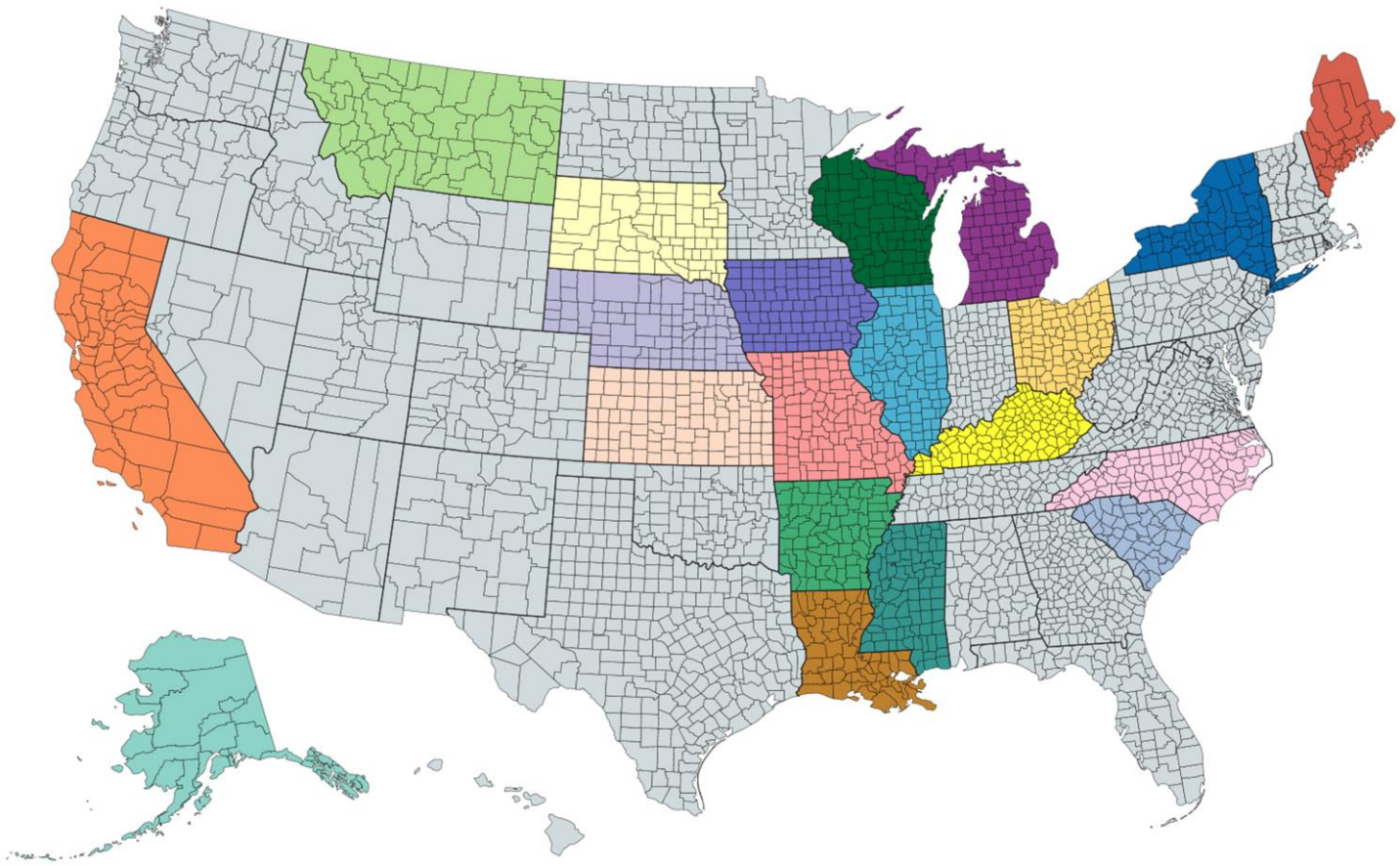
Grantee Directory

Small Health Care Provider Quality Improvement Program

2016 - 2019



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

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Grantee Directory

Small Health Care Provider Quality Improvement Program

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

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

While many quality improvement initiatives focus on inpatient and hospital care, quality improvement is also needed in the primary care environment. Timely disease treatment and management in the outpatient setting can improve patient health and decrease costs by preventing emergency care and hospital admissions.

Organizations participating in the three-year Rural Quality Grant Program are required to utilize an evidence-based quality improvement model, perform tests of change focused on improvement, and use health information technology (HIT) to collect and report data on quality and cost. The ultimate goal of the program is to promote the development of an evidenced-based culture and delivery of coordinated care among medical team and provider entities in the primary care setting. Additional objectives of the program also include: improved health outcomes for patients; enhanced chronic disease management; and better engagement of patients and their caregivers.

This directory provides contact information and a brief overview of the thirty two-initiatives funded under the Small Healthcare Provider Quality Improvement Grant Program's 2016-2019 funding cycle.

2016 - 2019 Small Health Care Provider Quality Improvement Program Grant Ricipients
(Listed by State)

State	Grant Organization Name	Project Officer	Technical Assistance Consultant	Page
Alaska				
	Cross Road Medical Center	Katherine Lloyd	Eric Baumgartner	1
	Providence Kodiak Island Medical Center	Katherine Lloyd	Tanisa Adimu	3
Arkansas				
	Arcare	Katherine Lloyd	Karen Wakeford	5
	Daughters of Charity Services of Arkansas	Salamatu Barrie	Amanda Phillips Martinez	6
California				
	Adventist Health System (Feather River Hospital)	Salamatu Barrie	Lisa McGarrie	7
	Hi-Desert Memorial Health Care District	Michael Blodgett	Wade Hanna	8
	Mountain & Community Health	Katherine Lloyd	Wade Hanna	10
Illinois				
	Clay County Hospital	Michael Blodgett	Deana Farmer	12
	Sarah Bush Lincoln Health Center	Salamatu Barrie	Lisa McGarrie	14
Iowa				
	Sanford Health Network dba Sanford Sheldon Medical Center	Katherine Lloyd	Catherine Liemohn	16
Kansas				
	Greeley County Health Services, Inc.	Salamatu Barrie	Wade Hanna	18
Kentucky				
	Mercy Health Partners of Southwest Ohio (Marcum & Wallace Memorial Hospital)	Katherine Lloyd	John Butts	20
Louisiana				
	Winn Community Health Center	Michael Blodgett	Deana Farmer	22
Maine				
	Cary Medical Center	Katherine Lloyd	Lisa McGarrie	24
	Pines Health Services	Katherine Lloyd	Wade Hanna	26
Michigan				
	Northwest Michigan Health Services, Inc. (NMHSI)	Michael Blodgett	Wade Hanna	28
	Upper Peninsula Health Care Solutions, Inc.	Salamatu Barrie	Catherine Liemohn	30
Mississippi				
	Delta Health Alliance	Katherine Lloyd	Karen Wakeford	32
Missouri				
	Cox Monett Hospital	Salamatu Barrie	Catherine Liemohn	34
	Great Mines Health Center (GMHC)	Katherine Lloyd	Eric Baumgartner	36
	Washington County Memorial Hospital	Katherine Lloyd	Tanisa Adimu	38
Montana				
	Central Montana Medical Facilities, Inc. (Central Montana Medical Center (CMMC))	Michael Blodgett	Catherine Liemohn	40
Nebraska				
	Santee Sioux Tribe of Nebraska (Santee Health and Wellness Center)	Katherine Lloyd	Eric Baumgartner	42
New York				
	Bassett, Mary Imogene Hospital	Michael Blodgett	Eric Baumgartner	44
North Carolina				
	Granville Vance District Health Department	Katherine Lloyd	Catherine Liemohn	46
	Roanoke Valley Health Services, Inc.	Katherine Lloyd	Amanda Phillips Martinez	48
	St. Luke's Hospital, Inc. (Foothills Health Network)	Michael Blodgett	Lisa McGarrie	49
Ohio				
	Holmes County General Health District	Michael Blodgett	Eric Baumgartner	51
	Trinity Hospital Twin City	Michael Blodgett	Beverly Tyler	53
South Carolina				
	CareSouth Carolina, Inc.	Katherine Lloyd	Lisa McGarrie	55
South Dakota				
	Avera Queen of Peace	Katherine Lloyd	Catherine Liemohn	57

State	Grant Organization Name	Project Officer	Technical Assistance Consultant	Page
Wisconsin				
	Shawano Medical Center, Inc.	Katherine Lloyd	Tamanna Patel	59

Alaska

Grant Number	G20RH30591					
Grantee Organization Name	Cross Road Medical Center					
Organization	Federally Qualified Health Center					
Address	P.O. Box 5					
	City:	Glennallen	State:	Alaska	Zip-code:	99588
Grantee organization website	www.crossroadmc.org					
Grantee Project Director	Name:	Sherri Cox				
	Title:	Clinical Manager/Director of Nursing				
	Phone:	907-822-3203				
	Fax:	907-822-5805				
	Email:	scox@crossroadmc.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/01/2016 to 07/31/2017	$177,000
	08/01/2017 to 07/31/2018	$177,000
	08/01/2018 to 07/31/2019	$177,000

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

The communities/counties served through the grant-funded Quality Improvement intervention	The Valdez-Cordova, AK Census Area which includes: Chistochina, Chitina, Copper Center, Copperville, Gakona, Glennallen, Gulkana, Kenny Lake , Lake Louise, McCarthy, Mendeltna, Mentasta Lake, Nelchina, Paxson, Silver Springs, Slana, Tazlina, Tolsona, Tonsina, Willow Creek
The target population served	Patients with cancer, heart disease, stroke, lower respiratory disease, unintentional injuries and deaths, suicide
Focus Area(s)	Preventive health services, health education and routine screening and monitoring of key risk factors such as smoking status and readiness to quit, A1c blood sugar levels, cholesterol levels, obesity, diet/nutrition, Body Mass Index, exercise levels, blood pressure, hypertension, and cardiovascular disease, screening for substance use and mental health conditions is also needed
Health Information Technology System	SuccessEHS
Quality Improvement Model(s)	PDSA
Telemedicine/Mobile Health Technology	N/A
Quality Improvement Project Goal	Provide focused health care management and Patient Navigation for high-risk patients through the span of preventative health care, primary care, transitions to higher levels of care, and then transition back to their home community.
Description of the Quality Improvement project	Cross Roads Medical Center (CRMC) will enhance the training of our RN Care Coordinators to include Patient Navigation in order to build upon the care provided to our patient population. We see these enhanced services as benefitting all of our patients but in particular, the focus will be on our high-risk patients. CRMC defines high-risk patients as those who have one or more of the following factors and for whom we are their primary care provider. Factors include diabetes diagnosis, hypertension diagnosis, depression diagnosis, age over 75 years, two (2) or more MedEvacs in the past year, Comfort One status, and frailty. These patients have received the basic foundational care as laid out in Patient Centered Medical Home. However, due to the unique rural characteristics of our community which creates a health disparity for this population, we see the need for enhanced and focused services in three particular areas. Though we have always provided basic preventative health education, the culture of our community resists health

	information and, particularly, any chronic disease self-management education we have tried. The first area of our focus will be on preventative health education to be provided in a culturally relevant, sensitive manner. We will network with other Alaskan Care Coordinators/health care coaches in order to find rural Alaskan tools and methods for preventative health care education. In addition to providing health education to our current high-risk patients, we plan to provide this education to the wider community in order to reach chronic disease patients who may not already be coming to our health center or who may not already see us as their primary care provider. The outcomes we anticipate from this relevant health education to be a more informed high-risk patient population able to engage in their care planning. The second area of focus for our grant activities will be to build upon our strong foundation of primary care visit preparation and care planning. We propose to take our care planning to a more focused level with our high-risk patients. Though we have basic care plans for this population, we can see the need to enhance our expertise in Patient Navigation done in a culturally sensitive manner within our unique patient culture. Again, we hope to enhance the training of our RN Care Coordinators by networking with other experienced rural Patient Navigators. We feel the missing piece is in the area of true patient engagement with the care planning process. The benefits of this will be qualitative patients' stories, but we hope that it will also translate into small increases in our clinic performance measures as patients see our RN Care Coordinators and clinical team as a key part of their health process. The third area of focus involves transitions to higher levels of care and then back to the community. We have the foundations in place to follow referrals and also follow hospitalizations of our patients, obtaining records after the hospitalization. However, we can see the need to complete the circle by following up with our patients after they have been to a specialist or hospital. In keeping with the culture of an independent spirit, we often leave it up to the patient to book follow-up visits but this can result in large delays and miscommunication. We plan to train our RN Care Coordinators in the principles of Patient Navigation. We recognize we will have to remain culturally sensitive to our uniquely rural and independent culture. We will utilize networking with Alaskan Patient Navigators as well as our key referral hospitals to give us the tools to see improvement in this area. We anticipate the positive outcomes of this to be reduced emergency department visits and reduced 30-day hospital readmission rates for our high-risk patients. By achieving improvements in these three focus areas, we expect an enhanced level of patient care and coordination. We began this process with the 2012 Small Health Care Provider Quality Improvement Program Grant and a solid foundation for quality care was built. This program will refine the level of patient care for a focused population, our high-risk patients, and stretch us to provide solid Patient Navigation within a patient-relevant, culturally sensitive framework.

Alaska

Grant Number	G20RH30137					
Grantee Organization Name	Providence Kodiak Island Medical Center					
Organization type	Critical Access Hospital					
Address	1915 Rezanof Drive					
	City:	Kodiak	State:	Alaska	Zip-code:	99615
Grantee organization website	http://alaska.providence.org/locations/p/pkimc					
Grantee Project Director ***(primary contact person for your grant)***	Name:	LeeAnn Horn				
	Title:	Director of Senior Services				
	Phone:	907-212-6285				
	Fax:	N/A				
	Email:	Leeann.Horn@providence.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Providence Valdez Medical Center	Valdez, AK	Critical Access Hospital
	Valdez Medical Clinic	Valdez, AK	Clinic
	Providence Seward Medical Center	Seward, AK	Critical Access Hospital
	Seward Community Health Center	Seward, AK	Federally Qualified Health Center
	Kodiak Community Health Center	Kodiak, AK	Federally Qualified Health Center
	Anchorage Neighborhood Health Center	Anchorage, AK	Federally Qualified Health Center
	Providence Family Medicine Center	Anchorage, AK	Clinic
	Providence Senior Care Center	Anchorage, AK	Clinic
	Providence Alaska Medical Center	Anchorage, AK	Hospital

The communities/counties served through the grant-funded Quality Improvement intervention	Kodiak	Seward
	Valdez	Anchorage
The target population served	Patients with chronic disease, Patients with one or more emergency department visits related to a chronic disease, 55 years old or older	
Focus Area(s)	Care Management, Care Coordination	
Health Information Technology System	Epic, Greenway Intergy, EMDS, Alaska HIE	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The purpose of the consortium is to create a shared learning environment that promotes the exchange of best practices in care coordination, data sharing, and quality improvement with goals of: improved health status, seamless transitions of	

	care, and decreased hospital utilization.
Description of the Quality Improvement project	The project uses the Patient-Centered Medical Home model, the Chronic Care Model, and Duke University's Population Care Coordination mode to guide integrated quality improvement activities within each practice site. The project's target population is up to 350 high-risk older adults with multiple chronic conditions who overuse high-cost hospital care directly due to poorly managed chronic conditions. Quality improvement programs at each site will focus on elements, such as: coordination of care; provision of patient-centered care; use of multidisciplinary teams; collaboration and partnerships; the ability to collect, report and use data for quality improvement; participation in payment incentive programs; tracking utilization; and integration of the social determinants of health. By the end of the three year grant, the consortium hopes to demonstrate an improvement in reported outcome measures as a result of the implementation of evidence-based coordinated activities at each practice site. Additionally, the consortium hopes to influence health care systems change to improve the health of individuals with multiple chronic conditions and remove barriers that impede successful navigation of the patient across multiple settings, as well as timely exchange and use of health information technology.

Arkansas

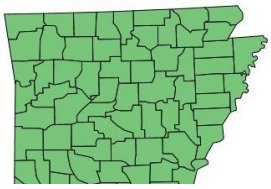
Grant Number	G20RH30123					
Grantee Organization Name	ARcare					
Organization type	Federally Qualified Health Center					
Address	117 South 2nd Street					
	City:	Augusta	State:	Arkansas	Zip-code:	72006
Grantee organization website	N/A					
Grantee Project Director	Name:	Emerson Goodwin				
	Title:	Corporate Regional Director				
	Phone:	270-908-4252				
	Fax:	270-908-4506				
	Email:	emerson.goodwin@arcare.net				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$199,611
	08/01/2017 to 07/31/2018	$199,265
	08/01/2018 to 07/31/2019	$199,447

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

The communities/counties served through the grant-funded Quality Improvement intervention		
	Ballard County, KY	Graves County, KY
	Calloway County, KY	Hickman County, KY
	Carlisle County, KY	Marshall County, KY
	Fulton County, KY	McCracken County, KY
The target population served	Patients with chronic conditions	
Health Information Technology System	Success EHS – Greenway	
Quality Improvement Model(s)	AADE Chronic Care Model, PCMH	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The overarching goal of the *KentuckyCare Chronic Disease Program* is to improve health outcomes and quality of life for residents with chronic disease conditions. Through the KentuckyCare Chronic Disease Program, we hope to develop and implement a care coordination system for patients with chronic disease conditions in the service area.	
Description of the Quality Improvement project	The purpose of this program is to expand the evidenced-based model used in our Arkansas primary care system and incorporate in all of our KentuckyCare clinics the systematic delivery of care and health outcomes for patients with chronic disease such as Diabetes Mellitus, Cardiovascular Disease, Hypertension, Stroke, and Depression. This action will allow the steps necessary to improve the care delivery by incorporating integration and the care team approach. Health reform supports new ways to coordinate and integrate care with a dual focus on patient outcomes as well as healthier communities. The primary focus of the program is to do the right thing the first time and eliminate duplicative procedures, reduce re-admissions, and achieve better care coordination.	

Arkansas



Grant Number	G20RH30128					
Grantee Organization Name	Daughters of Charity Services of Arkansas					
Organization type	Rural Health Clinic					
Address	161 South Main					
	City:	Dumas	State:	Arkansas	Zip-code:	71639
Grantee organization website	www.Dcsark.org					
Grantee Project Director	Name:	Brenda Jacobs DNP, APRN				
	Title:	CEO				
	Phone:	870-723-0105				
	Fax:	870-382-4895				
	Email:	Brenda.jacobs@dcsark.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$197,002
	08/01/2017 to 07/31/2018	$196,177
	08/01/2018 to 07/31/2019	$196,177

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

The communities/counties served through the grant-funded Quality Improvement intervention		
	Arkansas County	Desha County
	Ashley County	Drew County
	Chicot County	Lincoln County
The target population served	Impoverished patients with chronic diseases	
Focus Area(s)	Chronic Disease Management	NCQA PCMH Certification
Health Information Technology System	SuccessEHS	
Quality Improvement Model(s)	Chronic Care Model	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The goals of this Quality Improvement Project are to: Create the Quality Improvement Infrastructure and set priorities. Redesign Care and Business Systems Implement Quality Improvement, measure, evaluate and adjust	
Description of the Quality Improvement project	Daughters of Charity Services of Arkansas (DCSARK) proposes to use the Quality Improvement Grant funds to transform the practice and culture of two rural clinics through implementation of the Patient Centered Medical Home (PCMH). DCSARK will employ the PCMH model to strengthen current services, improve clinical outcomes, coordinate care by optimizing the SuccessEHS, redesign patient flow, enhance care transitioning, and improve methods and processes to extract meaningful clinical data to manage overall population health. Quality improvement measures will be focused on the target population of patients who are chronically ill with diabetes, hypertension and high cholesterol. Staff will be trained to optimize the EHR to improve data collection and reporting, and will improve communication with other providers and social service organizations in the medical neighborhood to support patients across the continuum of care.	

California

Grant Number	G20RH30122					
Grantee Organization Name	Adventist Health System (Feather River Hospital)					
Organization type	Rural Hospital					
Address	5974 Pentz Rd.					
	City:	Paradise	State:	California	Zip-code:	95969
Grantee organization website	N/A					
Grantee Project Director	Name:	Benjamin Mullin				
	Title:	Cardiopulmonary Director				
	Phone:	530-876-3162				
	Fax:	N/A				
	Email:	mullinbr@ah.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$199,141
	08/01/2017 to 07/31/2018	$195,173
	08/01/2018 to 07/31/2019	$199,935

Network Partners	Organization Name	City/County	Organization Type
	Gary Bess Associates	Paradise	Grant management

The communities/counties served through the grant-funded Quality Improvement intervention	Butte County, CA	Oroville, CA
	Chico, CA	Paradise, CA
	Magalia, CA	
The target population served	Elderly patients with chronic lung disease	
Focus Area(s)	Chronic Obstructive Pulmonary Disease	
Health Information Technology System	Cerner	
Quality Improvement Model(s)	PDCA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	Reduce Chronic Obstructive Pulmonary Disease (COPD) readmission rates substantially and improve patient education and medication compliance.	
Description of the Quality Improvement project	A program is being implemented that closely mirrors the Reversible Obstructive Airway Disease (ROAD) program at UC Davis Medical Center in Sacramento, CA. This program focuses on COPD patients specifically, including focused education for patients on disease processes and treatment, medication evaluation, and rehabilitation. Initially, the program will focus on inpatients at Feather River Hospital, a 100 bed rural hospital. Thereafter, Emergency Department patients and outpatients will be included. A COPD support group is added at the community level to increase disease awareness in the community. Smoking cessation is also encouraged through the program. Goals of the project include: a marked decrease in COPD patients being readmitted to the hospital within 30 days; improved quality of life scores for participants; and improved networking with community members and primary care physicians.	

California

Grant Number	G20RH30131					
Grantee Organization Name	Hi-Desert Memorial Health Care District					
Organization type	Federally Qualified Health Center					
Address	6530 La Contenta Road #100					
	City:	Yucca Valley	State:	California	Zip-code:	92284
Grantee organization website	http://www.mbhdistrict.org/					
Grantee Project Director	Name:	Kathy Alkire				
	Title:	Operation Director				
	Phone:	760-820-9223				
	Fax:	760-366-1544				
	Email:	kalkire@hidesertclinics.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Hi-Desert Medical Center	Joshua Tree	Hospital
	San Bernardino County Fire	Morongo Basin	County Fire
	Morongo Basin Haven	Morongo Basin	Non-Profit
	Morongo Basin Care Transition Program	Morongo Basin	Comm. Resource
	Center for Healthy Generations	Yucca Valley	Non-Profit

The communities/counties served through the grant-funded Quality Improvement intervention		
	Johnson Valley	Pioneertown
	Joshua Tree	Twentynine Palms
	Landers	Wonder Valley
	Morongo Valley	Yucca Valley

The target population served	Economically disadvantaged children, adolescents, and adults with one or more high risk, high utilization chronic diseases (defined by Performance Improvement Measurement System/National Quality Forum)	
Focus Area(s)	Care coordination	Emergency room visits and hospitalization prevention
	Case Management	Rural Resource Network formation
	Chronic illness	
Health Information Technology System	eMDs	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology)	N/A	
Quality Improvement Project Goal	Goals of this project include the development of a rural health network designed to better address population disease management, a reduction in Emergency Department (ED) visits and 30-day preventable hospital readmissions, and improvement upon the effectiveness of current health care services.	

Description of the Quality Improvement project	The project will address quality assurance and performance improvement gaps and improve the processes of delivering high-quality patient care in order to improve the well-being and quality of life of the communities we serve. By designing and implementing quality improvement strategies, we will be able to improve health care delivery. These quality improvement strategies include identification of key drivers of ED visits and 30-day readmissions, gap analysis of quality indicators and use of the Chronic Care Model transitioning to the Coleman Transitions Intervention Model to emphasize evidence-based, integrated, collaborative chronic care. Through development of a strategic plan, this project will also be used to strengthen and promote care strategies designed for long-term sustainability. Implementation of new electronic health record components will provide data which can be used to self-evaluate and monitor the changing needs of the service area. Further training of staff will be provided to better equip clinicians with the knowledge and skills to serve the unique and complex needs of the target population.

California

Grant Number	G20RH30134					
Grantee Organization Name	Mountain & Community Health					
Organization type	Federally Qualified Health Center					
Address	31115 Highway 94					
	City:	Campo	State:	California	Zip-code:	91906
Grantee organization website	http://www.mtnhealth.org/					
Grantee Project Director	Name:	Shannon Crowell, RN, MSN, MHA, PHN				
	Title:	Director of Nursing and Quality				
	Phone:	619-445-4026 Ext. 128				
	Fax:	619-478-9164				
	Email:	scrowell@mtnhealth.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

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

The communities/counties served through the grant-funded Quality Improvement intervention	Mountain Empire region (eastern San Diego County) including the communities of Bankhead Springs, Boulder Oaks, Boulevard, Buckman Springs, Campo, Descanso, Guatay, Jacumba, Lake Morena Village, Mount Laguna, Pine Valley, Potrero, Tecate, and Tierra Del Sol	
The target population served	Persons/families at or below 200% of the federal poverty level, and patients with chronic conditions including diabetes, Chronic Obstructive Pulmonary Disease (COPD), cancer, and coronary disease	
Focus Area(s)	Diabetes Management HgbA1c controlled to normal	Depression screening will receive counseling and/or pharmaceutical management
	Coronary Artery Disease Lipid controlled to normal level	Tobacco Use –Counseling for cessation
	Elevated Body Mass Index and counseling for weight control	Hypertension reduction to normal level
Health Information Technology System	NextGen	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	To develop internal quality analysis and quality improvement practices and tools that will help us to capture and identify areas where we need to do more for our patients, and showcase what we are doing right, and how it is benefiting our patients. To improve our patients' health through early access, education and treatment and to continuously monitor our ability to manage our patient care through accurate retrieval of quality data from our electronic medical record system. To share our best practices within our health care community for the overall health of all living in the rural areas of San Diego county.	

Description of the Quality Improvement project	Implement a training program at Mountain Health focused on Patient Centered Care. Creation of a written patient-centered screening tool to be used to guide clinical staff in the development of an individualized patient care plan considering the psycho-social aspects and the patient's health care desires. Develop a screening tool that provides an assessment of the patient's goals for their own health, the patient's motivation to attain these goals and any barriers present preventing the patient from meeting these goals. Redesign of the clinical team workflow to Design patient care flow and training plan that will reutilize the current clinical team to promote individualized care, individualized prevention and education using Next Gen Care Guidelines, Preventative Health Standard of Practice and the How Are You form. The Huddle communication tool includes graphing to see patient improvement and for the patient to visualize how they are doing with chronic disease management concerns; i.e. Diabetic and HgbA1c mapping. Creation of patient-centered teams-redesign of patient work flow, screening tools, Next Gen workflows and updated huddle communication tools. Implement annual C.A.R.E (Connect, Appreciate, Respond, and Empower) training curriculum that trains clinical staff on methods to more fully engage patients in their care plan. A central outcome of this is to be sure that all staff at Mountain Health have the appropriate training to be the best advocate for the patient. To create a structured preventative health education program and prevention plan for each patient suffering and especially patients with chronic disease management concerns. Develop a patient recording tool (e.g. log for diabetics, asthmatics, HTN and obesity) for patients to monitor their numbers and add an alert to our electronic health record.

Illinois

Grant Number	G20RH30126					
Grantee Organization Name	Clay County Hospital					
Organization type	Critical Access Hospital					
Address	911 Stacy Burk Drive					
	City:	Flora	State:	Illinois	Zip-code:	62839
Grantee organization website	www.claycountyhospital.org					
Grantee Project Director	Name:	Ariane Souder				
	Title:	Clinic Business Manager				
	Phone:	618-844-3076				
	Fax:	618-662-8090				
	Email:	Ariane.souder@claycountyhospital.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

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

The communities/counties served through the grant-funded Quality Improvement intervention		
	Clay County	Richland County
	Effingham County	Wayne County
	Marion County	
The target population served	Medicare patients with two or more chronic conditions	
Focus Area(s)	Providing case management, education and self-management assistance for Medicare patients with two or more chronic conditions	
Health Information Technology System	Nextgen, Medhost	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The goals of our chronic care program are as follows: • Improve care delivery for patients • Provide appropriate services to patients with chronic illness(es) • Deliver coordinated care to patients	

Description of the Quality Improvement project	The purpose of the Chronic Care program is to improve patient outcomes and reduce costs due to unnecessary ER visits and hospital readmissions. This will be accomplished by utilizing the evidence based Chronic Care Model to enhance current population health initiatives. ACO (Physicians Accountable Care Solutions) participation will further strengthen the program. The goals and expected outcomes of the program are:
	• Improve care delivery for patients
	  ○ Consistent and technically competent practices are established
	• Provide appropriate services to patients with chronic illness(es)
	  ○ Improved patient engagement and shared decision making
	  ○ Improved patient outcomes
	  ○ Increased access to healthcare services
	  ○ Enhanced communication among patient care team
	• Deliver coordinated care to patients
	  ○ Greater integration of healthcare services
	  ○ Lower healthcare costs
	
	The current state of healthcare delivery can be characterized by fragmentation in the delivery of services, high cost, and limited access to healthcare. The proposed Chronic Care Program supports healthcare delivery system reform through case management of patients with chronic illness to ensure coordination of care and access to healthcare services, while focusing on quality and cost of services rendered through ACO participation.
	
	The Chronic Care Model calls for a structural change from an acute care mindset to one of chronic disease where the typical patient needs more healthcare services, tools for self-management of medications and condition, and assistance with coordination of care. This model applies to a broad range of chronic illnesses. It is proactive and patient centered. This six elements of the model are:
	
	1. Organization – Clay County Hospital
	2. Clinical Information System – Medhost and Nexgen
	3. Decision Support – Individualized comprehensive care plan congruent with the patient's needs, choices, and values documented in Information Systems.
	4. Delivery System Design – Three RN's, case management, patients with chronic disease, enhanced communication between healthcare provider, care team, patient, and caregivers.
	5. Self-management Support – Emphasizes patient's role in managing health. Assistance provided for medication reconciliation and management, preventative services reminder and care coordination.
	6. Community – Links community resources that support healthcare efforts by clinicians.
	
	The Chronic Care Program uses Nextgen at the Clinics and Medhost at the hospital for data collection and reporting. The system facilitates and promotes exchange of information between providers and patients. Medhost will be used for pulling information related to Emergency Department visits and inpatient stays at the hospital.
	
	Sustainability will be achieved by continuous monitoring of both compliance and improvement outcomes. Patient and provider feedback will also be considered and acted upon to make the program work for both parties.

Illinois

Grant Number	G20RH30138					
Grantee Organization Name	Sarah Bush Lincoln Health Center					
Organization type	Non-profit hospital					
Address	1000 Health Center Drive					
	City:	Mattoon	State:	Illinois	Zip-code:	61938
Grantee organization website	https://www.sarahbush.org/					
Grantee Project Director	Name:	Carol Ray, RN				
	Title:	Director of Coordinated Care				
	Phone:	217-258-2404				
	Fax:	217-348-4113				
	Email:	cray@sblhs.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$190,235
	08/01/2017 to 07/31/2018	$185,410
	08/01/2018 to 07/31/2019	$190,297

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

The communities/counties served through the grant-funded Quality Improvement intervention	Clark County	Effingham County
	Coles County	Jasper County
	Cumberland County	Moultrie County
	Douglas County	Shelby County
	Edgar County	
The target population served	Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disorder (COPD) Family Medical Center patients who have at least one other chronic condition and two condition-related hospital uses (admission or ED) in the past 12 months	
Focus Area(s)	Care Coordination	Motivational Interviewing (coaching)
	CHF, COPD	Patient Engagement (PAM tool)
Health Information Technology System	Cerner Millennium®	
Quality Improvement Model(s)	LEAN	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	By supporting transitions of care and increasing engagement among CHF and COPD patients seen in an ambulatory care setting, Sarah Bush Lincoln (SBL) will improve patient self-management and reduce ED visits and hospital readmissions.	

Description of the Quality Improvement project	An embedded Care Coordination team will support care transitions, engage patients in a collaborative process to develop a care plan which reflects the patient values and priorities, and apply Motivational Interviewing to encourage the adoption of effective self-management techniques. In addition, the project will use the organization's robust integrated health care information system to share information across the care team and with the hospital and to gather data for project monitoring and self-assessment. By supporting transitions of care and increasing engagement among CHF and COPD patients seen in an ambulatory care setting, SBL will improve patient self-management and reduce ED visits and hospital readmissions. The proposed activities support the following objectives: • Within six months of the project start date, SBL will enhance organizational resources and strengthen the skills of the Care Coordination team in using tools for sharing health information, assessing patient needs, and using Motivational Interviewing strategies. • By the end of the project period, 25 percent of the enrolled population will maintain or improve in one or more of the following measures: patient activation, self-management behaviors (SF-12 scores), optimal medication management (medication reconciliation and adherence), and clinical quality measures. • The annual percent of 30-day unplanned readmissions by the care-coordinated population will be equal to or less than the organization's target for FY 16 (21.1 percent for CHF; 15.5 percent for COPD), and the number of ED visits will be reduced. A favorable case for project replication or expansion will be made, based on improved health outcomes and reduced hospital use by the target population.

Iowa

Grant Number	G2ORH30546					
Grantee Organization Name	Sanford Health Network dba Sanford Sheldon Medical Center					
Organization type	Critical Access Hospital					
Address	118 N 7th Ave					
	City:	Sheldon	State:	Iowa	Zip-code:	51201
Grantee organization website	www.sanfordhealth.org					
Grantee Project Director	Name:	Steve DeVoe				
	Title:	Clinic Director				
	Phone:	712-324-6513				
	Fax:	712-324-6515				
	Email:	Steven.devoe@sanfordhealth.org				
Project Period	2016 – 2019					

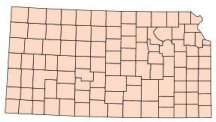
Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/01/2016 to 07/31/2017	$194,181
	08/01/2017 to 07/31/2018	$199,551
	08/01/2018 to 07/31/2019	$199,999

Network Partners	Organization Name	City/County	Organization Type
	Sanford Bagley Medical Center (MN)	Bagley/Clearwater	CAH
	Sanford Mahnomen Clinic (MN)	Mahnomen/ Mahnomen	Rural Health Clinic

The communities/counties served through the grant-funded Quality Improvement intervention	Communities: Sheldon, IA, Bagley, MN, Mahnomen, MN	Counties: O'Brien and Sioux, IA, Clearwater and Mahnomen, MN
The target population served	Patients with chronic disease	
Focus Area(s)	Diabetes, Hypertension, Cardiovascular Disease, and Behavioral Health	
Health Information Technology System	EPIC	
Quality Improvement Model(s)	PDSA, Lean, Six-Sigma, Just Culture, Root-Cause Analysis	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The goal of the project is to create partnerships for healthier communities to improve chronic disease outcomes.	

Description of the Quality Improvement project	The quality improvement project involves the adoption of a patient-centered advanced integrated medical home model in each consortium site. The advanced medical home model aligns with delivery system reform and focuses on care delivery, information and incentives. Sanford intends to promote the development of an evidence-based culture and delivery of coordinated care in the primary care setting. The patient-centered advanced integrated medical home model captures integration of behavioral health, coordination of care across the continuum, standardization to reduce variability, optimization of physical and digital environments and communication to assign the system. The physician-led team focuses on improving care delivery by implementing new ways to coordinate and integrate care. A key component is the make-up of the teams. The core team consists of a physician or APP, RN Health Coach, Integrated Health Therapist, Panel Manager, nurses, and pharmacists. This brings key talents from a number of individuals with shift toward shared patient care that ensures that care is provided by the right person at the right time. With a focus on improving chronic disease outcomes, the core team will collaboratively work together to help patients manage chronic diseases such as diabetes, hypertension, cardiovascular disease and behavioral health. In addition, the use of project management tools Sanford is committed to create partnerships for healthier communities to improve chronic disease outcomes.

Kansas



Grant Number	G20RH30130					
Grantee Organization Name	Greeley County Health Services, Inc.					
Organization type	Critical Access Hospital					
Address	506 East Third Street					
	City:	Tribune	State:	Kansas	Zip	67879
Grantee organization website	www.mygchs.com					
Grantee Project Director	Name:	Chrysanne Grund				
	Title:	Project Director				
	Phone:	785-821-1104				
	Fax:	785-852-4364				
	Email:	cgrund@mygchs.com				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$144,475
	08/01/2017 to 07/31/2018	$136,070
	08/01/2018 to 07/31/2019	$130,070

Network Partners	Organization Name	City/County	Organization Type
	Greeley-Wallace Co Healthcare Foundation	Sharon Springs, Wallace	Foundation
	Greeley County Health Department	Tribune/Greeley	Health Dept.
	Wallace County Health Department	Sharon Springs / Wallace	Health Dept.
	Compass Behavioral Health	Southwest KS	Area Mental Health
	Dixon Drug Store	Tribune/Greeley, Sharon Springs/Wallace and Syracuse/ Hamilton, Kansas	Pharmacy

The communities/counties served through the grant-funded Quality Improvement intervention	Greeley and Wallace Counties, Kansas	
The target population served	Rural patients with chronic conditions	
Focus Area(s)	Cardiovascular disease, diabetes, obesity and Patient Centered Medical Homes.	Care Coordination, care management, Health/wellness coaching
Health Information Technology System	Healthland Centriq	
Quality Improvement Model(s)	PDSA, LEAN, Six Sigma	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	We would like to help our patients find their own voice in their healthcare decisions and help them to access care beyond the barriers of time, distance and a confusing health system. We believe the primary care clinic can be the home for these patients and this model is very consistent with the evidenced based guidelines associated with the Patient Centered Medical Home.	

Description of the Quality Improvement project	The primary goal of this work is to improve chronic care management for rural patients and providers through the use of health coaches and care coordination. We will target chronically and seriously ill patients, often a patient population who has a difficult time navigating the rural barriers of distance, health literacy and cost. The project will use the evidenced based quality recommendations to make systematic improvements. We will create effective provider – patient partnerships to improve connectivity and relationships between our health systems and improved patient care. We will effectively use health information systems to better manage patients care. We will create shared systems of learning in our rural network to improve health systems individually and collectively. This project will work closely with local partners such as local health departments to improve public health strategies, education and results.

Kentucky

Grant Number	G20RH30133					
Grantee Organization Name	Mercy Health Partners of Southwest Ohio (Marcum & Wallace Memorial Hospital)					
Organization type	Critical Access Hospital					
Address	60 Mercy Court					
	City:	Irvine	State:	Kentucky	Zip-code:	40336
Grantee organization website	www.marcumandwallace.org					
Grantee Project Director	Name:	John Isfort				
	Title:	Director				
	Phone:	606 -723-2115 Ext. 8210				
	Fax:	606-723-2951				
	Email:	jisfort@mercy.com				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Juniper Health Care	Lee County	FQHC
	Foothills Clinic	Powell County	FQHC
	White House Clinics	Estill County	FQHC
	Estill Medical Clinic, PSC	Estill County	RHC
	Bluegrass.org	Estill/Powell County	Mental Health
	Westcare, Inc.	Estill County	Substance Abuse
	Lee Health Department	Lee County	Public Health
	Estill Health Department	Estill County	Public Health
	Kentucky Homeplace	Lee/Powell/Estill County	CHW initiative
	Hospice Care plus	Estill County	Hospice
	Estill County EMS	Estill County	EMS
	Mercy Health Clinics	Powell/Estill/Lee County	Provider- Based RHC
	US Acute Care Solutions	Estill County	Emergency Medicine Physicians
	Estill County Chamber of Commerce	Estill County	Chamber of Commerce
	Kentucky River Community Care	Lee County	Mental Health

The communities/counties served through the grant-funded Quality Improvement intervention	Estill County: Irvine, Ravenna	
	Lee County: Beattyville, Clay City	
	Powell County: Stanton	
The target population served	Emergency Department (ED) super-utilizers	Patients with chronic conditions
	Inpatients at high risk for readmission	
Focus Area(s)	Asthma	Hypertension
	Congestive Health Failure (CHF)	Behavioral Health/Substance

	Chronic Obstructive Pulmonary Disease (COPD)	Medication Issues
	Diabetes	Care Coordination
Health Information Technology System	Allscripts, NextGen, Paradigm, EPIC, and Avatar	
Quality Improvement Model(s)	Patient Centered Medical Home (PCMH), PDSA, LEAN Six Sigma	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	Utilizing the Chronic Care Model, the Project HOME Network will provide Medication Therapy Management (MTM) services through the integration of Registered Pharmacists within multidisciplinary care teams in ambulatory settings and certified patient-centered medical homes in the three-county service area. Strategies related to this project include leveraging an electronic health record (EHR) to promote: 1) medication reconciliation, 2) medication adherence, 3) patient understanding, and 4) disease control among an at-risk and medically under-served population. The anticipated results of this project include a demonstrable improvement in medication management issues, chronic disease outcomes, emergency department visits and hospitalizations, and patient satisfaction levels.	
Description of the Quality Improvement project	Marcum & Wallace Memorial Hospital (MWMH) is the grantee for the *Small Health Care Provider Quality Improvement Grant* on behalf of the Project HOME (Helpful Opportunities for Medical Care Enhancement) Network. MWMH is a 25 bed Critical Access Hospital (CAH) located in Irvine, Kentucky (Estill County). The Project HOME Network (PHN) was established in 2009 with a focus on collaboration between the Critical Access Hospital and Federally Qualified Health Center (FQHC). In 2012, MWMH received a Rural Health Care Outreach Grant from HRSA's Federal Office of Rural Health Policy. The PHN covers two counties in Eastern Kentucky with a combined population of 22,000 people. Fifteen (15) agencies are members of the network ranging from the Critical Access Hospital to several FQHCs to mental health and rural health clinics. The PHN was awarded $200,000 each year for a total of $600,000 for the development of a Medication Therapy Management Program (MTM). The program is aimed at reducing Emergency Department (ED) visits through the use of MTM. In many cases patients over utilize the ED due to medication issues such as the inability to obtain medication, confusion on how to take the medication, and limited understanding of interactions with other medications. The program will focus on 6 specific chronic health conditions (CHF, diabetes, COPD, asthma, hypertension, and behavioral health) as well as other identified diagnoses. The central focus of the program will use a Registered Pharmacist to meet with ED high utilizers (3 or more visits in previous 30 days) in the Project HOME Network's primary care clinics to provide navigation and education on medication usage and chronic disease management. In addition, the Registered Pharmacist will provide education to Primary Care Providers (PCP) and become an integral member of the health care team. It is anticipated that a decrease in ED visits will occur with the MTM program. In-patient readmissions should decline as well with the Registered Pharmacist serving as a member of the MWMH patient discharge team.	

Louisiana

Grant Number	G20RH30549					
Grantee Organization Name	Winn Community Health Center					
Organization type	Federally Qualified Health Center					
Address	431 W Lafayette Street					
	City:	Winnfield	State:	Louisiana	Zip-code:	71483
Grantee organization website	www.Winnchc.org					
Grantee Project Director	Name:	Deano Thornton				
	Title:	CEO				
	Phone:	318-648-0375				
	Fax:	318-302-3358				
	Email:	Dthornton@winnchc.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Winn Parish School Board	Winnfield	Local public school district
	Winn Parish Medical Center	Winnfield	Hospital
	Winn Community Health Center	Winnfield	FQHC
	LPCA	Baton Rouge	Association of FQHC

The communities/counties served through the grant-funded Quality Improvement intervention	Grant Parish	Winn Parish
The target population served	Patients with chronic conditions/diseases	Elderly
	People living at or below the poverty line	
Focus Area(s)	Chronic Obstructive Pulmonary Disorder (COPD)	Diabetes
	Congestive Health Failure (CHF)	
Health Information Technology System	Complete Medical Solutions My Win Med	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The long term, overarching goal is to improve quality of life for those with chronic disease, decrease the number of work days missed due to chronic disease complications in rural Louisiana, and reduce the disease burden.	

Description of the Quality Improvement project	The Cen-La Healthcare Improvement Partnership (CHIP) will address the growing burden of chronic disease in Winn and Grant Parishes as well as positioning health care providers for the pay for performance environment. This will be done by implementing an evidenced-based depression program named the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) and tailoring it as a co-morbidity solution in the chronic disease environment. Another strategy that will be implemented is health coaching utilizing a Patient Liaison. Health coaching will be utilized to help patients gain the knowledge, skills, tools, and confidence to become active patients in their care so that they can reach their self-identified health goals. The Quality Improvement (QI) Project will include the PDSA methodology currently utilized in the overarching QI Program of Winn Community Health Center, Inc. The objectives of the project will incorporate PDSA's relative to the completion of key action steps and time frames for accompanying them; measuring identified process or outcome measures; tracking evaluation measures; and those responsible for these actions. The objectives include the following: • Implement a community-based chronic care model for service area • Implement national evidence based PEARLS program for depression • Implement Patient Liaison services for patient education and coaching • Implement chronic disease case management • Develop a 5 year strategic plan • Develop a final assessment report & sustainability plan.

Maine

Grant Number	G20RH30540					
Grantee Organization Name	Cary Medical Center					
Organization type	Hospital					
Address	163 Van Buren Rd					
	City:	Caribou	State:	Maine	Zip-code:	04736
Grantee organization website	https://www.carymedicalcenter.org					
Grantee Project Director	Name:	Leslie Anderson				
	Title:	Director, Ancillary Services				
	Phone:	207-498-1204				
	Fax:	207-498-1355				
	Email:	landerson@carymed.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Northern Maine Medical Center	Fort Kent, Aroostook	Hospital
	Houlton Regional Hospital	Houlton, Aroostook	Hospital
	Mount Desert Island Hospital	Bar Harbor, Hancock	Hospital
	St Joseph's Hospital	Bangor, Penobscot	Hospital

The communities/counties served through the grant-funded Quality Improvement intervention	Aroostook County, Maine	Houlton, Maine
	Bangor, Maine	Penobscot County, Maine
	Bar Harbor, Maine	Madawaska, Maine
	Caribou, Maine	New Sweden, Maine
	Fort Kent, Maine	Stockholm, Maine
	Hancock County, Maine	Van Buren, Maine
The target population served	Patients with the chronic disease Chronic Obstructive Pulmonary Disease (COPD)	
Focus Area(s)	COPD	
Health Information Technology System	A large variety of EMR systems across all hospital networks	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	A virtual platform is utilized to assist with conducting meetings between the organizations.	
Quality Improvement Project Goal	The goal is to decrease the re-admission to either inpatient or the emergency department following a transition of care. An additional goal is to empower patients to manage their chronic disease (COPD) independently with outpatient services and support.	

Description of the Quality Improvement project	Our program recognizes that those patients facing the challenges of chronic disease often struggle during transitions of care (inpatient to outpatient). Often these patients and their families do not understand the medication changes encountered during inpatient admit. They also do not understand how to manage symptoms or potential worsening of symptoms independently when at home. This program intends to work with these patients to improve support and management of disease process during transitions of care. The program will work with patients to improve medication management, symptom management and the challenges of transitioning to outpatient care.

Maine

Grant Number	G20RH30136					
Grantee Organization Name	Pines Health Services					
Organization type	Federally Qualified Health Center (FQHC)					
Address	74 Access Highway					
	City:	Caribou	State:	Maine	Zip-code:	04736
Grantee organization website	www.pineshealth.org					
Grantee Project Director	Name:	Theresa Knowles				
	Title:	Chief Quality Officer				
	Phone:	207-992-9200				
	Fax:	N/A				
	Email:	tknowles@pchc.com				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Pines Health Services	Aroostook	FQHC
	Katahdin Valley Health Center	Aroostook	FQHC
	St. Joseph's Hospital	Penobscot	Community Hospital
	DFD Russell	Kennebec	FQHC
	Nasson Health Center	York	FQHC
	Hometown Health Center	Penobscot	FQHC
	Penobscot Community Health Care	Penobscot	FQHC

The communities/counties served through the grant-funded Quality Improvement intervention	Aroostook County	Piscataquis County
	Kennebec County	York County
	Penobscot County	
The target population served	Patients with chronic conditions	
Focus Area(s)	Cardiovascular care, diabetes, depression screening and treatment, care management	
Health Information Technology System	SuccessEHS, Centricity, NextGen, CPSI, Athena	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The focus of this initiative is on supporting rural, primary care providers (all members of the same Accountable Care Organization (ACO), Community Care Partnership of Maine or CCPM) in the planning and implementation of quality improvement activities via evidence-based practices that result in improved outcomes for patients; enhanced chronic disease management; and reductions in in emergency department (ED) visits and hospital admissions/readmissions.	

Description of the Quality Improvement project	Project Goals • Identify process to report on each of the seven Performance Improvement Measurement System (PIMS) performance measures, from a population level, on a quarterly basis. • Develop workflows and processes using aggregated data that will inform and engage individual practice teams and leadership at each site to drive quality improvement, with the help of a performance improvement team. • Utilize patient-level data and predictive modeling software to proactively reach out to patients (particularly high utilization/high-risk individuals) to provide appropriate care and improve quality. • With the help of the performance improvement team, develop "change" teams at each of the participating practices to assist with the adoption of best practices while altering workflows and processes. • Improve the quality of data collection, documentation, and reporting, ultimately standardizing the delivery of care across all settings within the ACO. • Meet or exceed the Healthy People 2020 goals for the associated measures for each of the participating organizations. Expected Outcomes • Improved patient access to standardized, preventive, and chronic disease care using evidenced-based guidelines and best practices for the delivery of that care. • Consistent and sustainable performance improvement standards at each of the ACO practices, resulting in Quality Improvement teams that are truly prepared to continuously improve patient care. • Improved performance on all associated PIMS measures (goal: 10% increase or decrease for each measure) for both individual practice sites and the ACO as a whole.

Michigan

Grant Number	G20RH30135					
Grantee Organization Name	Northwest Michigan Health Services, Inc. (NMHSI)					
Organization type	Federally Qualified Health Center (FQHC)					
Address	10767 E. Traverse Hwy.					
	City:	Traverse City	State:	Michigan	Zip-code:	49684
Grantee organization website	www.nmhsi.org					
Grantee Project Director	Name:	Gwen Williams				
	Title:	Director of Programs				
	Phone:	231-861-2130				
	Fax:	231-861-4964				
	Email:	gwilliams@nmhsi.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Michigan Public Health Institute	Michigan	Non-Profit
	Altarum Institute / Michigan Center for Effective IT Adoption (M-CEITA)	Michigan	Non-Profit
	Great Lakes Practice Transformation Network	Michigan	Non-Profit
	Great Lakes Health Connect	Michigan	Non-Profit
	Michigan Quality Improvement Network (MQIN) / Michigan Primary Care Association	Michigan	Non-Profit

The communities/counties served through the grant-funded Quality Improvement intervention	Antrim County	Manistee County
	Benzie County	Mason County
	Grand Traverse County	Oceana County
	Leelanau County	
The target population served	Patients with chronic health conditions	Migrant farm workers
	Low-income populations	
Focus Area(s)	Creating a culture of quality in the organization, with focus on hypertension and diabetes, care management, Patient Centered Medical Home (PCMH)	
Health Information Technology System)	eClinical Works	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	NMHSI's overall goal is to create a culture of quality in the organization, with staff well-versed in quality improvement techniques and tools and a quality improvement infrastructure in place that assures the organization "lives and breathes" quality in all aspects of work. This will improve chronic disease outcomes for our patients and assure we are successful in becoming / maintaining PCMH accreditation.	

Description of the Quality Improvement project	Since its inception in 1968, NMHSI has remained steadfast in its mission to serve the comprehensive primary care medical, dental and behavioral health needs of its targeted service area residents. Its primary target population is the low-income, uninsured, underinsured and underserved living in pockets of poverty throughout the service area, and migrant and seasonal farmworkers. The agency operates four sites, in the counties of Leelanau, Benzie, Manistee and Oceana, Michigan. The population of these four counties, which span 1,721 square land miles, is 90,663 (2014 estimate, UDS Mapper). NMHSI is the only FQHC, and the sole safety net provider, in the targeted counties, and the only comprehensive care organization that offers a sliding fee scale. The service area is notable for its lack of access to primary care, oral health and behavioral health providers, the numbers of residents not being seen by an FQHC yet qualify for health center services based on their incomes, and the high rates of chronic disease and preventable hospitalizations. The population-to-primary care provider ratio across the four counties is twice that of national and state rates. The lack of providers hinders access and impacts health disparities in chronic disease management, oral health, and preventable hospitalizations. This project will allow NMHSI to fully develop its organizational quality improvement program through the evidence-based Model for Improvement/Plan Do Study Act Cycle. Funding will be used for personnel costs and for staff training. These evidence-based tools will help staff examine the current culture, function, and flow of NMHSI activities, eliminate points of waste and ineffective practices, and implement measures to improve clinical performance and enhance efficiency. The goal is to create a culture that embraces quality improvement, compliance with Meaningful Use standards, and recognition as a PCMH. Patients will experience improved health outcomes, actively engage with their provider and, for those with chronic disease, effectively self-manage their conditions. At the same time, NMHSI will continue to take steps to improve provider reimbursements, participate fully in managed care plans and quality improvement networks, and participate in incentive and pay-for-performance programs.

Michigan

Grant Number	G20RH30141					
Grantee Organization Name	Upper Peninsula Health Care Solutions, Inc.					
Organization type	Nonprofit Organization					
Address	853 W. Washington St.					
	City:	Marquette	State:	Michigan	Zip-code:	49855
Grantee organization website	www.uphcn.org					
Grantee Project Director	Name:	Janey Joffee				
	Title:	Project Director				
	Phone:	906-226-4286				
	Fax:	906-225-8782				
	Email:	jjoffee@uphcs.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	46 locations serving a 15 county region: 2 Hospitals, 5 Critical Access Hospitals (CAH), 4 CAH affiliated clinics, 15 Rural Health Clinics (RHC), 8 clinics, 8 Federal Qualified Health Centers (FQHC), 1 Health Department with 4 sites.		
	Aspirus Ironwood Hospital & Clinics, Inc.	Gogebic	Hospital, 3 RHC/clinics
	Aspirus Iron River	Iron	CAH, 3 RHC/clinics
	Aspirus Laurium	Houghton	CAH, 3 RHC/clinics
	Aspirus Ontonagon	Ontonagon	CAH, 2 RHC/clinics
	Dickinson County Health System	Dickinson	Hospital, 8 RHC/clinics
	LMAS Health Department	Luce, Mackinac, Alger, Schoolcraft	Health Dept, 4 sites
	Michigan Wisconsin Family Practice	Dickinson	RHC
	Mackinac Straits Health System	Mackinac	CAH, 4 RHC/clinics
	Rivertown Clinic, (part of Mackinac Straits Health System)	Cheboygan	RHC/clinic
	Munising Memorial Hospital	Alger	CAH, RHC
	Riverside Medical Associates PC	Chippewa	RHC
	Superior Family Medical Associates	Chippewa	RHC
	Upper Great Lakes Family Health Center	Marquette, Houghton, Iron, Menominee, Ontonagon	8 Federally Qualified Health Centers

The communities/counties served through the grant-funded Quality Improvement intervention	Counties served are 14 of 15 counties located in the Upper Peninsula of Michigan and one county in Lower Peninsula.	
	Alger County	Iron County

	Chippewa County	Mackinac County
	Delta County	Keweenaw County
	Dickinson County	Luce County
	Gogebic County	Marquette County
	Houghton County	Menominee County
	Cheboygan County (Lower Peninsula, Michigan)	Ontonagon County
	Schoolcraft County	
The target population served	Target populations served are patients with chronic conditions who are utilize our network partners' 46 sites	
Focus Area(s)	Cardiovascular disease	Diabetes
Health Information Technology System	Allscripts, eMD's, IpatientCare, Practice Partner, eCW, Epic, Healthland	
Quality Improvement Model(s)	Lean for Clinical Redesign and Chronic Care Model	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	Project goals are to: 1) Provide continued support to promote the Chronic Care Model or LEAN Process of quality improvement in the development of an evidenced-based culture with expansion for delivery of chronic disease population focus coordinated care in partner locations utilizing certified EHR technology (CEHRT) and HIT functionality. 2) Identify client populations in need of quality improvement by expanding QI efforts to other conditions and populations while continuing to reach Meaningful Use attestation requirements for Medicaid submissions/reimbursements. 3) Sustain improvement, integrate quality improvement into organizations and spread quality improvement efforts to other conditions and populations in preparation for transition to value-based reimbursement models.	
Description of the Quality Improvement project	Upper Peninsula Health Care Solutions (UPHCS) is an established rural non-profit network, consisting of critical access hospitals, community hospitals, FQHCs and other health-related entities. Through their health care network, UPHCS provides services to 311,629 residents of the rural, 15-county area known as Michigan's Upper Peninsula. This collaboration, along with support from the Upper Peninsula Health Information Exchange (UPHIE), will assist in obtaining the required baseline Emergency Department visit rate and 30-day hospital readmission rate for chronic disease populations. Our desired outcome is demonstrated improvement in health status and reduction in emergency department visits due to chronic disease. UPHCS' project will focus on the chronic disease states of diabetes and cardiovascular diseases. UPHCS' project will promote the development of an evidence-based culture and delivery of coordinated care in the primary setting utilizing the "Chronic Care Model & LEAN Process", as well as resource support from the (ONC) Office of the National Coordinator for Health Information Technology. It also supports sustainability with additional quality initiatives such as Physician Quality Reporting System (PQRS), Patient Centered Medical Home (PCMH), Healthcare Effectiveness Data & Information Sets (HEDIS), Chronic Care Management and value-based reimbursement. By implementing quality improvement processes, along with PIMS and meaningful-use collection and reporting standards within the clinics, the results of the project will show improved health outcomes for patients, and enhanced chronic disease management with better engagement of patients and their caregivers.	

Mississippi

Grant Number	G20RH30129					
Grantee Organization Name	Delta Health Alliance					
Organization type	Nonprofit, 501(c)(3)					
Address	435 Stoneville Road					
	City:	Stoneville	State:	Mississippi	Zip-code:	38776
Grantee organization website	www.deltahealthalliance.org					
Grantee Project Director	Name:	Daniel Thomas				
	Title:	Asst. VP of IT/Clinical Affairs				
	Phone:	662-686-3916				
	Fax:	662-686-4770				
	Email:	dthomas@deltahealthalliance.org				
Project Period	2016 – 2019					
Expected funding level for each budget period	Month/Year to Month/Year		Amount Funded Per Year			
	08/01/2016 to 07/31/2017		$199,894			
	08/01/2017 to 07/31/2018		$198,723			
	08/01/2018 to 07/31/2019		$199,958			
Network Partners	Organization Name		City/County	Organization Type		
	N/A					
The communities/counties served through the grant-funded Quality Improvement intervention	Leland, MS		Washington County			
	Hollandale, MS					
The target population served	Patients With Chronic Conditions					
Focus Area(s) *coaching)*	Cardiovascular disease		Hypertension			
	Diabetes		Care Coordination and Management			
	Chronic Pulmonary Obstruction Disorder		Patient-centered Medical Home			
Health Information Technology System	Allscripts Touchworks					
Quality Improvement Model(s) (	LEAN					
Telemedicine/Mobile Health Technology	N/A					
Quality Improvement Project Goal	The project intends to: • Operationalize an evidence-based, sustainable Quality Improvement program based on the HRSA-approved *Lean Model* and disseminate findings for replication. • Actualize reductions in emergency room visits and 30-day re-admissions, improving patient engagement in developing customized health plans, and improving chronic disease management.					

Description of the Quality Improvement project	The *Mississippi Delta Quality Improvement Initiative* is establishing and operationalizing a sustainable quality improvement (QI) program at the Leland Medical Clinic (LMC) to improve care quality and operational efficiency while positively impacting health outcomes for patients with chronic illnesses, including diabetes, hypertension, heart disease and asthma. Following the evidence-based and HRSA -recommended *Lean Model*, the project will establish the infrastructure and processes required to continuously strengthen and improve LMC's healthcare service delivery. Leveraging electronic health information and data in LMC's electronic health record (EHR) system, this project will promote application of evidenced-based practices and compliance with current medical standards, as well as improve patient communication and empowerment, advance cultural sensitivity in health education and programs, and ultimately improve the health and wellness of low-income, geographically isolated, underserved communities. The initial investments in staff training, protocol development and automation of data capture and reporting will ensure the sustainability of proposed QI assessments.

Missouri

Grant Number	G20RH30127					
Grantee Organization Name	Cox Monett Hospital					
Organization type	Critical Access Hospital					
Address	801 Lincoln Ave.					
	City:	Monett	State:	Missouri	Zip-code	65708
Grantee organization website	N/A					
Grantee Project Director	Name:	Julie Clapper				
	Title:	Referral Coordinator				
	Phone:	417-224-6060				
	Fax:	417-269-4849				
	Email:	Julie.clapper@coxhealth.com				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$187,662
	08/01/2017 to 07/31/2018	$139,193
	08/01/2018 to 07/31/2019	$141,048

Network Partners	Organization Name	City/County	Organization Type
	CoxHealth Center Mount Vernon	Mount Vernon, Lawrence County	clinic
	CoxHealth Center Shell Knob	Shell Knob, Barry County	clinic
	CoxHealth Center Crane	Crane, Stone County	clinic
	Cox Family Medicine of Monett	Monett, Barry County	clinic
	Family Practice and Obstetrics of Monett	Monett. Barry County	clinic
	Family & Occupational Medicine of Monett	Monett, Barry County	clinic
	CoxHealth Center Aurora	Aurora, Lawrence County	clinic
	CoxHealth Center Cassville	Cassville, Barry County	clinic

The communities/counties served through the grant-funded Quality Improvement intervention	Barry County	Stone County
	Lawrence County	
The target population served	Patients with chronic conditions	
Focus Area(s)	Behavioral health intervention	PCMH
	Care Coordination	Population health
	Diabetes	Obesity
Health Information Technology System	Cerner	
Quality Improvement Model(s)	PDSA, LEAN	
Telemedicine/Mobile Health Technology	Carousel	
Quality Improvement Project Goal	To better use the already implemented population health software, and better coordinate care of the patients entering the health system in our rural health clinics	

Description of the Quality Improvement project	Cox Monett Hospital (CMH) is a community owned 501(c)3 hospital located in Monett, Missouri. Included in the hospital system are eight Rural Health Clinics. The primary service area for the hospital and the proposed initiative is Barry, Lawrence, and Stone Counties in southwest Missouri which is characterized by a predominantly low-income, aging population lacking health care insurance, steady employment, and large Hispanic population with multiple health-related disparities including a health literacy, language, and cultural barriers. The economy is driven partially by agriculture and entertainment affected seasonal unemployment. These realities make it difficult to provide coordinated primary care. The purpose of the proposed Primary Care Quality Improvement Program is to improve primary care quality through healthcare redesign using a Patient Centered Medical Home (PCMH) model, specifically the National Committee for Quality Assurance (NCQA) PCMH model; automating population health management through Phytel Outreach; using patient data collected through automation and through Cerner patient electronic health records (EHR) to determine gaps in care and breakdowns in quality; and utilizing the evidence-based quality improvement model of LEAN to improve quality in underperforming clinics. The target population that will be served in this grant initiative begins with the patients in eight primary care clinics operated by Cox. In 2015, the clinics treated 20,040 patients; 15% of these patients live with a chronic disease. In addition to the 20,040 primary care patients, uninsured patients who are without a primary care physician and present to the Emergency Room (ER) during the project period will also be included in the initiative. It is expected that automation of population health management will provide outreach and care coordination to the entire population through automated appointment reminders/ scheduling. Automation will increase patient volume by 10% annually resulting in a target population of approximately 28,000 by 2019. The hospital's goal is to move patients away from seeking treatment in the ER into a system of preventive care and treatment, therefore reducing avoidable hospitalizations and readmissions. Primary care quality will be tracked according to National Committee on Quality Assurance, Centers for Medicaid and Medicare Services, Meaningful Use, and HRSA PIMS measures. Clinics found to be underperforming will engage in a LEAN quality improvement process until quality standards are met. The quality improvement strategies will be supported and sustained after the grant period through increased revenue due to increasing patient volume, driving sustainability beyond the grant period. Throughout the three-year grant period, a sustainability plan will be followed, improvements made, and the budget will be assessed to ensure sustainability. The Primary Care Quality Improvement Program will be evaluated formatively and summatively, which will provide data to determine program effectiveness, areas in need of improvement and additional chronic disease quality measures to track.

Missouri

Grant Number	G20RH30543					
Grantee Organization Name	Great Mines Health Center (GMHC)					
Organization type	Federally Qualified Health Center					
Address	#1 Southtowne Drive					
	City:	Potosi	State:	Missouri	Zip-code:	63664
Grantee organization website	www.gmhcenter.org					
Grantee Project Director	Name:	Greg Roeback, NCC, LPC, PHR, SHRM-CP				
	Title:	Vice President of Human Resources & Administrative Services				
	Phone:	573-438-8358				
	Fax:	573-438-4583				
	Email:	groeback@gmhcenter.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

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

The communities/counties served through the grant-funded Quality Improvement intervention	Washington County, Missouri
The target population served	Patients with chronic conditions with frequent ED visits or 30 day re-hospitalizations for the same condition
Focus Area(s)	Chronic Obstructive Pulmonary Disease (COPD), heart disease, and/or stroke/cerebrovascular disease
Health Information Technology System	Aprima PRM 2015 EHR (electronic health record) and PM (practice management), v. 15.0.1
Quality Improvement Model(s)	PDSA
Telemedicine/Mobile Health Technology	N/A
Quality Improvement Project Goal	Identify GMHC's patient populations with chronic disease that have the highest hospitalization rates and employ coordinated care activities to reduce the number of emergency room visits and 30 day readmissions of this population. Additionally, efforts to improve upon engagement of the patient (and their caregivers) in their own care are a priority of the project.

Description of the Quality Improvement project	For this quality improvement initiative, GMHC's Targeted Case Manager Registered Nurses and Referral Coordinators will contact Washington County Memorial Hospital each morning to assess the number of admissions of all GMHC patients, highlighting the target patients diagnosed with COPD, heart disease, and/or stroke/cerebrovascular disease. Admission records will be received through a secure electronic fax server and interfaced into the patient's electronic medical record and sent to the respected clinician in an electronic task message to review the emergency department (ED) or admission report. Follow up appointments will be identified and scheduled by the Medical Records Coordinators at the time of scanning. At the time of the follow up appointment with GMHC, Target Case Management nurses will room our patients and provide recommended treatment/care by means of a health risk assessment. This data will be placed in an excel file and reported to the Quality Improvement Committee on a monthly basis. Findings will be reported directly to the Management Team. Based on the findings, the Quality Assessment Team will submit a Corrective Action Plan to address re-admissions or ED use of this identified patient population, to the Management Team one (1) month after the report. The Quality Improvement Coordinator will monitor for effectiveness of actions and report all findings to the Medical Director for further guidance.

Missouri

Grant Number	G20RH30142					
Grantee Organization Name	Washington County Memorial Hospital					
Organization type	Critical Access Hospital					
Address	300 Health Way					
	City:	Potosi	State:	Missouri	Zip-code:	63664
Grantee organization website	www.wcmhosp.org					
Grantee Project Director	Name:	Amber Coleman				
	Title:	Executive Assistant				
	Phone:	573-438-5451				
	Fax:	573-438-2399				
	Email:	acoleman@wcmhosp.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$199,971
	08/01/2017 to 07/31/2018	$183,333
	08/01/2018 to 07/31/2019	$191,081

Network Partners	Organization Name	City/County	Organization Type
	NRACO (National Rural Accountable Care Consortium)		Supports rural healthcare transformation
	PCCM (Primary Care Case Management)		Chronic Case Management

The communities/counties served through the grant-funded Quality Improvement intervention	Washington County	Potosi, Missouri
The target population served	Patients with chronic health conditions	
Focus Area(s)	Coronary artery disease	Diabetes
	Chronic Obstructive Pulmonary Disease (COPD)	Hypertension
	Congestive heart failure	
Health Information Technology System	NextGen	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The overarching goals of the Quality Matters project are to improve health outcomes, enhance chronic disease management, create better engagement of patients, and to improve the quality of life of the patients served in and by the Washington County Memorial Hospital rural health clinics and hospital site.	

Description of the Quality Improvement project	The Washington County Memorial Hospital chose *Quality Matters* as a concept and title to represent the importance of reform in the healthcare delivery system and the need for reduction of disparities. This will be achieved by altering the way we see patients, teach patients, and follow up with patients in our rural health clinics and the hospital site. By improving the communication between patient and provider through the Quality Matters program, it is expected that there will be an increase in patients' understanding of their chronic conditions that will lead to better patient engagement, increased compliance, and satisfaction. By educating patients about their chronic conditions and ensuring they have the correct equipment and supplies to manage their conditions, improved health outcomes will be reached; and by focusing on the sickest of the sick, we can reduce emergency department and hospital readmissions and improve their quality of life. Quality Matters will use the Lean principle Plan, Do, Check, Act (PDCA) to monitor the progress and success of the implemented changes.

Montana

Grant Number	G20RH3054					
Grantee Organization Name	Central Montana Medical Facilities, Inc. (Central Montana Medical Center (CMMC))					
Organization type	Critical Access Hospital					
Address	310 Wendell Avenue					
	City:	Lewistown	State:	Montana	Zip-code:	59457
Grantee organization website	www.cmmccares.org					
Grantee Project Director	Name:	Doris T. Barta, MHA				
	Title:	Project Director				
	Phone:	406-690-0734				
	Fax:	406-535-1544				
	Email:	dbarta@cmmccares.com				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Central Montana Community Health Center	Lewistown/ Fergus	Nonprofit Community Health Center
	Family Wellness Center	Lewistown/ Fergus	Independent Physician Practice
	Billings Clinic	Billings/ Yellowstone	Urban Tertiary Care Center

The communities/counties served through the grant-funded Quality Improvement intervention	Chouteau County, including the community of Geraldine, Garfield County, Fergus County, including the communities of: Buffalo, Coffee Creek, Denton, Grass Range, Forest Grove, Lewiston and Moore	
The target population served	Patients with chronic diseases	
Focus Area(s)	Diabetes	Obesity
	Smoking	Cardiovascular Disease
	Care Coordination	Health/wellness coaching
Health Information Technology System	CMMC will be migrating to Cerner in May of 2017 so that will be the primary Electronic Medical Record for the program.	
Quality Improvement Model(s)	Chronic Care Model	
Telemedicine/Mobile Health Technology	We will be choosing a patient self-directed technology in 2017. We have not chosen the one we will be using yet.	
Quality Improvement Project Goal	The purpose of the project is to coordinate healthcare through evidence-based quality improvement activities that achieve better health, better healthcare and lower costs. The goals are: 1) to improve financial and operational efficiency within the Central Montana QICCI Consortium using quality improvement strategies and optimizing the use of the electronic medical record (EMR); 2) to improve patient healthcare outcomes focusing on clinical indicators for management of diabetes and cardiovascular disease, as well as reduction of obesity and smoking; and 3) to improve patient engagement and satisfaction by improving access to care, ongoing provider support and lowing out of pocket expenses.	

Description of the Quality Improvement project	The focus of the grant will include revisiting the health care systems of Consortium members to redefine health care team roles (e.g. nurses, instead of primary care providers become responsible for conducting foot examinations). Other changes include the addition of a Community Care Coordinator to help manage patients who are non-compliant with their disease management, and who might need a little extra help navigating the health care system. Another component of the program is to engage the patients in their own health management through a self-management education and self-reporting program (using the CCIQ app). The QICCI Consortium will explore the use of telehealth (interactive videoconferencing) in the eight rural communities in the region for educational and outreach efforts. Program such as Diabetes Self-Management Education (DSME), smoking cessation, or nutritional and exercise programs for both diabetes and cardiovascular disease management will be provided through a community service that includes a patient audience in Lewistown and a patient audience in the rural community. We believe that this approach will allow patients to engage in group educational programs (and/or individual level) without the added burden of travel which can (and does) effect disease management compliance. Patients served through the 3-year program will be identified and tracked through data gathered by Consortium members, and patient self-reporting. Data will be gathered from EMRs, claims data, lab and pharmacy and the ChronicCareIQ patient self-reporting. Consortium members will employ a collaborative clinical information approach through the use of disease registries and electronic medical records, enabling multiple health care providers (e.g. Primary Care Physicians, nurse practitioners, nurses, Certified Diabetes Educators, physician assistants, the Community Care Coordinator, medical assistants, etc.) to review detailed reports on laboratory and examination results and identify lapses in diabetes and/or cardiovascular care (e.g. missed visits, laboratory appointments, and examinations). This system will help patients and providers set self-management goals and review progress reports to determine whether the patients have met their predetermined goals. Improved tracking through the use of patient registries, EMRs, and CCIQ of individual health outcomes (e.g. HBa1c and blood pressure trends), will provide an expedient way to manage patient information and improve provider responses to clinical data (e.g. medication adjustment). Additionally, a benefit from getting patients self-report data through CCIQ is that they become partners in their own care, which will help improve patient outcomes. Data analysis will provide additional information for Consortium members to address patients who are non-adherent with their disease management who can benefit from additional focus by the healthcare team. This process will provide added care management for those patients who are dealing with multiple chronic conditions, which can contribute to higher utilization of care and higher healthcare costs. The program will be sustainable because it will integrate improvements in patient management for the Consortium members by building a structure that is designed like an Accountable Care Organization (ACO), or a Clinically Integrated Structure (CIS). The program goal will be to move from volume to value-based care, which is a means to control costs and improve outcomes. The quality improvement strategies will provide a better mechanism for patient management, which will increase patient compliance and reduce 30-day readmission rates, as well as reduce unnecessary costly emergency department visits.

Nebraska

Grant Number	G20RH30547					
Grantee Organization Name	Santee Sioux Tribe of Nebraska (Santee Health and Wellness Center)					
Organization type	Native American Tribal Health Facility					
Address	110 S. Visiting Eagle St.					
	City:	Niobrara	State:	Nebraska	Zip-code:	68760
Grantee organization website	www.santeesiouxnation.net					
Grantee Project Director	Name:	Lanny Turner, MD				
	Title:	Medical Director of the Santee Health and Wellness Center				
	Phone:	402-857-2300				
	Fax:	402-857-2315				
	Email:	lanny.turner@ihs.gov				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/01/2016 to 07/31/2017	$200,000
	09/01/2017 to 07/31/2018	$200,000
	09/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Avera Sacred Heart Hospital	Yankton/South Dakota	Regional Hospital
	Nebraska Office of Rural Health	NE Office of Rural Health	State Office of Rural Health
	North Central Nebraska Public Health Department	O'Neill, NE	Local Health Department
	Yankton Medical Clinic	Yankton, SD	Multi-disciplinary clinic
	Santee Sioux Nation EMS	Santee, NE	EMS

The communities/counties served through the grant-funded Quality Improvement intervention	Bonhomme County, SD	Santee, NE
	Knox County, NE	Village of Niobrara, NE
The target population served	Patients with pre-diabetes	Santee Sioux Tribal Community
	Patients with Type II diabetes mellitus	
Focus Area(s)	Overuse of emergency department for health maintenance	Type II diabetes, obesity, cigarette smoking, Artherosclerotic Cardiovascular Disease, patients with elevated A1c, sedentary lifestyle, wellness coaching
	Care coordination for above groups	
Health Information Technology System	Resource and Patient Management System (RPMS) which is the Indian Health Service clinic-wide system electronic health record	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	MyLink4Life Home3 Monitoring Program Tele-psychiatry currently used for depression and related issues among patients with Type II Diabetes	
Quality Improvement Project Goal	Our goal is to formally evaluate best practices for the management of diabetes mellitus and then initiate their implementation, one at a time, to create a significant improvement in the delivery of diabetic care. We will measure some diabetic tcome	

	values (such as A1c), but our primary focus will be on improving internal processes for the entire team to more effectively treat these patients (i.e. staff process directed rather than patient outcome directed). We believe that by doing this, we will be able to document improvement in patient outcomes as a natural consequence.
Description of the Quality Improvement project	Currently, within our Native American patient population, the incidence of diabetes (Type II) is greater than 22%. In addition, the Santee Tribal Community has very disturbing prevalence levels for tobacco use, poor nutrition, diabetic treatment compliance, atherosclerotic cardio-vascular disease (ASCVD), obesity and sedentary lifestyle as well as the disturbing claim that the average age of death (i.e. mortality) in our community is only 56.3 years of age (so that people live 35% fewer years in Santee than is the national average). Overall, the Great Plains Region for the Indian Health Service (IHS) (one of seven total regions), has been documented as having the worst outcome numbers among all other IHS regions. Furthermore, Santee has the worst numbers within the Great Plains Region of all the other seventeen entities therein. This is all to say that unfortunately, health-wise (especially as it relates to diabetes morbidity), Santee is currently the "worst of the worst" in terms of current health status. We have structured our grant design to (1) determine baseline provider practices for consistency and overall effectiveness, and then (2) disrupt those current approaches to patient evaluation and treatment among the staff so that ultimately only best practices will be employed to care for this critical patient group. The final goal will then be to determine what the actual impact on patient outcomes has been, but only after a thorough evaluation and revision of *how* the entire treatment team delivers care to this important group.

New York

Grant Number	G20RH30132					
Grantee Organization Name	Bassett, Mary Imogene Hospital					
Organization type	Academic Medical Center					
Address	1 Atwell Rd					
	City:	Cooperstown	State:	New York	Zip-code:	13326
Grantee organization website	www.bassett.org					
Grantee Project Director	Name:	Martha Sunkenberg				
	Title:	Senior Director Health Center Operations				
	Phone:	607-547-3034				
	Fax:	607-547-4504				
	Email:	martha.sunkenberg@bassett.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$199,890
	08/01/2017 to 07/31/2018	$195,832
	08/01/2018 to 07/31/2019	$199,099

Network Partners	Organization Name	City/County	Organization Type
	Herkimer County HealthNet	Herkimer, Herkimer County	501(c)(3) - Rural Health Network

The communities/counties served through the grant-funded Quality Improvement intervention	Cherry Valley, Otsego County	Norwich, Chenango County
	Cooperstown, Otsego County	Little Falls, Herkimer County
	Hamilton, Madison County	Richfield Springs, Otsego County
	Herkimer, Herkimer County	Sherburne, Chenango County
The target population served	Patients with high blood pressure and other chronic conditions; Patients with diabetes	
Focus Area(s)	Care coordination/management	Quality Improvement
	Diabetes	Self-management
	High blood pressure	Wellness coach
	Patient-centered medical home	
Health Information Technology System	EPIC	
Quality Improvement Model(s)	PDSA cycles will be used to improve activities related to patient care and outcomes, while Lean Six Sigma will be used to improve workflow and office functionality.	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	1) Select and utilize evidence-based quality improvement frameworks; 2) Implement best-practices for chronic disease management and patient engagement; and 3) Sustain the successes in Quality Improvement (QI) beyond the grant period.	

Description of the Quality Improvement project	Targeted services will be provided to patients with diabetes and high blood pressure receiving primary care services at one of seven Bassett-owned Regional Health Center sites (Cooperstown, Hamilton, Herkimer, Little Falls, Norwich, Richfield Springs, and Sherburne) and one non-Bassett, rural health clinic (Cherry Valley) owned and operated by the town. It is projected that a total of 480 patients will be targeted in years one through three of the QI program—120 patients in year one, 180 patients in year two, and 180 patients in year three. At the recommendation of the QI Council, patient education groups will utilize the Chronic Disease Self-Management Program and the Diabetes Self-Management Program developed by the Stanford Patient Education Research Center. These two evidence based models will bring 10-16 patients together in community settings for 2.5 hours once a week for 6 weeks. These workshops will be facilitated by two peer leaders with their own health problems who have been trained to deliver the Stanford programs. The workshops are highly interactive, focusing on building skills, sharing experiences, and support. In addition, the Quality and Technical Assistance Center of New York (QTAC-NY) created the hypertension module, "Living Healthy with High Blood Pressure," to increase interest in the Self-Management model. This introductory educational session teaches people living with hypertension or high blood pressure strategies to better manage their condition. Organizations that offer the hypertension module have reported higher levels of enrollment and completion, especially for the Diabetes Self-Management Program. For these reasons participants will begin their patient education experience with this program. Further, we will hold an additional session to connect patients with diabetes with their local diabetic educator. At this final session, we will offer facilitated enrollment for the self-directed, evidence-based Walk with Ease program developed by the National Arthritis Foundation. At this session we will practice stretches and exercises included in the Walk With Ease and Living A Healthy Life with Chronic Conditions books. Following the PDSA model, we will utilize health coaches at three clinic sites to determine the additional impact of reinforcing personal self-management goals patients identified for themselves at the end of the Stanford program sessions. Grocery store gift cards, excluding alcohol and tobacco, will be utilized to support the recommendations for healthy behavior changes.

North Carolina

Grant Number	G20RH30542					
Grantee Organization Name	Granville Vance District Health Department					
Organization type	Local Public Health Department					
Address	101 Hunt Drive, P.O. Box 367					
	City:	Oxford	State:	North Carolina	Zip-code:	27565
Grantee organization website	www.gvph.org					
Grantee Project Director	Name:	Wendy Smith				
	Title:	Home Health Supervisor				
	Phone:	252-492-7151				
	Fax:	252-492-3613				
	Email:	N/A				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Maria Parham Medical Center	Henderson/Vance	Hospital
	Granville Medical Systems	Oxford/Granville	Hospital
	NC Heart and Vascular	Raleigh/Wake	Provider
	Rex Heart Failure Center	Raleigh/Wake	Provider

The communities/counties served through the grant-funded Quality Improvement intervention	Granville County	Vance County
	Franklin County	Warren County
The target population served	Congestive Heart Failure	Wound patients in the service area
	Diabetes	
Focus Area(s)	Congestive Heart Failure (CHF)	Wound Infections
	Diabetes	
Health Information Technology System	HealthCare First	
Quality Improvement Model(s)	PDSA	
Telemedicine/Mobile Health Technology	Medtronic for CHF patients	
Quality Improvement Project Goal	Decrease re-hospitalization rates for CHF, Diabetic, and Wound patients referred and admitted by membrour Home Health agency through telemonitoring, education, and other evidence-based methods	

Description of the Quality Improvement project	Granville Vance Home Health (GVHH) aims to improve the status of a home health patient population in a rural northern piedmont district in NC through delivery system reform using quality improvement methods and tools, health information technology data collection efforts, improved data management, training of staff, and local collaboration with health care providers. GVDHD staff members have made tremendous progress in the past three years, yet we still have a lot to learn and apply regarding data management and Quality Improvement (QI) in home health to reduce hospital readmissions. According to Emergency Room data collected by two local hospitals and by data collected through Granville Vance Home Health, it is clear that patients with Diabetes, Congestive Heart Failure, and Infection from wounds are of primary concern for readmissions to inpatient hospital care as well as for emergency room visits, and need the most attention by home health staff. Granville Vance Home Health will reduce the number of hospital readmissions of patients discharged to home health in the Vance and Granville County area by 30% over a three year period between 2016 and 2019. Goals of the Granville Vance Home Health Improvement Program include: 1. Reduce hospital readmissions within 30 days of patients discharged to home health in the Vance and Granville County area by 30% over a three year period between 2016 and 2019. 2. Establish and maintain a prevention consortium to support training, organizational culture change, and coordination of care. 3. Increase home health staff knowledge skills and collaboration effectiveness (multidisciplinary team effectiveness) through training and modeling. 4. Provide integrated care plans (or care pathways) informed by evidence-based clinical practice specific to the rural patient populations' needs. 5. Expand the use and impact of health information technology including electronic health record and point-of-care information for effective management of home health outcomes. The Granville Vance Home Health Improvement Program will leverage existing local and state-level partnerships for training and evaluation and will seek to build a local coalition of partners including the Granville Vance District Health Department, Duke Division of Community Health's Northern Piedmont Community Care, Primary Care offices, long term care facilities, two local hospitals, the local Federally Qualified Health Center, the NC Institute for Public Health at UNC-Chapel Hill, Population Health Improvement Partners, and other community-based organizations. Together we will coordinate care for improved patient outcomes in Granville and Vance Counties and help navigate health system reform for our community.

North Carolina

Grant Number	G20RH30545					
Grantee Organization Name	Roanoke Valley Health Services, Inc.					
Organization type	Rural Health Clinic					
Address	1385 Medical Center Drive					
	City:	Roanoke Rapids	State:	North Carolina	Zip-code:	27870
Grantee organization website	http://www.roanokeclinic.com/					
Grantee Project	Name:	Tiffany Mose				
	Title:	Administrative Director of Physician Practices				
	Phone:	252-535- 8436				
	Fax:	252-535-8466				
	Email:	tmose@halifaxrmc.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/2016 to 08/2017	$200,000
	09/2017 to 08/2018	$200,000
	09/2018 to 08/2019	$200,000

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

The communities/counties served through the grant-funded Quality Improvement intervention	Halifax County	Warren County
	Northampton County	
The target population served	The target population of this project is the Medicare and Medicaid patients who have not received preventive health care visits in the last 12-24 months. The three-county service area consists of three of the most economically distressed counties in North Carolina: Halifax, Northampton and Warren counties.	
Focus Area(s)	Focus areas include preventative care, care management/coordination, patient and family engagement, and management of chronic conditions, such as diabetes mellitus, hypertension, chronic obstructive pulmonary disease, and asthma	
Health Information Technology System	Athena	
Quality Improvement Model(s)	NCQA PCMH Level 3	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The project goals are to improve operational efficiency to include access to primary care, care coordination, care transition, patient outcomes, and to increase patient satisfaction.	
Description of the Quality Improvement project	As a HRSA-qualified Rural Health Clinic, the purpose of this project is to expand the reach of our Patient Centered Medical Home (PCMH) by identifying the vulnerable population of patients not receiving preventative healthcare thereby promoting better health outcomes and improving our clinical quality measures. The PCMH serves as the foundation for transforming care from acute- focused episodic care to coordinated, proactive and preventive care. A key principle of the PCMH is a team approach to care. The primary care delivery model is strengthened by implementing a team approach to care, utilizing a physician-led group, with each clinician on the team practicing to the top level of their licensure.	

North Carolina

Grant Number	G20RH30139					
Grantee Organization Name	St. Luke's Hospital, Inc. (Foothills Health Network)					
Organization type	Critical Access Hospital					
Address	101 Hospital Dr.					
	City:	Columbus	State:	North Carolina	Zip-code:	28722
Grantee organization website	http://www.saintlukeshospital.com/					
Grantee Project Director	Name:	Michele O. Trofatter, MPH				
	Title:	Director				
	Phone:	828-894-0824				
	Fax:	828-894-2155				
	Email:	Michele.trofatter@slhnc.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$200,000
	08/01/2018 to 07/31/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Blue Ridge Community Health Services	Hendersonville	FQHC
	The Free Clinics	Hendersonville	Free Clinic

The communities/counties served through the grant-funded Quality Improvement intervention	Polk County, North Carolina and surrounding areas	
The target population served	Patients with high rates of Emergency Department (ED) utilization; Inpatient Transition of Care patients	
Focus Area(s)	Chronic disease	High ED utilization
	Case Management	Transitional Care
Health Information Technology System	Paragon	
Quality Improvement Model(s)	PDSA and LEAN	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal	The purpose of the Quality Improvement Program is to address delivery system reform and impact ED utilization rates. Another goal of this project is to decrease the 30-day readmission rate.	

Description of the Quality Improvement project	The purpose of the Foothills Health Network (FHN) Quality Improvement Program is to address delivery reform and impact Emergency Department (ED) utilization rates with a tiered approach to address the underlying causes of non-emergent visits to the ED in Polk County, NC. Using available internal data and corresponding research, an evidence-based approach will be used to inform and determine the care of individual patients. The primary target population to be addressed by this project includes patients with ≥3 visits to the ED in the past year. Currently, over 84% of these patients report not having a medical home or primary care provider. The major goals of delivery system reform with this project are as follows: • Identification of patients with ≥3 ED visits in the previous calendar year using health information technology (HIT); • Using evidence-based treatment to improve the quality and delivery of healthcare services for addressing the most significant health related issues in Polk County including diabetes, pulmonary disease, hypertension, coronary artery disease, and mental health disorders and tracking outcomes through HIT; • Intervention with and education of identified patients to ensure placement into a medical home or with a primary care provider; • Implementation of extensive case management and care coordination based on utilization of evidence-based health care practices and tracking of health status outcomes to address both medical and social needs that may be creating health and wellness barriers; • Creating and increasing availability of medical care outside regular business hours to address non-emergent and primary care needs; • Using an evidence-based transitional care model to reduce or eliminate hospital readmission for primary and/or complicating conditions, improve health outcomes after discharge, and enhance patient and family caregiver experience with care. The ability to reform the delivery system for ED care in Polk County will significantly impact health outcomes and overall cost of care.

Ohio

Grant Number	G20RH30544					
Grantee Organization Name	Holmes County General Health District					
Organization type	Local Health Department					
Address	85 N Grant St., Ste. B					
	City:	Millersburg	State:	Ohio	Zip-code:	44654
Grantee organization website	www.co.holmes.oh.us/health/					
Grantee Project Director	Name:	Michael Derr				
	Title:	Health Commissioner				
	Phone:	330-674-5035				
	Fax:	330-674-2528				
	Email:	mderr@holmeshealth.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/2016 to 07/2017	$200,000
	08/2017 to 07/2018	$200,000
	08/2018 to 08/2019	$200,000

Network Partners	Organization Name	City/County	Organization Type
	Hostetler Management Group	Wooster/Wayne County	Management Consultant
	East Holmes Family Care	Baltic/Berlin/ Walnut Creek, Holmes County	Primary Care Provider
	Millersburg Clinic, Inc.	Millersburg, Holmes County	Primary Care Provider
	Holmes Family Practice Center	Millersburg, Holmes County	Primary Care Provider
	Pomerene Family Care	Millersburg, Holmes County	Primary Care Provider

The communities/counties served through the grant-funded Quality Improvement intervention	Holmes County, Ohio
The target population served	Rural Population, 50% of whom are Amish
Focus Area(s)	Chronic Obstructive Pulmonary Disorder, Cardiovascular Disease
Health Information Technology System	Allscripts
Quality Improvement Model(s)	PDSA and LEAN
Telemedicine/Mobile Health Technology	N/A
Quality Improvement Project Goal	1) Establish and maintain a multi-agency workgroup to oversee quality improvement projects, 2) Plan initiatives addressing poor performance, 3) Implement quality improvement plans, and 4) Evaluate the impact of the initiatives

Description of the Quality Improvement project	The project utilizes the Chronic Care Model. The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements include mobilizing community resources, creating a culture of quality in health systems, supporting patient management of illnesses, designing effective delivery of care, making decisions based on scientific evidence and using clinical information systems to monitor health outcomes. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The project is implementing the proposed objectives through the Holmes County Primary Care Provider Network (HCPCPN). The HCPCPN is an informal network of primary care providers from all five private primary care practices and the public health department in Holmes County. The network includes East Holmes Family Care, Holmes Family Medicine, Millersburg Clinic, Pomerene Family Care, and Holmes County General Health District. The HCPCPN will be responsible for providing staff members to the Quality Improvement Workgroup and implementing quality improvement projects in their practices. Members of the HCPCPN routinely work collaboratively to provide care to patients and have a strong history of working together on projects such as sentinel influenza surveillance. The Network has met bimonthly since 2013 to review quality measures and has demonstrated a capacity to make designs collectively. All members decided to adopt the AllScripts electronic health records system and have completed implementation by 2013. AllScripts will be used to assess and monitor clinical performance measures identified by the Quality Improvement Workgroup. The members will also apply the LEAN model to the quality improvement efforts.

Ohio

Grant Number	G20RH30140					
Grantee Organization Name	Trinity Hospital Twin City					
Organization type	Critical Access Hospital					
Address	819 N. First Street					
	City:	Dennison	State:	Ohio	Zip-code:	44621
Grantee organization website	www.trinitytwincity.org					
Grantee Project Director	Name:	Robin Brown, Jennifer Demuth (alternate contact, Grant Coordinator)				
	Title:	Project Director				
	Phone:	740-922-7450, ext. 2106; ext. 2198 for Jennifer				
	Fax:	740-229-7255				
	Email:	rbrown@trinitytwincity.org; jdemuth@trinitytwincity.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$200,000
	08/01/2017 to 07/31/2018	$168,662
	08/01/2018 to 07/31/2019	$153,662

Network Partners	Organization Name	City/County	Organization Type
	Trinity Health System	Steubenville, OH	Hospital
	STI Innovations	Encinitas, CA	Health Software Provider

The communities/counties served through the grant-funded Quality Improvement intervention		
	Tuscarawas County	Harrison County
	Carroll County	Coshocton County
The target population served	Adults with two or more of the following diagnoses: congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), diabetes, hyperlipidemia, hypertension, and obesity. Priority is given to patients who are considered high-risk and most in need for care navigation, including patients age 65 and older, and patients who do not have a medical provider/doctor (including the indigent and uninsured).	
Focus Area(s)	Chronic disease management	Patient navigation
	Care coordination	Health/wellness coaching
Health Information Technology System	eClinicalWorks, BridgeIT, STI Innovations custom software	
Quality Improvement Model(s)	Plan-Do-Study-Act	
Telemedicine/Mobile Health Technology	N/A	
Quality Improvement Project Goal (	Following the Care Improvement Model and accessing health information technology (to collect, report, and utilize information on cost and quality), Trinity Hospital Twin City has started a chronic disease management program to improve health outcomes, enhance chronic disease management, and improve patient engagement.	

Description of the Quality Improvement project	Trinity Hospital Twin City (THTC) is utilizing its hospital-owned group primary physician practice (Trinity Medical Group or TMG) to substantially improve the care we provide for adults with chronic disease in our rural Appalachian Tuscarawas County, Ohio, region. Following the Care Improvement Model and accessing health information technology (to collect, report, and utilize information on cost and quality), TMG has begun a chronic disease management program to improve health outcomes, enhance chronic disease management, and improve patient engagement. To achieve these goals, TMG utilizes patient navigators to help deliver coordinated care, education, and support for hospital and TMG patients who have two or more chronic diseases (congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, hyperlipidemia/high cholesterol, hypertension, and/or obesity). The primary objectives of this project are to (1) improve the health status of patients with chronic disease, (2) reduce the number of hospital emergency department visits due to chronic disease, and (3) utilize innovative health IT solutions to coordinate patient care. TMG is further embedding the Model for Improvement system (the Plan-Do-Study-Act cycle) in its activities in order to test changes made, structure data collection and reporting, and reinforce an evidence-based practice culture. THTC works in consortia with Trinity Health System of Steubenville, Ohio, and STI Innovations of California, on this project for assistance with staff training and health information technology implementations. There are currently no chronic disease management programs in our area for adults with two or more chronic diseases. Many go without adequate care, resulting in higher healthcare costs through inpatient readmissions and emergency department visits. 21.1% of THTC's emergency department visits from October 2014-September 2015 were for symptoms and complications from chronic diseases. As of February 2015, TMG had a record of 3,000 patients age 65 and older who have two or more chronic diseases. Priority is given to patients who are considered high-risk and most in need for care navigation, including patients age 65 and older, and patients who do not have a medical provider/doctor (including the indigent and uninsured).

South Carolina

Grant Number	G20RH30125					
Grantee Organization Name	CareSouth Carolina, Inc.					
Organization type	Federally Qualified Health Center					
Address	201 South Fifth Street					
	City:	Hartsville	State:	South Carolina	Zip-code:	29550
Grantee organization website	www.caresouth-carolina.com					
Grantee Project Director	Name:	Takisha T. Bittle				
	Title:	Quality Improvement Project Director				
	Phone:	843-858-8109				
	Fax:	843-378-4209				
	Email:	Takisha.bittle@caresouth-carolina.com				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$114,260
	08/01/2017 to 07/31/2018	$165,583
	08/01/2018 to 07/31/2019	$170,551

Network Partners	Organization Name	City/County	Organization Type
	Northeastern Rural Health Network		Rural Health Network
	South Carolina Office of Rural Health		State Office of Rural Health
	The ALPHA Center	Chesterfield, SC	Treatment Center
	Chesterfield County Coordinating Council	Chesterfield, SC	Community County Agency
	Northeastern Technical College	Cheraw, SC	College
	Marlboro County coordinating Council	Bennettsville, SC	Community County Agency
	Department of Health and Environmental Control Region 4	Chesterfield, SC	Governmental Agency
	Tri-County Behavioral Care	Bennettsville, SC	Treatment Center
	McLeod Health Systems	Florence, SC	Health care Center
	Tri-County Community Mental Health Center	Chesterfield, Marlboro and Dillon Counties	Mental Health Center

The communities/counties served through the grant-funded Quality Improvement intervention	Chesterfield County, Darlington County, Dillon County, Lee County, Marlboro County
The target population served	Chronic Disease (conditions), Mental Health Issues, Substance Abuse, Uninsured, High Utilizers of Emergency Department (ED) services
Focus Area(s)	Reduce cost of individuals who utilize area hospital ED for non-emergent care, Chronic disease-diabetes and cardiovascular disease, Improve health outcomes for patients, Improve access to high quality care, Coordination of care delivery arose the safety net system, Improve patient experience, Mental health and substance abuse issues
Health Information Technology System	GE Centricity with i2i Tracks, ClinView (Clinical Intelligence) for claims-based/cost data
Quality Improvement Model(s)	Model for Improvement and PDSA

Telemedicine/Mobile Health Technology	N/A
Quality Improvement Project Goal	This project is to develop and implement an integrated quality framework to drive change and improvement across the region.
Description of the Quality Improvement project	CareSouth Carolina Inc. (CSC) is a federally qualified health center providing primary, preventive, and integrated medical and behavioral health care for medically underserved residents of Chesterfield, Darlington, Dillon, Lee, and Marlboro counties in South Carolina. CSC also operates Miles of Smiles Transportable Dental Program serving Title I schools, Healthy Start programs and Disability and Special Needs Boards clients across the region. CareSouth Carolina's primary partner in this project is the Northeast Rural Health Network along with South Carolina Office of Rural Health to improve access and collaboration in Chesterfield, Dillon, and Marlboro counties. Members also include South Carolina Office of Rural Health, the Alpha Center, Chesterfield Coordinating Council, Marlboro County Coordinating council, Northeastern Technical College, South Carolina Department of Health and Environmental Control Region 4, Tri-County Community Mental Health center, Trinity Behavioral Care and McLeod Health Systems and its hospital facilities. The overall goal for the project will be to develop and implement an integrated quality framework to drive change and improve health across the region. This project will improve health outcomes for individuals with mental health or substance abuse issues who utilize area hospitals emergency departments for non-emergent care, especially those with chronic disease such as diabetes. Treating chronic care in an acute-care setting proves extremely expensive for the hospital and the safety net system as a whole. The proposed QI systems will be designed to improve coordination of care delivery across the safety net system, link patients without a primary care medical home at CSC in order to improve patient health outcomes, and reduce the burden of cost on the hospital though decreased emergency department utilization and decreased 30-day readmission. Quarterly reports in tracking systems will document change in targeted indicators among targeted patients. Indicators include increased patient satisfaction, required health outcomes and others to be defined by the QI Task Force, as well as decreased emergency department utilization by target population, decreased 30-day readmissions, and decreased cost. CSC anticipates this project will have a demonstrable and positive impact on the identified measurable parameters. The health centers will be able to secure additional funding for variety of sources to help maintain these efforts including PCMH-based incentives from insurance providers. In addition, CSC will work with the SC Office if Rural Health and through the HOP to advocate for reimbursement of cost-efficient services through SC Medicaid. All of these will ensure that the improvements implemented as a result of the project be sustained beyond the grant period.

South Dakota

Grant Number	G20RH30124					
Grantee Organization Name	Avera Queen of Peace					
Organization type	Small Health Care Provider					
Address	525 N Foster St					
	City:	Mitchell	State:	South Dakota	Zip-code:	57301
Grantee organization website	www.avera.org					
Grantee Project Director	Name:	Angie McCain				
	Title:	Director Service Excellence and Maternal Care				
	Phone:	605-995-5666				
	Fax:	605-995-2441				
	Email:	Angie.mccain@avera.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	08/01/2016 to 07/31/2017	$147,743
	08/01/2017 to 07/31/2018	$180,283
	08/01/2018 to 07/31/2019	$179,150

Network Partners	Organization Name	City/County	Organization Type
	Dakota Women's Clinic	Mitchell/Davison	OB Clinic
	AMG Providers	Mitchell/Davison	OB Clinic
	Sanford Clinic	Mitchell/Davison	OB Clinic

The communities/counties served through the grant-funded Quality Improvement intervention	Aurora County	Hanson County
	Brule County	Hutchinson County
	Buffalo County	Jerauld County
	Charles Mix County	Lyman County
	Davison County	McCook County
	Douglas County	Miner County
	Gregory County	Sanborn County
The target population served	Patients with gestational diabetes	Rural populations
	Pregnant women	
Focus Area(s)	Care management	Health/wellness coaching
	Gestational diabetes	
Health Information Technology System	Meditech	
Quality Improvement Model(s)	Care Model	
Telemedicine/Mobile Health Technology	AveraNow app (via American Well)	
Quality Improvement Project Goal	The goal of the *Before Baby: Avera Remote Gestational Diabetes Monitoring Project* is to deliver healthy babies to healthy mothers in 14 rural counties in south central South Dakota. This will be done by decreasing complications from unmanaged gestational diabetes by combining instant remote gestational diabetes blood sugar monitoring with interactive video visits with a certified diabetes educator/registered dietitian (CDE/RD), thus reducing the risk of chronic disease for both mom and baby in the future.	

Description of the Quality Improvement project	A baby's future health starts in the womb. Early-life influences, beginning with the intrauterine environment, shape the trajectory of a person's health and well-being. Epidemiologic research has primarily targeted risk factors for diseases that operate during adulthood and prevention efforts focus on behavior modification during adult life. More and more evidence, however, points toward the earlier origins of chronic diseases, according to the 2003 report "Early Life Predictors of Chronic Disease" published in the *Journal of Women's Health*. Many chronic diseases result from the interaction of multiple factors, some of which operate as early as in utero. If not managed properly, gestational diabetes, diabetes that presents during pregnancy, has serious, long-term consequences for both baby and mother, including a predisposition to chronic health problems like obesity, metabolic syndrome and diabetes later in life. Gestational diabetes treatment strategies from the American Diabetes Association include daily blood sugar monitoring and a healthy diet. If blood sugar is too high, medication is needed. The goal of the *Before Baby: Avera Remote Gestational Diabetes Monitoring Project* is to deliver healthy babies to healthy mothers in 14 rural counties in south central South Dakota. This will be done by decreasing complications from unmanaged gestational diabetes by combining instant remote gestational diabetes blood sugar monitoring with interactive video visits with a certified diabetes educator/registered dietitian (CDE/RD), thus reducing the risk of chronic disease for both mom and baby in the future. Expected outcomes in meeting the project goal include: • Increased patient access to a CDE/RD via telehealth • Increased patient blood sugar reporting and control • Earlier identification and diagnosis of gestational diabetes • Increased nutritional and dietary education distributed to patients • Tracked and improved health indicators • Fewer labor and delivery complications • Decreased admission to the NICU to control infant blood sugar • Reduction of risk of future chronic disease for mom and baby

Wisconsin

Grant Number	G20RH30548					
Grantee Organization Name	Shawano Medical Center, Inc.					
Organization type	Critical Access Hospital					
Address	100 County Road B					
	City:	Shawano	State:	Wisconsin	Zip-code:	54166
Grantee organization website	www.ThedaCare.org					
Grantee Project Director ***(primary contact person for your grant)***	Name:	Carrie Riley				
	Title:	Director, Care Transitions				
	Phone:	920-540-7898				
	Fax:	N/A				
	Email:	Carrie.riley@thedacare.org				
Project Period	2016 – 2019					

Expected funding level for each budget period	Month/Year to Month/Year	Amount Funded Per Year
	09/01/2016 to 08/30/2017	$198,758
	09/01/2017 to 08/30/2018	$198,758
	09/01/2018 to 08/30/2019	$198,758

Network Partners	Organization Name	City/County	Organization Type
	Stockbridge-Munsee Health & Wellness Center	Bowler, WI	Federally Qualified Health Center
	Rural Health Initiative	Shawano, WI	Grant Funded Outreach clinic
	Northeast Wisconsin Technical College	Green Bay, WI	School
	Menominee Tribal Clinic	Keshena, WI	Federally Qualified Health Center
	Shawano County Health Department	Shawano, WI	Health Department

The communities/counties served through the grant-funded Quality Improvement intervention	Shawano County, Menominee County, Waupaca County
The target population served:	Dangerous and High-Risk Patients with Diabetes and Hypertension
Focus Area(s)	Diabetes, Hypertension
Health Information Technology System	Epic
Quality Improvement Model(s)	Lean
Telemedicine/Mobile Health Technology	N/A
Quality Improvement Project Goal	The objectives of the project are to: 1) improve health outcomes for medically complex patients; 2) strengthen chronic disease management; and 3) improve patient engagement.

Description of the Quality Improvement project	The project will allow ThedaCare Medical Center – Shawano to apply the Lean QI model through which it will expand a multidisciplinary coordinated care approach to primary care settings in Shawano and Waupaca counties (ThedaCare Physicians-Waupaca, ThedaCare Physicians-Shawano and ThedaCare Physicians-Clintonville) and in Menominee County through a learning collaborative including two American Indian-owned and operated tribal clinics. The program will focus on dangerous and high-risk patients with diabetes and hypertension. The objectives of the project are to: 1) improve health outcomes for medically complex patients; 2) strengthen chronic disease management; and 3) improve patient engagement. Outcomes will include improvements in National Quality Forum measures of diabetes care, lipid and blood pressure control, tobacco use, BMI screening and follow-up, depression screening, influenza immunizations, emergency department visit rates and 30-day hospital readmission rates. A consortium of community-based health and social service providers will 1) serve in an advisory capacity; 2) strengthen engagement of and provide community resources to medically complex patients; 3) participate in a learning collaborative that will strengthen their ability to provide multidisciplinary team-based care to medically complex patients while leveraging the tools of QI. The consortium will include two American Indian tribes with tribal health centers, a rural health collaborative, a community technical college and the Shawano-Menominee County Health Department. The project will bring needed healthcare resources to three rural counties in northeastern Wisconsin that have been federally designated as Health Professional Shortage Areas (HPSAs).

Contact Information

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