charles Mix	SD	Head Start

The communities/counties the project serves:	Seven South Dakota Indian reservations including the following counties: Bennett, Shannon, Ziebach, Dewey, Jackson, Mellette, Todd, Tripp, Corson, Pennington, Buffalo and Charles Mix.

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	
	Pre-school Children	X	African Americans	
	School-age children (elementary)		Latinos	
	School-age children (teens)		Native Americans	X
	Adults		Pacific Islanders	
	Elderly		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	X	Oral Health	X
Chronic Disease: Cardiovascular		Pharmacy Assistance	
Chronic Disease: Diabetes		Physical Fitness and Nutrition	
Chronic Disease: Other		School Health	
Community Health Workers /Promotoras		Substance Abuse	
Coordination of Care Services		Telehealth	
Emergency Medical Services		Transportation to health services	
Health Education and Promotion		Other: (please describe)	
Health Information Technology		Other: (please describe)	

Description of the project:

The Delta Dental/Head Start Early Childhood Caries Prevention Project (ECC Project) will increase access to preventive dental care for American Indian children ages 0-5 on South Dakota reservations. The goal is to improve the oral health of American Indian children enrolled in reservation-based Head Start/Early Head Start agencies by performing: caries risk assessments; charting of tooth caries, surface and activity; effective communication with patients and their parents/guardians; development and maintenance of self-management goals for the families; tropical fluoride applications to re-mineralize caries on patients; referrals based on patient's clinical needs and parent's desires; and return visit intervals based on caries risk.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The project is designed based upon the promising practice model for risk-based prevention and disease management of early childhood caries for children 0-5 utilized by the DentaQuest Institute's Early Childhood Caries (ECC) Collaborative. This project is adapting the disease management protocols to use in a mobile setting with dental hygienist-provided care.

Federal Office of Rural Health Policy Project Officer:	Name:	Linda Kwon				
	Tel #:	301-594-4205				
	Email:	lkwon@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	State:	Maryland	Zip code:	20857
Technical Assistance Consultant's Contact Information:	Name:	John A. Shoemaker, MPH				
	Tel #:	888-331-0529				
	Email:	ta@jasmph.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

South Dakota

Sanford Health Network DBA Sanford Vermillion Medical Center

Grant Number:	D04RH28431					
Organization Type:	Hospital					
Grantee Organization Information:	Name:	Sanford Health Network d/b/a Sanford Vermillion Medical Center				
	Address:	20 South Plum Street				
	City:	Vermillion	State:	SD	Zip code:	57069-0401
	Tel #:	605-624-9111				
	Website:	http://www.sanfordvermillion.org/ourfacilities/hospital/				
Primary Contact Information:	Name:	Susan Halbritter				
	Title:	Co-Project Director				
	Tel #:	605-328-8000				
	Email:	Susan.Halbritter@sanfordhealth.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$194,114
	May 2016 to Apr 2017	$193,805
	May 2017 to Apr 2018	$193,808

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	*Douglas County Memorial Hospital	Douglas	SD	Rural Hospital
	*Sanford Medical Center (hub/oncology)	Minnehaha	SD	Hospital
	*Sanford Health	Minnehaha	SD	Parent company-IT support

The communities/counties the project serves:	Communities: Vermillion, SD, Armour, SD/Clay and Douglas counties

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	X
	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	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health		Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	
	Community Health Workers /Promotoras		Substance Abuse	
	Coordination of Care Services		Telehealth	X

	Emergency Medical Services		Transportation to health services	
	Health Education and Promotion		Other: (please describe) Oncology	X
	Health Information Technology		Other: (please describe)	

Description of the project:

The project will bring oncology infusion services to rural communities through the use of telemedicine. The target population for the project is individuals who receive oncology care in southeastern South Dakota. The project is modeled after other successful telemedicine models at Sanford Health and recommendations and guidelines from the American Telemedicine Association. The formation of project will provide rural health care providers serving the target population with the resources to enhance and eliminate barriers to quality care and access to services.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Sanford Health has been the proud recipient of several telehealth related grant that have elevated the pace and success of implementation of telemedicine. Successful projects include eICU, Telestroke, and Tele-emergency. It was the success of the above named projects that led the Project Directors for Virtual Infusion to believe that telemedicine could be used to help manage oncology infusion centers. Currently, support is provided via telephone but this will give providers the capabilities to lay "eyes on" in situations that are hard to describe over the phone. The oncology advanced practice nurse based in Virtual Infusion will be able to provide timely and expert direct supervision for unexpected problems that develop in the rural infusion centers. The other projects demonstrate that direct expert supervision can be provided via telemedicine.

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	Tel #:	301-443-0837				
	Email:	vdarden@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	State:	Maryland	Zip code:	20857
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	Tel #:	770-641-9940				
	Email:	cliemohn@crlconsulting.com				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

South Dakota

University of South Dakota Department of Dental Hygiene

Grant Number:	D04RH28389					
Organization Type:	University					
Grantee Organization Information:	Name:	University of South Dakota Department of Dental Hygiene				
	Address:	414 E. Clark Street				
	City:	Vermillion	State:	SD	Zip code:	57069
	Tel #:	605-677-5379				
	Website:	www.usd.edu				
Primary Contact Information:	Name:	Ann Brunick				
	Title:	Chairperson				
	Tel #:	605-677-5580				
	Email:	Ann.Brunick@usd.edu				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$196,922
	May 2016 to Apr 2017	$198,358
	May 2017 to Apr 2018	$199,012

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Ethan School District*	Davison	SD	School
	Parker School District*	Turner	SD	School
	McCook Central School District*	McCook	SD	School
	Freeman Public School District*	Hutchinson	SD	School
	Montrose School District*	McCook	SD	School
	Parkston School District*	Hutchinson	SD	School
	Canton School District*	Lincoln	SD	School
	Montrose School District*	McCook	SD	School
	Wakonda Heritage Manor*	Clay	SD	Elder Care
	Avera Sister James Care Center*	Yankton	SD	Elder Care
	Avera Yankton Care Center*	Yankton	SD	Elder Care
	Pioneer Memorial Hospital and Health Services*	Turner	SD	Elder Care
	Oakview Terrace*	Hutchinson	SD	Elder Care
	Sunset Manor*	Yankton	SD	Elder Care

The communities/counties the project serves:	Southeastern South Dakota

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

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

Description of the project:

The University of South Dakota Department of Dental Hygiene students, faculty and staff dentist will provide dental and dental hygiene services at the consortium partner sites of 7 school districts and 6 nursing homes. Focusing on high-risk children and elders, screenings/exams, x-rays, cleaning fluoride varnish, sealants, oral health education and dental referrals will be provided. Four local dentists have agreed to accept patient referrals from this program. It is intended that access to dental services will increase for high-risk children and elders who are low-income, Medicaid/Medicare-eligible, uninsured, or immobile living in southeast South Dakota.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The USD Dental Hygiene Community Outreach Program is based on the following practice models: 1) RACs School-based Model that delivers preventative services such as fluoride varnish, dental sealants, and oral health education to school-aged children in a school setting; 2) School-based Dental Sealant Program outlined by ASTDD indicates dental sealant programs are effective in preventing caries in children and can reduce racial, ethnic and economic disparities in the prevalence of dental sealants; 3) Preventing Dental Caries: School-based Dental Sealant Delivery Program outlined by the Community guide promotes dental sealants to increase the identification of caries in children who do not regularly visit a dentist and improve access to dental health services by referring children who need intervention; 4) Comprehensive School-based Program Innovation Model recommends providing preventive dental services to low-income children to decrease dental disease; and 5) Elder Smiles is a model that recommends dental and dental services to persons in a nursing home facility in order to improve their overall health.

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	Name:	Linda Kwon				
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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:	Tamanna Patel				
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	Email:	Tpatel25@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Texas

Plainview Foundation for Rural Health Advancement

Grant Number:	D04RH28426					
Organization Type:	Non-profit foundation – operating two community clinics and one school-based health center					
Grantee Organization Information:	Name:	Plainview Foundation for Rural Health Advancement				
	Address:	P.O. Box 727; 705 Second Street				
	City:	Hart	State:	Texas	Zip code:	79043
	Tel #:	806-938-2299				
	Website:	www.smalltownhealth.org				
Primary Contact Information:	Name:	Retta Knox				
	Title:	Executive Director				
	Tel #:	806-937-0014				
	Email:	rettaknox@gmail.com				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$196,165
	May 2016 to Apr 2017	$196,165
	May 2017 to Apr 2018	$196,165

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Plainview Foundation for Rural Health Advancement *	Castro	TX	Non-profit foundation operating two community clinics and one school-based health center
	Hart Independent School District *	Castro	TX	Public School
	Pope Dental *	Lubbock	TX	Private Dental Practice
	Nelson Counseling *	Castro	TX	Private Practice
	Texas Tech University Health Science Center Pediatric Department	Lubbock	TX	Medical School Contributing Partner
	Texas A&M university Health Science Center Family Practice Department in Victoria	Victoria	TX	Medical School Contributing Partner

The communities/counties the project serves:	Counties Served : Castro, Briscoe, Hall, Lamb, Swisher & Parmer Communities Locations: Hart, Earth & Turkey

The target population served:	Population	Yes	Population	Yes
	Infants	X	Caucasians	X
	Pre-school Children	X	African Americans	X
	School-age children (elementary)	X	Latinos	X
	School-age children (teens)	X	Native Americans	
	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	X	Health Professions Recruitment and Retention/Workforce Development	
	Access: Specialty Care		Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health	X	Migrant/Farm Worker Health	
	Children's Health		Oral Health	X
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	X
	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 purpose of the PFRHA Outreach Project is to insure continuation of all services (medical, dental and mental health) currently offered by PFRHA and to enhance and expand oral health and mental health services. The program will serve small rural farming/ranching communities with a declining population and economy, with no or very limited medical resources, in a six-county area of the Texas Panhandle – Castro, Hall, Lamb, Briscoe, Parmer and Swisher Counties. The target population is uninsured or underinsured clients and publicly insured clients in these areas where the need is great. Access to care is limited due to limited providers and the distance to access existing providers. The focus area of the project will be oral health delivery and mental health services, complimenting established primary medical care, with the aid of telemedicine. Dental services will include preventive and primary care: exams, cleanings, sealants, dental x-rays, fillings, extractions and oral health education. Mental Health services will concentrate on individual and family counseling, including Telemed sessions. These services will be delivered as stand-alone services and coordinated services with primary medical care. Consortium members for the PFRHA Outreach program include Plainview Foundation for Rural Health Advancement, a non-profit involving the operation of 3 community medical clinics as well as telemedicine capability at all 3 sites, and manages the school-based health center and the dental clinic at Hart; Pope Dental, a practice owned by Dr. Kevin Pope who serves as the Dental Director for the project, providing professional guidance in provision of a quality dental operation; Nelson Counseling, owned by Lyndy Nelson who is serving as Mental Health Director and providing direct services while instrumental in establishing a quality counseling program; and Hart Independent School District, who has provided the health center at Hart and supported numerous renovations to make the facility appropriate for operations. Vital contributing partners are: Texas Tech University Health Science Center Department of Pediatrics and Rural Outreach via the Maria Hall Institute and Texas A&M University Health Science Center Family Practice Department with Dr. Sidney Ontai.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Implementation of evidence-based promising practice model – SCHOOL BASED HEALTH CENTER – modified for delivery of dental services to clients of all ages while located on a school campus and serving children as first priority.

Implementation of evidence-based promising practice model – PRIMARY CARE-BEHAVIORAL HEALTH INTEGRATION MODEL REVERSE CO-LOCATION – adapted for delivery of mental health services to operate in coordination with the school-based health center and delivery of some services via telemedicine.

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	Email:	cvillalobos@hrsa.gov				
	Organization:	Federal Office of Rural Health Policy				
	City:	Rockville	State:	Maryland	Zip code:	20857
Technical Assistance Consultant's Contact Information:	Name:	Lynne Kernaghan				
	Tel #:	478-474-0095				
	Email:	kernaghanL@cox.net				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Vermont

Bi-State Primary Care Association

Grant Number:	D04RH28383					
Organization Type:	Primary Care Association					
Grantee Organization Information:	Name:	Bi-State Primary Care Association				
	Address:	61 Elm St				
	City:	Montpelier	State:	VT	Zip:	05602
	Tel #:	802-229-0002				
	Website:	www.bistatepca.org/specialpopulations				
Primary Contact Information:	Name:	Kate Simmons, MBA MPH				
	Title:	Director, Vermont Operations				
	Tel #:	802-229-0002, ext. 217				
	Email:	ksimmons@bistatepca.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	University of Vermont Extension	Statewide	VT	Extension Service
	Open Door Clinic	Addison	VT	Free Clinic

The communities/counties the project serves:	Franklin, Grand Isle, Chittenden, Caledonia, Orleans, Essex, Washington, Lamoille, Bennington, Rutland, and Addison

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		Pacific Islanders	
	Elderly		Uninsured	
	Pregnant Women		Other: (please describe) Migrant farmworkers and their families	X

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

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

Description of the project:

Bridges to Health is a statewide care coordination program for migrant and seasonal farmworkers and their families. Through consortium collaboration, health care promoters at University of Vermont Extension and a bilingual Outreach Nurse at the Open Door Clinic will provide direct services to at least 375 individuals through outreach to over 125 farms a year. This outreach will include distribution of at least 1,800 access guides on local health services. 100% of patients who express interest in receiving health care will be assisted in making appointments, and provided case management to include coordination of transportation and language services, appointments, and follow-up. The consortium will present to health centers, free clinics, and Planned Parenthood, representing 70+ sites, and offer technical assistance to reduce barriers to care, while collaborating with supportive service points statewide to build their capacity in care coordination and service provision. Bridges to Health will also work closely with two universities to further support their outreach efforts, which will include monthly medical resident visits to farms, summer internship projects, and development of bilingual materials to further benefit the program. Bridges to Health, in coordination with other stakeholders working with the migrant population, plans to organize a statewide Migrant Conference in 2017. This conference will include legal, advocacy, education, and health. Bridges to Health's expected impacts include more farmworkers accessing primary care and dental services, leading to a decreased unnecessary emergency room usage and improved health outcomes.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Bridges to Health employs the 'Lay Health Promoter' or 'Community Health Worker' Model. Health promoters have a close understanding of the community and are poised to facilitate meaningful access to resources. Often these would be individuals who are from the community, but the farmworker population in Vermont is extremely migratory, which would create constant turnover. Therefore, Bridges to Health funding allowed the consortium partners, UVM Extension (UVM) and Open Door Clinic (ODC), to enhance the use of existing bilingual/bicultural staff, including Migrant Education Recruiters and an Outreach Nurse and Front Desk Staff, respectively. UVM had existing bilingual/bicultural Recruiters who were conducting outreach to Vermont farms to promote the Vermont Migrant Education Program's services. With the Bridges funding, UVM has enhanced capacity of staff Recruiters to also provide health outreach and care coordination, and has hired a Migrant Health Coordinator to oversee the health component of their job, providing training, technical assistance, and care coordination. At ODC, the bilingual nurse provides medical outreach to farms, and refers back to the clinic where there is a bilingual, front desk staff person that coordinates transportation, language needs and follow-up care. This model has created an enhanced staffing model of individuals already respected and trusted within the target population, and has been key to reaching the hidden, isolated, and fearful population that is spread out over many farms.

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	Organization:	Federal Office of Rural Health Policy				
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Technical Assistance Consultant's Contact Information:	Name:	Amanda Phillips Martinez				
	Tel #:	404-413-0293				
	Email:	aphillipsmartinez@gsu.edu				
	Organization:	Georgia Health Policy Center				
	City:	Atlanta	State:	Georgia	Zip code:	30303

Virginia

Bay Rivers Telehealth Alliance

Grant Number:	D04RH28395					
Organization Type:	Non-Profit Telehealth Consortium					
Grantee Organization Information:	Name:	Bay Rivers Telehealth Alliance				
	Address:	518 Hospital Road, Suite 104				
	City:	Tappahannock	State:	VA	Zip code:	22560
	Tel #:	804-443-6286				
	Website:	www.Bayriverstelehealth.org				
Primary Contact Information:	Name:	Donna Dittman Hale				
	Title:	Executive Director				
	Tel #:	804-443-6286				
	Email:	execdirector@bayriverstelehealth.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Bay Aging	Middlesex	VA	Agency on Aging
	Riverside Health System (RHS)	Newport News	VA	Hospital System
	Middle Peninsula/Northern Neck Community Services Board (CSB)	Middlesex	VA	CSB
	Hospital Corporation of America (HCA), HCA Capital Region	Richmond	VA	Hospital System
	Virginia Commonwealth University Medical Center	Richmond	VA	Hospital System

The communities/counties the project serves:	Northern Neck and Middle Peninsula: Counties include Essex, Gloucester, Mathews, Middlesex, King William, King & Queen, Lancaster, Northumberland, Richmond, and Westmoreland.

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	X
	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		Pharmacy Assistance		
Chronic Disease: Diabetes		Physical Fitness and Nutrition		
Chronic Disease: Other	X	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 Bridges to Care Transitions project provides remote patient monitoring to a rural area that encompasses 2,635 square miles and a population of 131,255 individuals collectively. The project's service area is the Middle Peninsula and Northern Neck and includes ten rural counties. The needs being addressed are the geographic isolation and socioeconomic barriers that limit health care access for rural Eastern Virginians. Those with chronic and complex health conditions suffer even more, with frequent hospitalizations and emergency department visits, due to lack of resources and skills to manage their conditions. The project serves those patients with chronic or complex health conditions who have either just been discharged from the hospital or have been referred by their physician.

Anticipated outcomes include: improved patient management of chronic conditions, earlier identification of health issues, identification and treatment of behavioral health issues, overall improved health status, reduced hospital admissions and emergency room usage, improved access to health services, reduced cost of care delivery, and improved integration and oversight of services with regional providers and specialty centers. The project will achieve sustainability as a result of strenuous evaluation protocols that measure and evaluate the triple aim of cost, quality and access to services through an expanded Telehealth infrastructure and through savings created by reduced healthcare costs through the reduction of re-hospitalizations, unnecessary transfers, and more timely care management by providers.

Evidence Based/ Promising Practice Model Being Used or Adapted:

BRTA, in a Consortium including its five member organizations, proposes to expand the network's scope to include remote patient monitoring, partnering with coaches from the Eastern Virginia Care Transitions Partnership (EVCTP), based on the success of the Coleman Model© , and community-based education using the Stanford Model of Chronic Disease Self-Management. Coaches will work with patients to ensure that they understand discharge instructions, and use remote monitoring equipment so that vital signs can be monitored daily for a 90-day period. The telemonitoring equipment also will provide the capability for behavioral health assessments, patient surveys, patient education, with other consults available through telemedicine sites. A remote monitoring clinician (RN) will monitor daily transmissions from the patients and will ensure follow-up to any potential health concerns identified.

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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:	Karen H. Wakeford, MPA, Technical Assistance Consultant				
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Virginia

St. Mary's Health Wagon

Grant Number:	D04RH28411					
Organization Type:	Free Health Care Clinic					
Grantee Organization Information:	Name:	St. Mary's Health Wagon				
	Address:	P.O. Box 7070				
	City:	Wise	State:	Virginia	Zip code:	24293
	Tel #:	276-328-8850				
	Website:	www.thehealthwagon.org				
Primary Contact Information:	Name:	Marcus Adkins				
	Title:	Director of Development				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$200,000
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Wise County Department of Social Services*	Wise	VA	Social Services
	Mountain States Health Alliance*	Wise	VA	Hospital System

The communities/counties the project serves:	Counties: Buchanan, Dickerson, Russell, Scott, Lee, and Wise

The target population served:	Population	Yes	Population	Yes
	Infants	X	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	X	Other: (please describe)	

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

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

Description of the project:

The project is aimed at the prevention and treatment of diabetes mellitus type II utilizing evidenced based models. The program is aimed at the underserved population of Southwest Virginia, primarily in the area categorized as the "Coalfields." Lack of transportation services, primary care providers, and specialty services created an atmosphere of untreated chronic disease, primarily diabetes mellitus and cardiovascular disease. High instances of obesity, lack of healthy food sources, and sedentary lifestyles led to increased risk for diabetes mellitus.

As such, the program focuses on the prevention of diabetes through lifestyle coaching techniques, and the treatment of diabetes utilizing the chronic care model. Patients with hemoglobin A1c readings of greater than 7.0 are scheduled with the endocrinologist for specialized diabetes care. Lifestyle coaches work with patients in a group setting to improved fasting glucose tolerance, decrease weight, improve physical activity and provide valuable nutritional information.

Bi-annual biometric testing will demonstrate change over time and allow for quality improvement measures to be performed. All patients entering the Health Wagon or seen during outreach events will be screened for diabetes and placed into the program for increased education, enhanced medical care, and lifestyle management if found to be at risk.

Evidence Based/ Promising Practice Model Being Used or Adapted:

CDC Diabetes Prevention Program is an evidenced based model that focuses on lifestyle coaching to increase healthy eating habits and increase physical activity. The program focuses on individuals diagnosed with impaired fasting glucose and has been proven to decrease weight by 7%. The program showed that by decreasing weight by 7%, participants also decreased their risk for diabetes.

The Chronic Care Model uses a systematic approach to restructuring medical care to create partnerships between health systems and communities.

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Washington

Yakima Valley Farm Workers Clinic

Grant Number:	D04RH28420					
Organization Type:	Federally Qualified Health Center (FQHC)					
Grantee Organization Information:	Name:	Yakima Valley Farm Workers Clinic				
	Address:	518 West First Avenue				
	City:	Toppenish	State:	WA	Zip code:	98948
	Tel #:	509-865-5898				
	Website:	www.yvfwc.com				
Primary Contact Information:	Name:	Linda Sellsted				
	Title:	Clinic Manager				
	Tel #:	509-574-3207				
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Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$200,000
	May 2017 to Apr 2018	$200,000

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Yakima Valley Memorial Hospital*	Yakima	WA	Hospital
	Yakima Valley Memorial Foundation*	Yakima	WA	Foundation
	Comprehensive Mental Health*	Yakima	WA	Mental Health

The communities/counties the project serves:	Yakima County

The target population served:	Population	Yes	Population	Yes
	Infants	X	Caucasians	X
	Pre-school Children	X	African Americans	
	School-age children (elementary)	X	Latinos	X
	School-age children (teens)	X	Native Americans	X
	Adults		Pacific Islanders	
	Elderly		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	X	Integrated Systems of Care	
	Aging		Maternal/Women's Health	
	Behavioral/Mental Health		Migrant/Farm Worker Health	
	Children's Health	X	Oral Health	
	Chronic Disease: Cardiovascular		Pharmacy Assistance	
	Chronic Disease: Diabetes		Physical Fitness and Nutrition	
	Chronic Disease: Other		School Health	

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

Description of the project:

Yakima Valley Farmworkers Clinic (YVFWC) is one of the largest FQHC systems in the country and has a history of effectively implementing health programs in the local communities. Many of the communities served by the Yakima Valley Farm Workers Clinic have significant populations of farm workers and low-income families.

Children's Village, a YVFWC, offers pediatric medical care, pediatric dental care and behavioral assessments. The purpose of Children's Village 2015 Outreach grant program is to provide evidence-based, culturally competent, patient navigation and care coordination services to families with Children with Special Health Care Needs (CSHCN) and those referred for Developmental Behavior evaluations.

Diverse partners work together to improve coordination of care for these families by bringing together healthcare, education, social service, and public health professionals. A Public Health Nurse (PHN) and patient navigator determine family needs and priorities and to develop a care plan. Staff provides these services through the coordination of care services and home visits. Staff also participates in community health fairs or other events, each year, providing linguistically appropriate information on developmental steps and early developmental screening.

Evidence Based/ Promising Practice Model Being Used or Adapted:

A nationally recognized evidenced-based patient navigation (PN) model developed by Dr. Harold P. Freeman to reduce health disparities and eliminate barriers to timely diagnosis and treatment of cancer has been adapted for low-income, underserved, rural CSHCN and their families.
CaCoon, a care coordination program that has been recognized as a promising practice by the Association of Maternal & Child Health Programs (AMCHP) is being utilized to guide Public Health Nurses as they work with families to determine family needs and priorities and to develop a care plan.

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West Virginia

Future Generations

Grant Number:	D04RH28374					
Organization Type:	501c3 non-profit organization					
Grantee Organization Information:	Name:	Future Generations				
	Address:	390 Road Less Traveled				
	City:	Franklin	State:	WV	Zip code:	26807
	Tel #:	304-358-2000				
	Website:	www.future.org				
Primary Contact Information:	Name:	Nicky Fadley				
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	Email:	nfadley@future.org				

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

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Sentara RMH Medical Center*	Rockingham	VA	Hospital system
	Northwestern Community Services Board*	Warren	VA	Public mental health provider
	Shenandoah County Free Clinic*	Shenandoah	VA	Free clinic
	Veterans Community Resources*	Shenandoah	VA	Community-based organization
	United Way of the Northern Shenandoah Valley*	Frederick	VA	Foundation
	Valley Health System*	Frederick	VA	Hospital system

The communities/counties the project serves:	Shenandoah and Page Counties, Virginia

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		Uninsured	
	Pregnant Women		Other: (please describe) Veterans, Guardsmen, and Reservists	X
			Other: (please describe) First responders	X

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

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

Description of the project:

The *PTSD Awareness and Resilience Project* seeks to increase the numbers of individuals with post-traumatic stress disorder (PTSD) who obtain peer and/or professional mental health services and improve their health-related quality of life and wellbeing in Shenandoah and Page Counties, Virginia. It includes a two-pronged approach. The first strategy is to outreach to and engage individuals with PTSD symptoms in peer-led activities and connect them with services. The second strategy is to increase access to mental health services for individuals with PTSD symptoms by strengthening mental health services and raising awareness. The project targets Veterans, citizen soldiers (i.e. National Guardspeople and Reservists), and first responders (i.e. firefighters, emergency medical services (EMS) personnel, and law enforcement). These populations are at higher than average risk for PTSD and other mental and behavioral health issues.

The project will facilitate peer support groups and provide participants peer-led case management services. A Certified Peer Support Specialist will combine facilitated discussion with active excursions, social events, and community service projects. He also will provide participants one-on-one assistance with seeking and navigating mental health and other community services. The project also will recruit and train volunteers as Peer Support Officers further extending the project's reach and sustainability. Additionally, the project partners with a local free clinic to provide participants clinical mental health services and consult with the Peer Support Specialist. Finally, the project will educate mental health service providers, primary care providers, faith leaders, community leaders, and the community at large about PTSD and other mental and behavioral health issues through outreach, an annual Mental Health First Aid training, an annual trauma-informed summit, and mass media.

Evidence Based/ Promising Practice Model Being Used or Adapted:

The program is based on three promising models:

1. The *Peer Support Program* provides veterans with PTSD and substance use disorders peer support groups and one-on-one "engagement visits". The program was developed in early 2012 at the Sonora clinic of the Veterans Administration's Palo Alto Healthcare System in rural California as a clinical demonstration project to augment PTSD care offered by overburdened mental health professionals. The program found that a peer support program could be implemented in a rural area to increase levels of engagement in mental health care for underserved veterans with PTSD and substance use disorder. In the first ten months, 53 veterans used the program and 28 veterans participated in engagement visits. This project bases its peer support groups and case management on this model.

2. The *Buddy-to-Buddy Volunteer Veteran Program* trains volunteer National Guard Veterans to provide active Guardsmen peer support and referrals to resources. Volunteer "Buddies" maintain in contact with Guardsmen, help to identify those with clinical needs, encourage enrollment in treatment programs, and support adherence after starting treatment. This approach is based on the idea that it takes someone who "has been there" and can be trusted to help others overcome cultural barriers to seeking services: "using culture to change culture." Among participants surveyed, more than 20% were referred to formal health care and mental health services. More than half reported using resources or services suggested by their Buddy. This project bases its volunteer Peer Support Officers on this model.

3. The *Arkansas Yellow Ribbon Task Force* program developed partnerships between the Central Arkansas Veterans Healthcare System and community stakeholder groups to promote and encourage engagement in mental health care for Veterans. This program also targets rural communities with few mental health providers and where anonymity is difficult when seeking out mental health care. The program provided training to clergy, criminal justice personnel, and postsecondary educators on psychosocial issues of Afghanistan and Iraq veterans and services available to them. Combining these efforts under one initiative was found to increase the likelihood of rural Veterans coming into contact with individuals in their community who could connect them with services. This project bases its community education approach on this model.

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Wisconsin

Prairie du Chien Memorial Hospital Association DBA Crossing Rivers Health

Grant Number:	D04RH28427					
Organization Type:	Critical Access Hospital					
Grantee Organization Information:	Name:	Prairie du Chien Memorial Hospital Association DBA Crossing Rivers Health				
	Address:	37868 US Hwy 18				
	City:	Prairie du Chien	State:	WI	Zip code:	53821
	Tel #:	608-357-2000				
	Website:	www.crossingrivers.org				
Primary Contact Information:	Name:	Rick Peterson				
	Title:	Project Director				
	Tel #:	608-357-2087				
	Email:	Rick.peterson@crossingrivers.org				

Expected funding level for each budget period:	Month/Year to Month/Year	Amount Funded Per Year
	May 2015 to Apr 2016	$200,000
	May 2016 to Apr 2017	$196,223
	May 2017 to Apr 2018	$193,702

Consortium Partners:	Partner Organization *Indicates partners who have signed a Memorandum of Understanding	County	State	Organization Type
	Prairie du Chien Memorial Hospital Association d/b/a Crossing Rivers Health*	Crawford	WI	Critical Access Hospital
	Crawford County Human Services*	Crawford	WI	Human Services
	Richland County Health and Human Services*	Richland	WI	Human Services
	Rural Wisconsin Health Cooperative	Sauk (Serves 30 Counties)	WI	Rural Health Advocate

The communities/counties the project serves:	Crawford, Richland and parts of Grant County, Wisconsin

The target population served:	Population	Yes	Population	Yes
	Infants		Caucasians	X
	Pre-school Children		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	X	Other: (please describe)	
			Other: (please describe)	

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

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

Description of the project:

Prairie du Chien Memorial Hospital, doing business as Crossing Rivers Health (CRH) (with a hospital and two clinics serving rural Wisconsin), has partnered with Crawford County Health and Human Services Department and Richland County Health and Human Services Department (serving rural Wisconsin), to design and implement a much-needed telemedicine system that will dramatically enhance the availability of specialized mental health services accessible in remote, rural locations throughout Wisconsin. Telemedicine networks will dramatically reduce travel time requirements for both patients and doctors, focusing on improving access to much-needed psychiatric and behavioral health services.

The initiative will improve health outcomes of patients with mental health issues, and increase knowledge levels about the functionality of Telemedicine to support primary and specialty health care with providers, patients, and consumers. The project budget has been designed to support full-scale sustainability, ensuring all required technology and equipment necessary for implementation are purchased and utilized during the initial project period. Over three years, our consortium will serve at least 1,500 patients through Telemedicine capabilities. Each patient will be tracked throughout their participation, revealing a picture of progress, care received, medicines prescribed, and status updates. Baseline measures will be collected (demographics, PIMS, project-specific measures), with ongoing monitoring occurring every 90 days for individual screening. Technology will facilitate the comparison of resulting clinical results by sub-group (gender, age, insurance status), enabling the consortium to measure differences in impact among unique population sectors. These communities in rural SW Wisconsin have been identified as Health Professional Shortage Areas for mental health services. A full-time Psychiatrist will be hired to address this critical gap in services. The new Psychiatrist will divide their time among five unique sites, managing a caseload of approximately 1,250 unique patients.

The addition of telemedicine technologies will enhance both the depth and the breadth of these planned services – permitting the Psychiatrist and existing mental health care staff to work with patients in crisis virtually over a secure network, eliminating the barrier of transportation for patients AND mental health providers. Telemedicine will allow patients to have more frequent contact with their clinician, and will dramatically reduce the waiting time for those wishing to schedule an immediate appointment. These technologies have the potential to dramatically improve health outcomes for patients suffering from mental health issues in rural, remote communities.

Evidence Based/ Promising Practice Model Being Used or Adapted:

Mental Health through Telemedicine is a replication of the "Telemedicine-Based Collaborative Care" model described on SAMHSA's National Registry of Evidenced-based Programs and Practices. Although modifications to implementation will be made to meet the specific needs of the targeted community, these strategies represent additions and expansions to existing strategies. Modifications include:
Serving youth through telemedicine
Linking project activities to expanded outreach and education
Linking project activities to expanded offerings of free mental health screenings

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