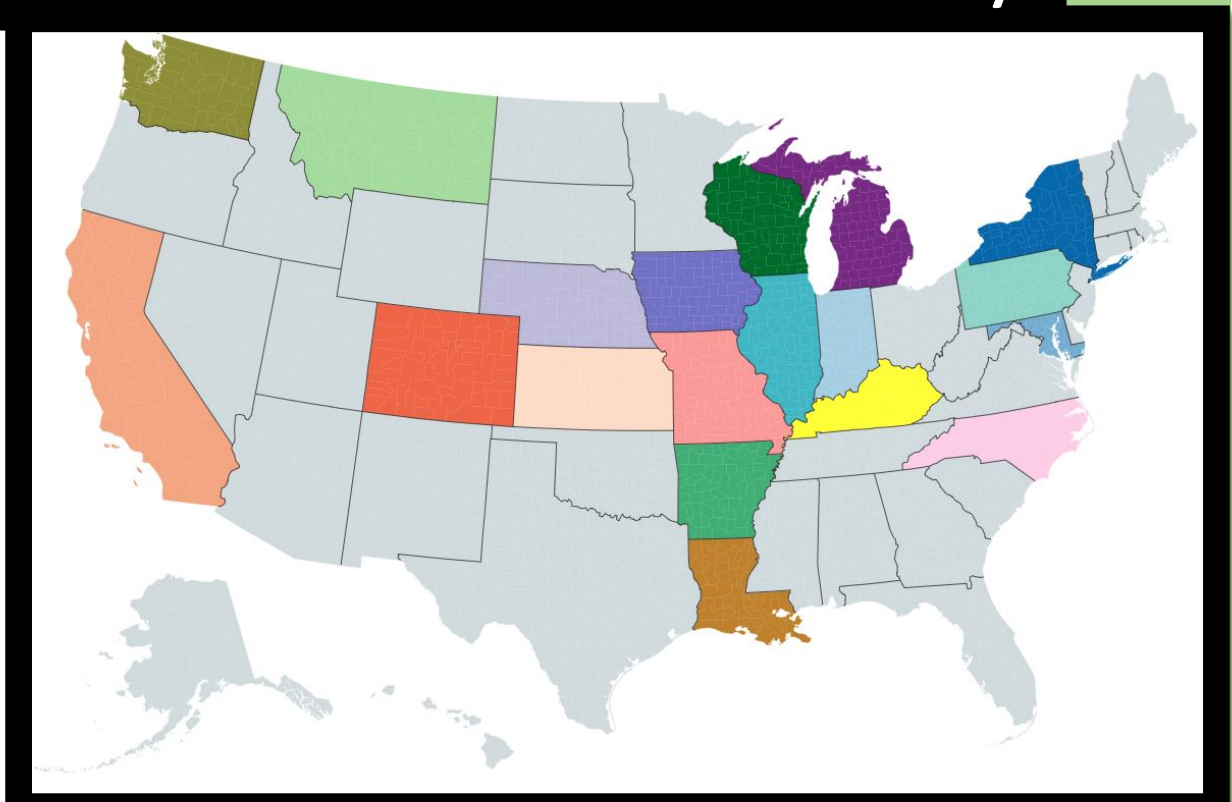
Small Health Care Provider Quality Improvement Program

2019-2022

Grantee Directory



March 2020

U.S. Department of Health and Human Services
Health Resources and Services Administration
Federal Office of Rural Health Policy

HRSA
Health Resources & Services Administration

Introduction

Small Health Care Provider Quality Improvement Program

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 purpose of the Small Health Care Provider Quality Improvement (Rural Quality) Grant Program is to support planning and implementation of quality improvement activities for rural primary care providers, or providers of health care services, such as a critical access hospital or a rural health clinic, serving rural residents. These activities include providing clinical health services to residents of rural areas by funding projects that coordinate, expand access, contain costs, and improve the quality of essential health care services.

The primary goal of the program is to improve the quality and delivery of rural health care services through promoting development of an evidence-based approach to quality improvement and delivery of coordinated care in the primary care setting. Additional program objectives include: improved health outcomes for patients; enhanced chronic disease management; and better engagement of patients and their caregivers. The program also encourages quality improvement activities that address the integration of behavioral health into the primary care setting, value-based care, and patient centered medical homes.

This directory provides contact information and a brief overview of each of the thirty-two initiatives funded under the Small Health Care Provider Quality Improvement Grant Program's 2019 - 2022 funding cycle.[1]

1 The profiles of each of the funded initiatives in this directory, including focus areas and program descriptions, are based on information submitted by grant awardees.

This publication was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

Table of Contents

Grantees by State

State	Grantee
Arkansas	Arkansas Rural Health Partnership
	DePaul Community Health Centers
	Mainline Health Systems, Inc.
California	El Dorado County Community Health Center
	Mayers Memorial Hospital District
	Mountain Health & Community Services, Inc.
	Tahoe Forest Health System Foundation
Colorado	Tri-County Health Network
Illinois	Henderson County Rural Health Center, Inc.
	Jersey Community Hospital District
Indiana	Marion General Hospital
Iowa	Greater Sioux Community Health Center, Inc.
Kansas	Sheridan, County of
	United Methodist Health Ministry Fund
Kentucky	Mercy Health Partners of Southwest Ohio
	Purchase District Health Department, Inc.
Louisiana	Innis Community Health Center, Inc.
	Teche Action Board, The
Maryland	Garrett County Memorial Hospital
Michigan	Upper Peninsula Health Care Solutions, Inc.
Missouri	Douglas County Public Health Services Group
	Health Care Coalition of Lafayette County
	Pike County Memorial Hospital
Montana	Northern Montana Hospital
Nebraska	Four Corners Health Department
New York	Westchester-Ellenville Hospital, Inc.
North Carolina	Granville-Vance District Health Department
Pennsylvania	Keystone Rural Health Consortia, Inc.
Washington	Pullman Regional Hospital Foundation
	Washington Rural Health Collaborative
Wisconsin	Fort Healthcare, Inc.
	Upland Hills Health, Inc.

Grantees by Focus Areas

Focus Area	Grantees	
Behavioral/Mental Health Services	DePaul Community Health Centers Fort Healthcare, Inc. Four Corners Health Department Health Care Coalition of Lafayette County Innis Community Health Center, Inc. Jersey Community Hospital District	Mayers Memorial Hospital District Pullman Regional Hospital Foundation Sheridan, County of Tahoe Forest Health System Foundation Upper Peninsula Health Care Solutions, Inc. Washington Rural Health Collaborative
Cardiovascular Disease (includes Stroke, Hypertension)	Arkansas Rural Health Partnership Four Corners Health Department Greater Sioux Community Health Center, Inc. Henderson County Rural Health Center, Inc. Innis Community Health Center, Inc. Mainline Health Systems, Inc. Marion General Hospital Northern Montana Hospital	Pike County Memorial Hospital Purchase District Health Department, Inc. Sheridan, County of Tri-County Health Network Upland Hills Health, Inc. Washington Rural Health Collaborative Westchester-Ellenville Hospital, Inc.
Care Coordination	Douglas County Public Health Services Group El Dorado County Community Health Center Fort Healthcare, Inc. Four Corners Health Department Garrett County Memorial Hospital Greater Sioux Community Health Center, Inc. Health Care Coalition of Lafayette County Henderson County Rural Health Center, Inc. Keystone Rural Health Consortia, Inc. Mainline Health Systems, Inc.	Marion General Hospital Mountain Health & Community Services, Inc. Northern Montana Hospital Pike County Memorial Hospital Pullman Regional Hospital Foundation Teche Action Board, The United Methodist Health Ministry Fund Upland Hills Health, Inc. Upper Peninsula Health Care Solutions, Inc. Washington Rural Health Collaborative
Chronic Obstructive Pulmonary Disease (COPD)	Mercy Health Partners of Southwest Ohio	Upland Hills Health, Inc.
Community Health Workers (CHWs)	Marion General Hospital Purchase District Health Department, Inc.	Westchester-Ellenville Hospital, Inc.
Diabetes	Arkansas Rural Health Partnership El Dorado County Community Health Center Fort Healthcare, Inc. Four Corners Health Department Greater Sioux Community Health Center, Inc. Henderson County Rural Health Center, Inc. Innis Community Health Center, Inc. Mainline Health Systems, Inc.	Mercy Health Partners of Southwest Ohio Northern Montana Hospital Pike County Memorial Hospital Sheridan, County of Tri-County Health Network United Methodist Health Ministry Fund Upland Hills Health, Inc. Washington Rural Health Collaborative
Health/Wellness Coaching	Mainline Health Systems, Inc. Pullman Regional Hospital Foundation	United Methodist Health Ministry Fund Westchester-Ellenville Hospital, Inc.

Hospital and/or Emergency Department Utilization Reduction/Prevention	Douglas County Public Health Services Group Pike County Memorial Hospital	Pullman Regional Hospital Foundation Purchase District Health Department, Inc.
Obesity	Sheridan, County of	Westchester-Ellenville Hospital, Inc.
Patient Centered Medical Home (PCMH) Model	Arkansas Rural Health Partnership Douglas County Public Health Services Group El Dorado County Community Health Center Health Care Coalition of Lafayette County	Henderson County Rural Health Center, Inc. Jersey Community Hospital District Upper Peninsula Health Care Solutions, Inc.
Patient Engagement	Arkansas Rural Health Partnership	Keystone Rural Health Consortia, Inc.
Practice Facilitation/ Improvement	Douglas County Public Health Services Group Keystone Rural Health Consortia, Inc.	Tri-County Health Network
Social Determinants of Health	El Dorado County Community Health Center Keystone Rural Health Consortia, Inc. Mountain Health & Community Services, Inc.	Purchase District Health Department, Inc. Tri-County Health Network
Substance/ Opioid Use Disorder	Health Care Coalition of Lafayette County Mercy Health Partners of Southwest Ohio	Tahoe Forest Health System Foundation
Telehealth/Telemedicine/ Telemonitoring	Mayers Memorial Hospital District	Washington Rural Health Collaborative
Tobacco Use	Mercy Health Partners of Southwest Ohio	
Value-Based Care	Keystone Rural Health Consortia, Inc.	United Methodist Health Ministry Fund
Workforce Development/ Training	Upper Peninsula Health Care Solutions, Inc.	

Other Focus Areas

Focus Area	Grantee
Treatment of chronic and acute pain using non-opioid medical approaches and ancillary therapies (acupuncture, meditation, massage, dietary consults, counseling)	Garrett County Memorial Hospital
Oral health and integrated care	Granville-Vance District Health Department
Medication management	Mainline Health Systems, Inc.
Hepatitis C	Mercy Health Partners of Southwest Ohio
Colorectal cancer screening, tobacco use, immunizations, dental sealants	Sheridan, County of
General chronic disease management	Upper Peninsula Health Care Solutions, Inc.

Grantee Profiles

The following section contains contact information and brief descriptions of the 32 Small Health Care Provider Quality Improvement Program grantees funded during the 2019-2022 grant period. They are arranged alphabetically by organization name. These profiles include a description of the target population, project focus areas, evidence-based models, health information technology, project goals and objectives, and project description.

Arkansas

Arkansas Rural Health Partnership

Grant Number:	G20RH33260			
Organization Name:	Arkansas Rural Health Partnership (ARHP)			
Organization Type:	Public nonprofit partnership			
Organization Address:	1969 Lakehall Rd., Lake Village, AR 71653			
Project Title:	ARHP Quality Improvement Project			
Website:	www.arruralhealth.org			
Project Contact:	**Name:**	Amber O'Fallon		
	Title:	Director of Quality Improvement		
	Phone:	(870) 461-0276		
	Email:	amberofallon@arruralhealth.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Ashley Health Services		Ashley	Rural Health Clinic
	BCMC RHC/BCMC Women's Clinic		Bradley	Rural Health Clinic
	Baptist Health Family Clinic - Brinkley		Monroe	Rural Health Clinic
	Baptist Health Family Clinic - Clarendon		Monroe	Rural Health Clinic
	Baptist Health Family Clinic - DeWitt		Arkansas	Rural Health Clinic
	Baptist Health Family Clinic - England		Lonoke	Rural Health Clinic
	Baptist Health Family Clinic - Hazen		Prairie	Rural Health Clinic
	Baptist Health Family Clinic – Stuttgart		Arkansas	Rural Health Clinic
	Chicot Memorial Medical Clinic		Chicot	Rural Health Clinic
	Connelly Family Medical Clinic		Drew	Rural Health Clinic
	Delta Health Services		Desha	Rural Health Clinic
	Family Care of South Arkansas		Union	Rural Health Clinic
	Family Clinic of Ashley County		Ashley	Rural Health Clinic
	Ferguson Rural Health Clinic		Arkansas	Rural Health Clinic
	Hamburg Health Clinic		Ashley	Rural Health Clinic
	Lake Village Clinic		Chicot	Rural Health Clinic
	Magnolia Family Medical Clinic		Columbia	Rural Health Clinic
	Marsh-George Clinic		Bradley	Rural Health Clinic
	McGehee Family Clinic		Desha	Rural Health Clinic
	South Arkansas Adult Medicine Center		Union	Rural Health Clinic
Target Population(s):	Chronic care management services will be provided to Medicare eligible patients at partnering rural primary care clinics, specifically for chronic disease (cardiovascular disease, diabetes, obesity, hypertension, depressing, and smoking related illnesses).			

Focus Area(s):	• Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes • Patient Centered Medical Home Model (PCMH) • Patient Engagement
Evidenced-Based/ Promising Practice Model(s)	Plan-Do-Study-Act (PDSA)
Health Information Technology System(s)	• Azalea Health • CPSI/Evident • eClinicalWorks • eMDs • Epic
Project Goals & Objectives	**Goal** Strengthen the organizational and infrastructural capacity of hospital & primary care clinic partners to address critical quality improvement needs throughout rural south Arkansas **Objectives** • The ARHP Consortium will share the responsibility of the achievement, dissemination, and sustainability of QI Program activities • Determine the QI needs of primary care clinic partners • Develop the infrastructure and tools to support existing and new QI activities throughout the region • Train local health workforce partners to utilize and implement an evidence-based QI model within their practice setting • Assist primary care clinic partners to improve the utilization of the electronic medical record • Provide chronic care management services to approximately 450 Medicare eligible patients per year to improve self-management of chronic conditions, treatment and medical adherence • Assist clinic partners to improve selected clinical measures by 3-5% through focused quality improvement efforts • Incorporate elements of PCMH into activities throughout the project period. **Goal** Improve documentation in electronic medical record (EMR) **Objectives** • Standardize the tracking of clinical measures across all participating clinic • Improve the number and quality of reports (referrals, hospital discharge, labs, etc.) received electronically. • Improve the number and quality of reports (referrals, hospital discharge, labs, etc.) received electronically **Goal** Demonstrate improvements to delivery of care **Objective** • Delivery of preventive services to an increased number of patients **Goal** Improve communication with patients **Objective** • Utilization of needs assessment and satisfaction surveys to monitor whether clinics are meeting the needs of the patient population **Goal** Provide education for patient with chronic conditions **Objective**

	• Provide chronic care management services to Medicare eligible patients at partnering rural primary care clinics
Project Description	This project will prepare primary clinic partners to gain national PCMH recognition from NCQA beyond grant funding. This will be accomplished through a variety of methods, including enhancing EMR documentation, improving communication between provider and patient, as well as documenting processes, procedures, and work plans. This project will also provide assistance in evaluating current processes for chronic disease management and provide quality improvement education and tools to align with PCMH processes. ARHP will incorporate elements of PCMH into activities throughout the grant project period. During this time, clinics will increase their capacity to meet PCMH requirements without overextending their capacity. Elements of PCMH that will be included are 1)improvement in EMR documentation, 2) demonstrate improvement to delivery of care, 3) improve communication with patients, 4) provide education for patients with chronic conditions, 5) provide education for preventive measures and 6) standardize procedures, processes, and workflows.

Arkansas

Depaul Community Health Centers

Grant Number:	G20RH33266			
Organization Name:	Daughters of Charity Health Services (d.b.a. DePaul Community Health Centers (DCHC))			
Organization Type:	Community Health Center (CHC)			
Organization Address:	161 S Main St., Dumas, AR 71639			
Project Title:	Whole Health Program			
Website:	www.dcsark.org			
Project Contact:	**Name:**	Brenda Jacobs DNP APRN FNP-BC		
	Title:	CEO		
	Phone:	(870) 382-3080		
	Email:	brenda.jacobs@dcsark.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	DePaul Community Health Centers-Dumas		Desha	CHC
	DePaul Community Health Centers-Gould		Lincoln	CHC
Target Population(s):	The project is focused on a cohort of 1,523 patients who have co-morbid chronic disease diagnoses of diabetes, hypertension and/or high cholesterol and are included in the clinic system's Chronic Disease Patient Registry (CDPR).			
Focus Area(s):	Behavioral/Mental Health Services (includes Integration into Primary Care)			
Evidenced-Based/ Promising Practice Model(s)	• Four Quadrant Clinical Integration Model (FQCI) • IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) Model • Screening, Brief Intervention, and Referral to Treatment (SBIRT) • Wagner Chronic Care Model			
Health Information Technology System(s)	Intergy (EHR)			
Project Goals & Objectives	**Goal** Implement a standardized practice design for behavioral health integration that screens all patients for BH disorders, uses a structured patient triage protocol for patients needing behavioral health care, and provides an effective therapeutic approach for these patients within a collaborative care contract. **Objectives** • Execute agreements with Psychiatric providers for specialty treatment services • Redesign the patient flow plan, procedures, and processes to integrate behavioral health points of care • Provide comprehensive behavioral health integration training to appropriate clinic staff • Develop and implement clinical protocols and administrative procedures to provide telepsychiatric consults **Goal** Complete a comprehensive behavioral health assessment for every patient in the DCHC Chronic Disease Patient Registry **Objectives**			

	• Select validated multidimensional screening tools for mental health and substance abuse disorders and a Care Plan format • Develop and adapt a behavioral health care plan for Chronic Disease Patient Registry (CDPR) patients with mental illness and or substance use disorder • Pilot behavioral health integration processes and procedures in real time, finalize and fully implement integration • Provide telepsychiatric consults for those patients with behavioral health disorders who would otherwise be unable to access psychiatric services **Goal** Ensure the quality of behavioral health data fields provided by DCHC CDPR patients is data driven and that the expansion of behavioral health services is sustainable **Objectives** • Ensure appropriate behavioral health data fields exist in the electronic medical record (EMR) and that the system can generate patient specific alerts for care follow-up • Ensure that unidentifiable patient data can be accurately aggregated and extracted via the population health management system for timely reporting of behavioral health integration clinical outcomes at the clinic and provider levels • Implement a comprehensive billing plan to sustain the provision of behavioral healthcare, including telepsychiatric consults
Project Description	DCHC is a 501 (c) (3) non-profit faith-based and HRSA-designated Rural Health Clinic caring for the population of one of the poorest areas in rural America, the Mississippi Delta Region of Southeast Arkansas. Two counties, Desha and Lincoln, comprise DCHC's primary service area. DCHC seeks to improve the quality of life for adult patients with multiple chronic diseases by providing this fragile population with access to treatment for mental health and substance use disorders. The behavioral health integration program, DCHC Whole Health, will be characterized by a practice design that identifies mental health and substance use disorders among targeted patients, provides timely and effective primary-cared based intervention and therapy, including medications when indicated, and links patients with complex multiple morbidities to psychiatric consults. DCHC will implement the Whole Health program in partnership with the AIMS Center at the University of Washington and the University of Arkansas for Medical Sciences e-Link Telemedicine Network. The IMPACT model is a practice design structure for improving access to, and the quality of mental health care through the use of Collaborative Care Teams in a primary care setting. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, public health approach to the delivery of early intervention for individuals with risky alcohol and drug use, as well as the timely referral to more intensive substance abuse treatment for those who have substance abuse disorders. Four Quadrant Clinical Integration Model (FQCI) is a conceptual system-wide framework that serves as a guideline for assigning treatment responsibility between specialty mental health providers and primary care providers. Telepsychiatry consults will be an adjunct to the Whole Health program in order to address the severe shortage of psychiatrists in Arkansas and as a means to address transportation barriers facing DCHC patients.

Missouri

Douglas County Public Health Services

Grant Number:	G20RH33261			
Organization Name:	Douglas County Public Health Services Group (dba. Missouri Ozarks Community Health)			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	504 W 10, Ava, MO 65608			
Project Title:	Missouri Ozarks Health Improvement Project			
Website:	www.mo-ozarks.org			
Project Contact:	**Name:**	Debby Jeckstadt		
	Title:	Quality Resources Coordinator		
	Phone:	(417) 683-5739, ext. 408		
	Email:	djeckstadt@mo-ozarks.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Ava		Douglas	FQHC
	Mansfield		Wright	FQHC
	Gainesville		Ozark	FQHC
	Mountain Grove		Wright	FQHC
	Cabool		Texas	FQHC
	Houston		Texas	FQHC
	Licking		Texas	FQHC
Target Population(s):	Individuals identified with a diagnosis of diabetes, cardiovascular disease, hypertension, and/or depression, and individuals who have a history of smoking or tobacco use and/or weigh outside normal parameters. Specific emphasis is placed on individuals with no primary care provider and those who frequent the hospital emergency department.			
Focus Area(s):	• Care Coordination • Hospital and/or Emergency Department Utilization Reduction/Prevention • Patient Centered Medical Home Model (PCMH) • Practice Facilitation/Improvement			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care Model • Community Health Worker Model • Institute for Health Improvement Model • Patient Centered Medical Home (PCMH) Model • Plan Do Study Act (PDSA)			
Health Information Technology System(s)	• Azara / DRVS Data Warehouse • Care Message • Eagle Dream • Missouri Health Connect • NextGen			
Project Goals & Objectives	**Goal** To provide better care and sustain health improvement of 500 chronic disease patients accessing services from the health center **Objectives**			

	• Improved quality and frequency of communication between providers, care team, patients and their families, and community stakeholders • Improve processes for care transitions and care coordination for target population presenting in the hospital emergency department or transitioning from the inpatient setting • Improve care coordination for target population served in the health center's primary care setting • Increase the knowledge and confidence level of project providers and their care teams to provide effective care transitions • Increase the knowledge and confidence level of project care teams to provide evidence-based chronic care management • Demonstrate quality and performance improvement in the delivery of care to patients living with chronic disease (target population) • Reduce reported condition severity and improve reported quality of life for target population with project-specific chronic diseases
Project Description	Missouri Ozarks's Health Improvement Project (MOHIP) aims to improve the quality and safety of patients with chronic disease. Through this project, outcomes expected include better patient engagement in care, improved patient self-management, decreased use of the hospital emergency department for preventable visits and, ultimately, improved health status for the target population. MOHIP will improve coordination and integration of care using the Chronic Care model, Community Health Worker model, and Institute for Health Improvement model for improvement in a Patient-Centered Medical Home framework.

California

El Dorado County Community Health Center

Grant Number:	G20RH33272			
Organization Name:	El Dorado County Community Health Centers (EDCCHC)			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	4327 Golden Center Dr., Placerville, CA 95667			
Project Title:	Diabetes Prevention and Management Program			
Website:	https://www.edchc.org			
Project Contact:	**Name:**	Alicia Kelley		
	Title:	Quality Improvement Manager		
	Phone:	(530) 350-7839		
	Email:	akelley@edchc.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	EDCCHC - Placerville		El Dorado County	FQHC
	EDCCHC - Cameron Park		El Dorado County	FQHC
	Community Hub 1- El Dorado Hills Library		El Dorado County	Community Library
	Community Hub 2- Cameron Park Library		El Dorado County	Community Library
	Community Hub 3- Placerville Library		El Dorado County	Community Library
	Community Hub- 4 Georgetown Library		El Dorado County	Community Library
	Community Hub- 5 South Lake Tahoe Library		El Dorado County	Community Library
Target Population(s):	The target patient populations for this project are 1,500 adult pre-diabetic and 900 adult diabetic patients of El Dorado County Community Health Centers (EDCCHC).			
Focus Area(s):	• Diabetes • Patient Centered Medical Home Model (PCMH) • Social Determinants of Health • Care Coordination			
Evidenced-Based/ Promising Practice Model(s)	• Centers for Disease Control and Prevention (CDC) Healthy Lifestyles • The Model for Improvement • Plan-Do-Study-Act (PDSA) • PRAPARE - Implementation and Action Toolkit			
Health Information Technology System(s)	• BridgeIT • eClinicalWorks • Tableau			
Project Goals & Objectives	**Goal** To improve chronic disease prevention and management for 1,500 pre-diabetic and 900 diabetic adult patients **Objectives** • Offer evidence-based lifestyle change classes to 100% of identified adult pre- diabetic and diabetic patients in the communities where they live and work • Implement the PARPARE Implementation and Action Toolkit to assess, understand, and begin addressing social determinants of health of identified adult pre-diabetic and			

	diabetic patients • Development and implementation of provider dashboards to conduct proactive outreach to and population management of pre-diabetic and diabetic patients • Incorporation of key Patient Care Medical Home standards and elements in the care of pre-diabetic and diabetic patients
Project Description	El Dorado County Community Health Centers (EDCCHC) proposes to improve chronic disease prevention and management for 1,500 pre-diabetic and 900 diabetic patients living in rural El Dorado County, California through a diabetes prevention and management program focused on lifestyle education, enhanced care coordination, and efforts to address social determinants of health. Working with an existing community consortium, lifestyle education and assistance with social determinants of health will be provided to pre-diabetic and diabetic patients through community-based classes and partnerships with Community Hubs and clinics. Access El Dorado (ACCEL) is a consortium of community-wide private and public agencies that seek to create healthier communities. Consortium members include: EDCCHC, Marshall Medical Center, and El Dorado County Health Services. Community- based classes will be facilitated by trained lifestyle change coaches and will use a researched-based curriculum like that recommended in the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program. The PRAPARE Implementation and Action Toolkit will be implemented at EDCCHC and referral systems to Community Hubs will be established to address social determinants of health needs. This project proposes to enhance care coordination for pre-diabetic and diabetic patients by implementing a data analytics and reporting tool to enable EDCCHC to conduct proactive outreach and population management of pre-diabetic and diabetic patients. EDCCHC also plans to more fully incorporate key Patient Centered Medical Home (PCMH) standards and elements into the care of pre-diabetic and diabetic patients and renew level 3 recognition at all EDCCHC sites. EDCCHC will use two evidenced-based quality improvement models during project implementation: The Model for Improvement and Plan-Do-Study-Act (PDSA). The Model for Improvement used in conjunction with PDSA will help staff ensure continuous quality improvement of program activities during project implementation. Expected project outcomes include: 5-7% weight loss maintained by lifestyle change class participants; reduction by 5% of the number of patients with HbA1c values greater than 9%; increase by 5% the number of pre-diabetic and diabetic patients who receive weight screenings and counseling; and screening for social determinants of health of 75% of program participants.

Wisconsin

Fort Healthcare, Inc.

Grant Number:	G20RH33262			
Organization Name:	Fort HealthCare, Inc. (FHC)			
Organization Type:	Non-Profit Community Health System			
Organization Address:	611 Sherman Ave. E., Fort Atkinson, WI 53538			
Project Title:	Improving Diabetes Care for Healthier Communities			
Website:	www.forthealthcare.com			
Project Contact:	**Name:**	Dwight Heaney		
	Title:	Executive Director - Foundation		
	Phone:	(920) 568-5404		
	Email:	dwight.heaney@forthc.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Fort HealthCare, Inc.		Jefferson County, WI	Community Hospital
Target Population(s):	All Fort HealthCare patients 18 years or older with diabetes diagnosis and HbA1C≥8% meeting Cerner HealtheRegistries attribution logic.			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Care Coordination • Diabetes			
Evidenced-Based/ Promising Practice Model(s)	Plan-Do-Study-Act (PDSA)			
Health Information Technology System(s)	• Cerner HealtheAnalytics • Cerner HealtheIntent platform • Cerner HealtheRegistries • Cerner Millenium EHR			
Project Goals & Objectives	**Goal** Improve diabetes care and patient health outcomes **Objectives** • FHC will improve all project-specific measures in FHC's Cerner Diabetes Registry to FY goals • Increase the number of Chronic Care Management (CCM) referrals & improve proportion of CCM engagement through launch of a new CCM program • Increase the number of Diabetes Self-Management Education (DSME) referrals to an average of at least 50 per month & improve proportion of DSME engagement to at least 30% of total direct & proposed referrals • Incorporate new goals & benchmarks as determined • Conduct at least one state &/or national level presentation and at least two written case briefs **Goal** Increase community member access to health care & services **Objectives** • FHC will increase the number of attributed persons (denominator) in the FHC Cerner			

	Diabetes Registry • Continued increase in number of individuals in the diabetes registry from baseline & have growth in subsequent years **Goal** Increase the collection and analysis of select social determinants of health measures to identify and address disparities **Objectives** • FHC will pilot at least one social determinants of health (SDOH) tool with a subset of the target population • Increase use of SDOH tool with target population from baseline & have growth in subsequent years
Project Description	Initial project activities include launch of a Chronic Care Management (CCM) program; staff training and patient education; depression screening in primary care and through CCM program; tele-ophthalmology project planning; Diabetes Self-Management Education (DSME) referral and engagement coordination; ambulatory pharmacy program exploration; strategic community outreach and partnership to increase access to care and data; IT and population health build of select measures into FHC's Cerner Electronic Health Record (EHR) or data systems; and testing of SDOH tool(s) and data points. Following years will be implementation-focused with dissemination of results, incorporating a systems approach to assure sustainability of evidence-based practice. The final year will explore application to other priority chronic diseases (e.g., hypertension) for improved management outcomes.

Nebraska

Four Corners Health Department

Grant Number:	G20RH33267			
Organization Name:	Four Corners Health Department (FCHD)			
Organization Type:	Local Public Health Department			
Organization Address:	2101 N Lincoln Ave., York, NE 68467			
Project Title:	Small Health Care Provider Quality Improvement			
Website:	www.fourcorners.ne.gov			
Project Contact:	**Name:**	Laura McDougall		
	Title:	Executive Director		
	Phone:	(402) 362-2621		
	Email:	lauram@fourcorners.ne.gov		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Four Corners Health Department		Butler, Polk, Seward, York	Health Department
	York General		York, Polk, Seward, Fillmore	Critical Access Hospital
	York Medical Clinic (YMC)		York, Polk	Primary Care Clinic Accountable Care Organization (ACO)
Target Population(s):	Individuals utilizing medical services from York General and/or the York Medical Clinic Specifically, this includes a focus on patients at high risk for heart failure, diabetes and depression. The target population resides primarily within York County, and its contiguous counties in Nebraska.			
Focus Area(s):	• Care Coordination • Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes • Behavioral/Mental Health Services (includes Integration into Primary Care)			
Evidenced-Based/ Promising Practice Model(s)	• Living Well with Chronic Conditions • Medicare Beneficiary Quality Improvement • National Diabetes Prevention Program • Patient-Centered Medical Home • Stepping On (fall prevention) • Tai Chi (fall prevention) • Tobacco Cessation Programs • Worksite Wellness			
Health Information Technology System(s)	Allscripts			
Project Goals & Objectives	**Goal** Build a comprehensive integrated coordinated care network between primary care, public health, and critical access hospital **Objectives** • Organize an integrated care coordination team consisting of staff from YMC, FCHD, and York General to guide and oversee the grant project • Identify the specific roles and responsibilities of each team member, processes and			

work flows, and the decision-making process of the team (sharing of cost savings)
- Determine all performance measures, including mandatory clinical measures, identify baselines, and set targets for all measures
- Develop capacity for integrating a behavioral health partner(s) into the care coordination team
- Add a behavioral health member(s) to the York Care Coordination Network

Goal
Identify all patients at high-risk for congestive heart failure, diabetes, and depression

Objectives
- Use the American Academy of Family Physicians (AAFP) Risk Matrices screening tool to assign a risk score to all attributed patients at YMC and patients presenting at York General ER/Admissions (in-patient/observation). Risk scores will be entered into patient medical records at YMC and York General
- Use the PHQ-9 (Patient Health Questionnaire-9) screening tool to identify patients with depression at YMC and patients presenting at York General emergency room (ER)/admissions (in-patient/observation). Results will be entered into patient medical records at YMC and York General
- Develop a treatment and intervention plan for each patient based on their AAFP risk score and PHQ9 results

Goal
Implement high quality treatment practices and community/population-based interventions

Objectives
- Implement high quality treatment plans for all appropriate patients and report baseline data within YMC and York General's electronic medical record (EMR)
- Develop a community/population-based intervention strategy and referral plan for YMC and York General's high-risk patients
- Identify gaps in treatment services and community/population-based interventions
- Build capacity and implement additional high-quality treatment practices and community/population-based interventions to address identified gaps

Goal
Determine ways to share data between all network partners

Objectives
- Establish a system to share data between all network partners; produce agreements to demonstrate how data is shared
- Establish a plan to create more efficient and seamless data-sharing; identify resources to accomplish the plan
- Secure resources and implement a more efficient and seamless data-sharing system for all network partners

Goal
Monitor progress and evaluate patient and population health outcomes

Objectives
- Begin collecting data on selected patient and population health outcomes and record in EMR
- Establish a data dashboard and submit project measures/outcomes as required. Prepare and submit annual evaluation report

Goal
Develop a sustainability model to ensure continuation of the project beyond the grant period

Objectives
- Identify Centers for Medicare & Medicaid Services (CMS) and private insurer programs (e.g., chronic care management) and billing codes that could be used to

	fund chronic disease management and behavioral health interventions. Develop a plan to sustain the model beyond the grant period and submit to HRSA as required • Compare the costs of care coordination activities with the cost savings (e.g., decrease in readmissions and unnecessary ER visits) and report to network partners • Meet with state Medicaid officials to discuss potential cost savings and appropriate reimbursement • Report on economic impact of the project as required
Project Description	In this quality improvement project, York General, York Medical Clinic, P.C. and the Four Corners Health Department are collaboratively and cooperatively building a comprehensive integrated coordinated care network to improve health outcomes and strengthen the rural health care system. This collaborative network/model of rural care coordination will provide comprehensive patient-centered care by implementing high quality treatment practices and community population-based interventions. The Four Corners Health Department serves as the lead applicant, fiscal agent, and Project Director. The health department provides evidence-based community programs to local residents to prevent/cope with chronic diseases and social conditions. The York Medical Clinic, P.C., provides primary care services, is a member of the South East Rural Physicians Alliance Network (SERPA) ACO and has an established care coordination team. A public health nurse from Four Corners is being integrated into this care coordination team to assist in connecting patients to community services. York General is the partnering local critical access hospital, which plans to integrate its care coordination with the clinic team and develop pathways for improved information-sharing. Lastly, the group also intends to integrate behavioral health into the network to better address local behavioral health needs. The vision, in summary, is to take a leading role in developing targeted and effective care coordination strategies to meet the needs of high-risk patients living in York County and to enhance the delivery of services by improving the integration of critical access hospital, primary care and public health interventions, services and programs.

Maryland

Garrett County Memorial Hospital

Grant Number:	G20RH33278			
Organization Name:	Garrett County Memorial Hospital, DBA Garrett Regional Medical Center			
Organization Type:	Acute care hospital			
Organization Address:	251 N 4th St., Oakland, MD 21550			
Project Title:	Integrative Pain Center			
Website:	www.grmc-wvumedicine.org			
Project Contact:	**Name:**	Kimi-Scott McGreevy		
	Title:	AVP Marketing & Development		
	Phone:	(301) 533-4356		
	Email:	kmcgreevy@gcmh.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Garrett Regional Medical Center		Garrett County, MD	Acute care hospital
	Potomac Valley Hospital		Mineral County, WV	Critical access hospital
Target Population(s):	Patients with chronic and acute pain referred to the clinic by the Primary Care Provider or a specialist. This includes patients of all income levels, though, the majority of targeted patients are expected to include Medicaid and/or Medicare recipients due to the low income levels of the area.			
Focus Area(s):	• Care Coordination • Treatment of chronic and acute pain using non-opioid medical approaches and ancillary therapies (acupuncture, meditation, massage, dietary consults, counseling)			
Evidenced-Based/ Promising Practice Model(s)	• Assistant Secretary For Health Draft Report on Pain Management Best Practices • Validated opioid and pain screening/risk assessment tools - SOAPP-R: Screener and Opioid Assessment for Patients with Pain- Revised; PEG - Pain Screening Tool; ORT - Opioid Risk Tool			
Health Information Technology System(s)	Meditech			
Project Goals & Objectives	**Goal** Establish integrative pain clinic that provides non-addictive pain solutions and avoid use of opioids **Objectives** • Limit the number of clinic patients prescribed opioids for pain relief • Gradually reduce the dosage for patients previously prescribed opioids for pain relief • Ensure patients whose pain needs include opioid protocol feel supported and are carefully monitored **Goal** Provide a multi-disciplinary approach to pain management that incorporates various disciplines in addressing the components of pain using the biopsychosocial treatment model **Objectives** • Create a biopsychosocial care plan with input from the patient • Reassess the created care plan on a bimonthly basis with patient input			

	• Limit exposure to opioids for all patients, but especially those who screen as more likely to abuse opioids or other drugs **Goal** Address pain management practices in inpatient and out-patient hospital settings **Objective** • Adopt perioperative guidelines that minimize opioid use and emphasize alternative pain relief measures
Project Description	This project seeks to create a model program that helps address the opioid epidemic prevalent in rural communities throughout the United States, particularly in the Appalachian region. The Integrative Pain Centers will provide alternative pain treatment programs that use methods other than opioids to address both chronic and acute pain episodes. The purpose of the Integrative Pain Center with its two locations is to provide positive options for pain relief and control for chronic disease patients as well as patients experiencing acute pain episodes in rural Appalachia. The clinics will work with patients to find the pain approach that best suits their situation and pain sources. Alternative methods of treatment will be explored, and opioids will only be prescribed for patients whose conditions dictate that route of pain relief. Among the alternative pain management treatments made available will be steroid injections, radio frequency ablations, spinal cord stimulation, Botox injections, occipital nerve blocks, and sphenopalatine ganglion (SPG) blocks. Chronic disease and other patients will be weaned away from opioid use, or, for new pain patients, will be prevented from using opioids to address their pain at all, if possible. Ancillary services offered in addition to the direct treatment of pain will include acupuncture, massage therapy, meditation, dietary consults, and counseling. The idea of the pain clinics is to lessen the number of opioid prescriptions provided residents of the communities and to help those pain patients currently struggling with opioid use to lessen and, if possible, eliminate their dependence on opioids for pain relief over time. As patients are referred to the clinic by a primary care provider or specialist, staff will review their health/pain as well as life stressors that can impact their health such as child care, elder care, housing needs, etc. A health history as well as a specific history of their pain, and all medications prescribed, will be taken. Staff will work with patients to create individual patient care plans. Patients will be active participants in the creation of their plan, and will help staff tweak the plan as they strive for pain relief and drug independence moving forward. Patients will set goals regarding pain relief as well as addressing stressors in their lives that may be negatively impacting the pain they experience. The IPCs will employ a Community Health Worker to help patients find community agency assistance in addressing life stressors.

North Carolina

Granville-Vance District Health Department

Grant Number:	G20RH33263-01			
Organization Name:	Granville Vance District Health Department/Carolina Fellows Family Dentistry			
Organization Type:	Public Health/Dental Clinic			
Organization Address:	101 Hunt Dr., Oxford, NC 27565			
Project Title:	Rural Integrated Care and Oral Health Improvement Initiative (RICOHII)			
Website:	www.gvph.org			
Project Contact:	**Name:**	Wendy Smith		
	Title:	Special Projects Officer		
	Phone:	(252) 492-7151		
	Email:	wsmith@gvdhd.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Carolina Fellows Family Dentistry (CFFD)		Vance and Granville County	Public Health Dental Clinic
	Granville Vance Public Health (GVPH)		Vance and Granville County	Public Health
	Franklin Vance Warren Opportunities		Vance and Granville County	Early Childhood Development Program
	Franklin Granville Vance Smart Start		Vance and Granville County	Early Child Care and Education
	Henderson Collegiate		Vance County	Charter School K-12 (>90% of kids living in poverty)
Target Population(s):	Pregnant women (all ages) and children (aged 0-18) with a focus on children <5 years old, in Vance and Granville Counties			
Focus Area(s):	Oral Health and Integrated Care			
Evidenced-Based/ Promising Practice Model(s)	• Lean • Model for Improvement • Plan-Do-Study-Act (PDSA)			
Health Information Technology System(s)	Dentrix Enterprise			
Project Goals & Objectives	**Goal** Increasing by 20% the number of prenatal patients served by CFFD who receive oral health care during the program period **Objectives** • Conduct needs assessment survey of target population • Develop communication process ensuring staff are providing the same message and completing referrals effectively for target population • Conduct at least 4 planning meetings annually with target population departments/agencies • Implement oral health education including importance of proper care and treatment			

	during pregnancy **Goal** Increase annual preventive oral health services at CFFD by 30% for Medicaid children birth to 18 years of age **Objectives** • Conduct needs assessment survey of target population • Develop communication process ensuring staff are providing the same message and completing referrals effectively for target population • Conduct at least 4 planning meetings annually with target population departments/agencies • Implement oral health education including importance of proper care and treatment during child health and WIC (Women, Infant, and Children) program visits **Goal** Increase by 30% the number of pre-Kindergarten students in the district who have a dental home **Objectives** • Conduct needs assessment survey of target population • Conduct at least 4 planning meetings annually with target population departments/agencies • Implement information/education sessions with all pre-kindergarten agencies and parents/guardians of target population regarding importance of oral health care and having a dental home, receiving recommended cleanings, how oral health affects physical health in adulthood • Develop communication process ensuring staff are providing the same message and completing referrals effectively for target population **Goal** Increase by 40% the number of referrals to CFFD from integrated care and healthcare partners **Objectives** • Develop an effective, streamlined referral process for oral health care with GVPH integrated care clinics and stakeholders • Develop a community outreach program to promote dental care among private daycares, charter schools and community clubs • Conduct at least 12 community outreach events in both counties
Project Description	The Rural Integrated Care and Oral Health Improvement Initiative in North Carolina (RICOHII) aims to apply quality improvement tools and methods to further an integrated, whole-person care model in our two-county district, including improved access to dental care for pregnant women and children in the district. Links between oral health and overall health have become increasingly evident, especially among pregnant women. Granville Vance Public Health (GVPH) aims to improve the oral health status of the patient population in a rural northern piedmont district in North Carolina 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. GVPH will leverage existing local and regional partnerships established in 2018 for integrated care planning and implementation. We seek to extend an existing network of partners including the Health Department, UNC-Chapel Hill School of Dentistry, Franklin- Granville-Vance Smart Start, local behavioral health agencies including Alliance Rehabilitative Care and Recovery Innovations International, and local primary care and obstetric care offices. Together, we will coordinate care for improved patient outcomes in Granville and Vance Counties and help support health system integration including oral health initiatives.

Greater Sioux Community Health Center, Inc.

Grant Number:	G20RH33268		
Organization Name:	Greater Sioux Community Health Center, Inc./Promise Community Health Center (CHC)		
Organization Type:	Federally Qualified Health Center (FQHC)		
Organization Address:	338 1st Ave. NW, Sioux Center, IA 51250		
Project Title:	Population Health Program to Improve Chronic Disease Management and Expand Preventive Services Access		
Website:	www.promisechc.org		
Project Contact:	**Name:**	Stephanie Van Ruler	
	Title:	Population Health Manager	
	Phone:	(712) 722-1700	
	Email:	svanruler@promisechc.org	
Project Service Sites:	**Site Name**	**County/Counties Served**	**Site Type**
	Promise CHC	Sioux, O'Brien, Plymouth	FQHC
	Community Health Partners	Sioux	Health Department
Target Population(s):	All rural Promise CHC patients. Patients from 144 zip codes received services at Promise in 2018. Many of the patients served are considered vulnerable populations due to poverty, insurance status and language barriers. In 2018, 45% of patients served were uninsured. Patients with poorly controlled diabetes and hypertension will be a specific focus of this project.		
Focus Area(s):	• Care Coordination • Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes		
Evidenced-Based/ Promising Practice Model(s)	Model for Improvement		
Health Information Technology System(s)	• Athena EMR • Chart Scout		
Project Goals & Objectives	**Goal** Team-Based Care and Practice Organization **Objectives** • Hire new team members • Adjust organization structure and staff responsibilities to support expanded Population Health Program • Develop clearly defined roles and responsibilities of staff **Goal** Training and education to support Chronic Disease Management and Population Health strategies **Objective** • Create a sustained, comprehensive, culturally competent and patient-centered model by investing in training and education **Goal** Implement Care Management & Support through structured Chronic Disease Management and		

	enhance Preventive Services **Objectives** • Chronic Disease Management through protocols and policies based on American Diabetes Association (ADA) and American Hospital Association (AHA) standards • Achieve accreditation as American Diabetes Association (ADA) facility • Provide resources for patient to take control of chronic care management in their homes (i.e.- Home BP kits, CGM, glucometers) • Preventive Care services through evaluation of barriers for those not accessing preventive services • Community Outreach through collaboration with area schools **Goal** Knowing and responding to patient needs **Objectives** • Training on impacts of social determinants of health • Assessment implementation for SDOH and Health Literacy • Develop resources and pathways to assist patients in their identified barriers **Goal** Build a robust data methodology approach for review and improvement strategy planning **Objectives** • Utilization of care planning and recall systems within HER • Customized reporting on all PIMS and project-specific measures • Implementation and training on data analytics tool
Project Description	Promise CHC is developing a structured, team- based, chronic care management approach to improving health outcomes in rural Northwest Iowa. Five key strategies are being utilized to improve chronic care coordination and preventive services. The first strategy is to hire new team members, adjust organizational structures to support the Population health program and clearly define roles and responsibilities of team members. The second strategy will be to provide education and training to support chronic disease management and population health strategies. Strategy number three is to provide structured chronic disease management and enhanced preventive services. The fourth strategy has a strong focus on collection and assessment of patient needs related to social determinants of health. The final strategy of the project is to utilize the QI framework for measurement review and improvement strategy planning.

Missouri

Health Care Coalition of Lafayette County

Grant Number:	G20RH33254			
Organization Name:	The Health Care Coalition of Lafayette County (HCC)			
Organization Type:	Rural Health Network and Federally Qualified Health Center (FQHC)			
Organization Address:	608 Missouri St., Waverly, MO 64096			
Project Title:	Integrated Behavioral Health Initiative			
Website:	https://hccnetwork.org/			
Project Contact:	**Name:**	Amanda Arnold		
	Title:	Director of Quality and Risk Management		
	Phone:	(816) 807-5795		
	Email:	amanda@livewellcenters.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Live Well Community Health Center--Waverly		Carroll, Jackson, Lafayette, Saline	FQHC
	Live Well Community Health Center--Concordia		Carroll, Jackson, Lafayette, Saline	FQHC
	Live Well Community Health Center--Carrollton		Carroll, Jackson, Lafayette, Saline	FQHC
	Live Well Community Health Center--Buckner		Carroll, Jackson, Lafayette, Saline	FQHC
Target Population(s):	All HCC patients, particularly patients identified with undiagnosed chronic disease(s) and those at-risk for a chronic disease diagnosis. This includes HCC patients with a chronic disease diagnosis of diabetes, cardiovascular disease, hypertension or depression, with or without co-occurring mental health issues, substance or opioid use disorder. An added focus on patients with high rates of emergency department use as well as individuals incarcerated in local jails are also included within the project's target patient population.			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Care Coordination • Patient Centered Medical Home Model (PCMH) • Substance/Opioid Use Disorder			
Evidenced-Based/ Promising Practice Model(s)	• Health Behavior Assessment and Intervention (HBAI) • National Committee for Quality Assurance (NCQA) • Medication Assisted Therapy (MAT) • Patient Centered Medical Home (PCMH) • Plan-Do-Study-Act (PDSA)			
Health Information Technology System(s)	eClinicalWorks			
Project Goals & Objectives	**Goal** Increase the number of HCC patients accessing integrated mental health and primary care services through HCC clinics and via outreach in jail setting **Goal** Reduce the ED visit rate among patients with chronic disease, behavioral health, SUD or OUD			

	diagnoses by 20% by the end of the project **Goal** Improve clinical quality measures among the target population by 25% by the end of the project period **Goal** Increase the number of patients with diagnosed opioid use disorders receiving evidence-based MAT services by 15% **Goal** Provide enabling services to 20% of patients served through HCC's Community Health Worker staff to address social determinants of health
Project Description	HCC will follow the Health and Behavior Assessment Intervention (HBAI) models within the Patient Centered Medical Home Model for addressing chronic disease, including diabetes, cardiovascular disease, hypertension or depression, with or without co-occurring mental health issues, substance or opioid use disorder with community-based and jail-based patient populations. These evidence-based models provide a systematic approach to improving outcomes for patients. The HBAI model focuses on identifying and addressing the psychological, behavioral, emotional, cognitive and social factors important to the treatment and management of physical health problems. HBAI is an established intervention designed to enable individuals to overcome the perceived barriers to self-management of their chronic disease(s). For patients with an opioid substance use disorder, evidence-based Medication Assisted Therapy (MAT), also an evidence-based practice, will be deployed. HCC will implement these evidence-based practices within the Patient Centered Medical Home model. This evidence-based model, with defined practices and methods for accreditation, puts the patient front and center in the delivery of health care. The focus is on building a relationship with the patient built on joint accountability and the delivery of care in which the patient is actively engaged in improving their health outcomes. This approach reduces silos, aligns payers, improves the patients' experience with the healthcare system, improves provider and caregiver satisfaction, and ultimately drives down costs to the healthcare system and results in patients who are actively engaged in managing their health. These evidence-based approaches, implemented simultaneously, will result in improved clinical quality measures and patient health status for the long-term. HCC further utilizes Community Health Workers to help connect patients to supportive services in the community and to help address patient needs between appointment times. These team members serve as the "glue" between the patient and providers and are a critical component of the project.

Illinois

Henderson County Rural Health Center, Inc.

Grant Number:	G20RH33279			
Organization Name:	Henderson County Rural Health Center			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	PO Box 198, Oquawka, IL 61469			
Project Title:	Small Health Care Provider Quality Improvement			
Website:	www.eagleviewhealth.org			
Project Contact:	**Name:**	Jana L Cozadd		
	Title:	Director of Operations		
	Phone:	(309) 867-2202, ext. 235		
	Email:	jcozadd@eagleviewhealth.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Eagle View Community Health System - Oquawka, Il		Henderson, Knox, Warren, Mercer and McDonough	FQHC
	Eagle View Community Health System - Stronghurst, Il		Henderson, Knox, Warren, Mercer and McDonough	FQHC
Target Population(s):	The target patient population includes adults age 18 and older that are already part of EVCHS or entering our system for chronic care management as part of our quest to attain PCMH status. As of the end of 2018, 41.8% of our patient population is age 40 or older. The current number of patients between the ages of 50-65 is 896, who are just now or will be entering the Medicare system within the next 10 years. As of our 2018 UDS report EVCHS has 202 total patients with a diagnosis of diabetes, 539 patients with hypertension, 197 patients with hyperlipidemia, 937 total have all three of these chronic conditions.			
Focus Area(s):	• Care Coordination • Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes • Patient Centered Medical Home Model (PCMH)			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care Management (CCM) • Patient Centered Medical Home (PCMH) • Plan Do Study Act (PDSA)			
Health Information Technology System(s)	NextGen			
Project Goals & Objectives	**Goal** Achieve Patient Centered Medical Home (PCMH) Certification **Objective** • Achieve PCMH certification via NCQA **Goal** Implement Chronic Care Management (CCM) **Objectives** • Medicare patients eligible for AWV had been completed; therefore, patients found having 2 or more chronic diseases offered and enrolled in CCM • Adult patients ages 18 and older with 2 or more chronic disease needing care			

	coordination and support (PCMH CM-A) **Goal** Implement standardized, evidence based clinical guidelines for diabetes and tracking performance measures **Objective** • Decrease the number of patients with diabetes not in control by 10% each year of the project **Goal** Implement standardized, evidence based clinical guidelines for hypertension and tracking performance measures **Objective** • Decrease the number of patients with hypertension not in control by 10% each year of the project
Project Description	In order to provide cost-effective, high quality care that is patient-centered and safe, this project aims to achieve certification and recognition as a PCMH and establish CCM according to Centers for Medicare and Medicaid Services (CMS) guidelines as well as meeting the competencies for Care Management and Support (PCMH CM-A) required to certify as PCMH. The PCMH model encompasses not only care management and support, but also patient-centered care, cultural competence, and the medical home. We will plan and redesign our workflow as we apply the Plan-Do-Study-Act Model of Improvement, with focus on specific tasks and action steps that align with these goals, or to address digressions.

Louisiana

Innis Community Health Center, Inc.

Grant Number:	G20RH33269			
Organization Name:	Innis Community Health Center, Inc. (dba Arbor Family Health)			
Organization Type:	Federally Qualified Community Health Center (FQHC)			
Organization Address:	6450 La Highway 1, Ste. B, Batchelor, LA 70715			
Project Title:	Arbor Health Chronic Care Program			
Website:	www.arborfamilyhealth.org			
Project Contact:	**Name:**	Linda Matessino, RN, MPH		
	Title:	Grants Program Director		
	Phone:	(225) 921-5196		
	Email:	linda@arborfamilyhealth.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Arbor Family Health Livonia		Pointe Coupee Parish	FQHC
	Arbor Family Health New Roads		Pointe Coupee Parish	FQHC
	Arbor Family Health Innis		Pointe Coupee Parish	FQHC
	Arbor Family Health Maringouin		Pointe Coupee & Southern Iberville Parish	FQHC
Target Population(s):	Existing health center patients with a dual diagnosis of two chronic diseases, specifically hypertension and diabetes, being seen within the primary care clinics of Arbor Family Health and who reside in the parishes of Pointe Coupee and southern Iberville. This target population represents 4% of the patients seen within the Arbor Family Health Centers. Significant health challenges for this area indicate a 42.2% hypertension diagnosis rate, 10.3% age adjusted diabetes prevalence, stroke death rate of 57.7%, and 36.2% adult obesity prevalence. Centers for Disease Control and Prevention (CDC) ranks Louisiana as the most obese state.			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes			
Evidenced-Based/ Promising Practice Model(s)	• Medicare Chronic Care Management • Patient Center Medical Home (PCMH) • Patient Health Coaching Intervention • Quality Improvement Model			
Health Information Technology System(s)	• AZARA DRVS • E-Clinical Works			
Project Goals & Objectives	**Goal** Improve quality of life for patients with chronic disease **Objectives** • Implement an evidenced based model -" Chronic care model" for the • community • Develop infrastructure for sustaining the Chronic Care Model Program for the organization • Implement a health coach program to improve patient outcomes and compliance by providing a touch point between visits with PCP to ensure patients are adhering to			

	treatment plans, medication schedules, monitoring of Vital signs, blood pressure and/or glucose levels, HgbA1C • Identify key stakeholders, resulting in " buy-in" of program objectives for permanent clinical practice change **Goal** Evaluate program outcomes for sustainability and replicability **Objectives** • Implement final assessment report at end of each grant performance year • Develop final sustainability plan • Publish grant performance within Louisiana and national forums for education and replication • Complete economic impact analysis **Goal** Evaluate overall patient outcomes, identifying key quality improvement patient care strategies **Objectives** • Measure specific clinical indicators tracking improvement, at aggregate level • and individual patient level. • Implement recognition program for patients achieving improvements
Project Description	Innis Community Health Center (dba. Arbor Family Health) with its 4 primary care delivery sites will address the burden of chronic disease in the area. The primary strategy of the project is "health coaching" for patients with chronic illnesses. This will be done by implementing an evidenced based health coaching program which has been proven to engage patients in self-management of health conditions and encourage health behavior and life style changes. The goal of the project is to have 70% of the identified patient population, having a dual diagnosis of diabetes and hypertension, participate in the focused program entitled: "Healthy Patient, Healthy Life". Health quality outcomes for the patients within the program will be compared to those who choose not to participate. Lessons learned through this program will impact the organization's overall quality program of clinical care. The Quality Improvement Model utilizes the "Health Coach "function to improve patient compliance with the treatment plan and care goals through: • improved patient understanding of the management of chronic disease through one-on-one regular visits with a Health Coach; • improved active patient participation in their plan of care in the one-on-one scheduled visits with the Health Coach; • improved achievement of self-identified health goals established and agreed upon in the coaching sessions; • improved emotional support to the patient through the "Health Coach" role; • Health Coaches serving as a "continuity figure" in helping patients live with their chronic disease; • improved relationships with Primary Care Providers at those scheduled provider visits; • greater connectivity with resources of Arbor Family Health System of Care and within the community as appropriate; • improved clinical measures from baseline implementation of the program specific to the diagnosis; and • improved communication about the plan of care consistently through integration of the provider, nurse, and health coach in a structured approach to care management. As a result of implementing this model of chronic care management, Innis /Arbor Family Health staff will be able to determine significant barriers that patients face in maintaining treatment compliance when managing and living with dual diagnoses. In addition, focused strategies individualized to the patient will be initiated in order to reduce barriers that affect quality of life. Additional, tracking of

	clinical quality measures will allow analysis of data in order to identify trends that may be transformed into information that is actionable and informative to Arbor Family Health staff and its quality program.

Jersey Community Hospital District

Grant Number:	G20RH33255			
Organization Name:	Jersey Community Hospital (JCH) District			
Organization Type:	Public Hospital District			
Organization Address:	400 Maple Summit Rd., Jerseyville, IL 62052			
Project Title:	Helping At-Risk Patients (HARP) Program			
Website:	www.jch.org			
Project Contact:	**Name:**	Erin Kochan, MBA		
	Title:	Director of Population Health		
	Phone:	(618) 498-8344		
	Email:	ekochan@jch.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Jersey Community Hospital District		Greene/Jersey Counties	Hospital
	Jersey County Health Department		Jersey County	Health Department
	Greene County Health Department		Greene County	Health Department
	JCH Medical Group, Illini Clinic		Greene/Jersey Counties	RHC
	JCH Medical Group, McDow Clinic		Greene/Jersey Counties	RHC
	JCH Medical Group, Carrollton Clinic		Greene County	RHC
	JCH Medical Group, Roodhouse Clinic		Greene County	RHC
Target Population(s):	Rural Medicare residents of Greene and Jersey counties, Illinois, who are Medicare patients with more than one chronic condition			
Focus Area(s):	• Behavioral/Mental Health Services (includes integration into primary care) • Patient Centered Medical Home Model (PCMH) • Chronic Care Management program, not diagnosis specific			
Evidenced-Based/ Promising Practice Model(s)	• Patient Centered Medical Home Model (PCMH) • The Chronic Care Model			
Health Information Technology System(s)	• Intergy • ThoroughCare			
Project Goals & Objectives	**Goal** Increase capacity of JCH to provide high quality health care at Rural Health Clinics with a focus on chronic disease management, in rural Greene and Jersey Counties in Illinois **Objectives** • Secure PCMH designation for four JCH Rural Health Clinics • Initiate a chronic disease care management program based on the evidence- based practice, The Chronic Care Model, for all four JCH Rural Health Clinics • Integrate behavioral health services into the primary care setting and incorporate behavioral health services into the treatment plan for any patients enrolled in the chronic care management (CCM) program with identified behavioral health needs • Continue to develop and refine the HARP Consortium process to seamlessly			

	coordinate care for patients enrolled in the CCM program on an ongoing basis • Achieve at least a 10% reduction in the annual number of emergency department visits by 90% of patients enrolled in CCM program • Demonstrate an improvement in hemoglobin A1c (HgA1c) level of 80% of patients enrolled in CCM program for 12 months, with a primary or secondary diagnosis of diabetes
Project Description	The Helping At Risk Patients (HARP) Consortium consists of Jersey Community Hospital, Jersey County Health Department and Greene County Health Department. The anticipated outcomes of this project include increasing access to coordinated care for patients with chronic disease, increased access to high quality health care overall as a result of PCMH accreditation, increase access to behavioral health services, enhanced billing capabilities, increased health literacy for patients, reduced ED visits and reductions in HgA1c levels for enrolled patients.

Pennsylvania

Keystone Rural Health Consortia, Inc.

Grant Number:	G20RH33264			
Organization Name:	Keystone Rural Health Consortia, Inc. (KRHC)			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	PO Box 270, Emporium, PA 15834			
Project Title:	Improving Connections of Patient Information to Care			
Website:	www.keystoneruralhealth.com			
Project Contact:	**Name:**	Kristie Bennardi		
	Title:	CEO/CFO		
	Phone:	(814) 486-1115		
	Email:	kriben@keystoneruralhealth.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Cameron County Health Care Center		Cameron	Medical/ Behavioral Health Clinic
	Cameron County Dental Center		Cameron	Dental Clinic
	Johnsonburg Dental Center		Elk	Dental Clinic
	Ridgway Medical Center		Elk	Medical/ Behavioral Health Clinic
	Fox Township Dental Center		Elk	Dental Clinic
	Fox Township Medical Center		Elk	Medical Clinic
	Kane Dental Center		McKean	Dental Clinic
	Mountain Top Area Medical Center		Centre	Medical Clinic
Target Population(s):	The project's target population will be KRHC's full patient panel of all age ranges.			
Focus Area(s):	• Care Coordination • Patient Engagement • Practice Facilitation/Improvement • Social Determinants of Health • Value-Based Care			
Evidenced-Based/ Promising Practice Model(s)	• Deming's Model for Improvement • Lean			
Health Information Technology System(s)	• GE Centricity • Get Well Network • i2i Population Health Management software • Sure Scripts			
Project Goals & Objectives	**Goal** Instill a deeper focus on quality improvement through initiatives at all sites led by a quality improvement (QI) Champion **Objectives**			

- Establish a dedicated QI role on the senior leadership team for initiatives
- Improve the quality and accuracy of patient data
- Utilize automated, patient-entered data to inform and update the electronic health record

Goal
Improve new and returning patients visit experience

Objectives

- Reduce patient wait times by one half hour per patient
- Patients complete easy-to-use electronic intake forms.
- Enable patients to pre-register and schedule appointments online

Goal
Enable clinic to connect patients to their care needs more effectively and efficiently

Objectives

- Staff access data in real time to determine patient needs and response during visit
- Increase screenings
- Identify chronic disease risk factors

Goal
Improve staff engagement with patients

Objectives

- Provide nurses access to comprehensive data in real time
- Increase front desk efficiency by reducing data entry
- Revise clinic workflow to provide support to patients during transition to
- automation
- Reallocate clinical staff time from reviewing paperwork to extend face to face engagement
- Personalize patient education
- Staff respond to patient's mental/BH issues quickly

Goal
Significantly increase patient access to health services

Objectives

- Serve patients with high needs with additional encounters
- Add new patients due to increased capacity of 25% more encounters
- Improve patient satisfaction by 20%
- Increase referrals for patients by 40% to community services
- Increase referrals for patients by 50% to substance use treatment
- Provide targeted marketing to services based on patients' stated records

Goal
Increase patient access

Objectives

- Increase number of patient encounters by 25%
- Reduce costs by 5% by eliminating paper forms
- Reduce claim rejections due to data entry errors
- Utilize billing codes more consistently

Goal
Facilitate transition to value-based patient care

Objectives

- Monitor accountable care organization (ACO) patients for progress towards outcomes
- Complete enrollment as a patient centered medical home (PCMH)

Project Description	The goal of the project, Improving Connections of Patient Information to Care, is to improve KRHC's care delivery capacity and quality by reducing patient wait times and addressing patient needs through providing rapid staff access to patient data. KRHC will implement the Getwell Network by the end of 2019. KRHC will be able to serve their patients better and more often by increasing the capacity for encounters and reducing patient wait times, reducing data entry, and directing data on patients' needs (e.g. mental and behavioral health and/or chronic disease management) to designated staff. Patients will have a significantly improved experience in preparing for and receiving care. In brief the goals of this project fall into four areas: • Quality of patient care will improve because patient data will populate quickly into each patient's medical record enabling staff to prioritize needed screens and address patient challenges. With dedicated quality improvement staff, KRHC can maximize this project's value and build new QI initiatives. • Patients will have greater access to appointments, provider interaction, services and referrals because clinic staff will be able to focus more directly and quickly on patient needs and risk factors. • Patients' experience and satisfaction will improve, benefiting their engagement in care. • The consortia will be able to complete meeting Patient-Centered Medical Home (PCMH) qualifications and make significant progress in the transition to value-based care.

Arkansas

Mainline Health Systems, Inc.

Grant Number:	G20RH33273			
Organization Name:	Mainline Health Systems, Inc. (MHSI)			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	134 S Strickland St., Dermott, AR 71638			
Project Title:	MHSI Chronic Care Quality Initiative - VIP Program			
Website:	www.mainlinehealth.net			
Project Contact:	**Name:**	Jeni Barham		
	Title:	Clinical Quality Director		
	Phone:	(870) 538-5414		
	Email:	jbarham@mainlinehealth.net		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Mainline Health Systems, Inc.- Eudora		Chicot	FQHC
	Mainline Health Systems, Inc.- Wilmot		Ashley	FQHC
	Mainline Health Systems, Inc.- Portland		Ashley	FQHC
	Mainline Health Systems, Inc.- Dermott		Chicot	FQHC
	Mainline Health Systems, Inc.- Monticello		Drew	FQHC
	Mainline Health Systems, Inc.- Star City		Lincoln	FQHC
Target Population(s):	Non-Medicare patients who have a behavioral health diagnosis and hypertension and/or diabetes.			
Focus Area(s):	• Care Coordination • Diabetes • Cardiovascular Disease (includes Stroke, Hypertension) • Health/Wellness Coaching • Medication Management			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care Model (CCM) • The Asheville Project			
Health Information Technology System(s)	• BridgeIT reporting software • eClinicalWorks			
Project Goals & Objectives	**Goal** Improve Health outcomes for high-risk patients with chronic disease **Objectives** • Establish a CCM model program • Implement Clinical Pharmacist program • Implement Health Coach Program • Develop 5 year strategic plan for sustainability			

Project Description	Mainline Health Systems, Inc. (MHSI) is implementing a Clinical Pharmacist into our care team to provide multiple services including managing medications, responding to consultations, assisting with medication related policies, assisting with enrollment of medication programs, and educating patients, providers, and members of the care team. In addition, a Health Coach has been added to provide additional support to patients and engage them in self-management of health conditions and encourage behavior change. The project is modeled after the Asheville Project which focused on incorporating community-based pharmacists into a patient's chronic care management of patients with chronic health problems such as diabetes, hypertension, and asthma. Education, consultations, goal setting and monitoring, as well as other methods were used to create a Pharmaceutical Care Service program. MHSI's *Chronic Care Quality Initiative - VIP Program* will include enrollment of a target population of non-Medicare patients with a behavioral health diagnosis and who also have hypertension and/or diabetes. The target population will be followed for the entire three-year program to provide comparable health outcomes. The target population will be enrolled over 4 set enrollment periods that will also allow for comparison as well as monitoring of health outcomes for the target population that does not enroll. The visits will either be a warm handoff from a provider or will be a scheduled "pharmacy" visit. The overall process to be implemented is as follows: At the initial visit, the program will be explained to the patient and a consent form will be signed if they agree to enrollment. A welcome letter along with a care plan will be mailed to the patient within a month of enrolling. This care plan will contain a list of the patient's medications along with education regarding their blood pressure and/or diabetes. After the initial visit, the rest of the program services will be primarily conducted over the telephone. This approach allows for the extension of care while minimizing the burden on patients receiving care. For the purposes of the project, MHSI will track the following clinic outcome measures for all within the target population: • NQF 0059: Diabetes Care Hemoglobin A1C Poor Control (>9.0%) • NQF 0074: Chronic Stable Coronary Artery Disease: Lipid Control • NQF 0018: Controlling High Blood Press • NQF 0028: Tobacco Use: Screening & Cessation Intervention • NQF 0421: BMI Screening and Follow-up • NQF 0041: Influenza Immunization • Emergency department (ED) visit rate

Indiana

Marion General Hospital

Grant Number:	G20RH33282			
Organization Name:	Marion General Hospital			
Organization Type:	Hospital			
Organization Address:	441 N Wabash Ave., Marion, IN 46952			
Project Title:	Quality Processes for Health Improvement			
Website:	www.mgh.net			
Project Contact:	**Name:**	Kelley Hochstetler		
	Title:	Project Director/Community Coordinator		
	Phone:	(765) 660-7204		
	Email:	Kelley.hochstetler@mgh.net		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Marion General Hospital		Grant County	Acute Care Hospital
	Marion Housing Authority		Grant County	Low Income housing
	Wesleyan Health Care Center		Grant County	Rehab and long term care
	Colonial Oaks Health Care Center		Grant County	Rehab and long term care
	Rolling Medows Health Care Center		Wabash County	Rehab and long term care
	Marion General Hospital Physician Practices		Grant County	Physician Practice
	Bridges To Health		Grant County	Free health and Dental Clinic
Target Population(s):	Project year one: individuals with fulminating heart failure, Project year two: add people with controlled heart failure, Project year three: add people at risk for heart failure			
Focus Area(s):	• Cardiovascular Disease (includes Stroke, Hypertension) • Community Health Workers • Care Coordination			
Evidenced-Based/ Promising Practice Model(s)	• American Hospital Association (AHA) - Remote Patient Monitoring • Agency for Healthcare Research and Quality (AHRQ) - Telehealth Evidence Map • CDC & CMS - Million Hearts Campaign • Lean			
Health Information Technology System(s)	• E-Clinical Works • Meditech			
Project Goals & Objectives	**Goal** Improve chronic disease management for heart failure (HF) **Objectives** • Increasing HF patient's quality of life through better care coordination, engagement, and access			

	• Decreasing HF patients' incidence of HF • Decreasing conditions leading up to an HF diagnosis • Increasing patients' usage of appropriate health care resources **Goal** Quality improvement methodology to implement robust improvements for HF process **Objectives** • Utilize QI to correct barriers to existing care as for revisions to the hospital's • Value stream and standard work • Utilize the LEAN First curriculum • Training Lean Daily Improvement Facilities • Train Advance Lean Practitioners • Implement and trial QI improvement
Project Description	The project Quality Processes for Health Improvement (QPHI) is designed to address hospital and ambulatory care of patients diagnosed with Heart Failure (HF) who are living in a rural county in Indiana burdened by high rates of poverty, obesity, and tobacco use. Heart Failure, a chronic disease, is debilitating for patients who become less independent as the disease progresses, and chronic disease affects the community, which feels the impact on an economic and personal/societal level through the immense the strain placed on family caregivers. Through this project, Marion General Hospital aims to revamp and streamline its coordination of chronic disease management surrounding HF while, at the same time, investing in the establishment of an in-house process improvement department. Marion General has a post-acute care team that works in our area housing, rehab, and long term care areas to enhance care coordination and quality of life for patients, and reduce unnecessary utilization of health care services. Short Term Results (1-3 years) - reduce hospital readmissions and cost of care for HF, improve quality of life for larger population, enhance collaboration and employee engagement for continuum of care, improve HF patient convenience and access to care Long Term Results (4-6 years): Sustainability of improved measures with in-house process improvement, coordination of care across continuum for additional chronic disease management, improved specialist efficiency Ultimate Impact: decrease in number of patients diagnosed with HF, decrease in number of active tobacco users, decrease in mortality and morbidity for HF, and improved quality of life.

Mayers Memorial Hospital District

Grant Number:	G20RH33265			
Organization Name:	Mayers Memorial Hospital District			
Organization Type:	Critical Access Hospital (CAH)			
Organization Address:	PO Box 459, Fall River Mills, CA 96028			
Project Title:	Take Four: Telemedicine in a Rural School District			
Website:	https://www.mayersmemorial.com/getpage.php?name=Take_Four_Mental_Health_Program			
Project Contact:	**Name:**	Amanda Harris		
	Title:	Telemedicine Coordinator		
	Phone:	(530) 336-5511, ext. 1316		
	Email:	aharris@mayersmemorial.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Burney Elementary School		Shasta	School
	Burney High School		Shasta	School
	Mountain View High School		Shasta	School
	Fall River Elementary School		Shasta	School
	Fall River High School		Shasta	School
	Soldier Mountain High School		Shasta	School
Target Population(s):	The target population includes all students enrolled in the Fall River Joint Unified School District (FRJUSD) at the beginning of the 2019-2020 school year. Based on current District census, there will be about 1,200 students, ages 6-17 and of diverse backgrounds, included in the project's target population. In academic year 2018-2019, 59.6% of students enrolled in FRJUSD come from socioeconomically disadvantaged backgrounds. 8.8% of FRJUSD students are considered "English Learners". 0.3% of students are foster youth. The factors contributing to reduced access to specialty care for this population include: financial barriers, geographic constraints, inconsistent availability of specialty care, and limited information exchange between specialists and primary care providers.			
Focus Area(s):	• Telehealth/Telemedicine/Telemonitoring • Behavioral/Mental Health Services (includes Integration into Primary Care)			
Evidenced-Based/ Promising Practice Model(s)	Lean A3 will prompt all program staff to identify potential and current problems and utilize problem-solving measures with the goal of continuous improvement.			
Health Information Technology System(s)	• Tablets (e.g. i-Pads) • Zoom Videoconferencing			
Project Goals & Objectives	**Goal** Improve teletherapy delivery through Lean A3 practices. **Objectives** • Establish need for mental health services by surveying high school students in FRJUSD with emotional-behavioral survey. Compare data to State student survey • Establish need for mental health services by surveying elementary school teachers on classroom disruptions and behavior • Measure grant performance through bi-annual surveys distributed to elementary			

	school teachers to assess correlation between mental health services accessibility and student performance • Measure grant performance through post-appointment surveys distributed to middle and high school students to assess correlation between mental health services accessibility and student wellness **Goal** Expand access to mental and behavioral health services via teletherapy, and ensure its on-going practice at all schools within the FRJUSD **Objectives** • Establish Telemed2U as a telehealth provider at two elementary schools and • one high school in FRJUSD • Establish Mountain Valley Health Centers (MVHC) as a telehealth provider at one high school and four continuation schools in FRJUSD • Develop, implement and integrate proactive strategies for patient and parent/guardian engagement • Expand MVHC's teletherapy program to all schools within FRJUSD **Goal** Leverage data and outcomes of the Take Four program to enact district policy on use of telehealth technology **Objectives** • Create best practices for use of telehealth technology in rural school districts • Collaborate with FRJUSD Superintendent to write and enact district policy
Project Description	To address the needs of Take Four's target population, Mayers Memorial Hospital District has formed a consortium with organizations dedicated to improving the target population's quality and access to care. The Take Four consortium includes: Telemed2U, Inc., California's largest telemedicine provider; Mountain Valley Health Centers, a not-for-profit community health center organization which offers quality health and dental care to the rural community; Mayers Memorial Hospital District, a Critical Access Hospital that has served the community for over 60 years by offering inpatient, outpatient, emergency, surgical, telemedicine and long-term care health services; and Fall River Joint Unified School District, comprised of two elementary schools, two high schools and four continuation schools. The consortium will use the Lean A3 management model as the quality improvement tool. Lean A3 is a continuous improvement approach that provides a simple, yet stringent, procedure to problem solving. In the context of Take Four's project scope, Lean A3 will prompt all program staff to identify potential and current problems and utilize problem- solving measures with the goal of continuous improvement. Take Four proposes to establish teletherapy services at all schools within the Fall River Joint Unified School District. To this end, the consortium plans to institute a teletherapy training program for four paraprofessionals; conduct teletherapy sessions at all schools; collect program data and assess quality improvement performance measures; improve student performance; and develop telehealth policy and procedures for FRJUSD. Through Take Four's project activities and implementation of the Lean A3 approach, improvements are expected in the delivery of mental health services to the target population, improvement in student performance, and improved information exchange between partners within the consortium.

Mercy Health Partners of Southwest Ohio

Grant Number:	G20RH33256			
Organization Name:	Mercy Health Marcum and Wallace Hospital (Project HOME Network)			
Organization Type:	Critical Access Hospital (& Rural Health Network)			
Organization Address:	60 Mercy Ct., Irvine, KY 40336			
Project Title:	Population Health Management Program			
Website:	N/A			
Project Contact:	**Name:**	John W. Isfort		
	Title:	Senior Project Manager		
	Phone:	(606) 723-2115, ext. 8210		
	Email:	jisfort@mercy.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Mercy Health Marcum and Wallace Hospital		Estill	Critical Access Hospital (CAH)
	Mercy Health Irvine Primary Care		Estill	Provider-based Rural Health Clinic
	Mercy Health Powell County Primary Care		Powell	Provider-based Rural Health Clinic
	Mercy Health Lee County Primary Care		Lee	Provider-based Rural Health Clinic
	Estill Medical Clinic		Estill	Independent Rural Health Clinic
Target Population(s):	Members of Estill, Lee, and Powell Counties (all designated MUAs per HRSA) who are seeking treatment for Hepatitis C, medication assisted treatment (MAT), or management/education for atrial fibrillation (AFib)/congestive heart failure (CHF)/chronic obstructive pulmonary disease (COPD)/diabetes/smoking cessation.			
Focus Area(s):	• Chronic Obstructive Pulmonary Disease • Diabetes • Substance/Opioid Use Disorder • Tobacco Use – Prevention/Cessation • Hepatitis C, atrial fibrillation (AFib), congestive heart failure (CHF)			
Evidenced-Based/ Promising Practice Model(s)	Chronic Care Model			
Health Information Technology System(s)	EPIC (Electronic Medical Record)			
Project Goals & Objectives	**Goal** To provide specialty, multidisciplinary care for those patients with a high risk for hospital readmission or ED recidivism due to a chronic disease condition **Objectives** • Develop and institute a population health management model of care • Develop a Medication and Education Specialty Clinic aimed at addressing population health in the service area			

	Goal To provide a specialty care multidisciplinary clinic that is aimed at treatment of hepatitis and the prevention of its wider dissemination in the community **Objective** • Develop a Hepatitis Screening and treatment clinic within the Population Health Management Program **Goal** To provide a local treatment option for the treatment of substance and opioid use disorders **Objective** • Develop a Medication Assisted Therapy Clinic
Project Description	Marcum and Wallace Hospital (MWH), serving as the primary grantee, in conjunction with the Project HOME (Helpful Opportunities for Medical Enhancement) Network will lead the implementation of this project. The proposed Population Health Management Program draws upon each of the critical features of the Chronic Care Model: clinical information systems, decision support, self-management, and delivery system redesign. Clinical information systems will assist in identifying at-risk patients through an evidence-based screening algorithm that is embedded within the electronic health record (EHR) system. This electronic screening process, combined with physician referrals, will provide an identifiable population that will benefit from access to the Population Health Management Program. Decision support services will be provided by the population health pharmacist, the Kentucky Hepatitis Academic Mentorship Program (KHAMP)-trained advanced practice provider, and affiliated chronic disease specialists (accessed through telehealth). Relative to delivery system design, primary and acute care sites will reorganize their workflows to allow patients to be referred into the Population Health Management Program without disruption to other provider relations.

Mountain Health & Community Services, Inc.

Grant Number:	G20RH33283			
Organization Name:	Mountain Health & Community Services, Inc.			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	31115 Highway 94, Campo, CA 91906			
Project Title:	Fighting Cancer through Internal Care Coordination			
Website:	www.mtnhealth.org			
Project Contact:	**Name:**	Judith Shaplin		
	Title:	CEO/President		
	Phone:	(619) 445-6200		
	Email:	jshaplin@mtnhealth.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Mountain Health Family Medicine		San Diego	FQHC
Target Population(s):	The rural target population selected for this quality improvement project consists of residents of the eastern region of San Diego County encompassing the Mountain Empire, also known locally as the "back country" that covers 950 square miles. Mountain health has established Mountain Health Family Medicine in the Mountain Empire Community of Campo CA.			
Focus Area(s):	• Care Coordination • Social Determinants of Health • Skin, gynecologic, and colorectal cancer screenings and procedures			
Evidenced-Based/ Promising Practice Model(s)	Model for Improvement			
Health Information Technology System(s)	• NextGen EDR • NextGen HER • NextGen EPM			
Project Goals & Objectives	**Goal** Coordinate colorectal cancer screening training/review for Campo providers **Objective** • Provide training materials and supplies in order to implement project training and testing **Goal** Increase access to care by increasing the number of colorectal cancer screenings performed at the Campo health center **Objective** • Increase number of patients screened for colorectal cancer by 65% **Goal** Improve tracking of patients referred to a specialist by tracking consults received with a Category II CPT code that can be used for reporting and follow up **Objective** • Train Data Processor to enter a CPT code in the EHR system when a consult is returned from a specialist			

Goal
Create report for Referral Coordinator to run in NextGen monthly

Objective

- Establish a new workflow and reporting process to support the Referral Coordinator in tracking follow up with specialists

Goal
Coordinate Pap Smear training/review for Campo providers

Objective

- Provide training materials and supplies in order to implement project training and testing

Goal
Increase access to care by increasing the number of Pap smears performed at the Campo health center

Objectives

- Increase number of Pap smears performed by 150% and HPV tests increased by 104%
- Decrease number of referrals to a specialist

Goal
Coordinate colposcopy training for Campo providers

Objective

- Training materials and supplies will be available for the training

Goal
Increase access to care by providing colposcopy and endometrial biopsies

Objectives

- Increase number of colposcopies performed from 0 to 20 and endometrial biopsies from 0 to 10
- Decrease number of referrals to a specialist

Goal
Coordinate training for IUD and Nexplanon placement and removal

Objective

- Provide training materials and supplies in order to implement project training and testing

Goal
Increase access to care by increasing the number of placement and removals of IUD and Nexplanon devices are performed at the Campo health center

Objective

- Increase number of IUD and Nexplanon placements by 300% and removals by 186%

Goal
Coordinate dermatology training for the Campo providers

Objective

- Training materials and supplies will be available for the training

Goal
Increase access to care by increasing the number of dermatology procedures performed at the Campo health center

Objectives

- Campo providers will perform skin tag and mole removals, and shave, punch and

	excisional biopsies • Referrals to dermatologists will decrease
Project Description	Mountain Health has carefully designed the work plan to achieve this project's goal of improving the quality healthcare of rural Mountain Empire residents. In an effort to improve cancer screenings and bring specialty services directly to our patients in their medical home, Mountain Health will improve the rate of cancer screenings and early diagnosis, implement procedures in-house to treat our patient population, and follow up of care provided by closing gaps in the referral process. Skin cancer treatment, gynecologic cancer diagnosis and reproductive health, colorectal cancer screenings, and referral tracking will be the focus over the three year grant period. With the Model for Improvement we will reach the goal of this program by continuing our efforts on enhancing and refining how Mountain Health screens for cancer and provides other necessary women's health care. The bulk of this will be accomplished by performing the following: conducting in-house specialty diagnostic and therapeutic procedures to reduce long wait times for outside specialties by decreasing backlog of referrals, improve the referral tracking process both internally and externally, and by using the following steps of the Model for Improvement: 1) set an aim to determine what we're trying to accomplish; 2) establish the measures to determine how we'll track the changes implemented; 3) identify changes needed to add the improvements and enhanced services; 4) test the changes added to the practice by running reports to see how many procedures, tests, and referrals tracked have been completed since the staff have been trained; 5) implement the changes to Mountain Health's additional five sites throughout San Diego to reach all target populations. Mountain Health will continue to improve and monitor the cancer screenings at all locations, to increase the number of patients that will have early prevention and treatment of skin, reproductive, or colorectal cancer.

Montana

Northern Montana Hospital

Grant Number:	G20RH33270			
Organization Name:	Northern Montana Hospital			
Organization Type:	Hospital / Rural Health Clinic (RHC)			
Organization Address:	PO Box 1231, Havre, MT 59501			
Project Title:	Northern Montana Quality & Chronic Care Initiative (NMQCCI)			
Website:	http://nmhcare.org			
Project Contact:	**Name:**	Susan Morgan		
	Title:	Director of Clinic Nursing		
	Phone:	(406)-262-1586		
	Email:	morgsusk@nmhcare.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Northern Montana Family Medical Center		Hill, Blaine, Choteau, Liberty, Phillips	RHC
	Northern Montana Specialty Medical Center		Hill, Blaine, Choteau, Liberty, Phillips	RHC
Target Population(s):	Patients that reside in service areas with chronic health issues			
Focus Area(s):	• Care Coordination • Diabetes • Cardiovascular Disease (includes Stroke, Hypertension)			
Evidenced-Based/ Promising Practice Model(s)	Chronic Care Model			
Health Information Technology System(s)	Meditech			
Project Goals & Objectives	**Goal** Improve financial and operational efficiency within Northern Montana Hospital sing the Chronic Care Model quality improvement strategies and optimizing the use of the electronic medical record (EMR) **Objectives** • An Advisory Group will be convened to provide strategic direction for improving access to disease self-management programs and specialty care for rural / frontier residents of northern Montana • Identify Chronic Care Management software that has capability of remote patient monitoring • Develop a process for using data analysis to implement a population health management plan for the medical community that serves northern Montana and surrounding regions. • Conduct a strategic evaluation of core services – determine which services are sustainable with Medicare and Medicaid payments • Develop a plan for advancing initiatives to enhance community perception of clinical quality and consumer service so patients will choose healthcare services in the local community			

	Goal Improve patient healthcare outcomes focusing on clinical indicators for management of diabetes and cardiovascular disease, as well as reduction of obesity and smoking **Objectives** • Hire a Health Care Coordinator position • Establish all positions in place for the project's the Chronic Care Management team • Implement a new Chronic Care Model that is focused on growth based on current population trends such as chronic disease management and the senior population. • Develop a clinical pathway for diabetes management that includes a depiction of the process steps that will result in an idealized critical pathway to optimize glycemic control • Develop a clinical pathway for cardiovascular disease management that includes a depiction of the process steps that will result in an idealized critical pathway to optimize hypertension control • Chronic Care and Clinic staff will receive training on implementing an evidence-based care delivery system design component (E.G. guidelines such as ADA Standards of Care, and self- management support through DSME) **Goal** Improve patient engagement and satisfaction by offering health coaching and self-management support **Objectives** • Conduct focus groups that include patients and families as well as local business leaders to identify current service needs and to develop educational strategies to address community need and concern • Develop educational programming that incorporates the strengths and skill sets of each Advisory Council member • The NMQCCI program will improve health access and ultimately quality outcomes for patients seeking healthcare services in the local community
Project Description	Expand and improve chronic care management using the Chronic Care Model to achieve better health, better healthcare, and lower costs. The focus of the grant includes revisiting the healthcare system to redefine healthcare team roles (e.g. nurses instead of PCP becoming responsible for diabetic foot examination, etc.). Other changes will include the addition of a Panel Manager / Health Coach in each of the Rural Health Clinic sites to help close the gaps in patient care. Another component of the program is to engage patients in their disease self-management through education and self-reporting. Expected project outcomes include a stronger continuum of care for the target population (patients with a chronic condition of cardiovascular disease or diabetes); improved chronic condition management of the target population; informed, activated patients; and a prepared, proactive practice team.

Missouri

Pike County Memorial Hospital

Grant Number:	G20RH33250			
Organization Name:	Pike County Memorial Hospital			
Organization Type:	Critical Access Hospital (CAH)			
Organization Address:	2305 Georgia St., Louisiana, MO 63353			
Project Title:	Effective Care Transitions			
Website:	www.pcmh-mo.org			
Project Contact:	**Name:**	Lisa Pitzer		
	Title:	Grants Director		
	Phone:	(573) 754-5531		
	Email:	lpitzer@pcmhmo.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Pike County Memorial Hospital (PCMH)		Pike, Lincoln, Audrain, Montgomery, Ralls	CAH
	PCMH Louisiana Clinic		Pike, Lincoln, Audrain, Montgomery, Ralls	Rural Health Clinic (RHC)
	PCMH Bowling Green Clinic		Pike, Lincoln, Audrain, Montgomery, Ralls	RHC
	PCMH Vandalia Clinic		Pike, Lincoln, Audrain, Montgomery, Ralls	RHC
	PCMH Walk-In Clinic		Pike, Lincoln, Audrain, Montgomery, Ralls	RHC
Target Population(s):	Individuals with chronic disease conditions admitted to the hospital's inpatient unit and/or individuals with chronic disease conditions who seek care at the hospital's emergency department.			
Focus Area(s):	• Care Coordination • Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes • Hospital and/or Emergency Department Utilization Reduction/Prevention • Depression			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care Model • Institute for Healthcare Improvement (IHI) • Plan Do Study Act (PDSA)			
Health Information Technology System(s)	• Allscripts - Hospital • eClinicalWorks – Clinics • **Note:** Hospital and Clinics will be transitioning to Cerner within 12 months			
Project Goals & Objectives	**Goal** Provide better care and sustain health improvement of 150 chronic disease patients accessing services from the hospital and rural health clinics **Objectives** • Enhance access and continuity by improving access to chronic disease management services • Identify and manage patient population by improving processes for care transitions			

	and care coordination for target population resulting in greater percentage of care plan goals achieved • Increase the knowledge and confidence levels of project providers and care teams to provide effective care transitions and evidence-based chronic care management • Provide self-care support and community resources by increasing access to community resources to address social determinants of health • Track and coordinate care by demonstrating quality and performance improvement in the delivery of care to patients living with chronic disease • Measure and improve performance with a fully developed clinical information system that allows for monitoring of the care system while also facilitating care coordination among patients and their providers
Project Description	Pike County Memorial Hospital will implement an Effective Care Transitions (ECT) project to improve the quality and safety of health care. Through ECT, care transitions from the hospital emergency department and inpatient settings to other settings will be improved, thereby reducing hospital readmissions and inappropriate emergency department utilization. ECT will also focus on improving coordination of care and establishing a primary care health home for chronic care patients without an identified primary care provider.

Washington

Pullman Regional Hospital Foundation

Grant Number:	G2ORH33284-01-00			
Organization Name:	Pullman Regional Hospital Foundation			
Organization Type:	Critical Access Hospital (CAH)			
Organization Address:	840 SE Bishop Blvd., Ste. 200, Pullman, WA 99163			
Project Title:	Health Coaching/Motivational Interviewing in Acute & Primary Care Settings			
Website:	https://pullmanregional.org			
Project Contact:	**Name:**	Becky Highfill		
	Title:	Grants Manager		
	Phone:	(509) 332-2033		
	Email:	becky.highfill@pullmanregional.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Pullman Regional Hospital		Whitman	CAH
	Pullman Family Medicine		Whitman	Family Practice
	Palouse Pediatrics		Whitman	Pediatrics
Target Population(s):	Patients who have two or more comorbid chronic diseases, prioritizing those with depression (PHQ-9 (Patient Health Questionnaire-9) greater than 9 for the clinic and greater than 10 for the hospital) and/or anxiety (General Anxiety Disorder (GAD) score greater than 15 for the clinic and greater than 10 the for hospital).			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Care Coordination • Health/Wellness Coaching • Hospital and/or Emergency Department Utilization Reduction/Prevention			
Evidenced-Based/ Promising Practice Model(s)	Health Coaching, specifically, Motivational Interviewing			
Health Information Technology System(s)	• Greenway (Palouse Pediatrics) • Centricity (Pullman Family Medicine) • Meditech (Pullman Regional Hospital)			
Project Goals & Objectives	**Goal** Build a sustainable health coaching model utilizing motivational interviewing (MI) for chronic disease management and integrate this intervention into acute and primary care settings **Objectives** • Develop two trained and certified health coach registered nurses (RNs) that will lead a "train-the- trainer" model to Pullman Regional Hospital, Pullman Family Medicine and Palouse Pediatrics • Train the hospital and clinic staff to be competent in using health coaching tools in patient care • Ensure ongoing competency for all clinicians to utilize health coaching as an integral part of our patient care model			

Project Description	Two registered nurses will be trained and certified as health coaches. They will lead a "train-the-trainer" model for Pullman Regional Hospital, Pullman Family Medicine and Palouse Pediatrics staff and providers. The quality improvement project will embed motivational interviewing (MI) proficiency among 125 vital primary care partners. The project will track patients receiving the intervention and measure progress toward disease-specific self- management goals.

Kentucky

Purchase District Health Department, Inc.

Grant Number:	G20RH33275			
Organization Name:	Purchase Area Health Connections/ Purchase District Health Department			
Organization Type:	Regional Coalition/Health Department			
Organization Address:	916 Kentucky Ave., Paducah, KY 42003			
Project Title:	Community Health Improvements through Partnerships			
Website:	www.purchasehealthconnections.com			
Project Contact:	**Name:**	Kaylene Cornell		
	Title:	Health Education Coordinator		
	Phone:	(270) 444-9625, ext. 180		
	Email:	Kaylenes.cornell@ky.gov		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Purchase District Health Department		McCracken, Ballard, Carlisle, Hickman, Fulton	Health department
	Baptist Health-Paducah		McCracken, Ballard, Carlisle, Graves, Marshall	Hospital
	Mercy Health-Lourdes		McCracken, Ballard, Graves, Marshall, Calloway	Hospital
	Purchase Area Health Connections		McCracken, Ballard, Carlisle, Fulton, Hickman, Graves, Calloway, Marshall	Regional coalition
Target Population(s):	Purchase Area residents with a diagnosis of Heart Failure that have been hospitalized, Medicare and Medicaid patients			
Focus Area(s):	• Cardiovascular Disease (includes Stroke, Hypertension) • Community Health Workers • Hospital and/or Emergency Department Utilization Reduction/Prevention • Social Determinants of Health			
Evidenced-Based/ Promising Practice Model(s)	Lean Six Sigma - Define, Measure, Analyze, Improve and Control (DMAIC)			
Health Information Technology System(s)	Mediview			
Project Goals & Objectives	**Goal** Improve patient health outcomes; Develop capacity of Network to use QI practices **Objectives** • 100% of PAHC and evaluation team will be trained on the DMAIC QI model; 80% of hospital team members will be trained on the new discharge protocol and will make referrals to the CHW intervention; Hospital readmission rates (defined as readmitted within 90 days of discharge) will decrease by 10% over baseline in year one, 25% of patients will make and complete follow-up care visits with their physician or clinic per discharge orders • Hospital readmission rates (defined as readmitted within 90 days of discharge) will			

	decrease by 15% over baseline in year two, 30% of patients will make and complete follow-up care visits with their physician or clinic per discharge orders • Hospital readmission rates (defined as readmitted within 90 days of discharge) will decrease by 20% over baseline in year three, 50% of patients will make and complete follow-up care visits with their physician or clinic per discharge orders.
Project Description	Using the DMAIC (Define, Measure, Analyze, Improve, Control) evidenced-based model for Quality Improvement, two hospitals (Lourdes and Baptist) and the Purchase District Health Department are implementing implement a redesigned discharge process combined with home visitation by community health workers (CHWs) for individuals with a heart failure diagnosis. Entitled Project CHIPs, the newly redesigned discharge process is based on best- practices adapted to meet local needs and situations. Project hospital partners will identify patients at high-risk for readmission and refer them while still in the hospital to the health department for CHW home visitation. Combined, these two interventions will decrease the hospital readmission rate for patients (defined as readmission within 90 days of original discharge), and improve patient overall health outcomes. Patients will also participate in educational programs that improve their health literacy and ability to self-manage their disease.

Kansas

Sheridan, County of

Grant Number:	G20RH33257			
Organization Name:	Sheridan, County of			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	826 18th St., Ste. A, Hoxie, KS 67740			
Project Title:	Practice Transformation through Team-Based Care			
Website:	http://sheridancountyhospital.com/slide-view/medical-clinic/			
Project Contact:	**Name:**	Whitney Zerr, RN BSN		
	Title:	Director of Nursing/Quality Director		
	Phone:	(785) 677-4196		
	Email:	wzerr@schchmed.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Selden Community Clinic		Sheridan County, KS	FQHC
	Hoxie Medical Clinic		Sheridan, Cheyenne, Decatur, Gove, Graham, Logan, Norton, Rawlins, Sherman, Thomas, and Wallace Counties, KS	FQHC
Target Population(s):	All rural medical patients served by Hoxie Medical Center			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes • Obesity • Colorectal cancer screening, tobacco use, immunizations, dental sealants			
Evidenced-Based/ Promising Practice Model(s)	• Patient Center Medical Home (PCMH) Model • Team-Based Care Model • PACEe (Plan, Act, Check, Enhance and Efficiency) QI Model			
Health Information Technology System(s)	NextGen			
Project Goals & Objectives	**Goal** Implement a team-based approach to the delivery of integrated health care **Objectives** • BMI and follow-up plan documented as indicated for 50% of adults • Colorectal cancer screening for 50% of patients aged 50-75 • Controlled hypertension for 75% of hypertensive patients aged 8-85 • Uncontrolled diabetes in fewer than 16% of diabetic patients • Counseling and/or pharmacotherapy for 98% of tobacco using patients • Screening for depression of 98% of patients 12 and older, with a follow-up plan documented for those screening positive • Complete series of childhood immunizations for 80% of patients aged 2 • Dental sealants for 60% of patients aged 6-9 • Statin therapy for 85% of patients at high risk for cardiovascular events			

Project Description	The proposed project will utilize evidence-based Quality Improvement models for Patient Centered Medical Home, and Team-Based Care. In addition, the project will use the Effective Quality Improvement model PACEe (Plan, Act, Check, Enhance and Efficiency) to improve operational processes. Project activities include hiring 1.0 FTE Community Educator/PCMH RN, and 4.0 FTEs Certified Nursing Assistants (CNA). The project will add a CNA to each of the four existing treatment teams currently comprised of a provider and a nurse. The addition of the CNA will complete the treatment team, make team-base care possible, and facilitate providers and nurses practicing at the top of their licensure. Outcomes expected as a result of the proposed project include streamlining the patient visit resulting in shorter wait times, better management of chronic illness, and more timely communication with the patient. In addition, patient and community education will facilitate an increase in information about chronic illness and health lifestyles. Clinical quality measures to be included include: 1) Statin therapy for the prevention and treatment of cardiovascular disease; 2) Comprehensive diabetes care; 3) Adult BMI screening and follow up; 4) Controlling high blood pressure; 5) Screening and tobacco cessation intervention; 6) Screening and follow-up for clinical depression; 7) Dental sealants for children; 8) Colorectal cancer screening: and 9) Immunizations.

Tahoe Forest Health System Foundation

Grant Number:	G20RH33271			
Organization Name:	Tahoe Forest Health System Foundation			
Organization Type:	Nonprofit 501c3			
Organization Address:	10121 Pine Avenue, Truckee, CA 96160			
Project Title:	Behavioral Health Integration into Primary Care (BHIPC)			
Website:	www.tfhd.com			
Project Contact:	**Name:**	Eileen Knudson		
	Title:	Director of Behavioral Health		
	Phone:	(530) 582-6496		
	Email:	eknudson@tfhd.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Tahoe Forest Health System Multi-Specialty Clinics- Primary Care		Placer (CA); Nevada (CA); El Dorado (CA); Washoe (NV)	RHC, CAH
Target Population(s):	All patients ages 12 and older who have a face-to-face encounter with a medical provider in the primary care clinics of TFHS and at least one of the following conditions: (i) have a local zip code of residence, or (ii) a local primary care provider (PCP) listed as their PCP. Primary care clinics within TFHS include Family Practice, Internal Medicine and Pediatrics clinics.			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Substance/Opioid Use Disorder			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care model • IMPACT model • Patient Health Questionnaire - PHQ (evidence- based screening tool)			
Health Information Technology System(s)	Epic - Mercy			
Project Goals & Objectives	**Goal** Increase early identification of mental health needs and ultimately improve patient mental/behavioral health as evidenced by pre/post-depression screenings **Objectives** • Increase the proportion of the full patient panel who are screened annually for depression using the Patient Health Questionnaire (PHQ) from baseline by 10% per project year • Increase the proportion of [primary care] patients aged 12 years and older screened for clinical depression using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen from baseline by 10% per project year **Goal** Increase access to behavioral health services 10% per project year from objective baseline through integration of mental/behavioral health into primary care clinics for Tahoe Forest Health System patients ages 12 and older **Objectives**			

	• Increase the proportion of primary care clinics that provide mental/behavioral health services by integrating at least one behavioral health specialist into at least two primary care clinics • Increase the proportion of persons with co-occurring substance use disorder and mental disorder who receive treatment for both disorders from baseline by 10% per project year
Project Description	The purpose of the Behavioral Health Integration in Primary Care (BHIPC) project is to increase early identification of mental/behavioral health needs and access to timely services for patients ages 12 and older through the integration of mental/behavioral health services into primary care clinics. According to the Centers for Disease Control and Prevention (CDC), "7.6% of Americans aged 12 and over had depression (moderate or severe depressive symptoms in the past 2 weeks)". Two-thirds of primary care physicians report not being able to access outpatient behavioral health for their patients due shortages of mental health providers, insurance barriers and inadequate health care coverage. Depression goes undetected in more than 50% of primary care patients, and for those with detected mental/behavioral health needs, 30-50% of referrals to behavioral health from primary care do not make their first appointment. Integrating behavioral health specifically into primary care will result in increased depression screening rates, increased access to behavioral health services, and improved mental/behavioral health. The BHIPC project focuses on improving workflows to increase early identification of patient mental health concerns by instituting infrastructure, algorithms, and staffing to ensure universal screening and follow-up planning targeted to mental/behavioral health. Specific project activities include integrating a Behavioral Health Intensivist (BHI) into primary care clinics, training Primary Care Providers and support staff in screening workflows and follow- up algorithm, universal annual depression screenings, linkage to the BHI as screening scores indicate, documentation of a follow-up plan, support from the bilingual Community Health Promotora and Clinical Psychologist as needed, ongoing process of program evaluation and quality improvement through data analysis and reporting. The project also includes a Behavioral Health Advisory Group consisting of nonprofit service providers, community coalitions, schools, and county service departments to ensure multiple points of entry into health care, provide coordinated care to community members and meet our rural community health needs specifically around linking residents to mental and behavioral health services. Expected outcomes include increased early identification of patients with mental/behavioral health needs, increased patient access to care, and improved mental/behavioral health. These outcomes reflect increased knowledge of mental health resources, reduced substance use, increased ability to self-regulate and apply healthy coping skills, and reduction in ED crisis evaluations. Additional impacts are increased collaborative care and enhanced wellbeing.

Louisiana

Teche Action Board, The

Grant Number:	G20RH33276			
Organization Name:	Teche Action Board (dba Teche Action Clinic)			
Organization Type:	Federally Qualified Health Center (FQHC)			
Organization Address:	1115 Weber St., Franklin, LA 70538			
Project Title:	Closing the Loop on Electronic Referrals: A Quality Improvement Initiative Using the Care			
Website:	www.tabhealth.org			
Project Contact:	**Name:**	Dr. Jennifer Fabre		
	Title:	CHIO, Director of Quality & Clinical Risk Management		
	Phone:	(337) 828-2550, ext. 2116		
	Email:	jfabre@tabhealth.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Teche Action Clinic @ Franklin		St. Mary Parish	FQHC
	Teche Action Clinic @ Morgan City		St. Mary Parish	FQHC
	Teche Action Clinic @ Pierre Part		Assumption Parish	FQHC
	Teche Action Clinic @ Thibodaux		Lafourche Parish	FQHC
	Teche Action Clinic @ Galliano		Lafourche Parish	FQHC
Target Population(s):	Medical patients 18 years of age and older treated at one of our 8 rural primary clinics who receive a referral for preventive or disease specific screening, and/ or specialty care services.			
Focus Area(s):	Care Coordination			
Evidenced-Based/ Promising Practice Model(s)	The MacColl Institute for Healthcare Innovation's Care Coordination Model (CCM)			
Health Information Technology System(s)	CompuGroup Medical Electronic Health Record and Practice Management System			
Project Goals & Objectives	**Goal** To Improve the quality of life in the rural communities we serve by implementing an organizational strategy to effectively manage patient outcomes with electronic referrals systematically (EMPOWERS) **Objectives** • Build upon the sound infrastructure developed in our pilot project and spread the evidence-based interventions adopted from the CCM • Proactive management of referrals by referral clerks conducting chart preps • Acquire and implement an electronic population health management platform • to customize reports and extract data to meet reporting requirements • Acquire and implement an E-faxing system **Goal** Implement evidence-based strategies to ensure organizational accountability and increase patient support to achieve high quality referrals			

	Objectives • Designated referral staff • Identify and assist with patient barriers • Primary care physician office scheduling appointment for patients • Use of E.H.R. to internally track and manage referrals • Clearly delineated referral process • Use of structure and free-text fields • Standardized processes
Project Description	Guided by the Care Coordination Model (CCM), this quality improvement initiative is building upon the sound referral infrastructure developed in our recent pilot project by spreading the adopted evidence-based interventions to achieve similar statistically significant improvements throughout our organization. In an effort to mitigate the barriers and inefficiencies of our current electronic health record, we acquiring and implementing an electronic population health management platform (PHM) and an e-faxing system. The PHM platform will allow us to develop customized reports and extract the necessary data needed to meet internal and mandatory reporting requirements. The e-fax will reduce waste and improve workflows. Expected outcomes include: organization-wide implementation of our redesigned referral process; a strengthened infrastructure and improved efficiency; the capacity to build electronic reports to capture data necessary to improve health outcomes and clinical quality measures; the ability to meet our mandatory reporting requirements; increased referral completion rates; increased rate of annual wellness, preventive, and disease specific screenings; decreased gaps in care; improved NQF, HEDIS, CQM, and UDS scores; and, improved internal integration of primary, dental, and behavioral health care services.

Colorado

Tri-County Health Network

Grant Number:	G20RH33258			
Organization Name:	Tri-County Health Network (TCHNetwork)			
Organization Type:	Network			
Organization Address:	238 E Colorado Ave., Telluride, CO 81435			
Project Title:	Chronic Disease Outreach Program			
Website:	www.tchnetwork.org			
Project Contact:	**Name:**	Lynn Borup		
	Title:	Executive Director		
	Phone:	(719) 480-3822		
	Email:	lynn@telluridefoundation.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	TCHNetwork		San Miguel, Ouray, Montrose	Network
	Basin Clinic		Montrose	Rural Health Clinic
	Telluride Regional Medical Center		San Miguel	Primary Care Clinic
	Uncompahgre Medical Center		San Miguel, Montrose	FQHC
Target Population(s):	The target population is those with diabetes, heart disease, and/or at-risk of diabetes or heart disease that access primary care at clinics in San Miguel, Ouray, or the West End of Montrose counties, Colorado.			
Focus Area(s):	• Cardiovascular Disease (includes Stroke, Hypertension) • Diabetes • Practice Facilitation/Improvement • Social Determinants of Health			
Evidenced-Based/ Promising Practice Model(s)	• Appreciative Inquiry Model • Chronic Care Model • Healthy Food Prescription Program • Motivational Interviewing • PDSA • Patient Health Navigator Model • Accountable Health Communities (AHC) Screening Tool			
Health Information Technology System(s)	• Amazing Charts • Chronic Disease Registry (developed internally) • CiviCases • E-Clinical Works • Quality Health Network (QHN) Health Information Exchange (HIE)			
Project Goals & Objectives	**Goal** Improve health outcomes for those diagnosed with or at-risk of diabetes or cardiovascular and contain costs by expanding access to evidence-based, coordinated health services in our rural, underserved 3-county region **Objectives**			

	• Work with 3 primary care clinics to incorporate a social determinant of health assessment and tobacco screening tool into their clinical workflow, as demonstrated by patient health navigators (PHNs) screening 85% of patients with DM or CVD who attend an appointment each project year • PHNs break down barriers to achieving health by providing targeted referrals to partner community-based organizations or interventions to 85% of patients with a chronic disease that screen positive for a social determinant of health need and/or tobacco use over the course of the grant period • Improve health outcomes for up to 430 residents who identify as food insecure by enrolling patients in the FoodRX Program. Assess effectiveness of intervention through reductions in HbA1c, BMI, and blood pressure for participants with levels outside of normal parameters • PHNs support patient chronic disease self-management by developing patient-centered care plans for patients with BMI outside of normal parameters. 10% of patients with BMI outside of normal parameters and a care plan reduce their BMI **Goal** Develop a culture of continuous quality improvement among TCHNetwork members **Objectives** • Convene a Clinical Subcommittee comprised of 7 members. The Subcommittee will meet at least 4 times per year with 75% attendance at each meeting • Support the use of a Chronic Disease Registry to track 5 biometric risk factors (LDL, A1c, BMI, tobacco, and blood pressure) and promote proactive patient health management for chronic disease patients at the 3 partner clinics
Project Description	TCHNetwork's Chronic Disease Outreach Project is working to develop a culture of quality improvement among TCHNetwork members and improve health outcomes by expanding access to evidence-based, coordinated health services in our rural, underserved 3-county region. To accomplish these goals, we will utilize the following strategies: • Integrating patient health navigators (PHNs) into clinics to provide ongoing care coordination and peer support to patients and develop care plans in collaboration with patients. PHNs promote chronic disease self-management; minimize medical expenses; and increase provider satisfaction. Developing a care plan in collaboration with a patient can lead to improvements in health outcomes and self-management of chronic conditions. When care planning is integrated into a clinical setting, it is even more effective. • Incorporating a social determinant of health and tobacco assessment tool into the clinical workflow and screening patients for social determinants and tobacco use. When a patient screens positive, the PHNs refer patients to relevant community-based and telehealth resources. Many patients in our region experience barriers to health outside of our clinics. Asking about and addressing social determinants of health can promote health equity, decrease unnecessary healthcare utilization, decrease rates of chronic conditions, and improve patient health. Similarly, tobacco use is a modifiable risk factor for chronic diseases and premature death. Enrolling patients who receive primary care at our clinics and identify as food insecure in the FoodRX Program. Many residents in our region experience food insecurity and do not purchase fresh fruits and vegetables due to perceived high costs and/or a lack of knowledge about how to cook with produce. The FoodRX Program breaks down these barriers by providing funding for people to shop for produce and having our PHN coach participants to shop for, cook with, and use fresh produce. • Convening a Clinical Subcommittee to adopt evidence-based guidelines and best practices across our region. This can help improve patient care and processes

	• Supporting use of a Chronic Disease Registry to track biometric risk factors and promote proactive health management for chronic disease patients. Our local providers have limited ability to collect and interpret data, and, without the Registry, would be unable to get a view of regional population health. On a patient level, the Registry helps for risk stratification and allows clinicians/PHNs to provide care tailored to each individual patient and conduct more efficient appointments.

Kansas

United Methodist Health Ministry Fund

Grant Number:	G20RH33280			
Organization Name:	United Methodist Health Ministry Fund - Kansas Frontier Community Health Improvement			
Organization Type:	Non-profit, rural network			
Organization Address:	100 E 1st Ave., Hutchinson, KS 67501			
Project Title:	Patient Experience in Rural Kansas			
Website:	N/A			
Project Contact:	**Name:**	Chrysanne Grund		
	Title:	Project Director		
	Phone:	(785) 821-1104		
	Email:	cgrund@mygchs.com		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Greeley County Health Services		Greeley, Wallace Counties	CAH
	Minneola Health Care		Clark, Ford, Meade Counties	CAH
	Kearny County Hospital		Kearny County	CAH
	Citizens Medical Center		Thomas County	Public hospital
	Phillips County Health Systems		Phillips County	CAH
	Sheridan County Health Systems		Sheridan County	CAH / FQHC
Target Population(s):	Patients diagnosed with type two diabetes in rural, Western Kansas			
Focus Area(s):	• Care Coordination • Diabetes • Health/Wellness Coaching • Value-Based Care			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care Improvement • Collaborative Care Model • Patient Centered Medical Home (PCMH) • Patient Experience Assessments • Plan Do Study Act (PDSA)			
Health Information Technology System(s)	• Aprima • Cerner • CPSI • GP Dynamics • Healthland Centriq			
Project Goals & Objectives	**Goal** Create Project Management Infrastructure **Objectives** • Convene Project Advisory group • Confirm project staff descriptions • Confirm project director • Identify Data Analyst and Clinician Champion • Identify Network Team members and local clinician champion			

	• Label patients in patient populations **Goal** Assess patient experience for patients with diabetes **Objectives** • Convene Patient Experience Groups • Provide Training to Network Members for Patient Experience • Determine specific quality goals to measure **Goal** Develop engagement strategies for patients with diabetes **Objectives** • Care Path Development • Outcomes Measurement **Goal** Create shared strategies for patient centered care with network partners **Objectives** • Query, define and manage reporting capabilities • Identify opportunities to provide better care for patients in all rural settings • Research appropriate value based reimbursement strategies **Goal** Improve health outcomes for patients with diabetes **Objectives** • Increase clinical resources available to patients. Increase community based education • Improve adherence for evidenced based recommendations
Project Description	The Patient Experience in Rural Kansas project proposes to help our rural communities and patient populations navigate the transition from quantity to quality through the goals and objectives of this project. The proposed partner activities will escalate learning and preparation among health systems all across western Kansas. The Kansas Frontier Community Health Improvement Network was founded with the idea of accelerating the quality based abilities of member organizations by shared learning strategies. The Patient Experience in Rural Kansas project combines the known elements of chronic disease care through care coordination and health coaching and will attempt to add value by gaining improved knowledge of our patient's goals. Measuring and engaging patients through Patient Experience will allow our organizations to better understand the needs, issues and objectives for our target patient population. This project is designed to partner patient-centered learning with chronic disease quality improvement strategies to produce better health outcomes for our patients. The target patient population includes rural adults 18 and over who have a diagnosis of diabetes type two and are not pregnant or terminally ill. The Kansas Frontier Community Health Improvement Network members will designate three communities as the first communities to begin Patient Experience evaluations. PERK project will utilize experience group methodology to gain a better understanding of the patient's needs. The Experience Group methodology stresses empathy as a bridge to achieving better health outcomes for people struggling with illness. Experience Group sessions use semi-structured conversations and exploratory research design methodology that allows participants to reveal what matters most to them as opposed to traditional focus groups that ask patients their opinions on ideas generated by clinical teams.

	Findings generated from Experience Group sessions allow clinical teams and others to "step into the shoes" of the patients. These sessions uncover key aspects of how people are affected by a medical condition. Conversation among a small group of people who share similar medical characteristics illuminates the daily unmet and unarticulated needs of patients, gaps in care, and challenges to achieving better health outcomes. During the initial patient experience work with consultants, network organizations will be training and learning how to implement patient experience groups as the project moves forward. Care coordination and health coaching will also continue among the full patient population. Once patient designated goals from the experience group are identified, the first phase organizations will begin to implement strategies to improve care, education and training options for patients. These goals will be quantified and measured. In year two, additional organizations will build their capacities for patient experience using the data and information gained from year one. Although we would anticipate that there may be different goals identified in different communities, we do believe there will also likely be enough overlap to provide insight and education to be shared among the group.

Wisconsin

Upland Hills Health, Inc.

Grant Number:	G20RH33281			
Organization Name:	Upland Hills Health (UHH)			
Organization Type:	Nonprofit hospital			
Organization Address:	800 Compassion Way, Dodgeville, WI 53533			
Project Title:	Upland Hills Health Transitional Care Program			
Website:	www.uplandhillshealth.org			
Project Contact:	**Name:**	Amy Haesler		
	Title:	Transitional Care Project Director		
	Phone:	(608) 930-7200 ext. 3300		
	Email:	haeslera@uplandhillshealth.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Upland Hills Health (UHH)		Iowa, Grant, Lafayette, Sauk, Dane, Richland	Hospital
	Mineral Point Medical Center of UHH		Iowa, Grant, Lafayette	Clinic
	Dodgeville Medical Center of UHH		Iowa, Grant, Lafayette	Clinic
	Upland Hills Health Clinic - Highland		Iowa, Grant	Clinic
	Upland Hills Health Clinic - Montfort		Iowa, Grant	Clinic
	Upland Hills Health Clinic - Barneveld		Iowa, Dane	Clinic
	Upland Hills Health Clinic - Mount Horeb		Iowa, Dane	Clinic
	Upland Hills Health Clinic - Spring Green		Iowa, Sauk, Richland	Clinic
Target Population(s):	Patients who seek primary care at one of the seven UHH clinics who have a recent discharge from the Medical/ Surgical Unit, or Intensive Care Unit at UHH with a primary or secondary admission diagnosis centered on exacerbations of chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), or diabetes.			
Focus Area(s):	• Care Coordination • Cardiovascular Disease (includes Stroke, Hypertension) • Chronic Obstructive Pulmonary Disease • Diabetes			
Evidenced-Based/ Promising Practice Model(s)	• FOCUS Plan-Do-Check-Act (PDCA) • Lean • Relational Coordination Theory • Six Sigma			
Health Information Technology System(s)	Epic E.H.R			
Project Goals & Objectives	**Goal** Establish a Transitional Care Team (TCT) and create and institute its charter **Objectives** • Hire and onboard 0.8 FTE transitional care coordinator and one 0.8 FTE project director to oversee grant funds and objectives, as well as to serve as a second care coordinator when appropriate			

- Establish a TCT that meets monthly to review individualized plans of care and current caseloads
- Provide a written update to the UHH Board of Trustees annually
- Provide quarterly updates of the transitional care program to the UHH Quality Council

Goal
Provide ongoing and evidence based medical direction to support and grow transitional care opportunities and initiatives

Objectives

- Hire one 0.3 FTE physician to provide medical direction and supervision of protocol implementation and patient outcomes
- Using best available research, create protocols and pathways for patients with primary or secondary admissions diagnosis of diabetes, CHF, and COPD
- Integrate the Living Well with Diabetes into transitional care for those with diabetes
- Designate and train individual clinical liaisons to function as ambassadors of the transitional care program
- Train and mentor clinic staff to provide coordinated transitional care

Goal
Develop transitional care relationships with all regional tertiary healthcare institutions where Upland Hills Health (UHH) patients and Iowa County residents are hospitalized acutely for primary and secondary diagnosis of COPD, CHF and/or diabetes

Objectives

- Develop education curriculum to generate awareness of the transitional care program
- Develop a PowerPoint presentation to share with the local service clubs, and civic and church groups

Goal
Develop a sustainability plan to ensure that the Patient Centered Medical Home Model and related programs continue beyond grant period

Objectives

- Beginning phases: explore funding streams that can be incorporated into model to ensure its ongoing support
- Work with civic, social and faith-based groups to develop a system of volunteers to support various program components
- Expand the model to include all patients discharged from Upland Hills Health and tertiary care facilities who are not already receiving transitional care management

Goal
Develop, implement, and refine the program evaluation program and format for reporting successes to share with additional providers

Objectives

- Complete and submit all required grant evaluations according to established timeframe
- Publicize results to all affiliated clinics/ the SSM Health System

Goal
Advance and communicate new knowledge through research and participate in scholarly activities

Objectives

- Publish outcomes in regional or national journals or present outcomes and approach at regional or national conferences
- Collaborate with Rural Wisconsin Health Cooperative to disseminate successes and

	failures to statewide rural health partners
Project Description	A well-established network of Iowa County Wisconsin health care providers/service agencies including Upland Hills Health Hospital, Upland Hills Health Clinics, and the Aging and Disability Resource Center of Southwest Wisconsin will develop a seamless, transitional care program for patients who have a recent Upland Hills Health hospital discharge of Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and/or diabetes. Upland Hills Health Hospital and Clinics will partner with the Aging and Disability Resource Center to incorporate evidence based programs, such as Living Well with Diabetes, into their transitional care program. During the first year of the program, emphasis will be placed on facilitating the development and implementation of the transitional care program, as well as coordination of care for patients who are discharged from Upland Hills Health hospital with a primary and/or secondary diagnosis of COPD, CHF, and/or diabetes. During the second year, the program will be expanded to patients who are transferred from Upland Hills Health to the tertiary facilities: UW Health University Hospital, UnityPoint Health - Meriter, and SSM Health St. Mary's Hospital. In the third year, the organization will expand the transitional care program to include all Upland Hills Health discharged hospital patients.

Michigan

Upper Peninsula Health Care Solutions, Inc.

Grant Number:	G20RH33277			
Organization Name:	Upper Peninsula Health Care Solutions (UPHCS), Inc.			
Organization Type:	Nonprofit Organization			
Organization Address:	853 W Washington St., Marquette, MI 49855			
Project Title:	UPlift Collaborative Care Program			
Website:	www.uphcs.org			
Project Contact:	**Name:**	Janey Joffee		
	Title:	Assistant Director		
	Phone:	(906) 226-4286		
	Email:	jjoffee@uphcs.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Schoolcraft Rural Health Clinic		Alger, Luce, Mackinac, Schoolcraft	Rural Health Clinic
	Gibson Family Health Clinic		Alger, Luce, Mackinac, Schoolcraft	Rural Health Clinic
Target Population(s):	Patients receiving care at project service sites who: • Have Medicaid, Medicare, or dual eligible insurance type • Have comorbid chronic disease diagnoses and mental/behavioral health diagnoses • Are residents of the Michigan Counties of Alger, Luce, Mackinac, or Schoolcraft There are over 700 patients that meet these criteria for inclusion			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Care Coordination • Patient Centered Medical Home Model (PCMH) • Workforce Development/Training • General Chronic Disease Management			
Evidenced-Based/ Promising Practice Model(s)	• Collaborative Care Model • Lean • Plan Do Study Act (PDSA)			
Health Information Technology System(s)	• Advancing Integrated Mental Health Solutions (AIMS) Caseload Tracker • Cerner • Cotiviti Provider Intelligence • eClinicalWorks • Upper Peninsula Health Information Exchange			
Project Goals & Objectives	**Goal** Improve health outcomes by implementing the Collaborative Care Model **Objectives** • Increase number of referrals from primary care to Behavioral Health Care teams • Increase number of patients enrolled in integrated Behavioral Health • Increase engagement among enrolled patients • Improve patient experience among enrolled patients • Improve provider experience at participating clinics • Increase the percent of patients screened for depression and, if positive, for whom a			

	follow-up plan is documented • Decrease the percent of adult diabetic patients who have hemoglobin A1c>9.0% during the past quarter • Increase the percent of adult patients for whom BMI is documented and, if outside of normal parameters, for whom a follow-up plan is documented • Increase the percent of patients with hypertension whose blood pressure was adequately controlled in the past calendar quarter • Increase the percent of adolescent and adult patients with a diagnosis of major depression or dysthymia who have completed PHQ-9 during the four-month period in which there was a depression encounter • Increase the percent of patients with a diagnosis of major depression or dysthymia who reach remission within 12 months of diagnosis • Increase the number of adult patients with a diagnosis of major depression disorder, for whom a suicide risk assessment is completed during the visit in which a new diagnosis or recurrent episode was identified • Increase the percent of patients with depression or bipolar disorder diagnoses, who are appraised for alcohol or chemical substance use • Establish and train BH care teams at each participating clinic • Establish full patient panel at each participating clinic • Use Lean to improve workflows to accommodate the Collaborative Care Model • Use ECHO cased-based learning to help develop the workforce at participating clinics in behavioral health care integration using the Collaborative Care Model
Project Description	UPHCS has enacted memoranda of understanding with two care delivery partners who are engaged in the UPlift program: Gibson Family Health Clinic in Newberry, MI and Schoolcraft Rural Health Clinic in Manistique, MI. Both sites are federally designated Rural Health Clinics. The project is integrating behavioral health services into these participating primary care clinics using the evidence-based Collaborative Care Model (CoCM) of behavioral health integration. Primary activities include: establishing behavioral health care teams at each participating clinic, developing clinic workflows using Lean methodology, workforce development through online training and ECHO case-based learning opportunities, and continuous quality improvement through the periodic measurement of patient health outcomes and the acquisition of patient and provider feedback. The project's Behavioral Health (BH) Care Teams consist of primary care providers, licensed master social workers (LMSWs), care managers/coordinators, non-physician care providers, and other personnel who are involved in the direct care of patients (i.e. psychotherapists, community health workers, patient navigators etc.). CoCM requires a team of professionals with complementary skills to work together to care for patients with common mental health conditions. It involves a shift in how medicine is practiced and the creation of entirely new workflows involving a specially trained BH care managers who coordinate the overall efforts of the group to ensure effective communication among team members and a psychiatric consultant who supports the BH Care Team in treating patients with behavioral health diagnoses. The UPLift Program is guided by the Rural Services Integration Toolkit from the Rural Health Information hub and uses Plan-Do-Study-Act (PDSA) cycles to test changes to workflows. CoCM also requires that BH Care Managers obtain special training in behavioral health integration. Participating clinics have access to web-based training provided by the University of Michigan School of Social Work. UPlift Program staff members are conducting work sessions at participating clinics to provide an overview of CoCM, an introduction to Lean and Kata Storyboards (tools to help develop the skills to make small incremental changes regularly), and review American Medical Association practice improvement trainings. In addition, clinic staff are undergoing documentation and coding training and in- depth coaching and mentoring via multiple series of Extension for Community Health Outcomes (ECHO), case-based learning sessions with BH integration experts at the University of Michigan School of Medicine.

	The UPlift program's design is consistent with evidence indicating that integrating behavioral health with primary care improves health outcomes for patients with comorbid chronic disease and behavioral health diagnoses. Periodic measurement of patient health outcomes using health information technology and feedback from both patients and providers guides process improvement efforts.

Washington

Washington Rural Health Collaborative

Grant Number:	G20RH33285			
Organization Name:	Washington Rural Health Collaborative			
Organization Type:	Non-Profit			
Organization Address:	114 W Maple St., Mccleary, WA 98557			
Project Title:	Along the Journey to Excellence			
Website:	www.washingtonruralhealth.org			
Project Contact:	**Name:**	Heather Muller		
	Title:	Project Director		
	Phone:	(360) 726-2333		
	Email:	heather@washingtonruralhealth.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Summit Pacific Medical Center		Grays Harbor	Critical Access Hospital (CAH)
	Klickitat Valley Health		Klickitat	CAH
	Skyline Health		Klickitat	CAH
	Newport Hospital and Health Services		Pend Orelle	CAH
	Arbor Health		Lewis	CAH
	Ocean Beach Hospital		Pacific	CAH
	Snoqualmie Valley Hospital		King	CAH
	Forks Community Hospital		Clallam	CAH
	Mason General Hospital		Mason	CAH
	Prosser Memorial Health		Benton	CAH
	Willapa Harbor Hospital		Pacific	CAH
Target Population(s):	Our target population includes patients in rural areas in need of behavioral health services integrated with primary care services. The primary individuals of interest are those within the 45-64 and 65+ age cohorts with diabetes or hypertension. The patient panel to be measured for the grant will be patients serviced by rural health clinics, with an emphasis on those diagnosed with depression, uncontrolled hypertension and/or diabetes.			
Focus Area(s):	• Behavioral/Mental Health Services (includes Integration into Primary Care) • Care Coordination • Diabetes • Telehealth/Telemedicine/Telemonitoring • Cardiovascular disease			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care Model • Collaborative Care Model			
Health Information Technology System(s)	• Cerner Community Works • CPSI • Epic • Epic/Lawson			

	• Healthland • Meditech 6.1 • Meditech Magic 5.67
Project Goals & Objectives	**Goal** Improve access to behavioral health care for rural populations **Objectives** • Implement process for behavioral health screenings and treatment • Implement telehealth/telepsychiatry where needed • Implement billing processes and procedures for behavioral health integration • Begin implementation of Care Coordination program
Project Description	This grant project seeks to build out quality improvement efforts in a step-by-step fashion in several small rural health systems in Washington State. The primary target area for quality improvement efforts is enhanced behavioral health access, followed by chronic disease management and care coordination. Specifically, the intent is to better and more systematically provide depression screening, treatment and care coordination support for patients with chronic disease in order to increase patient engagement, reduce costs and improve patient outcomes. The service area population for this grant includes 11 small rural communities. Together their population is just over 220,000 and is expected to grow another 5% by 2023.The grant applicant is the Washington Rural Health Collaborative (WRHC), an existing, mature and robust rural network consisting of 15 rural public hospital districts and their respective health care facilities (hospitals and clinics), providers and programs. Eleven of the 15 Network members will be active participants in this grant, with the goal of incorporating the other members over time. WRHC's quality improvement efforts in this grant utilize components of two evidence-based models, the Chronic Care Model and the Collaborative Care Model. More specifically, the project focuses on quality improvement using care coordination and/or telemedicine. Expected outcomes for this project include the direct improvement of specific identified clinical and process measures for the patient panel related to both chronic disease and depression. Consistent with value-based care transformation principles, other expected outcomes include increased patient satisfaction, reduced provider burn-out, and decreased total costs of care due to the reduced number of visits for other than scheduled follow-up. Importantly, the learnings from this grant will also help to assure Network member relevance in the landscape of Washington's robust value-based care transformation efforts.

New York

Westchester-Ellenville Hospital, Inc.

Grant Number:	HRSA-19-018			
Organization Name:	Westchester Ellenville Hospital			
Organization Type:	Critical Access Hospital (CAH)			
Organization Address:	10 Healthy Way, Ellenville, NY 12428			
Project Title:	Small Health Care Provider Quality Improvement Program			
Website:	www.ellenvilleregional.org			
Project Contact:	**Name:**	Victoria Reid		
	Title:	Executive Director, Rural Health Network		
	Phone:	(845) 647-6400, ext. 326		
	Email:	vreid@eryny.org		
Project Service Sites:	**Site Name**		**County/Counties Served**	**Site Type**
	Westchester Ellenville Hospital		Ulster County	Critical Access Hospital
Target Population(s):	The target population to be served by this project is individuals between the age of 30 and 85 who have one of more of the defined risk criteria. Risk criteria includes a body mass index (BMI) that is considered obese, current tobacco use (or having quit within the past 12 months), hypertension or currently taking medication for hypertension, diabetes or a pre-diabetic A1c score, or are indicted to be at increased risk of stroke or heart attack by the Centers of Disease Control and Prevention (CDC) Heart Age Calculator.			
Focus Area(s):	• Cardiovascular Disease (includes Stroke, Hypertension) • Obesity • Health/Wellness Coaching • Community Health Workers			
Evidenced-Based/ Promising Practice Model(s)	• Chronic Care Model (CCM) • Community Health Worker Model			
Health Information Technology System(s)	• Athena • Pacs • Scotts Care			
Project Goals & Objectives	**Goal** The overall goal of the project is to use evidence-based preventive screenings, and clinically led lifestyle change interventions, including nutrition and physical therapy, to reduce the 10-year cardiovascular risk among the target population of at-risk members of the Wawarsing community. **Objectives** • During all funding years, continue the Ellenville Regional Rural Health Network Healthy Hearts Consortium to lead the Cardiac Wellness program. • Over the project period, 300 community residents who meet criteria for cardiovascular risk screening will be referred for preventive screening via electronic referrals from the Emergency Department and Institute for Family Health, referrals from other service providers, and community events. • Over the project period, at least 75 at-risk community residents will receive a Carotid Screening. • Over the project period, at least 75 at-risk community residents will receive a			

	Calcium Scoring Test. • Over the project period, at least 100 unduplicated at-risk community residents will receive a minimum of one individual consultation with the Nutritionist. • Over the course of the project period at least 90 unduplicated individuals will participate in the dietary support group. • Over the project period, enroll at least 75 at-risk community residents into the four-month Cardiac Wellness Program led by the Physical Therapy Department. • Over the project period, engage an additional 200-300 community residents in ongoing education programming, resulting in improved knowledge and behavior regarding cardiovascular health. • Leverage the combined strengths of the consortium partners to achieve permanent, demonstrable improvements in clinical service delivery and availability of community resources that support population cardiovascular health.
Project Description	Looking specifically at the Cardiac Wellness project from the perspective of the CCM and these six basic components, the project will address cardiovascular disease (CVD) prevention within the targeted population (individuals between the ages of 30 and 85) in the Town of Warwarsing who exhibit one or more of the defined risk criteria for CVD. Hiring a Community Health Worker (CHW) for this project will enhance the health care delivery system because this healthcare professional's work will be focused on assisting the target population. The CHW will help the targeted patients secure a screening at Ellenville Regional Hospital if they are shown to have a risk factor for CVD. The CHW will then help to ensure that screening results get to the patient's primary care provider (PCP) for follow-up and additional preventive care. Thus, the CHW will also help to provide better linkages between patients and their primary care providers which can result in better CVD health outcomes for those patients. The CHW will also connect the targeted patients to dietary counseling and a physical training program for cardiac wellness. These are both programs which can improve cardiovascular outcomes of patients and which provide patients with support for better self-management of their health. Measurable outcomes associated with the CHW will be the: • number of patients referred for CVD screening • number of patients who have a Coronary Artery Calcium Scoring (CAC) and a Carotid Screening • number of patients referred to primary care providers for follow-up preventive care • number of patients referred to the Cardiac Wellness program and to dietary counseling • number of community members educated at health events about CVD prevention and availability of screenings. Clearly, the focus of the CHW also ties in with the Community Linkages component of the Chronic Care Model and as described, will provide another measurable outcome for this project. The Cardiac Wellness project will also allow providers at Ellenville Regional Hospital and the Ellenville Family Health Center to utilize their clinical information systems to determine which of their patients are in the cohort and use that data to better inform the care that they provide these patients. Therefore, this component of the CCM also can help to improve cardiovascular outcomes for the targeted patients. The number of patients in the cohort that these providers care for will provide another measurable outcome for the project.

Glossary of Acronyms

ACO	Accountable Care Organization
CAH	Critical Access Hospital
CCM	Chronic Care Model or Chronic Care Management
CHC	Community Health Center
CHF	Congestive Heart Failure
CHW	Community Health Worker
CMS	Centers for Medicare & Medicaid Services (CMS)
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
EHR/EMR	Electronic Health Record/Electronic Medical Record
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
MI	Motivational Interviewing
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PDSA	Plan-Do-Study-Act Quality Improvement Model
PHQ-9	Patient Health Questionnaire-9
QI	Quality Improvement
RHC	Rural Health Clinic
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Determinants of Health
TCM	Transitional Care Management
VBC/VBP	Value Based Care/Value Based Payment

HRSA
Health Resources & Services Administration

Health Resources and Services Administration
5600 Fishers Lane, Rockville, MD 20857
301-443-0835
www.hrsa.gov